

Health care

THE WHITE HOUSE
WASHINGTON

MEMORANDUM

To: John Galles
From: Carol Rasco and Bob Rubin
Date: November 10, 1994
Re: Memo to Erskine Bowles regarding Purchasing Cooperatives
cc: Erskine Bowles

Erskine Bowles has advised us of your interest in developing innovative ways to establish purchasing groups for small businesses. As you know, we are extremely interested in arrangements that have potential to expand choice and access of health insurance to businesses and their employees.

We were pleased to learn of your conversation with Chris Jennings from yesterday. He has informed us that representatives from the Treasury Department and the Department of Health and Human Services will be meeting with you and your technical assistants next Wednesday, November 16th. We think that you will find Mark Iwry (Treasury) and Gary Claxton (HHS) to be informed and ready to discuss your proposal.

We will ask Chris to keep us advised of the status of your proposal. Again, thank you for making us aware of your work in this area. Erskine sends his regards.

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To ERSKINE BOWLES	From JOHN GALLES
Co. WHITE HOUSE	Co. NSBU
Dept. CHIEF OF STAFF	Phone # 293-8830
Fax # 456-2883	Fax #



NATIONAL SMALL BUSINESS UNITED

1155 15TH STREET, N.W.

SUITE 710

WASHINGTON, D.C. 20005

202-293-8830

FAX: 202-872-8543

MEMORANDUM

TO: Erskine Bowles
 FROM: John Galles
 RE: Health Care Purchasing Cooperatives

DATE: October 28, 1994

*Bob Rubin
 Cawl Rasco -
 He has a good point
 Plus the group could
 be very sup. of our new
 initiative. How would
 you like
 me to follow
 Erskine*

Erskine, I really need your help.

As you may recall, we have been struggling to establish health care purchasing cooperatives. So far, we have made attempts in California and Texas. We hit a roadblock in California when state bureaucrats refused to recognize our cooperative because of the California HIPC. They wanted a single, exclusive entity. Since it started, they have done well. They have sold policies to about 80,000 lives in a year and a half of operation. However, there are 6 million people in the state. We had thirteen carriers prepared to participate in our purchasing cooperative until the state sent the negative signals. And so, we are still looking for an opening to do business in California.

When we learned about legislation in Texas which authorized privately organized cooperatives, we took our prototype there. We believed that we had a "level playing field" and that we could fairly compete in the health care marketplace. We raised about \$1,000,000 to get this up and running. We received 24 proposals in response to our RFP and chose 11 carriers for our Texas HIPC. However, the Texas Insurance Commissioner has determined that the state's purchasing alliance can offer HMO coverage that is age and gender rated and that our cooperative cannot. And so, the playing field is not level and our carriers are backing away from our project.

As I mentioned to you in the past, we want to use a VEBA, a Voluntary Employee Benefit Association, as established under IRS Code 501(c)6 so that we can move forward with these entities and not be trapped by state regulation which puts us in a disadvantageous position. We sought technical advice from IRS and were told that a VEBA required "an employment-related bond" to establish a VEBA. There is no statutory foundation for that requirement. That requirement was written when VEBA's were first created because that is the way insurance carriers rated employers and employees, by industry sector. Now that many states have community-rating, it makes more sense to build community purchasing groups. The insurance environment has changed. The regulation should now allow for diverse businesses to collectively purchase coverage. We are not talking about self-insured coverage; we are talking about fully insured products—HMOs, PPOs, and indemnity products—individually chosen by employees of employers participating in the purchasing cooperative.

Erskine Bowles
October 28, 1994 - page 2

Erskine, now that health care reform is not a hot topic, a simple expansion of an outdated regulation would help us get several of these cooperatives up and running. We know how hard it is to get these started. We have experience dealing with carriers and state governments.

We will be attempting to start one in Colorado next under their law. I was even invited to North Carolina and encouraged to start one there. We could move much more skillfully with a classification as a VEBA.

This change requires a "will" to change. Your help to establish that "will" within this administration could make this happen.

Please give me a chance to make these purchasing co-ops happen.

I hope we can meet soon.

Health Care

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

Carla/Bru
Thank you
Erskine

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Date: November 10, 1994
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THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: JB

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : Accept Pending Regret

Designee to attend: _____

Remarks: _____

Full - This is the
correct std. reply from Pres.
on health care. Is it ok?

NOV - 9 1994

November 8, 1994

file: health care

Edward J. Petrus, M.D.
3413 Spanish Oak Drive
Austin, Texas 78731

Dear Edward:

Thank you so much for sharing your plan for health care reform.

Your suggestions are important to me, and I'm glad you've taken the time to examine ways to improve our health care system. We agree that meaningful health care reform must include a commitment to universal coverage, a greater emphasis on preventive care, and a continuance of private sector competition. In order to achieve these goals, we must change our country's health system -- building on what is positive and fixing what we know does not work.

Although Congress did not pass health care legislation this year, I am encouraged that our nation has come further than ever before in the effort to reform our health care system.

I remain committed to our mission to provide health security for all American families, and I greatly value your involvement. Our journey is far from over, and I appreciate your support.

Sincerely,

BC/MHM/KM/MM/jfc
(11.petrus.ej)

(Corres. #1902759)

cc: Staff Secretary

cc: w/incoming Carol Rasco, 2nd Floor ~~WW~~

EDWARD J. PETRUS, M.D.
3413 Spanish Oak Drive
Austin, Texas 78731
Fax (512) 453-0066
Tel (512) 454-6500

Thayer Podesta

94 OCT 22 A 8 : 46

10/12/94
October 18, 1994

President William J. Clinton
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear President Clinton:

You have impressed me with your sincere desire to provide health care reform. Enclosed is an outline of a proposal that I believe provides some of the goals you have articulated to the American people. Besides providing health care for the uninsured, it provides universal coverage, portability, preserves physician choice, controls cost, is affordable and as an added bonus - provides jobs.

The ideas presented for your consideration are an eclectic approach gleaned from many writers with a slant from a medical practitioner. In this approach, each state establishes a health care authority to provide and oversee a basket of health care plans to the residents which includes a basic health package that provides protection from catastrophic illnesses. A federal oversight agency would provide national guidance to insure portability between the states and insure uniform coverage of the basic health package.

One aspect of this proposal is the utilization of existing unused hospital beds for drug rehabilitation, mental health services, extended care for the elderly, and for the homeless. Instead of closing existing hospitals or closing hospital wings, many jobs will be created for the unemployed, underemployed, or those looking for careers in the health care field. Training programs for hospital attendants, lab technicians, orderlies, food preparers, laundry, security, and drug counselors could be organized to provide jobs.

If you find any merit in my proposal, it would be an honor to meet with you and discuss this outline. I am not presumptuous to believe that this proposal is unique, or the complete answer to the problems, or that I have any insight that the many experts have not addressed. But I do believe that this plan would be more acceptable to the American people.

My sincere best wishes to you and your family.

Sincerely,


Edward J. Petrus, M.D.

Enc: Health Care Reform Plan

HEALTH CARE REFORM

Congress just concluded an unsuccessful holy crusade to change the health care system of this country. The plans before congress were defeated due to a fear that a federally run system would be too expensive, bureaucratic and impersonal, with a loss of choice of physicians and eventually rationing of services. I believe that a plan is available that addresses the needs expressed by the American people that provides health care for the uninsured, provides universal coverage, portability, preserves physician choice, controls cost, and can be affordable.

We do not have a health care crisis, but measures can be taken to fine tune the greatest health care system in the world to better meet the needs of each individual. There is no need to parade a group of unhappy patients before the media to tell their case history to justify reform. Such rhetoric can be found for any industry. It is said that we have a crisis because we spend 14% of our gross domestic product (GDP) on medical care - more than any other country. We also spend 26% of our GDP on leisure activities from bowling to yachting (more than any other country), but that is not seen as a crisis. In 1945, the average family spent about 5% of its income on medical care, and less than 3% on taxes. By 1993, each family spent about 12% on medical care, but a whopping 40% on taxes. Now, there's a real crisis.

The majority of Americans (over 75%) are pleased with their health care. Virtually every American has access to medical care, and no American can be refused treatment for an emergency condition at a hospital. Doctors from around the world come to our teaching hospitals to learn the latest treatments and techniques. The United States produces nearly half of all new drugs. We are the leaders in health care.

Many of the Washington experts in an effort to explain the increased cost of medicine have been focusing on the problems of modern medicine, namely greedy pharmaceutical and insurance companies; physicians, unnecessary procedures, bureaucratic inefficiency and paperwork, expensive technologies, and so forth. But the increase costs are not a result of the failures but from its successes. We have an unbridled appetite for health care and a continuing expansion of the definition of what constitutes health care.

Health care in America has become the target of many special interest groups whose political agenda ranges from abortion to zero population growth and includes high risk lifestyles, drug addiction, unwed mothers, infant mortality, contraception, and sex education. All of these entities increase the overall costs of health care and give the impression of accelerated cost increases when in fact health care has become the victim of inclusion of health related projects. Health care is not a product or a simple service that can be standardized, packaged, marketed, or adequately judged by consumers according to quality and price.

Many try to show the failure of health care in America by noting the high infant mortality rate. Researchers at the Harvard Center for Population and Development Studies found that D.C. has one of the highest rates of unmarried mothers and that single mothers statistically are tied closely to infant deaths. Studies found that unmarried pregnant women are more likely to engage in behavior that leads to low birth weights and higher incidence of infant deaths. Infant mortality is a poor indicator of the status of health care in this country.

Quality medical care can be defined as care given to a particular patient under particular circumstances by a compassionate and competent physician who has

access to consultants and the best current information, who is not influenced by economic incentives to do more or less than is medically appropriate, and who is committed to serve the patient's best interests guided by the latter's wishes and medical needs. The physician's key role is providing appropriate medical resources and preserving standards of quality. Health care providers are learning that in order to survive, they need to operate more as businesses, providing their customers with the best medical services, competitively priced with maximum efficiency.

UNINSURED

About 85% of Americans have health insurance of some type. It is estimated that about 34 million are without insurance. The majority of the uninsured are under 35, in good health, and only temporarily uninsured; others are uninsured by choice. Should a system that provides health care for 250 million be changed to meet the needs of an estimated core of 8 to 16 million people? A farmer will tell you that you don't plant a new soybean variety on all your land. You try the new variety on a few plots, and if it works, phase in the new variety over a few years.

PROPOSAL

Any health care plan must give consideration to cost, access and quality. Cost is the driving force behind the reform movement. Health care costs represent one seventh of the economy or 12% of the GDP. Education and defense each represent about 6% of the GDP. Medical care in this country is an \$800-billion-a-year industry. How does one contain medical costs yet maintain access and quality?

From the end of World War II through the mid-1980s, Americans paid for health care principally through a cost-plus system of financing. Medical care was administered in an environment in which cost was no object, and physicians were trained to

do everything possible to alleviate any and all illnesses. Because there is a limit to how much any society will pay for health care, the physicians were ultimately forced to limit the services by rules and regulations written by bureaucrats. Today, third-party payers (government, insurance companies) directly or indirectly control the entire system, and determine what technology can be used, what illnesses can be treated, and the amount that can be spent. Rules imposed by third-party institutions increasingly shape medical practice. Whether a procedure is performed is determined more by reimbursement rules from third-party payers rather than by clinical judgment.

The government is part of the health care problem. Medicare and Medicaid are able to obtain discounted health care costs at the expense of private insurance companies resulting in higher premiums and preventing many from obtaining affordable health insurance. This cost shifting is illustrated by the cost of a coronary bypass operation from Stanford University Medical Center (1990). The operation costs Stanford \$35,000 to \$41,000. Medicare paid only about \$27,000 and Medicaid about \$11,000. To recover its overhead, the Center charged privately insured patients about \$81,000. The government used their muscle to coerce price discrimination, then complained in the media about the high cost of private insurance, and how the government programs can do it for less.

Most Americans obtain their health insurance through their employers, and are largely insulated from health-care costs because of the "third party" payment system. For every dollar paid to a doctor, the patient pays 17 cents from his own pocket and the remaining 83 cents comes from a third party payer - the employer, insurance company or the government.

Decisions about health care matters should be determined in the states where

one resides, not in Washington. Individual states have broad powers to legislate health related matters. Each state licenses physicians, nurses, health care professionals, pharmacists, dentists, hospitals and insurance companies. Health care decisions are currently being made on a state level and are most capable of caring for its residents. The further removed decision makers are from you - geographically, economically, and politically - the less likely they are to make the same decision you would make with respect to your health care.

Freedom of choice is an important consideration, therefore each state should provide a minimum of four health plans to choose from which includes private insurance, managed care and fee-for-service. Fee-for-service is an important option because many physicians will be excluded from some plans because they order more tests, refer to more specialists, hospitalize more often and treat sicker patients.

Insurance premiums should be shared. One solution is for all employers to pay 50% of the premiums for the plan selected by the employee. If the employer pays more than 50% of the premiums, it would count as income for the employee. Likewise the amount of premiums and out of pocket expenses paid by the employee would be treated as a tax credit.

Every state resident would be given access to a basic package of health benefits. Each state would put a basic package of health benefits out for competitive bid. The premium cost would be treated as a tax credit (money taken off the tax obligation, not deducted from income). A reasonable figure would be \$1,500 for a single person and heads of households and \$1,000 for each dependent. The poor, unemployed or those with limited income would pay for the basic coverage on a sliding scale. This plan creates a level playing field and with a tax credit all state

residents would have access to a basic health package. It would offer sufficient protection against hospital costs and catastrophic illnesses. Rich or poor, self-employed or on welfare, everyone would have access to this basic package.

This plan would eliminate Medicare and Medicaid. By 1995, the Medicaid program (at \$120 billion this year) will probably overtake the \$145 billion Medicare program for the elderly (which the Social Security board of trustees says will exhaust its trust fund in 2003) as the nation's most expensive health entitlement. Shortly after the year 2000, the two combined will probably overtake the \$270 billion-per-year Social Security program, becoming the biggest contributor to the federal government's \$320 billion annual deficit. Health care costs are the main engine driving the federal budget toward bankruptcy.

The elimination of Medicare and Medicaid would create two huge savings to the country. The first is the \$50 billion savings to the states for Medicaid expenses. The second is the \$80 billion savings to workers and their employers who no longer have to pay the combined 2.9% payroll tax for the Medicare Part A Trust Fund. Savings from eliminating other federal health benefit programs amounts to \$40 billion (veterans' benefits - \$14 billion; government employee benefits - \$14 billion; military benefits - \$9 billion; Indian benefits - \$2 billion; miscellaneous - \$2 billion).

In the United States there are about 65 million heads of households, 135 million dependents and 50 million single persons. At a cost of \$1,500 for singles and heads of households and \$1,000 for dependents, the cost is \$308 billion. The cost of additional coverage for nursing home insurance amounts to \$31 billion, for a total cost of \$339 billion. The savings would be \$336 billion (savings from eliminating Medicaid - \$70 billion; savings from eliminating Medicare - \$45 billion; savings from eliminating

other federal health benefit programs - \$40 billion; additional taxes on employee benefit packages - \$46 billion; offsetting reductions in state aid or direct payments in lieu of current Medicaid expenditures - \$50 billion; revenues from Medicare payroll deduction without the \$135,000 salary cap - \$85 billion).

All this plan does is rearrange the system to make health care more equitable. The uninsured can then be incorporated at virtually no additional cost. Today 40% of those living in poverty are not eligible for Medicaid. Insurance will become portable resulting in a net increase in productivity by increasing the efficiency of the labor market. This plan will also spread the risk and lower the cost to insurers covering the elderly. The plan would also lower the administrative costs which account for 20% of our costs or about \$80 billion.

PREVENTIVE MEDICINE

Some experts claim that if more money were spent on preventive medicine, as opposed to therapeutic medicine, we could solve the problem of health care costs. Preventive medicine ultimately drives up the cost of health care by enlarging the population of the elderly and infirm. Preventive medicine's effect is the grief and misery that it averts and that it allows individuals to lead healthy and productive lives.

In 1952, more children died of polio than of any other infectious disease, and polio was much feared as the greatcripler of children. After many millions of dollars of research, the Salk vaccine was developed, virtually eliminating polio as a threat.

Diseases of the elderly accounts for about half of all health care costs, and that amount will increase as our nation ages demographically. Our only hope for a sustained reduction of those costs is to create new methods of treatment that reduce the need for hospitalization, surgery, and nursing home care. Prescription drugs are

usually the most cost-effective way of treating a disease, but neither Medicare nor half of all private insurance policies cover outpatient drugs. We must change a system that will pay \$20,000 for a surgical procedure but will not pay \$2,000 for a drug that eliminates the need for surgery.

We should strive for participation with the pharmaceutical companies as partners in health care not adversaries. We have much to gain by such an alliance. No other industry does research and development for low profit, low demand products as the pharmaceutical industry has for the development of medications for orphan diseases (rare disorders).

Like the Japanese, we should consider federal funding of biomedical research to be an investment in R&D for the health care industry, just as electronics research is the R&D for the computer industry. Basic biomedical research consumes less than 2% of the health care budget. Hepatitis B vaccine is estimated to save as much as \$95 million per year by preventing acute and chronic disease. Any single breakthrough of basic biomedical research could alone produce more savings in health care costs in one year than the entire federal budget for the National Institutes of Health, which funds most biomedical research in the United States.

MANAGED CARE

The movement from a fee-for-service to a managed care system is causing a ripple effect throughout the health care industry. Insurers and company health plans have already stampeded into programs like utilization review, health maintenance organizations (HMOs), preferred-provider organizations (PPOs) and point-of-service plans (POS), all of which aim to shave costs by managing care. They all share a common trait - treatment decisions are no longer up to you and your doctor alone,

your choice of treatment is subject to approval by others whose mission is to curtail costs. However, some managed-care plans wind up costing more than traditional insurance. A Foster Higgins survey showed that about 30% of employers said their HMOs were more expensive than their fee-for-service plans.

Managed care organizations such as HMOs are frequently praised as the solution to the problem of controlling costs. Managed care organizations bid competitively for contracts to provide care for large blocks of patients. Kaiser-Permanente is an example of an HMO that has excelled in providing quality care for patients in large cities.

Primary care doctors will have control of the patients' health care. If the patient is referred to a specialist, this primary care doctor's group must pay both the specialist's fee and for the hospitalization. With some managed care organizations, the physicians who are able to withhold the most care, and refer to the specialist the least, are judged the most successful because they save the most money. The physician becomes an advocate for the managed care company and an adversary to patients who need expensive medical care. Managed care companies track the dollars spent by each primary care provider. If the primary care provider exceeds the dollar norm established by the company he may be replaced by a more responsive physician. Primary care doctors will react by becoming more and more restrictive to their patients. Some managed care companies have eliminated training programs for health care personnel because it is not cost effective.

What happens to the doctor-patient relationship when for-profit investor owned companies take responsibility for providing care and expect financial rewards in exchange for risking capital? How do we ensure that the economic incentives do not

compromise the quality and availability of care? Caveat emptor - let the buyer beware. Who would want to be cared for in a health system built on that principle?

The Wall Street Journal reported that U.S. Healthcare is widely considered one of the country's toughest HMO companies. It keeps 30 cents of every premium dollar collected and zealously tracks the performance of doctors and hospitals. In 1993, its CEO Leonard Abramson was paid \$9.8 million in salary, bonus and stock options, and collected \$11.4 million in dividends. One of its doctors stated that "If I send too many patients to the dermatologist, I get penalized, if I save money for the HMO, I get rewarded. It puts the patient at odds with the doctor." There is a difference between forcing providers to be more efficient and coercing physicians to deny health services to patients to be cost effective. HMOs work well in big cities but can't provide care in rural areas.

RURAL AREAS

Rural areas don't have enough physicians or medical facilities. Farmers who are self-employed aren't allowed to deduct their medical insurance premiums the way corporations can. Insurers frequently price the seriously ill out of the market or deny them coverage for preexisting conditions. Farmers medical insurance premiums should be deductible, and tax considerations given to doctors to practice in rural areas.

PRICE CONTROLS

Price controls have been tried unsuccessfully to contain health care costs. Under the threat of price controls, investor interest in the health care industry is drying up. The biotech industry raised only \$1.6 billion in the public market in 1993, down from \$3.7 billion in 1991, according to Montgomery Securities. Threats of price

controls and added regulations have caused new biotech companies to drop from 120 in 1987 to 40 in 1993. The threat of price controls is already having a negative impact on medical research. Price controls have a negative impact on any industry and in the long run do not contain costs.

MEDICAL SAVINGS ACCOUNTS

One proposal presented for consideration is the Medical savings account (MSA) which are tax-free individual accounts that would pay for health care just as tax-free individual retirement accounts were originally planned to pay for retirement. As an example, every American would have a \$2,000 tax credit to cover their health costs. They would be required to put the money into an MSA, where it could be withdrawn for legitimate medical costs, you could either use the money to pay your own medical expenses or buy insurance, or both.

Senator Phil Gramm (R-Texas) is the promoter of a MSA that uses a high-deductible health-insurance policies coupled with MSAs that would be managed by individuals to pay expenses not covered by their insurance policies. Under this system, the employer and employee will be paying approximately the same amounts as they do under the current system. For the family of four, the employer would still pay \$4,500 per year. Instead of the entire amount for an insurance policy, the employer will be paying \$2,000 for the insurance policy and \$2,500 to the employee's MSA. The employee would continue to pay about \$500 out-of-pocket; but instead of paying providers directly, the money will be routed through the MSA. With this method consumers are using their own money to pay the first \$3,000 of health-care costs. The market forces of millions of people negotiating their own insurance would bring down health care costs. They are a partial answer, but MSAs can't provide a

comprehensive solution for everyone.

HOSPITALS

Hospitals are often overlooked by everyone but the merger and acquisition moguls. In Texas there are currently 509 hospitals. During the past 14 years 167 hospitals have closed, 71 were from the rural area. It is estimated that a third of the existing hospitals may close in the future. Hospitals are closed because we are told there is a decreased need for beds, decreased hospitalization since more procedures are done on an outpatient basis, less compensation and shorter hospitalization stays are mandated by third-party payers. We must stop closing our hospitals.

It costs approximately \$200,000 to provide a hospital bed today. Approximately 50% of the costs are attributed to equipment. On any given night, roughly 310,000 of the nation's 925,000 community hospital beds are empty. The hospital bed surplus could be used for drug rehabilitation, mental health services, extended care for the elderly, and for the homeless. By expanding the uses of the unused beds, a training program to supply the needed personnel would be established to provide jobs. Training programs for hospital attendants, lab technicians, orderlies, food preparation, laundry, maintenance, security, and drug counselors would be used to train the unemployed and provide them jobs.

The health care field is one of the fastest growing employment opportunities and by using the hospital beds to the advantage of the community, societal needs can be met and jobs provided to all levels of applicants.

SUMMARY

Health care reform is the largest legislative endeavor undertaken in the last thirty years, if not in our nation's history. It affects every American. When congress

reconvenes, healthcare reform will still be the number one issue on the agenda.

Reform is a giant puzzle, and each interest group holds one piece. As we try to put it together, not all the pieces fit, even some that looked promising standing alone. The key piece is still missing - someone to pay for it when it is assembled. That someone is not the big corporations, not government employees or retirees, not congress, not the elderly, not the poor, but the middle class and small businesses.

The cure for the ailments of the U.S. health care system is not increased government regulation, price controls, and mandates but a healthy, vibrant market that offers ever more effective and ever more cost-effective treatments and cures. There are no bumper sticker solutions. One-size-fits-all does not work in health care. Just as individuals require individual health care solutions, so each individual state should be treated on an individual basis. Health care managed on a state level with national guidance to insure uniformity or coverage is a reasonable solution that can be incorporated today without reinventing the entire health care system.

October 18, 1994

Edward J. Petrus, M.D.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO

Assistant to the President for Domestic Policy

To: JEN

Draft response for POTUS
and forward to CHR by: Roz Thanks! For Carol's files.

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: X

Reply using form code: _____

File: Health Care

Send copy to (original to CHR): _____

Schedule? : Accept Pending Regret

Designee to attend: _____

Remarks: _____

Sanford C. Bernstein & Co., Inc.
Investment Research and Management

Kenneth S. Abramowitz
Health Care Analyst

November 10, 1994

Ms. Carol Rasco
Domestic Policy Council
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

NOV 14 1994

Dear Carol:

As a health care analyst with 17 years of experience with a research and money management firm in New York, I thought you might be interested in knowing that I will be giving a speech in Washington D.C. on December 15 at 8:00-9:00 a.m. at the Washington Sheraton Hotel. I will be speaking to 150 health care industry executives with an update of the changes going on in the marketplace and in Washington relative to health care reform. I will also be presenting my hypothetical compromise solution, which may be of some use to you, should Congress wish to reconsider health care legislation in 1995.

Should you or one of your staff members wish to attend this speech, please let me know. If you are unable to attend, but would like to discuss some of my ideas, I will have some free time that day and would be pleased to meet with you to discuss some of these issues.

Sincerely,



Managing Benefit Costs: What Approach Should Employers Use?

A Conference Highlighting
"Outcomes Management"

The Ziller Group

Kenneth S. Abramowitz
Keynote Speaker
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Health Action Council of Northeast Ohio

Mark H. Glasser, M.D.
Chief, Departments of Obstetrics
and Gynecology
Kaiser Permanente Medical Center

Christopher J. Mathews
Principle
Williams, Thacher, and Rand

Ron McDaniel, M.D., M.B.A.
Assistant Director, Departments of
Outcomes Research and Epidemiology
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National Business Coalition on Health



MARK YOUR CALENDAR!

December 14-16, 1994

Sheraton Washington Hotel
Washington, D.C.

To register, call 1-800-338-4721, ext. 4605.

WHO SHOULD ATTEND?

Fortune 1,000 corporate benefits and human resource executives, benefit consultants, and other decision-makers responsible for the delivery and planning of corporate health care.

Learn the new approach to managing benefit costs by focusing on the outcome of treatment. You will hear employers and consultants describe how they are using outcomes management to purchase better care at better prices. Case studies, panel discussions, presentations, and an open forum for your questions will enable you to take home innovative ideas to help lower your health care costs without relinquishing health care quality.

TUITION

This conference is being offered at no charge through this invitation. This complimentary tuition covers all sessions, course materials, welcome reception, and additional meals.

To register, or for more information, please call
Discovery International at (800) 338-4721, ext. 4605.

This conference is sponsored by Tap Pharmaceuticals Inc. and Abbott Laboratories.

Hypothetical Compromise Solution

<u>Issue</u>	<u>Potential Compromise</u>	<u>Year 2000 Budget Impact</u>
1. Excise Taxes	Materially raise taxes on cigarettes, liquor, cholesterol and fat	\$25B
2. Tax Cap	Set high employer and employee tax cap of \$8,000 per family in an urban state and \$6,000 in a rural state; grow the cap level 0% for 5 years and then at CPI thereafter	\$15B
3. Tax Reform	Fully tax all not-for-profit insurance carriers and HMOs, partially tax not-for-profit hospitals and fully tax their PHO's	\$15B
4. Medicare	Set means tax at very high level, largely eliminating the \$3,000 annual subsidy for the top 10% of the beneficiaries; grow Part B payments 5% annually for HMO members, but 10% annually for non-HMO members	\$8B
5. Veterans Administration	Close 90% of VA hospitals by not rebuilding over 30 years	\$2B
6. Small Group Reform	Impose adjusted community rating for employers with less than 50 lives; disallow pre-existing exemptions; do not try to mandate a guaranteed benefit package, except for Federally-qualified HMOs	--
7. Alliances	Encourage voluntary, multiple alliances that cannot exclude competing plans. Wait 3 years before considering making into monopolies or mandatory for employers with fewer than 50 employees	--
8. Employer Mandate	Raise minimum wage from \$4.25 to \$4.50 and funnel the incremental \$0.25 into catastrophic insurance; funnel all future minimum wages increases into health insurance	--
9. Individual Mandate	Mandate all employees making over \$4.50 per hour to buy at least \$500 of tax deductible, catastrophic health insurance that the employer must offer; raise the mandate by \$500 annually (50% financed by employer) until it is sufficient to join a Federally qualified HMO within 10 years. Employers providing insurance must maintain current contribution to health benefits for 5 years	--
10. Individual/Employer Subsidies	Cut taxes \$100-500 annually for employees below 200% of poverty level to cover the cost of the individual mandate for those without health insurance; raise the subsidy (voucher) as the individual mandate rises; allow individuals to deduct 100% of the cost of a health plan up to the cap level	\$(35B)
11. Medicare Drug Benefit	Raise Medicare payments to HMOs from 95% to 100% of average costs to pay for drug benefit	--
12. Workers Compensation	Integrate group health and workers compensation	--
13. Malpractice Reform	Cap award for pain and suffering; encourage alternative dispute resolution mechanisms and set time limits; force losing plaintiff to pay 25% of court costs of the winner	--
14. Illicit Drugs	Set-up needle exchange programs; test the dispensing of illicit drugs under physician control, as in the UK	--
15. Federal Laws	Pass Federal pre-emption of state "any willing provider" and other anti-managed care laws; only slightly relax anti-trust laws	--
16. Long-Term Care Benefit	Double allowable IRA contributions; raise the \$40,000 threshold for tax deductibility to \$60,000. Raise Medicare payments to HMOs 2.5% to cover the cost of a modest benefit.	\$(15B)
17. Medicaid Reform	Mandate entry into an HMO, but allow choice of at least 2-5 HMOs	\$(10B)
18. Unemployed Individuals	Raise unemployment compensation by \$500 annually to cover catastrophic insurance	\$(5B)

\$0B

Kenneth S. Abramowitz
Health Care Analyst
Sanford C. Bernstein & Co.
(212) 756-4590

Jennifer Klein
fyi

THE WHITE HOUSE
WASHINGTON

November 6, 1994

Leo van der Reis, M.D.
Director
Quincy Foundation for Medical Research
70 San Pablo Avenue
San Francisco, CA 94127

Dear Dr. van der Reis:

Thank you for taking the time to write and share your thoughts with me on the issue of health care reform. It is very important that those of us working on health care reform hear from individuals like yourself who have valuable information to contribute.

Again, thank you for writing.

Sincerely,

Carol H. Rasco

Carol H. Rasco
Assistant to the President for
Domestic Policy

CHR:ram

OCT 31 1994

QUINCY FOUNDATION FOR MEDICAL RESEARCH
Charitable Trust

October 24, 1994

Carol H. Rasco
Assistant to the President for Domestic Policy
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Carol:

Since you are charged with reviewing and revitalizing the health care reform proposals by the Clinton Administration, I thought you might be interested in a letter which I recently wrote to Mrs. Clinton.

I am also enclosing a recent paper which appeared as part of a symposium to which Mrs. Clinton also contributed.

Sincerely,



Leo van der Reis, M.D.,
Director

LVDR/ag

Enclosure

70 San Pablo Avenue . San Francisco, California 94127
Tel: (415) 661-8865 . Fax: (415) 661-8845

QUINCY FOUNDATION FOR MEDICAL RESEARCH
Charitable Trust

October 10, 1994

Hillary Rodham Clinton, Esq.
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

Now that congressional action on health care reform has reached an impasse, I would like to call your attention to the following.

Even though many in this land are disappointed and frustrated about the fact that a historic opportunity to implement genuine health care reform has been missed, it is of value to reflect on the events which lead to this impasse.

During the presidential election campaign, it was apparent to some of us that too much advice was sought and given by individuals representing interests which never did and to this day do not aspire to genuine health care reform. Indeed the majority of these interests prefer the status quo. Even the Jackson Hole group reflected vested interests which from their perspective not only look askance at reform but are inclined to effectively place obstacles in the road to reform.

Thus, it came about that the amalgam of proposals for health care reform, which originally were intended to herald in genuine universal access to health care, ended up being a fragile nest which invited picking and destruction by left and right.

Although during the presidential campaign I strongly supported your husband and his ticket, in essence we are a nonpartisan, scientific institute which endeavors to educate and to inform about issues of health care. For your perusal I am enclosing an essay, part of a symposium to which you contributed as well.

I sincerely hope that after a period of recharging it will be possible for the Clinton Administration to formulate a comprehensive health care reform model which addresses universal access to

70 San Pablo Avenue . San Francisco, California 94127
Tel: (415) 661-8865 . Fax: (415) 661-8845

Hillary Rodham Clinton, Esq.
October 10, 1994
Page Two

health care in an economically and medically sound fashion such as
our Model for Universal Health Care for the United States.

Sincerely,

Leo van der Reis, M.D.
Director

LVDR/ag

Enclosure (1)

*Washington University
Journal of Urban and
Contemporary Law*



Volume 46

Summer 1994

A SYMPOSIUM ON HEALTH CARE REFORM—PERSPECTIVES IN THE 1990s

*Hillary Rodham Clinton
Gail R. Wilensky
Jackson Hole Group
Herschel V. Sellers III
Leo van der Reis, M.D.*

ARTICLES

NATIONAL HEALTH CARE REFORM:
WELFARE OUT OF CONTEXT

Roberta M. Berry

FEDERAL TAX TREATMENT OF HEALTH
CARE EXPENDITURES: IS IT PART
OF THE HEALTH CARE PROBLEM?

Paul J. Donahue

NOTES

RECENT DEVELOPMENTS

COMMENTS

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

NOV 10 1994

Mr. Colby King
Editor
The Washington Post
1150 15th Street, N.W.
Washington, D.C. 20071

Dear Mr. King:

Your editorial of November 9, criticizing the Health Care Financing Administration's (HCFA) response to the District's proposal to set up a managed care program for disabled children, distorts the facts. A much more accurate picture was presented in your own newspaper in a November 8 article, "Managed-Care Plan Draws Ire - D.C. Health Group's Competence Questioned."

HCFA has aggressively pursued this project and has constantly communicated with District officials, including awarding the District a grant of \$150,000 for the period August 5, 1994 through August 4, 1995, to help them develop this project. The grant award outlines 10 special terms and conditions the District is required to meet prior to seeking waivers to implement the project.

HCFA shares the District's concerns about the delivery and financing of services provided to children with special needs. But the original proposal did not adequately address those needs. The services to be provided were not specified, the method of putting together the network was not spelled out, the quality monitoring system was not described, and potential civil rights violations, including the exclusion of certain groups of children, were of major concern.

Local groups that currently provide services to these children, including United Cerebral Palsy and Easter Seals Society for Disabled Children and Adults, Inc., also expressed serious concerns about the demonstration.

Even after months of working with the applicant, the project still has significant deficiencies. We cannot, as your editorial suggests, simply "say yes or no." The Federal Government has a responsibility to these very vulnerable children to assure that any new system of care is well designed to provide for their special needs.

Sincerely,

Bruce C. Vladeck
Administrator

THE WHITE HOUSE
WASHINGTON

November 16, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco 
SUBJECT: DC Health Care Waiver

As a follow up to the previous memo sent to you after the editorial outlining the denial to date of a waiver to the District of Columbia for a disabled children's health care waiver, I am attaching a copy of the letter Bruce Vladeck sent to the Washington Post as well as back up material to that letter.

Please let me know if you have further questions.

Attachment

cc: Hillary Clinton

**District of Columbia 1115 Waiver Proposal
Managed Care System for Disabled Children
and Youth with Special Needs**

- o On March 25, 1994, the District of Columbia submitted a 1115 waiver-only proposal to conduct a Medicaid managed care demonstration for disabled children and youths with special needs. A local provider organization, Health Services for Children with Special Needs (HSCSN), was proposed to administer the managed care program on behalf of the District.
- o Although HCFA was interested in the basic concept of the demonstration, the proposal was deficient in several key areas. For example, it did not describe how the full range of services used by this vulnerable population would be provided under the demonstration, how the provider network would be established, the method of paying providers in the network, and how quality would be monitored under the demonstration.
- o There were significant issues concerning the civil rights of the disabled affected by the demonstration, including the proposal to exclude certain children with mental illness and AIDS, and the proposal to make participation in the demonstration mandatory on the part of disabled children and their families.
- o HCFA decided that the District needed assistance in developing the demonstration, and on August 5, granted \$150,000 to the District of Columbia to assist them in completing the development work for the demonstration and outlined 10 major areas of concern. HCFA also initiated contact with the Robert Wood Johnson Foundation (RWJF) to solicit their interest in providing additional grant funding to the District. RWJF has been quite willing to provide funds but the District needs to seek these funds through the Foundation's proposal process. The District/HSCSN has viewed this process as burdensome.
- o HCFA has worked closely with the District and HSCSN to make this a workable demonstration project. Attached is a chronology that identifies the activities, issues and concerns we have had during this process.
- o On October 15, the District submitted a draft response to our concerns. A preliminary review suggests considerable developmental work remains. For example, we are still concerned over the very low numbers of pediatricians available to serve 3,600 children under the demonstration.
- o On November 8, Sue Brown, the Acting Commissioner of the District's Medicaid agency verbally requested to our regional office that HCFA delay a decision regarding the waivers. She also requested that all communication go through the District to improve communication between HCFA, the District, and HSCSN.

Managed-Care Plan Draws Ire

D.C. Health Group's Competence Questioned

Post = 11/17/94 A1

By Amy Goldstein
Washington Post Staff Writer

A new medical company is trying to take over care for thousands of poor, disabled children in the District, creating a dispute over how best to treat some of the city's most vulnerable patients.

If approved by federal health officials, the arrangement would be one of the nation's first experiments in whether the insurance method of managed care can provide better, cheaper treatment for children who are mentally retarded, physically disabled or chronically ill.

But the proposal by Health Services for Children with Special Needs Inc. has infuriated other groups that cater to such children. They question the company's competence and accuse District officials of misconduct for deciding to pay the company nearly \$100 million in Medicaid subsidies without competitive bids.

Health Services is a spinoff of the Hospital for Sick Children in Northeast Washington. The company has assembled a staff, a computer system and more than 150 local doctors, therapists, medical equipment

See CARR, B5, Col. 1

Group Challenged on Managed-Care Plan

CARE From B1

companies and others willing to participate in the program.

The idea of managed care has come into vogue in the federal government and some states, including Maryland and Virginia, as a way to try to control the cost of Medicaid, the government health insurance program for the poor and disabled. Managed care is intended to save money by giving patients a main doctor, emphasizing preventive care and controlling the amount and kind of treatment.

But the experience of Health Services reflects the obstacles to putting the popular idea into practice: opposition from medical groups that stand to lose patients, governmental caution and the difficulty of proving ahead of time that patients will be better off.

Before the dispute is resolved, company officials say, Health Services may go out of business. It has spent more than \$2 million getting ready to begin and expects to run out of money within two weeks.

Parents such as Karen Nemsith, of the Hillcrest neighborhood of Southeast Washington, would welcome the coordination that Health Services would provide.

Nemsith's daughter, Chanel, was born prematurely 13 months ago, weighing 1 pound 3 ounces. After spending her first eight months at George Washington University Hospital, Chanel came home in June with a machine to monitor her heart and breathing, another to suck mucus from her underdeveloped lungs and an electric feeding pump.

But Medicaid workers told Nemsith that insurance would not pay for another machine to monitor her baby's oxygen level. "It took her going into the hospital three times in distress, turning blue on the way, for them to give her the machine," said Nemsith, 26.

"It would be beautiful . . . if you had someone to just fight those battles for the supplies and machines so you can just focus on your sick baby," she said.

But other parents, annoyed by the nuisance of checking with managed-care plans for their own care, are fearful of extending that red tape to their children and worry whether the company will authorize as much help as they think their children need.

Few places in the country have a greater stake than the District in learning how to spend less money on Medicaid. The program covers one in four city residents, and its annual cost has swollen by two-thirds since 1990 to \$668 million.

Last spring, the District switched most of its Medicaid recipients to managed-care plans, matching more than 70,000 patients with primary doctors who must authorize all their care. But the switch excluded about 3,000 children who receive Medicaid because they have disabilities such as cerebral palsy, blindness, mental retardation and serious heart and respiratory ailments.

Such children defy the very premise of managed care: helping to keep people from becoming sick enough to require expensive medical services.

need lots of medical help, therapy and training programs.

Yet there are signs that the District spends Medicaid money for disabled children inefficiently. Five percent of those children accounted for

"It jeopardizes a system that is tried and true for a system that doesn't have a clue."

—Thomas Wilds, executive director, St. John's Community Services

more than two-thirds of the \$30 million the District spent on them last year. Meanwhile, 72 percent of that sum went for treatment in hospitals; just 6 percent went for visits to doctors' offices.

Hospitalizing a disabled child can cost \$150,000 a year, said David Corro, Health Services' chief executive officer. Giving a child a full-time nurse and lots of medical equipment at home costs about \$60,000 and is more compassionate, he said.

Medicaid does not pay to install a telephone if a family lacks one, or for home renovations to accommodate a wheelchair. Under the Health Services experiment, it would. A Health Services employee would keep track of each child's doctor visits and arrange for transportation, medicine and home equipment. Twice a year, a team would visit to assess the child's condition.

The company has told the District government that, in the first year of the three-year project, it would save

2.5 percent in Medicaid spending for its clientele.

Some parents say they would like to have a built-in group of doctors and others willing to care for their children. "A lot don't want to mess with people who have disabilities," said Tom Tyler, of the Fort Totten area of Northeast Washington. Her son, Damon, is autistic.

Damon, 21, is hyperactive and cannot speak. Since he was 2 years old, he has attended the National Children's Center, where social workers and psychologists have referred him to doctors and other medical help. Still, Tyler has had trouble keeping a dentist for her son.

Tyler said her son's last dentist said she accepted disabled patients, but she did not treat Damon herself.

"Her staff . . . didn't know how to deal with a child that was flipping around," Tyler said. Damon became agitated and broke a bathroom sink. "Shortly after that, we stopped getting those little [appointment reminder] cards," his mother said.

The Health Services plan is ardently opposed by a group of organizations that provide medical care, therapy and education to disabled youngsters.

"It jeopardizes a system that is tried and true for a system that doesn't have a clue," said Thomas Wilds, executive director of St. John's Community Services, a non-profit agency for people with disabilities.

He and the leaders of similar organizations said Corro and his staff appear unfamiliar with available programs for disabled children, have not adequately worked out the project's finances and services, and lack plans

to evaluate its effects—criticisms that Corro rejects.

Wilds said he is particularly upset that David Coronado, the former District Medicaid chief, did not allow other groups to compete for the contract.

"It looks like, 'Forget all the historical services. Here comes health reform, and let's just sell the children to someone who can cut a political deal,'" Wilds said.

Vincent C. Gray, director of the D.C. Department of Human Services, said he is not sure competitive bids were needed because the project was experimental. But he said he was trying to satisfy the critics and had not decided whether to allow other groups to compete.

The company applied in March for permission to run the managed-care plan from federal health officials, who say they are trying to rule on Medicaid experiments within four months. In August, the officials told the District they wanted more information before deciding whether to let the project begin within a year. They gave Health Services \$150,000 in the interim.

Bruce C. Vladeck, administrator of the Health Care Financing Administration, said his staff wanted to be especially careful to make sure the project is well designed "because of the vulnerability of the kids and the novelty of this."

He said his agency also was concerned about whether the District's Medicaid agency had the staff and ability to monitor the project.

But with money running out, Corro is frustrated by the pace of government. "They just don't want to believe the program can work," he said.

THE WHITE HOUSE

WASHINGTON

November 10, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: Kathi Way *KW ram*
THROUGH: Carol H. Rasco *CHR ram*
SUBJECT: D.C. Waiver for Health Care

Eight months ago, March 25, 1994, D.C. submitted a medicaid waiver request that would allow a non-profit agency, Health Services for Children with Special Needs, to provide health care through a managed care, capitated rate plan for approximately 200 disabled children in the district. There were numerous concerns with the proposal. HCFA was concerned about potential civil rights issues because the children were disabled and because they were disproportionately minority. In addition, HCFA was concerned about the quality of care and the appropriateness of services. D.C. government representatives were unable to answer the questions posed by HCFA. On August, 5, 1994, HCFA approved a planning grant of \$150,000 for D.C. to assist in refining their proposal and addressing the points in question. They continue to wait for a response.

Avis Lavelle talked with the Post editorial board prior to publication and relayed the above information. HHS believes the contractor, Health Services for Children with Special Needs, is driving the Post story. Also, candidate, Marion Barry, wrote in support of this proposal and the contractor on November 3. Bruce Vladeck is writing a response to the editorial and will send a draft to this office for approval.

NOV 10 1994

MEMORANDUM FOR CAROL RASCO

FROM: KATHI WAY

DATE: 11/10/94

SUBJECT: D.C. WAIVER FOR HEALTH CARE

Eight months ago, March 25, 1994, D.C. submitted a medicaid waiver request that would allow a non-profit agency, Health Services for Children with Special Needs, to provide health care through a managed care, capitated rate plan for approximately 200 disabled children in the district. There were numerous concerns with the proposal. HCFA was concerned about potential civil rights issues because the children were disabled and because they were disproportionately minority. In addition, HCFA was concerned about the quality of care and the appropriateness of services. D.C. government representatives were unable to answer the questions posed by HCFA. On August 5, 1994 HCFA approved a planning grant of \$150,000 for D.C. to assist in refining their proposal and addressing the points in question. They continue to wait for a response.

Avis Lavelle talked with the Post editorial board prior to publication and relayed the above information. HHS believes the contractor, Health Services..., is driving the Post story. Also, candidate, Marion Barry, wrote in support of this proposal and the contractor on November 3. Bruce Vladeck is writing a response to the editorial. I have asked John to have that letter held until I get clearance from you.

The Washington Post

AN INDEPENDENT NEWSPAPER

THE PRESIDENT HAS SEEN

11.9.94

Bosnia on the Brink

BOSNIA'S Muslim-led government has surprised almost everyone—most of all its Bosnian Serb foes—by mounting its biggest offensive in three years of war. Partly through an American-sponsored accommodation with Cro-

to bear to protect these forces are foundering on the paralyzing fear—among the foreign governments that have provided the troops (no American troops are there)—of retaliation against them. Their withdrawal would remove an important sup-

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Health Care Reform, Up Close

NEXT TIME it talks about health care reform, perhaps the White House will consider the experience of a local organization, Health Services for Children with Special Needs, in trying to set up an experimental, D.C. government-approved managed care program for several thousand poor and disabled District children. Health Services has been waiting eight months for federal approval while spending an estimated \$2 million of its own money gearing up for the experiment. The approval has yet to come despite a supposed policy of quick response by the administration in such matters. Meanwhile, the organization is running out of money and could soon have to fold, the cost of D.C. Medicaid continues to soar, and the chronically ill children the experiment was—still is—intended to help remain entangled in a fractured, uncoordinated and in some respects wasteful health care system. This couldn't be what the Clinton administration had in mind.

In fact, it's not. President Clinton has made a point of saying that Medicaid waivers for state experiments should be approved by the Health Care Financing Administration (HCFA) within four months. There is a good reason for tilting toward expeditious handling of state experiments. The inability of Washington to produce health care reform has not prevented several states from seeking to achieve incrementally what Congress and the president couldn't accomplish. The Health Services experiment, which would span three years, is designed to achieve a 2.5 percent savings

in Medicaid spending while delivering quality care and cost-effective services. When you consider that the District's Medicaid program has ballooned by two-thirds since 1990 to \$668 million, and how hard-pressed the city is generally for funds, it's understandable that the Department of Human Services would be interested in exploring a more efficient alternative. The District government, however, isn't alone.

Close to 200 District health care providers, including Columbia Hospital for Women, D.C. General Hospital, Howard University Hospital, the Medico-Chirurgical Society of D.C., the Edward C. Mazique Parent Child Center, along with Del. Eleanor Holmes Norton and D.C. Council member Linda Cropp, have endorsed this project. There are dissenters, to be sure. Just about every state that has attempted to introduce managed care has encountered resistance in one form or another, especially where providers found themselves confronted for the first time with pressure to compete for business by holding down costs. But change is an integral part of health care reform, so opposition from a small segment of the provider community comes as no surprise. Less understandable, however, is the pace at which the federal authorities respond to legitimate, worthwhile local and state initiatives. A provider shouldn't have to sink to the point of almost going under to get the government's prompt attention. HCFA should say yes or no. Eight months is too long a time to tread water.

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