ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4567 HHES HB 440 (FILE 2) - HB 440 (FILE 3) 139

ALASKA LEGISLATURE COMMITTEE FILES 1987-
4567 HHES HB 440 (FILE 2) - HB 440 (

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FILE 3)

8672

139

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 9981
465-3759

March 28, 1988

Dr. Robert G. Thompson
Anchorage Obstetrics & Gynecology
Anchorage, Alaska 99508

Dear Dr. Thompson:

Thank your for your letter in support of HB 440, which would mandate coverage for treatment of infertility. We understand the importance and desire for treatment of the condition of infertility. The House HESS Committee, which we co-chair, is planning to hold a hearing on this bill on Thursday, April 7, and may continue hearing it on Friday. We expect that hearing to be teleconferenced and your testimony would be welcomed. HB 440 would mandate coverage for infertility treatment be included if pregnancy benefits are provided. At this time Alaska does not mandate maternity coverage. Testimony in a previous committee of referral indicated that passage of HB 440 might reduce the number of employers who cover maternity services. Six states have some form of mandated coverage for treatment of infertility, but they all have previously mandated maternity coverage.

We appreciate you taking the time to contact us and we will keep your concerns in mind. Please continue to stay in touch.

Sincerely,

Rep. Niilo Koponen, Co-Chair

Rep. Johnny Ellis, Co-Chair

NK/JE/ljm

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

December 24, 1987

MEMORANDUM

TO: Representative Curt Menard

FROM: Sandi Depue *Sandi*
Administrative Officer

RE: Proposed Massachusetts Health Coverage Law

You requested copies of the proposed health coverage law currently before the Massachusetts legislature. You also wanted pertinent back-up information.

Attached is a letter from Mr. Erik Canada, Research Intern, Massachusetts Legislative Service Bureau, forwarding the requested information.

If this agency can be of further service, please let me know.

Attachments

General Court Massachusetts
LEGISLATIVE SERVICE BUREAU
STATE HOUSE, BOSTON 02133

December 4, 1987

DR. [illegible]

Sandy Depue
House Research Agency
[illegible] Capitol, P.O. Box Y
[illegible] Alaska 99811-3100

Dear Ms. Depue:

In response to your recent request concerning legislation relative to Universal Health in Massachusetts, please find enclosed the following:

(1) House Bill Number 6000: A Message from His Excellency, the Governor, Recommending Legislation Relative to Making Health Care Available to Citizens of the Commonwealth of Massachusetts, and to Make Certain Other Improvements in the Health Care Delivery System of the Commonwealth.

(2) House Bill Nimber 6068: A Bill to Make Health Care Available to Citizens of the Commonwealth and Make Certain Improvements in the Health Care Delivery System in the Commonwealth.

[illegible]: A Bill Relative to Interim Hospital [illegible]harge.

[illegible] Status of H6000, H6068, and H6096.

[illegible]on Universal Health Care in Massachu[illegible] Boston Globe.

I hope that you find this information to be helpful. If I can be of any further assist[illegible], please do not hesitate to contact me again at (617)-722-2[illegible].

Sincerely,

Erik M. Canada
Research Intern
Supervisor: John M. Horgan
Senior Research Analyst

HOUSE . . . . . No. 6096

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, October 13, 1987.

The committee on Ways and Means to whom was recommitted the Bill to make health care available to citizens of the Commonwealth, and make certain other improvements in the health care delivery system of the Commonwealth (House, No. 6068, amended), reports (in part) recommending that the accompanying bill (House, No. 6096) ought to pass.

For the committee,

RICHARD A. VOKE.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Seven.

AN ACT RELATIVE TO INTERIM HOSPITAL RATES OF PAYMENT AND CHARGES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Notwithstanding the provisions of any other special or general law to the contrary, all rates and charges established for acute care hospitals pursuant to Chapter 6A of the Massachusetts General Laws and in effect on August 1, 1987 shall remain in effect during the period between October 1, 1987 and March 31, 1988, except as modified pursuant to paragraph 2 of this act.

SECTION 2. Notwithstanding the provisions of any other special or general law to the contrary, during the period between October 1, 1987 and March 31, 1988, the rate setting commission shall possess all powers, rights, obligations, and responsibilities possessed by said commission on August 1, 1987 along with the authority to issue and enforce regulations required to preserve the system for providing acute care hospital reimbursement in Massachusetts in a form identical to that existing on August 1, 1987.

SECTION 3. Notwithstanding the provisions of any other special or general law to the contrary, each and every entity charged with a responsibility under law on August 1, 1987 for providing or financing otherwise uncompensated care as described in the Massachusetts General Laws Chapter 6A, Section 75 shall bear that same responsibility during the period between October 1, 1987 and March 31, 1988.

SECTION 4. Notwithstanding the provisions of any other special or general law to the contrary, all parties bound on August 1, 1987 by the provisions of Hospital Agreement 30, the successor

agreement to Hospital Agr
Section 31, shall remain
agreement until March 31,

SECTION 5. The provi
October 1, 1987.

SECTION 6. The prov
operative on March 31, 19

agreement to Hospital Agreement 29 as defined in Chapter 6A, Section 31, shall remain bound by the provisions of that agreement until March 31, 1988.

SECTION 5. The provisions of this act shall be effective as of October 1, 1987.

SECTION 6. The provisions of this act shall cease to be operative on March 31, 1988.

Governor's Summary

SECTION-BY-SECTION SUMMARY

SECTION 1: Establishes new chapter that will require employers to enroll all employees and dependents in health benefit plans after an ERISA exemption is obtained. Mandatory benefits are defined in Section 5. Permissible exceptions to covering employees' dependents are defined in Section 6.

SECTION 2: If by January 1, 1989, the Commonwealth has not obtained an ERISA exemption from the federal government, employers who do not offer a health plan equivalent to the Kennedy bill plus mandated Massachusetts benefits will be required to contribute to the Massachusetts Health Partnership Trust fund to finance the state's purchase of health coverage for their employees.

SECTION 3: Amends Section 46 of Chapter 151A by adding words "Massachusetts Health Partnership."

SECTION 4: Mandates a study by the rate review board to evaluate comparative merits of administration of health insurance contributions by the Department of Employment and Security and the Department of Revenue, to be submitted to the Governor by October 31, 1988.

SECTION 5: Mandates a study by the commissioner of administration to establish guidelines for purposes of reimbursing cities and towns for reasonable costs incurred because of this Act.

SECTION 6: Establishes effective dates of SECTION 2 through SECTION 5.

SECTION 7: Amends Section 16 of Chapter 6A by adding "and the Massachusetts Health Partnership."

SECTION 8: Establishes new chapter defining the provisions of the department entitled "Massachusetts Health Partnership", which shall make health benefit programs available to residents of the Commonwealth. The Partnership has the authority to purchase <u>all</u> state-managed health care (Medicaid, state employees, uninsured, etc.), manage the acute hospital free care/bad debt pool, manage Medicaid and Group Health Insurance contracting and assume health responsibilities

from the Rate Setting Commission. This chapter also authorizes the Partnership to: include certain mandated services in health benefit plans; establish a program of medical care and assistance for certain disabled individuals; and establish and administer a re-employment training incentive program to provide training in health care professions for those employees who are or might be affected by hospital layoff, closure or reduction in hours.

SECTION 9: Establishes effective date of October 1, 1987 for start of the Massachusetts Health Partnership.

SECTION 10A: Authorizes Health Partnership assumption of all unexpended funds appropriated in FY88 for state agencies that will become part of the Health Partnership.

SECTION 10B: Amends Section 2(b) of Chapter 18 by adding words "financial assistance for health services and medical care."

SECTION 10C: Substitutes "Massachusetts Health Partnership" for the "Department of Public Welfare" in Section 2(b) of Chapter 118E.

SECTION 11A: Defines method of reimbursing acute hospitals for the four-year period beginning on October 1, 1987. In the first year, increased charges would be limited to inflation plus a 2% adjustment applied to the non-Medicare base. $60 million in allowances for extraordinary labor cost increases are also included in the proposed legislation. As of October 1, 1988, a negotiated rate between the purchaser and provider of hospital services is the preferred method of setting hospital rates. The Commissioner of the Health Partnership will have the authority to promulgate regulations to govern hospital rates from October 1, 1988 to September 30, 1991.

SECTION 11B: Grants authority to the Health Partnership to assume health insurance responsibility for Medex and nongroup populations if and when Blue Cross/Blue Shield ceases to serve those groups.

SECTION 11C: Repeals Sections 37 through 47 of Chapter 6A, which, among other things, authorize the Rate Setting Commission to regulate rates charged by non-acute hospitals.

SECTION 12: Eliminates Determination of Need (DoN) for acute care hospital projects under $10 million as well as for conversions of acute care services to skilled nursing, acute psychiatric, rehabilitation, and substance abuse services costing less than $600,000. New technology, innovative services, ambulatory surgery, and long-term care still require a DoN.

SECTION 13: Amends DoN law to account for possible successor agencies to health system agencies.

SECTION 14: Removes clinical laboratories from DoN.

SECTION 15: Establishes a review board composed of the secretaries of Human Services, Administration and Finance and the Commissioner of the Massachusetts Health Partnership to permit review of Public Health Council DoN decisions that may have a significant impact on health care costs. The review board decision overrides the Public Health Council decision in instances where differences occur.

SECTION 16 through SECTION 20: Requires all publicly and privately owned and operated facilities and programs to notify the Department of Public Health of any acquisition of new medical technology or a health care facility. Failure to provide such a notice shall result in a fine.

SECTION 21: Authorizes the establishment of rates of payment for Title XIX (Medicaid) services provided by acute and non-acute hospitals consistent where applicable with the principles of reimbursement under Title XVIII and Title XIX of the Social Security Act.

SECTION 22: Delineates the conditions for provider participation in the Medicaid program.

SECTION 23: Authorizes the Department of Public Health to permit the return of certain prescription drugs to a pharmacy for resale.

SECTION 24 through SECTION 27: Empowers the Department of Public Welfare to impose administrative fines against providers, to recover interest from providers for overpayments and to extend amnesty for such fines and interest to encourage voluntary payment.

SECTION 28: Amends statutory language regarding standards to be applied on provider rate appeals.

SECTION 29: Requires a nonprofit hospital service corporation to make available supplemental group coverage to Medicare to a group of Medicaid recipients designated by the Department of Public Welfare.

SECTION 30: Requires insurers who offer policies of accident and sickness insurance to make available supplemental group coverage to Medicare to a group of Medicaid recipients designated by the Department of Public Welfare.

SECTION 31: Requires health insurers and Health Maintenance Organizations (HMOs) to match their subscriber and beneficiary files with Medicaid eligibility files, in an effort to ensure that Medicaid is the payer of last resort.

SECTION 32 and SECTION 33: Requires attorneys to notify the Department of Public Welfare whenever filing a lawsuit or insurance claim on behalf of a recipient to recover monies due as a result of an accident, illness, or other loss, and simplifies procedures for perfecting the Welfare Department's liens in such cases.

SECTION 34: Allows the Department of Public Welfare to require a nominal copayment or deductible for medical services.

SECTION 35 through SECTION 39: Tightens rules for transfer of assets in determining Medicaid eligibility.

SECTION 40 and SECTION 41: These sections make the Department of Public Welfare a party in interest in guardianship proceedings involving individuals entitled to benefits from the Department, and require guardians and conservators to notify the Department of their appointment or any proceedings affecting the estate of the ward.

SECTION 42 and SECTION 43: Decreases the rate of interest payable in civil actions.

SECTION 61: Allows an employee or Division of Labor and Industries to complain and seek damages when an employer fails to notify the employee of the availability of extended group health and medical benefits.

SECTION 62: and SECTION 63: Expands the definition of entities subject to the unfair and deceptive insurance practices statute to include HMOs and PPOs.

SECTION 64: Subjects HMOs to the insurance laws applicable to mergers and acquisitions.

SECTION 65: Subjects health care facility mergers and acquisitions to Department of Public Health approval. Such approval will require analysis of the proposed transaction on access to health care, quality, cost and competition.

SECTION 66: Allows the Insurance Commissioner to consider local and regional competitive impact of proposed mergers and acquistions.

SECTION 67, 68, 70, 71: Permits Blue Shield to create a PPO comparable to commercial insurers and subject to Chapter 176I.

SECTION 69: Gives Commissioner of Insurance power to disapprove Blue Shield rules and regulations.

SECTION 72: Codifies provider rights to receive from Blue Shield full and fair explanation of payment decisions and establishes appeal mechanism. Also increases information on Blue Shield payment system available to providers.

SECTION 73: Allows providers to file class action suits against Blue Shield for unresolved disputes that do not involve compensation.

SECTION 74: Permits Blue Cross to create a PPO comparable to commercial insurers and subject to Chapter 176I.

SECTION 75: Establishes a process for determining whether and on which terms and conditions Blue Cross/Blue Shield should be reorganized into a commercial insurer. This process includes: (1) a detailed study of Blue Cross/Blue Shield and the relevant market; (2) a public hearing on reorganization issues; (3) a final decision to be made and terms and conditions imposed by a 5-member governmental panel. A major factor in the reorganization decision will be the continued availability of affordable nongroup and Medicare supplemental insurance.

SECTION 76 through SECTION 78: Directs the Commissioner of Insurance to promulgate regulations governing the scheduling of rate filings and the standards governing the rates of nongroup insurance except Medex, and to promulgate cost containment regulations.

SECTION 79: Creates a Bureau of Hospital and Medical Service Corporation Analysis within the Division of Insurance to advise the commissioner regarding requests for rates for nongroup contracts. Allows an assessment to be levied on Blue Cross/Blue Shield to pay for the Bureau, which is capped at $350,000.

SECTION 80 through SECTION 82: Allows Blue Cross/Blue Shield to seek increases in Medex rates based on changes in Medicare deductibles and coverages. Allows persons enrolled in HMO medicare plans to switch to Medex if the HMO cancels the plan.

SECTION 83: Standardizes the open enrollment period for HMOs, and prohibits HMOs from imposing "preexisting condition" clauses on nongroup contracts.

SECTION 84: Changes the hospital and clinic licensing law to allow the Department of Public Health to place prescribed quality and access conditions on licenses as well as conduct a public hearing on licensure applications upon request by fifty or more interested persons. The applicant must publish notice of the application.

SECTION 85: Establishes a grievance procedure for a licensee who has had a license conditioned, denied or revoked.

SECTION 86. Provides for a Department of Public Health unit to develop quality indicators and further provides for 90-day written notices of discontinued hospital services and operations and 30-day written notices of reduction in workforces or scheduled hours.

SECTION 87: Strengthens the Department of Public Health's license by service authority.

SECTION 88 through SECTION 90: Extends authority of advocacy office to investigate complaints based on discrimination from all federal and state payment sources and extends to it general investigatory powers held by survey branch of the Department of Public Health.

SECTION 91 and SECTION 92: Mandates hospitals to post the patients' rights statute and preserves those rights in law for the patients.

SECTION 93: Gives the Department of Public Health authority to issue orders to correct deficiencies, impose civil administrative fines for failure to correct deficiencies and to issue cease and desist orders to hospitals or clinics.

SECTION 94: Extends the Department of Public Health's authority to enforce the patients' rights statute into Health Maintenance Organizations.

SECTION 95: Authorizes a study on the nurses' shortage in acute care hospitals.

SECTION 96: Requires colleges and universities to offer health insurance to full time students.

SECTION 97 through SECTION 108: Improves protection of children and custodial parents' access to health insurance by tightening notice and reimbursement practices in a divorce situation.

SECTION 109 and SECTION 110 : Establishes standard clauses of severability and limitations on expenditures based on appropriated funds.

Section 111: Outlines budget request for the Massachusetts Health Partnership.

HIGHLIGHTS OF HOUSE WAYS AND MEANS HEALTH CARE BILL

I. HEALTH BENEFITS

Endorses and expands upon the Governor's proposal by:

A. Mandating insurers to provide Preventive Health Care to children from birth to age 6

B. Prohibits deductibles and co-insurance for low-income pregnant women

C. Allows low-income elders opportunity to purchase coverage from the state

D. Establishes a program of medical assistance ($5.0m) for disabled children not eligible for Medicaid

E. Makes new health agency the insurer of last resort for those with pre-existing conditions

F. Proposes expansion of Medicaid benefits to elderly, disabled, pregnant women, and severely disabled children

G. Makes Healthy Start part of the General Laws

H. Mandates Pilot Program for severely disabled children

II. ESTABLISHES NEW DEPARTMENT OF MEDICAL SERVICES

A. New Agency will administer Medicaid, GIC, and plan for uninsured

B. Makes any transfer of employees consistent with existing Civil Service and Collective Bargaining laws and subject to budget cycle

C. Rate Setting Commission will remain an Independent Agency thereby protecting against purchaser and provider conflicts

D. HW&M's eliminates all administrative funding for New Agency. Agency can only use existing Medicaid and GIC administrative funds. Any additional funds will have to be directly requested by the Administration through budgetary process

E. HW&M's allows DMS to contract through negotiation with providers

F. HW&M's Deletes excessive powers of Commissioner

III. HOSPITAL PAYMENT

A. Proposes inflation + 3% to be targeted to labor ($22.5m over Governor)

B. Removes CAP on BAD DEBT - ie. hospitals will continue to be reimbursed in full for BD-($40m over Governor)

C. Removes Medicaid CAPS on outpatient and all AMD days -($30m over Governor)

D. Continues $60m for labor for underfinanced hospitals

E. Allows unlimited discounts through negotiated agreements

F. Allows exemption from cap for out-of-country patients

*Thus HW&M's proposes an additional $90m to hospitals over Governor's package now worth at least $300m of new money to hospitals.

IV. DETERMINATION OF NEED

A. HW&M's allows full pass-through of costs for any project that receives a D.O.N.

B. HW&M's requires no DON review for any hospital bed conversions in an underbedded area as certified by DPH

C. HW&M's maintains $10m threshold and raises non-acute threshold to $800,000 for equipment and raises threshold for change in service to $350,000

D. HW&M's allows Public Health Council rather than A&F to make final determinations of projects

E. Allows Nursing Home builders in Urban-underbedded areas to be exempt from DON and RSC reimbursement CAPS

F. HW&M's mandates study to study criteria for the delicensure, conversion, and consolidation of excess beds

V. MEDICAID

A. HW&M's removes H.6000 proposals for deductibles and co-insurance; prohibitions against asset transfers, restrictions on chronic hospitals payments, and all provisions previously requested in REAP

VI. BLUE CROSS/BLUE SHIELD

A. HW&M's mandates state auditor to undertake audit of BC/BS

B. Mandates Secretary of Consumer Affairs and independent panel to study mutualization of BC/BS and to submit findings to legislature by 10/1/89 - Medex and BC/BS maintained as is until legislative changes

C. HW&M's allows Blue Shield to establish PPO's but only if consistent with New C. 176I

D. HW&M's continues protections against balance billing

VIII. DPH LICENSURE, QUALITY, AND LABOR

A. HW&M's endorses Governor's Licensure, Quality, Suitability Reviews, and consumer protections

B. HW&M's endorses labor protections and expands existing re-employment assistance program to hospital workers

VII. HMO'S AND PPO'S

A. HW&M's endorses 2.28% tax on HMO's and PPO's, but does not allow this revenue to go to DMS, but rather to general fund

B. HW&M's endorses the remainder of Governor's PPO provisions which will allow regulation of this new program

C. HW&M's sunset HMO Tax in 1991 if no tax on Blue Cross/ Blue Shield

VIII. BUDGET PROVISIONS

A. HW&M's removes all budget provisions except $1.0m for disabled adults and $5.0m for disabled children

B. Any additional administrative funds (other than those currently in Medicaid and GIC) will have to be requested in a Supplemental Budget or in FY'89 budget

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

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H.6000	HOUSE WAYS & MEANS CHANGES
SECTION 1 Mandatory health coverage following ERISA exemption	SECTION 1 - prohibited copayments and deductibles for prenatal, delivery, and well baby care for low income women - defined small employer and expanded definition of "coverage period" to 120 days relative to small employer - changed coverage period to begin 60 days after hire for other than small employer - changed civil penalty for failure to comply from 10% of payroll to 2% - added preventive care for children up to age 6 to be included in all coverage - changed definition of employee to require 25 hours per week
SECTION 2 Unemployment Health Insurance contribution	SECTION 2 - changed time frame for assessing a penalty if an employer fails to file appropriate reports or forms (H.6000 section 14I) from 15 to 21 days
SECTION 3 MHP added to Section 46 of Chapter 151A	SECTION 3 - named new agency Department of Medical Services
SECTION 4 Study of health insurance contributions by employers	SECTION 4 - added the Legislature as a recipient of the report
SECTION 5 Reimbursing cities and towns for mandated costs	SECTION 5 - no significant changes
SECTION 6 Effective dates	SECTION 6 - no significant changes
SECTION 7 EOHS amended to include MHP	SECTION 7 - EOHS amended to add Dept. of Medical Services
SECTION 8 Creation of Massachusetts Health Partnership	SECTION 8 - creation of Dept. of Medical Services - changed composition of advisory boards to be established - excluded transfer of Rate Setting Commission employees and duties - included civil service protections and deleted management rights provisions consistent with other state agencies - deleted excessive powers of the agency

	- included a program for medical assistance for disabled children not otherwise eligible for Medicaid - specified the establishment of a sliding fee program for the low-income elderly - added provision regarding pre-existing conditions so that DMS will be insurer of last resort - added provision that HMO's must accept Medicaid clients as a condition of contracting with the DMS - raised free care and bad debt to 100% reimbursement but exempted certain populations. Raised cap to $375M - eliminated new funds, the administrative fund and provision enabling 9% of total revenue to be spent for administration, all administrative funding made subject to appropriation - eliminated H.6000 Section 11 regarding access to financial records - specified that copayments and deductibles be established only by the Legislature
SECTION 9 Date new agency assumes powers	SECTION 9 - established date for DMS to assume authorities and powers (July 1, 1989)
SECTION 10 Interagency agreements with relevant agencies	SECTION 10 - eliminated the Dept. of Public Health and the Rate Setting Commission from specified list of interagency agreements
SECTION 11 FY'88 control of Medicaid, RSC, and GIC funds	SECTION 11 - eliminated reference to the Rate Setting Commission
SECTION 11A & 11B	SECTION 12 & 13 - no substantial change
[no comparable sections]	SECTIONS 14 - 19 - established Healthy Start in General Laws - established Medicaid eligibility for severely disabled children; presumptive Medicaid eligibility for pregnant women; expanded Medicaid eligibility for children, elderly, and disabled

SECTION 11C Hospital Financing	SECTION 20 - allowed unlimited discounts through negotiated agreements - proposed inflation + 3% to be targeted to labor - continued $60M for underfinanced hospitals - allowed full pass-through of costs for any hospital that receives a DoN - allowed exemption from cap for out-of-country patients
[no comparable sections]	SECTION 21 - exempted comprehensive cancer centers from hospital reimbursement system SECTION 22 - Removed nursing homes in underbedded areas from reimbursement caps SECTION 23 - required Rate Setting Commission to report to the Legislature on increased rates SECTION 24 - established uncompensated care pool for community health centers SECTION 25 - removed RSC oversight of Blue Cross contract if DMS takes over Medex and non-group
SECTIONS 12-20 Determination of Need	SECTIONS 26 - 36 - clarified the definitions of "new technology" and "innovative services" - raised threshold for non-acute health care facilities from $600,000 to $800,000 for capital expenditures - exempted DoN for hospital bed conversions in underbedded areas - eliminated reconversion provision - regarding non-acute facilities, raised bed capacity change in service from 4 beds to 12 and raised operating expenditure threshold (change in service or increase in staff) from $250,000 to $350,000 - eliminated A & F DoN oversight board of review, Public Health Council continues existing powers - added provision for optional DoN for projects not at threshold

SECTIONS 21-43 Medicaid provisions for coinsurance, deductibles, restrictions against asset transfers, restrictions on chronic hospital payments, and miscellaneous REAP provisions	- deleted all Medicaid provisions
	SECTION 37 - clarified continuation of Chapter 6A
SECTION 44 2.28% HMO tax on premiums	SECTION 38 - eliminated dedication to MHP Fund II - [illegible] revenues received from the tax will be deposited into the general fund
SECTIONS 45-49 Tax on commercial insurers dedicated to new agency	- deleted entire sections, therefore commercial tax assessments will continue to go to the genreal fund
SECTIONS 50 & 51 BC/BS subject to HMO and PPO tax	SECTIONS 39 & 40 - no substantial changes
SECTION 52 effective dates of taxes on premiums	SECTION 41 - corrected to reflect renumbered sections
[no comparable sections]	SECTIONS 42 - 44 - mandated preventive health care coverage for children thrcugh age 6
SECTION 53 New PPO statute (C.176I)	SECTION 45 - clarified that benefit levels to nonpreffered providers must be at least 80% of the benefit level for preferred providers and can not be less than 60% - in Section 11, eliminated dedication of taxes to MHP Fund II and clarified that assessment be based on premiums not gross revenues - changed PPO tax to be deposited into the general fund (not dedicated to new agency)
SECTION 54 rehabilitation and liquidation of HMO's	SECTION 46 - no change

SECTION 55 Risk management program as a condition of licensure	SECTION 47 - added DPH approval of risk management programs
SECTION 56 - 60 requires insurers or policy holders to give written notices if coverage is about to lapse	SECTION 48 - 51 - continued notification requirements, but mandated employers or policy holders to notify insured
SECTION 61 employee notification of eligibility for extended benefits	SECTION 52 - no significant changes
SECTIONS 62-63 HMO's and PPO's in unfair practices act	SECTIONS 53 & 54 - no substantial change
SECTION 64 Subjects HMO's to insurance laws	SECTION 55 - no change
SECTIONS 65 & 66 Mergers and acquisitions	SECTIONS 56 & 57 - clarified that long term care facilities are not included in the definition of health care facility - corrected (c) to read public hearing
SECTIONS 67 & 68 Blue Shield PPO	SECTIONS 58 & 59 - changed reference of nonpreferred to nonparticipating
SECTION 69 disapproval of Blue Shield rules and regulations	SECTION 60 - changed filing date to read "30 days before their effective dates"
SECTION 70 Blue Shield PPO	SECTION 61 - deleted second paragraph to be consistent with C.176I
SECTION 71 Blue Shield PPO	SECTION 62 - no substantial change
SECTION 72 Blue Shield PPO	SECTION 63 - included provision for termination of an agreement - clarified that Blue Shield PPO physicians are subject to balanced billing laws
SECTION 73 Blue Shield provider rights	SECTION 64 - no changes

SECTION 74 Blue Cross PPO	SECTION 65 - eliminated mandate for separating revenue sources
SECTION 75 BC/BS audit and study of mutualization	SECTIONS 66 & 67 - gave responsibilities for audit of BC/BS to the state auditor; mutualization report remains responsibility of Exec. Office of Consumer Affairs
SECTION 76 Rate filings	- deleted entire section
SECTION 77 Blue Cross standards for findings	SECTION 68 - no change
SECTION 78 Blue Shield standards for findings	SECTION 69 - deleted specifications of regulations
SECTION 79 New bureau at the division of insurance	- deleted entire section
SECTION 80 Medex rate adjustment	- deleted entire section
SECTIONS 81-83 Open enrollments	SECTIONS 70 - 72 - changed open enrollment period to January 1 through the last day in February
SECTION 84 Hospital Licensure	SECTION 73 - no substantial change
SECTION 85 Hearing for conditions on licenses	SECTION 74 - changed from public hearing to adjudicatory hearing
SECTION 86 Quality indicators and Hospital Closure	SECTION 75 - no substantial change
SECTIONS 87-89 Licensure by service, expansion of Advocacy Office	SECTIONS 76 - 78 - no changes
SECTION 90 Access to records	SECTION 79 - added "with the consent of the patient or the patient's legal guardian"

SECTIONS 91-92 DPH Advocacy Office	SECTIONS 80 & 81 - no substantial changes
SECTION 93 fines against hospitals	SECTION 82 - deleted (e) and (f)
SECTION 94 Patients' Rights	SECTION 83 - no change
[no comparable section]	SECTIONS 84 & 85 - established pilot program for handicapped children
SECTION 95 Study of nursing shortage	SECTION 86 - no change
[no comparable sections]	SECTION 87 - provided for identification of medically underserved areas
	SECTION 88 - added study on delicensure of excess beds
SECTION 96 Student benefits	SECTION 89 - no significant changes
SECTIONS 97 - 108 Access to health insurance in divorce settlements	SECTIONS 90 - 101 - no changes
SECTION 109 limits experditures to appropriated funds	SECTION 102 - no change
SECTION 110 Severability	SECTION 103 - no change
SECTION 111 Budget request	SECTION 104 - eliminated administrative funding

By Robert Lenzner
and Peter G. Gosselin
Globe Staff

Boston's Fidelity Investments, one of the country's largest mutual fund operators, sold off $850 million of stock during the stock crash Oct. 19, starting in London even before US markets opened and greeting the New York Stock Exchange with about a half a billion dollars of sell orders.

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December 15, 1987

Agreement reported on health bill outline

By Richard A. Knox
Globe Staff

Major interest groups reached agreement yesterday evening on the outlines of a new Massachusetts hospital financing mechanism and a phased-in approach to insuring workers who now lack health coverage, according to the Senate Ways and Means Committee chairman, Patricia McGovern (D-Lawrence).

"I'm cautiously optimistic," she said in a telephone interview. "I believe we've reached agreement on a general approach. It's still very volatile. ... But once you've reached general agreement on overall concepts – and we indeed have – you can begin to move forward."

McGovern has labored for weeks to salvage a bill out of the wreckage of Gov. Dukakis' original "health care for all" proposal, which was nearly killed on the House floor Oct. 5.

"Whatever emerges [from the committee] will be brand new and quite different from anything put on the table before," she promised.

McGovern declined to divulge specifics, but the tentative agreement among various interest groups reportedly would provide Massachusetts hospitals with new 1988 revenues just shy of $400 million and phase in a mechanism to provide affordable health

HEALTH, Page 40

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win her battle and all their lives will improve.

But these are just two of some 50,000 needy Massachusetts children who Globe Santa has been asked to help this year.

Globe Santa can respond only through the voluntary donations of readers who share the belief that no child should be forgotten on Christmas Day.

Help Globe Santa help these children now.

Principals reportedly agree on outlines of health bill

■ HEALTH

Continued from Page 1

coverage for currently uninsured workers.

The plan would also involve unspecified amounts of new state revenue to fund startup costs of an agency to set up a health insurance pool for workers and test-market the coverage. Another rumored provision would have the state offset some or all of the estimated $50 million Medicare cutback that Massachusetts hospitals expect in the coming year.

Hale Champion, the governor's chief secretary, represented Dukakis at the meeting in McGovern's office yesterday during which agreement was reached, but State House sources said the governor has not committed himself to the McGovern plan.

Others at the meeting represented the Massachusetts Hospital Association, Blue Cross-Blue Shield, the Life Insurance Association of Massachusetts, the Massachusetts Business Roundtable, Associated Industries of Massachusetts, a small-business group called the National Federation of Independent Businesses, and a consumer group called the Health Care for All Coalition.

McGovern was upbeat about the agreement yesterday evening, in sharp contrast to her mood several hours earlier, when she wondered aloud: "Will we run out of time, energy or will? I don't know the answer to that."

The McGovern plan is a race against the legislative clock. The current session expires at midnight on Jan. 6, and any Senate-passed version of the highly complex omnibus health bill would have to win either House concurrence or, more likely, survive a House-Senate conference committee.

McGovern says she plans to telephone Ways and Means Committee members today to brief them about the tentative agreement, working from her sickbed as she attempts to recover from a stubborn cold.

Meanwhile, the principals in the negotiations have been instructed to test the waters with their diverse constituencies and report back to McGovern tomorrow morning.

"My sense is that we will know within the next 48 hours how people will feel about the proposals hammered out by this group," she said.

Meanwhile, David McKenzie, McGovern's leading staff technician on the issue, is translating the agreement into legislative language.

"There will not be a draft available for another 24 to 48 hours," McGovern said. "Once we have that, maybe we will get some kind of agreement, but maybe we won't."

McGovern said her goal is to secure Ways and Means Committee approval of the proposal by the end of this week. "Candidly, we may have to go to next week," she said.

After weeks of negotiations, yesterday's 3½-hour meeting was the first time various parties had seen anything on paper outlining a proposal. One participant described the atmosphere as "real positive. People said they really would go back and try to sell this to their people."

McGovern stressed that there was "positive energy" among the principals, in contrast to the "negative energy" that prevailed when negotiations began. "I think the people around the table have been terrifically constructive," she said. "It fell apart on a number of occasions. So much damage was done by the total disintegration of the original bill that it has taken days and weeks to put all the parties back together again."

The Ways and Means chairman said she would "stop short" of calling yesterday's accord an agreement-in-principle. "I would love to call it that, but there is no piece of paper with agreements in principle, let alone a drafted piece of legislation," she said. "I do believe we are conceptually in agreement regarding the approaches that ought to be taken."

Officer in drug case skips hearing; fired

A Boston police officer, arrested three months ago on cocaine possession charges, has been fired after failing to appear at a Boston Police Department disciplinary hearing, a police spokeswoman said.

Salvador Aponte, who was arrested in his Jamaica Plain home by Boston police, did not contact police officials to say he would not be able to attend his disciplinary hearing last week, said spokeswoman Nancy Sterling Gleason.

That resulted in his automatic firing, Gleason said.

Although Aponte, who worked in the Area E police station, was found not guilty of cocaine possession charges last month in West Roxbury District Court, he was suspended with pay pending a disciplinary hearing.

18-20 year sentence in Groton slaying

United Press International

CAMBRIDGE – A Groton man, who fled to Italy after being charged with murder in 1980, pleaded guilty to manslaughter yesterday and was sentenced to 18 to 20 years in prison, officials said.

Lawrence Mescile, 37, pleaded guilty in Middlesex Superior Court in the death of Anthony Mavilia, 31, also of Groton. Judge James McDaniel Jr. ordered that he serves the term at Cedar Junction state prison in Walpole.

Gerry Manning and his mother, Mary, present Globe Sa

'All us kids,' join

■ SANTA'S FRIENDS

Continued from Page 1

...eeded his help.

□

...s no question that Cur... the city, and that he was ...y Robin Hood who took ...ich and gave to the poor. ...re any doubt that he was ...even by the ethics of his ...ch were fairly loose. He ...rag that he had never ac... donation from a person ...idn't afford it, but that ...es a lot to the imagina... ...as said that nobody ever ...m hand-to-hand, but the

. Page 2

UPI photo

Pope John Paul II receives flowers from Mandy Lynn Wolff, 10, on his arrival in San Antonio yesterday.

"Come back to this source of p...," the pontiff told them, in a message aimed at a nation where use of the sacrament has fallen drastically since the Second Vatican Council ended in 1965.

"Christ himself is waiting for you," he said. "He will heal you and you will be at peace with God."

About 20 persons were taken to hospitals for heat-related illness by the end of the Mass, and dozens more were reported stricken in the long walk from the Mass site to parking areas.

Choice of the Mass site was controversial, and the medical director chosen for the event resigned in July to protest the lack of public health precautions.

POPE, Page 5

Inside

Dukakis health proposal to meet political reality

Quick action by Legislature, industry sought

By Richard A. Knox
Globe Staff

Gov. Dukakis' gamble that this is the time and Massachusetts is the place to show the nation how to restructure its ju...y-rigged health care system now will be put to the test.

The governor's move is embodied in legislation rushed into final form this weekend. Its preamble simply states: It shall be the policy of the commonwealth to implement programs that will make affordable health care available to every citizen of the commonwealth.

Within the next few days, it should be possible to get a reading on whether the governor and his advisers are in touch with reality in trying to enact such an ambitious proposal by the end of this month. That is the administration's deadline, dictated by the expiration of the state's current hospital financing law – and, with it, the state's current $315 million-a-year pool for covering hospital costs of the uninsured.

The governor's proposal, which carries a price tag of up to $600 million a year, would be funded mostly by businesses, with additional amounts from state tax funds and consumers.

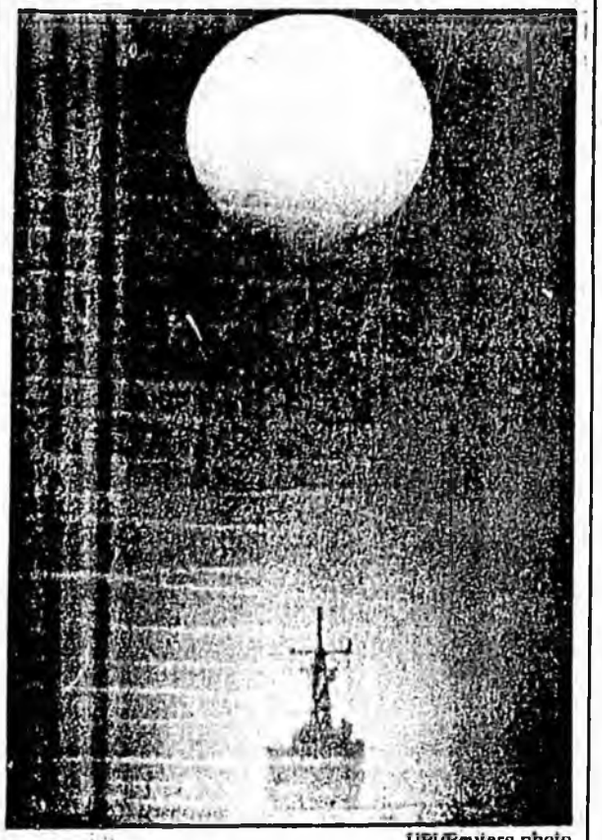
"The most shocking prospect is that this might actually be passed by Oct. 1," one leading Massachusetts health care analyst said yesterday after perusing the 159-page proposal. "And I guess that it's not that unlikely. The attitude in this Democratically-controlled state may well be, 'We've got to do it for the governor and we'll fix it later.' "

Dukakis is proposing a major redesign of both the financing and the infrastructure of Massachusetts health care – a $12.7 billion-a-year enterprise – in order to insure the nearly 600,000 citizens who now lack health insurance. Much of the task would be put in the hands of a health care czar at the top of a new agency called the Massachusetts Health Partnership.

Within the administration and the health care community, state Welfare

HEALTH INSURANCE, Page 16

TWILIGHT PASSAGE



UPI/Reuters photo

The US Navy warship Flatley steams through the Persian Gulf as the sun goes down. The Flatley was helping clear the way for two Kuwaiti tankers. Page 6.

Diver... organ... Bork'

By Gregory Wil...
Globe Staff

WASHINGT... confirmation h... Supreme Court broad national his confirmatio... the "soul of th...

These oppo... women's, civil ... have or... light v... ...a... hearin... do... marches in a ... against Bork.

Former c... pict Robert H... ful and shar...

Bork's su... brilliant juris... Constitution. ... legal opinions ... man who w... clock of socia... of back-alley ... rants, on-the ... its on free sp...

In Minnes... taking testi... US Appeals ... today. An ... courthouse ... today. In W... front of the ... start tonigh... BORK, Page ...

Dukakis health insurance proposal to meet political reality

■ **HEALTH INSURANCE**
Continued from Page 1

Commissioner Charles A. Atkins is already widely rumored to be in line for the job, though one of Dukakis' top aides denied last weekend that any decision has been made.

The partnership would have very broadly defined powers to control hospital costs and purchase $2.5 billion in health care benefits on behalf of the poor, state employees, the unemployed, workers whose companies do not buy coverage, people who now buy individual health insurance policies from Blue Cross and, possibly, the elderly.

The proposal would also require:

- A major reorientation of the state's dominant health insurer, the nonprofit, financially troubled Massachusetts Blue Cross-Blue Shield, that would ultimately make it resemble any commercial insurance company.
- Incentives to nurture a host of new organizations to market, broker and manage health care, in the hope of sharpening competition among both insurers and care providers. New and existing "managed care" entities, such as health maintenance organizations, would be able to bargain for discounts from hospitals and doctors – but the state would limit such discounts to 10 percent.
- Dismantling much of the state's regulatory authority over health care and putting up new and entirely untested mechanisms designed to protect citizens from the new incentives on providers to cut costs – and perhaps corners – in their effort to survive.
- Closure or conversion of nearly 40 percent of the commonwealth's hospital capacity, a step discussed for nearly two decades but – because of its extreme political sensitivity – never actually attempted.

Groups must act this week

Given the intense pressure to act, major interest groups must take a position and swing into action this week. This is no easy task, those in the health care world said yesterday, because the legislation is so complex, sweeping and open-ended.

Major insurers and the state's largest businesses are convening this morning to determine its impact for them and decide whether they can support the governor's plan. At first reading of the bill yesterday, one source said it was not obvious whether businesses that now insure their employers – and subsidize firms that do not – would actually save much money.

Representatives of the poor and the elderly are nervous about some of the plan's features but are generally supportive.

Small businesspeople feel beleaguered and outgunned by the big-business support the governor appears to have in his attempt to make them buy insurance for the 480,000 Massachusetts workers who now cannot get coverage through their place of employment.

The governor would do this one of two ways: By securing congressional permission to require employers to purchase health insurance for their workers; or, if this fails by Jan. 1, 1989, by making all businesses pay a surcharge on the unemployment insurance they must buy. If they offered a basic health insurance plan and paid 80 percent of the premium, the surcharge would be essentially forgiven.

But perhaps the key question at this point is whether the state's $5 billion-a-year hospital industry will play the pivotal role in the fate of the governor's proposal that it has in previous years when major health care legislation has been enacted.

Closely related to this is the extent to which hospital workers and their unions will support hospitals' arguments that the

says the report, noting that proportion of Massachusetts h pital budgets devoted to pay has declined in recent years.

The Massachusetts Nurses sociation, while urging that st officials recognize the need for nificant increases in hospi wages, does not want to be blam for helping to scuttle the Duka proposal, an association lobby said yesterday.

Steven Hegarty, president the Massachusetts Hospital As ciation, said last week he was c fident that hospitals – the do nant employers in many lo communities – can get their m sage across to legislators. "'I real decisionmakers have to list to their local constituency. a our people are speaking very clo ly to every legislator in the co monwealth right now," Hega said.

Dukakis and his administr tion, who have the public supp of legislative leaders of bo houses, are painting the hospit as unreasonable in their immed ate financial demands.

Hospitals, for instance, a pressing for Massachusetts insu ers, government and consumers make up for the fact that the fe eral Medicare funds will not go i in 1988. Medicare provides abo 40 percent of hospitals' revenue

Dr. J. Robert Buchanan, gen al director of the Massachuset General Hospital, said in an inte view Friday his institution w suffer a $15 million deficit in th coming year unless its revenue climb by 9.1 percent. Becau

nor's bill does not provide enough money in the coming year to fund a pent-up demand for wage increases. This demand, fueled further by a severe shortage of nurses and other skilled hospital workers, is beginning to result in double-digit wage settlements.

The Massachusetts Hospital Association is orchestrating a major campaign to persuade legislators that the governor's bill is too stingy to permit needed wage increases. On Wednesday the trade group plans to bus several thousand hospital workers to the State House for a rally, followed by visits to local legislators.

However it appears that hospitals and unions are not speaking with one voice when it comes to how much additional hospital revenue is needed. Local 285 of Service Employees International Union, which represents about 6,000 hospital workers, will issue a report today that sharply challenges hospitals' record in using revenue surpluses to increase wages.

"While hospital costs continue to grow well beyond inflation, fewer of these dollars are going to health care workers' salaries,"

Medicare won't pay more, this would require nearly 18 percent more from Massachusetts payers.

"I have very serious questions whether several hundred million dollars more for insuring the uninsured is tolerable at a time when the system requires some serious readjustment after five years of tight control," Buchanan said.

Hegarty argued last week with Dukakis that hospitals need 17.7 percent more from Massachusetts payers next year – an additional $544 million.

Dukakis officials have flatly said no to that kind of increase, offering only about $200 million more. Privately they express exasperation with hospitals for making the demand. After meeting with Hegarty, Dukakis increased a special fund in his proposal earmarked for hospital wage increases from about $45 million to $60 million.

Under the governor's proposal, one administration official said yesterday, Massachusetts businesses and consumers would pay about 10 percent more to hospitals in the coming fiscal year. This would produce about 5 percent more in net hospital revenues, the official said.

Hurdles remain in bid for global ozone treaty

By Dianne Dumanoski
Globe Staff

MONTREAL – Several key

their consumption of chlorofluorocarbons, or CFCs – which are widely used in air conditioners, refrigerators, aerosol spray cans,

contacted no one else, including Mayor Flynn, the owner of the quarry and the town of Weston. Bulger said he hoped his suggestions would be considered on the merits, but he was not optimistic.

"I'm hopeful that the mayor will look at it and say, 'I welcome a new idea,' " Bulger said in an interview in his office. "But once I make the suggestion I want to be away from it so the critics will no

INCINERATOR, Page 68

Constitution Day, as it is being called here, is the culmination of years of planning and millions of dollars in government, corporate and individual spending that have drawn applause and criticism.

It is also the beginning of a yearlong series of special events celebrating the progress of the Constitution through the ratification process by a confederation of

al principles.

The celebration here is being viewed by Philadelphians as an opportunity to boost the image of the city as well as a historical obligation to commemorate the drafting and signing of the 200-year-old document.

"The hope I have is that the confidence of the city to do things, to get things done, will be en-

CONSTITUTION, Page 23

Pope John Paul II reache
ception School in Los An

Inside

Today: Calendar, Money

House backs import limits

The House yesterday approved tighter limits on imports of textiles, apparel and shoes. Page 41.

O'Neill on '62 Senate fight

In the fifth of six excerpts from his memoirs, former House Speaker Thomas P. O'Neill Jr. discusses the maneuvering behind the 1962 Edward Kennedy-Edward McCormack Senate primary fight. Page 2.

Guide to features

Health plan cost seen as eroding support

By Richard A. Knox
Globe Staff

Thousands of hospital workers gathered at Boston Common yesterday to protest the governor's universal health care proposal. Page 56.

While Massachusetts hospitals were telling legislators yesterday that Gov. Dukakis' proposed health plan would underfund them to a dangerous degree, big-business and insurer representatives have concluded that the bill is too rich for a hospital system they consider already bloated.

New estimates of the sweeping plan's cost impact appear to be eroding support for the proposal among business and insurance interests. The governor is counting heavily on that support to push his plan through the Legislature in the next few weeks.

Groups representing the poor, elderly and parents of disabled children are also complaining about how the proposal addresses their concerns – or fails to.

Hale Champion, the governor's chief secretary, said last night that the balance of interests the administration tried to achieve is not yet toppling under the mounting criticism. None of the objections he has heard, Champion said, "are frozen or fixed or seriously jeopardize the bill."

However, business and insurance leaders are taking a hard-line stance on further increases in revenues sought from the Legislature by the hospital industry, which says it needs $544 million in additional funds next year.

The business community analysis, completed late yesterday, concludes that the Dukakis plan would increase payments to Massachusetts hospitals in the coming year by $248 million. This figure is widely at odds with the hospital industry's estimate of $115 mil-

HEALTH INSURANCE, Page 14

Pope calls to work a

By James L. Franklin
Globe Staff

LOS ANGELES – In th important address so far second American visit, Pop Paul II yesterday urged t tion's Roman Catholic bis hold the line on disser mount a new campaign to hearts and minds of a well- ed and questioning churc bership.

In a four-hour meeting w National Conference of C Bishops, the pontiff ackno that some church memb lieve that dissent fro church's teaching "is total patible with being a 'good lic' and poses no obstacle t ception of the sacrame ts.

clusion runs counter to arguments by some scientists that acid-rain damage is widening in the United States and poses an increasing threat to the nation's lakes and forests. The report supports the Reagan administration's position that acid rain does not warrant new pollution controls. (Washington Post)

Vrdolyak aligns with Republicans

CHICAGO – Edward Vrdolyak, who once headed one of the nation's most powerful Democratic machines but lost his bid to unseat Chicago's black mayor, has become a Republican, pledging to make the GOP the city's dominant party. "There is no future in the

Agency urges rules for fishermen, boats

WASHINGTON – The National Transportation Safety Board broke sharply with Reagan administration policy yesterday in saying sweeping regulations should be imposed on fishermen and fishing vessels to cut down on accidents and deaths at sea. Joseph T. Nall, a member of the independent federal agency, told a Senate subcommittee that the Coast Guard should mandate training for captains and crews, require licenses for captains, establish vessel stability standards, order added lifesaving equipment, require periodic vessel certification and bar on-board alcohol and drug use. Nall said the recommen-

tions ranging from treatment and medication to preventing bedsores and injuries. No state-by-state records were made available. (AP)

N.Y. woman killed in escalator mishap

NEW YORK – A woman was killed yesterday when an escalator opened up at a New York Telephone Co. building and she was pulled in, police said. Emma Niskala, 35, of Lynbrook, was riding the down escalator to the mezzanine of the building in Brooklyn when the accident occurred at 7:45 a.m., police said. Officials said she was on her way to her job as an accounting clerk when the escalator mechanism failed and the bottom step opened. (AP)

Health plan cost seen eroding support

HEALTH INSURANCE

Continued from Page 1

lion in additional 1988 revenue, and nearly $60 million more than the governor's figure.

Under the Dukakis plan, health insurance premiums would go up about 17 percent for the hospital component alone, according to the analysis, which administration officials say is in line with their revised figures.

When nonhospital components of health insurance premiums are added in, the typical policy could jump more than 20 percent in cost, said Massachusetts Blue Cross-Blue Shield president John Larkin Thompson.

Thompson said he considers the proposal as it is written to be "generous" to hospitals. "The new numbers by themselves don't lead us to withdraw from continuing to work on the bill," he said. "It's got to be seen somewhat in the sense of where the hospital industry is coming from, which was a number substantially higher than that. But if a higher number comes out of the process, we'd have a very difficult time living with it."

"I can't see how anybody could think it is too generous for hospitals," responded J. Antony Lloyd of Beth Israel Hospital, who said major teaching hospitals are working on a rebuttal to the big-business and insurer critique.

Spokesmen for big business groups, who had been generally supportive of the governor's plan or at least open-minded about it, said last night they are balking at its short-term costs. They also are raising fundamental objections about other features, such as the requirement that all employers would eventually have to pay 80 percent of their workers' health insurance premiums.

"Based upon our present reading, the bill fails to contain costs in a significant way, and the move to mandate universal health insurance is too much too fast," said John Crosier of the Massachusetts Business Roundtable. "Yes, you can accuse us of being a little late with our criticism. We have tried to stay in discussion [with the administration] and understand how the numbers work. We come down concluding that it doesn't contain costs the way it was supposed to."

Richard Mastrangelo of Associated Industries of Massachusetts said his organization has decided that Dukakis should abandon his attempt to enact a broad health care reform bill – with the centerpiece of insuring the 600,000 residents now without coverage. He said the Legislature should merely "roll forward" the current hospital reimbursement law with some sort of cap on reimbursement for hospital free care and bad debt.

Not on board

"We're not getting on board because it's a different ship than we thought it would be, and it's not taking us to the same place we planned to go," said Mastrangelo.

The revised computation was done by a group that calls itself the purchasers of health care. It includes the Roundtable, Associated Industries, Blue Cross-Blue Shield and the Life Insurance Association of Massachusetts, representing commercial health insurance companies.

The analysis suggests that hospitals could count on at least 6 percent in total additional revenues next year. Those who pay premiums to Blue Cross and commercial insurers, the analysis concludes, would pay nearly 12 percent more in hospital costs to make up for shortfalls in Medicare and Medicaid payments.

The Massachusetts Hospital Association insists, on the other hand, that hospitals can count on only 2.3 percent more.

The hospitals' assumptions about their 1988 Medicaid and Medicare revenues also are strongly disputed. An industry fact sheet projects a $40 million drop in Medicaid in the fiscal year beginning Oct. 1, and no increases in their Medicare payments, which account for about 40 percent of the total.

Dukakis administration officials, say, however, that Medicaid efforts to reduce hospital reimbursement for outpatient care and for patients awaiting nursing home placement will save, at most, $20 million in 1988. They added that other increases in Medicaid payments to hospitals may offset those reductions.

The Medicare picture is less clear, since Congress has not yet acted on fiscal 1988 payment levels. However, Stuart Altman of Brandeis University, chairman of a national Medicare task force on hospital payments, said in an interview that Medicare payments to Massachusetts hospitals are likely to increase in the coming year.

"I don't understand why they're saying they'll get a zero increase," Altman said.

the contenders in the Democratic presidential campaign looked like characters out of Walt Disney's "Snow White and the Seven Dwarfs."

Now they look as if they're trapped in a reissue of the classic Agatha Christie novel "And Then There Were None" – with the press playing the role of killer.

With the withdrawal of Gary Hart amid reports of his relationship with Donna Rice and the controversy over Sen. Joseph Biden's unattributed use of the political speeches of others and his plagia-

happened 22 years ago, when Biden was in law school, rather than on "important issues," such as relations with the Soviet Union, jobs and literacy?

The answer, according to a number of political observers, reporters and press critics, is no.

What is happening instead, several suggest, is that the role of the press in a presidential campaign is changing.

"In the old politics, before 1968, the candidates were picked

PRESS, Page 4

Inside

Today: Sci-Tech

Red Sox take two

Roger Clemens picked up his 17th victory as the Red Sox beat the Orioles twice yesterday, 5-1 and 6-3. Page 45.

'Promise' wins 5 Emmys

"Promise," a drama about mental illness, won five Emmys last night, while "L.A. Law" won four awards for dominant NBC. Page 11.

The throwaway society

Combustion of waste, a method almost abandoned in the 1970s after federal Clean Air Act standards forced many older incinerators to shut down, has come back in demand in recent years. Sci-Tech, Page 33.

Guide to features

Compromises reached on health plan

By Richard A. Knox
Globe Staff

The Dukakis administration agreed yesterday to make significant changes in the governor's proposed health plan in an effort to placate elderly, disabled and low-income constituents as well as organized labor.

However, one leading administration figure said last night that Dukakis will hold firm against hospitals' demands to increase their revenues next year, despite heavy industry pressure on legislators.

The compromises reached this weekend may signal that the administration has virtually abandoned its strategy of trying to hold together a diverse coalition of interest groups. One state official said the politics of the governor's plan "appear to be lining up in the traditional way" – consumers and labor unions in favor and business and hospitals against.

The proposal will have its first legislative hearing today before the House Ways and Means Committee.

HEALTH PLAN, Page 22

tal – $3,149 – than in Massachusetts General... tal – $2,821, while Winthrop Hospital's price matched MGH.

The inconsistent hospital pricing is exhaustively documented in the first Massachusetts hospital price guide, published today by the Massachusetts Business Roundtable and the Massachusetts Health Data Consortium.

> The price guide 'opens up the black box of hospital prices.'
>
> – Debra Lerner, research director, Data Consortium

The document, nearly two inches thick, provides an unprecedented glimpse of what individual hospitals charge for 19 common surgical procedures as well as charges for vaginal childbirth. These charges often vary by thousands of dollars from one institution to another. They have heretofore been an industry secret so carefully kept that even hospitals did not know their competitors' prices – and sometimes their own – for a particular procedure.

The price guide "opens up the black box of hospital prices," said Debra Lerner, research director of the Data Consortium, which intends to update the survey annually.

> 'This is not the last word; it's a guide.'
>
> – John Crosier, president, Business Roundtable

One of the most "intriguing" findings, Lerner said on Friday, is that "the smallest of the community hospitals are frequently the most expensive."

For example, 183-bed Southwood Community Hospital in Norfolk charged $2,895 for an uncomplicated hernia repair, while the median charge for the same procedure was only $1,260 in 221-bed Emerson Hospital in Concord.

A dozen Massachusetts hospitals with fewer than 200 beds charged more than the statewide median of $3,930 for uncomplicated abdominal hysterectomy, compared with higher prices in nine hospitals with more than 200 beds.

The guide is based on analysis of nearly 90,000 cases of hospitalization in the state's 109 acute-care hospitals. All involved people under age 65 who were insured at the time by Blue Cross and commercial carriers.

The purpose of the massive guide, which sells for $275, is not to enable individual consumers to look up the cheapest place to deliver a baby or undergo cardiac surgery. In fact, its authors say they are concerned consumers would use such data to choose the most expensive hospital in the mistaken belief that high price stands for high quality.

HOSPITALS, Page 22

ary widely in state

community hospitals

ırison among hospital charges for uncomplicated cases of gallbladder procedures. Other guides have lumped together routine cases and son more difficult, since some hospitals can claim their caseload those other institutions. While the new guide does not eliminate the ısetts Health Data Consortium. Even in comparing only Median charges for a coronary artery bypass operation involving one spital to $25,361 at St. Elizabeth's Hospital. The Massachusetts ıc surgery programs, charged on the low end of the scale – $14,607.

)ER REMOVAL
de: $3,800)

	No. of Cases	Median charges
(200-plus beds)		
Regional	24	$4,781
	17	4,517
	34	4,313
ial	41	4,270
	47	4,249
	65	4,200
	21	4,130
	23	3,599
th Serv.	30	3,508
	28	3,505
	59	3,418
	42	3,397
	36	3,363
	37	3,262
	32	3,256
	59	3,219
	36	3,181
	46	3,073
	23	3,035
	38	2,884
d	65	2,823
	40	2,820
	41	2,710
	32	2,696
	46	2,531
	35	2,404
	31	1,893
than 200 beds)		
	13	$6,569
	9	5,113
	9	4,483
y	17	4,411

ABDOMINAL HYSTERECTOMY
(Statewide: $3,930)

Hospital	No. of Cases	Median charges
Nonteaching (200-plus beds)		
Union (Lynn)	19	$4,989
New England Memorial	54	4,676
Choate-Symmes Health Serv.	25	4,645
Charlton	114	4,379
Morton	36	4,236
Quincy City	36	4,187
Milford-Whitinsville Reg.	33	4,181
Leonard Morse	33	3,990
St. Joseph's	10	3,863
St. Luke's-New Bedford	115	3,794
St. John's	35	3,661
Norwood	67	3,651
Melrose-Wakefield	51	3,646
Winchester	92	3,470
South Shore	108	3,465
Goddard Memorial	93	3,441
Lowell General	77	3,430
Emerson	60	3,312
Cape Cod	83	3,167
Holyoke	28	3,099
Beverly	43	2,830
Lawrence General	58	2,803
Bon Secours	72	2,797
Sturdy Memorial	66	2,739
Mercy	61	2,716
Providence	61	2,527
Cooley Dickinson	72	2,418
Nonteaching (less than 200 beds)		
Martha's Vineyard	17	$7,379
Somerville	10	5,039
Anna Jaques	34	4,954
Farren Memorial	9	4,929

Compromises reached on health plan

■ **HEALTH PLAN**

Continued from Page 1

The compromises have apparently won over consumer advocates who were unsure Friday whether they would continue to support the governor's proposal, even though they strongly favor its primary goal – extending health insurance to 600,000 Massachusetts residents who now lack it.

The administration has backed away, for instance, from its attempt to begin the commercialization of Massachusetts Blue Cross-Blue Shield, a nonprofit company that is currently required to offer coverage to the elderly and to people who cannot buy group health insurance.

Advocates for the elderly were upset about the administration's perceived haste to change Blue Cross-Blue Shield's special social function, so that issue has been deleted from the proposal. Attorney General James Shannon had also expressed reservations about proposals relating to Blue Cross-Blue Shield.

It appeared last night that the compromises have had the intended effect on consumer advocates.

"The significant thing is that the parameters of the debate are now set, and the administration has decided that access to care for the elderly, the poor and the disabled will drive its policy decisions," said Susan Sherry of Massachusetts Health Action Alliance. "They have decided to stop trying to satisfy all the interest groups."

In fact, one new provision decided upon yesterday is certain to antagonize the insurance industry lobby. It would bar insurers from refusing coverage to anyone based on preexisting medical conditions.

This is apparently in response

Ludlow Hospital Society	17	4,411
Addison Gilbert	12	4,327
Fairview*	9	4,275
Whidden Memorial	21	4,235
Anna Jaques	26	4,096
Marlborough	17	4,030
Fairlawn	6	3,877
Franklin Medical Center	14	3,595
Brookline	10	3,498
Harrington Memorial	23	3,477
Hubbard Regional	10	3,434
Milton	30	3,420
Haverhill Munic. (Hale)	34	3,356
Sancta Maria	6	3,351
Glover Memorial	11	3,284
Parkwood	7	3,281
St. Anne's	24	3,174
Noble	24	3,084
North Adams Regional	17	3,061
Leominster	23	2,979
Henry Heywood Memorial	21	2,942
Amesbury	6	2,922
Jordan	32	2,891
Falmouth	9	2,850
Hunt Memorial	31	2,850
Mary Lane	12	2,839
Tobey	12	2,793
Nashoba Community	12	2,151

Farren Memorial	9	4,929
St. Luke's-Middleboro	14	4,912
Ludlow Hospital Society	9	4,881
Fairview	8	4,786
Marlborough	18	4,659
Addison Gilbert	28	4,498
Whidden Memorial	20	4,448
Glover Memorial	6	4,104
Sancta Maria	19	4,034
Brookline	16	3,897
St. Anne's	29	3,621
Franklin Medical Center	29	3,611
Amesbury	10	3,602
Hubbard Regional	8	3,601
Milton	25	3,557
Falmouth	20	3,521
Haverhill Munic. (Hale)	83	3,481
North Adams Regional	30	3,427
Tobey	19	3,294
Clinton	8	3,282
Henry Heywood Memorial	14	3,281
Hunt Memorial	49	3,257
Wing Memorial	12	3,212
Leominster	44	3,090
Harrington Memorial	20	3,022
Noble	6	2,947
Nashoba Community	17	2,672
Jordan	44	2,591
Mary Lane	14	2,392

ges in fiscal year 1985
were insured by Blue Cross and commercial insurers

Boston teaching hospitals

GALLBLADDER REMOVAL
(Statewide: $3,800)

Hospital	No. of Cases	Median charges
Cambridge	7	$6,770
Carney	17	6,295
St. Elizabeth's	21	5,757
Beth Israel	37	5,745
Framingham Union	49	5,640
Brigham & Women's	35	5,621
New England Deaconess	17	5,606
Children's	7	5,398
University	8	5,357
Faulkner	26	5,319
New England Medical	15	5,020
Massachusetts General	71	4,874
New England Baptist	24	4,649
Waltham Weston	29	4,304
Mount Auburn	36	4,159
Lahey Clinic	56	3,871
Newton-Wellesley	48	3,571

ABDOMINAL HYSTERECTOMY
(Statewide: $3,930)

Hospital	No. of Cases	Median charges
Boston City	11	$20,763
University	25	7,896
Cambridge	12	6,849
New England Medical	24	6,686
Beth Israel	65	6,217
Brigham & Women's	303	5,934
St. Elizabeth's	62	5,822
Massachusetts General	103	5,535
Faulkner	25	5,443
St. Margaret's for Women	57	5,395
Carney	11	5,350
Framingham Union	101	5,246
New England Deaconess	50	5,096
New England Baptist	65	4,351
Mount Auburn	74	3,919
Waltham Weston	45	3,917
Newton-Wellesley	73	3,839
Lahey Clinic	93	3,834

ges in fiscal year 1985
were insured by Blue Cross and commercial insurers

Globe staff chart

This is apparently in response to concerns voiced by the parents of handicapped children that they were left out of the governor's plan, although it would also benefit many others who are currently uninsured or underinsured.

Secretary of Human Services Philip W. Johnston acknowledged in an interview last night that the insurance industry will not be happy with the ban on preexisting condition clauses, a provision modelled after a proposal by Sen. Edward M. Kennedy that is currently before congress.

"I doubt that [insurers] will like it," Johnston said, "but many of the consumer groups and the disabled groups will. This has been a major issue for many of them, particularly the disabled. We think it makes sense at the state as well as the national level."

Johnston listed some of the changes that the administration will present to the Legislature today and said that others are still being discussed. Still under negotiation, he indicated, is language to "clarify our intent" about the broad powers that would be given to a new Massachusetts Health Partnership.

The administration has abandoned its attempt to make the partnership exempt from civil service requirements, a proposal that outraged labor groups. Johnston said other questions about the partnership's structure and authority are still being discussed.

"We have no monopoly on wisdom on these questions," Johnston said. "We're very interested in continuing to talk with advocates and legislators regarding these concerns."

Among the other compromises already reached, the administration has agreed to delete parts of the plan that would have required out-of-pocket payments from Medicaid patients and permitted the state to seize the property of nursing home residents, Johnston and consumer advocates said.

The administration has also agreed to an amendment that would entitle low-income elderly people, those whose incomes are under 200 percent of the federal poverty level, access to the state-mandated fund to finance hospital free care. Advocates for the elderly were especially anxious to get such guarantees because of a recently announced increase of 38 percent in federal Medicare premiums plus existing Medicare coinsurance and deductibles.

Johnston said the administration is still interested in addressing the status of Blue Cross-Blue Shield, the state's dominant health insurer, in the interest of a more competitive insurance market. He said this will be addressed in separate legislation "after this bill is passed."

The human services secretary said he believes the governor's health proposal will pass, with further changes, despite growing opposition to it among major business leaders, insurers and hospitals.

For the record

Correction: Because of an editing error, a news analysis in Sunday's Metro/Region section about objections to Gov. Dukakis' proposed health plan incorrectly stated that the insurance industry favors granting the state authority to inspect individuals' bank and insurance records. The industry does not think the authority should have the power to inspect those records.

■ Comedian ***Soupy Sales*** says his infamous television ploy of the 1960s, when he jokingly told children watching his show to send him the "green pieces of paper" from their parents' pockets, has had lasting influence. "***Jim*** and ***Tammy Bakker*** probably saw that show, and that's where they got the idea" for the PTL television ministry they founded, he said in a speech over the weekend at his alma mater, Marshall University in Hungtington, W. Va. After Sales, whose nickname Soupy is from a play on his real name, Milton Supman, told station officials that he received $80,000 from the ploy, they suspended him for a week, he said. "If I'd have received all the money people said they sent me, I wouldn't be here talking to you," he said.

Kooped up

■ US Surgeon General ***C. Everett Koop*** and his wife, ***Betty***, dropped in on "The Golden Girls" and sat around a table with the stars of the popular NBC-TV show after the taping of a new episode. Koop posed for pictures with ***Bea Arthur***, ***Betty White***, ***Rue McClanahan*** and ***Estelle Getty***, who appear in the series as two widows, a divorcee and one of the women's mother. Koop remarked that he can't get his wife to go out on Saturday nights because she likes to watch the show, but he doesn't mind because he also likes it.

Symphonic pitch

■ Actor ***John Hillerman***, who plays the cultured Higgins on the popular television series "Magnum P.I.," is pitching in to help the Houston Symphony in his home to raise money for the symphony, according to a public relations firm handling the campaign. Hillerman, who has agreed to act as principal spokesman for the fundraising campaign, also will record radio spots urging Texans to send money to the orchestra, says publicist ***Jim Schell***.

AP Photo

Wheels – Millionaire publisher Malcolm Forbes watches Liz Taylor try out the 1988 Harley Davidson motorcycle he gave her yesterday at his Bedminister, N.J., estate.

RO/REGION

rally around magistrate

ıown bigotry; charge unfair treatment

ıano say he is the last
:nter of a controversy
ıis sensitivity toward.

nagistrate at Charles-
:d bigotry firsthand,

growing up Japanese in blue-collar Charlestown during World War II.

They say members of his family were once held in California internment camps during the war. And, they say, a generation later, Hamano's children endured taunts and racial slurs.

But Hamano, friends and acquaintances say, is liv-

HAMANO, Page 32

Health bill advances

House panel adds $192m for hospitals; sends it to floor

By Richard A. Knox
Globe Staff

Gov. Dukakis' universal health care plan whisked through the House Ways and Means Committee yesterday after the panel made significant changes and threw in an extra $192 million in new 1988 revenues for the hospital industry.

The panel's action clears the way for floor debate on the measure beginning next Monday. But Democratic legislators warned that Dukakis had better start to lobby House members personally on the controversial proposal if he wants to avoid its getting mired in weeks or months of delay.

Legislators said the political stakes for the governor's health legislation – which were already high – increased sharply yesterday after the resignation of John Sasso as Dukakis' presidential campaign manager. Sasso confessed to leaking material that caused Sen. Joseph Biden to withdraw from the race for the Democratic nomination.

"Now more than anything else [Dukakis] has to show a win on this to avoid the appearance that everything is unraveling," said one House Democratic leader. "If a motion to postpone this for 90 days prevails, his whole thrust and timing are off."

Dukakis hopes to make his proposal to guarantee health coverage for all Massachusetts residents a cornerstone of his campaign for the Democratic presidential nomination.

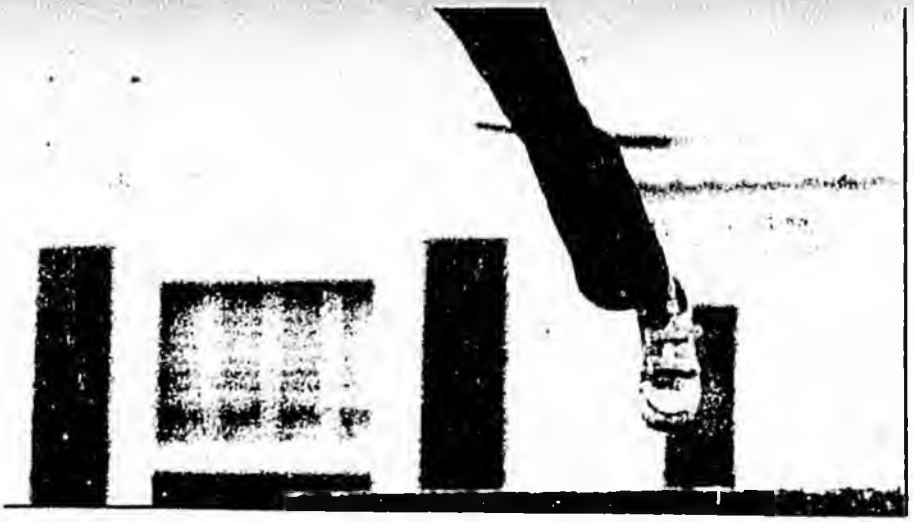
Rep. Richard Voke (D-Chelsea), chairman of the House Ways and Means committee, said in an interview yesterday that the proposal would not be a drag on the state's economy, as business leaders have argued.

"This is a good time to address these issues," he said. "I think we can provide these benefits to people and do it realistically. Other states probably couldn't. Here it's difficult but it's doable."

Voke had previously refrained from endorsing the governor's proposal, which is supported by House Speaker George Keverian (D-Everett).

The chairman added that he has "never seen as many constituencies involved in a bill – never."

The proposal, as reworked by the Ways and Means Committee chairman and staff in the last 10 days, maintains the main elements of the massive Dukakis



Globe staff photo/David L. Ryan

Dorchester takes a short leap off a fence post on his way home from school.

The proposal, as reworked by the Ways and Me Committee chairman and staff in the last 10 d maintains the main elements of the massive Duk bill. The central idea is to push Massachusetts b nesses to provide health insurance for 433,800 worl and dependents who can't buy it through the w place.

The House version also considerably enriches proposal for hospitals, tries to meet some objecti from the business community and trims the powers new state agency that would purchase or pro health coverage for 1.5 million or more people left u sured by their employers.

In one provision that has caused some confus the committee's version would permit Massachus businesses and municipalities that already provide surance to pay 50 percent of the premium, instead o percent required by the Dukakis bill, as long as the ference were offset by higher benefits.

HEALTH INSURANCE, Page 30

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ort

Plaza in Bridgeport, tion workers in April, icrete floor tore loose of ed to wrench up a sec- sources investigating

irds investigation into ces said, that numer- he building's construc- two hydraulic jacks to floor – set off a chain structure in less than

ly to go. The structure ne person close to the

ose is the worst con- ngland history. The ding was about 60 per- vith seven floors com- he rest of the floors e. An adjoining wing

eing shifted into place bove the seventh floor,

ructed using a contro- "lift-slab" method in uilding were poured on columns by jacks and

City Council fires two Scondras aides

By Peggy Hernandez
Globe Staff

Two aides to a Boston city councilor were fired by the City Council yesterday because of their participation in a group that advocates the rights of people accused of, or victims of, homosexual activity between adults and minors.

The two men, Gary Dotterman and Junis French Wall, said yesterday that they are consulting attorneys and they vowed to continue working for Councilor David M. Scondras (Back Bay-Beacon Hill-Fenway-Mission Hill).

Because each councilor has retained hiring and ing controls over his or her staff by longstanding pr tice, yesterday's action was considered rare.

The dismissals were called for 11 days ago by Co cilor at Large Albert L. O'Neil, who said that if Dot man and Wall were retained, the council would app to be indicating to the public that it tolerates child r lestation.

Scondras labeled the 9-2 council vote "a witch hu and said he believes the two men were slandered a their civil rights violated. Scondras also accused his

CITY COUNCIL, Page 48

Globe photo/John Mo

A worker at the Fenway Community Health Center.

Fenway center in forefront of AIDS figh

By Joanne Ball
Globe Staff

A once-filthy basement of a former Fenway antiques store that a handful of neighborhood volunteers

drome epidemic has tripled patient needs at the con tently busy neighborhood agency.

Last year the center, at the corner of Haviland Str and Edgerly Road, had 12,000 medical visits. About percent of those were from AIDS patients. That perce

Committee advances health care bill

■ **HEALTH INSURANCE**
Continued from Page 25

"This will allow a lot of existing insurance plans to keep what they have," said committee budget director David Lord.

Hospital lobby

Hospitals, which have lobbied House members intensely in recent days, convinced the committee to grant them about $315 million in additional 1988 revenues, according to committee analysts. By comparison, administration officials have said their bill offered hospitals about $256 million more.

The committee also voted for a separate, six-month-old bill that would ensure an additional $100 million in revenues for 39 hospitals deemed underfunded by the previous state hospital reimbursement law, which expired today.

The committee earmarked $127.5 million of the increased revenues for wage increases of patient-care workers.

The $415 million in new hospital revenues approved by the committee translates into about 18.5 percent more on the hospital bills paid by Blue Cross-Blue Shield and commerical insurers, according to a committee analyst.

However, Massachusetts Hospital Association president Steven Hegarty said yesterday that his organization was still unsatisfied with the $415 million in new hospital revenues approved by the committee. He said the $5 billion-a-year industry must have an additional $488 million in 1988.

Dukakis said yesterday referring to the Ways and Means package: "I certainly hope the line can now be held at these levels."

Delay attempts

Republican members of Ways and Means yesterday led several unsuccessful attempts to delay committee action on the governor's bill by 90, 30 and five days. "It's pretty clear that the Republicans will vote as a bloc next week to postpone action," said one majority member, adding that it was unclear how many Democrats might go along.

However, Rep. Iris K. Holland (R-Longmeadow), who voted for delay, predicted after the session that the House "will pass a bill that provides for universal access to health care, without question. The leadership has spoken.

"No one," Holland added in an interview, "wants to vote against universal access."

Judging from yesterday's committee session, numerous amendments will be proposed next week from both sides of the House chamber. Voke predicted that House debate on the bill will consume "a minimum of two and probably three to four days."

Both Dukakis and business spokesmen expressed concern that floor amendments would further inflate the proposal's cost, which the committee has already increased by hundreds of millions of dollars.

Dukakis said in a press statement that the cost of insuring the uninsured in the House panel's version "seemed to be close to those in our legislation." The administration says that provision would cost between $588 million and $636 million.

Voke called the administration's cost estimate "conservative" but said "we don't have a number" for the committee version's cost.

Welcon

By Ed Siegel
Globe Staff

TV

NEW SEASON
9 p.m. Thursdays, Cb

Lord Peter Wimsey "Mystery's" got him. we saw the Roaring criminological cutup, and he was played by chael in a "Masterpie series so popular it pr the impetus for WGBH to create "Mystery" a series.

Carmichael has gi Edward Petherbridge, cally noble Newman "Nicholas Nickleby." T miliar with both Dicke ers, it may seem like a ble leap from Noggs but Petherbridge, like British cohorts, has th make the jump comfort

Petherbridge brings but more substance to ter than Carmichael. It understated performan seems in danger of di in the role, which was of his predecessor. On hand, there's more whi Wimsey, an everyman wardness that grants h mythic aura and there his pursuit of Harriet believable and affecting

WEATHE

Cloudy,

National Weather Service

Boston area: Consid erable cloudiness, north west winds 15-25 m.p.h. highs 60-65 (16-18 C). To night, clear, lows 40-4 (4-7 C). Tomorrow, partly sunny, highs in mid-60 (18-19 C).

Globe photo/Vyto Starinskas

Leo Dennis, ski director at the Killington Ski Area in Vermont, last night was considering opening temporarily one lift and one trail this morning for free skiing.

reached over 50 miles per hour and where more than 1½ inches of rain fell. The winds, said police at Boston Harbor, tore a handful of boats loose from their moorings in the harbor and the Charles River.

The weather service replaced forecasts of rain and light snow with winter advisories yesterday morning for areas between the Hudson Valley and western New England.

"We weren't expecting the storm to be as strong as it was," said Wyllie. Cold air from

SNOW, Page 8

le as court convenes

) be heard in new term

rin Hatch said yes- it President Reagan withdraw Robert H. nination. Page 4.

. That is an unsatis- ome to an important al case and the jus- ve such cases a second ront of a full court. esident Reagan nomi- in July to replace the s F. Powell Jr., Bork's have argued that he the court to the right. derate, often provided fifth vote especially in lding affirmative ac- ortion.

pivotal role and the presented by an eight-member court were illustrated when Powell fell ill in early 1985 and missed nearly three months of the court's term. Of the cases heard during his absence, the justices issued five 4-4 decisions and ordered new arguments in three others.

Bork's potential impact on the court is significant. He has criticized scores of decisions expanding constitutional rights for women and minorities, reserving some of his most scathing commentary for rulings – including the one upholding the right to an abortion – that have been based on a constitutional right to privacy. Before the Senate Judiciary Committee, Bork said he would respect precedent.

He has also stated that capital

SUPREME COURT, Page 4

Reagan salutes accord on trade with Canadians

From Wire Services

WASHINGTON – President Reagan yesterday hailed a new US-Canadian free trade agreement designed to eliminate tariffs over 10 years and cut restrictions on commerce between the North American neighbors. The accord was reached Saturday just before midnight under pressure of a congressional deadline.

"Now, in addition to sharing the world's largest undefended border, we will share membership in the world's largest free trade area," Reagan said in a statement released at the White House.

A Canadian official, however, warned that the pact could "easily unravel" in the next six months.

CANADA, Page 7

the union would file an unfair labor practice charge with the National Labor Relations Board, and that if Wilson makes the drivers public employes, the union would sue to annul that move.

"What kind of education does Laval Wilson present to the world,' Barrett asked. "Should workers no longer have the rights to bargain?"

Γ RIVERS, Page 31

A dilemma for state's hospitals

By Richard A. Knox
Globe Staff

NEWS ANALYSIS

The Massachusetts hospital industry, which has led the fight against Gov. Dukakis' proposal for universal health insurance, now finds itself in a political quandary.

Hospitals have been so successful in getting the Legislature to enrich the governor's proposal that it appears they cannot afford for it to lose.

The calculus works this way.

The House of Representatives, which begins debate on the proposal today, has several choices: Accept the current version, which Dukakis supports; prolong consideration for weeks or months, which could result in a stalemate like one that occurred last spring; or merely "roll over" the state's current hospital payment system, which expired last Wednesday.

If the House passes the plan and the Senate leaves its hospital payment provisions intact, the $5 billion-a-year industry will be richer by $252 million to $348 million in the coming year, depending on whose estimate one believes.

But if the House kills the bill and merely extends the current hospital payment system – as many in the business community strongly advocate – hospitals will be poorer in 1988 by anywhere from $60 million-$75 million (an industry analyst's estimate) to $124 million (the administration's estimate).

There are indications that the Massachusetts Hospital Association understands this. "We say

HOSPITALS, Page 9

A political dilemma for the state's hospital industry

■ HOSPITALS
Continued from Page 1

that House 6068 [the current bill] would produce $65-$70 million more than if the current law were extended," said Larry Seck, an analyst on the association staff.

Many hospital administrators say privately the industry must begin to make hard choices about which institutions should survive rather than pursue the old strategy of raising the tide for everybody. But many add there is strong pressure not to break ranks at this critical juncture.

Publicly the industry group has stuck to its claim that it needs an additional $544 million in revenue in 1988. This would require an additional $200 million to $300 million in the payment formulas within H6068.

"We do not feel the cost figures we've put forward are in any way unreasonable," hospital association president Steven Hegarty said last week. "Those are our legitimate needs."

"I'm perplexed by the hospitals' strategy," one Rate Setting Commission analyst said Saturday. "They are risking scuttling the bill, whereas they'd get more money from it than from the current system."

Nelson Gifford, chairman of the Massachusetts Business Roundtable's health care committee, agrees that hospitals would be considerably better off under the governor's proposal.

That is why Gifford, as a representative of employers who would pay increases in hospital bills through insurance premiums, called for a one-year rollover of the current system in an interview Friday. "We've got to hold the hospital efficiency. That has led many – inside and outside the industry – to question whether the public and business community ought to continue subsidizing inefficient and failing institutions.

There is broad agreement among industry analysts that previous and current hospital payment systems have protected such hospitals. New statistics from the state Rate Setting Commission and other sources, obtained by the Globe, reveal some of these wide disparities publicly for the first time.

They show, for instance, that the cost per inpatient hospital case, adjusted for severity of illness, is higher at many community hospitals than it is at the big-league Boston teaching hospitals. In nearly every case, these high-cost community institutions have very low occupancy rates but they have been able to jack up their charges to compensate for the loss of business.

Thus, the 1986 average cost per case at Norwood Hospital ($5,134), Union Hospital of Lynn ($5,341) and New England Memorial Hospital in Stoneham ($5,528) is considerably higher than at Massachusetts General Hospital ($4,985).

This is especially striking when one considers that MGH's sicker patients require care that is about 50 percent more intense, on average, than those community hospitals. MGH also has considerable teaching, technology and standby costs that the community hospitals do not have.

Similarly, 26 nonteaching hospitals had higher costs per case in 1986 than Harvard-affiliated Beth Israel Hospital.

Massachusetts hospital profile

The fewer patients, the more expensive occupancy and cost per case in 1986*

	Occupancy rate avg.	Cost per case*
All major teaching hospitals	72.3%	$5,227
All minor teaching hospitals	65.6%	$4,782
All community hospitals	58.4%	$4,716
High-cost community hospitals	53.0%	$5,657

*Cost per case is adjusted for severity of illness to make up for the fact that some hospitals admit more complex cases than others
Source: Massachusetts Rate Setting Commission, 1987

Globe staff chart

The real problem, Roper said, is that "there are a lot of hospitals in Massachusetts – more than necessary. We need to wring out the excess capacity."

Some hospitals will gain

A closer examination of the Medicare payment shift, however, also reveals that many institutions would actually gain from the new Medicare rates if their previous costs were below the national average.

Medicare gains for many of these low-cost hospitals range from 2 to 12 percent, with an average gain of 3 percent, according to state Rate Setting Commission estimates. Combined with a 17-percent jump in private payers' payments under H6068, these 39 low-cost hospitals should enjoy a 10 percent increase in 1988 revenues.

Teaching hospitals, on the other hand, will probably lose from 4 to 7 percent in direct Medicare payments during the coming year, though this loss may be offset by slight increases in indirect costs, such as teaching and capital allowances.

Because teaching hospitals will suffer in the Medicare payment shift, the hospital association or a group of hospitals is expected to offer an amendment to H6068 this week that would redistribute some of the Medicare funds to teaching hospitals.

Since community hospitals are not expected to appreciate this, the hospital association is also pushing for enactment of a separate proposal before the House, H4692, that would funnel an extra $83 million to $100 million to low-cost hospitals.

The administration's main worry now is that the hospitals' money demands will sink the bill, and with it the opportunity to enact "health care for all." They argue this would not be in hospitals' interest.

As one analyst said this weekend: "I think hospitals should remember what Medicare and Medicaid has done for them and think twice about killing this bill."

Mass. hospital costs

Inpatient expenses per admission in 1985 made Massachusetts hospital costs the most expensive among 12 industrial states of which the average cost per admission was $3,025.64.

	Per admission
1. Massachusetts	$4,193.71
2. California	$4,049.96
3. New York	$3,929.98
4. Michigan	$3,666.40
5. Illinois	$3,607.22
6. Ohio	$3,427.50
7. Pennsylvania	$3,412.17
8. Florida	$3,381.46
9. Maryland	$3,237.37
10. Indiana	$2,941.64
11. New Jersey	$2,914.07
12. Texas	$2,798.88

Source: American Hospital Association and Health Planning Council of Greater Boston

Globe staff chart

pitals back from the gorging they've been doing," he said. "It's an orgy."

The House Ways and Means chairman, Richard A. Voke (D-Chelsea), and his staff also believe hospitals would do better under his committee's version of the bill than under the status quo.

Dukakis and his top officials argue that the extra 1988 money for hospitals is the short-term price the state must pay in order to pass universal entitlement to health care. But the governor is expected to plead with legislators this morning to "hold the line" on further hospital cost increases.

If the hospital association's strategy appears perplexing, the explanation may lie in the internal dynamics of the hospital industry, according to many observers.

Disparities revealed

Though hospitals have successfully presented a united public front in the past weeks and months, the debate over the governor's proposal has deepened schisms within the industry.

The debate has highlighted, for instance, the wide disparities in

Systemwide problems

These are major systemwide problems in the Massachusetts hospital industry, not isolated examples. Seven out of every 10 Massachusetts hospitals had occupancy rates below 70 percent in 1986, the most recent data. Lower occupancy tends to be associated with high costs per case.

Another major point of confusion in the recent debate concerns the failure of the federal Medicare program to increase payments to Massachusetts hospitals in 1988, despite rising costs for personnel, equipment, supplies and new burdens such as the costs of treating patients with acquired immune deficiency syndrome.

The hospital association argues that Massachusetts payers should make up for Medicare "shortfalls."

Medicare's chief administrator at the federal level, William Roper, said in an interview Friday that Massachusetts hospitals will lose about $100 per Medicare inpatient case in the coming year as the program begins to pay them on national rather than regional rates.

Most expensive community hospitals in Mass.

	1986 figures	
	Occupancy rate avg.	Cost per case*
Marlborough Hospital	55.1%	$4,834
J.B. Thomas Hospital	66.9%	$4,853
Leonard Morse Hospital	63.8%	$4,870
Fairview Hospital	9.0%	$4,877
Hahnemann of Boston	67.2%	$4,925
Somerville Hospital	51.1%	$4,965
Parkwood Hospital	49.1%	$5,021
Norwood Hospital	59.7%	$5,134
Hale-Haverhill Hospital	69.2%	$5,143
Lawrence Memorial Hospital	55.1%	$5,164
Union of Lynn Hospital	55.0%	$5,341
**Mary A. Alley Hospital	50.6%	$5,392
Central Hospital	67.9%	$5,525
New England Memorial	56.4%	$5,528
Brookline Hospital	15.5%	$7,355
Huntington General	26.0%	$7,500
Southwood Hospital	53.7%	$9,753
Average	53.0%	$5,657

*Cost per case is adjusted for severity of illness to make up for the fact that some hospitals admit more complex cases than others

**Has since ceased inpatient services

Source: Massachusetts Rate Setting Commission, 1987

Globe staff chart

ting off US oil purchases from that country, depriving it of currency that could be used to buy arms to fuel the Iran-Iraq war and attacks on shipping in the Persian Gulf, where a US task force is on duty escorting oil tankers.

It was the second time in a week that the Senate voted such a

events in the gulf. The action is considered somewhat symbolic because Iranian oil not purchased by the United States could easily be sold elsewhere.

The House measure, which differs slightly from the Senate version, also urges the United States to persuade Japan and US allies

EMBARGO, Page 4

Bus drivers, Wilson agree to arbitration

By Patricia Wen
Globe Staff

Superintendent of Schools Laval S. Wilson and striking bus drivers agreed last night to enter binding arbitration to end the 28-day walkout, leading both sides to predict buses may roll as early as tomorrow.

This proposed solution to the strike – which came as Wilson was starting the arduous task of hiring replacements – must be approved by the Boston School Committee to become effective. Committee President John A. Nucci has scheduled an emergency meeting for 5 p.m. today.

The proposal unfolded when union members emerged from a three-hour membership meeting in Dorchester last night to say they would return to work as soon as school officials agreed to enter binding arbitration.

"There will be a return to work as soon as the document is signed," said Warren Pyle, an attorney representing the United Steelworkers of America, Local

DRIVERS, Page 12

Judge refuses to free mother

By Steve Curwood
and Diego Ribadeneira
Globe Staff

Essex County Probate Judge Haskell Freedman yesterday gave custody of Nicole LaLonde to his court's probation department and rescinded an order that granted temporary custody to her father after her mother, Virginia LaLonde, fled the state with her in June 1986.

Freedman made the ruling at a hearing at which Virginia LaLonde's lawyers asked the judge to give custody of the child to the Archdiocese of Boston and to free Mrs. LaLonde from prison, where she has been held for contempt since March 31.

Freedman did not explain why he chose to award custody of the child to the probation department of the Essex County Family and Probate Court. He said a written order will be released later.

Freedman added, "The child will be held at a hospital and evaluated by three court-appointed experts" to determine whether she has been sexually abused.

Judge Haskell

At the same
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Inside

Today: Food

Cardinals beat Giants, 5-3

The Cardinals topped the Giants last night, 5-3, in the National League playoff opener. Page 79.

Development outlook

Officials said yesterday that private development in the center city in the early 1990s will have to take a back seat to public construction. Page 21.

Reagan shift on Latin plan

President Reagan, in a strategy shift, will voice support today for the Central American peace plan, aides said yesterday. Page 3.

Guide to features

Health bill faces overhaul

By Richard A. Knox
and Frank Phillips
Globe Staff

Gov. Dukakis' beleaguered health care bill faces a major overhaul after House leaders yesterday assessed the political damage from the first floor debate on the proposal Monday, State House sources said last night.

The governor got the bad news last night from a delegation of House leaders headed by House Speaker George Keverian (D-Everett). Emerging from a half-hour meeting, Dukakis acknowledged that more time will be needed to overcome strong opposition to the proposal.

Keverian and other leaders reportedly told Dukakis that the bill is in such trouble that fundamental changes may be needed. The governor and his chief secretary, Hale Champion, reportedly suggested some alterations in the proposal, "but nothing was resolved," one source said.

"It may not be something we'll be able to do overnight," Dukakis told a group of reporters as he left his office for a presidential campaign trip to Baltimore and Washington. "It may take time. But everybody knows that we've got to act on these issues."

At stake is Dukakis' high-visibility push to

HEALTH, Page 37

The mirr

Robert Lewis (left) and Stuart Kerme
club at the site of a century-old Jama

Dukakis' health bill faces overhaul

■ HEALTH

Continued from Page 1

make Massachusetts the first state to guarantee health insurance to all its citizens. The 155-page bill also attempts to control hospital costs.

The bill's fate is also wrapped up with Dukakis' presidential ambitions, not only as a bold initiative but also as demonstration of his managerial and political abilities. Before Monday, the administration, House leaders and even the Massachusetts Hospital Association were predicting that the health care bill would pass the lower chamber this week.

Last night, however, Dukakis left open the possibility that House consideration of the bill would be delayed beyond next Tuesday. The bill was postponed until then by a vote of 126-29 after it became evident that it would fail on a direct vote.

House leaders will be polling members today to determine how much support exists for Dukakis' "health care for all" proposal. Although Keverian declined comment, sources close to the leadership said last night that "something will be done tomorrow. There will certainly be some news about the bill tomorrow."

Others speculated this means the complicated proposal would be returned to the House Ways and Means Committee for a major redrafting. The chairman of that committee, Rep. Richard A. Voke (D-Chelsea), made substantial changes in the original bill in an unsuccessful attempt to placate opposition from the hospital industry and business community.

"Strongly committed"

The governor said he needed to "get a better sense of what concerns legislators have and some of the ways we can respond to that. If it takes a little longer than we thought, then we'll spend the time at it. We're all strongly committed to getting a good health care bill."

Some House leaders were critical of the administration's political strategy on the bill, saying the governor and his staff failed to counter the barrage of opposition from the hospital industry and small businesses to major features. The impact of small-business opposition in particular was underestimated, several said.

"Every one of us has been to the dry cleaners and barber shops and harangued about this. Our local people are crying survival," said one House leader. The administration "didn't give us the answers. We didn't have the ammunition to answer it."

One feature of the proposal would have required all businesses to provide health insurance for their employees or pay a 12 percent surcharge on the unemployment insurance premiums. This provision would hit small businesses especially hard, critics argued, since they often do not provide health insurance benefits now.

Critics in both parties yesterday placed the blame for the bill's troubles on Dukakis and his staff. They charged that the governor relied on House leaders to round up the votes he needed to pass the proposal and failed to lobby legislators personally to overcome stiff opposition from local hospitals and businessmen.

"There was a tremendous void in reacting to what was obviously going on on the House floor," said Rep. John Flood (D-Canton), chairman of the Joint Taxation Committee.

Sasso's absence

Flood and others said the bill's difficulties show that Dukakis is suffering from the absence of longtime aide John Sasso, who had served as his chief secretary until resigning to become chief of his presidential campaign earlier this year.

"Sasso was always valuable in sensing the pitfalls," said Flood, whose relationship with Sasso was stormy. "The guy was very tuned in and anticipated the resistance and tensions. They didn't do it in this instance and they fell on a big one."

Sasso resigned from the campaign post last week after he admitted leaking a videotape that helped sink Sen. Joseph Biden's presidential bid.

Flood said he has had no contact at all with Champion, Sasso's successor as chief secretary and the main architect of the complex health care bill. "I've never met the man nor talked to him," Flood said.

Republican leader Steven D. Pierce (R-Westfield) charged that Dukakis' failure to move the health bill, which the governor identified as his highest legislative priority, reflects "how out of touch he really is."

"This really clashes with the overall campaign theme of managerial and political competence," Pierce said. "He talks over and over again of his great relationship with the Democratic Legislature. This really pulls the plug on that."

Champion last night brushed aside criticism that he failed to lay the political groundwork for the health care bill in the Legislature.

"Nobody is somebody else, and I have no aspirations to be somebody else," Champion said, referring to criticism that he had not been as politically skillful in moving the bill as Sasso might have been. "People have different styles, and I'd be the last to say that criticism of me is unwarranted."

However, one top legislative staffer argued that Sasso – and Dukakis – had never had to push such a complicated and controversial issue through the Legislature. "John Sasso never had to do anything like this," the staffer said.

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House turns down GOP measure to shorten hospital fund extension

By Richard A. Knox
Globe Staff

Democratic leaders of the Massachusetts House won the first vote yesterday in their attempt to break the current legislative deadlock over Gov. Dukakis' massive health care reform proposal.

House Speaker George Keverian (D-Everett) and other majority leaders are trying to extend the state's current hospital financing system until April. The move would put pressure on hospitals to compromise on their demands for up to $544 million in additional revenue during the fiscal year that began Oct. 1.

At one point during yesterday's debate, Keverian was on the floor lobbying individual House members – an unusual step for the speaker, observers said.

The House voted 103 to 41 against a Republican-sponsored motion to shorten the extension period to 60 days.

Although the issue seems procedural, State House observers said its outcome may decide the scope and the future chances of the Dukakis health plan, which includes a proposal to guarantee health insurance for all citizens as well as provisions to control hospital costs.

Time factor said crucial

The length of an extension is considered crucial by both sides, since a longer-term extension puts greater financial pressure on hospitals to compromise. Thus, if hospitals succeed in shortening the extension, their position in further negotiations over cost control and other issues would be strengthened.

> 'I don't understand why we think we'll solve the problem by extending the current system six months. We're just going to exacerbate it.
>
> – Rep. Marjorie Clapprood

The House is scheduled to take up the extension bill again today, when legislators sympathetic to hospitals are again expected to offer amendments that would shorten the 6-month extension.

Hospital industry representatives said they were alarmed yesterday morning when they saw the language of the House leadership extension proposal, which they interpreted as a six-month freeze on hospital charges at the rates in effect on Aug. 1.

Confusion over this point led to heated exchanges on the House floor between Rep. Marjorie Clapprood (D-Sharon) and other hospital supporters and Richard A. Voke (D-Chelsea), chairman of the House Ways and Means Committee, author of the extension proposal.

"It's not a freeze and does not say that it is a freeze," Voke insisted.

"A freeze is a freeze is a freeze," responded Clapprood, saying she had been informed by Voke's own staff and members of the Ways and Means Committee that the proposal had that effect.

"I don't understand why we they would like to avoid the need for substantive amendments, which they fear could lead to protracted procedural wrangling.

By extending the hospital financing system that expired Oct. 1, House leaders said, the measure would allow hospitals to raise their charges only about 4 percent. An increase of about 16 percent was contained in a Dukakis-House proposal that the hospital industry helped stave off last week. Hospital representatives said that proposal was not generous enough to cover their 1988 fiscal needs.

Rep. Peter Forman (R-Plymouth) argued that a six-month extension would put many hospitals "in serious financial difficulties."

"I understand that some have to send a message to the hospital community," Forman said. However, he added, "we have got to keep hospitals financially sound. We do that by a short-term extension" of the financing mechanism that expired Oct. 1.

Voke countered that a six-month extension, by applying pressure for a negotiated solution, would "save this system from chaos and, frankly, keep this legislative body from chaos with so many [legislators] running around with little pieces of a bill."

Could be shortened

Voke noted that a six-month extension of the current system could be considerably foreshortened if the involved parties could agree on a compromise before then.

Meanwhile, the governor's staff vowed to keep fighting for the administration's proposal to guarantee health insurance coverage for all Massachusetts citizens.

"We're still for health care for all," said Hale Champion, the governor's chief secretary. Dukakis will meet today with representatives of small business, a sector whose opposition was instrumental last week in persuading House leaders to withdraw the proposal from the floor before it was amended to death.

responded Clapprood, saying she had been informed by Voke's own staff and members of the Ways and Means Committee that the proposal had that effect.

"I don't understand why we think we'll solve the problem by extending" the current system six months, Clapprood said. "We're just going to exacerbate it." Clapprood also said she favored splitting the universal health insurance part of the Dukakis plan from its hospital cost-control provisions – a step that most agree would kill the governor's health-care-for-all proposal.

Want to avoid wrangling

Voke said in a subsequent interview he will attempt today to allay House members' concern about the freeze issue. "We don't think the bill is flawed," Voke said. If the proposal needs clarifying language, he said, it might be added today on the House floor. Voke and other House leaders said will meet today with representatives of small business, a sector whose opposition was instrumental last week in persuading House leaders to withdraw the proposal from the floor before it was amended to death.

Sen. Patricia McGovern (D-Lawrence), chairman of the Senate Ways and Means Committee, also said she remains committed to the universal health insurance part of the legislation, though she is "not wedded to any particular way of doing it in terms of the strategy or the tactics." The Senate must await House action on the proposal, since it includes new state revenue-raising authority, and all tax matters must originate in the House.

"People need to keep speaking out that universal access to care is an achievable goal in this legislative session," said McGovern, who will speak about the subject this noon before statewide Community Action Program representatives.

Dukakis health proposal may hitch a ride

McGovern exploring whether to use House bill as vehicle for universal health insurance

By Richard A. Knox
Globe Staff

The Massachusetts House yesterday passed and sent to the Senate a measure that might become a vehicle for Gov. Dukakis' universal health insurance proposal.

The House bill, passed on a voice vote, merely extended the state's six-year-old hospital financing system for another six months.

Sen. Patricia McGovern, chairman of the Senate Ways and Means Committee, said she is exploring whether some version of the governor's proposal could be loaded onto the limited House measure.

McGovern (D-Lawrence) said in an interview that she hopes the hospital financing extension bill could legally become the vehicle for universal health care access as well as hospital cost-containment reform, "but it has to be looked into." It might take a few days to decide, she added.

"Basically I think we should proceed right now to see what we can accomplish," McGovern said. "I think we should try to go as aggressively at this as we can. ... If we don't seize this moment, we'll deeply regret it, we'll lose the moment."

There was widespread speculation at the State House yesterday that McGovern would grab the initiative on the universal health insurance issue.

During House floor debate on the extension bill, Rep. Iris K. Holland (R-Longmeadow) asked the House Ways and Means chairman, Richard A. Voke (D-Chelsea), if the bill could be remodelled into a full-scale universal health insurance proposal in the Senate. "I have no idea what, if anything, would return from that chamber," Voke said.

"I believe this is what is going to happen: When this bill comes back to us, it will have attached to it Pat McGovern's version of a universal health insurance bill," Holland said in an interview. "What I anticipate is that we will have a universal health care bill this year and that it will be revised by Sen. McGovern."

Told about Holland's statement, McGovern laughed. "Let's see if Iris Holland is indeed correct," she said. "I wish Pat McGovern knew the answers."

The House also gave preliminary approval, also without a roll-call vote, to another bill that would provide an estimated $100 million in additional 1988 revenue to 39 "underfunded" hospitals.

The second bill was reported out of the House Ways and Means Committee on Oct. 13 but had been held in the clerk's office until yesterday. The Massachusetts Hospital Association has pressed House Speaker George Keverian for the bill's release. One hospital association leader said last week that Keverian had pledged his support for the bill.

Catherine Dunham, the governor's director of human resources, speculated yesterday evening that the second bill, House 4692, "might become a vehicle too" for the universal health insurance package if the extension bill is deemed procedurally inappropriate.

"We're not that far away" from legislative approval of "the whole thing," Dunham said, referring to a proposal that would begin the process of insuring the 600,000 Massachusetts residents without health insurance.

One important issue concerns the flow of money to about 30 hospitals that provide the bulk of the state's "free care." These funds, totalling more than $315 million a year, are raised through a 13.25 percent surcharge on all hospital bills; the money is transferred from hospitals with low volumes of "uncompensated care" to hospitals with high volumes, such as Boston City Hospital, Carney Hospital and Brigham and Women's Hospital.

The state hospital financing law that expired Oct. 1 provided for the transfer of these funds. Until the extension bill is passed by the Senate and signed into law by the governor, there is no legal mechanism for the transfer.

Today – the 15th of the month – is when the accumulated funds are ordinarily paid to the hospitals with a high amount of free care. Thus, those institutions will begin to suffer financially from the current legal hiatus.

Dunham said the administration has been trying to persuade the hospital association to organize a voluntary transfer of the funds, but is not sure whether the hospitals will go along. Since hospitals strongly oppose a six-month extension of the old system, she said, the administration has argued that they "should not give the Senate any excuse to pass the extension bill."

Ten days ago, the House leadership abruptly withdrew the measure from floor debate in the face of overwhelming opposition from small-business representatives concerned that the Dukakis plan was too expensive and the hospital industry, which argued that it did not provide them enough money.

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Attachment G

"The Need and Unmet Need for Infertility Services
in the United States"

Research Note

The Need and Unmet Need for Infertility Services In the United States

By Stanley K. Henshaw and Margaret Terry Orr

This article estimates the number of women of reproductive age who need infertility services because they want to have children but suffer impairments of their own or their partners' fecundity; it also estimates the number who have obtained such services. The analysis is based on data from the 1982 National Survey of Family Growth (NSFG), which involved a nationally representative sample of 7,969 women aged 15–44 of all marital statuses. Standard errors have been calculated for all estimates presented below, using equations published by the National Center for Health Statistics.[1] T-tests have been used to test the significance of differences in proportions.

Classifications

Figure 1 represents all U.S. women aged 15–44 classified according to their fecundity status. Assignment has been made hierarchically, since some women fall into more than one category. Of the 54.1 million U.S. women of reproductive age, 19.4 million (36 percent) are subfecund or infecund. Nearly three-quarters of this group—13.7 million—are infecund because they or their partners have been surgically sterilized: Ten million have had tubal ligations or vasectomies and 3.7 million have had hysterectomies or ovariectomies. The latter procedures are irreversible, whereas tubal ligations and vasectomies can sometimes be reversed (although at great cost) by means of microsurgery.

Nearly 900,000 of the subfecund or infecund women state that it is impossible for them to have a baby because they are menopausal or because they or their partners have had an accident or an illness; these women are classified as nonsurgically sterile. Another 1.5 million are classified as "perceived subfecund" because they report that they or their partners have some problem related to becoming pregnant. Approximately 2.1 million women are not sterile or subfecund but report that it would be dangerous or difficult for them to carry a pregnancy to term, that it would be dangerous for the baby, or that they have been advised by a doctor not to become pregnant; these women are unable to have a baby but report no problems related to conception per se.

Just over one million women are not surgically sterile and do not report any problems in conceiving or carrying to term, but they do report that during at least the preceding 12 months of continuous marriage or cohabitation, they neither practiced contraception nor became pregnant.* Without further information, we have categorized couples in this "long-interval" group as subfecund/infecund, although some of them may be able to conceive in the future without treatment; indeed, some will conceive without treatment given a longer period of trying to become pregnant. However, we have equated 12 months with a long interval because many couples seek infertility services after a year of trying to become pregnant.

As a result of the underreporting of abortions in the NSFG, the number of women estimated to belong in the long-interval category may be too high.[2] The problem of underreporting is minimal among married white women but is substantial among married black women; however, since married blacks constitute only a small proportion of all subfecund and infecund women, correcting the error would have only a small effect on the estimate for the subfecund/infecund category. (Unmarried noncohabiting women who have not practiced contraception and have not become pregnant are excluded from the long-interval category because of uncertainty about their frequency of intercourse over the 12-month time period.)

All women who are not already classified as subfecund or infecund and who report having had a pregnancy within the three years prior to the interview are classified as fecund. The 10.6 million women (20 percent of all those aged 15–44) who make up this group constitute a minimum estimate because of the underreporting of abortions, particularly among unmarried women. Such underreporting could mean that the number of fecund women should be adjusted upward by as much as 18 percent, to 12.5 million (23 percent). This adjustment has not been made, however, because of uncertainty about the exact correction factor to use and the categories the women should be taken from.

The number of women whose fecundity status is unknown is estimated to be 24.2 million (45 percent of all women aged 15–44). However, this figure is undoubtedly inflated by the underreporting of abortions. Nearly one-half of the "fecundity unknown" group—11.7 million women—are currently using a reversible method of contraception. Another one-fifth—4.9 million women—are classified as not currently practicing contraception; they are not eligible to be put in the long-interval category because their period of contraceptive nonuse is shorter than one year, or because they are neither married nor cohabiting. Finally, nearly one-third of those whose fecundity is not known (7.5 million women) have

Stanley K. Henshaw is deputy director of research at The Alan Guttmacher Institute (AGI). Margaret Terry Orr, who was principal investigator for the research project upon which this article is based, was senior research associate at the AGI. She is now senior associate with Pickman Consulting Group, a social policy consulting firm in New York. The research project was supported by grant number FPR-000037-01-0 from the Department of Health and Human Services (DHHS). The ideas expressed in this article are the authors' and do not necessarily represent those of the DHHS.

*Among women in this group, the period during which they did not conceive despite unprotected coitus was 12–23 months for 35 percent, 24–35 months for 14 percent, and 36 or more months for 52 percent.

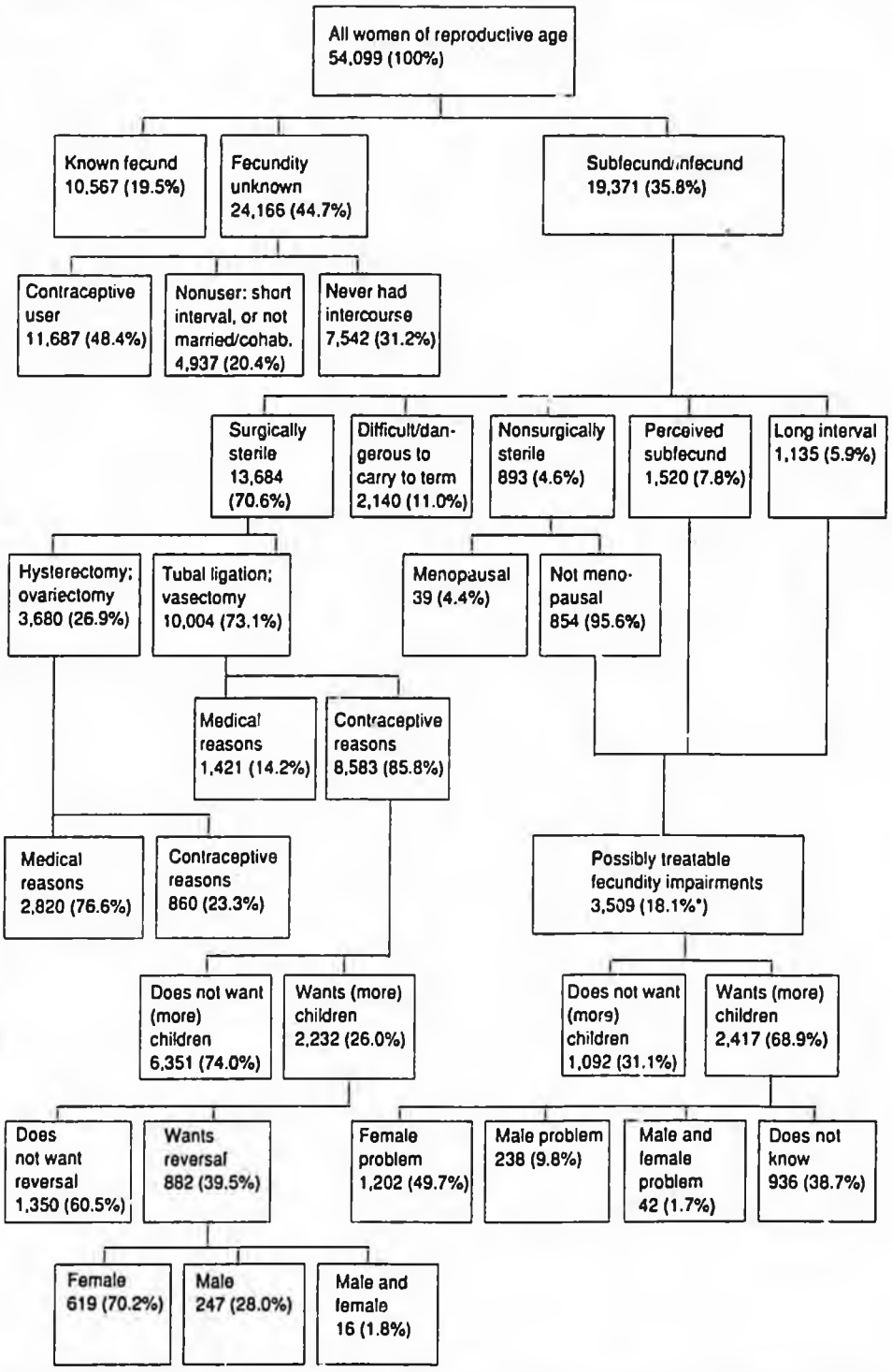
never engaged in sexual intercourse.*

Who Needs Services? Who Gets Them?

In estimating the need for infertility services, we are concerned with three of the categories presented in Figure 1: the nearly 900,000 women who report that they or their partners are nonsurgically sterile; the 1.5 million who perceive themselves or their partners to be subfecund; and the 1.1 million who make up the long-interval group. Except for the small proportion of women who are menopausal, all are considered to have potentially treatable fecundity impairments. (Excluded from the treatable category are couples who have had tubal ligations or vasectomies that they want to have reversed† and those who say it is difficult or dangerous for them to carry a pregnancy to term. The appropriate care for these groups differs from what is usually considered to be infertility treatment.)

In all, an estimated 3.5 million women have fecundity impairments that could possibly be treated. Sixty-nine percent, or 2.4 million, of these women say they would like to have children (or more children) and are therefore defined as needing infertility services. (The proportion who say they want more children is the same among those who believe they are subfecund as among those who are experiencing a long interval without conceiving [71 percent], but it is slightly lower among the nonsurgically sterile [62 percent], who are older, on average, than the other two groups.) The definition of need is thus based entirely on women's reports of their fertility aspirations and of their own and their partners' fecundity status; we assume that these reports accurately reflect their actual physical condition and desire for children. Among those considered to need services are women in the long-interval group, who may not yet suspect a possible infertility problem, and women who are not actively trying to become pregnant. Most such women would not seek infertility care. On the other hand, many women classified as being of unknown fecundity may have infertility problems that will become appar-

Figure 1. Classification of U.S. women aged 15–44, by fecundity status



*Percentage shown is of subfecund/infecund women. Note: Numbers are in thousands; except as noted in preceding footnote, percentages (in parentheses) are based on the next higher level subgroup.

*This category includes women who had coitus before their first menstrual period but not since, and women who are under age 25 and have had coitus only once.

The classification of fecundity status presented in this article differs slightly from that used by the National Center for Health Statistics (NCHS), which conducted the NSFG. (See: W. D. Mosher and W. F. Pratt, "Fecundity and Infertility in the United States, 1965-82," *Advance Data from Vital and Health Statistics*, No. 104, 1985; and reference 2.) The NCHS includes in the subfecund category both women who have difficulty conceiving and those who have difficulty carrying to term; women who say that it would be dangerous for them to carry a pregnancy to term are classified as subfecund only if they also say either that they would have an abortion to terminate a pregnancy or that they are planning to be sterilized to prevent pregnancy. In contrast, this article classifies all women who say pregnancy would be dangerous as subfecund, without any qualifications; and it distinguishes the "difficult/dangerous to carry to term" category from the "perceived subfecund" group. In addition, the NCHS considers to be fecund those women who are classified in this analysis as being of unknown fecundity. Finally, the present analysis uses a 12-month rather than a 36-month interval of unprotected intercourse within marriage or cohabitation to define "long-interval" subfecundity. The differences in definition stem in part from differences in focus: The primary concern of this article is the need for infertility services, whereas the focus of the NSFG reports is the demographic impact of impaired fecundity.

†Some 882,000 couples want a reversal of a previously obtained tubal ligation or vasectomy. (See: S. K. Henshaw and S. Singh, "Sterilization Regret Among U.S. Couples," *Family Planning Perspectives*, 18:238, 1986.)

Table 1. Number of U.S. women who have possibly treatable infertility problems and want to have (more) children, and number and percentage distribution, by person needing treatment and type of infertility services received; according to subfecundity category

Characteristic	Treatable infertile		Nonsurgically sterile†		Perceived subfecund		Long interval	
	No. (000s)	%	No. (000s)	%	No. (000s)	%	No. (000s)	%
Want (more) children	2,417	100	530	100	1,082	100	806	100
Person needing treatment								
Female only	1,202	50	263	50	939	87	0	0
Male only	238	10	164	31	74‡	7‡	0	0
Both	42‡	2‡	10‡	2‡	31‡	3‡	0	0
Not known/not asked	936	39	92‡	17‡	38‡	4‡	806	100
Services received								
Advice	387	16	143‡	27‡	188‡	17‡	56‡	7‡
Treatment	787	33	219‡	41	401	37	168‡	21‡
None	1,242	51	168‡	32	493	46	581	72

†Excludes those who are menopausal. ‡Relative standard error >30 percent.

ent in the future. However, the need estimate we present here applies to one point in time; it does not indicate the number of new cases that occur each year or the number of women who seek treatment in a year. Finally, we must note that even with treatment, not all of the women defined as needing infertility services will ultimately succeed in having a child; nevertheless, it is reasonable for them to seek medical help for their infertility problem.

As Table 1 shows, a large share of the estimated need appears to be for services for women. For half the couples in need, it is the woman who is thought to have the fecundity impairment; in only 10 percent of couples is the male partner described as having the problem. However, whereas 31 percent of nonsurgically sterile women attribute the fecundity problem to their male partners, only seven percent in the "perceived subfecund" group do so. This difference may reflect more certainty about the cause of the problem among women who report themselves or their partners to be nonsurgically sterile. For 39 percent of those with potentially treatable impairments, there is no indication of which partner needs treatment; most of the 39 percent are in the long-interval group.

Forty-nine percent of couples in need of infertility care have received medical attention: Thirty-three percent have received treatment and 16 percent have been given advice only. Sixty-eight percent of those who say they are nonsurgically sterile have received services, as have 54 percent of the "perceived subfecund" group. Among women in the long-interval category, 28 percent have received medical attention for infertility, although by definition women in that category have not reported any infertility problem. For all the categories, however, the timing of such medical attention in relation to the onset of the current fecundity problem is unknown. Thus, it is possible that women in the long-interval group who report seeing a doctor may have done so years earlier, and may have been treated successfully (indeed, about 70 percent of the women with long intervals have had children).

Table 2 illustrates the demographic characteristics of the women estimated to be in need of infertility services. As the table shows, 54 percent are in their 20s and 36 percent are aged 30–39. Relatively few are teenagers or women 40 and older (five percent each). Eleven percent are black and 12 percent are Hispanic. The large majority (75 percent) are currently married, and a smaller majority (59 percent) have had no children. Just over 80 percent live in metropolitan areas. Regional differences reflect the population distribution of the country, with the largest proportion of those in need (32 percent) residing in the South and the smallest proportion (18 percent) residing in the Northeast.

Although 15 percent of women who need infertility care have family incomes below 150 percent of the federally defined poverty level,* only four percent are Medicaid recipients. One reason is that the Medicaid program was designed primarily to serve dependent children and their mothers and consequently covers relatively few childless women of childbearing age. It is possible that the NSFG underestimates the number of women with Medicaid coverage by about one-fifth.† But even if the proportion of Medicaid recipients among those in need is actually about five percent, the fact that Medicaid reimbursement is available for no more than one-third of poor women in need has important implications for the access of low-income women to infertility services.

The 2.4 million women in need of infertility care represent five percent of all U.S. women of reproductive age. The proportion varies somewhat by demographic characteristics, as is shown in the table. Women aged 20–34, and particularly those aged 25–29, are more likely than women in other age-groups to need services. Need is also relatively higher among those who are currently married and those who have had no births. It appears to be less prevalent among poor women than among women of higher income regardless of age. One reason is that poor women are more likely to be unmarried, and unmarried women are about one-third as likely as married women to be in need of services. Race, Hispanic ethnicity, metropolitan status and region have no statistically significant relation to the probability of being in need.

As noted previously, 49 percent of those in need of infertility care have already received some professional attention. Again, the proportion differs according to demographic characteristics. As might be expected, age is a strong predictor of which women will have obtained services: Only 10 percent of women aged 15–19 in need and 29 percent of those 20–24, as compared with 70 percent of women 40 and older, have consulted a professional about their infertility problem. Similarly, married women are more likely than unmarried women to have obtained services.

Among those in need, black women are less likely than nonblacks to have obtained services, and low-income women are less likely than higher income women to have done so. In the latter analysis, the difference between the income subgroups remains large even when age is controlled for, although the differential is no longer statistically significant because of the small number of respondents in the subgroups. Medicaid recipients appear to be less likely than other women to have obtained services, although the sample sizes are again too small to show statistical significance. Med-

*In 1985, the federally defined poverty-level income was $10,989 for a family of four.

†According to estimates from the 1984 Current Population Survey (CPS), the number of women covered by Medicaid is about five million. (See: R. B. Gold and A. M. Kenney, "Paying for Maternity Care," *Family Planning Perspectives*, 17:105, 1985, Table 1.) This figure compares with an estimate of about four million derived from the NSFG. The CPS estimate may include women who are eligible for Medicaid but have not actually received Medicaid-covered services.

Table 2. Number of U.S. women of reproductive age; number and percentage in need of infertility services;†and among those in need, percentage who have obtained services and number and percentage distribution of women who have not obtained services; by selected characteristics

Characteristic	No. of women 15–44 (000s)	In need of infertility services					
		% of women 15–44	No. (000s)	% distribution	% who have obtained services	Have not obtained services	
						No. (000s)	% distribution
Total	54,099	4.5	2,417	100	49	1,242	100
Age							
15–19	9,521	1.2*,‡	115‡	5‡	10*,‡	103‡	8‡
20–24	10,629	5.3	564	23	29‡	398	32
25–29	10,263	7.3	751	31	48	392	32
30–34	9,381	5.6	529	22	69	167‡	13‡
35–39	7,893	4.3	337	14‡	57	145‡	12‡
40–44	6,412	1.9‡	120‡	5‡	70	36‡	3‡
Race/ethnicity							
Black	6,985	3.8	268	11‡	30*	187‡	15
Nonblack	47,114	4.6	2,149	89	51	1,056	85
Hispanic	4,393	6.4	282	12‡	39‡	172‡	14‡
Non-Hispanic	49,706	4.3	2,134	88	50	1,070	86
Marital status							
Married	28,231	6.4*	1,803	75	57*	776	62
Unmarried	25,868	2.4	614	25	24	466	38
No. of births							
0	22,941	6.2*	1,422	59	54	647	52
≥1	31,158	3.2	995	41	40	595	48
Metropolitan status							
Metro	43,199	4.6	1,982	82	46	1,065	86
Nonmetro	10,900	4.0	435	18‡	59	177‡	14‡
Region							
Northeast	11,852	3.7	440	18‡	39	266	21‡
North Central	13,981	5.0	694	29	50	346	28
South	17,308	4.4	765	32	54	348	28
West	10,958	4.7	519	21	46	282	23‡
Income level, by age							
<150% of poverty	13,843	2.7*	374	15‡	26*,‡	277	22
≥150% of poverty	40,256	5.1	2,043	85	53	965	78
<30, <150%	9,503	3.1*	291	12‡	26‡	217‡	17‡
<30, ≥150%	20,910	5.5	1,140	47	41	677	55
≥30, <150%	4,340	1.9‡	83	3‡	27‡	60‡	5‡
≥30, ≥150%	19,346	4.7	903	37	68	288	23‡
Medicaid status							
On Medicaid	3,964	2.5‡	101‡	4‡	25‡	75‡	6‡
Not on Medicaid	50,135	4.6	2,316	96	50	1,167	94

*Difference between subgroups statistically significant ($p<0.05$). In the analysis by age, at least one of the differences is statistically significant. In the analysis of income level by age, difference between the first two subgroups is statistically significant.

†Those who have a possibly treatable fecundity impairment (other than surgical sterilization) and who want more children.

‡Relative standard error >30 percent.

icaid has not been successful in eliminating the income differential in access to services because a majority of the low-income women who need infertility care are ineligible for Medicaid, and even those who are Medicaid-eligible are less likely than higher income women to obtain services. There are no significant differences by Hispanic ethnicity, parity, metropolitan status or region in the proportions who have obtained care.

The 51 percent of those in need who have not obtained professional care number some 1.2 million women. This unmet need is concentrated among younger women: Seventy-two percent of those who have not obtained services are under age 30. Blacks and Hispanics each constitute about 15 percent of the unmet-need group, as do nonmetropolitan women. Twenty-two percent are poor, with incomes under 150 percent of the poverty level; six percent are Medicaid recipients.

In defining unmet need, we should add to the group of women who need infertility services but have not obtained them those who have received some care but who would benefit from further professional attention. The number of such women is unknown, however.

As the table below shows, a large majority of those who received infertility services during 1979–1982 obtained that care from private physicians:

Most recent source of care	%
Private physician	67.0
Private medical group	12.2
Hospital clinic	12.1
Community health center/clinic	3.7
Military clinic	2.3
Family planning clinic	2.1
Public health clinic	0.6
Total	100.0

After private physicians and medical groups, which were the most recent sources of care for 79 percent of NSFG respondents who obtained services, hospital clinics were the most frequent source, serving 12 percent. Only a small proportion of women evidently utilized specialized infertility centers, since hospital clinics and private medical groups—the categories that would include infertility centers—together served no more than 24 percent of infertility patients. Family planning clinics provided services to just two percent of respondents. However, since these figures indicate only the most recent source of care (which in many cases was the final source), they may understate the importance of family planning and other nonhospital clinics in providing initial evaluation, counseling and referral for couples with concerns about their fertility.

Demographers and medical specialists have suggested that the need for infertility services will expand in the coming years for several reasons.[3] The number of people of reproductive age will continue to grow, and the number with impaired fecundity will therefore rise. More women are postponing childbearing to their 30s, thus delaying their discovery of fertility problems as well as prolonging the period during which they are exposed to the risk of disease and other factors that might impair their fecundity. In addition, medical advances in the diagnosis and treatment of fertility problems are increasing the number of infertile women whose conditions can be treated.

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Credits

Cover design: Ira Shapiro. Cover photograph: Archive.

Perspectives is indexed in *Cumulative Index to Nursing and Allied Health Literature, Current Contents, Human Resources Abstracts, Index Medicus, POPLINE Previews, Psychological Abstracts, PAIS Bulletin, Review of Population Reviews* (CICRED), *Sage Family Studies Abstracts, Social Sciences Citation Index*, and *Statistical Reference Index*.

Attachment H

"Desperately Seeking Baby:
Ten Million Americans are Struggling to have Children"

US News + World Report, 5 Oct 87.

DESPERATELY

Ten million Americans are struggling to have children

■ The couples who visit Dr. Alan DeCherney at Yale-New Haven Hospital are much too modern to say what Jacob's wife Rachel said thousands of years ago—"Give me children or else I die"—but there's no mistaking their plight. In their minds, DeCherney says, they're suffering through a "life crisis as devastating as any disease known to man." They are struggling to have a baby, and perhaps half of them will never succeed. "Telling a couple they can never have children," the doctor has learned, "is worse than telling a 70-year-old he is dying of cancer."

Even though this is a decade of wonder cures for the barren, infertility is a serious problem that's getting worse. Amid the ballyhoo over science's breakthroughs, not to mention the controversy over surrogate motherhood and papal prohibitions, several cruel facts emerge. More and more women are waiting till age 35 or later to try to become pregnant, and a fourth of them are failing. "For many baby-boom women, there is a trend toward desperately seeking baby," says psychoanalyst Douglas LaBier, author of *The Fallout of Success*. "They're getting older, and it's constantly on their mind." Even women in their early 20s are having more difficulty becoming mothers. In all, 10 million Americans—1 couple in 6 of childbearing age—are defined as involuntarily infertile. That is, they have tried for a year or more to achieve a successful pregnancy and haven't.

High costs, few quick cures

Although specialists are seeing twice as many patients as they did a decade ago, help remains financially out of reach for many if not most would-be parents. Treatment costs average nearly $3,000 per couple, and insurance often contributes nothing. Some couples have sold their cars and homes to pay for surgery that occurs again and again, frequently at $5,000 a try.

People who get medical attention spend months or years wondering if it was worth it. Quick cures are rare. Tests that sacrifice privacy and dignity are common. Some procedures, with forbidding names like *laparotomy* and *hysterosalpingogram*, require painful invasions of the body. Sex is performed according to a doctor's timetable. At some point, after doing everything they're told, couples often are hit with a new sense of despair. "They can't believe that they haven't conceived," says Dr. Wayne Decker, director of New York's Fertility Research Foundation. "They have tremendous anger, anger toward the physician, anger toward the spouse, anger at themselves."

As the tests and treatments drag on, many couples finally concede failure and decide to adopt a baby—only to find that they're starting another frustrating and money-consuming venture. Adoption costs can exceed $10,000,

FROM ZERO TO FIVE

▶ You'd never know that Eileen and Dennis Alcardi of San Francisco spent four years enduring what she calls a "dehumanizing" bout with infertility. At about the time a specialist diagnosed and fixed their problem, they arranged to adopt Jonathan (in middle), now 3½. Since then, Eileen has given birth to Michael, 15 months, and Robert, 2½, plus James and Richard, both of whom arrived last June. "After all those years of putting your bottom up on a pillow for a half-hour, to think I had twins!" she marvels. "It proves it's totally out of control"

SEEKING BABY

and the wait may stretch up to eight years. By then, one or both would-be parents are likely to be over 40—too old, many agencies contend, for someone to become a mother or father.

Yet everything is worthwhile, every taxing fertility test, every nit-picking adoption question, if the eventual payoff is a baby. Barbara Brooks of Springfield, Va.—who spent seven years seeing seven specialists—describes her son, Dan'l, as "a joy beyond anything I ever experienced." Dan'l, 3, is a test-tube baby, one of nearly 1,000 American children conceived by in vitro ("in glass") fertilization—a process in which an egg from a woman's ovaries is mated in a dish with male sperm and replanted in her uterus. Even though Dan'l's mother is now 44, she and husband Dan are hoping that specialists can help them have a second child.

To be sure, a plethora of fertility therapies and drugs has given hope—and babies—to huge numbers of Americans troubled with conditions that a generation ago had few if any remedies. As recently as the 1960s, women who didn't ovulate got virtually no help. Now, two types of drugs will benefit a large majority of them. Nearly 10,000 couples a year turn to artificial insemination, a once rare treatment, and most of them are having babies.

Ironically, however, the miracle cures are indirectly prompting new cases of infertility. "Technology has given people unreasonably high expectations," explains Shulamit Reinharz, a Brandeis University sociologist. "Couples delay marriage and pregnancy, use contraceptives and stop, and then expect to conceive." If they encounter an infertility problem, they expect doctors to have the solution. New York's Decker has seen this happen time and again. "People think they can wait and have in vitro when all else fails," he says. "But in vitro is only about 20 percent effective. At age 24, a woman reaches the peak of fertility. The longer she waits after that, the more likely she is to develop a disease like endometriosis or suffer the effects of infections. The aging process takes its toll."

Many who wait are professionals on the fast track—so many, in fact, that infertility is dubbed "the curse of the career woman." Ten years ago, notes Williams College philosopher Rosemarie Tong, "the women's movement pushed career fulfillment, the idea you could be a real woman, full and complete, without having a child. Women talked a big game, but they didn't believe it. Now they're saying, 'Yes, I want a career, but it isn't the end-all and be-all.'" One new study shows that only 2 percent of women who wed want to be childless. "They are a rare population," says William Mosher, who conducted the survey for the National Center for Health Statistics.

THE FACTS ON FERTILITY

- Most couples want kids. Only 2 percent of married women actually prefer to be childless.
- 1 of every 6 couples of childbearing age has an infertility problem.
- The infertility rate among women age 20 to 24 has tripled to 11 percent since the 1960s. The rate among women age 35 to 39 has jumped to 25 percent.
- Among couples who get medical help, 2 out of 5 still cannot produce their own babies.
- For every healthy white infant who is up for adoption, there are 100 couples or singles seeking such a baby.

From chemicals to contraception

Despite its image as a yuppie woe, infertility occurs 1½ times more often among blacks than among whites and is most common among high-school dropouts. And it's on the rise not just among women in their late 30s, but also among those in their early 20s. At last count, in 1982, nearly 11 percent of married women age 20 to 24 were having trouble conceiving, compared with 3.6 percent in 1965. Researchers blame the surge on environmental factors like toxic chemicals and tobacco smoke. Increased sexual activity also plays a part: Sexually transmitted diseases can result in pelvic inflammatory disease (PID), which can damage the Fallopian tubes. And one recent study indicates that up to 88,000 women are infertile because of infections from intrauterine contraceptive devices.

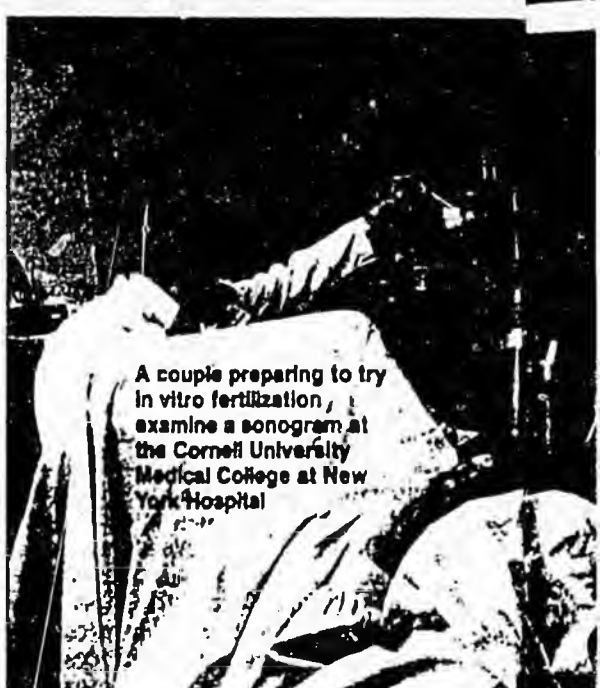
Many women in their 30s are only

now realizing that they're infertile—and probably have been for years—and thus have less time for doctors to work their wonders. Even those who are fertile run some risks. Hormone systems start to go askew, preventing ovulation. Women on the Pill for eight years or more may have trouble conceiving. Older women face a greater threat of developing diseases that wreck the reproductive organs. And there's a bigger risk of miscarriage or ectopic pregnancy, a potentially lethal condition in which the fertilized egg stays in the tube. Says Dr. Richard Blackwell, an infertility specialist at the University of Alabama at Birmingham: "Waiting to have children is clearly a gamble."

In some cases, doctors can tell quickly what ought to be done. A $50 test of the husband's semen may reveal a shortage of healthy sperm, a problem sometimes cured by antibiotics or just a cutback in alcohol consumption. Specialists occasionally encounter couples with a far simpler problem—they have sex barely two or three times a year and wonder why they're childless. Much more frequent, however, are visits from couples who've tried every pop cure they've ever heard of, from Robitussin cough syrup to baking-soda douches (both of which, some researchers say, may help certain people). What these couples and other victims of infertility too often face are tests, treatments and frustration that seem never to end.

An emotional ordeal

The ordeal endured by San Francisco pediatrician Eileen Aicardi went on for four years—a time, she says, of dehumanizing experiences like making love on cue and then "getting on a table and having sperm taken out and examined." Superstitions haunted her. She shunned routes where she had seen black cats. She came to hate holidays, a result of having miscarriages on Father's Day, Palm Sunday and New



A couple preparing to try in vitro fertilization examine a sonogram at the Cornell University Medical College at New York Hospital

CAUSES AND CURES

Why many couples can't conceive

TESTS AND TREATMENTS

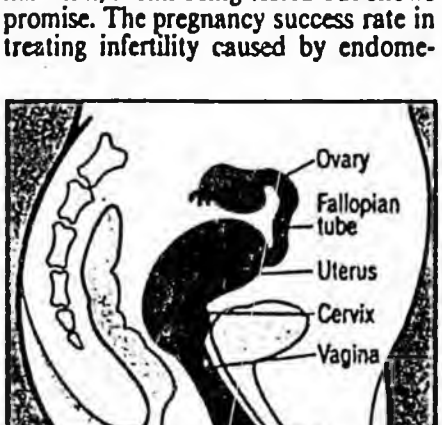
The most common definition of infertility is one year of frequent intercourse, with no contraception, that does not result in pregnancy. There are numerous possible causes for infertility in both men and women. Some correct themselves over time. Others require treatment, which can be long and costly. Among the causes and cures:

FEMALE INFERTILITY

• **Endometriosis:** In this disease, which is diagnosed in nearly one third of all women who have fertility problems, the tissue that lines the inside of the uterus begins to grow outside the womb. This tissue often prevents the sperm from meeting the woman's egg in the Fallopian tubes, thus preventing conception. Doctors do not know what causes endometriosis, but it is often called the working woman's disease because it tends to strike women in their late 20s or 30s who have not yet had children.

Symptoms of endometriosis include irregular periods, heavy bleeding and severe cramps, although about 1 in 3 victims suffers no telltale symptoms at all. The disease can be diagnosed by pelvic exam and laparoscopy. In the latter procedure, the patient is put under general anesthesia and a tube containing a tiny fiber-optics camera is inserted into the pelvic region through a nick near the navel.

Severe cases usually require surgery to remove the offending tissue—and the most serious require hysterectomy. Mild cases are usually treated with drug therapy. Two popular drugs are danazol, a male hormone, and progesterone. Both can cause unpleasant side effects and are expensive. A new drug, nafarelin, is still being tested but shows promise. The pregnancy success rate in treating infertility caused by endometriosis ranges from 73 percent in mild cases to 40 percent in severe ones.



• **Other tubal problems:** There are a host of other conditions that can cause Fallopian blockages. A common culprit is pelvic inflammatory disease, which leaves lots of scar tissue. Surgery in the pelvic region—for example, to remove an ovarian cyst or endometriosis tissue, can also cause serious scarring. Tubal problems are usually diagnosed through laparoscopy or a special X-ray procedure known as a hysterosalpingogram, in which a dye is injected into the uterus through the cervix.

Treatment involves surgery to clear the blocked tubes. If that fails, the next step is in vitro fertilization. The success rate in treating tubal disease caused by PID is only 20 to 30 percent. For other tubal problems, the success rate ranges from 30 to 60 percent.

• **Ovulatory anomalies:** Some women can't conceive because they don't ovulate—that is, release an egg—properly. Symptoms include irregular periods or no periods at all. Usually, the cause is a hormone imbalance, although a relatively rare type of pituitary tumor can also interfere. Ovulation problems sometimes can be pinpointed by charting the woman's body temperature every morning—it should rise significantly when ovulation occurs.

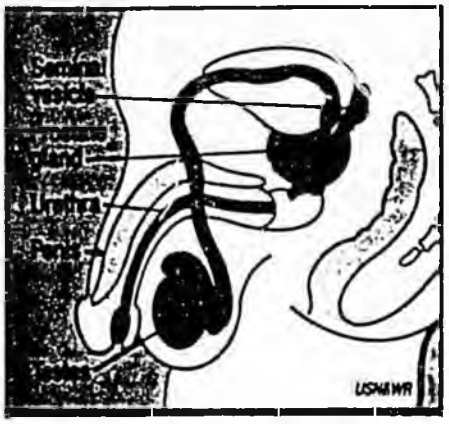
Ovulation can be induced by administering a fertility drug such as Clomid or Pergonal. Both—and particularly Pergonal—can cause multiple births. Women taking Pergonal should have sonograms daily at the time of ovula-

Year's Eve. She received little comfort from her doctor, who remarked: "All infertile women are depressed. See this box of Kleenex? I go through three boxes per day." When he prescribed a drug that can cause low blood pressure and dizziness, she looked for another specialist. This time, she got help. Her new doctor removed tissue that had been acting like an IUD on her uterus. Meanwhile, her office received a serendipitous phone call—from someone seeking an obstetrician for a pregnant teenager. Aicardi arranged to adopt the girl's baby. Within weeks Aicardi was pregnant, too. Now, at 38, she and her husband Dennis have five children, including twins who arrived in June.

Three out of 5 couples with serious infertility problems will eventually succeed in making a baby. That means, of course, that 2 of every 5 will fail. When should they quit trying? Wayne Decker keeps looking for a reason why a couple can't have a baby; until he finds it, he won't tell them to give up hope. One woman had 133 artificial inseminations and two operations before giving birth. "Should I have told her to stop trying?" Decker asks.

John and Joanne Smith in Maryland (Smith isn't their real name; the natural mother of their adopted baby knows only their first names) wish one of their three infertility specialists had told them to stop. Joanne, now 34, went through four operations in five years to remove ovarian cysts. "Each time, they'd take a piece of the ovary. So I was down to maybe a half of an ovary left. And I had endometriosis, which also causes infertility." Last year, one specialist suggested that Joanne undergo in vitro. But this doctor, John says, had never produced an in vitro birth, and their insurance wouldn't cover the $7,000 cost of an attempt. "That's when we finally said, 'Enough's enough. Let's try the adoption route.'"

Their specialists, Joanne is convinced,



tion to help reduce the risk of multiple births. A month's treatment with Pergonal typically costs at least $1,000.

The pregnancy rate for women being treated for ovulatory problems ranges from 30 to 60 percent, although their rate of miscarriage is somewhat higher than that of fertile women.

• **Cervical mucus:** In some women, cervical mucus may block sperm from reaching the egg. This problem can be diagnosed by examining the cervical mucus 2 to 4 hours after intercourse has taken place, and it is treated by administering the hormone estrogen. Vaginal infections can also cause the cervical mucus to hinder sperm; curing the infection may clear up the problem.

• **Sperm allergy:** Perhaps 10 percent of women can't conceive because their immune system kills their husbands' sperm. The problem can be diagnosed by postcoital pelvic exams, and is usually treated with drug therapy or intra-uterine insemination.

MALE INFERTILITY

• **Varicocele:** This problem is caused by a varicose or swollen vein in a testicle. The swelling can cause higher temperatures within the testicle, and the heat, in turn, can retard or even destroy sperm production. Varicocele is usually detected during a physical examination and can be treated surgically. The success rate ranges from 30 to 70 percent.

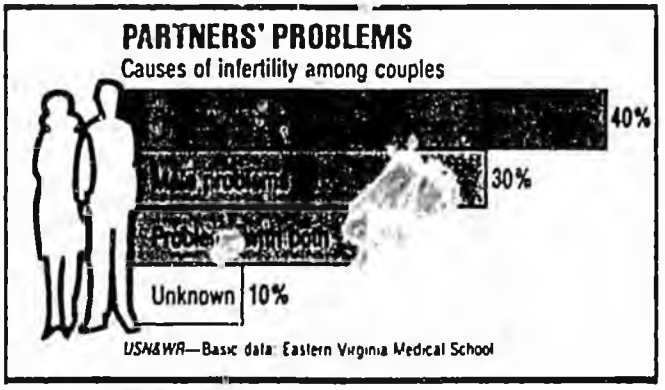
• **Low sperm count:** Some men fail to produce enough sperm because of hormone imbalances, a pituitary tumor or physical obstructions. Depending on the cause, treatments include hormone therapy—administration of testosterone, thyroid hormone or cortisone, for example—surgery, artificial insemination and in vitro fertilization. A viral or bacterial infection can also cause a temporary dip in sperm production. In such cases, diagnosing and treating the infection itself will usually restore the sperm count to normal levels.

• **Low motility:** Sometimes, male infertility is the result of sperm that don't swim very fast. Treatment of low motility includes hormone therapy and artificial insemination.

CAUSE UNKNOWN

Despite advances in fertility testing, for an unfortunate minority, doctors can find no known cause of the inability to conceive. This can be the most exasperating and frustrating determination of all. Before arriving at this point, couples are likely to undergo the full battery of infertility tests and treatments, including extensive treatment with potent fertility drugs and in vitro fertilization. A technique called gamete intra-fallopian transfer, or GIFT, is frequently recommended for infertile couples who have no known problem. This process involves collecting the woman's egg and the man's sperm and placing them together in the Fallopian tube. Then you wait for nature to do the rest.

The success rate for treating couples with unexplained infertility is 50 to 60 percent.



won't be hurting without their business. "They're already stretched out. They have speaking engagements. They book so many appointments they can never keep their schedule." After one operation, she says, she waited for two days for the doctor to come by and tell her how it went. He never showed up.

What bothered the Smiths is something that's causing more and more concern: A fear that the demand for treatment is so great that many couples will be exploited by the medical establishment. Critics make these points:

- Even though the first operation is the one with the best chance of fixing such problems as endometriosis and PID, doctors often urge patients to endure multiple surgeries. Repeated operations can cause more harm than good by creating scar tissue that thickens and blocks the tubes.
- Nearly 150 in vitro clinics are operating in the U.S. Half have yet to produce a pregnancy. Even fewer have produced babies. With profit-oriented hospitals moving into the field, there's concern that some in vitro clinics will push women into the procedure before other, less costly treatments are tried.
- Obstetricians and gynecologists are taking crash courses in laser surgery to treat women with blocked tubes, even though studies indicate that this technique, while more expensive, is no more effective than conventional operations in producing babies. Some doctors hang certificates on their walls after attending laser-surgery seminars that last a day—hardly enough, critics say, to make them experts.

Often the couples themselves can be blamed for their frustrations. Many keep shopping for new treatments, even after being told that little can be done. "There's no question that some couples are exploited," says Dr. Robert Rebar of Northwestern University School of Medicine. "But you have to ask, 'Are they intentionally exploited?' When the couple says they'll do anything to have a baby, it's very difficult for the doctor to say it's time to stop."

A boom in the business

Exploited or not, far more couples are seeking help than in the past. In the 1970s, doctors counted about 1 million visits per year from patients having trouble conceiving. Visits in this decade have exceeded 2 million per year. With huge numbers of baby-boomers approaching their mid-30s, the infertility industry is sure to surge even more in the next few years. The boom would be even bigger if more people could afford to get help. Most who go to fertility clinics are above average in income.

SNAPSHOTS OF SUCCESS

Howard and Georgeanna Jones grabbed headlines when they helped make the nation's first in vitro baby in 1981. Now, the husband-and-wife team collects photographs—of the more than 300 children conceived in vitro at their Jones Institute for Reproductive Medicine in Norfolk. The clinic's 30 percent conception rate is the highest in the United States

Treatment expenses vary sharply. A typical charge for one artificial insemination is $75. Usually, two or three are performed during each monthly cycle, and 4 of every 5 couples achieve a pregnancy within six months. Women who take Pergonal, a fertility drug, are on a $1,000-a-month regimen. In vitro costs even more—usually about $5,000 for the procedure and $1,000 for 10 days' food and lodging—and several tries are often required to achieve a pregnancy.

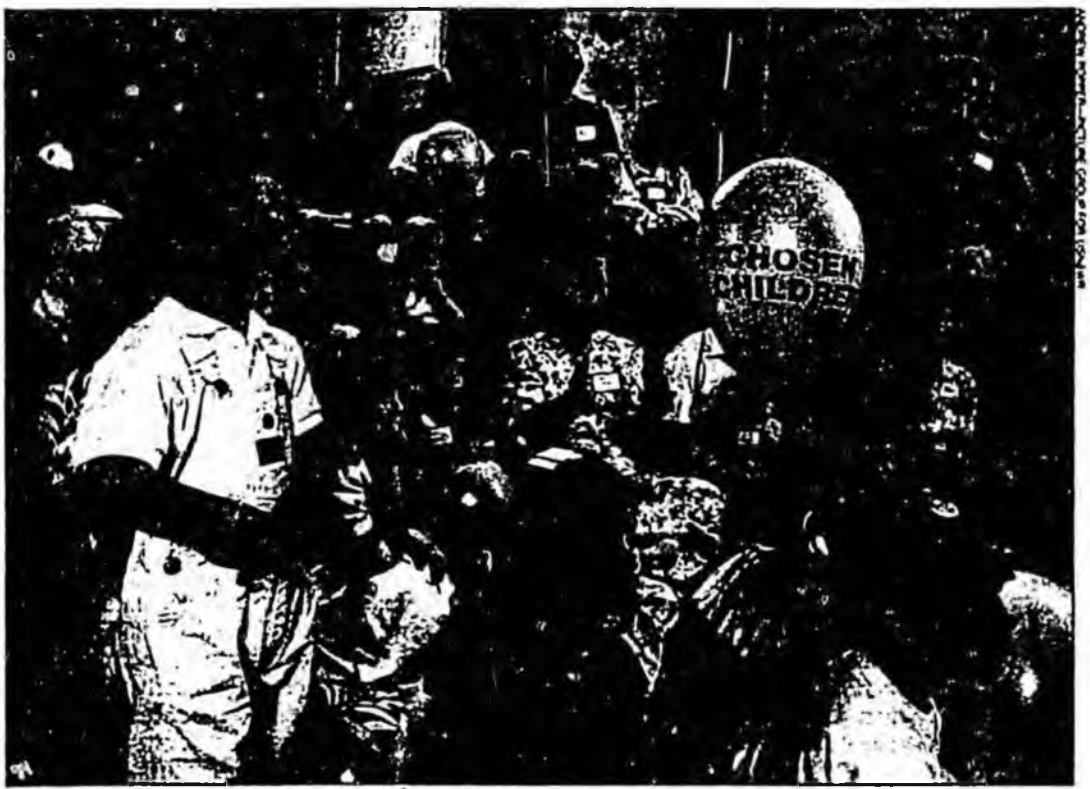
Insurance coverage is erratic. Some group-health plans cover drugs and treatments for the infertile. Many other policies don't. Although in vitro has produced nearly 5,000 babies around the world in the past 10 years, it's dismissed by many insurance firms as experimental. Representative Patricia Schroeder (D-Colo.) is urging Congress to add infertility coverage to health-insurance plans for federal employes. Under laws enacted in Texas and Hawaii this year, insurers must offer infertility coverage, including in vitro costs, in any group-health plan that provides maternity benefits.

Even when infertility's financial burden is eased, there's no letup in its emotional load. Insurance has picked up 80 percent of the nearly $25,000 in medical costs in Connie Ross's six-year struggle to have a baby, but the Orange County, Calif., housewife is still on "an emotional roller coaster, the worst thing I've ever gone through in my life." At 33, she's overwhelmed by guilt. "I think maybe if I hadn't tried so hard not to get pregnant when I was 21 that this wouldn't be happening. I resent seeing a pregnant woman. I go through immense depression and anger. I prefer anger to depression; at least, when you're angry, you can throw a Tupperware bowl."

Part of Connie Ross's ordeal is that no one can figure out why she can't get pregnant. Mary Martin Mason of Minneapolis, who wrote a book about herself and other infertile people called *The Miracle Seekers,* doesn't have that problem. After four years of tests, doctors found that her Fallopian tubes were permanently closed. Without that diagnosis, she and husband Dave might

still be trying to conceive and would never have started the three-year adoption wait that rewarded them with the toddler they know as Joshua.

Until the Masons' door of hope shut, they were tortured even when they ambled beside Minneapolis's city lakes. They'd see children in strollers and Mary would cry. They began shunning family get-togethers where little nieces and nephews were constant reminders of their elusive goal. When Doug learned that his closest friend—the best man in their wedding—was expecting a second child, he hid the news. Mary heard about it only when the couple called to say that they'd just had a new son. "I went to the hospital and looked



The Chosen Children Adoption Agency holds a reunion of adoptive families in Queens, N.Y.

down at the little guy," Doug recalls. "I thought, 'This isn't fair. They can have two children and we can't even have one.' " He wept all the way home.

Now, even with Joshua playing pat-a-cake on the living-room floor, the Masons are still troubled. "You know you are going to have to explain the adoptive process to him," says Mary, who herself was adopted. Nor does society relent in its pressures. "People say things like, 'Oh, you're not his real mother? Who is his real mother?' "

The Masons, plus thousands of other people like them, have coped by joining a support group for infertile couples called Resolve, a national organization with chapters across America. Many members are still trying to conceive. Others are looking for help in adopting a child.

Couples who opt for adoption often face new kinds of heartache. Many hang around the phone yearning to hear that somewhere there's a baby they can have. But, with an estimated 100 couples or singles in quest of every available healthy white infant, it's usually a long wait. Georgia's public-adoption agency is just now studying requests made in 1979. Wisconsin's waiting list for adoptive children became so unrealistic that the state agency scrapped it for a lottery.

The baby shortage—a result of the Pill and the rise in abortions—is prompting more and more couples to look beyond traditional sources. There are plenty of "special-needs children," babies with handicaps or older children from poor families. Foreign children also are relatively easy to adopt; nearly 15 percent of current adoptions involve babies from other countries.

Many couples are turning to small, privately run agencies, like Louisville's Chosen Children Adoption Services, Inc. It has a small maternity home with space for seven unmarried pregnant women (average age: 17½) and matches their newborns with couples, who pay fees based on their income plus legal costs, maternity-home care and hospital bills. Average total: $9,000 to $10,000. The normal wait for an adoptive baby is three years. "By the time they get that kid," says owner Raymond Kalef, "they're ready to lick it up one side and down the other."

The biggest shift is toward individual adoptions, arranged not by agencies but by couples and birth mothers, usually with a lawyer's help. Some experts believe, in fact, that private deals now account for more than half of the adoptions of healthy infants. Agency workers bemoan the lack of screening rules, but desperate couples regard these private arrangements as their one hope for getting a healthy American-born infant in less than a year.

Falling through, trying again

It's not always a sure way, as the Smiths in Maryland can attest. After writing dozens of letters to agencies—and getting dozens of discouraging responses—Joanne happened to hear about a pregnant woman who was spending the winter in a shelter with two children and who wanted to put her baby up for adoption. They met, and the woman agreed to give them her infant. "We went to the hospital, and she has the baby, a little boy," Joanne recalls. "She says, 'I just want to take him home with me for a day or two and then I'll let you have my baby.' We're all in tears. We knew then that we had a fall-through, that there would be no adoption." And there wasn't.

But they kept trying. They ran ads in five Maryland newspapers: "Loving couple wishes to adopt infant. Will help on medical expenses and legal fees. Call collect." They told friends and relatives of their decision. Soon came a call from a friend, an infertile woman who, after placing dozens of ads herself, had lined up two birth mothers. Joanne gladly contacted one, a teenager in a distant state. This summer, after months of fears of another fall-through, the baby arrived—and came to a new home in Maryland. "He's an angel," Joanne beams. "What else could he be? We're on top of the world. Our dreams have come true." ■

by Lewis J. Lord with Patricia M. Scherschel, Jeannye Thornton, Lisa J. Moore, Barbara E. Quick and domestic-bureau reports

MARK J. ZIMMERMAN, M.D., F.A.C.O.G.
DIPLOMATE OF THE AMERICAN BOARD
OF OBSTETRICS AND GYNECOLOGY
JOY E. ROSSTON-ZIMMERMAN, R.N.C., A.N.P.
ADVANCED NURSE PRACTITIONER

February 29, 1988

Representative Curt Menard
P.O. Box V
Juneau, Alaska 99811

Dear Representative Menard:

I am writing in support of House Bill Number 440.

I strongly feel that women or men who have problems with fertility have been discriminated against by the insurance companies. It is understandable if these companies do not wish to pay the fees involved with the reversal of voluntary sterilization procedures.

However, I cannot understand why they will not provide benefits for people who are deserving of evaluation and care due to problems that are either natural (congenital) in nature, or due to complications of infections and other problems.

Any medical insurance policy that provides coverage for obstetrical care and/or termination of pregnancy should not discriminate against the infertile patients.

Sincerely,

Joy Zimmerman, A.N.P.

JZ:ces

HUMANA MEDICAL PLAZA • 1200 AIRPORT HEIGHTS DRIVE, SUITE 350 • ANCHORAGE, ALASKA 99508 • 907/264-2345

RECEIVED

HC 34 Box 2026
Wasilla, AK 99687-9601
February 29, 1988

Honorable Mr. Maynard
P.O. Box V
Juneau
Alaska 99811

Dear Mr. Maynard,

I think its a crime for insurance companies to cover bills for the murder of American babies ("abortion") while excluding medical coverage for the infertile man and woman. America needs to help those who want to add to our country rather than take away.

It took me five years before I was able to get pregnant. It was slow paying as I went for one test then another. And, sadly my little Grace will not get to be a sister because now I'm too old to have more precious babies.

So count me as a supporter of legislation to require insurance companies to treat fairly the infertile. I'm sure our faithful Lord will bless your every effort.

Sincerely,
Brenda Valley

Anchorage Obstetrics & Gynecology

Richard T. Nist, M.D.
Diplomate of the American Board,
Fellow, American College
of Obstetrics and Gynecology

Robert G. Thompson, M.D.
Diplomate of the American Board
of Obstetrics & Gynecology

March 16, 1988

The Honorable Niilo Koponen
P.O. Box V
Juneau AK 99811

RE: House Bill No. 440

Dear Representative Koponen:

I am sending this letter as a physician's statement in support of House Bill No. 440 entitled "An Act Relating to Insurance Company Coverage for the Treatment of Infertility", which is currently before the Alaska State Legislature.

WHEREAS one out of every six couples of childbearing age in the State of Alaska, consistent with elsewhere in the United States, is currently unable to conceive for one year of regular sexual relations, defined as infertility or having an infertility problem, and

WHEREAS 15% of couples of usual childbearing age from 22-40 are currently unable to conceive after one year of effort, and

WHEREAS over 90% of single mothers today are retaining their babies instead of considering adoption, making less babies available for adoption as an option for the fertility or completion of families in these particular couples, and

WHEREAS most of these couples are currently employed and paying for insurance with pregnancy-related coverage which they may never be able to utilize, and

WHEREAS the diagnosis and treatment of infertility is no longer considered experimental in any way, shape, or form in modern medical practice with overall success rates of 70-80% in treatment of some medical problems related to fertility including a 50% success rate after three attempts of in-vitro fertilization, indicating a significant resolution of a large number of fertility cases, and

WHEREAS involuntary childlessness creates a tremendous social impact on society, pervading every waking moment, making the couples' decisions for the future nearly impossible, and creating stressful events that significantly threaten their well-being and psychosocial health, and

WHEREAS most problems related to infertility or inability to conceive are related to specific medical treatments that may otherwise be covered in most circumstances or specific medical instances, e.g. endometriosis; however, in the case of the patient trying to conceive where her chart reveals that the treatment of this condition is related to fertility, insurance companies may

have the right or the option to deny payment or reimbursement for such treatment, and

WHEREAS the insurance companies' current ability to discriminate against the patients with a diagnosis of infertility in selective payment of their medical costs represents an outright injustice in their fair treatment of medical problems which may normally be covered and may have come to light only with the onset of evaluation for fertility reasons in many cases, in addition to the fact mentioned above that these patients are paying for coverage which they are not able to utilize, i.e. pregnancy-related coverage.

BE IT RESOLVED THEREFORE, that it is my opinion that the legislators of the State of Alaska should strongly consider support of House Bill No. 440, which is receiving the same overwhelming support in other states as it originally received in the State of Massachusetts where a similar bill was passed in 1987. This bill states that infertility is defined, and correctly so, that basically the individual who is unable to conceive and has been attempting to do so for at least one year and is now under medical treatment, which may in some cases be required to achieve a successful conception, must be covered by her insurance company to the same extent that she would be covered for the cost of medical care that she would be receiving if she were pregnant and under a physician's care.

LET IT BE FURTHER RESOLVED that these patients, as stated above, are currently paying for pregnancy-related coverage which they may not be able to utilize in many cases. Medical insurance companies' ability to discriminate against these people in regards to receiving medical care for the diagnosis and treatment of their fertility-related condition is an outright injustice and implies discrimination, specifically against these couples.

LET IT BE FURTHER RESOLVED that it is quite clear that any choice but to support this legislation would be considered supporting the discrimination of selective reimbursement by insurance companies against one-sixth of couples in the State of Alaska whose mere problem is that they want to have a baby.

FINALLY, LET IT BE RESOLVED that the diagnosis and treatment of infertility or fertility problems does not imply specifically that there is a serious or life threatening problem for this particular couple but merely a problem with which medical therapy or specific treatment, and in some cases surgery, may help them to successfully enjoy the blessings of completing their Alaskan family. I encourage you to consider this bill carefully and hope that you will arrive at the same conclusion that I have outlined above, that this bill needs to be supported and passed.

Sincerely,

Robert G. Thompson, M.D.

DIST: Editor, Anchorage Times
Editor, Daily News

RGT:smc

The American College of Obstetricians and Gynecologists

LEGIS-LETTER

EDITOR: KATHRYN GLOVIER MOORE

Vol. 7, No. 1
WINTER 1988

Editor's Note: *This issue of LEGIS-LETTER provides an overview of legislative activity which is of interest to obstetrician-gynecologists occurring during the 1987 state legislative sessions. The focus is on maternal health laws and trends. Please note that tort reform, AIDS, and surrogate motherhood were the subjects of special issues of LEGIS-LETTER last year and will not be revisited here. (see, in particular, Vol. 6, Nos. 1, 2, and 4)*

Turning our attention to the 1988 sessions, what can we expect? 1988 is an election year in many states. This means that sessions will be shorter as a rule and, in a few states, only budget bills may be introduced. It also means that rhetoric and political maneuvering will be more in evidence as legislators position themselves for the November elections. Forced roll call votes on politically sensitive bills or amendments can be expected in many states. In others, controversial issues will be avoided altogether this year as legislators attempt to gain the political edge in the election.

Seasoned observers speculate that AIDS will again be the number one legislative issue for the states in 1988, with indigent and long-term health care the second and third most important. Health care for poor pregnant women and children is expected to be the major focus of indigent care initiatives, as more and more state legislators recognize the cost savings potential of early and uninterrupted health care services for this population and as lack of access to obstetric care rises and reaches crisis proportions in many areas of the country.

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MATERNAL AND NEWBORN SERVICES

Testing and Screening - Several states enacted legislation in 1987 requiring specific testing and screening of maternity and newborn patients. **Colorado** became the first state to mandate newborn testing for cystic fibrosis. Data suggests that cystic fibrosis is more common than other conditions typically covered under newborn screening programs. **Hawaii** now requires hepatitis B screening of pregnant women. **Indiana** established a centralized system for newborn testing, with designated state laboratories, a quality assurance mechanism, centralized coordination, tracking and follow-up, and a $12 surcharge for tests. **Indiana** legislators also approved legislation addressing the problems of children born with a drug dependency and additionally, repealed a law denying marriage licenses to persons with venereal disease, instead voting to impose a third trimester pregnancy testing requirement for syphilis. **Michigan** also expanded newborn screening requirements last year. **New Jersey** legislators approved legislation

requiring testing during pregnancy for rhesus hemolytic disease. Oklahoma now requires reporting of newborns with a drug dependency. Legislators in that state also established a statewide birth defects surveillance program. Rhode Island amended its Crippled Children's Services Act to require statewide testing of newborns for metabolic disorders and sickle cell disease. Funding for the statewide testing program will come from an assessment on hospitals and other health care facilities in the state. The universal testing mandate was presented as a cost effective approach to preventing mental retardation.

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Fetal Alcohol Syndrome - Fetal alcohol syndrome legislation has been introduced in the states with increasing frequency since the harmful effects of alcohol ingestion during pregnancy were first documented in the early 1970's. The legislation has taken a variety of forms, but primarily addresses the need for public education, either through media campaigns, warning labels on alcoholic beverage containers or retail warning signs. Alaska, California, Delaware and Illinois were a few of the states that considered legislation on this subject last year. Initiatives considered in these states are representative of state legislative activity overall. In Alaska, legislators approved a Senate Resolution establishing a Fetal Alcohol Awareness Week. California voters approved a clean drinking water proposition that also included a requirement for fetal alcohol syndrome retail warning signs. Legislation requiring retail liquor establishments to post warning signs failed to be enacted in Delaware. Illinois' Governor vetoed legislation requiring information on Fetal Alcohol Syndrome to be distributed to marriage license applicants in that state.

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Prenatal Care - The Maryland legislature failed last year to impose strict requirements on physicians and health care facilities providing prenatal care services. Under the proposed bill, providers would have been required to notify pregnant women of each scheduled visit for prenatal care not more than one week in advance, and to state the time and place of the visit. The bill would have subjected providers to misdemeanor penalties. Pregnant women failing to appear for their appointments or failing to cancel and reschedule appointments would have been subjected to a $500 fine, 30 days imprisonment, or both. Additionally, the bill would have authorized the courts to create "any remedy to assure that a woman gets prenatal care."

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Fetal Abuse - The controversial and widely publicized Pamela Rae Stewart case may have been the impetus for legislation introduced in two states last year making crimes against the fetus a misdemeanor. This case involved an indigent California woman who delivered a brain damaged baby which subsequently died. Amphetamines were detected in the baby's blood. The mother was charged with child endangerment under California's penal code for her alleged failure to follow medical advice. At issue was the mother's alleged record of drug abuse and sexual activity during her pregnancy. (California Penal Code Section 270 was enacted in 1926 to force fathers to pay for prenatal and pediatric care for illegitimate children. In 1974 the code was amended to establish misdemeanor penalties for women who fail to provide necessary medical care to a child or a fetus.)

In California, legislation introduced on this subject in 1987 was carried over to the 1988 session where it is pending. The bill would create a new mandatory reporting category for fetal abuse under the state's child abuse reporting statute.

Two bills were introduced in Oregon last year, but both failed to get a hearing. One of the bills would have created a misdemeanor for "knowingly or recklessly" causing physical injury to the fetus, including the mother's ingestion of controlled substances. Abortion was specifically excluded from the bill's definition of injury to the fetus. The other bill was similar to California's and would have codified fetal abuse under the state's child abuse statute.

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Informed Consent - A hysterectomy informed consent bill imposing strict requirements on gynecologists before a hysterectomy may be performed was enacted in California last year. Attempts to derail the bill were largely unsuccessful; however, the final bill was modified to delete a 30-day mandatory waiting period in response to the concerns of the state's obstetrician-gynecologists. The bill sponsor's intent reportedly was the promotion of alternatives to hysterectomy, specifically, "pelvic reconstruction surgery." Under the new law, physicians must obtain the verbal and written consent of the patient prior to performing a hysterectomy. This involves a discussion of the medical justification for the procedure, alternatives, and risks and benefits. The patient also must be informed that the procedure is considered irreversible and that infertility will result. The law provides an exception for a "life-threatening emergency situation" as determined by the physician. Failure to comply with these informed consent requirements constitutes unprofessional conduct.

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FINANCING MATERNITY CARE

In the state capitols, the Congress, and corporate boardrooms, financing maternity care has become central to policy debates on the problems of indigent or so-called uncompensated health care. This is not surprising as pregnancy-related care represents the largest, single source of uncompensated care in this country. Data show that women of childbearing age (15-44) are disproportionately represented in the ranks of the poor, the uninsured, and the unemployed.[1] More than one-fourth of all births occur among poor women. Nearly 15 million women of childbearing age lack coverage under private or public insurance programs for maternity care; births to these 15 million women account for 15 percent of all births.

But data also show that comprehensive services provided during pregnancy are cost-effective.[2] Indeed, early, regular and uninterrupted prenatal care can save the public money in the long run. Savings can be achieved through improved birth outcomes, specifically, the prevention of low birthweight and and related conditions that can require costly medical care.[3]

The need for new initiatives to improve access to and the availability of maternity care for all pregnant women is particularly compelling today, in view of a recent study by the Children's Defense Fund (CDF) which shows that after 25 years of progress, efforts to reduce infant mortality in this country came to a standstill in 1984. The CDF study shows neonatal mortality rates increasing for blacks and nonwhites; an increase in the number of low birthweight babies

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[1] All data is from the recently published Alan Guttmacher Institute report. Blessed Events and the Bottom Line: Financing Maternity Care in The United States, 1987.

[2] Institute of Medicine, Preventing Low Birthweight, 1985.

[3] The Institute of Medicine (IOM), in its 1985 landmark report, Preventing Low Birthweight, examined the implications of low birthweight for the health of the Nation. IOM emphasized the relatedness of prenatal care to infant mortality and low birthweight. Low birthweight is strongly correlated with several of the leading causes of infant mortality, including prematurity and malnutrition. Higher infant mortality rates generally are found in low-income populations and particularly among those women receiving little or no prenatal care. The IOM concluded that for every dollar spent for prenatal care among a targeted high-risk population, $3.38 could be saved in the total cost of caring for low birthweight babies requiring expensive medical care.

and babies born to women who received little or no prenatal care; and an increase in maternal deaths among minority women. This latter figure has been attributed to lack of access to basic health care services for this population.

State policymakers and legislators have been exploring a variety of initiatives to improve access to and financing of maternity care for poor women, ranging from an expansion of publicly funded programs for maternity care, to employer insurance coverage mandates, third party mandated benefits, universal health insurance, and state-funded and managed universal systems of health care. Initiatives of note that were legislated in 1987 are recounted below. In all of these, we are seeing a growing recognition of the wisdom of providing comprehensive services during pregnancy and a corresponding willingness to finance improvements in maternity care services for poor women.

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Expansion of Public Insurance Programs (Medicaid) - Expansion of public insurance programs for maternity care, and specifically the Medicaid program, has become an increasingly attractive initiative for the states, in part because Congress has provided financial incentives to the states to promote this expansion. Beginning in 1984, Congress has sought to ameliorate the infant mortality problem by encouraging states to expand their Medicaid programs to more low-income pregnant women.

Medicaid is an entitlement program which is financed jointly by the federal government and the states and administered individually by each state. The federal government reimburses the states through matching payments which cover at least 50 percent (and as much as 80 percent) of program costs. The matching rate is calculated individually by state, based on per capita income and population in poverty. The states administer the Medicaid program within minimum standards established by federal law and are free to set income ceilings for eligibility. Eligibility varies across the states, with 21 states setting eligibility levels at or below 50 percent of the poverty level (annual income of $4,650 for a family of three). For example, Alabama sets Medicaid eligibility below 16 percent of the federal poverty level ($1,416 for a family of three). In consequence, many poor pregnant women are denied needed services. Incidentally, despite the fact that many poor women do not qualify for the Medicaid program because of eligibility restrictions, Medicaid remains the major insurer of health care services for poor women and therefore it plays a critical role in providing access to maternity care.

Twenty-six states approved legislation last year (commonly referred to as the SOBRA Medicaid options) to cover additional poor pregnant women under their Medicaid programs; a lesser number also voted to improve the timing and scope of maternity services. (In many states, initial prenatal care services may be delayed or denied altogether due to the time-consuming application process. Additionally, some states limit the number of visits per beneficiary to fewer than the number usually recommended for optimal prenatal care.) These 26 states are: **Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Missouri, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and West Virginia.**

It should also be noted that three of these 26 states — **Michigan, Minnesota, and Rhode Island** — plus **New York** approved state funding for new or existing prenatal or maternity care programs for so-called near poor women (those with incomes above the federal poverty level but below a state set level and without health insurance coverage for maternity care). In **Michigan**, the Prenatal/Postpartum Care Program (PPC), which has provided comprehensive prenatal care to poor women who do not qualify for Medicaid but have incomes less than 185 percent of poverty, received additional funding in 1987 to reimburse physician fees for labor and delivery services for the first time. In **Minnesota** and **Rhode Island**, new programs were funded, called Right Start and Rite Start respectively. **Rhode Island's** is the more comprehensive

of the two, as it will provide delivery services as well as prenatal and postpartum care for pregnant women with incomes up to 185 percent of poverty. **New York's** Prenatal Care and Nutrition Program (PCNP), which provides prenatal care to poor women ineligible for Medicaid, was made a permanent program and received additional funding in 1987, a portion of which will support an increase in provider fees.

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Universal Health Insurance - Other state legislative initiatives designed to improve access to and availability of maternity care services for poor women target employers by attempting to improve coverage for maternity care under employer-based insurance plans. Although a 1978 federal law, the Pregnancy Discrimination Act, was designed to do just that, its impact has been somewhat limited. The Act does not cover policies that are not employer-based, nor does it apply to small employers (those with 15 or fewer employees). Moreover, the Act does not extend to non-spouse dependents, specifically teenage daughters. Added to these inherent shortcomings, is the bias of private insurance policies generally which, since their inception, have emphasized treatment for episodic illnesses or injuries rather than preventive, predictable or long-term health care needs. The Alan Guttmacher Institute (AGI) reports that ten years after enactment of the Pregnancy Discrimination Act, many women age 15-44 have private health insurance coverage that does not cover maternity care. AGI also reports that some existing insurance plans that do cover maternity care, nevertheless do not pay the full cost of services nor do they pay for newborn hospitalization.

Massachusetts' Governor proposed a universal health insurance initiative last fall which would ensure health care for all **Massachusetts** residents by requiring employers in the state to provide health benefits for their workers. At the same time, the unemployed would continue to be covered under an existing free-care program funded by a surcharge on hospital bills. The state's senior senator in the Congress, Senator Kennedy, has introduced a similar measure. Both proposals are expected to trigger lively debate in the coming months.

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Mandated Benefits Laws (Maternity and Newborn Services, IVF, Mammography and Cytologic Screening) - Mandated benefits laws are another strategy states are exploring to address the health care needs of poor pregnant women. **Rhode Island** lawmakers last year enacted broad legislation providing insurance coverage for maternity care and pediatric preventive care. Under the new law, which was introduced at the request of the Lieutenant Governor, all health insurance plans and HMOs must provide pediatric preventive care and maternity care without deductible or co-pay requirements. Maternity care is defined under the law to encompass all services recommended by a physician. **Rhode Island** is the only state of which we are aware that enacted a mandated benefit law in 1987 specifically related to maternity care.

Other mandated benefits laws of interest to obstetrician-gynecologists were enacted last year in **Arkansas, California, Florida, Hawaii, Illinois, Massachusetts** and **Texas.** The legislatures in **Arkansas, Hawaii,** and **Texas** voted to require insurance coverage for in vitro fertilization procedures. The **Arkansas** law applies to disability insurers in that state. **Hawaii's** law applies to all individual and group health insurance policies providing pregnancy-related benefits and is limited to a one-time only benefit for out-patient expenses. In **Texas,** all insurance companies and HMOs providing pregnancy benefits must also provide benefits for outpatient in vitro fertilization procedures. It should be noted here that **Maryland** was the first state to mandate insurance coverage for in vitro fertilization. The mandate was approved in 1985.

Legislation approved in **Massachusetts** last year requires all insurers providing pregnancy-related benefits to also provide benefits for medically necessary expenses of diagnosis and treatment of infertility. Infertility is defined under the law as the "condition of the presumably healthy individual who is unable to conceive or produce conception during a period of one year."

Emergency regulations were promulgated by the state's Division of Insurance soon after the law's enactment which identified the required infertility benefits and established permissible limitations on coverage.

Under legislation enacted in **California**, insurers that provide benefits for mastectomy, prosthetic and reconstructive surgery must also cover mammography screening. A new **Florida** law requires insurers in that state to cover breast reconstruction. And in **Massachusetts**, all insurance policies and all employer health and welfare funds which provide hospital and surgical benefits must now provide benefits for both mammographic exams and cytologic screening of the uterine cervix.

In **Illinois**, legislation was enacted which prohibits insurance policies from excluding coverage of hospital and medical services for newborns.

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Universal Managed Health Care Systems - Perhaps the least tested among the many and varied state initiatives to improve access to and availability of health care services for the poor, is that of state funded and managed universal health care systems. This initiative is presently being tested on a limited, pilot basis in the state of **Washington**. Washington's Health Care Access Act was signed by the Governor in June 1987. Developed from the recommendations of a state commission, the Act is designed to meet the health care needs of 160,000 of the estimated 400,000 **Washington** state citizens who are without health insurance through a managed care system. In 1986, **Washington** legislators and policymakers debated the merits of basic health care for all citizens. Once consensus was reached on the desirability of such a concept and on a definition of basic health care — no easy task — the debate centered on potential funding mechanisms during the following year. The original plan called for both a payroll tax and a tax on all professional services, including physician services. The tax funding mechanism was deleted, however, in the final version of the bill. Instead, funding is to come solely from general revenues. $19.1 million was earmarked through general appropriations for start-up of five pilot, managed care projects serving no more than 30,000 uninsured citizens. An emergency clause made the law effective upon enactment; however, the actual start-up of services will occur July 1, 1988. Emphasis is on primary and preventive health care services, with special attention given to the needs of pregnant women and children. Eligible citizens must have incomes at or below 200 percent of poverty and must be under the age of 65. Coinsurance rates will be levied based on individual income. Recent reports from **Washington** indicate that start-up of the pilot projects may be jeopardized due to an increasing fiscal crisis.

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ADOLESCENT PREGNANCY

Laws enacted by the states last year on adolescent pregnancy were many and various. The issue is of increasing interest to state legislators and policymakers as the social and economic consequences of unintended pregnancy have become more visible and widespread. Estimates show that adolescent pregnancy represents a $16 billion drain on the nation's social welfare resources, not to mention the loss of human potential and productivity. Adolescent pregnancy and the related issue of sex education also received renewed attention last year as a result of the AIDS crisis. Newly enacted laws of interest to obstetrician-gynecologists are recounted below.

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Financing Prevention Programs and Services - **Connecticut, Maine, Maryland, Massachusetts, Ohio, Tennessee,** and **Wisconsin** allocated general revenues last year for start-up or expansion

of prevention programs. In **Connecticut**, the governor's budget request of $1.06 million to fund competitive grants to local governments to prevent teen pregnancy was approved by the legislature. This is the first time such funding has been earmarked in **Connecticut**. A pilot program for New Britain, **Connecticut** was also approved last year and will provide training in parenting skills for teen mothers and fathers. The **Maine** legislature appropriated $700,000 over two years to fund nonschool prevention, parenting, and teacher sex education training programs. In **Maryland**, a Baltimore-based pilot Peer Companionship Project, that pairs older teens with younger ones to tell them about motherhood and pregnancy, was financed through the state's Health Services Cost Review Commission. The pilot project is based on two, six-month studies conducted in 1983 and 1985. In **Massachusetts**, the governor's Challenge Fund, a teen pregnancy prevention initiative, received a $1.2 million budget allocation last year. **Ohio**'s State Health Department received a $400,000 budget allocation for prevention and services programs. An original proviso in the allocation that would have required 75 percent of all funds to be directed to programs encouraging abstinence, was line item vetoed by the governor. The **Tennessee** legislature, continuing a voting pattern of recent years, voted for new and expanded programs in 1987. Taken together, these programs are comprehensive, addressing not only prevention but prenatal care, parenting skills, and family life curricula. **Wisconsin** continued funding of the Adolescent Pregnancy Prevention and Services Board, established in 1985 to stimulate and support local pregnancy prevention efforts through competitive grants. The first summary report of the Board's activities was released in November 1987 and documents a mixed success rate of initial grants funded in 1986.

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School-Based Health Clinics and Sex Education - Unarguably, one of the most controversial aspects of teen pregnancy is sex education. Controversy about the content of sex education and even its legitimacy has been rampant since the subject was first taught in the schools. The Alan Guttmacher Institute reports that prior to 1987, three states required sex education in the schools (**Maryland, New Jersey,** and the **District of Columbia**). Three more states mandated sex education last year; these were **Kansas, Nevada,** and **Rhode Island**. A fourth state, **Virginia**, approved a sex education mandate in principle last year and the mandate's supporters, which include the governor, are seeking funding to implement the mandate this year. All four states allow parents to withdraw their children from sex education classes and two of the states, **Rhode Island** and **Virginia**, require instruction on abstinence to be included in the curricula.

Separate legislative initiatives addressing the health needs of adolescent students were approved in **California, Connecticut, Massachusetts, Michigan, Mississippi, Rhode Island** and **Wisconsin. California, Connecticut, Michigan** and **Wisconsin** appropriated money for school-based health clinics. However, the **Michigan** appropriation includes a restrictive clause prohibiting abortion counseling, referrals, and services and further, prohibits the distribution of contraceptives on school grounds; **Wisconsin**'s appropriation was vetoed by the governor. **Mississippi** established a public health school nurse intervention program which includes reproductive health education and referrals for pregnancy prevention. **Rhode Island** established a pilot program for school-based health services as well as support services for adolescents. Like **Michigan, Illinois**' governor and the **South Carolina** legislature took action to prohibit the distribution of contraceptives on school grounds.

In what is certainly a new trend, several states have begun to reexamine the merits of sex education in the context of a growing recognition of the need for public education on sexually transmitted diseases and AIDS in particular. We are aware that at least seven states tackled this aspect of the issue last year; these were **Illinois, Indiana, Maryland, Nevada, North Carolina, Oklahoma,** and **Rhode Island**. While the new laws vary in intent, they generally require health education classes to include instruction on AIDS transmission and prevention and the majority proclaim abstinence as the best method of prevention.

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FAMILY PLANNING

The Alan Guttmacher Institute reports that nearly three-quarters of the states currently provide state funding for family planning services. Notable funding allocations were approved in several states in 1987, among them, **California, Connecticut, Illinois, New Hampshire, New Jersey** and **New York. California** has the largest budget for family planning, with $34.2 million allocated last year. **Connecticut** appropriated $455,000, and an additional $106,000 for free and confidential pregnancy testing for poor women. **New Hampshire** legislators voted for the first time to fund family planning services with a $325,000 appropriation. In **New Jersey**, the Campaign to Prevent Unintended Pregnancy was instrumental in securing a sizeable increase over last year's budget. $1.2 million was allocated for family planning services in that state. Lastly, the **New York** legislature increased family planning monies by $1 million, bringing the total allocation to $11 million. The increase was largely the result of the efforts of the Campaign To Make **New York** First in Family Planning, which has been operating in the state since 1985.

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ABORTION

Legislation is rarely a fait accompli when the subject is abortion. Relatively few bills are enacted as compared to the vast number that are introduced each year in the state legislatures. Moreover, enactment is no guarantee of implementation or enforcement. In fact, these laws, in most instances, are subject to gubernatorial vetoes, court restraining orders, or temporary or permanent injunctions.

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Parental Consent - Of the four states (**Alabama, Arizona, California,** and **Georgia**) approving mandatory parental consent or notification laws for abortion last year, only **Alabama**'s consent law is in effect at this writing. **Arizona**'s parental consent law and **Georgia**'s parental notification law have both been enjoined from enforcement. These laws were found by the courts to be unduly burdensome, and to violate the minor's right to a "timely" abortion and right to privacy respectively. **California**'s parental consent law has been temporarily enjoined. ACOG District IX is one of several plaintiffs in a court action seeking to block implementation of the 1987 law. The new law, reportedly, was a major setback for proponents of choice in the state which, for many years, have been successful in defeating or thwarting abortion restrictive measures.

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Public Funding - The **California** and **Michigan** legislatures voted last year to discontinue public funding of abortion services for poor women. In **California**, laws of this type are not new and few have survived the scrutiny of the courts. However, the new conservative makeup of the state's highest court makes such an outcome uncertain with this newest law. In **Michigan**, too, the political landscape has been altered. With uncanny regularity, a public funding prohibition has been approved by the legislature and vetoed by the governor each year for most of this decade. Last year, however, the legislature succeeded in circumventing a sure gubernatorial veto with approval of a citizen-sponsored initiative not subject to the governor's action. This initiative does not take effect until April of this year and may be suspended pending qualification of a pro-choice ballot initiative for the 1988 general election in November.

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Other - **Pennsylvania** was the only state of which we are aware approving an omnibus antiabortion measure last year. The measure was vetoed by the governor, however. Among

its many provisions was a requirement for the woman to notify her sexual partner prior to obtaining an abortion.

Texas lawmakers approved the first abortion regulation law in that state since the 1973 landmark U.S. Supreme Court decision legalizing abortion. The 1987 law imposes strict requirements for third trimester abortions, prohibiting them except in cases of life endangerment or fetal abnormality.

Lastly, an unusual abortion measure was debated in the Illinois legislature last year which would have amended the state's Right of Conscience Act to allow pregnant women to refuse diagnostic testing to detect fetal abnormalities where such testing may result in an abortion. The proposed amendment to the Right of Conscience Act would have permitted physicians to refuse to perform diagnostic tests to detect fetal abnormalities. The measure was passed by the legislature, but vetoed by the governor. The legislature subsequently attempted, unsuccessfully, to override the governor's veto. A "total veto" was sustained.

Attachment F

"Infertility Services in the United States:
Need, Accessibility and Utilization"

Infertility Services in the United States: Need, Accessibility and Utilization

The Alan Guttmacher Institute
New York

The Research for this report has been supported by DHHS grant FPR-000037-01-0.

December, 1985

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Executive Summary

Purpose and Data Sources

The purpose of this study was to describe the number and characteristics of American women and couples who need infertility services and the availability of medical infertility services from private physicians, family planning clinics and specialized infertility centers. Special attention was given to the needs and service access problems of low-income women. Need for infertility services was estimated from the National Survey of Family Growth, (NSFG), Cycle III, conducted by the National Center for Health Statistics, DHHS, in which almost 8,000 women aged 15-44 were interviewed in 1982 about their reproductive histories. The availability of infertility services provided by private physicians was assessed from data collected from some 2,200 office-based physicians of four specialties (general/family practice, obstetrics/gynecology, general surgery and urology) surveyed by The Alan Guttmacher Institute in 1983. Other data on infertility services were obtained from a national stratified sample survey of 508 hospitals, health departments, Planned Parenthood affiliates, and other agencies which have family planning clinics, and from a survey of 19 specialized infertility treatment centers.

Findings

Fecundity status and need for services

- 35.9% of women (couples) of childbearing age have fecundity impairments: 17.5% are surgically sterilized for contraceptive reasons, 7.8% are surgically sterile for other reasons, 1.7% are nonsurgically sterile, 2.8% are subfecund, 4.0% say it would be difficult or dangerous to carry a pregnancy to term, and 2.1% are classified as "long-interval" (married for 12 months or more without practicing contraception and without becoming pregnant).

- Blacks and Hispanics differ little from other women in fecundity impairment except that they employ contraceptive sterilization (their own or their partner's) less than do other women.

- Because they are younger, low-income women are less likely than other women to have fecundity impairments. Medicaid recipients are similar to other women in the percentage with fecundity impairments.

- Regional and metropolitan/nonmetropolitan differences in fecundity status are minor.

- Of women who want to have children (or want more children), 25% have fecundity impairments, including 14% who are surgically sterile (half for contraceptive reasons).

- 6.5% of women (couples) have fecundity impairments which are possibly treatable; 4.5% also want (more) children and are therefore considered to be in need of infertility services. A total of 2,417,000 women (couples) need services, including 1,082,000 who perceive themselves to be subfecund, 530,000 who are non-surgically sterile, 806,000 who are "long-interval."

- It is the woman who needs treatment in 50% of the couples needing infertility services and the man in 10%; in 39%, it is not known which partner needs treatment.

- 15% of those needing services have low income (under 150% of the federal poverty level). At most one-third of these are Medicaid-eligible. Race and Hispanic background have no association with needing services, although low-income women are less likely than wealthier ones to be in need.

- About half (49%) of those in need of infertility care have already received some professional attention - 33 percent have been treated and 16 percent have received advice only. The remaining 51% represent unmet need for infertility services.

- Among those needing services, black women and low-income women are less likely than others to have received services. These results suggest that low income is a significant barrier to obtaining infertility services.

- Of those who have received infertility services, 78% did so most recently from private physicians or medical groups, 12% from hospitals, 2% from family planning clinics, and 7% from other types of clinic.

- Aside from the couples who need infertility care as described above, there are 882,000 in which one or both partners have been sterilized but would like the sterilization to be reversed.

- About 10 percent of women (couples) who have been contraceptively sterilized would like the operation to be reversed; the proportion is especially high among blacks, Hispanics, poor women, and Medicaid recipients.

Infertility services provided by private physicians

- Nationally there are 45,500 private physicians in the four specialties surveyed who provide at least some infertility services: 17,500 general/family practitioners, 20,600 ob/gyns, 1,400 general surgeons, and 6,100 urologists.

- 80% of these provide at least one specialized infertility test or treatment, most commonly clomiphene administration or hysterosalpingograms. Of the tests and treatments asked about, the least commonly provided were male and female microsurgery and artificial insemination by donor, provided by 3,000-8,000 physicians.

- According to the physicians' reports, they see a projected national total of 1,550,000 infertility patients a year; estimates from the NSFG indicate that 950,000 women (couples) received infertility care in 1981, the most recent source of care being a private physician. Most physicians serve only a few patients a year. (The median number is 12.)

- Almost all physicians refer patients they cannot serve; however, 9% of physicians who treat infertility problems sometimes do not refer because the cost is prohibitive to their patients, laboratory facilities are inadequate, or needed treatment is unavailable.

- Although 45% of physicians in the specialties surveyed provide infertility services, only 21% accept Medicaid patients and only 6% are willing to vary their fees for low-income patients.

Infertility services provided by family planning agencies

- 70% of all family planning agencies provide at least some preliminary infertility services other than counseling. Such services are most likely to be provided by hospitals and least likely to be provided by health departments.

- Only a minority (37%) provide any specialized tests or treatments. The ones most commonly provided are genetic counseling and screening (31%), clomiphene drug therapy (15%) and sonography (15%).

- 92% of agencies refer patients for whom they are unable to provide needed services, usually to private physicians, next most often to hospitals, and next to infertility centers.

- 39% of all family planning agencies use Title X funds to provide infertility services, and 51% accept Medicaid for those services. Of the agencies which treat infertility, 83% serve a majority of infertility patients at a reduced fee, at no charge, or under Medicaid.

Infertility services provided by specialized centers

- Most infertility treatment centers provide a full range of procedures and treatments, although a few serve only women or only men.

- Over three-fourths of the centers charge full fee to a majority of patients. About half accept Medicaid reimbursement, and smaller proportions use various public sources such as state and local funds and Title X to subsidize their services. Only 16% will reduce their fees to low-income patients.

Availability of services - conclusions

- For couples with adequate financial resources, infertility services are relatively available from private physicians, supplemented by hospitals, infertility centers and other sources of medical care.

- Infertility services are less available to low-income couples, as evidenced by the finding that a smaller proportion of low-income than of other women needing services have received medical attention for their infertility problem.

- Family planning agencies and presumably public hospitals as well as a minority of physicians who accept Medicaid or reduce their fees are important in providing preliminary infertility services to low-income women. Because of the intrinsic cost and the lack of reduced-fee services, low-income women face serious financial obstacles to obtaining specialized or complex infertility services.

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