

file # 2878

THE WHITE HOUSE

WASHINGTON

November 24, 1993

OK

MEMORANDUM FOR:

FIRST LADY'S STAFF (DIANE LINO)
JOHN PODESTA (PAUL RICHARD)
BERNARD NUSSBAUM (CLARISSA CERDA)
CHRISTINE VARNEY
HOWARD PASTER
✓ CAROL RANCO
ALEXIS HERMAN (DAN WEXLER)
DAVE WATKINS

FROM:

Lana Dickey/Erich Vaden
for MARSHA SCOTT

SUBJECT:

(Draft Proclamation)
National Hospice Month, 1993 and
1994

Attached for your review is the above-mentioned proclamation designating the months of November 1993 and November 1994 as "National Hospice Month."

It was submitted by the Department of Health and Human Services, through the Office of Management and Budget and edited/revised by the Presidential Letters and Messages Office.

IMMEDIATE ATTENTION REQUIRED. Written or oral response required by no later than C.O.B., TODAY, Wednesday, November 24, 1993. If we have not heard from you by 5:30 p.m., we will assume that the draft is acceptable to you.

For questions, discussion, or routine clearance, contact Lana Dickey, extension 7487, or Erich Vaden, extension 2276, via phone or interoffice mail, in room 91. Thank you.

cc: Ron Gaisler

NATIONAL HOSPICE MONTH, 1993 AND 1994

- - - - -

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA**A PROCLAMATION**

As Americans work together to reform our Nation's health care system, I am pleased to proclaim November 1993 and 1994 as National Hospice Month.

Hospice is an eminently successful program, a vital health care service that allows the terminally ill to die with dignity. It addresses the importance of being in a warm, familiar, and comforting environment until one dies. This care helps not only in preserving and enhancing the patient's quality of life during an illness, but also in giving support to the family following the death of a loved one. Such attention underscores the importance of the needs of the total family and highlights the dedication of this supportive and knowledgeable interdisciplinary team.

The public and private sectors have forged a unique partnership in the development of high standards and new programs for hospice care. These and other changes to be brought about by health care reform hold the promise for even greater accomplishments as we try to improve the quality of life of those most in need. Thus, my Administration is deeply committed to maintaining and strengthening these efforts in our health care system.

In recognition of the importance of hospice programs and in honor of the many dedicated volunteers and professionals who care for the terminally ill and their families, the Congress, by House Joint Resolution 159, has designated November 1993 and 1994 as "National Hospice Month" and has authorized and

requested the President to issue a proclamation in observance
of these months.

2

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, do hereby proclaim November 1993 and 1994 as National Hospice Month. I encourage all Americans to observe these months with appropriate activities and programs.

IN WITNESS WHEREOF, I have hereunto set my hand this

day of _____, in the year of our Lord nineteen hundred and ninety-three, and of the Independence of the United States of America the two hundred and eighteenth.

...recognizes one exists. But this Crime bill is only a start. We need to know much more about the risks of violence and abuse faced by the disabled, and we need good ideas for other solutions, particularly at the state and local level.

#

10/25
Sent/Logged
BH.

OCT 25 REC'D

DPC Program
Staff

EXECUTIVE OFFICE OF THE PRESIDENT

24-Oct-1993 07:14pm

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs
SUBJECT: Health Care Talking Points 10/25

The White House
Health Care Reform Today
October 25, 1993

* Virtually every health reform proposal being considered on Capitol Hill calls for slowing the growth in spending on Medicare and Medicaid and using the savings as a source of financing for reform. But unlike most of the other proposals, the President's plan reinvests that money in new benefits for older Americans and the disabled.

* The President's plan preserves the Medicare program, and protects Medicare beneficiaries by providing them with a new benefit so important to millions of seniors-- coverage for prescription drugs.

* It also uses Medicare savings to begin funding a new home and community-based long-term care program, which will provide needed services to elderly and disabled Americans who would otherwise be at risk for entering a nursing home. Finally, it increases financial protection for seniors who do enter nursing homes by increasing the asset protection limit so seniors don't have to spend themselves to destitution before they can get help paying for their care, and by increasing the amount of spending money seniors in nursing homes have each month.

* The President will deliver the Health Security Act of 1993 to Capitol Hill this week. To clarify, this is not the bill's introduction but is the delivery of the legislation to the Hill. The actual introduction of the bill will take place after the parliamentarians have determined areas of jurisdiction.

* There will be supporting documents released along with the legislation including the President's Report to America on health care reform. Copies will be available from the Government Printing Office as well as through electronic distribution methods. We'll publish a full listing of outlets later this week.

Health Care Reform Today * The White House *
202-456-2566 * Fax: 202-456-2362

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DPC Prog Staff

Roz - Use however
many of these you
need to get to our
program staff.

The White House

Health Care Reform Today

September 14, 1993

◆ The American Medical Association said Monday that "the moment of truth had arrived for health care reform and that doctors were cautiously optimistic about the Clinton administration's initial proposals. "The time is now to get something done," said James Todd, executive vice president of the group.

Reuters-9/13/93

◆ In the coming days, you will hear a growing drumbeat of naysayers who will predict the opposite. We have two items of note. First, a Tom Oliphant column from the *Boston Globe* dated 9/13/93. Second, the *Wall Street Journal* article headlined: "Small Business Sees Burdens Getting Lighter" from 9/13/93. Oliphant writes: "Of all the absurdities being spread around here by the status quo's shameless defenders, none is more preposterous than the false alarm that more than a million people could lose their jobs because President Clinton is trying to put small business in a regulatory vice of death. The truth is that the nearly gestated Clinton plan constitutes a luscious opportunity for a minority now at a competitive disadvantage (small businesses that offer their workers no health insurance and are thus bailed out by all taxpayers) to join the more competitive majority (those that do have health coverage)."

◆ The *Wall Street Journal* article contains strong testimonials from small business people including Jay Edward Jones from Technical Land Consultants in Youngstown Ohio. After crunching the numbers in the plan he said: "I'll take it." He compares the \$429 a month he pays for his employee's family coverage to \$420 a year he would pay under the plan. Anne-Marie Corner of Biosyn says: "Anything that would guarantee buying into a pool at reasonable rates would be beneficial."

◆ Yet despite all this, John Motley of the NFIB continues his litany of doom for small business. What's interesting to note though is that in the same Wall Street Journal article, Motley never talks about whether or not it would be good for his members...just that it's too "...radical." We believe his members will think different, when given an opportunity to review the plan.

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**The National Association of Children's Hospitals
and Related Institutions, Inc.**

*Roz - Make sure
Heenan got her file
ce of this
as indicated 9/2/93*
LAWRENCE A. McANDREWS, FACHE
President & CEO

August 13, 1993

File
Ms. Carol Hampton Rasco
Assistant to the President
for Domestic Policy - West Wing/Second Floor
The White House
Washington, DC 20500

AUG 18 REC'D

Dear Carol:

Thank you very much, both for taking the time from your busy schedule to meet with us this morning and for engaging NACHRI's Public Policy Council in a very helpful discussion about the role of children's hospitals in health care reform.

There are three ways in which I thought it would be helpful to follow up on our conversation: to offer suggestions for addressing the role of children's hospitals in managed competition; to offer suggestions for how HCFA can invest in the development of pediatric risk adjusters; and to highlight issues that time did not permit us to discuss, which we will try to pursue further with Christine Heenan.

First, I would like to reiterate several suggestions made during our conversation that would address the need for children's hospitals to serve a large population of children with a diverse case mix in order to fulfill their missions of service to all children, service to children requiring the most specialized services, and medical education and research on behalf of future generations of children:

- Because they devote more than 40 percent of their care to children of low income families, devote more than 70 percent of their care to children with chronic and congenital conditions, and train more than a quarter of the nation's pediatricians, children's hospitals should be designated "essential providers," thereby assuring them of the opportunity to contract with health care plans.
- Children's hospitals should be able to contract with multiple health care plans in order to ensure their ability to serve a large population that makes it possible to sustain their specialized services.
- Families should be assured of access to pediatric specialists and subspecialists within their plans.
- Health care reform should allow the development of comprehensive pediatric care networks that either can contract directly with health care plans or can subcontract with health care plans.

Ms. Carol Hampton Rasco
August 13, 1993
Page 2

Each of these recommendations speaks to the current experience of children's hospitals in strong managed care markets, in which plans refer all but the most complex and high cost cases away from children's hospitals. Yet, these cases are so complex and high cost that hospitals cannot sustain either their missions of care to all children or their missions of medical education unless they also serve children requiring less expensive primary and acute care.

Second, I want to give you more information regarding the great unfilled need for investment in the development of pediatric risk adjusters, especially for children with special health care needs. I am enclosing a brief summary of the current state of this research and HCFA's involvement, which is devoted at the moment only to risk adjusters for the elderly population. It would be very helpful if the White House could encourage HCFA to expand its current contracts on the development of risk adjusters to include pediatrics.

Third, we appreciated very much your raising the issues of medical education and research in your remarks. You were so right in understanding how important both are to the missions of children's hospitals. We will call Christine to see if we might be able to meet with her to discuss in more detail how these issues affect children's hospitals and how the President's plan might address them.

I am also enclosing for you a new publication NACHRI has just published, which highlights our research to document the differences in the health care resource requirements of children and adults, and children's hospitals patients and the patients of community hospitals. I hope that this might be useful to you and your staff.

Please call upon NACHRI to help in working for health care reform that fulfills the President's and your personal devotion to improving health care for children.

Sincerely,


Lawrence A. McAndrews

Enclosures

cc: Ms. Christine Heenan, Senior Policy Analyst, Old Executive Office Building, Room 212R, The White House, Washington, DC 20500

**BACKGROUND ON RISK ADJUSTMENT
FOR CAPITATED PAYMENT RATES FOR CHILDREN'S HEALTH CARE**

As the U.S. health care system moves toward managed competition and away from fee-for-service medicine, the issue of how capitation rates will be established becomes increasingly important. Children, and especially children with chronic medical conditions, as well as the hospitals that treat these children, will be vulnerable unless a payment system that reflects the higher costs of treating these children is developed. For example, children born with AIDS or children who develop a chronic illness are much more expensive to treat on an annual basis than healthy children. These children will gravitate towards children's hospitals because of the specialized services they offer.

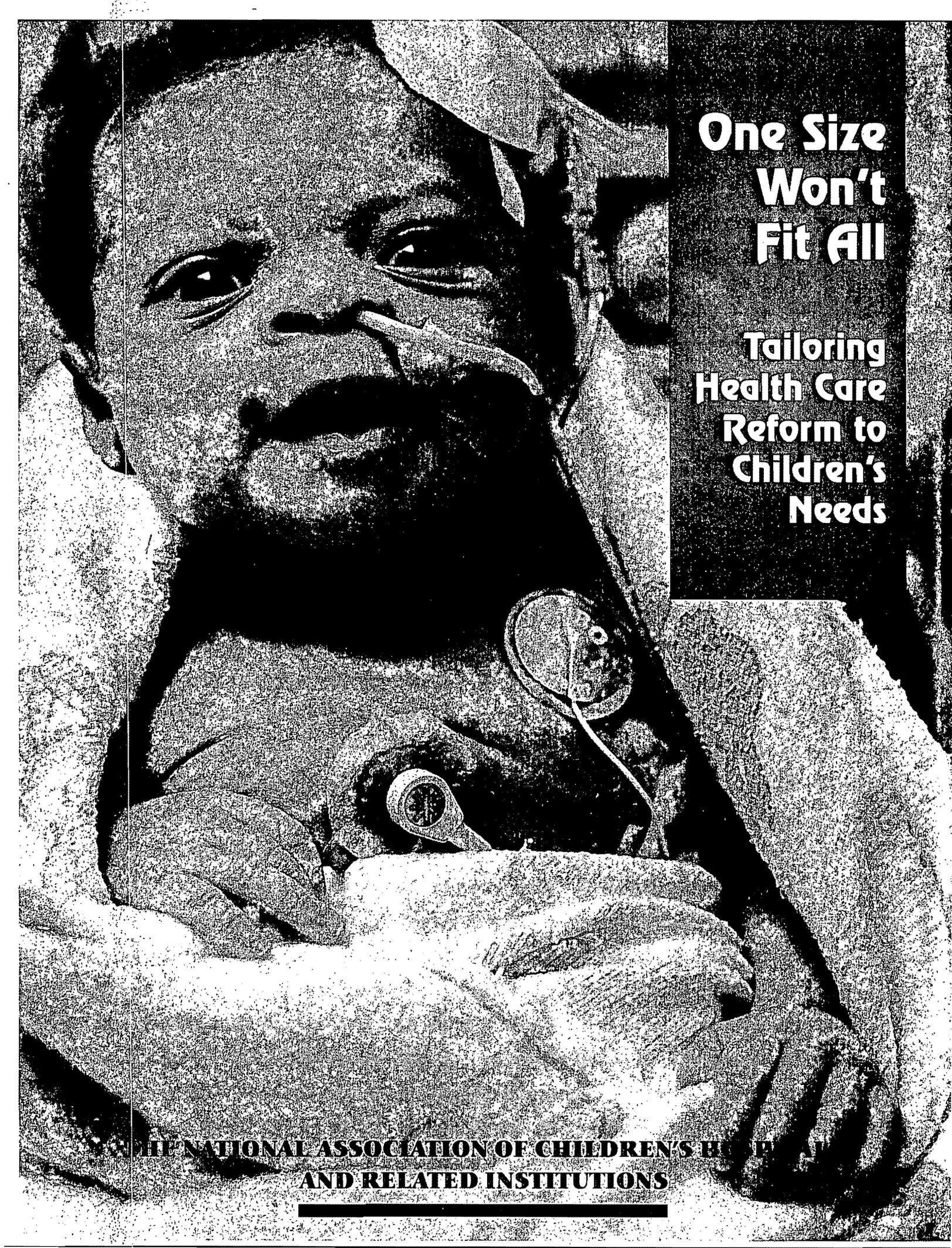
Several methods for setting capitation payment rates have been developed in recent years with most of the policy and academic interest focussing on prior utilization models. These models use the health care utilization patterns of individuals to predict future use and, therefore, future expenditures. Predicted future expenditures are then used to set capitation rates.

Three systems based on prior utilization of health care services have been developed to date. From a pediatric standpoint, a major problem with all three methods is that the focus has been primarily on elderly populations. The one system that has been calibrated using a pediatric population is based solely on prior use of ambulatory care services. This limitation has certain implications for children whose contact with the health care system is primarily inpatient based.

HCFA is currently sponsoring two major projects to refine the capitation payment system using refined prior utilization models. Both projects focus only on the Medicare population. AHCPR has no projects on this topic.

One or more projects are necessary to develop a risk adjustment system for the non-elderly population. The methodologies being developed for the Medicare population will need to be revised in order to reflect the different clinical conditions which children and adults experience as well as the cost of caring for people at different ages. These projects will require two years or more to complete. They will involve data from Medicaid programs and private insurers in order to obtain information on a cross section of the non-elderly population.

For more information, please call John Muldoon or Peters Willson, National Association of Children's Hospitals and Related Institutions, (703)684-1355



**One Size
Won't
Fit All**

**Tailoring
Health Care
Reform to
Children's
Needs**

**THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS
AND RELATED INSTITUTIONS**

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7/16/93

sent, logged RT

Rathi Way - fyi

COALITION FOR NATIONAL HEALTH REFORM AND ACCESS TO CARE FOR THE UNDERSERVED

July 15, 1993

Secretary Donna M. Shalala
U.S. Department of Health and
Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

JUL 15 1993

Dear Secretary Shalala,

We are a broad group of advocates and providers who represent persons who are underserved or vulnerable in America's current health care system. We have formed the Coalition to ensure that as reform of our health care system is considered, debated and planned, the needs of these underserved and vulnerable populations are not forgotten.

We know that health care reform is a top priority for your Department, as well as for the entire Administration and Congress. Our desire is to fully support enactment of effective health care reform, and we anxiously await submission of the President's proposal so that the deliberative process on this critical issue can begin.

We are also aware, at the same time, that a number of states are actively pursuing their own health care reform efforts, driven in large part by health spending-related budget deficits. We have recently learned that several states have submitted, or will soon submit, proposals to the Health Care Financing Administration (HCFA) for Social Security Act Section 1115 research and demonstration waivers, and for waivers under Section 1915(b) of the Act, to implement state-specific health care reforms -- submissions which, we understand, are encouraged by the Administration. In our view, waivers under Sections 1115 and 1915(b) of the Social Security Act, if done well, have the potential to improve access and quality of care. Done poorly, they can create great harm. Most importantly, we are concerned that proposals to streamline the waiver application process could make it dangerously one-sided, threatening to deprive HCFA of information, time and other tools needed to safeguard patient care.

HCFA's waiver policies, of course, should take into account the concerns of the Governors, who administer Medicaid programs. However, they should also take into account the needs of indigent consumers, for whom Medicaid is their sole source of health care, and the providers that serve low-income communities. State fiscal interests are not the only issues at stake when waivers are requested. Restructured Medicaid

systems can dramatically affect the well-being of some of the most vulnerable members of our community, people who are both poor and sick. The current push to streamline the waiver application process should not be carried to the point where it endangers one of HCFA's most important functions -- helping states improve their waiver proposals to address serious concerns about quality and access to essential care.

Any new HCFA policy statement concerning waivers should include the following elements to ensure a balanced and fair process that shields Medicaid beneficiaries from harm:

1. **Medicaid beneficiaries, their representatives, and the providers that serve them, not just the states, should be involved with HCFA in waiver development and evaluation.** During the early stages of waiver development, HCFA's informal consultation should go beyond the states to include Medicaid beneficiaries, their representatives, as well as providers that serve low-income communities. In addition, states making formal waiver proposals should be required to show that they have given public notice of such proposals, with an opportunity to inspect and copy relevant documents, to interested members of the public, including Medical Care Advisory Committees, just as they currently do with much smaller policy changes. HCFA should make available copies of relevant correspondence and receive and consider public comment before making decisions on waiver applications.

Such procedures would make the waiver process more even-handed and give HCFA the information it may need to decide whether waiver proposals would harm Medicaid beneficiaries. Currently, advocates for low-income patients are often shut out of the process. These advocates frequently do not learn of waiver applications until shortly before they are granted, if at all. Certainly, they are rarely part of the informal consultation between HCFA and states that often precedes the formal submission of waiver requests and sometimes decides the major issues. Access to waiver applications and related correspondence depends on advocates' "connections" to sympathetic state officials. States are under no clear legal obligation to provide copies of documents or even notice of waiver applications, and HCFA takes the position that, pending approval, waiver documents are exempt from mandatory disclosure under the Freedom of Information Act. As one HCFA official remarked to an advocate in a state with a pending waiver application, "I hope you somehow get a copy of the waiver application, because I am concerned about the possible impact on your clients and I would like to know your opinion. Unfortunately, I can't give you a copy."

2. **HCFA should independently evaluate waiver proposals' effect on cost, quality and access.** Simple reliance on state assurances may be expedient, but it would also endanger Medicaid beneficiaries' access to quality care. In the past, despite state assurances that waiver proposals would not harm access and quality, HCFA has found to the contrary and forced significant improvements in waiver proposals. Such mistaken assurances would grow even more common if states knew that HCFA would not review them.

As far as we know, no one has suggested that HCFA should rely on state assurances of cost neutrality. Such reliance is equally unwarranted on issues of access and quality. State assurances regarding access and quality are no more reliable than those regarding cost. Access and quality of care for Medicaid beneficiaries is every bit as important as cost-neutrality.

3. HCFA should not be under inflexible deadlines in evaluating waiver requests.

Properly responding to a waiver request requires an initial analysis of the request, a decision about the information needed to make a ruling, obtaining that information, engaging in necessary consultation, proposing a decision to the state, and, if necessary, negotiating with the state and advocates. This can take time, especially since waiver applications are often enormously complex, sometimes hundreds of pages in length, and health care policy questions often are difficult to resolve. Cutting this process short by imposing inflexible deadlines would increase the odds of a bad decision that reduces access or quality, harming the low-income patients who receive their care through Medicaid. The well-being of indigent patients should not be endangered by rushing to decide waiver applications prematurely. If deadlines are imposed on HCFA, the agency must receive substantial additional resources to conduct a proper expedited review. Without additional resources, hasty reviews will be largely pointless, and low-income patients will be placed at risk.

4. HCFA should deny waivers that would reduce Medicaid eligibility or services or harm the infrastructure that serves low-income patients. While awaiting adoption and implementation of health care reform, HCFA should ensure that waivers do not reduce the preexisting level of Medicaid eligibility and services in affected states. Current reductions in coverage will only increase the future cost and difficulty of implementing reform.

Similarly, HCFA should deny waivers of Medicaid protections for essential community providers. HCFA should not waive Medicaid provisions such as those guaranteeing access to and reimbursement for Federally Qualified Health Centers and Rural Health Clinics, assuring reimbursement for Disproportionate Share Hospitals, and guaranteeing access to family planning. These essential community providers have been granted special legislative consideration because of the vital role they play in caring for low-income patients. There is a real danger that, on the eve of health care reform, some states' desire for immediate cost savings will cause irreparable, long-term harm to the small portion of our health care system that addresses low-income patients' needs. An Administration that puts people first should not allow this to happen.

Many states are submitting 1115 waiver proposals that could easily have been submitted under Section 1915(b), particularly in light of the flexible eligibility options provided under Section 1905 (r)(2). Under Section 1915(b), of course, states may not waive the above-described protections for essential community providers, nor Section 1903(m)'s quality controls for federally and state qualified HMOs. HCFA should not allow states to circumvent these Congressional protections by the

simple expedient of slapping the label, "1115 waiver", on proposals that could have been (and thus should be) submitted as 1915(b) waiver requests. Instead, HCFA should apply the same requirements and restrictions to these proposals that would have applied had they been submitted under Section 1915(b).

5. **HCFA should not permit states to begin putting Medicaid beneficiaries into systems that violate Medicaid laws until after waivers have been granted.** In several instances, HCFA staff have informed state officials that they could begin operating waiver systems before receiving federal approval, subject to possible later denials of federal financial participation. States should not be allowed to operate systems that are illegal under the Medicaid statute until HCFA has waived applicable requirements. This "retroactive approval" procedure compromises the integrity of the waiver process. Once HCFA indicates that a state may begin operating a waiver system subject to later retroactive approval, approval is virtually guaranteed. Medicaid beneficiaries should not be asked to receive care from a proposed health care system while HCFA is taking the time it needs to decide whether the system will harm access or quality.

6. **HCFA should take into account the potential adverse impact of waivers on people of color and the disabled.** Waivers that harm access or quality almost always have a disproportionate adverse impact on people of color, who are over-represented among Medicaid beneficiaries. Waivers that inadequately address the special needs of the disabled can endanger their access to care. State waiver applications should document the impact of proposed policies on these protected groups. The normal waiver review process should include consultation with the Office of Civil Rights to ensure consistency with applicable civil rights statutes, which are not subject to waiver. The latter step would be a part of HCFA's discharge of its own duties under these civil right statutes.

While there may be short-term benefits in allowing multiple states to press forward with their own reform plans, we feel that the longer-term potential losses in beneficiary protections, primary care infrastructure and political momentum that may result from such actions is antithetical to prospects for enacting national health reform, and requires your immediate and direct attention. We urge you to look into this matter immediately, and to take whatever steps may be necessary to assure that all such waivers approved by your Department are consistent with both the statutory purpose and requirements of the Social Security Act and the fundamental goals of national health reform.

Because of the importance and urgency of this matter, and its serious implications for national health reform, we wish to request a meeting with you and your key staff at your earliest convenience to discuss this matter in further detail.

Sincerely,

AIDS Action Council
American College of Nurse Midwives
American Medical Student Association
American Psychiatric Nurses' Association
Alliance To End Childhood Poisoning
Association of Asian Pacific Community Health Organizations
Association of Maternal and Child Health Programs
Children's Health Fund
East Coast Migrant Health Project
Legal Action Council
Migrant Clinicians Network
National Association of Children's Hospitals and Related Institutions
National Association of Community Health Centers
National Association of Public Hospitals
National Association of Rehabilitation Facilities
National Family Planning and Reproductive Health Association
National Rural Health Association
New Mexico Public Health Association
Planned Parenthood Federation
Service Employees International Union
The Alan Guttmacher Institute
Women's Legal Defense Fund

cc: Bruce Vladeck, Administrator for the Health Care Financing Administration
Philip Lee, M.D., Assistant Secretary for Health
Carol Rasco, Assistant to the President for Domestic Policy

The New York Times

229 WEST 43 STREET
NEW YORK, N.Y. 10036

NOV 12 REC'D

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

November 11, 1993

Dear Ms. Rasco:

I thought it would be helpful for you to receive some early copies of our upcoming Health Debate section, which will appear in this Sunday's New York Times.

As the national debate on the implications and merits of the Clinton administration's health care plan intensifies, we felt it would be natural for citizens, legislators, the media, business and opinion leaders to turn to the world's most authoritative source for news coverage and analysis: The New York Times. As you will see, our editors and writers have compiled a compendium of articles on health care coupled with a fresh overview which will surely guide the reader through the intricacies of the plan as we know it.

Please let me know if your office or Mrs. Clinton's would like additional copies of our section. We anticipate a very strong response from our 4 million readers, and I would be happy to share that story with you as well.

Best regards,



Eileen G. Lewis
Corporate Advertising Manager

Health Debate

Moment of Decision For Health Care

By ERIK ECKHOLM

It was only two or three years ago that the phrase "job-lock" began to appear in public discourse. The ugly new term described an ugly new condition faced by millions of people: fear of leaving or switching jobs out of a well-founded concern that health coverage, once given up, might not be regained because of price, "pre-existing conditions" or other factors.

Now less than three weeks after President Clinton's 240,000-word proposal for health care was placed before Congress, now as months of intensive debate begin amid a chorus of hope about the goals and a cacophony of warnings about the details, it is easy to forget the serious underlying problems — spreading job-lock being symptomatic of them — that led to calls for drastic change on the scale of the New Deal or the Great Society. For his part, Mr. Clinton was moved to gamble his own place in history on an issue that had been a nonstarter for many Presidents before.

Now the President and Hillary Rodham Clinton, his chief torchbearer on health care, are doing their best to remind everyone of the costs to individuals and the economy of inaction. Thus their mantralike descriptions of a health-care system that's "badly broken," their endless promises of "security" and of "comprehensive benefits that can never be taken away."

If there is no consensus on how to fix things, there is wide agreement that two intertwined problems — an erosion of health insurance and a rocketing of medical costs — are jeopardizing the security of families and the economic health of the country.

Some 37 million Americans, mainly the working poor, live without the basic peace of mind offered by health insurance. Every other industrial country provides something close to universal coverage and the ever-growing number of uninsured Americans has long been seen by medical experts as an index of national shame.

Still, it was not a sudden rise in compassion for the poor that suddenly thrust health care to the top of the national agenda. Increasingly, middle-class Americans have tasted the fear, degradation and risk of financial catastrophe that come with a lack of health insurance. As costs soar, insurers have found more ways to discriminate among customers, excluding those most likely to run up large bills and to require

surgery can cost \$15,000, the fear is palpable. Federal experts estimate that over the next two years close to one in four Americans will spend time uninsured. Thus the White House has sought to redefine the debate, focusing as much on the insecurity of the currently covered as on the plight of the chronically deprived.

"All these trends add up to a growing sense of unease: 'Yes, I'm insured today but will I be tomorrow?'" says Henry Aaron, an economist at the Brookings Institution.

At the same time, many economists say runaway medical costs have eroded wages and threatened the competitiveness of American industry. Certainly they threaten the solvency of the Federal Government.

This year, about 14 percent of the gross national product will be devoted to health care, one dollar in every seven. By comparison, no other country devotes more than 10 percent of its economy to health. By the year 2000, according to Federal projections that assume no radical policy changes, health spending would reach 19 percent of the econ-

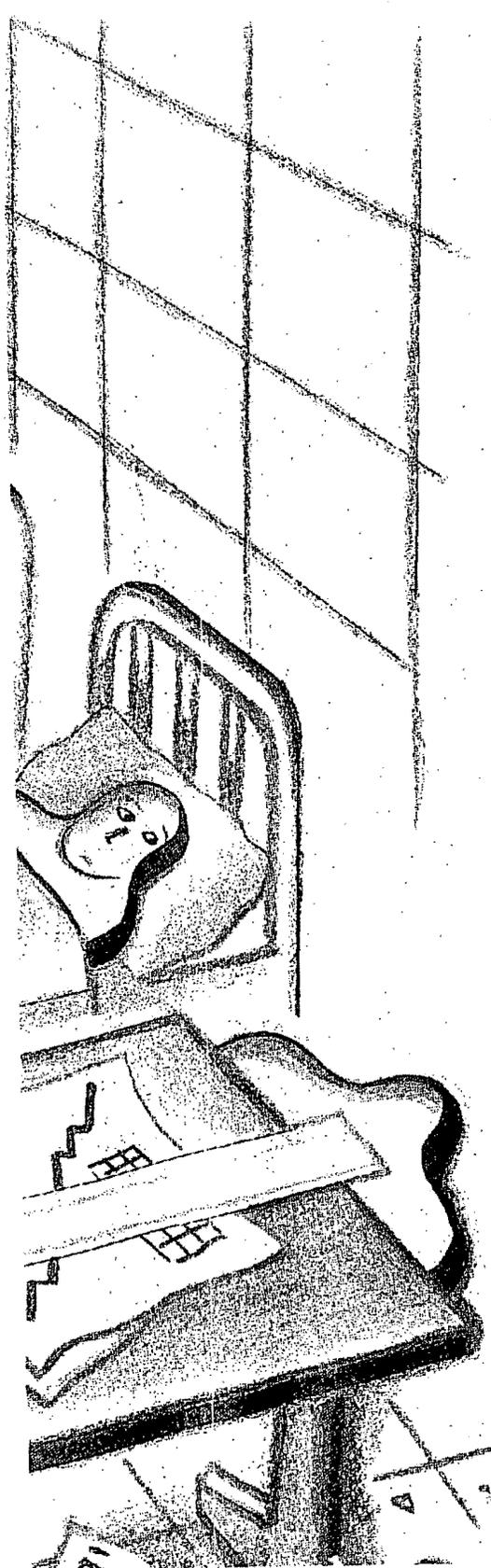
A SPECIAL SECTION

Reviewing the issues and the outlook, as Congress prepares to tackle Clinton's program.

omy. And by that year, the Medicare program for the elderly and the Medicaid program for the poor would eat up an astounding 23 percent of the entire Federal budget, dooming any hopes of taming the deficit.

If it were just a question of guaranteeing universal coverage the country would face a relatively simple task. But assuring coverage cannot, alas, be considered apart from the vastly more complex and divisive question of cost control. Continued inflation would not only fling ever more people into the ranks of the uninsured, but also drive the costs of any subsidy scheme through the roof.

Mrs. Clinton said the goal is "to preserve what is right and works about the American health care system, but, finally, to fix what is wrong." But there is no agreement yet on



Finally - should we say something about need to do health care for universal coverage prob. solving ~~the~~ where a person transitioning off welfare has coverage but person by whom they work who has worked years still has no coverage?

TALKING POINTS
HEALTH CARE AND WELFARE REFORM

We must have comprehensive health care reform before we can move forward on the President's domestic agenda. Without reform, health care costs will continue to explode and eat up our investment dollars. Without reform, people will continue to be locked into jobs and on welfare.

current → perhaps should say "or"

The bottom line: real welfare reform cannot happen without comprehensive health care reform.

The President has already launched a major, comprehensive welfare reform effort. It has four parts: the Earned Income Tax Credit; health care reform; personal responsibility and education and training.

(1) Expanding the Earned Income Tax Credit. Enacted in last year's budget, this step will ensure that no family that has a full-time worker will have to raise its children in poverty. Expanding the EITC represents a giant step forward in reducing those dependent on welfare.

(2) Passing comprehensive health care reform. Today millions of welfare recipients stay on Medicaid -- the federal government's health care program for the poor -- because taking a job means they will lose health benefits for themselves and their children. True health reform will eliminate so-called "Medicaid lock" and enable people to seek jobs, secure in the knowledge that they and their children will be covered. By ensuring universal coverage, the Health Security Act provides the necessary foundation for welfare reform. In fact, the proposals being drafted by the President's working group on welfare are specifically designed to complement health reform.

(3) Ensuring personal responsibility. The President's welfare reform plan will include initiatives to prevent teen pregnancy and ensure that parents fulfill their child support obligations.

(4) Promoting education and training. The final part of the President's welfare plan includes programs for job training and education to ensure that people are trained for tomorrow's jobs and are able to be retrained when necessary.

President Clinton has been at the forefront of welfare reform in this country since he led the nation's governors in writing and passing the Family Support Act of 1988. The same Republicans who today are calling for welfare reform voted against that Act and refused to fund it under President Bush. We have to look past the rhetoric and examine the record.

No President -- Democrat or Republican -- has done more to "end welfare as we know it." President Clinton's four-step welfare reform package makes economic and common sense. But health care reform must come first.

Also - need a sentence about people often coming back on welfare after getting off due to need for health care.

Bruce/Kathi what else should be said here

this first sentence needs to emphasize that POT & Gov. are working w/ Congre

what are facts on this?

We have to be careful here. I don't think the states are drawing down all the A's even now due to inability to pay match. Kathi - how could we say it?

STATES REBELLING AT FEDERAL ORDER TO COVER ABORTION

THE NEW YORK TIMES, WEDNESDAY, JANUARY 5, 1994

RAPE AND INCEST AT ISSUE

Medicaid Directors Say Clinton Failed to Offer Discretion as Congress Intended

By ROBERT PEAR

Special to The New York Times

WASHINGTON, Jan. 4 — Medicaid officials in many states have objected to a new directive from the Clinton Administration that requires states to help pay for abortions for low-income women in cases of rape or incest.

In a letter written on behalf of the State Medicaid Directors' Association, Ray Hanley, the chairman of the group, strongly objected to the Administration position. Mr. Hanley is also the Medicaid director of Arkansas.

The new directive, the latest in a series of efforts by the Administration to expand access to abortion, interprets an appropriations bill passed by Congress and signed by President Clinton on Oct. 21. But Mr. Hanley said the Administration had misinterpreted the law and imposed a firm requirement where Congress intended to give states flexibility.

"Congressional intent in this area was to be permissive for states, not mandatory," Mr. Hanley wrote.

Volatile Issue

The complaint by state Medicaid directors reopens the volatile issue of abortion just as Congress and the Administration prepare for a fight over whether to require insurance coverage for the procedure as part of Mr. Clinton's health plan.

Mr. Hanley was apparently not speaking for all 50 state Medicaid directors. The organization did not vote on the question. He wrote the letter, dated Dec. 30, after consulting with a number of state Medicaid directors and the organization's executive committee, which is made up of eight state directors. In interviews with several state officials, some said they strongly supported Mr. Hanley's letter and a few said they did not know about it. None of them expressed objections to it.

The association has asked the Federal Government to reconsider the directive, and the state officials interviewed said lawsuits to challenge it were likely.

Timing of Announcement

In an interview today, Mr. Hanley said the Clinton Administration had "decided to make a political statement by distorting what was intended to be an optional clause" in the new Federal law.

He said the Administration had not consulted state officials before issuing the directive on Dec. 28 and had not given the states time to adjust their laws.

At least one state, Utah, has rejected the Federal mandate to pay for Medicaid abortions in case of rape or incest.

"We don't intend to implement that mandate until it is clarified to our satisfaction that it was intended to operate in the way described by the Clinton Administration," said Rod L. Betit,

States Rebel at Federal Directive For Medicaid to Pay for Abortions

Continued From Page A1

executive director of the Utah Health Department.

The Utah Medicaid program does not cover abortion in case of rape or incest, and Congress did not demonstrate a clear intent to supersede state law on this point, Mr. Betit said. "There is substantial uncertainty about the meaning of the Federal law, so we will not move forward until we've had time to explore it further," he added.

Federal officials insist that their reading of the law is correct and that Congress intended to require states to pay for abortions when pregnancies resulted from rape or incest.

In an interview, Sally K. Richardson, director of the Medicaid bureau of the Federal Health Care Financing Administration, said: "Our interpretation is legally correct. I see nothing in Mr. Hanley's letter that would cause us to reconsider our position."

She said she suspected that some state officials agreed with the Clinton Administration. In any event, she said, the new policy would require Medicaid coverage for only about 1,000 abortions a year.

In the past, Federal law said no Federal Medicaid money could be used to perform abortions "except where the life of the mother would be endangered if the fetus were carried to term."

Language of the Law

The new law is more convoluted. It says, "None of the funds appropriated under this Act shall be expended for any abortion except when it is made known to the Federal entity or official to which funds are appropriated under this Act that such procedure is necessary to save the life of the mother or that the pregnancy is the result of an act of rape or incest."

Ms. Richardson said, "States are required to cover abortions that are medically necessary." By its action last year, she said, Congress added abortions for rape and incest to the category of medically necessary abortions.

Asked tonight about the new directive from Washington, Audrey Rowe, the Commissioner of Social Services in

Connecticut, said: "There wasn't any consultation. That's for sure."

She said the extra abortion coverage should be optional. "It's very important that states have the option to determine what their Medicaid programs pay for," she said, noting that the Federal Government and the states share the cost.

Differences Among States

In his letter, Mr. Hanley said that some states would have voluntarily "expanded abortion coverage as an optional service for which the Congressional appropriation language would have allowed Federal financial participation." On the other hand, he said, "some states, for different reasons, would not elect to expand abortion coverage — again in keeping with the optional nature of the appropriation language."

Opponents of abortion made similar arguments when the policy was announced. They said the Administration had violated assurances to Congress that the additional coverage for abortions would be optional.

In New Jersey, Alan G. Wheeler, the acting state Medicaid director, said the new Federal requirement would not have a significant effect because the state was already using its own money to pay for medically necessary abortions.

Policy in New York

In New York, Richard M. Cook, a health policy adviser to Gov. Mario M. Cuomo, said he had not seen Mr. Hanley's letter. The Medicaid program in New York pays for approximately 45,000 abortions a year, using \$15 million of state and local money.

Mr. Hanley said the Federal directive imposed "another unfunded Federal mandate with apparently no notice or allowed time for comment." This, he said, appears to violate an executive order in which President Clinton on Oct. 26 promised to reduce such mandates.

The Arkansas State Constitution says, "No public funds will be used to pay for any abortion, except to save the mother's life." Mr. Hanley said that a dozen states had similar laws.

The White House
Health Care Reform Today
January 5, 1994

* In order to move forward on the President's domestic agenda, comprehensive health care reform must be passed in 1994. Today, millions of welfare recipients stay on Medicaid or return to welfare to avoid losing health benefits for themselves and their children. Thus, the proposals being drafted by the President's working group on welfare are specifically designed to complement health reform.

* The President's welfare reform plan will include initiatives to prevent teen pregnancy, ensure that parents fulfill their child support obligations, and try to keep people from going on welfare in the first place. People who can work will be required to do so after two years of receiving welfare benefits, either in the private sector or community service. This will include providing education, training, and job search and placement for those who need it.

* Comprehensive health reform will eliminate so-called "Medicaid lock" and enable people to seek jobs, secure in the knowledge that they and their children will be covered. By ensuring universal coverage, the Health Security Act provides the necessary foundation for welfare reform.

u A recent poll conducted by the Employee Benefit Research Institute and the Gallup Organization, reported in the January 10th issue of Business Week, that 75% of Americans felt that guaranteed health insurance was more important than having unlimited choice of physicians. The study further indicated that on average, Americans would be willing to pay \$227 a year in added taxes for a guarantee that they and their families would never be without health benefits, and \$169 more a year to guarantee that all Americans have health coverage.

* According to the poll, 20% of Americans say that they or a family member have passed up a job opportunity or stayed in a particular job specifically to retain health care benefits. 11% reported that they or a family member had been denied health care insurance because of a medical condition. The President's Health Security Act would provide health care that could never be taken away...not if you change jobs or if you have a pre-existing condition.

Health Care Reform Today * The White House *
202-456-2566 * Fax: 202-456-2362

Morie Althoff Health Care Interview

THE WHITE HOUSE
WASHINGTON

KAREN -

Can you review
the attached and let
Julie know if it's ok.

Thanks,

J.

Done good 5/10

Julie -
Here are my changes

Ben Klein

MAY 2 1995



SYSTEMEDIC CORPORATION

Managed Care Programs

FAX TRANSMITTAL

DATE: 5/1/95 TIME: 8:41 AM

SENT TO: ~~Julie Pasco~~ Jeremy

SENT FROM: Tom Strickland / Marie Althoff

TOTAL PAGES SUBMITTED: 4
(Including This Copy)

NOTES: Julie, attached is the written
interview with Ms. Pasco that you
submitted to us for "The Case Manager"
article. Please advise me by phone
if any corrections or revisions. Thank
you for your assistance.
Tom Strickland
Editor
The Case Manager

IN CASE OF INCOMPLETE TRANSMISSION - CALL (501) 227-5553
SYSTEMEDIC FAX # (501) 227-8362

cc = Marie Althoff

THE WHITE HOUSE
WASHINGTON

FAX COVER SHEET

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-2216 PHONE
(202)456-2878 FAX

TO: Tom Strickland
FAX #: (501) 227-8362
FROM: CAROL N. RASCO
DATE: 5/10/95
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If you have any problems with the fax transmission, please call
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NO	REMOTE STATION I. D.	START TIME	DURATION	#PAGES	COMMENT
1		5-10-95 16:11	3'36"	5	

TOTAL 0:03'36" 5

THE WHITE HOUSE

WASHINGTON

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SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202)456-2216 PHONE
(202)456-2878 FAX

TO: Tom Strickland

FAX #: (501) 227-8362

FROM: CAROL H. RASCO

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Carol Rasco Interview

TCM:

It appears that there is extensive health reform occurring around the country in both health and workers' compensation, but it seems to be coming from the state and private sectors. Are these local incentives now setting the pace as opposed to federal legislation?

Rasco:

The Clinton administration is continuing to fight for federal health reform legislation. Last year, the President's bill spurred an unprecedented debate as Congress and Americans across the country began to discuss the problems in our health care system as well as possible solutions. While we were unable to pass health reform legislation, that debate has continued. We welcome the work being done at state legislatures and in private businesses as we continue our efforts to take the first steps toward national health reform.

TCM:

Are there any specific state or private initiatives that you are particularly impressed with, and which you feel are good models for national reform policy?

Rasco:

Well, we have seen that health insurance has become more accessible and affordable in states that have set up voluntary purchasing pools. As the President said in his State of the Union address, we think that we can make real progress by giving states assistance to set up these pools.

TCM:

Following up on the voluntary purchasing pool idea, do you feel this concept has merit and how would this system work?

Rasco:

Today, many small firms pay exorbitant amounts for insurance or cannot get it at all, and many cannot afford to give their employees any choice of health plans. Administrative costs alone for small businesses are up to eight times more than large businesses. Voluntary purchasing pools would simply increase the purchasing power of small business that are severely disadvantaged in the current health insurance market.

TCM:

Another key concept appears to be a ban on pre-existing condition exclusion, whereby insurance companies would not be able to deny coverage because a person is sick or in a high-risk category. What would be the administration's position on this concept?

Rasco:

The administration remains firmly committed to guaranteeing health security to all Americans and to containing health care costs for families, businesses and federal, state and local governments. The President believes we should take a step-by-step approach. This year, we can take the first steps.

One thing that the Congress can and should do is reform the insurance market — so that people cannot be denied coverage because they have a so-called pre-existing condition, so that people don't lose their insurance when they lose a job or change jobs or a family member falls ill, and so that small businesses can afford to buy insurance for their workers. After all, almost all of the health reform proposals introduced last year — by Democrats and Republicans — included significant insurance market reforms.

TCM:

In regard to financing, the concepts of "medical savings accounts" or medical IRAs have been proposed. Is this something you would support and how would this work?

Rasco:

As you have noted, ~~both~~ ^g medical savings accounts and managed care have been discussed as ways to contain health care costs. We have some concerns about medical savings accounts that would need to be addressed before we could endorse them. For example, we don't want healthy people to buy medical savings accounts and "select out" of managed care plans while sicker people stay in — so that premiums go up for those enrolled in the plans. We must also ensure that people with low incomes are not discouraged from getting the medical care they need, particularly preventive care. And from the federal government's point of view, we must assure that there is no significant revenue loss. We do, however, want to work with Congress and the industry on medical savings accounts.

TCM:

Will the Administration attempt to promote faster enactment of managed care programs, or will private and local programming continue to be the primary initiators of managed care programs?

Rasco:

Any discussion of ways to improve access to high-quality, cost-effective medical care in federal health programs as well as the private sector must include efforts to increase choice of managed care plans. It is important to note, however, that recent surveys showing savings for managed care often do not measure the ability of these plans to serve older, sicker — and consequently more expensive — patients. We therefore need to look more carefully at the ability of managed care to produce savings. As we look to managed care, we must assure — through the use of effective case management and other measures — that quality of care and adequate access to providers is maintained for all patients, especially for the most vulnerable elderly and disabled.

We have begun this process in our own programs. The administration continues to grant waivers to states under the Medicaid program to allow them to experiment with managed care in order to reduce costs while preserving coverage. In the Medicare program in 1994, enrollment in managed care plans increased by 16%, and we are continuing to look for ways to increase choice of managed care plans for Medicare beneficiaries. As you noted, our military health programs are also working to give beneficiaries more of the choices that exist in the private market.

TCM:

Case management, with its emphasis on both quality care and cost containment, is increasingly being utilized in the various health care delivery systems including health insurance, workers' compensation, Medicare and Medicaid. How do you view case management as a resource in health care reform?

Rasco:

We agree that effective case management can both improve quality and contain costs. Case management — including outreach, follow-up and patient education — is a very promising way to achieve better health outcomes, improve continuity of care, and reduce costs for the system as a whole. This is particularly true for chronically ill and high-risk individuals.

TCM:

What do you see as the major differences between the Clinton administration's ambitions regarding health reform and the Republican reform proposals?

Rasco:

The major difference between the Clinton administration's visions for health reform and some Republican proposals is that, for too many Republicans in Congress, "health reform" has turned into code words for slashing Medicare and Medicaid to pay for tax cuts for the wealthy. Republicans in the House and Senate have talked about cutting both Medicare and Medicaid by hundreds of billions of dollars.

It's not hard to figure out what that means for the health professionals who treat patients in these programs and for the patients themselves. It means shifting a staggering financial burden to elderly and disabled Medicare beneficiaries. Or to small businesses and families who will pay higher premiums if these programs are slashed without overall reform. It means dropping coverage or shrinking benefits for mothers and children of Medicaid. Or it means asking states to pick up the tab to preserve the Medicaid program and in doing so, forcing them to raise taxes or cut spending for services like education and public safety. And finally, it means significant cuts in payments to hospitals, physicians and other providers.

under

The President has consistently said that we cannot get a hold of the deficit without passing meaningful health reform. Over the next five years alone, almost 40% of the growth in total federal spending will come from rising costs in federal health care programs. We must contain costs in these programs. But we must do it as we reform our health care system as a whole — not by arbitrarily cutting programs that serve the most vulnerable Americans.

TCM:

Are you optimistic that these differences can be resolved this year, resulting in a bipartisan health reform bill?

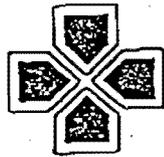
Rasco:

The administration will continue to fight against these deep and arbitrary cuts in Medicare and Medicaid. We believe, however, that — with bipartisan support — we can take the first steps toward national health care reform this year. ~~In addition to the insurance reforms I mentioned earlier, we can make coverage more affordable for and available to children, help workers who lose their jobs keep their health insurance, level the playing field for the self-employed by giving them the same tax treatment as that of businesses, and help families provide long-term care for a sick parent or disabled child. We look forward to working with both Democrats and Republicans to reach agreement on real health care reform.~~

See attached.

The President has said that he will have a simple test for every health care proposal, including changes to Medicare and Medicaid. He will evaluate them against four criteria, as he has throughout our work on health reform. Does it work toward our goal of expanding coverage or does it go backward and increase the number of uninsured Americans? Does it expand choice -- so that Medicare beneficiaries have the range of choices available in the private market? Or does it financially coerce beneficiaries into managed care plans? Will this proposal reform the Medicare and Medicaid programs to make them more efficient without threatening quality? Or are these simply arbitrary and excessive cuts used to pay for other priorities -- like tax cuts for the wealthy? And finally, will this proposal contain costs in the health care system?

202
456-2878



INDIVIDUAL CASE MANAGEMENT ASSOCIATION

10809 Executive Center Dr., Suite 105
Little Rock, Arkansas 72211-6020
(501) 227-5553 ~~954-7444~~
FAX (501) 227-8362

CONFIDENTIAL FAX TRANSMITTAL

DATE: 3/8/95 TIME: _____

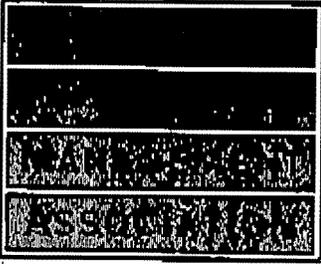
SENT TO: Julie Demeo
Carol Rasco's office

SENT FROM: Morie ALTHOFF
ICMA

TOTAL PAGES
TRANSMITTED: 2
(Including This Copy)

NOTES: Julie - here is the proposal
we discussed. It's ROUGH
but let's talk about it
as soon as you have
had an opportunity to
talk with Carol.
Thanks
Morie

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954-7444



sent her
a fax
3/11/95

FAX TRANSMITTAL

DATE: March 8, 1995
SENT TO: Carol Rasco
Assistant to the President for Domestic Policy and Health Care Reform
SENT FROM: Morie Althoff
Executive Director *ma*

TOTAL PAGES TRANSMITTED: 1 (Including this copy)

Dear Carol,

I visited with Julie Demeo yesterday and on her suggestion I am faxing you a proposal that is very rough, but at least it will be starting point. From some of my previous correspondence, you know that the Individual Case Management Association (ICMA) is a national educational and support organization for case managers and related managed care professionals. ICMA was the group that organized the task force to create the certification for case managers (CCM). We sponsor the Medical Case Management Conference (MCMC VII will be in New Orleans, October 18-21, 1995) which is America's largest annual conference for case managers and related professionals. I have spoken with Julie previously about the possibility of your being a speaker and we will follow up with that as the time approaches.

The professional and business publication of ICMA is *The Case Manager* magazine and that is what I would like to discuss with you. We would like to do a cover story featuring you as the Democratic viewpoint on health care reform with a corresponding Republican representative for the Republican viewpoint. The article would be in Question and Answer format.

We would provide both parties with a questionnaire that would include 15-20 questions on the current state of health care reform, indications for the future of reform and other health care related topics. We anticipate sending the questionnaire to you around March 20th and it needs to be returned by March 28th. Additionally, we would like to schedule approximately 1 1/2 to 2 hours of time somewhere between April 2 and April 4 for an interview and photo session. This is during the time that we will be in Washington for the National Managed Health Care Congress. The photo session would consist of a cover portrait of Carol and the Republican representative and 3-4 conversational shots during the interview.

Carol, I really hope that this will be an opportunity that you will consider. If you have any questions, please feel free to contact me at the off ice or at home (Home 501 666-1913). I will look forward to hearing from you!

Look
at in
late
summer

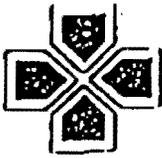
45 mins
K
another
time.

OKAY. NEED 8 DAYS.

DUBIOUS.

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SAN DIEGO



INDIVIDUAL CASE MANAGEMENT ASSOCIATION

10809 Executive Center Dr., Suite 105
Little Rock, Arkansas 72211-6020
(501) ~~227-0362~~
FAX (501) 227-0362

954-7444

CONFIDENTIAL FAX TRANSMITTAL

DATE: 3/20/95

TIME: _____

SENT TO: Julie Demeo/Carol Pasco

SENT FROM: Morie ALTHOFF

TOTAL PAGES
TRANSMITTED: _____

(Including This Copy)

NOTES:

Hi Julie and Carol -
Questionnaire attached!
Will look forward to
hearing from you! more

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954-7444

Morie (home) 501 666-1913

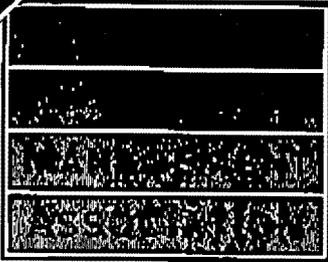
Questions for Health Reform Cover Article

TCM:

1. It appears that there is extensive health reform occurring around the country in both health and workers' compensation, but it seems to be coming from the state and private sectors. Are these local incentives now setting the pace as opposed to federal legislation?
2. Are there any specific state or private initiatives that you are particularly impressed with, and which you feel are good models for a national reform policy?
3. In his State of the Union address in January, President Clinton called for incremental step-by-step reform that would enable self-employed and small businesses to purchase health insurance more affordably through "voluntary purchasing pools." Is this still a key element of the administration's reform program?
4. There seems to be a budding consensus in Congress on several basic principles of reform, and I would appreciate your comments on these. Let's start with *voluntary purchasing pool*. From your perspective, how would this system work?
5. Another key concept appears to be a ban on pre-existing condition exclusion, whereby insurance companies would not be able to deny coverage because a person is sick or in a high-risk category. What would be the administration's position on this concept? *Insurance portability* appears to be another area where Democrats and Republicans have agreement. What would the president like to see incorporated in this area of reform?
6. In regard to financing what is anticipated to be increased costs with reform, the concepts of medical savings accounts or medical IRAs have been proposed. Is this something the administration would support and how exactly would this work? The most recent statistics coming from private surveys over the last few months indicate that managed care is resulting in substantial cost savings in our health care delivery system. Will the administration attempt to promote faster enactment of managed care programs, or will private and local programs continue to be the primary initiators of managed care programs?
7. Case management, with its emphasis on both quality care and cost containment, is increasingly being utilized in the various health care delivery systems including health insurance, workers' compensation, Medicare and Medicaid. How does the Clinton administration view case management as a resource in health care reform?

8. At medical case management conferences, we are seeing increasing numbers of representatives from Medicaid, Medicare and military programs. Could you comment about the increasing use of managed care and case management in these areas?
9. What do you see as the major differences between the Clinton administration's ambitions regarding health reform and the Republican reform proposals?
10. Are you optimistic that these differences can be resolved this year, resulting in a bipartisan health reform bill?

W:\WP60\TCM\REFORM.M

**FAX TRANSMITTAL**

DATE: March 8, 1995

SENT TO: Carol Rasco
Assistant to the President for Domestic Policy and Health Care Reform

SENT FROM: Morle Althoff
Executive Director *MA*

TOTAL PAGES TRANSMITTED: 1 (Including this copy)

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Cover
photo

Senator Robert Bennett
Wynoham Bristol ~~Room~~
955-6400 526

Write on the money 

Julie-Lyn

3/30/15

This what Jen prepared
for Mone. Although Carol
approved a fax copy last
night. *Kay*

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Individual Case Management Association
Answers to Questions for Health Reform Cover Article

1. The Clinton Administration is continuing to fight for federal health reform legislation. Last year, the President's bill spurred an unprecedented debate as Congress and Americans across the country began to discuss the problems in our health care system as well as possible solutions. While we were unable to pass health reform legislation, that debate has continued. We welcome the work being done in state legislatures and in private businesses as we continue our efforts to take the first steps toward national health care reform.
2. We've seen that health insurance has become more accessible and affordable in states that have set up voluntary purchasing pools. As the President said in his State of the Union Address, we think that we can make real progress by giving states assistance to set up these pools.
3. Answered in question 2.
4. Today, many small firms pay exorbitant amounts for insurance or cannot get it at all, and many cannot afford to give their employees any choice of health plans. Administrative costs alone for small businesses are up to eight times more than large businesses. Voluntary purchasing pools would simply increase the purchasing power of small businesses that are severely disadvantaged in the current health insurance market.
5. The Administration remains firmly committed to guaranteeing health security to all Americans and to containing health care costs for families, businesses and federal, state and local governments. The President believes we should take a step-by-step approach. This year, we can take the first steps.

One thing that the Congress can and should do is reform the insurance market -- so that people cannot be denied coverage because they have a so-called preexisting condition, so that people don't lose their insurance when they lose a job or change jobs or a family member falls ill, and so that small businesses can afford to buy insurance for their workers. After all, almost all of the health reform proposals introduced last year -- by Democrats and Republicans -- included significant insurance market reforms.

6. As you've noted, both medical savings accounts and managed care have been discussed as ways to contain health care costs. We have some concerns about medical savings accounts that would need to be addressed before we could endorse them. For example, we don't want healthy people to buy medical savings accounts and "select out" of managed care plans while sicker people stay in -- so that premiums go up for those enrolled in the plans. We must also ensure that people

with low incomes are not discouraged from getting the medical care they need, particularly preventive care. And from the federal government's point of view, we must ensure that there is no significant revenue loss. We do, however, want to work with Congress and the industry on medical savings accounts.

Any discussion of ways to improve access to high quality, cost effective medical care in federal health programs as well as the private sector must include efforts to increase choice of managed care plans. It is important to note, however, that recent surveys showing savings from managed care often do not measure the ability of these plans to serve older, sicker -- and consequently more expensive -- patients. We therefore need to look more carefully at the ability of managed care to produce savings. And as we look to managed care, we must ensure -- through the use of effective case management and other measures -- that quality of care and adequate access to providers is maintained for all patients, especially for the most vulnerable elderly and disabled.

We've begun this process in our own programs. The Administration continues to grant waivers to states under the Medicaid program to allow them to experiment with managed care in order to reduce costs while preserving coverage. In the Medicare program in 1994, enrollment in managed care plans increased by 16 percent, and we are continuing to look for ways to increase choice of managed care plans for Medicare beneficiaries. As you noted, our military health programs are also working to give beneficiaries more of the choices that exist in the private market.

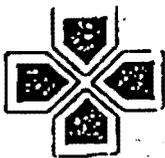
7. We agree that effective case management can both improve quality and contain costs. Case management -- including outreach, follow up and patient education -- is a very promising way to achieve better health outcomes, improve continuity of care, and reduce costs for the system as a whole. This is particularly true for chronically ill and high risk individuals.
8. Answered in question 6.
9. The major difference between the Clinton Administration's vision for health reform and some Republican proposals is that, for too many Republicans in Congress, "health reform" has turned into code words for slashing Medicare and Medicaid to pay for tax cuts for the wealthy. Republicans in the House and the Senate have talked about cutting both Medicare and Medicaid by hundreds of billions of dollars.

It's not hard to figure out what that means for the health professionals who treat patients in these programs and for the patients themselves. It means shifting a staggering financial burden to elderly and disabled Medicare beneficiaries. Or to small businesses and families who will pay higher premiums if these programs are slashed without overall reform. It means dropping coverage or shrinking benefits for

mothers and children on Medicaid. Or it means asking states to pick up the tab to preserve the Medicaid program, and in doing so, forcing them to raise taxes or cut spending for services like education and public safety. And finally, it means significant cuts in payments to hospitals, physicians and other providers.

10. The Administration will continue to fight against these deep and arbitrary cuts in Medicare and Medicaid. We believe, however, that -- with bipartisan support -- we can take the first steps toward national health care reform this year. In addition to the insurance reforms I mentioned earlier, we can make coverage more affordable for and available to children, help workers who lose their jobs keep their health insurance, level the playing field for the self-employed by giving them the same tax treatment as other businesses, and help families provide long-term care for a sick parent or disabled child. We look forward to working with both Democrats and Republicans to reach agreement on real health care reform.

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gen - this
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NOTES: Hi Julie and Carol -
Questionnaire attached!
Will look forward to
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Morie (home)



P6(b)(6)

Questions for Health Reform Cover Article

TCM:

1. It appears that there is extensive health reform occurring around the country in both health and workers' compensation, but it seems to be coming from the state and private sectors. Are these local incentives now setting the pace as opposed to federal legislation?
2. Are there any specific state or private initiatives that you are particularly impressed with, and which you feel are good models for a national reform policy?
3. In his State of the Union address in January, President Clinton called for incremental step-by-step reform that would enable self-employed and small businesses to purchase health insurance more affordably through "voluntary purchasing pools." Is this still a key element of the administration's reform program?
4. There seems to be a bulling consensus in Congress on several basic principles of reform, and I would appreciate your comments on these. Let's start with *voluntary purchasing pool*. From your perspective, how would this system work?
5. Another key concept appears to be a ban on pre-existing condition exclusion, whereby insurance companies would not be able to deny coverage because a person is sick or in a high-risk category. What would be the administration's position on this concept? *Insurance portability* appears to be another area where Democrats and Republicans have agreement. What would the president like to see incorporated in this area of reform?
6. In regard to financing what is anticipated to be increased costs with reform, the concepts of medical savings accounts or medical IRAs have been proposed. Is this something the administration would support and how exactly would this work? The most recent statistics coming from private surveys over the last few months indicate that managed care is resulting in substantial cost savings in our health care delivery system. Will the administration attempt to promote faster enactment of managed care programs, or will private and local programs continue to be the primary initiators of managed care programs?
7. Case management, with its emphasis on both quality care and cost containment, is increasingly being utilized in the various health care delivery systems including health insurance, workers' compensation, Medicare and Medicaid. How does the Clinton administration view case management as a resource in health care reform?

8. At medical case management conferences, we are seeing increasing numbers of representatives from Medicaid, Medicare and military programs. Could you comment about the increasing use of managed care and case management in these areas?
9. What do you see as the major differences between the Clinton administration's ambitions regarding health reform and the Republican reform proposals?
10. Are you optimistic that these differences can be resolved this year, resulting in a bipartisan health reform bill?

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