

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	From: Hillary Rodham Clinton, To: Mr. & Mrs. Markson (1 page)	4/18/94	b(6)
001b. letter	From: Hillary Rodham Clinton, To: Mr. & Mrs. Markson (1 page)	2/17/94	b(6)
001c. letter	From: The Markson Family, To: Mrs. Rodham Clinton (6 pages)	2/4/94	b(6)
002. memo	From: Jennifer Klein, To: Hillary Rodham Clinton, Re: Telephone Calls [partial] (1 page)	2/18/94	b(7)(E)
003a. letter	From: Policyholder to: Lynn Gruber [partial] (1 page)	4/6/94	b(6)
003b. letter	From: Policyholder, To: Lynn Gruber [partial] (1 page)	4/7/94	b(6)
003c. letter	From: Policyholder, To: Commissioner Ullaud [partial] (1 page)	4/11/94	b(6)
003d. letter	From: Policyholder, To: Those considering premium increases [partial] (2 pages)	3/26/94	b(6)
003e. letter	From: Policyholder, To: Minnesota Comprehensive Health Association [partial] (1 page)	4/4/94	b(6)
003f. letter	From: Policyholder, To: Commissioner Ullaud [partial] (1 page)	3/7/94	b(6)
003g. letter	From: Policyholder, To: Gentlemen [partial] (1 page)	3/31/94	b(6)
003h. letter	From: Policyholder, To: Ms. Gruber [partial] (1 page)	3/28/94	b(6)

COLLECTION:

Clinton Presidential Records
 First Lady's Office
 Pam Cicetti
 OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S
 sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
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003i. letter	From: Policyholder, To: Mr. Gruber [partial] (1 page)	3/20/94	b(6)
003j. letter	From: Policyholder, To: Lynn Gruber [partial] (2 pages)	3/22/94	b(6)
003k. letter	From: Policyholder [partial] (1 page)	3/21/94	b(6)
003l. letter	From: Policyholder, To: Lynn B. Gruber [partial] (1 page)	3/28/94	b(6)
003m. letter	From: Policyholder, To: Lynn Gruber [partial] (1 page)	nd	b(6)
003n. letter	From: Policyholder, To: Mrs. Lynn Gruber [partial] (2 pages)	3/26/94	b(6)
003o. letter	From: Policyholder, To: Sir or Madam [partial] (1 page)	3/9/94	b(6)
003p. letter	From: Policyholder, To: Sir/Madam [partial] (1 page)	3/7/94	b(6)
003q. letter	From: Policyholder [partial] (1 page)	nd	b(6)
003r. letter	From: Policyholder, To: Lynn [partial] (1 page)	3/23/94	b(6)
003s. letter	From: Policyholder, To: Mr. Gruber [partial] (1 page)	nd	b(6)
003t. letter	From: Policyholder, To: MCHA Board of Directors [partial] (1 page)	3/6/94	b(6)
003u. letter	From: Policyholder, To: Board of Directors [partial] (1 page)	3/17/94	b(6)

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004. resume	George D. Monardo, Personal Data [partial] (1 page)	nd	b(6)
005a. letter	From: Hillary Rodham Clinton, To: Ms. Mary Musk (1 page)	10/28/94	b(6)
005b. letter	From: Mary Musk, To: Hillary Clinton (3 pages)	10/6/94	b(6)
005c. memo	From: Karen Guss, To: File, Re: letter from Mary Musk (2 pages)	11/21/94	b(6)

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HRC
HC CORR 94-M

PERSONAL
&
~~CONFIDENTIAL~~

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: LAG DATE: 12-4-13

PHOTOCOPY
PRESERVATION

Callahan's Office

A.R.

MAILED

USCG Governor's Island
N.Y.

Health Care Reform

Balanced Budget

To Jennifer Klein -
Can you write to ask

PHOTOCOPY
HRC HANDWRITING



PHOTOCOPY
PRESERVATION

Adult Services Division
Marathon, Inc.
Box 319

THE WHITE HOUSE
WASHINGTON

September 20, 1994

Warrant Officer A.R. MacLeod
United States Coast Guard
Governor's Island, New York

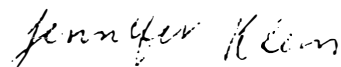
Dear Warrant Officer MacLeod:

The First Lady asked me to contact you. She would very much like to hear your comments and suggestions about health care reform and a balanced budget.

I look forward to hearing from you and can be reached at the following address:

Second Floor, West Wing
Office of the First Lady
The White House
Washington, D.C. 20500

Sincerely yours,



Jennifer Klein
Senior Policy Analyst

U.S. Department
of Transportation

United States
Coast Guard



Commander (k)
Maintenance & Logistics Command
Atlantic

Governors Island
Bldg 400, Section K.
New York, NY 10004-5080
Phone: (212) 668-7413

4200

NOV 28 1994

Ms. Karen Guss
Office of the First Lady
Old Executive Office Building
Room 212
Seventeenth Street and Pennsylvania Avenue
Washington, DC 20500

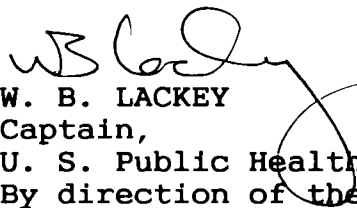
Dear Ms. Guss,

As you requested in our recent phone conversation, I am enclosing a status report on our ongoing pilot projects to provide health care for Coast Guard active duty dependents. These projects are very limited in scope and selected to meet very specific criteria. Because the populations are so small and the time frame so short, I can not draw any conclusions with confidence from the data obtained so far. In such small transient populations, it may take many years to separate a valid trend from extreme year to year fluctuations.

We have more experience with providing care for our active duty population. The key to our success has been a cadre of knowledgeable Coast Guard health care personnel taking personal interest in getting an appropriate level of care at a reasonable cost for our patients. They have had some success in reducing costs by preventing unnecessary procedures, negotiating for more reasonable costs, and directing care to preferred providers or military treatment facilities.

I appreciate your interest in our programs. If I can be of further service please let me know.

Sincerely,


W. B. LACKEY
Captain,
U. S. Public Health Service
By direction of the Commander

Encl: (1) Pilot Project Status Report



4200

NOV 28 1994

From: Commander, Maintenance & Logistics Command Atlantic
To: Commandant (G-KOM)

Subj: DEPENDENT HEALTH CARE PILOT PROJECT

Ref: (a) COMDT (G-K) ltr 4200 of 8 May 91

1. As outlined in reference (a), the Omnibus Act of 1990 authorized the Coast Guard to provide outpatient primary health care for dependents of active duty members by contracting with non-federal practitioners and providers. We undertook a limited number of pilot projects on a test basis aimed at providing comparable level of care at a lower cost or enhanced level of care at no increase in cost. Factors we considered in establishing a Dependent Health Care Pilot Project (DHCPP) were:

- a. "remote" sites with geographic barriers;
- b. sites where medical treatment was not readily available;
- c. sites where area providers did not accept CHAMPUS;
- d. and sites where the costs of the medical treatment and/or provider services were considered "excessive."

2. After evaluating thirteen potential sites from Maine to Texas, we finally established a DHCPP at Chincoteague, Virginia (May 1992), at Owensboro, Kentucky (October 1992) and at Grand Isle, Louisiana (February 1993). These sites had an average beneficiary population of 181, 31, and 69 respectively.

3. In Chincoteague we learned that although the command requested a provider on the island, the patients preferred providers nearer their homes. Through data obtained from pharmacy invoices, we found that dependents generally tended to use their preferred non-contracted provider instead of our contracted (on-island) provider. Lack of access to health care providers who accepted CHAMPUS appeared to be less a problem than we initially thought. This contributed to our decision to discontinue the DHCPP at Chincoteague on 1 October 1994.

4. In Owensboro, the DHCPP is still active. While many providers were available there when we inaugurated the project, none in the immediate area accepted CHAMPUS. In FY93, the contract provider for our active duty population agreed to provide primary care in support of DHCPP at fees less than or equal to the CHAMPUS Maximum Allowable Charge (CMAC). However, this DHCPP agreement and active duty contract were subsequently terminated with this provider at the end of FY94 because of patient dissatisfaction and the provider's noncompliance with several contract stipulations. Beginning in FY95, the DHCPP was

NOV 28 1994

Subj: DEPENDENT HEALTH CARE PILOT PROJECT

reestablished with a hospital-based health care provider network. This arrangement permits dependents a choice of providers, and preliminary results indicate this arrangement is working well.

5. In Grand Isle, the DHCPP also continues. At the beginning of this project there was only one provider occasionally available two days per week, with the nearest medical facility to Grand Isle over one hour's transit time away. As part of this DHCPP we negotiated an agreement with the nearest medical facility to locate contracted providers at various sites convenient to Grand Isle beneficiaries. The providers agreed to render primary care in support of DHCPP at fees less than or equal to the CMAC. This long-term plan effectively provides a full-time contracted provider presence on Grand Isle. This was in addition to a part-time provider who also agreed to participate in the DHCPP.

6. The DHCPP data base is small and subject to anomalies and spikes, as for example, singularly high cost medical treatments. Comparative analysis has been hampered by still maturing data bases and software. For example, CHAMPUS pharmacy costs were unavailable to us, as was CHAMPUS information on individuals, providers, and individual treatment plans. The data must be approached cautiously, understanding that it serves more to stimulate further analysis than to suggest results or trends. Preliminary data is summarized in enclosure (1) and seems to indicate some cost savings.

7. We can not with certainty pinpoint the reasons for the apparent cost savings. They may be solely due to anomalies in a very small data base, the vagaries of a small population or the lag time from delivery of services to bill submission leading to incomplete FY 93 costs. A few possible causes are:

a. Improved accessibility to an identified primary care provider ("Gatekeeper") may have contributed to a reduction in ancillary visits and related costs.

b. Reduced outpatient visit costs to the patient may have lead to early intervention and detection of illnesses and conditions before they required more expensive emergency or long term treatment regimes.

c. Inability to pay up-front for medical care (as required by some providers) coupled with having to wait for CHAMPUS reimbursement may have previously lead patients to delay health care visits.

4200

NOV 28 1994

Subj: DEPENDENT HEALTH CARE PILOT PROJECT

8. Customer satisfaction with DHCPP has remained high attributable to such factors as improved accessibility to care, minimal paperwork (claim filing), and reduction of overall out-of-pocket expenses.

9. Additional lessons are being learned from DHCPP experiences:

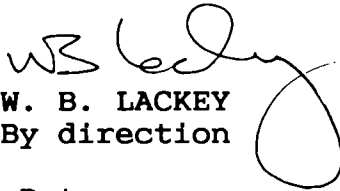
a. Compiling and analyzing appropriate data is extremely labor intensive at this time especially considering the small populations involved. Better access and improved accountability of data in computerized media is essential for long-term enhancements.

b. Multiple variables among the existing data can easily skew the data, e.g., high cost procedures, ever-changing demographics of dependent populations caused by end-of-tour rotations of active duty sponsors, trust or confidence in the provider, and location of the primary care.

c. We have also learned that DHCPP needs to provide dependents incentives to use "our" contracted provider or disincentives to use non preferred providers.

10. Three potential DHCPP sites (Sault Ste Marie, Michigan; Brunswick, Georgia; and Southwest Harbor, Maine) have been evaluated by my staff. Of these, only Brunswick, Georgia appears likely to meet our criteria for the establishment of a project.

11. My point of contact regarding this project is CDR James Lachowicz, at (212) 668-7816.


W. B. LACKEY
By direction

Encl: (1) MLCLANT Pilot Project Data

Copy: CG MLCPAC(k)

MLCLANT PILOT PROJECT DATA

Grand Isle

Out Patient and Ancillary Services

	FY-91	FY-92	FY-93
CHAMPUS costs	\$17,706	\$38,186	\$11,146
DHCPP costs	\$0	\$0	\$1,787
Total Government Costs	\$17,706	\$38,186	\$12,933

Pharmacy

	FY-91	FY-92	FY-93
DHCPP costs	\$0	\$0	\$2,145

NOTE: CHAMPUS pharmacy costs were not available through the KRIS data system.

Out Patient Visits

	FY-91	FY-92	FY-93
CHAMPUS	115	180	99
DHCPP	0	0	42
Total Visits	115	180	141

Ancillary Service Episodes

	FY-91	FY-92	FY-93
CHAMPUS	219	368	239
DHCPP	0	0	7
Total Episodes	219	368	246

Sponsor Costs

	FY-91	FY-92	FY-93
CHAMPUS	\$6,748	\$7,247	\$3,991
DHCPP	\$0	\$0	\$370
Total Sponsor Costs	\$6,748	\$7,247	\$4,461

ENCLOSURE (1)

MLCLANT PILOT PROJECT DATA

Owensboro

Out Patient and Ancillary Services

	FY-91	FY-92	FY-93
CHAMPUS costs	\$16,999	\$14,610	\$4,532
DHCPP costs	\$0	\$0	\$2,503
Total Government Costs	\$16,999	\$14,610	\$7,035

Pharmacy

	FY-91	FY-92	FY-93
DHCPP costs	\$0	\$0	\$2,262

NOTE: CHAMPUS pharmacy costs were not available through the KRIS data system.

Out Patient Visits

	FY-91	FY-92	FY-93
CHAMPUS	70	78	23
DHCPP	0	0	48
Total Visits	70	78	71

Ancillary Service Episodes

	FY-91	FY-92	FY-93
CHAMPUS	213	195	103
DHCPP	0	0	25
Total Episodes	213	195	128

Sponsor Costs

	FY-91	FY-92	FY-93
CHAMPUS	\$4,811	\$4,785	\$3,254
DHCPP	0	0	\$470
Total Sponsor Costs	\$4,811	\$4,785	\$4,040

MLCLANT PILOT PROJECT DATA

Chincoteague

Out Patient and Ancillary Services

	FY-91	FY-92	FY-93
DHCPP costs	\$0	\$2,139	\$5,595

Pharmacy

	FY-91	FY-92	FY-93
DHCPP costs	\$0	\$4,935	\$22,130

Out Patient Visits

	FY-91	FY-92	FY-93
DHCPP	0	64	244

Sponsor Costs

	FY-91	FY-92	FY-93
DHCPP	\$0	\$640	\$2,350

NOTE: CHAMPUS Data was not available through the KRIS data system for Chincoteague Island area.

F

Memorandum To: President Clinton
Hillary Rodham Clinton

From: Ira C. Magaziner

Subject: Next Steps on Health Reform

Date: 8/21/94

The latest " rump group " proposal is less comprehensive than the Senate Finance Committee bill, and accomplishes less than the plan offered by former President Bush during his last year in office. Saturday's Washington Post said accurately that " in its scope and financing, the plan... is closer to the minimalist health care plan sponsored by Dole than it is to Mitchell's scaled-back version of Clinton's plan." Core democratic constituencies such as Labor, Seniors, progressive health care providers and consumer groups will oppose the plan vehemently." The moderate Republicans have "moved the bar" away from us again.

As we have suspected, there is not the will in the Senate to raise the funds necessary to achieve anywhere near 95% coverage. The Mitchell bill contains a number of funding sources --the high cost plan assessment, the removal of tax deductibility for health care in cafeteria plans and the risk adjustment assessment on large companies-- which were bound to be unpopular. The " rump group " removes them. They go further, and remove the assessment for academic health and research and do not integrate Medicaid into the private sector, further reducing available funds.

To compensate for these losses, the " rump group " proposes a tax cap, reduces long-term care spending by 80% from the already reduced levels in the Mitchell bill, eliminates the Medicare drug benefit and the research and academic health initiatives and guts the public health initiatives. They also set a goal of reducing the deficit by \$100 billion over ten years from health reform. Though no coverage estimates are yet available, it is likely that their proposal will fall well short of 95% coverage.

As with the Mitchell bill, the sustainability of the " rump group's " financing is highly questionable. Tax caps are even less likely to pass the Senate than premium caps. Sustaining over \$240 billion in Medicare cuts with no drug benefit, virtually no long-term care program and only marginal increases in coverage may be very difficult.

Other troublesome aspects of the bill are provisions which encourage companies potentially to drop coverage. Requiring companies who cover some full time employees to cover all full time employees in a voluntary world may simply encourage some companies to drop all coverage. This is especially true, when combined with another provision which makes the purchase of insurance deductible to the individual.

The " rump group " proposal contains only a soft trigger to some Congressional review by 2002 if 95% coverage is not reached and when the tax cap is removed, it has no cost containment. Those who thought that one could give up on all forms of premium caps and employer mandates and still produce a comprehensive bill are now learning otherwise.

These latest developments, in my opinion, leave us with three choices:

- 1 If Mitchell can work something out with the " rump group " that Labor, seniors and other health care reform supporters can stomach, we can hope for a stronger bill in the House and go to conference.
- 2 We can fight for a strengthened Mitchell bill, either go to a vote and lose with perhaps 40+ votes or not go to a vote and urge Congress to go home, vowing to fight for universal coverage next year.
- 3 We can propose our own minimalist alternative which makes more sense than those on the table either through a " summit " or as a leadership substitute, try to pass it, and then vow to fight for universal coverage next year.

A Mitchell-Rump Group Compromise

If we believe that the House can pass a substantially stronger bill than the Senate and that a reasonable agreement can be reached between Senator Mitchell and the " rump group, " then this approach could make sense. There would be a health care bill this year. It would accomplish some positive goals. We could avoid total defeat.

On the downside, the passage of this bill over what would likely be the objection of most Republicans, would leave us vulnerable in a number of respects. Because it is a minimalist bill, it will leave in place most of the causes for popular discontent with today's health care system. The poor would get some subsidies to buy insurance, it would be harder for insurers to discriminate against those with pre-existing conditions. But, people would still be denied coverage; their benefits would still be cut back; costs would continue to rise; treatments would continue to be denied to consumers by managed care companies saving money at consumer's expense; hospitals in inner cities and rural areas would close; Medicare and Medicaid cuts in the absence of universal coverage would mean more doctors offices and hospitals might drop coverage for these populations; Medicare premiums would rise for some; etc. Now, there would be a risk that all of these occurrences would be blamed on the Clinton health plan instead of on the status quo health system.

In addition, it is unlikely that either the public or the media would view this bill as a success for the president. We could end up with the worst of both worlds; a political defeat and blame for a health bill that doesn't work. We have always known that once a health bill passes, all ills of the system would be blamed on it. With this minimalist bill, there may not be enough positives nor the correction of enough of today's negatives to win that battle.

No Bill

The Republicans are trying to block any bill from passing and are perceived in many circles as obstructionists. If the public perceives that the President is fighting for principles he and they believe in, that he has been willing to compromise but is being blocked by Republicans who for political purposes are trying to kill health reform (all of which is true), the Republican strategy might backfire on them.

Urging Congress to go home and telling the public that the President would try again next year could avoid our having to accept a bill which later is perceived by the public as a "lemon." It also puts the onus on the other side and leaves us fighting for our principles. We are perilously close to the line now on whether the bill proposed does more harm than good, so this is not a case of allowing the perfect to be the enemy of the good.

If we cannot get good reform from the next Congress, then we can continue to fight for it into the next term. The problems with the health care system will only get worse. The public will want something done. If we continue to fight for our principles rather than accept something which does not fix the problems and be saddled with its failure, we may produce more for the American people in the long run.

This option also has many potential downsides. The next Congress may not do health reform and might take Medicare and Medicaid savings only for the deficit, making health reform that much more difficult. Democrats could be blamed severely at the polls this year and the President in 1996 for having failed to pass any health bill. The recriminations against the President, the First Lady, the health care team and the Administration in general could be devastating.

An Administration Minimalist Approach

If we must accept a minimalist approach, and having some bill is better than having no bill, we could try to put an alternative on the table which will do as much good and as little harm as possible. While this would require broader discussion, a proposal like the following might have merit:

- 1 Use Medicare, Medicaid integration and tobacco tax funds as proposed in the Mitchell bill and eliminate from it all other sources of funding which essentially as those with good insurance today.
- 2 Fund coverage for all children and pregnant women and for all people who have insurance but lose their jobs for six months (with subsidies adjusted for income).
- 3 Fund a scaled back Medicare drug benefit and a scaled back long-term care initiative.
- 4 Provide \$100 billion in deficit reduction over the ten year period.

- 5 Carry out the various insurance and market reforms described in the Mitchell bill as amended by the " rump group," with an eye toward disrupting the current market as little as possible.
- 6 Try to maintain the Mitchell bill trigger with some type of cost containment commission which makes recommendations on slowing the growth of costs if certain specified targets are not met.
- 7 If Medicare cuts cannot be sustained, then cut the drug benefit. If the Mitchell trigger cannot be sustained, there is still worth to the program.

We cannot claim victory with this type of proposal, but it is a responsible one which will allow us to claim correctly that we are helping people with health insurance problems and that we are using health reform to help fight the deficit into the next decade.

The downside to this approach is that the President will still be open to attack for failing to achieve his goals and accepting less than universal coverage. He also will still be open to blame for problems people have with the health care system. Since this will be more closely identified as an administration position if we suggest it, we will have a harder time distancing ourselves from it later on.

This option may also be moot. Congress may not want to take our suggestions.

F

D R A F T

8/21/94

Possible Options

1. Mitchell accommodates enough of the mainstream to gain broader support of Mitchell, as revised, with the balance of mainstream proposals being debated and voted on.
 - How critical is the triggered mandate in Mitchell? If it is supplanted by the 95% goal of the mainstream, and if the rest of Mitchell revised works, can it be argued that it puts the country on the path to universal coverage and, if so, should the President support it?

The definition of "what works" is critical. If the President cannot support Mitchell revised, should he declare an impasse; that the Republicans are unwilling to support health care reform this year; but that he will fight for health care reform next year.

If, after recess, the Congress enacts health care legislation, the President can then decide whether to sign it or not.
 - It is likely, however, that many of the leadership groups supporting health reform will walk away from Mitchell revised.
 - Even if the President wants to declare an "impasse" and to ask the Senate to adjourn, Senator Mitchell may resist this course.
 - If Mitchell revised cannot be supported by the President, should he demand a vote on the Mitchell triggered mandate as well as on the key provisions to show the country who is blocking health reform?
 - Even if Mitchell revised, without the Mitchell mandate, should be pushed, what effect will it have on the House? This will depend upon the configuration of Mitchell revised.
2. If Mitchell cannot accommodate Chafee:
 - A. Carry on with the debate on Mitchell and force an early vote on the Mitchell mandate.

- If the vote retains the Mitchell mandate, it is unclear where the process then goes.
 - If the vote defeats the Mitchell mandate, the President can declare an "impasse"; state that the Republicans blocked health reform; ask the Senate to recess; and state he will fight for health reform next year.
- B. Mitchell tells the President that he needs a recess to work out a modified bill (thus effectively telling the President there isn't sufficient support in the Senate to enact the pending bill); the Senate goes on recess; the press declares health reform dead this session; during the recess, the President and at least the Democratic leadership devise a bill that can be characterized as putting the country on the path to universal coverage, along the lines of the congressional resolution (or some other workable minimal approach) described in paragraph numbered 2 below.
- The President could say that while the universal coverage as he has worked for so hard can't be achieved this year, this alternative proposal, which he devised with the Congress, is a giant step toward that goal.
 - Although the public would likely support such a proposal, the leadership groups favoring health reform may disown it.
- C. Mitchell tells the President that he cannot get his bill through the Senate. The President declares an "impasse"; states that he has done everything possible to achieve universal coverage, but the Republicans block it; call a Democratic leadership summit (perhaps including some Republicans) to work out an alternative that can command the necessary votes in both chambers, but which will not include universal coverage.
- Even under this option, the President may need a vote on the Mitchell mandate before declaring an impasse and calling the leadership summit to show he went the distance in trying to achieve universal coverage.
 - This is a very risky strategy because it is highly probable that the process will drag out, no agreement will be reached that can

Options-Mitchell
8/21/94

command sufficient support, and the President will merely become bogged down in the process.

Other issues:

1. The clock: If Mitchell cannot reach an accommodation with the mainstream, at least in principle, this week, he may well not be able to hold the Senate in session after the final vote on the crime bill. If so, the Senate is not scheduled to return until 12 (Monday) September at the earliest and perhaps not until 19 September.

The House is scheduled to return on 8 September (Thursday), but if the Senate has not acted on health reform, it is unlikely that the House begin considering health reform before the Senate has acted.

Even if the House begins debate before the Senate acts, will enough time remain to enact health care this year?

2. If Mitchell is unable to accommodate Chafee, is there any proposal that is less than Mitchell that would be acceptable both politically and policy wise? .

For example a congressional resolution (a) declaring a national goal to achieve universal coverage by a date certain; (b) appointing a bipartisan commission to make recommendations to the next session of Congress to achieve that goal; (c) enacting critical insurance reforms dealing with portability, pre-existing conditions, life time limits, rate bands, medical underwriting (increasing rates), etc; (d) providing coverage for children, pregnant women, and selected others to the extent funds are available; (e) providing prescription drugs and the beginning of long term care for seniors; and (f) some deficit reduction (whether all of (d),(e) and (f) can be financed may be questionable).

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	From: Hillary Rodham Clinton, To: Mr. & Mrs. Markson (1 page)	4/18/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Jennifer will do more
comprehensive reply.

Let's wait for
that since I answered her
in person at event -
see if Jennifer can
get transcript
of my
answer

PHOTOCOPY
HRC HANDWRITING

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. letter	From: Hillary Rodham Clinton, To: Mr. & Mrs. Markson (1 page)	2/17/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001c. letter	From: The Markson Family, To: Mrs. Rodham Clinton (6 pages)	2/4/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
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THE WHITE HOUSE

March 2, 1994

Mr. S. Hubert Mayes, Jr.
Mitchell, Williams, Selig,
Gates & Woodyard
320 West Capitol Avenue
Suite 1000
Little Rock, Arkansas 72201-3525

Dear Hubie:

Thank you for your letter and clarification of Mr. Taylor's testimony before the House Subcommittee on Commerce. I have a bit of experience myself with being misrepresented and misquoted so you have my understanding!

I appreciate hearing from you and thanks for your support.

With kind regards, I remain

Sincerely yours,


Hillary Rodham Clinton

As R

*cc: Melanne
Mike*

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WRITER'S DIRECT DIAL

*LICENSED IN DISTRICT OF COLUMBIA AND ARKANSAS
ALL OTHERS LICENSED IN ARKANSAS

501-688-8837

February 9, 1994

PAM FEB 9 1994

Ms. Hillary Rodham Clinton
The White House - West Wing
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500-2000

Dear Ms. Clinton:

Alliance of American Insurers had its first opportunity to testify "on the hill" on the Health Security Act last week before the Subcommittee on Commerce, Consumer Protection and Competitiveness of the House Committee on Energy and Commerce. Thomas Taylor, Executive Vice President and Chief Operating Officer of Amica Mutual Insurance Company and Chairman of the Alliance's Special Auto Insurance/Health Care Reform Task Force, testified that the Alliance supports the goals of health care reform articulated by you and the President and the concept of coordination of the medical portions workers' compensation and auto med pay/liability insurance, but pointed out some problems we have with specific provisions of Title X. As you know, this is consistent with the position we took with the Clinton/Gore staff during the Campaign, with the Health Care Reform Task Force during its deliberations, with Administration officials during drafting and now before Congress since introduction of the Plan.

Yet, following the testimony, a Journal of Commerce article was headlined "Insurers Group Slams Clinton Health Plan." I was present for Mr. Taylor's testimony and want you to know that this is a misrepresentation of his remarks and to assure you that we do not "speak with forked tongue" by telling Congress one thing and the Administration something different. We now know how you and the President must feel when some of the press/media distort some of your statements and their intended meaning. This inaccurate reporting of our testimony was an "unintended consequence" but beyond our control.

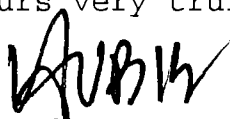
MITCHELL, WILLIAMS, SELIG, GATES & WOODYARD
A PROFESSIONAL LIMITED COMPANY

Ms. Hillary Rodham Clinton
February 9, 1994
Page 2

We continue our interest in health care reform but since our 214 member companies provide workers' compensation and auto insurance products to millions of Americans, our primary focus and expertise are on the matters addressed by Title X. Should you or Administration representatives care to discuss these provisions or positive changes to them outside of the Congressional arena, we would be happy to meet at any time and would welcome the opportunity.

Kindest personal regards to you and the President.

Yours very truly,



S. Hubert Mayes, Jr.

SHM:la

cc Ms. Carol Rasco
Assistant to the President,
Domestic Policy
The White House - West Wing
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

August 19, 1994

TO: Hillary
FROM: Melanne
CC: Lisa

RE: Comments of Johnny Apple on the Charlie Rose Show

- Rose asked whether or not HRC appeared to be less public on health care.

Apple said it was appropriate to have a lower profile in the congressional phase of health care.

- Apple said that "all the plans owe a good deal to her and her people." He added that HRC is "indispensable" to the POTUS. She "benefits" the POTUS.
- When asked if she is "soured on Washington," he said he had no information on that but said he'd underscore again that HRC will get "a lot of credit" if a plan is passed. "There are a lot people who believe that nothing would have happened, if it hadn't been for her."

THE WHITE HOUSE

January 10, 1994

Jack B. McConnell, M. D.
Chairman
Volunteers in Medicine Clinic
P. O. Box 23287
Hilton Head Island, SC 29923

Dear Dr. McConnell:

Congratulations on the success of the Volunteers in Medicine program. It makes eminent sense, and from what I read in the New York Times article, benefits everyone involved.

I will pass on your packet of materials to the Office of Policy Development and have someone contact you for more specific information.

With best wishes for the New Year and continued success with VIM, I am

Sincerely yours,


Hillary Rodham Clinton

~~cc:~~ Office of Policy Development

PHOTOCOPY
PRESERVATION

*It was great visiting
with you -*



**VOLUNTEERS
IN MEDICINE**

**PHOTOCOPY
PRESERVATION**



The Volunteers in Medicine Clinic has received support from a number of local and regional sources, and several national and charitable foundations. It is expected that residents and business leaders of Hilton Head Island and Dauterive Island will provide the financial support necessary to fund Clinic operations.

Since its conception, the VIM Clinic has received support from local businesses, religious, charitable and service organizations, the Hilton Head Hospital, and state and local governments. Professional medical groups throughout the state have also actively supported the Clinic's organization.

The next step in the development of the Volunteers in Medicine Clinic is critical. As the medical services at the Clinic will be offered to the *medically underserved* patients completely *free-of-charge*, the Clinic's operational resources must come from donated funds.

A goal of \$1 million dollars has been set for the Clinic's *Initial Funding Campaign*. These funds will cover estimated facility building costs (\$500,000)

and the Clinic's first year of operation (\$400,000). Subsequent to its initial fundraising efforts, the VIM Clinic anticipates on-going financial support from the community through such efforts as an annual fund-drive, corporate giving, employer contributions plans, and a series of special events to be held throughout the year.

At the national level, the Volunteers in Medicine Clinic will continue to approach foundations and corporations for grants and contributions.

The following donor categories have been designed to offer flexible funding opportunities for individual and corporate contributors:

VIM Founder's Circle \$10,000 and over
 VIM Partner \$5,000 - \$9,999
 VIM Gold Patron \$2,500 - \$4,999
 VIM Silver Patron \$1,000 - \$2,499
 VIM Bronze Patron \$100 - \$1,000
 VIM Friend up to \$100

An employer donation program entitled "Fair Share Payer" suggests employer donations based on the number of employees who will utilize the VIM Clinic for his/her medical care.

The Funding

VIM CLINIC

VOLUNTEERS IN MEDICINE

HILTON HEAD ISLAND, SOUTH CAROLINA

* The Volunteers in Medicine Clinic is a recognized 501(c)(3) authorized charitable organization. All contributions are tax deductible.

Post Office Box 23287
 Hilton Head Island, S.C. 29925-3287
 Phone: (803) 681-6612
 Fax: (803) 681-6614

VIM VOLUNTEERS
 IN MEDICINE
CLINIC

For more information on the VIM Clinic*:

The Clinic

The Volunteers in Medicine (VIM) Clinic is a non-profit volunteer staffed and operated free medical clinic being established to provide health and wellness services to the medically underserved who live or work on Hilton Head Island and Daufuskie Island.

A number of business and civic professionals on the Islands and around the state, as well as leaders from the medically underserved community have joined with retired medical professionals to develop the VIM Clinic and help it become a reality.

The Mission

The primary mission of the Volunteers in Medicine Clinic is to understand and serve the health and wellness needs of the medically underserved population living and/or working on Hilton Head Island and Daufuskie Island.

Perhaps the vision statement for the Volunteers in Medicine Clinic best explains its direction:

May we have eyes to see those who are rendered invisible and excluded,

Open arms and hearts to reach out and include them,

Healing hands to touch their lives with love,

And in the process heal ourselves.

The Volunteers

MEDICAL PROFESSIONALS

More than 100 medical professionals (doctors, dentists, nurses and other specialists) living in the area will donate their services to the Clinic. These volunteer medical personnel will be augmented by currently practicing professionals who have indicated a desire to contribute their time and donate their services to the VIM Clinic.

In addition to primary care, the following specialties will be represented at the Clinic:

Allergy	Obstetrics/Gynecology	Psychiatry
Anesthesiology	Ophthalmology	Radiology
Dermatology	Orthopaedics	Surgery
General Practice	Pathology	Urology
Internal Medicine		

COMMUNITY VOLUNTEERS

The community volunteers are a critical and significant factor in the success of the VIM Clinic. The VIM volunteers will be considered "partners in care" as they greet patients and escort them through the patient care process, offer explanation of Clinic procedures and services and let Clinic patients know that someone hears their problems and cares about them as individuals. Community volunteers will also provide operational and administrative support for the Clinic.

The Contribution

YES! I am interested in making a contribution to the Volunteers in Medicine Clinic.

I. I have enclosed:

- () My tax deductible gift* of \$ _____
() A matching gift form from: _____

II. I pledge to contribute \$ _____ during the calendar year 1993.

Please send me reminders: () monthly () quarterly

() specified dates: _____

III. I would like to become a Volunteers In Medicine Donor.
(Contribution levels described on reserve side)

- () VIM Friend \$ _____
() VIM Bronze Patron \$ _____
() VIM Silver Patron \$ _____
() VIM Gold Patron \$ _____
() VIM Partner \$ _____
() VIM Founder's Circle \$ _____

The Need

It is estimated that approximately 15% of the residents of Hilton Head Island and Daufuskie Island and a large majority of the workforce which commutes to the Island now receive little or no primary health care services. Reports indicate that a significant number of children entering school in South Carolina have never been seen by a physician.

The VIM Clinic will serve those who live or work on Hilton Head Island and Daufuskie Island who are presently medically underserved. This population includes those persons who now receive little or no medical care.

Preliminary census studies indicate approximately 7000-8000 persons who may be categorized as medically underserved in this area.

The Services

The Volunteers in Medicine Clinic will not be a full-service clinic nor will it offer the services of a hospital. The VIM Clinic will provide routine medical care, with the scope of its activities to include the following services:

- primary health services
- community wellness issues of the medically underserved
- physical examinations
- shots and vaccinations
- pre-natal and well baby clinics
- eye examinations
- dental care

A primary function of the Clinic will be screening and referral to more comprehensive local and regional medical and social resources when deemed appropriate.

The Facility

The VIM Clinic is slated open in the fall of 1993. The Town of Hilton Head Island has granted the VIM Clinic a 30-year lease of a 1.1 acre lot on which the Clinic facility will be built. The location, on the corner of Palmetto Parkway and Northridge Drive (north end of Hilton Head Island) provides for easy access by those who will be served by the VIM Clinic. The hours of operation will be adjusted to accommodate the needs of the patient population.

The facility and its staff are covered by the Joint Underwriters Association. This Association has provided full malpractice insurance coverage for all volunteers working in the VIM Clinic.

* Please make checks payable to: Volunteers in Medicine Clinic

NAME _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE () _____

BUSINESS NAME AND ADDRESS: _____

BUSINESS PHONE () _____



HIGH-QUALITY/LOW-COST PRIMARY HEALTH CARE

Our health care system may not be terminal but it needs some urgent attention. One of the critical problems the President highlighted was the shortage of primary care physicians. In contrast to Canada, with 50 percent of their physicians engaged in primary care, and England, with 70 percent, we have only 29 percent in the United States.

The President's suggestion was to decrease the number of specialty training programs and increase the number of primary care training programs. It would be unfortunate if we took that approach.

Even with our acknowledged shortcomings, our health care system is still the envy of the world. We have the highest quality clinical research and care in the world. Much of our well deserved reputation is due to the number and quality of our specialists.

We have created a physician specialty training system which will continue to turn out the best and brightest clinicians -- if we don't tinker with it. If we do, we will soon see an erosion of the sort of high-quality clinical specialty care and research which we and the world have learned to expect -- and which only our system is able to provide.

The President's suggestion to increase the number of primary care training programs makes sense as a long-term solution. But it will take decades before the impact of that approach will provide any significant benefit.

There is an approach to high-quality/low-cost primary care which could be undertaken almost immediately, does not involve tinkering with the present system, employs unused resources, and does not interfere with the major elements of the President's program. It is the use of retired medical personnel to provide primary health care for the medically underserved.

This suggestion is not made in a vacuum. A small group of individuals on Hilton Head, South Carolina has created The Volunteers in Medicine Clinic using retired medical personnel.



Our Mission is to understand and serve the health and wellness needs of the medically underserved who live or work on the island. We will provide a complete scope of primary health services including vaccinations, physicals, primary care, special diagnostic and therapeutic clinics, minor surgery, eye care, hearing care, and dental care -- all free of charge!

The services will be delivered by the retired medical personnel who live on Hilton Head. To date 57 physicians, 12 dentists, and 90 nurses have enrolled in the program. In addition, 74 community members have volunteered their services. All of them serving without compensation.

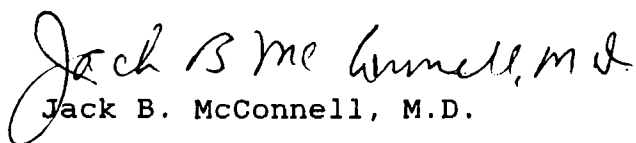
While Hilton Head has a generous supply of retired medical personnel, the clinic is being developed so it can be replicated anywhere in the United States by one physician and one nurse.

The United States is ignoring a valuable resource. Thousands of mature, experienced and caring physicians, dentists and nurses could be available almost immediately to provide primary health care.

If President Clinton established a small incentive -- perhaps forgiveness of a portion of the taxes of their savings plan stretched out over eight or ten years -- a pool of 100,000 or more retired physicians could be created almost immediately to take on the primary care dilemma for the country. In exchange for the tax advantage the physicians would be required to work half-time free-of-charge in a not-for-profit primary health clinic.

Equipment, materials, and pharmaceuticals will be essential, and an incentive tax advantage could be provided for those companies who contribute these items to the clinics.

I would be delighted to show you The Hilton Head Volunteers in Medicine Clinic and discuss the idea with you further if you are interested.

A handwritten signature in cursive script that reads 'Jack B. McConnell, M.D.'
Jack B. McConnell, M.D.

Free Clinic Provides Model for Nation

By LINDSEY GRUSON

Special to The New York Times

HILTON HEAD, S.C. — Every time Dr. Jack B. McConnell left his dream home here for the brief drive to the store, he passed through a nightmare.

The three-mile trip took him past his yacht club and golf club to roads lined with leaky clapboard houses without heat, running water or sewage disposal.

"It's a short drive, but a hell of a long journey," said the 68-year-old doctor, who moved here four years ago from New Jersey after retiring as corporate director of advanced technology for Johnson & Johnson. "Sitting cheek by jowl, you couldn't ignore the squalor. I couldn't drive by it and not ask why?"

What began as a gnawing question has now turned into a clinic where volunteer doctors, most of them retired, began this summer to offer free medical care from a temporary office to residents of this seaside slice of

Retired doctors show a way to cut medical costs.

South Carolina studded with pines and palmettos.

'Model for the Nation'

"It's a tremendous thing, a model for the nation," said Gov. Carroll A. Campbell Jr., who helped pass legislation enabling the clinic to operate without buying expensive malpractice insurance. "This is people, not government, solving the problem. This is really what we ought to be doing around the country."

Even people with health insurance through an employer have chosen the clinic when the insurance policy fails to

cover full costs. "My eyes nearly fell out of my head when my pediatrician told me his prices," said Maile Roberson, who moved here last month from Nevada with her husband, Jeff.

Mrs. Roberson said medical bills were breaking the family's tight budget even though her husband had health insurance through his job as chief of engineering at the Hyatt Hotel, one of the most luxurious resorts on this sandal-shaped island. So she recently took their 18-month-old son, Tyler, to the clinic for an examination and vaccination.

The center, Volunteers in Medicine, is staffed almost entirely by 200 retired doctors and other medical professionals, many of whom say the attraction is liberation from the fear of malpractice suits and insurance companies' mountainous paperwork. The bulk of the equipment and supplies are donated.

"This brings me back to my true love," said Dr. Sherman Gans, a 57-year-old volunteer who moved here three years ago after selling his Bronx dental practice. "I retired from 30 years of raising and supporting a family to a second honeymoon and a life of recreation. But no matter how wonderful recreation is, the dentistry spark is still there. Now I can put my life back together."

The clinic is intended to serve as a prototype for other communities. If copied around the nation, organizers say it would slash the nation's health care bill. Even better, they say, it would create a reservoir of desperately needed family doctors overnight, finessing onerous proposals to force young doctors into general practice by curtailing the training of specialists.

From Skeptic to Supporter

"What's needed is to increase the number of people providing primary care without cutting our noses off," Dr. McConnell said. "It would be a pity to solve our problem by destroying the most advanced health care system in the world, the envy of the world, when, at a very modest cost, you can create a pool of physicians practicing for free. And best of all, you haven't tinkered with our strengths and you've kept the government out of health care."

Dr. McConnell notes that about 120,000 doctors retire every year, about the same number of students that an-



Wade Speers for The New York Times

The Volunteers in Medicine clinic in Hilton Head, S.C., is staffed mostly by retired doctors and medical professionals. Maryann DeYoung, a nurse, gave Chandler Almond her shots as her mother, Beth, waited.

nually graduate from medical school. He says many of the retirees can be enticed into returning to medicine's front lines by exempting them from malpractice suits, as states already do for doctors who stop to help victims of highway accidents.

Supporters say the clinic will help reduce expenses at the local hospital, which has cared for many uninsured patients. Steven A. Caywood, president and chief operating officer of the Hilton Head Hospital, said it cost his emergency room more than 20 times as much as Dr. McConnell's clinic to treat a developing case of pneumonia. "The person isn't going to get out of here without a couple hundred dollars in tests," Mr. Caywood said.

Dr. Paul Long, an internist who has practiced on the island for 18 years, said that he had been a skeptic, like the rest of the local medical community, but that he was now an ardent supporter.

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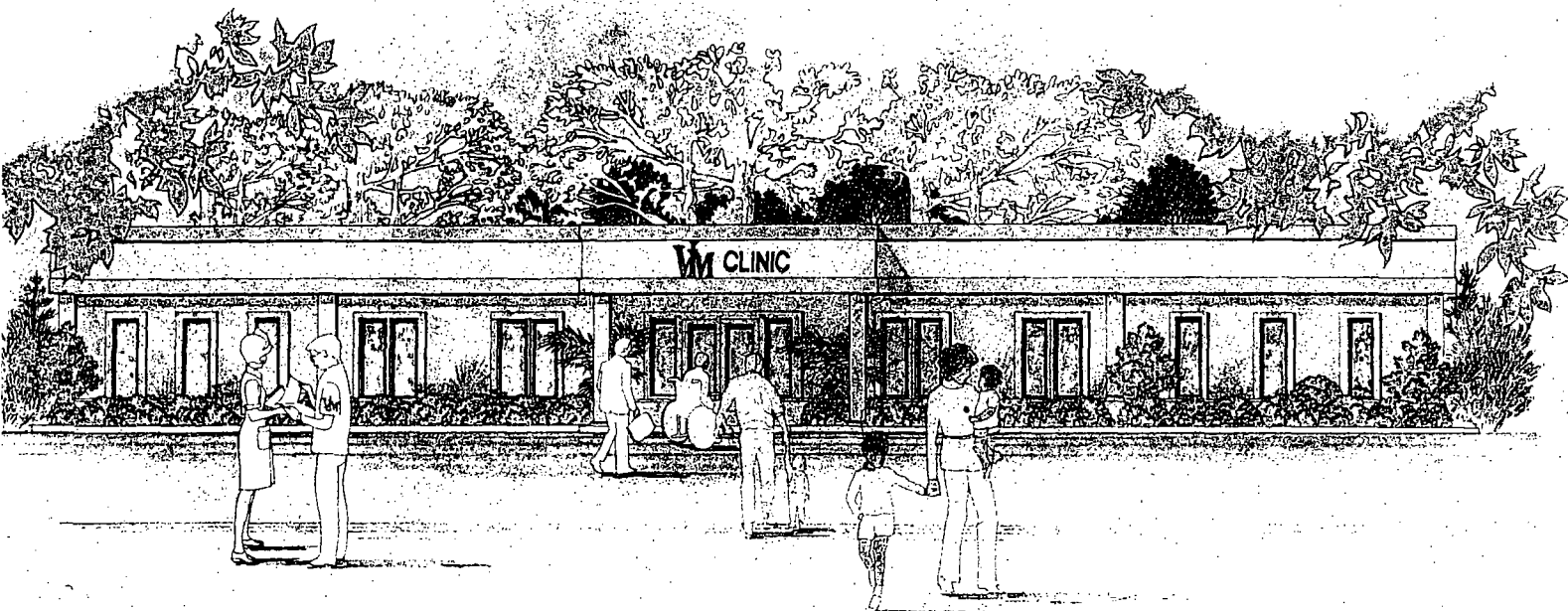
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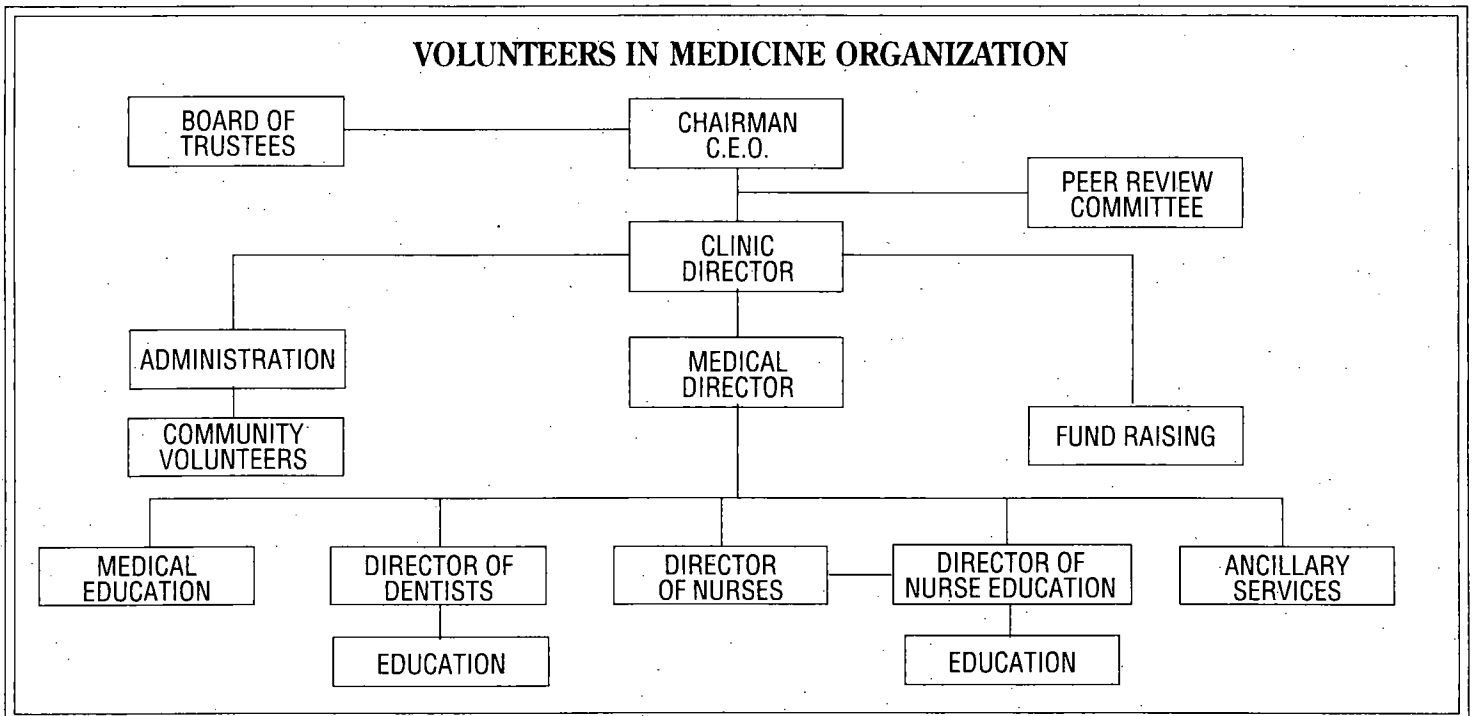
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VIM
CLINIC VOLUNTEERS
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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	From: Jennifer Klein, To: Hillary Rodham Clinton, Re: Telephone Calls [partial] (1 page)	2/18/94	b(7)(E)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

J. Klein

TO: Hillary Rodham Clinton
FROM: Jennifer Klein *J. Klein*
DATE: 2/18/94
RE: Telephone Calls

I spoke this week with Drs. Jeffrey Lindenbaum and Jack McConnell to follow up on letters that they had written to you.

002

(b)(7)e
You had asked us to ask Andrew Friendly if the President met him. The President did not meet him this year but did last year. Dr. Lindenbaum is concerned about primary care providers. He was not particularly interested in hearing about the Health Security Act's emphasis on prevention and on the workforce initiatives to increase the supply of primary care providers. He really just wanted to be heard.

I spoke with Dr. McConnell, the Chairman of the Volunteers in Medicine Clinic, at length about his program and about the Health Security Act. Through the Volunteers in Medicine Clinic, retired health care professionals provide basic medical services to low-income individuals in the community at no charge. Approximately 60 physicians, 75 nurses and 13 dentists currently volunteer at the clinic. Dr. McConnell told me that 22 communities in 19 states are planning to open similar clinics. I have more detailed information about the funding and operation of the clinic if you are interested.

Both were extremely pleased that you had made the effort to follow through. I told them to feel free to contact me with any further comments or questions.

Jennifer - HRC
would like some-
one to call
Dr. McConnell.
Who should do
that? She saw
him at Renaissance
Pam

THE WHITE HOUSE

January 10, 1994

Jack B. McConnell, M. D.
Chairman
Volunteers in Medicine Clinic
P. O. Box 23287
Hilton Head Island, SC 29923

Dear Dr. McConnell:

Congratulations on the success of the
Volunteers in Medicine program. It makes
eminent sense, and from what I read in the
New York Times article, benefits everyone
involved.

I will pass on your packet of
materials to the Office of Policy
Development and have someone contact you
for more specific information.

With best wishes for the New Year and
continued success with VIM, I am

Sincerely yours,


Hillary Rodham Clinton

cc: Office of Policy Development

It was great visiting
with you -

Free Clinic Provides Model for Nation

By LINDSEY GRUSON

Special to The New York Times

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"This brings me back to my true love," said Dr. Sherman Gans, a 57-year-old volunteer who moved here three years ago after selling his Bronx dental practice. "I retired from 30 years of raising and supporting a family to a second honeymoon and a life of recreation. But no matter how wonderful recreation is, the dentistry spark is still there. Now I can put my life back together."

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VOLUNTEERS IN MEDICINE CLINIC

*Plan - do letter coversats on project
etc + get someone to call*

Jack B. McConnell, M.D.
Chairman

to get specimens

P.O. Box 23287, Hilton Head Island, South Carolina 29925
Telephone (803) 681-6612 Fax (803) 681-6614

Home phone - 803-681-9348

PHOTOCOPY
HRC HANDWRITING

HILTON HEAD ISLAND, SOUTH CAROLINA

VOLUNTEERS IN MEDICINE



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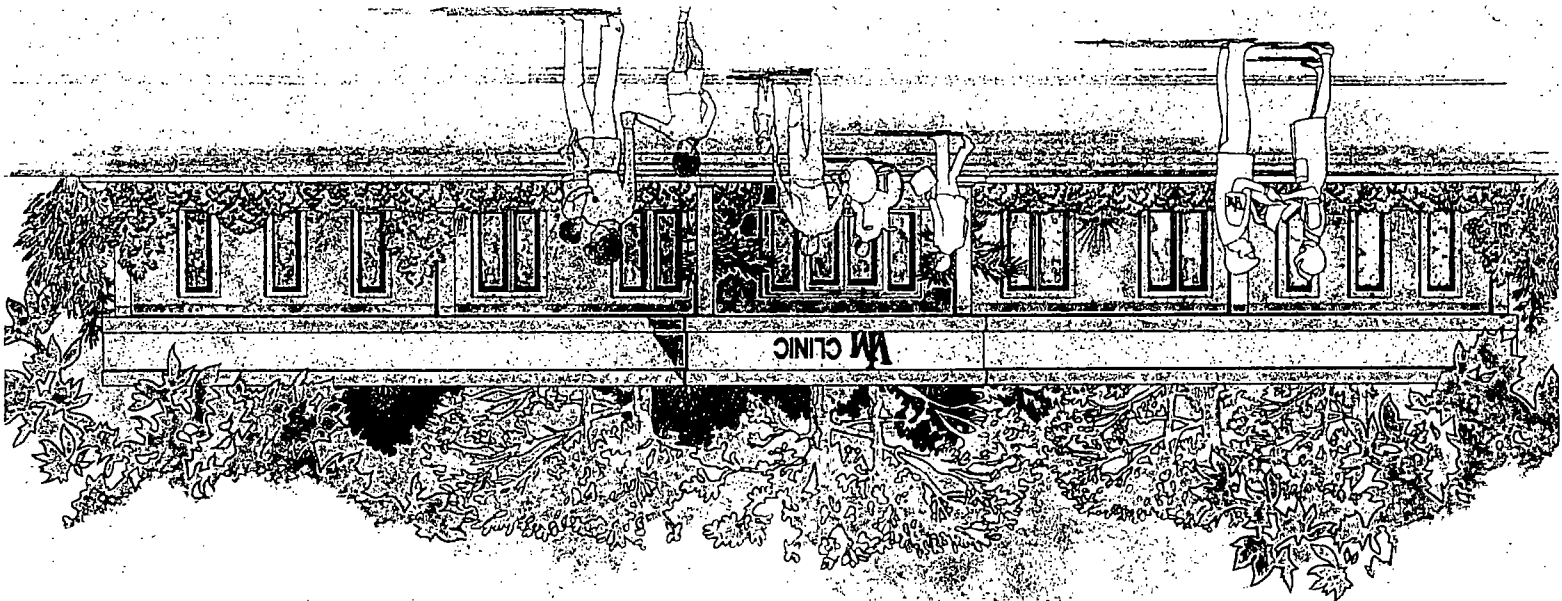
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For more information on the VIM Clinic*:



Post Office Box 23287
Hilton Head Island, S.C. 29925-3287
Phone: (803) 681-6612
Fax: (803) 681-6614

* The Volunteers in Medicine Clinic is a recognized 501(c) (3) authorized charitable organization. All contributions are tax deductible.



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The Contribution

YES! I am interested in making a contribution to the Volunteers in Medicine Clinic.

I. I have enclosed:

- () My tax deductible gift* of \$ _____
- () A matching gift form from: _____

II. I pledge to contribute \$ _____ during the calendar year 1993.
Please send me reminders: () monthly () quarterly

() specified dates: _____

III. I would like to become a Volunteers In Medicine Donor.
(Contribution levels described on reserve side)

- () VIM Friend \$ _____
- () VIM Bronze Patron \$ _____
- () VIM Silver Patron \$ _____
- () VIM Gold Patron \$ _____
- () VIM Partner \$ _____
- () VIM Founder's Circle \$ _____

The Need

It is estimated that approximately 15% of the residents of Hilton Head Island and Daufuskie Island and a large majority of the workforce which commutes to the Island now receive little or no primary health care services. Reports indicate that a significant number of children entering school in South Carolina have never been seen by a physician.

The VIM Clinic will serve those who live or work on Hilton Head Island and Daufuskie Island who are presently medically underserved. This population includes those persons who now receive little or no medical care.

Preliminary census studies indicate approximately 7000-8000 persons who may be categorized as medically underserved in this area.

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A primary function of the Clinic will be screening and referral to more comprehensive local and regional medical and social resources when deemed appropriate.

The Facility

The VIM Clinic is slated open in the fall of 1993. The Town of Hilton Head Island has granted the VIM Clinic a 30-year lease of a 1.1 acre lot on which the Clinic facility will be built. The location, on the corner of Palmetto Parkway and Northridge Drive (north end of Hilton Head Island) provides for easy access by those who will be served by the VIM Clinic. The hours of operation will be adjusted to accommodate the needs of the patient population.

The facility and its staff are covered by the Joint Underwriters Association. This Association has provided full malpractice insurance coverage for all volunteers working in the VIM Clinic.

* Please make checks payable to: Volunteers in Medicine Clinic

NAME _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE () _____

BUSINESS NAME AND ADDRESS: _____

BUSINESS PHONE () _____



HIGH-QUALITY/LOW-COST PRIMARY HEALTH CARE

Our health care system may not be terminal but it needs some urgent attention. One of the critical problems the President highlighted was the shortage of primary care physicians. In contrast to Canada, with 50 percent of their physicians engaged in primary care, and England, with 70 percent, we have only 29 percent in the United States.

The President's suggestion was to decrease the number of specialty training programs and increase the number of primary care training programs. It would be unfortunate if we took that approach.

Even with our acknowledged shortcomings, our health care system is still the envy of the world. We have the highest quality clinical research and care in the world. Much of our well deserved reputation is due to the number and quality of our specialists.

We have created a physician specialty training system which will continue to turn out the best and brightest clinicians -- if we don't tinker with it. If we do, we will soon see an erosion of the sort of high-quality clinical specialty care and research which we and the world have learned to expect -- and which only our system is able to provide.

The President's suggestion to increase the number of primary care training programs makes sense as a long-term solution. But it will take decades before the impact of that approach will provide any significant benefit.

There is an approach to high-quality/low-cost primary care which could be undertaken almost immediately, does not involve tinkering with the present system, employs unused resources, and does not interfere with the major elements of the President's program. It is the use of retired medical personnel to provide primary health care for the medically underserved.

This suggestion is not made in a vacuum. A small group of individuals on Hilton Head, South Carolina has created The Volunteers in Medicine Clinic using retired medical personnel.



Our Mission is to understand and serve the health and wellness needs of the medically underserved who live or work on the island. We will provide a complete scope of primary health services including vaccinations, physicals, primary care, special diagnostic and therapeutic clinics, minor surgery, eye care, hearing care, and dental care -- all free of charge!

The services will be delivered by the retired medical personnel who live on Hilton Head. To date 57 physicians, 12 dentists, and 90 nurses have enrolled in the program. In addition, 74 community members have volunteered their services. All of them serving without compensation.

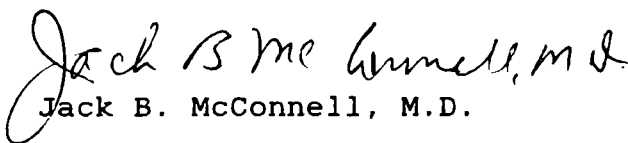
While Hilton Head has a generous supply of retired medical personnel, the clinic is being developed so it can be replicated anywhere in the United States by one physician and one nurse.

The United States is ignoring a valuable resource. Thousands of mature, experienced and caring physicians, dentists and nurses could be available almost immediately to provide primary health care.

If President Clinton established a small incentive -- perhaps forgiveness of a portion of the taxes of their savings plan stretched out over eight or ten years -- a pool of 100,000 or more retired physicians could be created almost immediately to take on the primary care dilemma for the country. In exchange for the tax advantage the physicians would be required to work half-time free-of-charge in a not-for-profit primary health clinic.

Equipment, materials, and pharmaceuticals will be essential, and an incentive tax advantage could be provided for those companies who contribute these items to the clinics.

I would be delighted to show you The Hilton Head Volunteers in Medicine Clinic and discuss the idea with you further if you are interested.


Jack B. McConnell, M.D.

Free Clinic Provides Model for Nation

By LINDSEY GRUSON

Special to The New York Times

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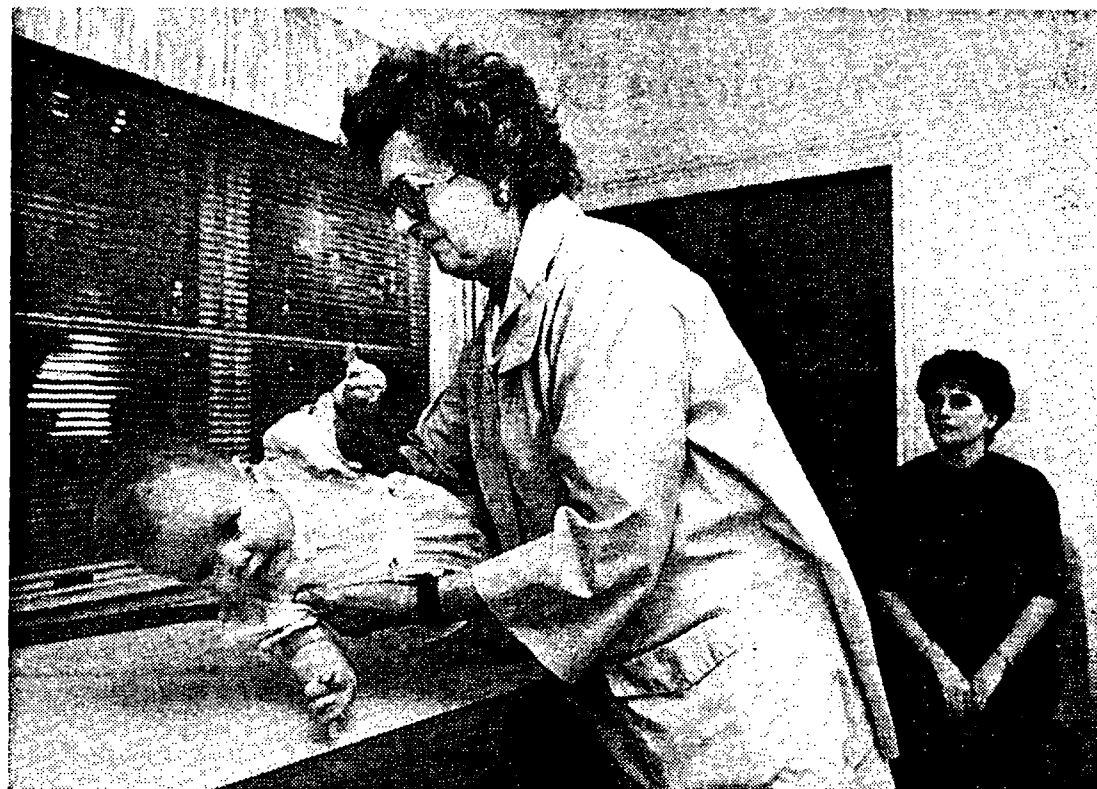
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Wade Speers for The New York Times

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Dr. Paul Long, an internist who has practiced on the island for 18 years, said that he had been a skeptic, like the rest of the local medical community, but that he was now an ardent supporter.

"It's the greatest thing since toasted bread," Dr. Long said. "There's nothing bad — with religion, mother nature, good ripe apples, flowers in spring, or this. It's first-class medical care without the taint of financial considerations."

The clinic, temporarily housed in a building donated by the town hospital, is still raising money to build a permanent home. At that time organizers plan to be more aggressive in marketing the free medical care. Already, there is interest from other states. Officials at Catholic Charities and St. Peter's Medical Center, a 416-bed community teaching hospital in New Brunswick, N.J., say they are developing plans for a similar clinic in central New Jersey.

Dr. McConnell acknowledges that, unlike this seaside resort, many areas of the country do not have enough retired medical people to run a full-service clinic. But he said that even a

smaller staff of retired medical people could offer some care. Still, he worries that the idea's implementation could be counterproductive, providing a strong incentive for employers to drop their employees' health insurance coverage and for "the greedy to pretend to be needy" in large numbers.

The state medical establishment has expressed concerns about insuring the continuing competence and medical currency of the aging staff, many of whom were trained decades ago. But supporters of the center say the potential problems are insignificant compared with the benefits.

"This is fantastic and very much needed," said Thomas Barnwell Jr., a third-generation native of Hilton Head and community organizer who is building low-income housing. "It's going to be the glue of this community. It's going to bring people together, bind them together and glue them together like nothing before."

NYNEX
300 East Washington Street, Syracuse, NY 13202
Tel 315 477.1967

Stephen G. McDermott
Vice President and General Manager

NYNEX

April 8, 1994

**Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500**

Dear Mrs. Clinton,

It was a pleasure to be at Syracuse University as part of the audience for the demonstration of telemedicine you participated in and to hear you speak afterwards. Like you, I am amazed at the technology that allows doctors to share medical images, data and video-communications. Even more amazing is the fact that the technology is here today and yet the vast majority of Americans don't have access to it because of Laws and regulations that are ten years out of date.

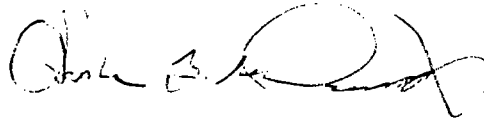
I am encouraged by the Clinton Administration's support of the concept of the Information Superhighway. You saw it work. You know that it can improve medical care while lowering costs. We find in the Markey-Fields bill (H.R. 3636), and in the version of the Brooks-Dingell bill (H.R. 3626) that was recently voted out of the House Energy and Commerce Committee, the policy which will encourage the Regional Bell Operating Companies to build the superhighway. Taxpayers should not have to fund a project that industry is willing to tackle.

In the Hollings bill (S. 1822) we have public policy which, in fact, will delay the advent of the superhighway by discouraging RBOC infrastructure investment within their home market areas. This can only hurt the national and local economies.



Thank you for visiting Syracuse and taking the time to see this revolutionary collaboration between Syracuse University, NYNEX Corporation and the other NYNET participants. Please feel free to contact NYNEX for further demonstrations of the new telecommunications technology.

Sincerely,

A handwritten signature in black ink, appearing to read "Charles B. Quinn". The signature is fluid and cursive, with a large, prominent loop at the end.

cc: Mr. Moynihan

Stephen G. McDermott
Vice President and General Manager



April 8, 1994

**The Honorable Patrick J. Moynihan
The United States Senate
464 Senate Russell Office Building
Washington, D.C. 20510**

Dear Senator Moynihan:

It was a pleasure to be with you at Syracuse University for a demonstration of telemedicine. The technology that allows doctors to share medical images, data and video communications is amazing. Even more amazing is the fact that the technology is here today and yet the vast majority of Americans don't have access to it because of laws and regulations that are ten years out of date.

I am encouraged at how the concept of the Information Superhighway has captured the national imagination. You saw it work. You know that it can improve medical care while lowering costs. We find in the Markey-Fields bill (H.R. 3636), and in the version of the Brooks-Dingell bill (H.R. 3626) that was recently voted out of the House Energy and Commerce Committee, the policy which will encourage the Regional Bell Operating Companies (RBOC's) to build the superhighway. Taxpayers should not have to fund a project that industry is willing to tackle.

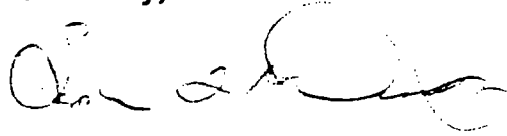
In the Hollings bill (S.1822) we have public policy which, in fact, will delay the advent of the superhighway by discouraging RBOC infrastructure investment within their home market areas. This can only hurt the national and local economics.

Thank you for engineering Mrs. Clinton's visit to Syracuse and taking the time to see this revolutionary collaboration between Syracuse University, NYNEX Corporation and the other NYNet participants. I am hopeful of the opportunity to meet with you and Morgan Kennedy, of NYNEX's Government Relations group, to further demonstrate how the NYNet project can serve New York's economy.



It has the potential to make both our service and manufacturing sectors much more competitive with other states and nations. Morgan will call your office to try to arrange a further demonstration of this remarkable technology.

Sincerely,

A handwritten signature in black ink, appearing to be "D. Morgan", written in a cursive style.

cc: Hillary Clinton

THE WHITE HOUSE

WASHINGTON

December 2, 1994

Ms. Abbey S. Meyers
National Organization for
Rare Disorders
100 Route 37
P.O. Box 8923
New Fairfield, CT 06812-8923

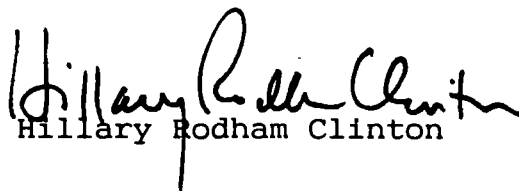
Dear Ms. Meyers:

Thank you for writing to share your ongoing support for health care reform and for your outstanding efforts to help Americans with rare "orphan diseases." Your educational, research, networking and advocacy programs are an invaluable part of ensuring access to high quality health care for the more than twenty million Americans living with rare disorders.

As you know, Congress was unable to pass health care legislation this year. Well-financed special interests have fought for sixty years to prevent health care reform and, over the past year, have waged an unprecedented battle. And yet, because of the will of the President, the courage of some members of Congress and the support of people like you, we have put health reform on the national agenda and begun a thoughtful discussion about how to reform our health care system.

Thank you again for writing on behalf of people with rare disorders. The President and I hope that we may continue to count on your support when we return next year to fight for meaningful health care reform.

Sincerely yours,


Hillary Rodham Clinton

VIP
LEFF

National Organization for Rare Disorders, Inc.®

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(203) 746-6518 • FAX (203) 746-6481 • TDD (203) 746-6927



... out of the darkness,
into the light ... ®

September 30, 1994

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20503

Dear Mrs. Clinton:

On behalf of twenty million Americans with rare "orphan diseases," I want to thank you for all your work and effort for health care reform. A few months ago, when I stood with you on the stage of the Humphrey Building with other members of the National Health Council, I was proud that you were leading the reform effort and grateful that the President had focused the nation's conscience on the needless human suffering caused by our current inequitable health system. We are profoundly saddened that Congress failed to come to a consensus.

When Senator Mitchell announced that health care reform was dead, he wrote the obituary for thousands of Americans who will continue to have no access to health care until reform is enacted. People with pre-existing conditions, people with hereditary diseases, people who cannot afford to pay for insurance are counting on you not to give up, and to keep this issue at the top of the 1995 congressional agenda.

We pledge our support and commitment to health care reform. We want you to know that you can count on us next year, or for as many years as it takes to rebuild our health care system.

Very truly yours,

Mrs. Abbey S. Meyers
President

ASM:aa

- Member Organizations:
- Alliance of Genetic Support Groups
- Alpha, Antitrypsin Deficiency National Association
- ALS Association
- American Brain Tumor Association
- American Porphyria Foundation
- American Society of Adults with Pseudo-Obstruction, Inc. (ASAP)
- American Syringomyelia Alliance Project, Inc.
- Aplastic Anemia Foundation of America
- Association for Glycogen Storage Disease
- Batten Disease Support & Research Association
- Benign Essential Blepharospasm Research Foundation, Inc.
- Carpal Tunnel Syndrome/RSI Association
- Charcot-Marie-Tooth Association
- Chromosome 18 Registry and Research Society
- Cornelia de Lange Syndrome Foundation, Inc.
- Cystinosis Foundation, Inc.
- Dysautonomia Foundation, Inc.
- Dystonia Medical Research Foundation
- Dystrophic Epidermolysis Bullosa Research Assoc. (D.E.B.R.A.)
- Ehlers-Danlos National Foundation
- Epilepsy Foundation of America
- Families of Spinal Muscular Atrophy
- Fanconi Anemia Research Fund, Inc.
- Foundation for Ichthyosis & Related Skin Types, Inc. (F.I.R.S.T.)
- Guillain-Barre Syndrome Foundation International
- Hemochromatosis Research Foundation, Inc.
- Hereditary Disease Foundation
- Histiocytosis Association of America
- Human Growth Foundation
- Huntington's Disease Society of America, Inc.
- Immune Deficiency Foundation
- Inclusion Body Myositis Association
- International Fibrodysplasia Ossificans Progressiva (F.O.P.) Assoc., Inc.
- International Joseph Diseases Foundation, Inc.
- International Rett Syndrome Association
- Interstitial Cystitis Association of America, Inc.
- Lowe's Syndrome Association
- Malignant Hyperthermia Association of the United States
- Meniere's Network (EAR Foundation)
- Myasthenia Gravis Foundation
- Myeloproliferative Disease Center
- Narcolepsy Network, Inc.
- National Adrenal Diseases Foundation
- National Alopecia Areata Foundation
- National Ataxia Foundation
- National Chronic Fatigue Syndrome and Fibromyalgia Association
- National Foundation for Ectodermal Dysplasias
- National Fragile X Foundation
- National Leigh's Disease Foundation
- National Marfan Foundation
- National Mucopolysaccharidoses Society, Inc.
- National Multiple Sclerosis Society
- National Neurofibromatosis Foundation
- National PKU News
- National Retinitis Pigmentosa Foundation, Inc.
- National Sjogren's Syndrome Association
- National Spasmodic Torticollis Association (NSTA)
- National Tay-Sachs & Allied Diseases Association, Inc.
- National Tuberos Sclerosis Association, Inc.
- National Urea Cycle Disorders Foundation
- National Vitiligo Foundation, Inc.
- Neurofibromatosis, Inc.
- Obsessive Compulsive Foundation
- Osteogenesis Imperfecta Foundation
- Oxalosis and Hyperoxaluria Foundation
- Paget Foundation
- Parkinson's Disease Foundation, Inc.
- PKR Foundation
- Prader-Willi Syndrome Association
- Reflex Sympathetic Dystrophy Syndrome Association
- Scleroderma Federation, Inc.
- Scleroderma Info Exchange, Inc.
- Sickle Cell Disease Association of America, Inc.
- Sjogren's Syndrome Foundation, Inc.
- Tourette Syndrome Association, Inc.
- Tongue-tie Syndrome Association
- United Leukodystrophy Foundation, Inc.
- United Parkinson Foundation
- United Patients' Association for Pulmonary Hypertension, Inc.
- Vestibular Disorders Association
- VHL Family Alliance
- Wegener's Granulomatosis Support Group, Inc.
- Williams Syndrome Association
- Wilson's Disease Association

Associate Members

- | | | | | | |
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| Alcaldi Syndrome Newsletter, Inc. | Center for Research in Sleep Disorders | Family Caregiver Alliance | L I F T (Living in Faith Together) | Parent to Parent of New Zealand | Sotos Syndrome Support Group |
| ALS Association/Greater Philadelphia Chapter | Charcot-Marie-Tooth International | Footsteps Institute | Lyme Disease Foundation | Recurrent Respiratory Papillomatosis Foundation | Sturge-Weber Foundation |
| American Bahcet's Association, Inc. | Children's Leukemia Foundation/MI | Freeman-Sheldon Parent Support Group | MR. Rogers Community Mental Health and Mental Retardation Service Board | Research Trust for Metabolic Diseases in Children/England | Tourette Syndrome Association of MD, DC, & VA |
| American Pseudo-Obstruction & Hirschsprung Disease Society, Inc. | Christina Lazar Foundation for Juvenile Laryngeal Papillomatosis | Help Hospitalized Children's Fund | National Association for Pseudoexanthoma Elastica | Restless Legs Syndrome Foundation | Tourette Syndrome Association of OH |
| American Self-Help Clearinghouse | Chronic Granulomatous Disease Assoc. Inc. | HHT Foundation International, Inc. | National Coalition for Research in Neurological & Communicative Disorders | Sarcoidosis Research Institute | Treacher Collins Foundation |
| Arc of Ohio | Congenital Adrenal Hyperplasia Support Assoc. Inc. (CAHSA) | JCM Resource Center | National Cushings Association | Shy-Drager Syndrome Support Group | Vaincre les Maladies Lysozymales/France |
| Association for Children with Russell-Silver Syndrome, Inc. | Earl J. Goldberg Aplastic Anemia Foundation | Just for the Kids of NPC, Inc. | National Niemann Pick Disease Foundation | Sickle Cell Association of the Texas Gulf Coast | West Central Head Start |
| Ataxia Telangiectasia Children's Project | | Klippel-Trenaunay Support Group | Parent to Parent of GA, Inc. | Society for Progressive Supranuclear Palsy, Inc. | |
| | | Leishman Society for Rare Disorders/Canada | | | |

*Associations are joining continuously. For newest listing, please contact the NORD office

Dedicated to Helping People with Orphan Diseases



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PO Box 8923
New Fairfield, CT 06812-8923
Phone: (203) 746-6518

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- Alpha, Antitrypsin Deficiency National Association
- ALS Association
- American Brain Tumor Association
- American Hemophilia Foundation
- American Society of Adults with Periodic Obstruction, Inc. (ASAP)
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- Aplastic Anemia Foundation of America
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- Batten Disease Support & Research Association
- Benign Essential Tremor Research Foundation, Inc.
- Caprol Tunnel Syndrome/RS4 Association
- Charcot-Marie-Tooth Association
- Chromosome IR Registry and Research Society
- Council of Large Syndrome Foundation, Inc
- Cystinosis Foundation, Inc.
- Dysautonomia Foundation, Inc.
- Dystonia Medical Research Foundation
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- Immune Deficiency Foundation
- Inclusion Body Myositis Association
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- International Ocular Association of America, Inc.
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- Miller's Neuropathy (EAN) Foundation
- Nephrology Group Foundation
- Nephrology Hereditary Disease Center
- Neurology Network, Inc.
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- National Chronic Fatigue Syndrome and Fibromyalgia Association
- National Foundation for Hereditary Dysplasia
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- National Tuberculosis Sclerosis Association, Inc.
- National Urea Cycle Disorders Foundation
- National Willing Foundation, Inc.
- Neuronal Ceroidosis, Inc.
- Obsessive Compulsive Foundation
- Oesophagus Imperforata Foundation
- Orphanic and Hyperbilirubinemia Foundation
- Paget Foundation

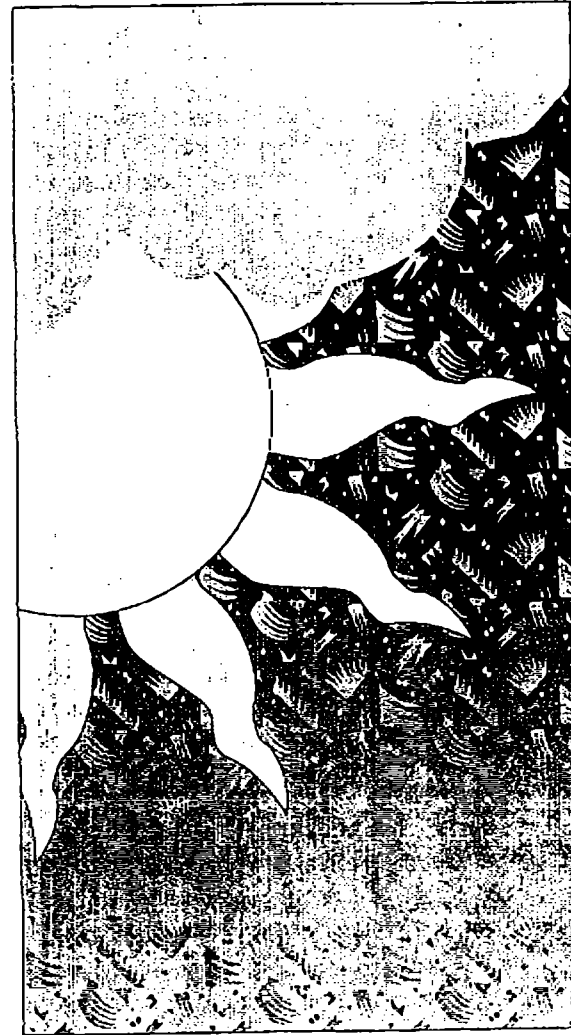
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- Parkinson's Disease Foundation, Inc.
- PSH
- Prader-Willi Syndrome Association
- Reflex Sympathetic Dystrophy Syndrome Assn.
- Scleroderma Federation, Inc.
- Scleroderma Info Exchange, Inc.
- Sicke Cell Disease Association of America, Inc.
- Sjogren's Syndrome Foundation, Inc.
- Tourette Syndrome Association, Inc.
- Trigeminal Neuralgia Association
- United Leukodystrophies Foundation, Inc.
- United Parkinson Foundation
- United Patients' Association for Pulmonary Hypertension, Inc.
- Vestibular Disorders Association
- Will Family Alliance
- Wegener's Granulomatosis Support Group, Inc.
- Williams Syndrome Association
- Wilson's Disease Association

ASSOCIATE MEMBERS:

- Aicardi Syndrome Knowledge, Inc.
- ALS Association/Greater Philadelphia Chapter
- American Behon's Association, Inc.
- American Bicuspid Aortic Valve & Aortic Dissection Society, Inc.
- American Self-Help Clearinghouse
- Art of Obit
- Association for Children with Russell-Silver Syndrome, Inc.
- Alexa Tefft/Janet's Children's Project
- Center for Research in Sleep Disorders
- Charcot-Marie-Tooth International
- Children's Leukemia Foundation/MI
- Christian Lutz Foundation for Juvenile Laryngeal Papillomatosis
- Chronic Granulomatous Disease Assoc. Inc.
- Earl J. Goldberg/Leishman's Anemia Foundation
- Family Caregiver Alliance
- Foster's Franchise
- Freeman Sheldon Parent Support Group
- Help Organized Children's Fund
- HHT Foundation International, Inc.
- Hydrophobia Association
- JCM Resource Center
- Just for the Kids of NPC, Inc.
- Klippel-Trenaunay Support Group
- Lathrop Society for Rare Disorders/Canada
- L.I.E.T. Living in Faith Together
- Lyme Disease Foundation
- Mt. Rogers Community Mental Health and Mental Retardation Service Board
- National Association for Pseudotumor Ectasia
- National Coalition for Research in Neurological & Communicative Disorders
- National Outlets Association
- National Niemann Pick Disease Foundation
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- Parent to Parent of New Zealand
- Recurrent Respiratory Papillomatosis Foundation
- Research Trust for Metabolic Diseases in Children/England
- Restless Legs Syndrome Foundation
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- Tourette Syndrome Association of OH
- Treacher Collins Foundation
- Tuberculous Sclerosis Association of IL
- United Les Maladies Neurosciences/France
- West Central Head Start

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NORD®
National Organization for Rare Disorders
PO Box 8923
New Fairfield, CT 06812-8923
Phone: (203) 746-6518



What Is NORD?

Mission Statement

The National Organization for Rare Disorders (NORD) is the federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. NORD is committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and service.

NORD—The Beginning

Began in 1983, NORD was an outgrowth of a unified effort by rare disease support groups who were determined to solve the "orphan drug" dilemma. Treatments for these disorders were not being developed by the pharmaceutical industry because they were "drugs of limited commercial value." Consequently, voluntary health agencies and support groups banded together to urge passage of federal legislation that would encourage pharmaceutical companies to develop "orphan drugs." In 1983, when the Orphan Drug Act was enacted, NORD formalized into a national non-profit health agency dedicated to the welfare of those with rare disorders.

Some Facts

Each rare disorder affects fewer than 200,000 people in the United States.

There are more than 5,000 orphan diseases affecting some 20 million Americans. One out of every 12 people suffers from a rare disorder.

NORD is unique. It is the only organization of its kind—a federation of more than 135 not-for-profit health organizations, and thousands of individuals and medical professionals—serving people with rare disorders throughout the world.

NORD Programs and Services

E ducation

NORD's primary program is education of the public and medical professionals. NORD is a worldwide clearinghouse for information about orphan diseases, answering more than 75,000 inquiries each year from throughout the world. The rare disease information is written in simple, understandable language so that patients and families can understand it. NORD's information is also made available to the public through our Rare Disease Database (RDB) which is available on the CompuServe electronic information system.

- The NORD literature order form lists more than 1,000 rare disorder entries from NORD's Rare Disease Database.
- NORD's book, *Physicians' Guide to Rare Diseases*, is a printed version of the database written in technical terminology for medical professionals.

R esearch

Besides advocating for increased government research funds, and referring patients to clinical trials and genetic investigators, NORD funds grants on new treatments for rare diseases. Clinical research has historically been underfunded, and NORD attempts to fill this void, creating hope for millions whose disorders are presently hopeless and untreatable.

F amily Programs

- NORD's "Networking Program" puts families with the same diagnosis in touch with each other. This helps people find mutual support and encourages the formation of new voluntary health agencies for specific diseases.
- NORD's Patient Services Program provides counseling and advice to people seeking help with accessing social services and learning about appropriate programs for people with disabilities.

- NORD's Medication Assistance Programs provide several free prescription drugs to needy patients who cannot afford treatments.

I nformation & Referral

NORD provides information to medical professionals, libraries, educators, corporations and individuals. NORD refers patients and families to appropriate sources of assistance and support. When patients are needed for clinical trials, we refer them to the researchers through NORD's confidential patient registry. NORD can usually locate patients with even the rarest diagnoses.

S upport Groups and Advocacy

- NORD provides technical assistance to support groups, helping them to start and grow with minimal waste of precious resources.
- NORD monitors implementation of the Orphan Drug Act and advocates for increased government funding of medical research. NORD participates in efforts to assure that people with disabilities maintain the rights and services they deserve.
- NORD is an advocate for the interests of all people with orphan diseases, helping to assure that government programs and services are available and accessible to patients and families.

T he NORD Story—Who Is Helped

- More than 75,000 people contact NORD directly each year for information and help.
- More than 210,000 people access NORD's Rare Disease Database (RDB) each year through CompuServe or on touch-screen computers in pharmacies and medical waiting rooms.
- Through NORD's Networking Program more than 7,000 families are linked to other families each year who have similar disorders.
- More than 4,000 financially needy individuals are provided critical, life-saving drug therapies through NORD's Medication Assistance Program each year.

- NORD's newsletter, *Orphan Disease Update*, is published three times annually. This newsletter is mailed to thousands of people throughout the world.

- NORD publishes the *Physicians' Guide to Rare Diseases*. This book enables physicians to find accurate and timely diagnostic information. One out of three individuals with a rare disease does not receive a correct diagnosis for up to five years, and one out of six wait more than six years.
- Sponsorship of an Annual Patient/Family Conference, which is aimed at providing help to patients and families who must cope with the impact of living with a rare disease. Information, networking opportunities and creating an environment of hope are the principal goals. NORD also convenes an Annual Membership Conference providing training and technical assistance to leaders of support groups and voluntary health agencies.

NORD Membership and Support

NORD is reliant on membership and charitable contributions to continue providing its programs of education, advocacy, research and services to people with rare disorders. NORD spends your contribution dollars wisely; less than 15 cents of every dollar donated to NORD is spent on fundraising and administration.

- Your membership in NORD will insure that you continue to receive the NORD newsletter, *Orphan Disease Update*, which reports on:
- Progress in research on rare disorders.
 - Recent government, health-related industries and scientific community activities.
 - Personal accounts of courageous struggles by people with orphan diseases.

Yes, I do wa diseases. M NORD's prog and services

Membershi

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it to in the effort to help conquer rare
membership/contribution will help continue
ams of education, research, advocacy

Annual Dues (Make checks payable to NORD)

- Contributing \$100
- Student \$ 50
- Individual/Family \$ 25
- Member gift for membership

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please accept my contribution of: \$ _____

please send me information on thoughtful ways
to include NORD in my will

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Name: (_____) _____

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NY 11231

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e Phone (_____) _____

H-INSURANCE

THE WHITE HOUSE

August 22, 1994

Ms. Carol Mollner
Executive Director
National Network of Women's Funds
1821 University Avenue
Suite 409 North
St. Paul, MN 55104

Dear Ms. Mollner:

Thank you for sending the letters from Minnesota Comprehensive Health Association (MCHA) policyholders that I asked about when we met.

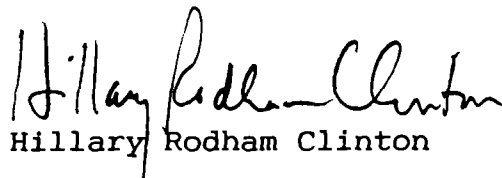
The proposed premium rate increases described in the letters demonstrate why we so desperately need real health care reform. The President wants to guarantee private health insurance to all American families. Without universal coverage, the poor will continue to receive health care through government programs and the wealthy will continue to be able to afford to purchase coverage, while the middle class will remain at risk. Twenty-four million Americans, most of whom work hard to earn a living, will have no insurance at all, and one million will lose coverage each month. And without universal coverage, cost shifting and the need of individuals without insurance to rely on costly emergency care will persist, causing health care costs to continue to skyrocket.

Ms. Carol Mollner
August 22, 1994
Page 2

As you noted in your letter, MCHA groups individuals and families together to purchase health insurance. However, because MCHA is a risk pool only for Minnesotans turned down by other health insurers -- mainly because they have so-called "pre-existing conditions" -- premium rates for MCHA policy holders continue to increase. The health reform bills introduced by Senator Mitchell and Congressman Gephardt will give small businesses and families the opportunity to band together to buy insurance. In contrast to MCHA, however, the bills will allow all people -- the healthy and the sick, the young and the old -- to join voluntary purchasing cooperatives to bargain for and purchase health insurance on the same basis as large employers. No longer will small businesses and individuals pay as much as 35 percent more than big businesses for the same health insurance.

Thank you again for your letter. I appreciate your support and your valuable work on health care reform.

Sincerely yours,


Hillary Rodham Clinton

NATIONAL NETWORK OF 
Women's Funds

1821 University Avenue • Suite 409 North • St. Paul, MN 55104
(612) 641-0742 • (612) 647-1401 FAX

April 22, 1994

Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

During the reception at the White House for the nonprofit sector on Tuesday, April 12, 1994, I told you about the letters that I had just read from policyholders concerned about premium rate increases proposed for the Minnesota Comprehensive Health Association. You asked me to send copies of some of the letters.

The Minnesota Comprehensive Health Association (MCHA) is the state's risk pool for Minnesotans who have been denied individual insurance coverage in the private market due to preexisting conditions. I am an MCHA policyholder, and a public/policyholder appointee to the MCHA board of directors.

MCHA is funded solely through enrollee premiums (which by law are required to be between 101% and 125% of the weighted average of rates charged by health carriers selling individual policies of health or accident coverage), and by an annual assessment on insurance companies, HMO's, Blue Cross and Blue Shield of Minnesota and fraternal organizations selling health or accident insurance in Minnesota. Because of ERISA law, self-insured health benefit plans do not contribute to MCHA.

Currently (2/94), 35,272 people have health insurance through MCHA. Over half live outside of the metropolitan Twin Cities area. Two recent studies of the MCHA population provide other demographic data about policyholders. The majority of MCHA policyholders are self-employed; a greater number are unemployed than in the general population; household income is significantly lower than the median household income for all Minnesotans; and about 83% of policyholders pay their entire premium. Only approximately 25% of the enrollees had medical costs that exceeded their annual deductibles (of either \$500 or \$1,000), and one percent (1%) of enrollees accounted for 30% of the plan's total billed charges. About 25% of the plan disenrolls annually (most finding other insurance); for the others, MCHA remains the only current option for health insurance.



MCHA adjusts its rates annually, effective July 1. Proposed rates must be distributed to policyholders for public comment. The attached sheet shows rates proposed for 1994, as well as the current rates which went into effect July 1, 1993. In almost all age categories, the proposed rates are at the maximum allowed by law. The enclosed letters were written to express concern about these proposed rates. If these rates are approved, they will increase the burden for many policyholders who are now barely able to pay their premiums. Some will be forced to pay as much as one third to two thirds of their income for health insurance. As these letters indicate and as you know so well, people are faced with impossible choices: paying for health care or for other necessities. Many talk about cutting back on medications because they can't afford the cost, and some may give up health insurance altogether; particularly bad options for people who have conditions which require health care.

Each year, I have read the many letters and attended some of the public meetings that MCHA holds to provide policyholders an opportunity to comment on the rates. Most of the policyholders are quite knowledgeable about health care costs; they attempt to review hospital and physician charges for overcharges and duplicate bills; they shop carefully for the best prices on medications and health care services. They also speak about the difficulties they have in paying the premiums, deductibles and co-pays; about their frustration with being forced into a risk pool; and about their general frustration with the escalating costs in the whole health care system.

I hope that these letters will be helpful to you and your staff in your efforts to secure meaningful health care reform. If you would like further information about MCHA or the concerns of its policyholders, I would be pleased to provide it.

Next week, my organization, the National Network of Women's Funds, will be holding a national conference in New York City on women's health care issues. The focus of the conference is on health care reform, and its impact for women. *Women's Health: From a Privilege to a Right -- A Platform for Change* is designed to educate women's foundations and other philanthropists about the importance of educating their own constituents about the stakes involved in the health care reform debate, and supporting grassroots organizing to assure that health care reform benefits all Americans.

Thank you for the leadership you and President Clinton are providing to achieve health care reform in the United States. Because of the work that you are doing, we have the opportunity to make quality, affordable health care available to all.

Sincerely,



Carol Mollner
Executive Director

LETTERS FROM POLICYHOLDERS
REGARDING 1994 PROPOSED PREMIUM RATE INCREASES IN
THE MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

Proposed MCHA Quarterly Rates

Effective date: July 1, 1994

Plan 1 and Plan 2

Age	Plan 1 \$1,000 Deductible			Plan 2 \$500 Deductible		
	Quarterly Rates Effective 7/1/93	Quarterly Rates Proposed 7/1/94	Percent of Increase (Decrease) 7/1/94	Quarterly Rates Effective 7/1/93	Quarterly Rates Proposed 7/1/94	Percent of Increase (Decrease) 7/1/94
	=< 14	\$178.86	\$196.38	9.8 %	\$229.44	\$257.07
15-29	\$182.31	\$196.38	7.7 %	\$261.30	\$257.07	(1.6)%
30-34	\$205.29	\$220.32	7.3 %	\$282.09	\$288.39	2.2 %
35-39	\$231.30	\$242.94	5.0 %	\$319.89	\$318.00	(0.6)%
40-44	\$272.34	\$267.27	(1.9)%	\$353.46	\$349.86	(1.0)%
45-49	\$320.94	\$311.88	(2.8)%	\$410.88	\$408.24	(0.6)%
50-54	\$370.83	\$383.43	3.4 %	\$473.94	\$501.90	5.9 %
55-59	\$430.17	\$472.02	9.7 %	\$548.13	\$617.88	12.7 %
60-64	\$514.41	\$540.39	5.1 %	\$654.66	\$707.37	8.1 %
- 65 +	\$585.39	\$589.14	0.6 %	\$765.75	\$771.21	0.7 %
Dependent Children						
1 Child	\$178.86	\$165.84	(7.3)%	\$229.44	\$217.08	(5.4)%
2 or more Children	\$244.02	\$307.08	25.8 %	\$342.93	\$401.97	17.2 %

Medicare Plans

	Policy Form Number	Quarterly Rates Effective 7/1/93	Quarterly Rates Proposed 7/1/94	Percent of Increase (Decrease) 7/1/94
1. Extended Basic Medicare Supplement	F4495	\$502.02	\$582.66	16.1%
2. Basic Medicare Supplement	F4494	\$130.11	\$152.13	
Part A Deductible Rider	F4561	\$58.80	\$59.88	
Part B Deductible Rider	F4562	\$21.00	\$26.97	
Additional Part B Rider for 80% of U & C	F4638	\$89.52	\$22.44	

The second plan for Medicare Supplement benefits is offered as a Basic Medicare Supplement contract with 3 optional riders. This contract and any of the optional rider combinations result in the following total package rates for the 7 possible combinations.

Basic Medicare Supplement <i>no drug-leave</i>	\$130.11	\$152.13	16.9 %
Basic & Part A Deductible Rider	\$188.91	\$212.01	12.2 %
Basic & Part B Deductible Rider	\$151.11	\$179.10	18.5 %
Basic & Part A & B Deductible Riders	\$209.91	\$238.98	13.8 %
Basic & Part A & B Deductible Riders & the Rider for 80% of U & C	\$299.43	\$261.42	(12.7)%

Other Option Combinations

Basic & Part A Deductible Rider & the Rider for 80% of U & C	\$278.43	\$234.45	(15.8)%
Basic & Part B Deductible Rider & the Rider for 80% of U & C	\$240.63	\$201.54	(16.2)%
Basic & the Rider for 80% of U & C	\$219.63	\$174.57	(20.5)%

April 11, 1994

Ms. Lynn Gruber, Executive Director
Minnesota Comprehensive Health Association
5775 Wayzata Boulevard, Suite 910
St. Louis Park, Minnesota 55416

RE: MCHA Proposed Premium Increase for Children in 1994

Dear Lynn:

I am writing to you once again to share our deep-seated concern about the proposed 1994 premium rate increase you are requesting for the children involved in the MCHA program. Although you indicated that the "average" proposed rate increase is 4.7%, the increase for children of 17.2% to 25.8% (Note: this is 3 to 5+ times the average increase) is excessive and outrageous. I ask you in your Board meeting to reduce the amount of premium increase you are requesting for the children involved in the MCHA program.

Because we have always had the rights of children foremost in our minds here in Minnesota, I find it contradictory that the Board of MCHA would choose to impose such a harsh penalty upon the children covered by its plans. I realize that out of the 35,500 individuals covered by the plans, very few are single children, and **even fewer** are multiple children within one family. Our collective voice isn't very large but it is a clear one.

I have attended each of the yearly rate review meetings, and have politely asked if the Board was aware of this effect upon the children's rate, and if their originally proposed rate increases ranging from 19% to 62.8% were considered to be "reasonable". I am pleased to say that both the MCHA Board and the Commissioner have been approachable about this issue after I raised their level of awareness, and reduced the final percentage increases to a high but more equitable amount.

This year, the MCHA Board has requested a **17.2% increase** in our children's premium in the MCHA2 program and an *unbelievable* **25.8%** for the children on Plan 1! It just doesn't seem fair . . . or reasonable. I expressed our concerns at the meeting held at the Holiday Inn - Metrodome on Friday, March 25th.

Because our entire family of 5 is forced to be in MCHA, we as a family face individual deductibles that initially total \$2,500.00 per year, **plus** the current yearly premium of almost \$4,500.00 (and whatever yearly increase is assigned as a result of this process), **along with** additional co-pay and non-covered expenses. To put it bluntly, the cost is unbelievable. Our other living needs must always be placed secondary to the overall cost of providing this minimum safety-net coverage.

We ask for your understanding and compassion in **revising downward** the proposed premium rate increases for children in the MCHA program. In a related issue that I have previously brought to the Board's attention, I also ask you to actively modify the MCHA healthcare program to resolve the inequity within the "individual deductible" penalty for family units. I would like you to consider recommending an aggregate deductible of at most three (3) times the base deductible for MCHA families.

We appreciate your concern and your consideration.

Sincerely,

cc: Commissioner James Ulland
Minnesota Department of Commerce
133 East Seventh St.
St. Paul, Minnesota 55101

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003a. letter	From: Policyholder to: Lynn Gruber [partial] (1 page)	4/6/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

U
Lynn Greber MCHM April 6. 74
Dear Lynn, this in regards to your proposed MCHM
Premium & increased Rate of July 1. 74

I'm 86 yrs old and very ill I can't attend the meeting
First of all I'm having trouble finding a good Dr on this
MCHM. Good Drs don't wait it. Right now I'm without a
Dr and I need a Dr. young Drs don't know how to take care
of old people.

This is a good Ins. I've never had to pay anything more
than a few dollars

on Tuesday April 5 I tried to reach you. I couldn't.
I did talk to Dianne Tenant. I told her I need a Dr.
in down town mpls. the list given out by medicare listed
all Drs on this are out in suburbs.

I'm struggling to keep this Ins. I can't pay a large
raise such as in your notice of \$582.⁶⁶ from 502.02.
My Present Premium lists an increase of 80.⁶⁴ It
was increased from \$475.98 to \$502.02 July 1. my only
income is social security is \$7.195.²⁰ \$50.⁴⁰ yet's Pension

Thank you

0039

(b)(6)

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003b. letter	From: Policyholder, To: Lynn Gruber [partial] (1 page)	4/7/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

received
4/11/94

4-7-1994

Lynn R. Gruber
Mn. Comprehensive Health Assoc.
5775 Wayzata Blvd.
Suite 910
St. Louis Park, Mn. 55416

Greetings,

I am writing you concerning my health insurance. Due to some health problems, my Blue Cross Blue Shield policy went up to \$1100 a quarter with some exclusions.

My husband is nearly 70 years old with a bad knee + can't work anymore. He receives social security in the amount of \$4,224. We also receive a rent amount of \$6,750 on 80 acres of land. We have a few other small incomes but this is the majority of our income.

My husband has a very good insurance policy with Blue Cross

Blue Shield costing \$321.99 a quarter.

Thankfully I got a health policy with MCHA for \$514.41 a quarter. If these MCHA's proposed rates go into effect, I'm not sure how long we can keep paying my health insurance. I'm 61 years of age + believe I can't get medicare for some years.

Hoping that you can apply some pressure to keep the rates where they are now, I am

Sincerely yours,

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(b) (6)

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003c. letter	From: Policyholder, To: Commissioner Ullaud [partial] (1 page)	4/11/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

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Ignor

received
4/11/94

We sent this to
Com Ulland. Also sending
you a copy.

d

marc

Dear Commissioner Ulland:

I am writing about the proposed rate increase Minnesota
Comprehensive Health Association insurance is considering for
its policy holders.

My Extended Basic Medicare Supplement would raise
from \$502.02 to \$582.66 a quarter, an increase of 16.1%. Very
shaking to a retired person on a fixed income, also the real-
ization this is only forced, use. My wife too must pay for a
health care supplement. This certainly points to a need for
universal health insurance. We, who have health problems, know
we can not depend on private insurance to care about the individual.

We attended the public meeting MCHA had at Redwood Falls.
Every MCHA policy holder was paying for his own insurance. Several
members said their savings would soon be depleted and they
would need government assistance, most of their income went to
health insurance. Other policy holders were close to the same pre-
dictment, either drop their health insurance and cease to get
needed health care or continue to dip into their savings. They feel
desperate and abandoned.

This has become a very serious problem to the senior citizen
or those forced to retire early because of their health. I hope there is still
some compassion in our government leaders to hold back the rapid
escalation in insurance premiums. Thank you.

(b)(6)

003C

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003d. letter	From: Policyholder, To: Those considering premium increases [partial] (2 pages)	3/26/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S
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Bloomington, MN 55425
March 26, 1994

7N. Comprehensive Health Assoc.
St. Paul, MN. 55164

003d

(b)(6)

MAIL SERVICES

Customer Service
MAR 28 1994

MAR 28 1994

To those considering premium increases,

I was unable to attend your public meeting, but wish to have my voice heard. I am a widow of 57 years of age. I'm living on a fixed income to be able to care for grandchildren. My son-in-law has been denied health insurance for a lengthy period following the removal of a cancerous testicle. My daughter must work full-time to get family coverage. Nobody can give children the love they need to start life like their own families, if they are sound ones. However, this isn't financially rewarding to me!

I have been denied individual (private) insurance due to a pre-existing condition. I've turned in little bills to MCHA but paid \$1,720 in yearly premiums with a \$1,000 deductible. I'm terrified to go to doctors or of getting ill. The proposed hike would mean for me - \$1,888 in basic premiums without any drugs or return to me. Then without any choice or options I have \$1,000 deductible on top of this and must spend about \$3,000.00 yearly to receive any return. That is about 1/6th of my income at present and rising.

Must all Americans have to "throw their

children to the dogs" in order to survive the economic pressures, especially in healthcare? These increased come on top of people who are already hurting and obviously not covered by employers.

It's hard to see the justification of nearly 10% increase in a period of 1.9% inflation. The appearance would seem to be of taking advantage where change of law permits.

The policy I currently have with MCHA is poor compared to a previous preferred one policy. My gynecological visit used to be covered, but I got nothing from MCHA including a reduction for using a MCHA provider. This is a sad situation for me and getting much worse as it is for many hurting families. Please do not raise rates as proposed! I have no options!

Sincerely,

003d

(b)(6)

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003e. letter	From: Policyholder, To: Minnesota Comprehensive Health Association [partial] (1 page)	4/4/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

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APR 04 1994

To: Minnesota Comprehensive Health Assoc

I am writing in regards to the premium rate increases. I feel that our rates are plenty high right now. why do they have to be raised every year? How can we pay more & more? I myself have poor health, I have diabetes & a heart problem. But am forced to work full time to pay for medicine & insurance premiums. This MCHA is for people like me that have no choice as no one else will accept us, on account of our health conditions. I guess if we can't afford to pay it we will have to go on welfare like so many others who don't try. I feel we are discriminated against with these high premiums. I have always tried hard to pay my way. I hope you will reconsider.

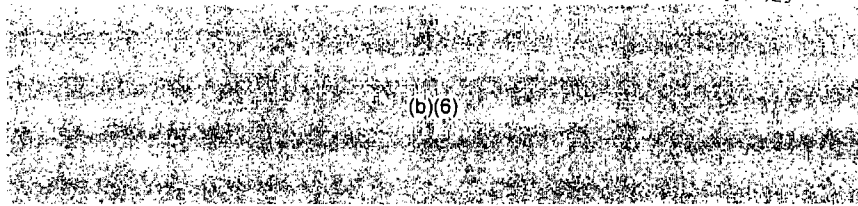
MAIL SERVICES

APR - 4 1994

P. W. #

Sincerely

11-
#



(b)(6)

003e.

Lynn R. Gruber

3/31/94

received
4/9/94

Min. Comprehensive Health Care).

As I was unable to drive to
Duluth Min. for the meeting, I
am appalled at the rate increase
again.

What percentage of people
actually use their Health Insurance
but must carry it if by
chance they do need medical
care. Sometimes never!

What will happen when
Pres. Clinton's Health bill goes
in effect? We should have a
reduction in Insurance premiums.

What is the difference in Min. Comp.
& Blue Cross - Blue Shield when
we pay more (higher) premiums
than Blue Cross does for its
participants?

With the ever increasing rates
people under a ^{1,000} per month
income, will slowly have to
give up health insurance

the who do not work
for various reasons in the
age (60 to 65) - Can't find work,
low pay, no pensions -

We have our other monthly
bills to pay and can't keep
up with higher premiums,

We the people who are over
the \$25.00 welfare limit but
under a \$1,000 Mth income, who
will no longer be able
to keep paying the continuing
high premiums will slowly
wither and die -

Policyholder

MARCH 7, 1994

COMMISSIONER JAMES WILAND
MINNESOTA DEPT of COMMERCE
133 E. 7th STREET
ST. PAUL, MN 55101

DEAR COMMISSIONER WILAND.

I would like to oppose the large 16% RATE INCREASE proposed by the MCIARA Board for the Extended Medicare Supplement offered by Minn. Comp Health Assn, for the following reasons:

I had my first HEART ATTACK in March of 1971 at the age of 42, ending my career as a commercial Pilot and having to sell my fixed base operation. Business in Albert Lea in 1972. I continued to work in Commission Sales, as no company would hire me with a history of heart problems. I was forced to quit working after two more heart attacks between 1973 + 1977, and my insurance was canceled.

I was covered by insurance at my wife's Employer as a Family Dependent until 1987 and Medicare since 1979 as a supplement, until my wife lost her job of 18 1/2 yrs to a company moving out of State. She worked for the company that took over the facilities until she had breast cancer and was laid off.

She is now employed by a Nursing Home working nights in order to get insurance benefits and after taxes in previous employers offices in order to make ends meet.

I had a HEART BYPASS operation in April 1986 and Atery by bypass to less in Sept of 1986 - Colon Cancer Surgery in Sept of 1987 and Foot Surgery for Morton's Neuroma in Feb of 1992.

To keep myself mentally alert I do volunteer help to our local Hospital Association which I started doing in 1978.

I have stated these facts to point out that I, as well as many other people under MEHA Medicare Supplements have never had the health to accumulate savings nor financial investments to use upon reaching AGE 65, and are entirely at the mercy of the MEHA Board whose primary focus is financial.

The last increase in Medicare payments was 2.6% less an increase in Medicare payments for 1994. The past years have been about the same. There is no way

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003f. letter	From: Policyholder, To: Commissioner Ullaud [partial] (1 page)	3/7/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

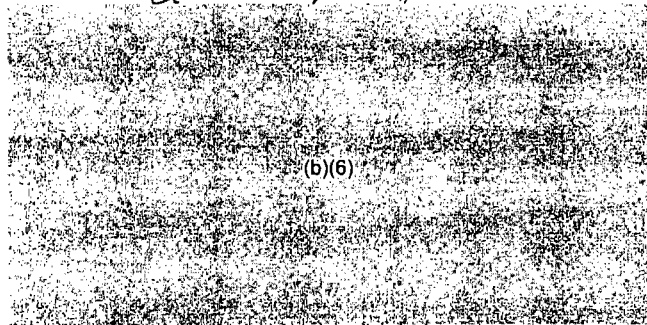
Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

We ^{can} continue to Live and pay out 30% of
our total low income on Health and
Insurance costs.

I Plead with you to use your FULL
Authority in lowering these rates to help
the people of this state, ^{who} have had long
Term illnesses, have had Insurance canceled,
or denied.

Sincerely,



(b)(6)

003f

March 22, 1994

MAIL SERVICES
MAR 31 1994

Dear Sirs:

I am writing about the increase in our insurance premiums. I feel a 16% increase is quite high.

Both my husband and I are receiving Social Security. We are both working a little. Last year I only made \$1000.00, because of my disabilities. Many people, on MCHA, pay the premiums, without the help of an employer, most of their lives, even when they were able to work.

MCHA has been a good insurance for me. We do not know what we would have done without it. I have had MCHA since the late 70's. We would probably had ~~been~~ filed bankruptcy, since we were not eligible for medical assistance.

Thank-you for listening to me.
Sincerely,

MEMBERSHIP
SUPPORT

MAR 31 1994

5

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003g. letter	From: Policyholder, To: Gentlemen [partial] (1 page)	3/31/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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MEMBERSHIP
SUPPORT

MAR 31 1994

Gentlemen:

Your insurance policy has been very good to ~~me~~ me through my last illness.

In 1992 my premium was 475.78 up from 436.68 in 1991. In 1993 I paid 502.02 and now you are proposing an \$80.00 increase. Does that seem fair. Every year it has gone up about \$30.

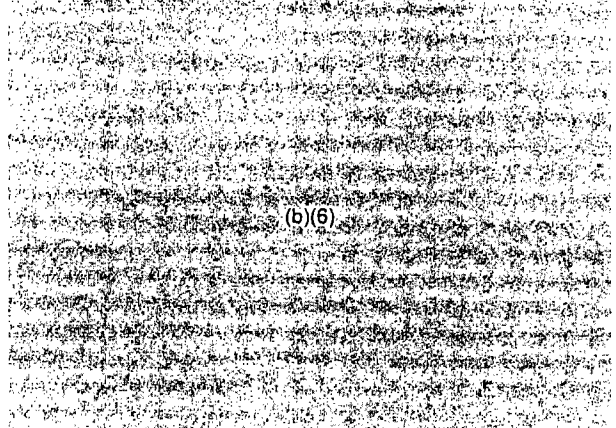
Now look at my side. I am on a fixed income. The 3.4% interest does not even come close to the \$80 increase you want. Gas has gone up by 70¢ per gallon tax. Real Estate taxes went up over 10% - provided are higher over time I go to the store.

It seems every thing I need to buy goes up at least 10% or more.

So if I tried to buy every thing I really need, each month I would go in the red. Then how I'd be on welfare as I am too old & crippled to hold down a job. It has paid close to \$1000.00. You are going to be golden. It is just a fight to exist all the time.

Hope you have the picture now. I am against the extreme rise in the insurance premium. I may be able to do some socializing if you didn't need that \$80.

Yours Truly



(b)(6)

0039.

MARCH 27, 1994

TO WHOM IT MAY CONCERN;

I AM WRITING TO YOU ABOUT THE PROPOSED MCHA PREMIUM INCREASES. WE ARE A FAMILY OF FOUR THAT ARE ON MCHA. I HAVE ASTHMA AND MY SON HAD FEBRILE SEIZURES WHEN HE WAS A BABY WHICH HE HAS OUT GROWN. WE TRIED TO GET INSURANCE THROUGH OTHER COMPANIES BUT AS YOU CAN GUESS THEY ALL TURNED US DOWN DUE TO PRE-EXISTING CONDITIONS. I'M GRATEFUL THAT MCHA WAS AVAILABLE FOR US TO GO ON SO THAT WE COULD HAVE HEALTH CARE COVERAGE. ITS BEEN A STRUGGLE AT TIMES TO PAY THE PREMIUMS AND EACH YEAR IT'S GETTING ALOT HARDER. I UNDERSTAND THAT THERE NEEDS TO BE INCREASES BUT WHEN I SAW THAT THE PROPOSED INCREASE FOR 2 OR MORE CHILDREN WAS GOING TO BE AN 25.8%. I WAS PRETTY SHOCKED! IF THIS HIGH OF AN INCREASE GOES THROUGH I'M NOT SURE WHAT MY FAMILY WILL DO. MAYBE ONE OF US WILL HAVE TO DROP OUT OF MCHA AND NOT HAVE ANY INSURANCE COVERAGE. THE THOUGHT OF THAT SCARES ME. PLEASE HELP US SO THAT THIS DOESN'T HAPPEN. IF THE PROPOSED INCREASES GO THROUGH WE WOULD BE PAYING ABOUT \$300.00 A YEAR MORE. THAT MAY NOT SOUND LIKE MUCH TO SOME PEOPLE BUT ITS TOO MUCH FOR US. PLEASE I ASK YOU TO TAKE ANOTHER LOOK AT THE 2 OR MORE CHILDREN \$1000 DED. RATE PROPOSAL AND SEE IF THERE IS ANY POSSIBLE WAY YOU CAN FIND TO KEEP FROM RAISING THE PREMIUMS 25.8%. I'M COUNTING ON YOU TO FIND A WAY SO THAT MY WHOLE FAMILY CAN STAY ON THE PROGRAM.

THANK-YOU FOR LISTENING

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003h. letter	From: Policyholder, To: Ms. Gruber [partial] (1 page)	3/28/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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(b)(6)

603h

March 28, 1994

Ms Lynn Gruber
Ex Director
MCHA
Suite 910
5775 Wayzata Blvd.
St Louis Park, MN 55416

Dear Ms Gruber,

On March 21, 1994, I attended an MCHA meeting here in Rochester.

I learned that there is to be another increase in our premiums.

I saw several people crying.

Most of us are on fixed income, and we are just being "strapped." We have no choice but to pay these premiums as we must have health insurance.

Please help to give us a break.

Sincerely,

(b)(6)

003h

MCHA 4

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003i. letter	From: Policyholder, To: Mr. Gruber [partial] (1 page)	3/20/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

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3/20/94

Dear Mr. Gruber,

This is in regard to a proposed rate increase by M.C.H.A.

We do not plan an illness, especially a chronic "pre-existing" one such as Parkinson's. It is a disappointment to us in our retirement but we are not willing to give into Medicaid yet. Or is this the way you want it for those with a debilitating disease? - I do believe we must go to a Universal health care plan which we all participate but equally.

Please, do not increase the rates anymore, we do not fear death, taxes cold or hunger but the insurance companies we now fear. Our grandchildren can never pay these premiums for health care and we will do all in our power to make sure something is done to decrease the cost.

Who can we trust anymore? -

0031

(b)(6)

MCHA 4

received

3/16/94

Lynda Gruba -

I am writing in regard to the notice I received about an increase in premiums for my supplemental insurance. I am ^{paying} now \$502 a quarter which is almost impossible for me to pay. Any increase will almost certainly cause me to have to give up my coverage.

I am 71 yrs old, a widow in a wheelchair for 20 yrs because of MS, I have had cancer surgery, congestive heart failure. My teeth are in terrible condition, but I can't afford to have them fixed. If anything major would go wrong with my home, I don't know what would happen.

I am writing to you because I

would not be able to get to
the meeting that you are
going to have in Rochester.
I am against any initial in-
premiums.

Is there any assistance available
at this time to help pay
premiums?

Thank you.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003j. letter	From: Policyholder, To: Lynn Gruber [partial] (2 pages)	3/22/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

1-45

MEMBERSHIP
SUPPORT

MAR 23 1994

MAIL SERVICES
MAR 23 1994

3-22-94

Lynn Grubet

In Regard to your price
increase in 7-1-94

I feel that you & your
others that make these changes
do not have Harvest people in
mind. \$50202 per of, over
my medicine, that is way to
much, I really don't understand
were you people are coming
from. You are suppose to
a help to people, not to
make a hardship on people.

What is America coming to
Everyone wants to run for
office when they can, but
no body doesn't want to stand
up for their position,

Some day in the future
you will understand then

(b)(6)

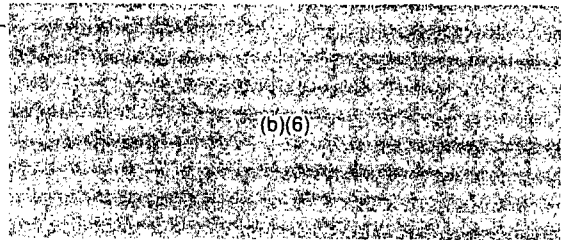
0033

IT will be Late, you will look
back SAY I made a mistake
Why not Correct Now.

you Realize that poor people
are getting poorer.

my self as an Exp. my
is total disabled cause of two ~~stroke~~
Stroke, I have two heart attacks &
UN operable. OUR Sale per mo.
\$1381.00 before Bills, after all Bills
Ins. BAS, Light, med. Bill etc, what is
left \$157 per mo. to pay Gas &
BAS for my CAR.

you tell me in your own
words how you can justify Ins
Premiums such as these, I thought
min. was to help us get cheaper
& Better Ins. I have lost FAITH
IN all you, in the Ins. Co &
Business



(b)(6)

003j

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003k. letter	From: Policyholder [partial] (1 page)	3/21/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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Freedom of Information Act - [5 U.S.C. 552(b)]

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Rochester, Minnesota

March 21, 1994

Last night I attended a meeting of MCHA in Rochester.

I am writing with hope that something will be done to stop the rising cost of health care, including the terrible cost of medications.

Contrary to reports, most senior citizens are not rich old people.

I am a widow, I am 70 years old and work at a Super market as a cashier. I work to pay my medicare supplement insurance. I pay every month, as I cannot pay by the quarter. I now pay \$167.34 a month - the proposed rate for my age is up 16.1% to \$582.66 a quarter, making the payment \$194.22 a month. When you add in the almost \$40.00 a month from Social Security for medicare, I would be paying \$234.22 a month plus 20% of my medications.

I have high blood pressure, which is under control with Cardizem, and high cholesterol, which I inherited, and is being helped with Mevacor - the mevacor is over \$3.00 a pill - my 20% is \$20.06 a month - the Cardizem is \$51.25 for 100 pills, my cost is \$10.05 - I also take prednisone, but that is inexpensive, so far.

My Social Security is \$696.00 a month - I do not have a pension, if the proposed raise in MCHA is accepted - I would not have a great deal of money left a month. At 70 years of age I'm sure my working days are numbered. The \$167.34 that I pay every month is becoming hard to do.

With the cost of insurances and medications going higher and higher - I'm afraid many senior citizens will have to rely on Medicaide - and that will cost Minnesota a lot of money. Things are getting out of hand - I have the extended basic - because what I need are medications.

Thank you.

Rochester, Minnesota

(b)(6)

003 K

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
0031. letter	From: Policyholder, To: Lynn B. Gruber [partial] (1 page)	3/28/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

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2014-0159-S

sb291

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3/28/94

(b)(6)

003 L

Dear Lynn D. Baker,

I am writing in regards to the proposed MCHA rates. I think the new proposed rates are outrageous. I am disabled from a chronic illness. My Social Security checks are 1700.00. How do you think I can manage to pay \$582.60, and still keep my home up. I can't!! I even barely able to pay 502.00. Every year you keep raising the rates, but our Social Security doesn't go up. Makes you wonder if its worth going on.

(b)(6)

003 L

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003m. letter	From: Policyholder, To: Lynn Gruber [partial] (1 page)	nd	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
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Gynn Strubel:

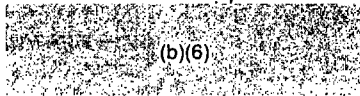
I'm writing a complaint to the proposed 16% raise in MCHA Medical supplement.

My reasons: My SS Check monthly is \$357, and proposed raise would bring monthly premiums to \$195, almost put me in a place unable to keep insurance coverage. Our assets are a little above Medicaid guidelines, and I want to avoid that. I hesitate to drop prescription coverage because of the unknown.

Please help me to be able to keep insurance coverage, as I was recently unfairly rejected for Standard Blue Cross Blue Shield Coverage.

Thank you

003 m



MOINC =
\$ 357

MOhealth insur.
prem =
\$ 195

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003n. letter	From: Policyholder, To: Mrs. Lynn Gruber [partial] (2 pages)	3/26/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

To: Mrs Lynn Ducker
MCHA Executive Director
P.O. Box 64566
St Paul MN 55164

3-26-94

003n

From:

(b)(6)

Subject: Letter in regard to the proposed MCHA Insurance
Premium of 16% rate increase, and its financial
impact on our budget and lives. (Medicare ^{EXTENDED} Supplement Plan)

I was fortunate to be able to
attend your MCHA meeting held last night, at
the Holiday Inn Metrodome. Mpls. 3/25/94
Your meeting was very informative. The
policymakers were given time to express views
and it was a great meeting.

I met most of your people & Secretary
of Board of Directors people. Also Charles Ferguson
of the State Dept of Commerce. and Dr. Express
my view to feeling on proposed increase.

I also was surprised, pleasantly
surprised to find these people and yourself
are real people that do care!

My wife has enjoyed the service
of MCHA (Pool) for 4 yrs. Other than this help,
as to govt. aid in the past 23 years - we
have not asked for any help in regard to
financial costs of her Parkinson disease past 23 yrs.
She is now 65 - and on Medicare Supplement

But now, the financial impact of increased home property taxes and with ⁵⁰ this very large increase of 16% or 322.41 on her WCHA Medicare Supplement ins. - Things are now running pretty THIN!

Few Comments.

(a) This letter is about money. How much can you make in a lifetime - ?

Well, we worked hard for 38 yrs - never missing work, had 6 children, (all thru college) now have 10 grandchildren and we are retired 3 yrs now -

- (b) There are two widespread attitudes about Money.
- ① Money is NOTHING?
 - ② Money is EVERYTHING!

Both attitudes are wrong. To say that money is not important is pretentious! and you can't say money is as important as other things: In our case - In areas where money counts, nothing CAN TAKE ITS PLACE? That's when we at -

(c) Short Financial Summary -

Retired 3 yrs ago - Social Security Income 1048⁰⁰ mo = 12,528⁰⁰ yr INCOME
 (no other wages - as I am caretaker for wife)

Less Expenses:

- ① MEDICAL EXPENSES (OUT of Pocket Paid Expenses - ~~12,528~~ 1,617.48)
 WCHA INS. Prem. & Med. Cost Allowance Both are Expense
- ② LIVING EXPENSES
 - Utilities 400
 - House Taxes 2080
 - Heat & Fuel 1080
 - Gasoline 750
 - Transportation 1380
 - Interest 350
 - Telephone 300
 - Food 2400
 - Clothing 5

Medical Expense to ~~12,528~~ of our Income

Net year Operating ~~Loss~~ Shortfall ~~12,528~~ 8710⁰⁰

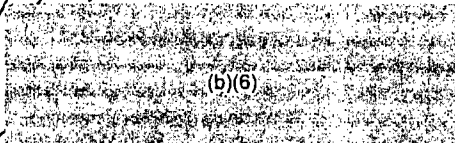
add another 322⁰⁰ income ~~12,528~~ year loss

I am not complaining, our financial situations have been from over \$100,000⁰⁰ in out of pocket expenses for drugs for 23 years for wife Parkinson's disease.

It's just that another \$322⁰⁰ a year increase in Medicare ^{Extended} Supplement Costs plus 41⁰⁰ on top of Medicare monthly costs (or 492⁰⁰ in) puts more pressure on us and what savings we have left.

We would appreciate your consideration of a lower percentage increase than the 16%. And would be very grateful! 8% would be more realistic if possible.

Thanks much



003 n

P.S. When looking at Medicare ~~supplement~~ - policies for ann. with prescription drug feature - I talked to at least 15 fifteen Co. with policies. (not all had drug feature) ~~I am surprised that talking to them I did not really know their product! I gave me concern.~~ Co. I talked to example:

AARP - Wash DC. Min Policy, Sellen Mann (Medicare Supplement asked about) was 80-20 prescription plan quote was 199⁷⁵ I asked if they could any other plan in min she said No. its too expensive. They do sell regular supplement Plus Basic.

Vs. Med Centers Prog - currently (80-20 Drug) \$34.⁰⁰ Mo Senior discount
Health Partners w/10⁰⁰ copay \$145.⁰⁰ Mo
Medica - ~~80-20 Drug~~ \$59.⁷⁵ Mo -

Owatonna, Mn.
March 23, 1994

DEar Ms Gruber,

I'm writing to you in regard to the card enclosed Group and I.D. No. enclosed. I am unable to attend any of your meetings as my wife works full time and I have a severe disability and I can't go myself and also the meetings are to far away.

My wife doesn't have any insurance with her job as shes self employed and I havn't been able to work for 21½ years. This insurance keeps going up for both of us and we just hardly can make it financiially. The present rate is more than we can handle and I don't see how we can pay any increase. The coverage I have I need and if I could drop some I sure would.

I go to Mayo Clinic and they have dropped some of their charges \$100.00 a treatment and yet Medicare and your insurance still don't cover it. I am after my drug store all the time on the costs. If I try to get them to lower their prices they say pills and medication if going up all the time. I got one item at Wal Mart less than ½ price and they are going after Wal Mart for cutting prices.

I would like some consideration as I have never tried to get the premium lowered before but I just con't pay it anymore. So I'm asking you to lower the premium but I have to have the same coverage as before. My wife is soon 65 years old and should slow down or quit her job as its a full time job taking care of me as I'm paralyzed ,bedridden and in a wheelchair but she can't afford to quit as we have no retirement built up.

Is this new health care bill going to be a benefit or a disadvantage to me? What do you think? I would appreciate some help and consideration to this matter, also a reply from you.

Yours truly,

03-21-94

Min Comprehensive Health Association
P.O. Box 64566
ST PAUL MN 55164

ATTN: Lynn Gruber, Executive Director

Re: Proposed premium increases for MCHA policyholders

I have been an MCHA policyholder for only one year - and am facing my third premium increase in July. I must protest.

My policy coverage began last April.

In July, I received a 15th monthly - 180th annual increase.

In March I observed my 60th birthday and faced an increase in annual premiums of 336.96 because I moved into a higher rate based on age.

The proposed rate increase for July this year would be 103.92 annual.

This would be a grand total of \$620.88 in premium increases for me in 15 mos. participation in MCHA. Furthermore, I have a \$1000 deductible policy and paid all my health care bills in the past year out of my own pocket. I feel I am being subjected to price gouging.

Sincerely yours.

Minneapolis MN 55426
March 23, 1994

Lynn R. Gruber, Executive Director
Minnesota Comprehensive Health Association
P.O. Box 64566
St. Paul MN 55164

Dear Lynn Gruber:

Once again, as I did last year, I feel obliged to write objecting to new MCHA rate increases. I am doing this not only on my own behalf but also on behalf of many of your other policyholders who are more or less in the same circumstances as I am.

I am quite sure that a fairly high percentage of your policyholders are, like myself, 55 or older and have taken early retirement for one reason or another so do not have group insurance at a place of employment. As for myself, I am now age 60. I took early retirement 3 years ago to take care of my mother, who is now age 93. I also have some pre-existing medical conditions so the only insurance I could get was MCHA. I feel there are many people like me no cannot easily pay over \$2,000 a year in insurance premiums plus another \$1,000 in deductibles before any benefit at all is derived from the coverage. When you are not working and don't have regular income, it is very difficult to pay these premiums in addition to other ongoing necessary expenses. I only regret that I have to go another 4½ years like this before I can get onto Medicare and a good, reasonable Medicare supplement that covers virtually everything.

Many other people, like me, keep this MCHA because they are afraid to be without any insurance at all in case of a major illness or hospital stay. Because of the deductibles and poor coverage of office calls, X-rays, lab tests etc., people don't always go to the doctor when they should. I know that has been the case with me because I would end up paying for it all myself, anyway.

To raise premiums further will just force more people to go without insurance. I thought the purpose of an insurance like this was to help make sure everyone would have insurance. Continually raising premiums certainly defeats this purpose.

I hope you will take these things into consideration before approving further rate increases.

Sincerely,

MCHA-1

4
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1
56073
'94

Re:

1,000 deductible
Quarterly Rates
\$196.38

Dear Lynn Gruber:

Beverly is in college full-time and not at home. Since my husband & I pay her insurance premiums while she is in school, we will speak to the proposed rate increase.

Help! Line #31 from our 1973 completed 1040 tax return: adjusted gross income, \$15,604. Beverly's adjusted gross income from her 1040 E2 tax return is \$2,527.

We do need money to live and for Beverly to go to college and now we are looking at insurance premium increases. When are we eligible for Minnesota Care?

We can not attend any of the public meetings. We write to you for help. Read this at the meetings if you think it will help. Thank you.

Sincerely,

M

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003o. letter	From: Policyholder, To: Sir or Madam [partial] (1 page)	3/9/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

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RR. Document will be reviewed upon request.

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March 9, 1994

MCHA
P.O. Box 64566
St. Paul, MN. 55164

MEMBERSHIP
SUPPORT

MAR 16 1994

MAIL SERVICES

MAR 16 1994

RE: Increase in Premiums

Dear Sir or Madam:

I am in receipt of your letter regarding the possibility of premium rate increases for my health insurance.

As I am working and unable to attend any of the mentioned meetings, I would like to give you my thoughts in writing.

My quarterly premium now is: \$514.41. I started out with approx \$356.00 quarterly. This is just for myself. I have always felt that I am paying health insurance for those that don't or WON'T pay health insurance premiums. I have to work just about 5 weeks to clear \$500.00, and my husband is on a fixed income. That leaves us very little for anything else. I can understand why SOME of the people do not have health insurance, they simply can't afford it. After feeding your children, paying the rent, and utilities, there is nothing left over to pay it with. However, there are some who drive new cars and sit in bars and go on vacations, that could pay insurance, but do not. Therefore, other than it's getting almost impossible for me to pay these rates, I have to go without to pay for those who will not pay it. The bottom line is, if this rate increase continues, it will be an even harder hardship for me, and I too, will join the ranks of those not having any insurance.

I do not mind paying my fair share, but "fair" is the key word here and I do hope you will consider the hardship it is for us paying these premiums. Something is wrong, terribly wrong, if the rates increase again. I can't hang on much longer.

Thank you.

0030

(b)(6)

4

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003p. letter	From: Policyholder, To: Sir/Madam [partial] (1 page)	3/7/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

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MAIL SERVICES

MAR 08 1994

MEMBERSHIP
SUPPORT

MAR 09 1994

March 7, 1994

Minnesota Comprehensive Health Association
PO Box 64566
St. Paul, MN 55164-0566

Dear Sir/Madam:

I recently recieved a letter regarding your annual rate increase.

I am 24 years old, and have an extensive spinal fusion and Harrington rod implants, and am in relatively constant pain. I have 3 years of a college education, which includes half of a major in Biology, in the past two years, I have found myself incapable of continuing in Biology because of it's demand on my concentration, and am now trying to transfer to a different school and change to a less demanding major. It's also difficult for me to find work in town because of the nature of work available here, medium to heavy manual labor.]

I live with my parents, am unemployed, and have no income. Any education I receive will be financed by loans.

I find it hard to believe that you are continuing to raise rates on people in situations like mine.

Thank you.

Yours truly,

(b)(6)

003 P

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003q. letter	From: Policyholder [partial] (1 page)	nd	b(6)

COLLECTION:

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First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

See enclosed note

0032

GROUP NO: [redacted]
IDENTIFICATION NO: [redacted] (b)(6)
PACKAGE NO: [redacted]

[redacted] (b)(6) 0032

1-800-382-2000, ext. 5540 (for greater Minnesota)

The MCHA Board will consider testimony from the public meetings at their April 11, 1994 meeting. Shortly after that, the Board will file their proposed rates with the Commissioner of Commerce, James Ulland. The Commissioner can accept the Board's proposed rates or modify them. We expect the Commissioner to make a decision by mid-May. If new rates are approved, they become effective July 1, 1994.

If you want to comment on the proposed rates, but cannot attend any of the public meetings, please write to me prior to April 11.

Sincerely,

Lynn R. Gruber

Lynn R. Gruber
Executive Director
Enclosure

I am unable to attend a meeting but feel I must express my thoughts. My increase according to the proposed sheet I received would be 52.71 - this is a struggle now to pay my quarterly premium. Is there a discount for anyone on SS. My monthly SS Ch is \$462.00 so I find myself struggling along. Isn't an 8.1% increase a large increase? Please let's be fair to us ~~and~~ as we already pay a high premium [redacted] (b)(6) 0032

3-18-94

Dear Huber:

Not being able to attend
a public meeting on
proposed rate increases, I
am writing to let you
know my concerns.

I am an individual
who had lung cancer
surgery 2 1/2 yrs ago
& therefore undergo quite
a few tests & trips
every yr. I cannot
afford to be without
insurance & if the
rates continually rise
I will not be able
to afford it, as it is,
I work part time

My insurance is my biggest expense. A 12.7% increase (ridiculous).

I am sure there are many people wiser off than I am, but I can readily see why our economy is in the shape it is.

March 20, 1994

Dear Lynn Kruber:

I have just received information regarding the

"Proposed MCHA Quarterly Rates" which would go into effect July 1, 1994.

On January 1, 1993, my premium was \$609.66 per quarter. The proposed rate for the same age bracket (60-64) and the same deductible would be \$707.77 per quarter. This is a 16% increase in a year and a half. I can't think of anything else that has risen 16% during the same time period. It is ridiculous. If the rates continue to increase like this I'm afraid I will have to go without insurance.

I am self-employed so I pay all my own premiums. My income has not increased 16% in the last year and a half. So far this year my income is less than 1993. And I don't see it improving enough to equal my 1993 income.

What is a person supposed to do? Is there any help available for those of us caught in this dilemma? I would appreciate hearing from you.

R...D...

56001

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003r. letter	From: Policyholder, To: Lynn [partial] (1 page)	3/23/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES

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Freedom of Information Act - [5 U.S.C. 552(b)]

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RR. Document will be reviewed upon request.

MW231994

Dear [Name]

Received a notice my insurance premium is
 going up again. Where will this end. My husband
 is 72 and I am 62 so we can not be under
 the same insurance we are not paying \$420⁰⁰
 per month for ins. we only receive \$800 from
 Social Security, we are really on a tight
 Budget. Why does the premium have to go up
 every year.

Sincerely Yours

[Redacted signature area]

(b)(6)

003c

[Redacted signature area]

(b)(6)

003c

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003s. letter	From: Policyholder, To: Mr. Gruber [partial] (1 page)	nd	b(6)

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Pam Cicetti
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6
2
1

Lynn R. Druber
Executive Director, MCHA
P.O. Box 64566
St. Paul, Mn. 55164

Dear Mr. Druber:

I will not be able to attend any of the public meetings, but I do wish to make myself heard.

I have been insured by MCHA since October 1988. At that time, I was working outside the home and had an income with which to pay the premiums. Now, in 1994, I am retired and living on Social Security. With the proposed rate increase, I will be spending 40% of my income on health insurance premiums. Soon I will have to decide whether I am going to buy groceries or pay my health insurance premiums. But, I really have no choice, because both are needed. To put it very bluntly, I cannot afford to pay more for health insurance.

Thank you for whatever help that you can give me.

Sincerely yours,

(b)(6)

0035

March 6, 1994

Customer Service
MAR 10 1994

Dear MCHA Board of Directors,

I have noticed that premium rates have increased every year since it began. At this rate I soon will not be able to afford insurance coverage. My income does not increase at this rate, infact it has been decreasing the last few years.

I don't see why it should be so hard for me to get insurance coverage. I have been in the past with several different insurance companies through work, and have never collected anything because my deductible always covered my medical expense for the year.

The last insurance I have had for 10 years since I quit working full time, but their premiums went up so high could no longer

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003t. letter	From: Policyholder, To: MCHA Board of Directors [partial] (1 page)	3/6/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

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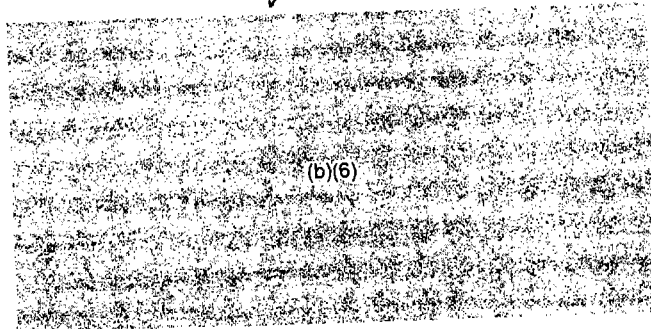
Freedom of Information Act - [5 U.S.C. 552(b)]

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afford it, I never collected from them
either, ~~but~~ why did their premiums
go up so high? I found that I
could not get other coverage because
of I have had diabetes the last
few years. That is why I am with
MCHA.

Please try to keep the premiums
affordable, so those that are paying
premiums can keep on doing so, and not
maybe, end up on medical assistance.

Thank you



(b)(6)

003t

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003u. letter	From: Policyholder, To: Board of Directors [partial] (1 page)	3/17/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
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0034

Customer Service

MAR 17 1999

(b)(6)

To:
Board of Directors,

Thank you for letting the policy holders know about the meetings I scheduled for the public to give their opinions on rate changes.

I realize it is difficult to run a company without rate increases. But I also want to state that increases are hard to absorb by policy holders. My husband is on a low fixed income and I haven't been working because of surgeries I've had, and find it very difficult to find work because of limited experience (& education) we try our best, but it is difficult.

Try your best to keep providers in line with their prices. It seems at times doctors think because of their talents, the sky is the limit with their costs. Perhaps they could keep their expenses in line more, and not pass all their personal costs down to patients.

I know you will all do your best.

(Our car is older & doesn't work too well, so I don't attempt to go to the cities) Thank you so I write instead of coming to the meeting)

(b)(6)

0034

received
4/6/94

4-2-94

FERGUS FALLS, MN.

MCHA
LYNN R. GRUBER
EXECUTIVE DIRECTOR

DEAR MS. GRUBER

IN REGARD'S TO MCHA'S RATE INCREASE PROPOSAL, I AM WRITING THIS LETTER TO LET YOU KNOW MY FEELINGS. I FEEL THE 16.1% RATE INCREASE IS VERY HIGH FOR THIS INSURANCE.

WHEN YOU ARE ON A FIXED INCOME LIKE I AM, IT IS VERY HARD TO TAKE A INCREASE LIKE THIS. IT HAS GOTTEN TO THE PLACE WHERE YOU HAVE TO SAY, ENOUGH IS A ENOUGH. THE FIRST OF THIS YEAR I RECEIVED A \$23.00 INCREASE A MONTH IN MY S.S. CHECK. MCHA HAS PROPOSED \$26.88 RATE INCREASE A MONTH. THIS WILL TAKE ALL MY S.S. RAISE + MORE. IN 1992 MY MCHA INS. WENT UP \$13.00 A MONTH, IN 1993 IT WENT UP \$8.68 A MONTH, AND \$26.88 A MONTH IN 1994 IS JUST WAY OUT OF LINE.

IF THIS INS. GOES UP 16.1% LIKE HAS BE PROPOSED, IT LOOK'S LIKE I WILL HAVE TO DO SOMETHING DIFFERENT, AND RIGHT NOW IT LOOK'S LIKE I WILL HAVE TO DROP MY INS., WITH MCHA, I KNOW IT IS NOT THE BEST

THING TO DO, BUT WHAT CAN I DO,
HAVING GONE THROUGH SIX BACK SURGIES
I HAVE LIFE TIME COVERAGES WITH WORKER'S
COMP., SO MCHA & MED-D-CARE I DON'T HAVE TO
PAY, SHOULD I NEED ANY MORE SURGERY ON MY
BACK. IT IS BECAUSE OF ALL MY BACK SURGIE:
THAT I HAVE TO HAVE MCHA INS.

THANK YOU FOR HEARING ME OUT
AS EVER

PHOTOCOPY
PRESERVATION



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

July 7, 1994

George D. Monardo
Davies Medical Center
Castro & Duboce
San Francisco, California 94114

Dear Mr.  Monardo:

Thank you very much for taking the time to send your kind words of support, and a copy of your correspondence to the First Lady.

As you know, our success at meeting the challenges facing us all depends on continuous hard work, and the support of people such as yourself.

Thank you again for your thoughtfulness.

Sincerely,


LEON F. PANETTA
Director

DAVIES MEDICAL CENTER

February 3, 1993

First Lady, Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mrs. Clinton:

Congratulation upon your being named to direct and move the health care front center and to a conclusion.

As the CEO of Davies Medical Center for the past 37 years, I've heard and seen all the proposal that have been talked about with little action, except the passage of Medicare by President Truman.

Upon my arrival here in 1955, I learned that non-profit organizations need not provide its employees unemployment insurance. No one could tell me why non-profit employees should be excluded.

In 1956 Davies provided its employees with unemployment insurance, the first non-profit corporation in the State of California to do so. You can imagine how many friends in non-profit corporations I had left in San Francisco.

Legislation was enacted in 1956 and all non-profit corporations must provide unemployment insurance. Which leads me to my favorite quotation: "God so loved the world that He didn't send a committee."

Do away with the health insurance industry. In most instances they act as a middle man, making a profit, buying and selling HMO (providing windfalls for management who hold stock-option and stocks) none of this benefits the patient.

May I suggest you expand the Medicare and Medicaid coverage to all those you plan to cover under single payor, U.S. Government. To fund the national health system, institute a national sales tax of ___ cents, individuals with incomes of \$400,000 or more; husbands and wives with incomes of over \$600,000 pay a surtax of ___ % and any one with more than \$1,000,000 a surtax of ___ % on every \$1,000,000 of income, including tax deductible investments.

President Clinton and you are at the right place at the right time in history to expand the present single payor national health system.

First Lady, Hillary Rodham Clinton
February 3, 1993
Page 2

Medicare for all Americans. Cost controls have been in place for hospital reimbursement by Medicare through Diagnostic Related Group since 1983. Cost controls are now in place for health providers through Resource Based Relative Value Systems.

Medi-Cal hospitals negotiate with State of California, California Medical Assistance Commission and it's tough to get your actual cost. So the State does a helluva job for its taxpayer and not so well for hospitals.

How does one control provider costs as they do in Canada. The government negotiates reimbursement of services with the hospital providers on even years and with the health care professionals, doctors, therapists, etc., on odd years.

Thereby prohibiting a national strike from occurring, as half the health team can't move and the other half dare not go out on strike. The voters would make it unbearable for a striker to strike a program that provides health coverage to all citizens of the United States of America.

You may wish to contact Jane Fulton, Ph.D. from The Health Group, in Ottawa, Canada. She is very knowledgeable about the Canadian Health System and is a great speaker.

I have been and am presently a member of the State of California's "California Health Facility Finance Authority;" enclosed is my biography.

I would be pleased to talk to you, Mr. Ira Magaziner or anyone else if you so wished.

Continued success to you and President Clinton in all your endeavors.

Cordially yours,



GEORGE J. MONARDO
Vice Chairman & CEO

GDM:bg
encl.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. resume	George D. Monardo, Personal Data [partial] (1 page)	nd	b(6)

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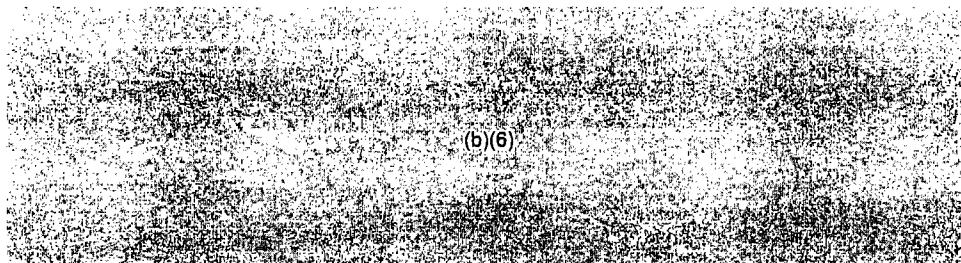
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GEORGE D. MONARDO

Personal Data

Birthplace:
Married:
Children:

Residence:
Business:



004

Education

X-ray Technique Course, State University of Iowa, Iowa City - 1940-1941
U.S. Navy - 1942-1945
A.A., Long Beach City College, Long Beach, California - 1948
B.S., Business Administration, Northwestern University - 1950
Masters Degree, Hospital Administration, Northwestern University - 1951
Faculty Member, University of California Program in Hospital
Administration, Berkeley Lecturer - 1957 - 1967
Professional Lecturer and Advisor, Golden Gate University, Health
Services Management, San Francisco, California - 1974-1986

Work Experience

X-Ray Technician, City Health Department, Long Beach, California -
1946-1948
Administrative Residency, Los Angeles County Bureau of Hospitals -
1950-1951
Administrator, San Pedro Community Hospital, San Pedro, California -
1951-1955
Administrator, Franklin Hospital, San Francisco, California 1955-1966
Executive Vice President, Franklin Hospital, San Francisco 1966-1971
Chief Administrative Officer and Secretary, Franklin Hospital
Foundation - 1959-1971
President and Chief Executive Officer, Franklin Hospital Foundation -
1971
President and Chief Executive Officer, Ralph K. Davies Medical Center,
Franklin Hospital - 1972 to 1988
Vice Chairman and Chief Executive Officer, Davies Medical Center,
1988 to Present

Professional Affiliations

Fellow, American College of Hospital Administrators - 1960 to present
Member, American Hospital Association, California Hospital
Association, and Western Hospitals Association - 1955-Present
Author, Articles in professional journals

Community Activity

President, San Pedro Chamber of Commerce, San Pedro, California -
1953; Member - 1953-1955

Vice President and Director, San Francisco Comprehensive Health Planning Council - 1968-1971
Director, San Francisco Comprehensive Health Planning Council - 1968-1974
Director, Bay Area Comprehensive Health Planning Council - 1968-1973
Director, San Francisco Health Professionals Council - 1968-1975
Director, American Association for Comprehensive Health Planning - 1971-1972
Chairman and Member, Board of Directors, Saint Vincent's School, San Rafael, California - 1975-1978
Director, West Bay Hospital Conference, San Francisco, California - 1976-1978, 1980-1982 (includes all hospitals located in the Counties of San Francisco, San Mateo and Marin)
Member, City of Mill Valley's Proposition 13 Budget Committee, Mill Valley - 1978-1979
Director, Hospital Council of Northern California - 1981 - June, 1985

National, State or Local Government Appointments

Member, Advisory Health Council, State of California, 1981-1985
Appointment made by Willie L. Brown, Jr., Speaker of the Assembly
Member, California Hospital Facilities Finance Authority, March 1983-1995
Appointment made by Willie L. Brown, Jr., Speaker of the Assembly
Member, Health Planning Law Revision Commission, State of California, March 1982 - March 1983. Appointment made by Willie L. Brown, Jr., Speaker of the Assembly
Member, California Commission on Health Care Policy & Financing, 1991
Appointment made by Willie L. Brown, Jr., Speaker of the Assembly
Member, Provider Task Force to Legislative Coalition for Health Care -
Appointment by Senator David Roberti
Member, National Advisory Council on Nurse Training - 1970-1974
Appointment made by Secretary Elliot L. Richardson, Secretary of Health, Education and Welfare on August 5, 1970 - 1974
Member, San Francisco Emergency Medical Care Committee - 1978 to Present. Appointment made by San Francisco Board of Supervisors
Chairman, San Francisco Emergency Medical Care Committee - 1976-1980
Member, Marin County Mental Health Advisory Board - 1970-1978
Appointment made by Marin County Board of Supervisors
Chairman, Marin County Mental Health Advisory Board - 1974-1975

Elected Official

Mill Valley City Councilman - 1960-1964; Vice Mayor, City of Mill Valley - 1964

Corporate Boards

Chairman and President, Franklin Holding Corporation - 1981 -
Trustee, Ralph K. Davies Medical Center, San Francisco, CA - 1972
Advisory Director, Blue Cross Northern California, - 1981-1984
Chairman and President, "M" Health Foundation - 1985 -
Director, Blue Cross of California - Woodland Hills, California - 1985-
Director, American Shared Hospital Services, San Francisco, CA - 1985 -
Director, California Hospital Insurance Corporation, Inc. Sept. 1990 -

THE WHITE HOUSE

February 7, 1994

James J. Mongan, M.D.
UMKC School of Medicine
2411 Holmes Street
Kansas City, Missouri 64108

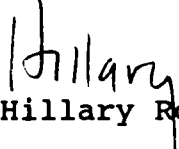
Dear Jim:

Thank you for your recent letter and Annapolis address to senior congressional staff.

With your support and dedication to the imperative of universal coverage, I am confident that the answer to history's question will be, yes. The President and I will do everything we can to make it so.

With appreciation and warm regards,
I am

Sincerely yours,


Hillary Rodham Clinton



Truman Medical Center
 2301 Holmes Street
 Kansas City, MO 64108
 816) 556-3153



University of Missouri-
 Kansas City
 School of Medicine
 2411 Holmes Street
 Kansas City, MO 64108
 816) 235-1808
 FAX: (816) 235-5277

James J. Mongan, M.D.

Executive Director, TMC
 Dean, UMKC
 School of Medicine

cc: Melanne

Pam - to Ty + R

REC 1 1994

January 24, 1993

PHOTOCOPY
 HRC HANDWRITING

First Lady Hillary Rodham Clinton
 The White House
 Washington, D.C.

Dear Mrs. Clinton:

I thought you might be interested in the attached, especially pages 10 to 13.

After listening to Senators Moynihan and Dole this past week or so, it is clear that the struggle to achieve Universal Coverage will continue to be difficult.

At this point it appears that a bipartisan backing away from Universal Coverage due to a distaste for mandates and taxes has already begun.

The only thing that might make this year different will be the continued effort put forth by you and the President to keep the nation focused on the historic goal of Universality.

We have never before had a President and First Lady, who could, and would, go before the cameras a few days before each key committee vote on the inevitable substitute motion gutting Universality, and focus the American people on the consequence of that vote.

Your continued efforts will be essential. If there is any way I can help, please let me know.

Sincerely,

James J. Mongan, M.D.
 Executive Director, TMC
 Dean, UMKC School of Medicine

KEYNOTE ADDRESS

RETREAT FOR SENIOR CONGRESSIONAL STAFF

Sponsored by:

Alliance for Health Reform
Catholic Health Association

Annapolis, Maryland
January 7, 1994

Presented by:

Dr. James J. Mongan
Executive Director, Truman Medical Center
Dean, University of Missouri-Kansas City School of Medicine

The one hundred congressional staff people here this morning, will play an absolutely critical role in the health care debate over the next nine months. For every one of you, whether a relative new-comer or a seasoned veteran, in some sense, all of your career to this point has been a preparation for nine months you will probably never forget. And, I suspect for most of you, what you do in the next nine months, may have more impact on our nation and its people than what you will do over the rest of your careers.

That is not intended to be a depressing thought—it is merely intended to point out how the tides of history and the courses of people's lives are such that a few key people, such as yourselves, end up in a critical place at a critical time.

I believe that I was asked to speak today, because, in a sense, I "walked in your shoes" a few decades back, and had an opportunity to deal with some of the pressures, questions, conflicts and uncertainties which you face today. I served as a member of the Senate Finance Committee staff from 1970 to 1977, and then with the Carter Administration at HHS and the White House, from 1977 to 1981.

In the next fifteen minutes I would like to distill the most important lessons I learned in those eleven years, and since.

Fifteen minutes forces focus, and I will focus on the one most important tension in this debate—the tug between the desire for Universal Coverage on the one hand, and the

desire to avoid taxation and mandates on the other. There are many other very important issues—cost control issues, benefit issues, administrative issues -but none of them will define the debate, and shape the outcome, as much as the tension between coverage and financing.

It was the financing issue that sank health insurance proposals in the Ways and Means and Finance Committees in the early to mid 1970s; and that sank the Carter Administration's proposal in the late 1970s. So I will focus my remarks on this tension between coverage and financing.

I will proceed as follows:

- First, I'll say a word about coverage, and why it is central to this debate,
- Then, I'll focus on the major competing approaches to financing coverage,
- Then, I'll say a word about some middle ground among these approaches, and,
- I'll close with a hard headed word or two, on politics.

Why do I assert that coverage, and specifically Universal Coverage, is central to this debate? For three reasons. First, because there is a real problem out there. Most of you accept that, although if indeed you are representative of your principal's views, there are probably ten or twenty percent of you who are not convinced it is a real problem.

An attack has already begun and will continue, not so much on the validity, but on the meaning of the oft-quoted number of 37 million people without insurance in the United States. Some attempt to minimize the impact of that number by pointing out that some of these people are between jobs and without coverage for less than three months. But in fact, about 85% of these 37 million are without coverage for more than three months. And, a full analysis must go on to point out that 61 million, or 26% of our people, are without coverage at some point over a two year period. All 61 million suffer some risk, anxiety and uncertainty, and many million more are locked into jobs for fear of losing coverage.

One other point on this problem—it is not just an economic problem—it is a health problem for the millions of chronically uninsured Americans. Some like to say that the uninsured get medical care when they need it. Though that is very often true for dramatic, acute, occurrences like child birth or exposed fractures, it is most often not true for chronic killers such as hypertension, diabetes and heart and respiratory diseases which frequently go untreated in their early controllable stages.

The second reason Universal Coverage is central to the debate, involves its relationship to controlling costs, the other important driving force in this debate. Most members of Congress, are somewhat nervous about heavily regulatory approaches to controlling costs. Most of these in turn, particularly the more conservative, have embraced "Managed Competition" as a more politically palatable approach to cost control. But, "Managed Competition" cannot work without very broad coverage. You simply cannot

expect health plans to compete, when carrying varying burdens of indigent care. The physicians and hospitals within a plan will in fact be forced to exclude the uninsured making their situation even worse than today. This link between Managed Competition and Universal Coverage has been preached at length by the most senior advocates of the Market Place, such as Alan Enthoven and Paul Ellwood, and it is an issue which will not conveniently go away.

The third reason Universal Coverage is central to the debate, is political. In my opinion, there will be a major political back-lash if a bill passes which does not provide very broad coverage. People's expectations about their coverage now, and the security of that coverage in the future, have been raised by both Democratic and Republican rhetoric. The debate has been cast as among competing means to achieve very broad coverage—none advertise their bills as falling far short of Universal Coverage. If we end up with vague, unfinanced goals for broader coverage, millions will feel duped and misled.

Now, although there is broad support for the principle of Universal Coverage from among a broad variety of groups—State and Local Government groups, business and labor groups, provider and consumer groups, Seniors, Children's and Minority groups, and Religious organizations — although there is broad support; there is less support, and even less consensus, on the financing needed to make broad improvements in coverage a reality. There is, as I have said, a tension between coverage and financing which lies at the very heart of the debate you are about to begin.

As you all well know, there have been three generic approaches put forth to finance broad improvements in coverage. Let me very briefly review each and their important pros and cons.

- First are the all-payor approaches, modeled on Canada or our own Medicare program; which would levy a direct federal tax, which would in good part replace private premiums, and federalize the financing of our health care system. The arguments in favor of this approach are that it could, and indeed does in a number of other countries, achieve the goal of Universal Coverage, and that it arguably could limit many current administrative expenses associated with private insurance. There are also downsides to this approach and I'll mention two. First, it would involve a substantial increase in the level of federal taxation, and most members of Congress seem not to believe that they can explain to constituents, the extent to which those taxes replace current private insurance premiums. Secondly, this approach with its very visible governmental role runs directly against the anti-big government ethos of our society.
- The second approach to financing broad coverage expansion, has been the employer mandate approach which seeks to build upon the current public/private system by mandating health insurance payments by all

employers, and establishing federal subsidies for the unemployed and heavily impacted small businesses. The advantage of this approach is that since over three-quarters of the uninsured have a relationship to the labor market, you could with some additional subsidy for those not related to the labor market, achieve very broad coverage expansion. Again, this model has been extensively used in other countries. Another advantage of this approach, in the eyes of some, is that it can be less disruptive to our current system than many other approaches. A major downside appears to be significant opposition from the Small Business community, in spite of any subsidies offered. Another downside to the employer mandate is that given the complexity of the current labor market and family employment patterns, employment based approaches become very complicated, very rapidly.

- The third approach to financing broad coverage expansions has involved the concept of an individual, rather than an employer mandate, under which all individuals would be required to have health insurance coverage, with subsidies for those with low income. This approach has the strong political appeal of avoiding the fierce battle over employer mandates and yet seeming at the same time to offer a route to Universal Coverage. But this approach, too, has its problems. One is a concern about potentially encouraging many employers who offer coverage, to drop that coverage. Some employers might

maintain coverage, some might substitute higher wages or other benefits and some might invest the resources elsewhere. A thorough analysis of the range of potential impacts would be useful to the debate. The other major concern regarding an individual mandate is that its effectiveness in achieving Universal Coverage is heavily dependent upon the adequacy of the subsidies made available. With so much attention focused on the federal cost of all-payor approaches, and employer mandate approaches, there has not yet been a full opportunity to debate the federal subsidy cost associated with an individual mandate. Any such analysis would be dependent upon two assumptions — the cost of a proposed benefit package, and an assumption about what percent of their income families can, and should be reasonably expected to, apply to the costs of mandated health insurance payments. It is more than likely that the individual mandate approach, to be at all effective in expanding coverage substantially, will entail the need for significant subsidies and tax increases. We should begin the important analysis of these numbers.

One more word about a financing issue common to all three financing structures. Advocates of all three approaches attempt to minimize the extent of taxes or mandated premiums by relying on savings from current health expenditures. Many members of Congress would like to say that all additional federal costs could, would and should be offset by reductions in federal costs for Medicare and Medicaid resulting in broadly

expanded coverage with no new taxes—surely the dream of anyone who must run for office. But, I urge you all to watch the math very carefully. Very real savings in Medicare and Medicaid would result from comprehensive health reform. But, it is highly unlikely that the costs of adequately subsidized Universal Coverage, could be offset by Medicare and Medicaid savings alone, and any such assertion should be examined very carefully. In particular, proposals to phase in coverage expansions only when federal savings have been achieved, must be analyzed and projected with great care; lest we promise the voters soon, something which might well not be achieved in our lifetime.

Let me turn now from this analysis of competing approaches to financing, and focus for a moment on the possibilities of combining elements of each. It is not my intent this morning to attempt to set out a so-called compromise proposal.

I have neither the standing nor the position to attempt that task. I would only like to suggest the obvious—that is that these three competing approaches can be mixed in a number of ways. Let me just mention a few, illustratively.

If the issue of an employer mandate and its impact on small employers, in particular, seems problematic, one might want to look at limiting the employer mandate to firms with more than 25 or 50 workers and combining that with an adequately subsidized individual mandate for workers in smaller firms. Yes, there would be issues of potential employer evasion at the firm-size margin, but given the percent of larger employers who already offer

coverage, it should be an issue that could be dealt with. A number of funding sources could be explored to subsidize the individual mandate including sin taxes, limiting deductibility for health insurance premiums and other taxes. There might also be an element of extensions of Medicare coverage, to early retirees, or to those disabled for 12 as opposed to 24 months, or to other groups, which might be helpful in structuring a mixed approach to financing.

There is a great deal of room for "politics" in its best and most noble form, as you and your principals grapple with this critical set of issues.

Now let me conclude my remarks, with a hard headed word or two on politics. As I said, I have seen major proposals to provide comprehensive coverage founder on at least two occasions—the Nixon and Kennedy-Mills proposals in the early 1970s and the Carter proposal in the late 1970s. They foundered on the tension between coverage expansion and financing. More specifically, there are two political currents which dragged these proposals under.

First, although a majority of the public and their representatives appear to favor Universal Coverage, there are a significant number, particularly on the conservative side of both parties who subordinate the desire for Universal Coverage to the desire to avoid any new taxes or mandates. This year, our nation, its citizens and their representatives will have

to face, in a more public and focused spotlight than ever before, this tradeoff between the desire to broaden coverage and the desire to avoid any taxes or mandates.

With a normal "inside the Beltway" political decision, that kind of trade-off is made in the minds of members of Congress. With the attention that will be focused on this issue, the trade-off will be made in the minds of millions of our more informed citizens. Our representatives -- your bosses -- will do what they do very well: they will attempt to read that voter sentiment as it develops.

Ultimately this issue will come down to a political judgment which will be made as this spring progresses, mostly by members of the conservative wings of both parties, as they look to the November election. They will have to sense the degree to which the public really values broader more secure health insurance coverage. They will then decide to either support broad legislation and attempt to put as conservative a stamp on it as possible, or pass limited legislation, judging that the voter's desire for broader coverage and security is thin and little back-lash will result; or, if they sense little support at all for broader coverage and security, they will stalemate the issue and run in November on a platform minimizing health concerns and stressing opposition to taxes and mandates.

I believe many of your principals have not yet made that judgment, and that much of their decision will be determined by the developing mood of the public as this debate takes shape.

The second major current which blocked passage of comprehensive legislation twice in the 1970s was what I would label "incrementalism", Our Government tends to operate incrementally—generally not taking bold steps but rather building gingerly on what has been built before. There are two reasons for this.

First, on most issues you have a fair proportion of the population that does not want things to change, and will tend to oppose any major change. In addition, our system of government is structured to make change difficult—with numerous hurdles any major legislation must pass, and numerous chokepoints to block passage.

So there is a strong tendency to work incrementally, and at the margin of many issues , given the difficulty of passing sweeping change.

But here again, there is a judgment which will be made over the next nine months. There will be a strong temptation to avoid comprehensive legislation, eliminating all mandates and eliminating Universality, and to work at the margins on Medicare, Medicaid and private insurance market reforms. But, in the glare of public attention will that be enough? Imagine your principals in the papers and on the talk shows, after passage of minimalist incremental legislation, being pressed as to how many million remain uninsured, as to what happens when people lose their coverage, and as to how we will deal with continued health care cost increases and their impact on the federal budget and our

economy. Incremental legislation might not seem as attractive after passage, as it might appear before.

Yes, we do operate incrementally—but we also take bold steps as a nation—when the public is ready. And, it is in fact these bold steps—not the rest of what we do—that are remembered by history. Get out your college history books over the next few weeks. See how little mention is made of most domestic legislation. Note the bold steps that are mentioned—steps such as the Federal Reserve legislation of 1913, Social Security in 1935 and the Civil Rights and Voting Rights Act of the 1960s.

With respect to the issue you will be grappling with these next nine months, history will have only one question—Is everybody covered? Passage of Universal Coverage will be historic. Small market insurance reform, modest Medicaid expansion, limits on Medicare spending will not meet history's test.

If the American people are indeed seeking the security of Universal health care coverage, and if the American people want our Country -- the greatest nation on earth -- to meet the test so many other countries, without our riches, have met; then members of Congress will recognize that desire, and they -- and you -- will play a part in shaping History.



Truman Medical Center
 2301 Holmes Street
 Kansas City, MO 64108
 (816) 556-3153

August 31, 1994

First Lady Hillary Rodham Clinton
 The White House
 Washington, D.C.

SEP 6 1994

Dear Mrs. Clinton:

About a year ago, I prepared the attached chart "The Slippery Slope from Universality" which, unfortunately, accurately depicted the deterioration of the drive for universal coverage and laid out how that deterioration would unfold. It gives me no pleasure to have seen this scenario play-out over recent months.

I am writing to a number of Executive and Legislative Branch officials at this time because of my strong concern that the debate has now deteriorated well beyond what I foresaw a year ago. I have attached a second chart called "The Slippery Slope to Diminished Coverage" which illustrates how we appear to be heading for a situation which would result in the deterioration of the existent Medicare and Medicaid programs for the poor and the elderly, and the potential for decreased private coverage.

The continued deterioration of this debate poses a major challenge to those who favor reform. There is an old saying among those who favor incremental change, "Do not let the best become the enemy of the good". There is much wisdom in that expression. However, supporters of reform must watch carefully for that point at which an incremental approach does more harm than good. In short, the good must remain the enemy of the bad.

As the search for an "incremental" approach begins inevitably to veer towards diminished coverage, doing nothing will at some point become better than slipping backwards. It would be better to continue the fight for true reform into 1995 or even 1997 if that proves necessary.

Sincerely,

James J. Mongan, M.D.
 Executive Director, TMC
 Dean, UMKC School of Medicine



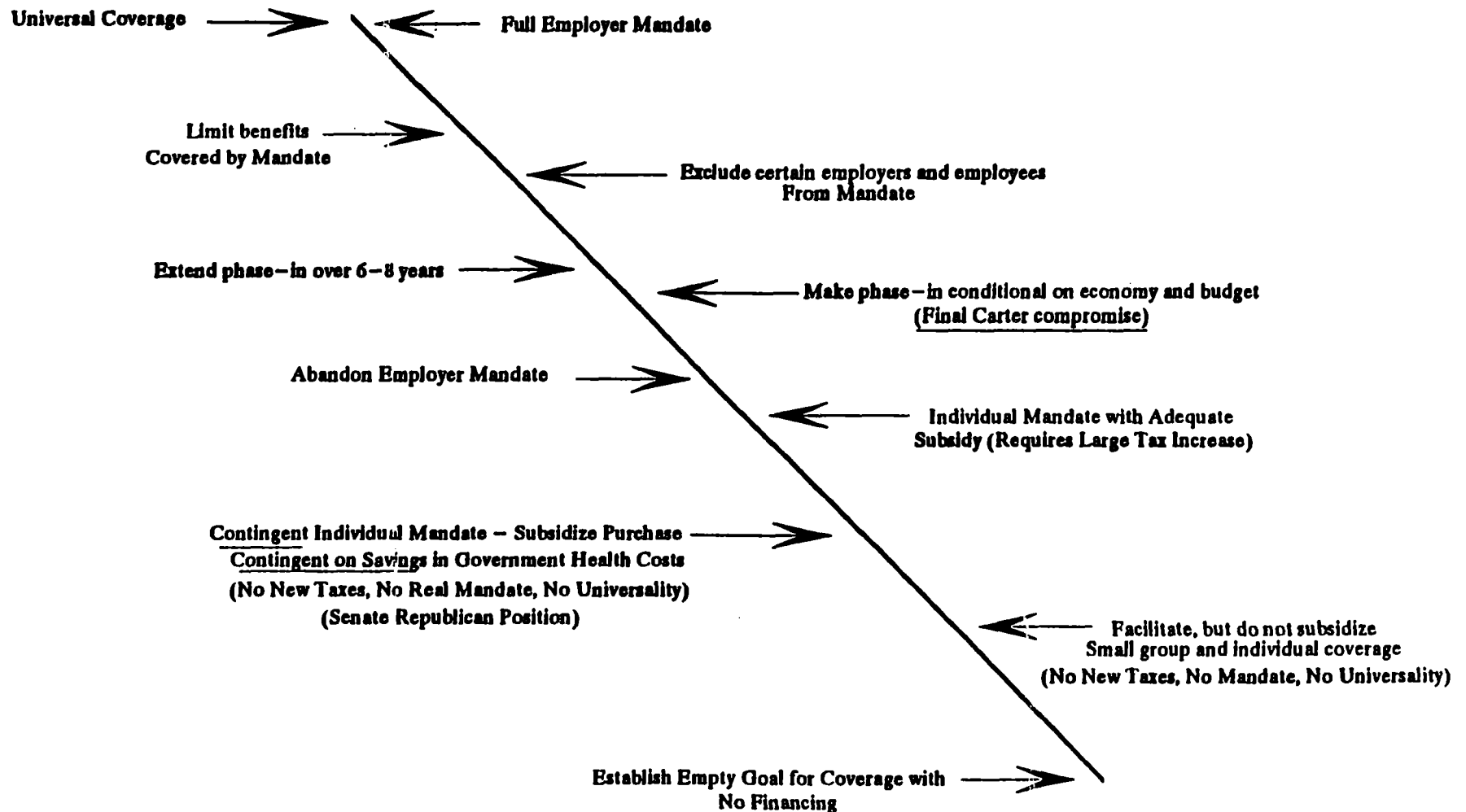
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 Kansas City, MO 64108
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James J. Mongan, M.D.

Executive Director, TMC
 Dean, UMKC
 School of Medicine

SLIPPERY SLOPE FROM UNIVERSALITY

*Begin With Universal Coverage Through
Employer Mandate and Expanded Public Program*



Prepared By:

Dr. James J. Mongan

- Executive Director, Truman Medical Center
- Dean, University of Missouri-Kansas City, School of Medicine

SLIPPERY SLOPE FROM UNIVERSALITY - Part II

SLIPPERY SLOPE TO DIMINISHED COVERAGE

End Point of Previous Chart

Inability To Agree On Financing
Results In Establishment Of Empty Goal
For Universal Coverage
With No Financing

Abandon Goal Of
Universal Coverage -
Substitute 95% Coverage
As Functional Equivalent

Overtly Disavow Goal Of Universal
Coverage - Seek Expansion Of Coverage
To 91% Through Subsidies Contingent On Savings
From Medicare And Medicaid Budget Cuts -
No Broad Taxes Or Mandates

Set Deficit Reduction As Higher
Goal Than Any Expansion of
Coverage - Slash Medicare And Medicaid
To Reduce Deficit 100 Billion - If Any
Funds Remain Apply To Coverage Expansion

NEW BOTTOM OF SLOPE

- No Universal Coverage
- No Goal For Universal Coverage
- No Guaranteed Expansion of Coverage To Any Target Level
- Establishment Of 100 Billion Deficit Reduction
As Precondition for Any Expansion
- Significant Reductions In Medicare And Medicaid
For Poor And Elderly (With No Off-setting Benefits)
- Insurance Market "Reforms" With Potential To Drive
Up Rates And Decrease Coverage When Not Tied To
Universal Coverage

Prepared By:

Dr. James J. Mongan - Executive Director, Truman Medical Center
- Dean, University of Missouri-Kansas City, School of Medicine

August 30, 1994

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005a. letter	From: Hillary Rodham Clinton, To: Ms. Mary Musk (1 page)	10/28/94	b(6)

COLLECTION:

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First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

sb291

RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005b. letter	From: Mary Musk, To: Hillary Clinton (3 pages)	10/6/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

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RESTRICTION CODES**Presidential Records Act - [44 U.S.C. 2204(a)]**

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005c. memo	From: Karen Guss, To: File, Re: letter from Mary Musk (2 pages)	11/21/94	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:

HRC Health Care Correspondence 94 - M

2014-0159-S

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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THE WHITE HOUSE

March 16, 1994

Ms. Blanche Moore
Director of Institutional Relations
Arkansas Children's Hospital
800 Marshall Street
Little Rock, Arkansas 72202-3591

Dear Blanche:

Thank you for your letter and for passing on the information from NACHRI. It was good to hear from you again and I appreciate your keeping me informed.

With warm regards, I remain

Sincerely yours,


Hillary Rodham Clinton

see: Melanne



800 Marshall Street, Little Rock, Arkansas 72202-3591, (501) 320-1100 or TDD (501) 320-1184

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Betty A. Lowe, M.D.
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Louis Rosen
Frank D. White

March 7, 1994

Mrs. Clinton
The White House
Washington, DC 20500

Dear Mrs. Clinton:

Thank you so much for spending the time talking with me on Thursday. I am enclosing the information you requested regarding TennCare. Many state Medicaid managed care programs will be detrimental to children's hospitals, but TennCare probably represents the most damaging system so far. I understand that you will not be able to speak to NACHRI, but I thought you might still want this information.

I hope that you will be able to put in a good word for the Arkansas Children's Hospital Nutrition Center with Secretary of Agriculture Espy.

It's such a delight to visit The White House and see all the Arkansans working there. You and the President have really made the people of Arkansas feel a part of your success.

Sincerely,

Blanche

Blanche Moore
Director of Institutional Relations

Enclosure

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

CHILDREN'S HOSPITALS KEY CONCERNS WITH TENNCARE

March 1994

Children's hospitals are supportive of Medicaid managed care programs for their potential to improve children's access to services and provide timely preventive and primary care services. When major problems occur, as they have in the case of TennCare, they primarily are due to why and how a state designs and implements its program rather than fundamental flaws in the overall concept.

The TennCare program is of concern not only to the children's hospitals in the state of Tennessee but to all children's hospitals because of its precedent-setting potential. A number of state Medicaid programs have indicated their intent to adopt a TennCare-like approach to reforming their Medicaid programs.

The major concerns children's hospitals have with the TennCare program include:

INADEQUATE FINANCING

- Tennessee excludes costs for graduate medical education (GME), capital and disproportionate share hospital (DSH) payments from the Medicaid cost base used to determine the capitation rates.

The Medicaid program nationwide is generally recognized as being underfinanced. Excluding these significant costs makes it unlikely that managed care organizations can pay children's hospitals adequate reimbursement rates. Most children's hospitals are primary teaching sites for pediatricians and pediatric subspecialists. They are also important Medicaid disproportionate share hospitals (DSHs). The loss of medical education and DSH funds will place a tremendous financial burden on children's hospitals.

Tennessee has agreed to develop two "supplemental pools" for GME and "essential providers" but does not have to guarantee to finance the pools. The definition of "essential provider" is the prerogative of the state and Tennessee will give first priority to all its public hospitals.

- Inadequate capitation rates are further discounted to reflect expected charity care contributions from providers; the availability of local government funding; and deductibles and copayments to be collected by managed care plans and/or providers.

Tennessee assumes that, on average, providers give five percent charity care. Children's hospitals which devote nearly half of their care to low income children experience significant levels of uncompensated care due to Medicaid shortfalls and other charity care. The impact of these discounts will fall disproportionately on children's hospitals and other high volume providers of care to low income populations.

NO ASSURANCE OF ACCESS OF CHILDREN TO ESSENTIAL PEDIATRIC PROVIDERS

- TennCare does not require that managed care organizations (MCOs) contract with essential providers nor does it guarantee that children's hospitals will be designated as essential community providers. In Tennessee and in metropolitan areas around the county, children's hospitals have become an essential safety net to children of low income families, especially those assisted by Medicaid. With the pressures created by inadequate capitation rates and no requirement that MCOs contract with children's hospitals, children enrolled in some managed care plans may not have access to any children's hospital services.
- TennCare does not recognize "centers of excellence" for child health. MCOs must demonstrate to the state that it has adequacy capacity to serve expected enrollees but no standards are in place requiring children's access to appropriate providers including pediatric subspecialists or pediatric tertiary inpatient services. Centers of excellence for children's specialized care needs are not recognized under TennCare. Parents of children assisted by Medicaid, particularly those with congenital or chronic conditions, may not be afforded the option to choose pediatric specialized providers for the care of their children.

NO SPECIAL CONSIDERATIONS FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

- TennCare does not recognize explicitly the special circumstances of children with special health care needs. Tennessee has little experience with the enrollment of children with special health care needs in managed care plans and has not developed any special access and quality standards to assure these children have timely access to pediatric specialists and are not underserved due to financing pressures.
- TennCare does not provide adequate risk adjustment for children with special health care needs. TennCare has developed eight capitation rates based primarily on age and

sex criteria, not health status. Risk adjustment is essential to avoid the negative effects of adverse selection under managed care, when a provider such as a children's hospital receives a greater number of high risk patients but receives payment based on an "average" patient. Children's hospitals are particularly vulnerable to adverse selection as, on average, more than 70 percent of their care is to children with chronic or congenital conditions. Tennessee has also not established alternatives to risk-adjusted capitation such as stop-loss or reinsurance.

Tennessee has little prior experience with capitated, risk-based managed care systems and programs and this lack of experience and resources, along with an aggressive implementation timetable, serves to exacerbate the problems outlined above.

Tennessee has had little experience with commercial or Medicaid managed care organizations operating within the state. About 120,000 state employees are enrolled in a Blue Cross/Blue Shield Preferred Provider Organization. Medicaid managed care experience is even less, with only 16,000 Aid to Families with Dependent Children (AFDC) women and children currently enrolled voluntarily in one health insuring organization. Under TennCare, the state plans to enroll 1,000,000 Medicaid recipients and 300,000 uninsured individuals during 1994, the first year of implementation.

As stated in its waiver request, Tennessee also does not plan to hire additional staff during this first year of implementation. Nor did the state involve providers, recipients or patient advocates in its planning process. This gap between Tennessee's ambitious plan as well as aggressive timetable and the state's lack of existing capacity and resources have thus far created numerous enrollment, communication and service delivery problems.

As a comparison, California, a state nationally recognized as a managed care leader and with 20 years experience with Medicaid managed care, is taking a more reasoned approach to its plan to expand its Medicaid managed care program. California already has enrolled 600,000 (12%) of its Medi-Cal population into managed care programs. Its new managed care plan has as a goal enrolling 50 percent of Medi-Cal recipients over a three year period.

As more states move aggressively to establish or expand Medicaid managed care plans, state capacity, resources, financing and implementation design and schedule, plus involvement and support of the provider and patient community, must be key considerations in assessing the feasibility and reasonableness of a state's proposal.