



2009 National Health Care Reform Debate- Comparative of NBCH's Priority Issues

Broadly, health care, particularly reform, is a partisan, ideology-driven issue. Though, it is important to point out the economy and health care are intertwined issues, particularly given that health care expense is considered to be the number one specific economic worry by many Americans.

Just as the general population has specific health care issues and concerns that they want national health care reform to address, coalitions and their employers have specific issues that they will use to evaluate the strengths of proposed health care reform legislation in Congress. NBCH's Government Affairs Committee developed a list of issues that are important to coalitions and their employers and that could be used to compare and contrast the proposals. [Please see the comparative chart below to help evaluate current proposals](#)

A wide-range of policy options currently are being considered to replace, modify or supplement the current health care system resulting in potentially significant implications for US-based employers. President Obama is pushing Congress to give him a comprehensive bill to sign this October. However, the timetable for passage has slipped in Congress. The House adjourned last Friday, July 31st and the Senate is expected recess tomorrow, August 7th but without reaching an agreement on reform legislation. This sets the pace for a busy fall legislative agenda when Congress returns after Labor Day. In the House of Representatives, moderate and conservative "blue dog" Democrats successfully negotiated concessions from the House leadership, leading to passage of a reform bill in the Energy and Commerce Committee just prior to recess. In the Senate, the bi-partisan "group of six" on the Senate Finance Committee, led by Committee Chair, Max Baucus (D-MT) set a revised mid-September deadline for an agreement on bi-partisan legislation. Health care reform is certain to be paramount on the minds of Senators and Representatives and their constituents back home.

Combined efforts to pass a workable, bipartisan bill falls within the jurisdiction of five House and Senate standing committees: Senate Health, Education, Labor and Pension (HELP), Senate Finance, as well as the House Energy and Commerce, Education and Labor, as well as Ways and Means. In terms of funding jurisdiction, Senate Finance and House Ways and Means are the only two committees with that level of oversight. Staff for these Committees will be working during recess to mitigate the remaining contentious issues.

Issues	Obama Administration Principles for Health Reform February 2009 www.healthcarereform.gov	Senate HELP Committee Affordable Health Choices Act Passed July 15, 2009	Senate Finance Committee Policy Actions May 2009 Tentative principles introduced; October 2, 2009- America's Healthy Future Act of 2009	House Tri-Committee- H.R. 3200 the Affordable Health Care Choices Act Passed July 31, 2--9 (Ways and Means Committee, the Education and Labor Committee and the Energy and Commerce Committee	House Republican Health Care Solutions Group June 11, 2009 Outline Provided
Government-Run Insurance Plan – “Public Plan Option”		<p>The HELP Committee wants a government-run insurance option to compete with private insurers, an approach favored by many liberal Democrats. Supporters say it would create more competition in the insurance market and pressure private insurers to lower costs.</p> <p>Establishes a "Community Health Insurance Option," run by the Department of Health and Human Services (HHS):</p> <ul style="list-style-type: none"> • The government would capitalize the plan by paying for the first three months of claims. For the first two years and longer if necessary, it would also qualify for “risk corridor protections” which offset or reclaim excessive losses and gains which could result during the start-up period (like in Medicare Part D). Premiums would be set to make it self-sufficient. • The public option would be one of the choices in the health insurance "gateway" or "exchange". It would follow the same rules as private plans for 	No, alternative is the “free-rider” program	<p>Establishes a national health insurance exchange with a relatively aggressive public health insurance option (summarized on the bill's fact sheets).</p> <p>HHS to develop the plan to be ready for offering starting in 2013 as a choice within the Exchange. Must abide by same standards as private plans.</p> <p>Premiums are to be geographically-adjusted.</p> <p>Payment rates are geographically –adjusted. Physician payment rates based on Medicare rates but with added incentive for first three years with extra 5% for physicians in both Medicare and public plan option. 5% add-on applies to practitioners not traditionally in Medicare (i.e. pediatricians)</p> <p>\$2 billion initial appropriation.</p>	No

		<p>defining benefits, protecting consumers, and setting premiums that are fair and based on local costs.</p> <ul style="list-style-type: none"> • The payment rates paid by the public option, negotiated by the HHS Secretary, would be no more than the local average private rates, but could be less. • Each State would create an "advisory council" of providers and consumers to recommend strategies for quality improvement and affordability. • Health care providers would have the choice of participating in the public option. 			
Member-run Health Insurance Co-operative		No	<p>Yes/tentative</p> <p>Senate Finance Committee members, led by Kent Conrad (D-ND), has expressed interest in developing a "co-op" model for providing health insurance competition to underserved areas.</p> <p>The Finance Committee would set up consumer-owned "co-ops" that would essentially function as nonprofit insurers to compete against private health insurance companies. The proposal is seen as a compromise designed to attract moderate Democrats and</p>	No	

			Republicans.		
Insurance Exchange			Yes	<p>Yes, with a minimum benefit standard requirement. Government by Health Choices Administration/Health Choices Commission-appointed by the President.</p> <p>Benefits: Exchange comprised of three tiers of coverage options: basic, enhanced, premium & premium plus. Cost-sharing is the difference between the first three tiers. The premium plus tier is based on benefits provided, such as dental and vision. The composition of each tier determined by the Advisory Committee. A participating plan is required to at least provide benefits equivalent to the basic plan.</p> <p>Plans eligible to participate on the Exchange must meet basic coverage requirements: no cost sharing for preventive benefits (well child/well baby care); limits annual out of pocket spending to \$5 K individual; \$10K (CPI indexed) for family.</p> <p>States can offer their own Exchange or join with a group of other state to create their own exchange in lieu of the federal Health Insurance Exchange, provided that the state/s perform all the duties of the federal Exchange.</p> <p>A standard is to be determined by the Health Choices Commissioner for plans not participating in the Exchange.</p>	

				<p>Participation: Individuals & employers both eligible to participate. Year 1: individuals not enrolled in other acceptable coverage & small employers with 10 or fewer employees. Year 2: Employers with 20 or fewer employees.</p> <p>Subsequent Years: Health Choices Commissioner would have the authority to expand employer participation as appropriate with the goal of allowing all employers access. Medicaid eligible stay in that program, except for childless adults with income 133% of the federal poverty level- they have a choice between the Exchange & Medicaid.</p> <p>Once in the Exchange, can remain even if circumstances change that would otherwise exclude a participant.</p> <p>Employers who offer coverage through the Exchange must contribute at least the required minimum amount toward coverage & allow employees to choose among the plan within the Exchange.</p> <p>State benefit mandates can be required of Exchange plans.</p>	
Minimum Benefit Standard		Yes		Plans eligible to participate on the Exchange must meet basic coverage requirements: no cost sharing for preventive benefits (well child/well baby care); limits annual out of	

				<p>pocket spending to \$5 K individual; \$10K (CPI indexed) for family.</p> <p>All group plans would have 5 years from the time of enactment to meet minimum benefit standards</p>	
Individual Coverage Mandate		Yes	<p>Yes, would require individuals to have coverage while allowing exemptions based on religious grounds and for undocumented workers. Fines for non-compliance would be based on a percentage of the average cost of the lowest premium option available. Individuals without coverage would not have to pay a fine if the lowest premium available exceeded 15 percent of income. Undefined "hardship" cases and individuals whose income is below the poverty line would be exempt from fines, as would be Native Americans.</p> <p>that would provide penalty exemptions for taxpayers who cannot find health care coverage at 8 percent of their adjusted gross incomes. The hardship waiver in the chairman's mark was 10 percent, a level Schumer called "too high."</p> <p>Schumer said the plan would prompt insurance companies to offer lower premiums. "This is the major</p>	<p>Individuals have the choice of maintaining acceptable coverage or pay a 2.5% tax.</p>	

			<p>amendment on affordability," he said.</p> <p>It also would eliminate a penalty imposed in the first year the insurance exchange takes effect on any person who is not eligible for a waiver and does not purchase health care. In the second year of the exchange, 50 percent of the penalty would be imposed. The full penalty would go into effect in the third year of the law.</p>	
<p>Employer Mandate- "pay or play" {i.e. Employer Responsibility}</p>	<p>Yes, the HELP Committee's "pay or play" policy would require employers to either offer coverage or pay a substantial fine. Businesses largely oppose such a mandate, as do many Republicans, though the policy is supported by many in the Democratic Party.</p> <p>Employers who do not offer adequate coverage to their full-time workers will be assessed an annual fee of \$750 for each uncovered employee.</p> <ul style="list-style-type: none"> • Employers who do not offer adequate coverage to their part-time workers will be assessed an annual fee of \$375 for each uncovered employee. • Employers must contribute at least 60 percent to the cost of monthly premiums to avoid the assessment. • Firms with fewer than 25 employees will be not assessed. 	<p>No, not directly. The Finance Committee is considering a "free rider" policy that would not force employers to provide coverage, but would penalize them if too many of their employees took coverage through the options provided by the government. The option is thought of as a slightly softer policy for businesses, though it would have much the same effect.</p> <p>The so-called "free rider" approach, under which there would be no minimum coverage requirement but employees can opt out of the employer plan if the contribution exceeds an adjusted gross income target level. In such cases, employers would make a contribution if the employees received coverage from Medicaid, and, under one version, if the employees received</p>	<p>Yes, includes a strong employer mandate that imposes a payroll tax if the employer does not "play" by meeting new minimum coverage and contribution requirements.</p> <p>"Offering employers"- the minimum contribution by an offering employer is 72.5% of the premium for individual coverage & 65% for family coverage or a proportional amount for non-fulltime employees. In lieu of coverage, employers must contribute 8% in behalf of each employee to the Exchange.</p> <p>Small employers exempt from mandate if annual payroll does not exceed \$250,000; phase in of 8% payroll tax for employers with annual payroll from \$250,000 to \$400,000.</p>	

		<ul style="list-style-type: none"> Assessments will be collected quarterly. The Secretary of Health & Human Services, in collaboration with the Secretaries of the Treasury and Labor, will establish rules and procedures to implement this requirement. 	a premium subsidy for coverage obtained within the exchange.		
Taxation of Employer-Sponsored Benefits	Promised to avoid this revenue raising method.		Support for capping the tax exclusion to raise revenue	<p>A new employer payroll tax of 3 percent on employer health care expenditures (estimate to raise \$200 billion);</p> <p>A cap on the exclusion of employer-provided health care coverage valued at more than 110 percent of the Federal Employee Health Benefit Plan (estimated to raise \$306 billion);</p>	Yes
Private insurance market reforms	End barriers to coverage for people with pre-existing medical conditions	Yes, bans rejection of coverage based on preexisting conditions.	Yes, likely to require that insurers in the small and non-group, or individual, market would have to take all comers. They couldn't set premiums based on health status or pre-existing medical conditions. Those with current coverage in the non-group market could keep what they have even if the insurer modifies the plan. Small group plans would also be "grandfathered" in but subject to phased-in rating revisions.	<p>Yes, provides substantial insurance & benefit standards.</p> <p>-no discrimination in benefits for mental health/substance abuse disorders, genetic disorders;</p> <p>- no preexisting condition exclusions;</p> <p>-ensure adequacy of provider networks;</p> <p>-guaranteed issue/renewal except if fraud;</p> <p>-insurance rating rules for age 2:1, allows variation based on geographic location;</p> <p>-adequate provider networks (yet TBD);</p> <p>-medical loss ratio-if plans exceed limit then rebate to enrollees required;</p> <p>-no rescission of benefit except for fraud;</p> <p>-standardized admin simplification for providers & insurers (i.e. claims,eligibility, enrollment & prior authorization) building on HIPAA;</p>	

				<ul style="list-style-type: none"> -employer reinsurance for covering age 55-64 retirees/families; -fair marketing practices by insurers; -fair grievance & appeals mechanism; -information transparency & plan disclosure (advance notice of plan changes, information to providers on their payment status; -timely payment of claims using Medicare standards; -standards for rules for coordination & subrogation of benefits. 	
ERISA Protection		No alteration of basic structure.	No alteration of basic structure.	Applies state law remedies for private plans in the health insurance "exchange," including group health plans. Ultimately, all group plans would have 5 years from the time of enactment to meet minimum benefit standards.	
Medicare/ Medicaid Expansion		<p>Expansion of eligibility for Medicaid (up to 150 percent of the federal poverty level) on federal revenue cost and insurance coverage.</p> <p>The HELP committee is assuming an expansion of Medicaid to people making 150 percent of the federal poverty level, which helps lower the cost of the bill by getting more people into the program.</p>	The Finance Committee is still working out the details on its approach, which could expand Medicaid eligibility for children and parents to only 133 percent of poverty. For individuals, eligibility would be set at 100 percent of poverty.	<p>Yes, to all households earning less than 133 percent of the federal poverty level.</p> <p>Extends the 1 year transitional Medicaid coverage for families leaving cash assistance to work from 12/31/10 to 12/31/12.</p> <p>Requirement of 12-month continuous coverage under certain CHIP programs: requires stand alone CHIP programs to provide 12-month continuous eligibility for all enrollees with incomes below 200% of the federal poverty level. Effect 1/1/10.</p> <p>Extension of prescription drug discounts to enrollees of Medicaid manage care organizations (MCOs): Requires manufacturers to pay rebates to state</p>	

				<p>Medicaid programs.</p> <p>Prescription drug rebates: Increases the minimum manufacturer rebate on brand-name drugs purchased by state Medicaid programs from 15.1% of the average manufacturer price to 22.1% of the average manufacturer price.</p>	
Subsidies to Buy Insurance		Yes, help to households earning up to 400 percent of the federal poverty level.	Likely to households earning up to 300 percent of the poverty level.	<p>Yes, help to households earning up to 400 percent of the federal poverty level.</p> <p>Provides employer reinsurance for covering retirees (age 55-64) and their families for costs between \$15K & \$90K. \$10 billion is allotted for this program.</p>	
Tax Credits to Buy Insurance			<p>Specifies that a temporary tax credit to provide coverage would be available to firms with fewer than 25 employees and average wages below \$40,000 until a state exchange is established to enroll individuals and small groups in insurance plans. Once the exchange is established, a small business tax credit would be available for five years to new businesses and firms newly offering coverage to workers through the exchange.</p>	<p>Individual Affordability Credit-eligibility applies to people with incomes up to 400% of the federal poverty level. The credit applies only to plans accessed through the Exchange independently of an employer.</p> <p>Small Business Employee Tax Credit for Health Coverage Expenses- provides a tax credit equal to 50% of the amount paid by a small employer for employee health coverage. The tax credit is phased out in the case of an employer with 10 to 25 employees and also is phased out in the case of an employer with average wages of \$20k to \$40k. per year.</p>	
Value-Based Purchasing					
Coverage Access	Assure affordable, quality health coverage for all	Purport to cover 97% of Americans when combined with Finance Committee plan.			

<p>Model</p>	<p>Americans.</p> <p>Maintain coverage when you change or lose your job.</p> <p>Guarantee choice of doctors and health plans.</p>				
<p>Provider Performance Measurement, Reporting & Incentives (including payment reform)</p>				<p>Empowers the HHS Secretary to reform the payment incentives and the delivery system for providers of the public option to improve quality and efficiency of care.</p> <p>Medicare Physician Services Part B: Sustainable Growth Rate Reform- allows primary care rate to grow faster than other services; incents the formation of Accountable Care Organizations (ACOs) by providing targets and update factors; provides incentive payments in Medicare program to physicians practicing in area that are identified as being the most efficient areas in the country; reduces Medicare payment to hospitals for potentially preventable Medicare readmissions for 3 conditions with risk adjusted readmission measures that are endorsed by NQF; requires the HHS Secretary to submit to Congress 3 years after the date of enactment a detailed payment reform plan on how to implement post-acute bundled payments; closes the loophole in physician self referral – prohibits physician ownership</p>	

<p>Quality & Cost Transparency/Quality & Safety Improvement</p>	<p>Improve patient safety and quality of care.</p>	<p>Specifically addresses "improving the quality and efficiency of health care" (see the official summary of Title II)</p>		<p>Creates Center for Quality Improvement at AHRQ with focus on other quality improvement, including identifying existing best practices, Medicare Advantage (MA) Reforms evaluate the impact of MA on access to services and quality of care; Research and Innovation to service level over these best practices. quality of payment rates in 2013; quality bonus payments; creates an Incentive Assistant Secretary for Health, High Quality, and Health Reform; report of key health indicators, fact over 2011-2013</p> <p>Medicare Part D Reforms: -eliminates the coverage gap "donut hole" between 2011-2013; discounts for certain Part D drugs in the coverage gap by incorporating the voluntary PhRMA agreement to provide discounts of 50% for brand name drugs used by Part D enrollees; allows mid-year changes in enrollment for formularies that increase enrollee cost-sharing.</p> <p>Medicare Physician Sunshine Provision: Must report relationships with manufacturers & distributors of covered drugs, biologics, and medical suppliers under Medicare.</p> <p>Medicare and CHIP and other incorporate recommendations from outside entities to focus on areas that contribute to</p>	
				<p>large disease burdens, high potential for decreased morbidity, mortality & improve performance, address disparities & have potential to produce rapid change based on current evidence.</p>	

				<p>Development of new quality measures; GAO evaluation of data collection for quality measurement.</p> <p>Multi-stakeholder pre-rulemaking input into selection of quality measures.</p> <p>Application of quality measures. Must ensure that quality measures selected by the HHS Secretary are endorsed by the contracted consensus-based entity. If the Secretary chooses to use non-endorses measures, then must provide explanation in the rulemaking. Measures apply to inpatient hospital, physician services and renal dialysis services.</p> <p>Consensus-based entity funding contract amount is increased to \$12million for 2010-2012.</p> <p>Public reporting on health care associated infections-requirement for public reporting by hospitals & ambulatory surgical centers.</p>	
<p>Health Care Information Technology Infrastructure (including e-prescribing & electronic medical records EMR,</p>					

<p>personal health records PHR)</p>					
<p>Patient-Centered Care/Medical Home/ Care Coordination</p>		<p>Primary Care Bonus Payment: Certain Medicare providers being eligible for a primary care services bonus payment of at least 5 percent over the fee schedule amount for providing certain evaluation and management services.</p> <p>Chronic Care Management Innovation Center (CMIC) - The establishment of the CMIC at CMS for Medicare by the Secretary of HHS for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination, with advancing PCMHs at the top of their list.</p> <p>Potential Items- The Committee would also look to reimburse states that use the PCMH model in their Medicaid programs.</p>		<p>Medical Home Pilot: Establishes a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes (2 kinds-community-based & independent). Provides approximately \$1.6 billion for a 5 year pilot. HHS can expand the program only if quality measures have been met and budget neutrality is demonstrated.</p> <p>Payment Incentives for Selected Primary Care Services: Increases the Medicare payment rate by 5% for primary care services of physicians specializing in primary care (family practioners, internists,etc.) and by share of practice in primary care (at least 50% of allowed charges are for primary care). Eligible practioners practicing in health profession shortage areas receive an added 5%.</p>	
<p>Population Health Improvement/ Chronic Illness Prevention & Manageme</p>	<p>Invest in prevention and wellness</p>			<p>Expands access to vaccines- transfers coverage from Medicare Part D to Medicare Part B for all Medicare-covered vaccines.</p> <p>Inclusion of public health clinics under the Vaccines for Children (VFC) program. Effective upon enactment.</p>	

<p>Clinical Effectiveness Research</p>				<p>Establish the Center for Community Health Effectiveness Research (CHER) Commission years 2010-2019. Public/private stakeholder group to oversee the Center, determine establishment priorities & overall strategy. Research approach of 85% of evidence, 15% of 2010-2019. Stakeholder Task Force & evidence & wellness research dissemination of findings based prevention and</p>	
<p>Medicare/Medicaid Program Reform</p>			<p>Create an independent Medicare commission to set targets for savings through program reforms and if targets are met, the commission would recommend ways to obtain additional savings.</p>	<p>Reimburse services, fraud & public health infrastructure activities. HHS to develop a national prevention & wellness strategy. Strengthens/codifies clinical & community preventive services, and</p>	
<p>Pharmacy Industry Reform</p>				<p>strengthens/codifies prevention & wellness research & coordination A prohibition on the deduction for prescription drug advertising expenses (estimated to raise \$37.5 billion); Research Grants: Establishes a CDC grant program to fund delivery of evidence-based, community-based prevention & wellness services across the country. Eligible entities: state/local government, non-profits & community partnerships representing Health Empowerment Zones. At least 50% of grant funds at \$30 billion are to be used to involve patients in coverage of half of the “donut hole,” the gap in Medicare prescription drug costs that CDC grants program pay 100 percent of prescription costs at certain levels at least equal to the Blue Cross agreement with the White House and the Secretary of the Committee for World Health Organization laboratory cost savings over 10 years, clearly</p>	

Cost Containment	Reduces long-term growth of health care costs for businesses and government Protects families from bankruptcy or debt because of health care costs			demonstrates that commitment.”	
Support for Small Business				Small Business Employee Tax Credit for Health Coverage Expenses- provides a tax credit equal to 50% of the amount paid by a small employer to provide health coverage. The tax credit is phased out in the case of an employer with 10 to 25 employees and also is phased out in the case of an employer with average wages of \$20k to \$40k per year.	
Financing Reform Plan \$\$	FY2010 budget provides an initial down payment for reform of \$649 billion over 10 years.	Initial proposal cost \$1 trillion over 10 years but only expanded coverage to 16 million uninsured.	Currently scored by CBO at \$ 10 years. The \$900 billion proposal would cover 95 percent of Americans, and is paid for by fees to health industry groups, taxes and Medicare cuts.	Small Business Employee Tax Credit for Health Coverage Expenses- provides a tax credit equal to 50% of the amount paid by a small employer to provide health coverage. The tax credit is phased out in the case of an employer with 10 to 25 employees and also is phased out in the case of an employer with average wages of \$20k to \$40k per year.	
Consumer Incentives/ Tools	Has indicated that a health care bill “must and will be paid for.”	As of 7/9/09: The HELP Committee legislation, without Medicaid expansion, carries an estimated federal revenue cost of \$611 billion. Committee does not have revenue-raising authority.	Draft Finance bill would total \$900 billion over 10 years and cover 95 percent of Americans. Considering imposing an excise tax on insurance companies that sell policies in excess of \$21,000 a year for family coverage or \$8,000 a year for individuals.	Provides a demonstration program on the use of patient decision aids and other technologies to help patients and consumers make informed decisions about their medical care. General cuts in the Medicare program;	
Family Medical Leave Act Reforms			Require wealthier seniors to pay more for prescription drug coverage under Medicare, and charge them co-payments for clinical lab procedures (lab co-pays are potentially lucrative, raising approx. \$20 billion over 10 years.)	A cap on the exclusion of employer-provided health care coverage valued at more than 110 percent of the Federal Employee Health Benefit Plan (estimated to raise \$306 billion); A tax of 10 cents per can on sweetened beverages to (estimated to raise \$112 billion);	
			Penalties on individuals who do not obtain health insurance; and a “free-	An increase in alcohol taxes (estimated to raise \$61.5 billion);	

			<p>rider” provision that would require employers that currently offer health insurance to continue to do so, or to reimburse the federal government for workers who switch to subsidized coverage through an insurance exchange. Both provisions could yield about \$43 billion over 10 years.</p> <p>impose a 40 percent tax on insurance companies for plans that, beginning in 2013, exceed \$8,000 for individuals and \$21,000 for families. The tax is a main source of revenue for the committee’s bill, bringing in about \$200 billion over 10 years, and is viewed by supporters as a mechanism to help bend the cost curve in health care.</p> <p>But Democratic Rep. Joe Courtney of Connecticut said such a tax would represent an “unacceptable burden” on middle-class families who may have given up wage increases to obtain better health care coverage, or live in areas with high medical expenses. “The purpose of the letter is to stake out a position with House leadership,” Courtney told reporters.</p> <p>The letter to House Speaker Nancy Pelosi, D-Calif., urges her to reject the</p>	<p>A prohibition on the deduction for prescription drug advertising expenses (estimated to raise \$37.5 billion);</p> <p>A new employer payroll tax of 3 percent on employer health care expenditures (estimate to raise \$200 billion);</p> <p>Certain items proposed by President Barack Obama in his budget, including international tax proposals, provisions targeting life insurers and their products and oil and gas provisions (Apparently, the President's proposal to cap the tax value of itemized deductions is not under consideration); and</p> <p>A value-added tax of 1 percent to 1.5 percent or a .65 percentage point increase in the Medicare payroll tax.</p>	
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