Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	From: Hillary Rodham Clinton, To: Breast Cancer Survivor [partial] (2 pages)	4/20/95	b(6)
001b. letter	From: Breast Cancer Survivor, to: Mrs. Clinton [partial] (2 pages)	9/23/96	b(6)
001c. letter	From: Blue Cross / Blue Shield of Georgia, To: Breast Cancer Survivor [partial] (1 page)	3/28/94	b(6)
001d. fax	From: GA Surgery - W Paces, To: Policyholder [partial] (2 pages)	4/5/94	b(6)
001e. letter	From: Breast Cancer Survivor, To: Representative Cynthia McKinney [partial] (1 page)	9/23/94	b(6)
001f. letter	From: Representative Cynthis McKinney, To: Mrs. Clinton [partial] (1 page)	10/31/94	b(6)

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

FOLDER TITLE:
HRC Health Care Correspondence 95 - E,F

2014-0159-S
sb297

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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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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HRC
HC CORR 95-E,F

PERSONAL
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DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: ASB DATE: 12-5-13

PHOTOCOPY
PRESERVATION

F

Date: 02/14/95 Time: 08:48

Employers Cut Health Care Costs in 1994 With Moves to Managed Care

WASHINGTON (AP) Employers cut their employee health costs in 1994 by steering more workers into managed-care plans.

The average employer with 10 or more workers spent $3,741 per employee on health benefits, down 1.1 percent from the year before, the benefit consulting firm Foster Higgins said Monday.

That was a sharp dropoff from the 8 percent increase the year before and double-digit increases in earlier years.

The companies did it by boosting the percentage of workers enrolled in managed care health maintenance organizations, preferred provider organizations and point-of-service plans from 52 percent to 63 percent in a single year.

Managed-care plans emphasize primary and preventive care, including low-cost checkups, in hopes of keeping patients healthy.

The growth of managed care was most rapid in the Northeast and slowest in the South, according to Foster Higgins' survey of nearly 2,100 employers.

Big employers, those with more than 500 workers, had the most success in holding down their medical bills. Their costs fell by 1.9 percent, to $4,040 per employee.

Those with fewer than 500 employees, which generally offer less generous coverage, saw their costs climb by 6.5 percent, to $3,452.

For years, health costs have been rising at two and three times the rate of general inflation. But that spiral slowed dramatically in 1994 while Congress debated, and eventually discarded, President Clinton's proposal to make all employers and employees buy health insurance.

Forty-one million Americans, or 16.1 percent of the population, are still uninsured, and the number is rising.

''Employers that have embraced and moved to managed care have been rewarded,'' said John Welch, a principal with Foster Higgins' Washington office.

Fifteen percent of employers offered a point-of-service option in 1994, up from 4 percent in 1993. They charge patients more if they go outside the plan's network of doctors and hospitals.

Employers for the first time induced a significant number of retirees to join HMOs. ''Getting this high-cost population into low-cost plans will have a big impact on employers' health care liability over the long term,'' said Dave Rahill, also a Foster Higgins principal.

In the Northeast, 63 percent of covered workers were in managed care, up from 34 percent in 1993. Employers' costs declined 9.7 percent, to $3,851 per employee.

In the Midwest, managed-care enrollment grew from 51 percent to 60 percent while costs rose 0.7 percent, to $4,048.

The West, the bellwether for managed care, enrollment grew from 72 percent to 80 percent, and costs rose 2 percent, to $3,693.

In the South, managed-care enrollment inched up from 57 percent to 58 percent, and costs rose 3.9 percent, to $3,389.

A sample of all employers with 10 or more employees was surveyed by ICR Survey Research Group for Foster Higgins. The company said the results are valid for more than 550,000 employers with 68 million employees.

APNP-02-14-95 0850EST

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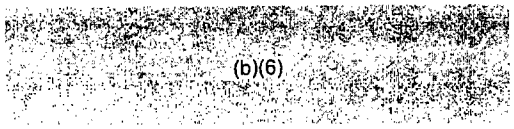
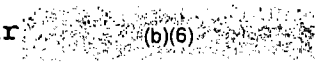
THE WHITE HOUSE

WASHINGTON

April 20, 1995



0019

Dear 

0019

Thank you for writing about your difficulty obtaining payment from Medicare for the mammogram you received last March.

As you point out, Medicare pays for what are called "screening" mammograms every other year. However, Medicare places no limit on the number of "diagnostic" mammograms. Because you were treated for breast cancer last year, the six-month follow up mammograms your doctor prescribed are diagnostic, and they will be covered by Medicare.

Many people agree that older women should receive mammograms every year and, therefore, that Medicare should cover annual mammograms for women aged 65 and older. However, many other well-respected scientists and physicians believe that mammograms performed every other year are just as effective as annual mammograms. This issue continues to be studied. I have brought your letter to the attention of Dr. Helen Smits, the Deputy Administrator of the Health Care Financing Administration, which runs the Medicare program.

Although it is clear that you are careful to take care of yourself and your health, you may be surprised to know how few of the women on Medicare obtain mammograms. Fewer than 40 percent of older women on Medicare have submitted a claim for a mammogram in the past two years. I have met with older women around the country to talk about mammography and Medicare, and during the next few months, I intend to continue to do what I can to help spread the word about the importance of mammograms and to urge older women to take advantage of this crucial Medicare benefit. I encourage you to remind friends and family who are 65 and older to obtain a mammogram at least every other year.

Thank you again for writing. You have my very best wishes for your continued good health.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

cc: The Honorable Cynthia McKinney

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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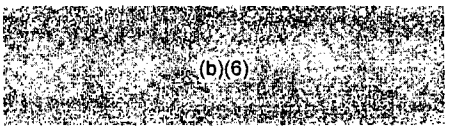


0016

September 23, 1994

Hilary Rodman Clinton
The White House
Office of the First Lady
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

I am a 67 year old breast cancer survivor. I can happily say this because I had a mammogram in conjunction with my annual physical in March of this year. This is the reason I am writing to you.

Medicare refused to pay for this mammogram because of my age. However, the mammogram showed very early cancer. I subsequently had a lumpectomy and six weeks of radiation. Their policy is to pay for a mammogram only every two years. They consider this a routine procedure. In my humble opinion a mammogram for women over 65 years old should be considered a diagnostic, not routine, procedure.

I support your efforts to reform the national health situation. We do need changes but we also need to review the methods we now have to keep healthy senior citizens healthy.

The ironic part of this whole episode is that Medicare paid the radiologist who read the x-ray, all the subsequent tests needed before surgery, a lumpectomy and the radiation and did not question one charge! Yet, it took them six months to approve payment of the original mammogram.

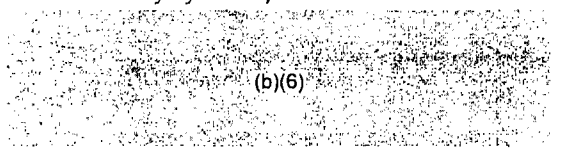
I am incensed that Medicare can arbitrarily decide who should and who should not have a mammogram! How many other women have they denied this procedure by not paying for it and who may have died of breast cancer because they were not diagnosed early enough!

My oncologist is scheduling me for a mammogram every six months for the next two years as a precautionary measure. My first one is scheduled for next week. I wonder if Medicare will refuse to pay for this one, too.

Enclosed are six documents to substantiate the information in this letter.

Thank you for taking the time to review this information.

Sincerely yours,



0016

enc: 1. Medicare letter, dated 3/28/94
2. Pathology report, dated 3/30/94
3. Cover letter from my surgeon, Dr. William A. Reid, dated 4/5/94
4. My appeal letter to Medicare, dated 4/18/94
5. Medicare reply to my appeal letter, dated 4/22/94
6. Medicare notification that bill was paid, after I called and asked for copy, dated 9/1/94

cc: Rep. Patricia Schroeder
Sen. Barbara Mikulski
Sen. Connie Mack
Sen. Barbara Boxer
Sen. Diane Feinstein
Rep. Cynthia McKinney

Withdrawal/Redaction Marker
Clinton Library

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001c. letter	From: Blue Cross / Blue Shield of Georgia, To: Breast Cancer Survivor [partial] (1 page)	3/28/94	b(6)

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

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BlueCross BlueShield of Georgia
A Member of the Blue Cross and Blue Shield Association,
An Association of Independent Blue Cross and Blue Shield Plans

Medicare

P.O. Box 9048
Columbus, Georgia 31908-9048
Beneficiary Customer Service - 706-322-4082
Provider Customer Service - 706-571-5417

404 953 3255

Federal Medicare
Intermediary

03/28/94

(b)(6) 601c

WEST PACES MEDICAL CENTER
3200 HOWELL MILL RD NW
ATLANTA GA 30327

RE: (b)(6) 601c
ICN:
SERVICE DATES: 03/10/94
03/10/94

MEDICARE COVERS A SCREENING MAMMOGRAM FOR A WOMAN OVER 65 EVERY 2 YEARS. A SCREENING MAMMOGRAM IS ALLOWED ONCE A YEAR FOR WOMEN FROM AGE 50 THRU 64. COVERAGE IS ONLY ALLOWED ONCE FOR A WOMAN AGE 35 THRU 39. A SCREENING MAMMOGRAM IS ALLOWED FOR A WOMAN AGE 40 THRU 49 IF AT HIGH RISK OR EVERY TWO YEARS IF NOT AT HIGH RISK.

ACCORDING TO THE INFORMATION ON YOUR CLAIM YOU DO NOT MEET THE REQUIREMENTS FOR COVERAGE OF THIS CLAIM. THEREFORE, NO PAYMENT CAN BE MADE FOR THE SERVICES YOU RECEIVED.

0403 OTHER IMAGING SERVICES - SCREENING MAMMOGRAPHY	1	$62.50
0001 CLAIM TOTALS	0	$62.50

IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE RIGHT TO APPEAL. YOU MUST FILE A WRITTEN REQUEST FOR REVIEW WITHIN 6 MONTHS FROM THE DATE OF THIS NOTICE. YOU MAY MAKE YOUR REQUEST THROUGH THIS OFFICE OR ANY SOCIAL SECURITY OFFICE.

BLUE CROSS AND BLUE SHIELD OF GEORGIA,INC.

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MEDICAL CENTER

DEPARTMENT OF PATHOLOGY

NAME: (b)(6) old DOB: (b)(6) old HOSP. NO. :944026423

DOCTOR(S):REID ROOM:ASU PATH. NO. :S94-1962

SPECIMEN:LEFT BREAST TISSUE DATE:03/30/94

Clinical History:LEFT BREAST MASS

DIAGNOSIS: INTRADUCTAL CARCINOMA, COMEDO TYPE WITH INTRALUMINAL MICROCALCIFICATIONS. THE LESION IS IDENTIFIED AT THE LINE OF SURGERY AND SHOWS FOCI OF MICROINVASION - left breast tissue with localization.

(174.9)

GROSS:
The specimen is received in the fresh state for faxitron examination labeled "left breast tissue". It consists of a lobular mass of flabby fat and breast tissues with a needle wire identification in place. The specimen measures 4.5 x 3.5 x 3.0 cm. An additional smaller sample measures 3.0 cm in diameter is present. The specimen is faxitroned in the whole, the identification needle removed, dipped in India ink, serially sectioned and faxitroned again. The cut section reveals areas of white breast tissue with a shiny cut surface and soft consistency. The faxitron study demonstrates presence of clustered microcalcifications similar to the ones identified in the mammogram.

INTRAOPERATIVE CONSULT: MAMMOGRAPHIC LESION OF MICROCALCIFICATIONS IS IDENTIFIED IN THE SPECIMEN.

Clustered microcalcifications are identified in four different slides and these are submitted in cassettes #1 through 4. Additional random samples are submitted in cassettes #5 through 10.
CA2/jlg

MICROSCOPIC:

Ten H & E stained sections are examined. The first four slides represent the area of microcalcifications identified in the faxitron study which demonstrates a linear lesion represented by a breast duct with neoplastic malignant changes of the ductal epithelium, proliferating in a ring-like fashion with the lumen occupied with cellular debris in which microcalcifications are present. The features are those of an intraductal comedo type carcinoma and the line of surgery in slides 1 and 3 appears involved with the lesion which has been painted with India ink. There are microscopic foci of breakthrough with microinvasion of ductal cells with desmoplastic reaction in slide #4 which has been examined at three deeper levels. Additional sections of the uninvolved portion of the specimen demonstrates breast tissue with no additional evidence of neoplastic lesions.

Carlos A. Zevallos, M.D./lf
3/31/94

C. A. ZEVALLOS, M. D.
PATHOLOGIST

C. H. THOLEN, M. D.
PATHOLOGIST

J. T. GODWIN, M. D.
PATHOLOGIST

C. P. GARRISON, M. D.
PATHOLOGIST

DR. SIGNATURE

TELEPHONED REPORT TO: PT NOTIFIED IDC EDC

MEDICAL CENTER

DEPARTMENT OF PATHOLOGY

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DOCTOR(S):REID ROOM:ASU PATH. NO. :S94-1962

SPECIMEN:LEFT BREAST TISSUE DATE:03/30/94

Clinical History:LEFT BREAST MASS

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Carlos A. Zevallos, M.D./jlg
03/30/94

C. A. ZEVALLOS, M.D.
PATHOLOGIST

C. W. NICHOLS, M.D.
PATHOLOGIST

J. T. GODWIN, M.D.
PATHOLOGIST

C. P. GARRISON, M.D.
PATHOLOGIST

IDC EDC

TELEPHONED REPORT TO: _____
DATE/TIME: _____

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: KAREN GUSS **PHONE:** 456-5603	**FROM:** HELEN L. SMITS, M.D. OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201 **PHONE:** 202-690-6726 **FAX :** 202-690-6262

TOTAL PAGES:	**ADDRESSEE'S FAX MACHINE NUMBER:**	**DATE:**
C+1	456-7431	1/4/95

REMARKS:

1/4/95

Memo to: Karen Guss

From: Helen Smith

I gather from the material you sent that Mrs. Clinton's reply to the breast cancer survivor has not yet gone. Here is some information that might help in the response:

The q. six month mammograms in the future should be paid because they are diagnostic (related to the previous cancer) rather than routine screening. If there was some particular reason to do the original screening mammogram, such as a family hisotry of the disease or other factors placing her in a high risk category, that should also have been coded as diagnostic and paid.

Our real problem with the mammogram benefit in Medicare is that beneficiaries simply don't use it enough; we're drafting a note from Bruce about that which should be over to Mrs. Clinton later this week. But you're right, we don't intend to increase the frequency of screening that we will pay for and we are supported in that by a number of expert organizations, including both geriatrics and cancer groups.

Let me know if I can be of any other help.

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001c [redacted] (b)(6)

RECEIVED
SEP 27 1994

September 23, 1994

Representative Cynthia McKinney
1 South DeKalb Center
2853 Candler Road
Suite 9
Decatur, Georgia 30034

Dear Representative McKinney:

Enclosed are copies of a letter and supporting documents I am sending to Mrs. Hilary Clinton in regards to a problem I had with Medicare. They refused to pay for a mammogram I had in March of this year because of my age. As you can see by the appeal letter I sent them, if I had not had a mammogram this year I could possibly be dead next year.

Because of finding the cancer in its earliest stages I was able to just have a lumpectomy and radiation and now I'm cancer free.

Please continue to fight for health reform and especially for senior citizens!

Miss McKinney, I also want to tell you how helpful your office staff were to me. I called your Decatur office several months ago to get the addresses of all the people on the enclosed list. Whoever answered the phone gave me all the addresses and was most gracious.

Sincerely yours,

[redacted] (b)(6) 001c

Enclosures: 7

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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October 31, 1994

Hillary Rodham Clinton
Office of the First Lady
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

Please find enclosed a letter my district office received from a (b)(6) 001f 001f (b)(6) She sent us a letter which she wanted forwarded on to you. It concerns her fight with breast cancer and also the struggle that ensued with Medicare. I thought her letter would be of interest to you. With warm personal regards, I remain

Sincerely,

Cynthia McKinney
Member of Congress

CAM: lsm
Enclosures
cc: (b)(6) 001f

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THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: February 17, 1995

Re: Jackson Hole Group

As I believe you know, Secretary Shalala recently accepted an invitation from Paul Ellwood to attend a meeting in Jackson Hole this weekend. She is scheduled to respond to their most recent health care proposal, which is attached for your review.

Also enclosed you will find Secretary Shalala's written response from which she plans to address the attendees this weekend. As you will note, behind the usual niceties, the letter is very critical and points out the shortcomings of their most recent take on health care reform. AARP'S John Rother, we are told, is planning on being at least as critical of the Jackson Hole proposal.

Lastly, because some essential information on the state-by-state impact of Medicare and Medicaid cuts will not be available until late in the week, we have decided to postpone the Wednesday Map Group meeting. We have rescheduled the meeting for Tuesday, February 28 and it is now on your calendar. Jen and I look forward to seeing you on Tuesday.

cc: Melanne Verveer

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FEB 17 1995

Paul M. Ellwood Jr., M.D.
President
Jackson Hole Group
P.O. Box 350
Teton Village, WY 83025

Dear Paul:

Thank you for the opportunity to review the new draft proposal of "Responsible Choices." I am looking forward to meeting with you and others in Jackson Hole to discuss our respective ideas for improving the nation's health care system.

I have appreciated the opportunity to work with the Jackson Hole Group in the past, in large part because we share a common commitment to improving both efficiency and fairness in the health care system. I think we all agree that health reform requires three elements to be effective — expanded coverage, lower costs and improved quality — and that a restructured marketplace is essential to achieving these elements. Our ultimate goal must be universal coverage in an efficiently operating marketplace.

You and your colleagues have made a significant contribution to the health care debate in this country by recognizing the critical role that consumer choice and private innovation can play in our health care system. I think that we both agree that choice is a critical element in improving quality and efficiency.

I was surprised, then, by the direction reflected in "Responsible Choices." The draft proposal seems to abandon your previous commitment to addressing the problems of the over 40 million uninsured in this nation. I understand that the political environment has changed, and that our strategies may need to change as a result. However, that does not alter the underlying fact that middle class people who lose their jobs, or working families struggling to get by, need some assistance to be able afford adequate health insurance.

The Jackson Hole Group has recognized this fact in the past, and has advocated substantial subsidies to assist the uninsured in purchasing private insurance. It deeply troubles me that the "Responsible Choices" proposal fails even to mention the need to move towards universal coverage, let alone suggest policies (short or long-term) to do so.

In fact, the arbitrary cap on funding for the Medicaid program proposed in "Responsible Choices" would actually decrease coverage. Over the past few years, enrollment in employer-based insurance has fallen by almost six percentage points (from around 66% to around 60% of the nonelderly population), while the percentage of the population covered by Medicaid has grown significantly. Between one-third and one-half of the projected annual growth in Medicaid spending results from projected growth in enrollment.

Furthermore, I am perplexed and disturbed that you would propose an arbitrary cap on the Medicare program. Like Social Security, Medicare is an inter-generational compact. Placing an arbitrary, pre-determined cap on Medicare spending, while at the same time eliminating its status as an entitlement, would put services to the elderly at risk and would violate that compact.

A cap on Medicare puts the elderly and disabled at risk. The vast majority of Medicare beneficiaries have modest incomes. Over 75% of beneficiaries have incomes below $25,000; 30% of beneficiaries get 80% or more of their income from Social Security. So while a voucher program like that proposed in "Responsible Choices" may expand choice for some beneficiaries, it would in fact diminish choice for many by effectively forcing them into a low-cost plan and away from the providers of their choice.

This does not mean that we oppose improving Medicare — quite the contrary. We are pleased that, during the Clinton Administration, projections for the average annual rate of growth for Medicare spending for the period 1996 - 2000 have decreased — by more than a percentage point a year — just in the period between the Mid-Session Review last spring and the President's Fiscal Year 1996 Budget. We are pressing ahead with improvements in Medicare management, data processing, contractor oversight, and program integrity activities.

Among the other improvements we are making in Medicare, I believe that we share a commitment to expanding and improving the managed care choices available to Medicare beneficiaries. Today, about 74 percent of Medicare beneficiaries have access to a managed care plan, and 9% of beneficiaries have enrolled in one. Enrollment is increasing rapidly — by over 1% per month. We also are working on ways to make our existing managed care program work better. Examples include our work with the industry to improve quality measures and the AAPCC methodology for the Medicare risk contracting program, and our collaboration with Alain Enthoven to design a competitive bidding demonstration. And, as we have testified in recent weeks, we are in the process of developing new managed care options under Medicare, including a PPO option.

While managed care appears now to be reaching a critical mass in private sector health programs, at least in some areas, it has taken many years to achieve this state. Many employers that have embraced managed care have moved cautiously to avoid disruption, by maintaining a fee-for-service option at affordable levels or by offering out-of-network options through point-of-service plans or PPOs. Most Medicare beneficiaries — and particularly the most elderly among them — have not had the benefit of a gradual exposure to managed care. I am strongly committed to expanding the managed care options available in Medicare, but the emphasis must be on choice. We should learn from the private sector and recognize that we need to move prudently if we are to foster understanding and acceptance of managed care approaches among beneficiaries.

I look forward to the upcoming discussions at Jackson Hole. We need to focus on how we can improve both the private insurance market and public programs. And we must discuss ways to expand coverage for vulnerable populations. I believe that there are many points on which we can agree. To me, making responsible choices means finding ways to improve what we have, not making arbitrary cuts in important programs that can leave the elderly, disabled, and poor at risk. I hope that we can work together over the coming months to accomplish meaningful health care reform.

Sincerely,

Donna E. Shalala

JACKSON HOLE GROUP

Paul M. Ellwood, M.D.
President

February 9, 1995

Secretary Donna Shalala
Department of Health and Human Services
200 Independence Ave, SW, Suite 615F
Washington, DC 20201

Dear Donna,

This is our first version of "Responsible Choices." We spent considerable time and drew on expertise in specific fields of relevance in devising the substance of these proposals. As you will see, the product is a hard-hitting document that lays out the actions that the private sector and government should take to: bring public programs into line with the private sector; increase consumer cost-consciousness; expand group purchasing for small groups and individuals; and establish a fair market with good, comparable information. Undoubtedly, "Responsible Choices" will produce differences of opinion within the Jackson Hole Group, particularly in the absence of political pressure for reform. However, I hope that we can reach consensus and offer the public a comprehensive proposal for incremental reform.

I think that the Jackson Hole Group is ahead of the curve with "Responsible Choices." I have not seen any other broad post-Clinton proposals for health reform, especially ones that take into account what is occurring in the private sector. Additionally, "Responsible Choices" will distinguish itself because it is based on actual clinical and operational experience gained from all participants in the Jackson Hole Group process. I cannot imagine another comprehensive proposal for reform that could include that level of experience and expertise.

The section of "Responsible Choices" that corresponds to your topic at the February meeting is **Bringing Medicare into the 1990's.** If you would like to discuss it or need further clarification, contact Graham Rich, MD of the Jackson Hole Group staff at 307-733-8781, fax: 307-739-9312. I would be grateful if you could ask someone to calculate the approximate savings which could be made if these proposals were adopted. (1)

We will take up all of "Responsible Choices" in detail at the February meeting. I would value your comments, as soon as possible, to further revise our recommendations. Your (2)

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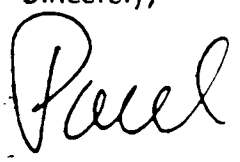
feedback and that coming out of the February meeting will be incorporated before the document is ready for wider circulation and critique at the end of the month.

Sincerely,



Paul M. Ellwood, M.D.

RESPONSIBLE CHOICES FOR ACHIEVING REFORM OF THE AMERICAN HEALTH SYSTEM

A Draft Discussion Paper
from the

Jackson Hole Group

February 1995

TABLE OF CONTENTS

INTRODUCTION

Paul M. Ellwood, MD

"Responsible Choices" identifies the actions that the private sector and government should take to improve the American health system. These suggestions build on the Jackson Hole Group's approaches outlined in "The 21st Century American Health System" (1991), which called for accelerating value-based competition in the health care marketplace. "Responsible Choices" is not based on untested economic and social theory. The recommendations are taken directly from the actual clinical and operational experience gained in providing health care and health insurance to over 100 million Americans. "Responsible Choices" spreads the benefits of better quality, lower cost health care with a minimum of prescriptive interference by government at no overall increase in cost.

The United States has been rapidly transforming health care by implementing a market-driven system that works—a unique approach that has resulted in significantly reducing rate increases for private purchasers and consumers of medical services. This evolution, turned revolution, which has been underway for at least twenty-five years, is being driven by corporate purchasers, and cost-conscious consumers. It has created an extraordinary array of health plans aggressively competing with one another on price and quality. Managed care plan enrollment has grown by 50 percent since "The 21st Century American Health System" was written. However, some consumers—such as most Medicare beneficiaries, individuals with preexisting illnesses, and the employees of small firms—are not fully benefiting from the health care revolution that is propelling us toward the twenty-first century. And, despite being the largest single purchaser of health care, the government has been slow in bringing public programs into line with those in the private sector.

It has taken at least twenty-five years for the new American health system to become established. As it continues to evolve, care must be taken not to disrupt its progress. The market works in health care because multiple purchasers, not only the government, are in

a position to introduce bold new methods of buying health care and because providers and insurers have substantial freedom to respond with new approaches to organizing and paying for care.

Keeping the market working in health care requires the consideration of factors that are unique to the health sector. When a day in the hospital can cost thousands of dollars, people need health insurance. But when this is fee-for-service insurance, there are few incentives for sick individuals and their trusted physicians to try to save money. Those who are poorly insured and have a great incentive to buy on price are in no position to shop for medical care based on price once they become sick. Medical care is a product that is best understood by doctors who are selling it and thus are in a position where they must make both the key clinical and economic decisions for their patients and their practices. "Responsible Choices" assumes that these factors, unique to the health sector, cannot be ignored. If they are disrupted by legislative fiat, the whole system of high-quality, market driven health care could come unraveled. "Responsible Choices" calls for intervention in certain facets of the marketplace to make it function better, while warning policy-makers that preventing further expansion of price and quality competition will disrupt the progress that the market is making.

As in any industry, genuinely lowering costs means vast increases in productivity. In this case, change threatens the livelihood of more than 100,000 specialist physicians, one-half of the country's hospital beds, and hundreds of health insurers.

The U.S. health system has been transformed thus far by adherence to the following principles:

- **Health plans should compete on the basis of price and quality.** Health plans that both finance and deliver comprehensive health care must compete on price and quality. Combining health insurance with health care is perhaps the most important change in the structure of the health system. It shifts the emphasis from increasing earnings by

subjecting the patient to more services to reducing demand for costly extended treatment by keeping people well. To effectively lower costs and improve quality, health plans must carefully select those providing care and match their numbers and skills to the needs of their consumers. This practice has been criticized for restricting doctor opportunities and patient choices, but shepherding resources remains as critical to health care quality and cost as the management of any enterprise.

- **Consumers can be cost-conscious when selecting health insurance.** Consumers can be motivated to be cost conscious at the time they select health insurance and choose lower cost plans when they are convinced that health care will be readily available and of good quality. Cost consciousness at the time of illness is less predictable and can cause expensive and dangerous delays in seeking care. This makes capping premium contributions better than high deductibles in motivating consumer choice.

- **Group purchasing of health care should continue.** Health care must be purchased by groups large enough to exert real leverage over competing health plans. Size allows these groups to exploit their knowledge of health plan performance and, above all, to spread the cost of insurance over both healthy and unhealthy individuals. As in any market, the presence of many powerful buyers and multiple competing sellers has been shown to be beneficial to consumers and encourages continued innovation and vigorous price competition. Diminishing the clout of group purchasers or dividing consumers into good and bad risks will destroy the burgeoning health market.

- **Information about the quality of care must be available to consumers.** For the health market to function properly, consumers, purchasers, and providers need understandable and comparable information on the cost and quality of care from various health plans. The quality of care information currently available to consumers is still incomplete and is perhaps the weakest link in the health care revolution. Because reliable and objective information is not available, the organizations providing the best quality of care are not necessarily attracting the most consumers. This

information gap jeopardizes the entire health revolution. The lack of comparative information on quality also makes the system vulnerable to unsubstantiated criticisms about costs being down because quality is deteriorating.

Without expanding entitlements or mandates, "Responsible Choices" expands the revolution in health care by asking government to play by the same rules as the private sector, by increasing the power of consumers, and by minimizing risk selection against individuals and small employers. "Responsible Choices" spreads the benefits of better quality, lower cost health care with a minimum of prescriptive interference by government at no overall increase in cost.

"Responsible Choices" has five objectives:

1. Align Medicare and Medicaid costs with revenues while expanding choices by offering public beneficiaries the same cost-conscious choices now available to private consumers through employers or purchasing groups. Set limits on the per capita growth of Medicare and Medicaid expenditure linked to revenue growth and allow competition and consumer choices to do the rest.

2. Make the tax benefits of health insurance coverage equitable, while increasing consumer awareness of cost and quality through a value-based tax credit for health insurance.

3. Give individuals and the employees of small firms, regardless of their health status, the same opportunity to purchase reasonably priced health insurance as large group purchasers. Insurance reforms mean all purchasers, including the self-insured, and sellers of health insurance should be subject to the same marketplace rules.

4. Ensure that consumers know what the various health plans offer in terms of benefits, satisfaction, access, and health outcomes.

5. Set timely realistic targets and measure results as reform proceeds. Manipulating a trillion-dollar enterprise may require a change in course if cost containment, health outcomes, consumer satisfaction, and access to health care do not improve as predicted.

BRINGING MEDICARE INTO THE 1990s

Graham Rich, MD, MBA

As the largest purchaser of health care in the U.S., the federal government is responsible for the continual growth in Medicare cost by maintaining a dysfunctional payment methodology and by failing to encourage intensive price competition and cost-consciousness. Like any other purchaser, it needs to adopt some aggressive buying policies so that all taxpayers, including seniors, can benefit from better quality and efficiency through competition among health plans and a cost-contained traditional Medicare program.

Even with the present defective system for encouraging enrollment in managed care, the number of seniors choosing this option is predicted to increase from 2.2 million at the end of 1994 to 2.5 million at the end of 1995. To enable new seniors to stay in managed care and to provide more choice for current beneficiaries, we need a better Medicare payment methodology, better access to comparative information, and the option of participating in any available health plan. Only then can seniors make responsible choices.

Why Update the Medicare Program?

The federal government's share of total U.S. health care costs was 28 percent in 1990, and 32 percent in 1993. Medicare expenditures were $160 billion, or 2.4 percent of gross domestic product (GDP), in 1994 and are projected to grow to $460 billion, or four percent of GDP, by 2005. Meanwhile, private sector HMO premiums, driven down by

employer purchasers, are projected to decline, on average, 1.2 percent in 1995.[1] For example, the California Public Employees Retirement System achieved reductions in premiums of 0.5 percent in 1994, 1.1 percent in 1995 and two percent for 1996.

Medicare's traditional insurance structure has a negative impact on the rest of the health care market because:

- Cuts in reimbursement cause cost shifting and drive up the cost of care for others.
- Hospitals suffer unpredictable changes in DRG rates.
- Physicians try to maintain income by increasing volume.
- Medigap policies that drive up use by covering first dollars become more attractive when consumer deductibles are increased in an effort to reduce program utilization.
- Low reimbursement rates make it difficult for seniors in some markets to find primary care physicians who are willing to accept new Medicare patients.
- The system rewards doctor's office visits and hospital stays instead of improvements in health.

Medicare cost problems will only get worse under the current system as managed care health plans, using resources efficiently, force nonparticipating physicians (particularly specialists) to depend on Medicare to earn a living. This will exacerbate regional variations in Medicare costs that have no corresponding premium differences in private sector managed care. For example, in 1995, the Medicare capitation rate is $467 in San Francisco and $559 in Los Angeles while the premium for a non-Medicare, non-Medicaid Kaiser plan is the same for both northern and southern California.

Parallels with the Private Sector

When unsustainable expenditures on health benefits threatened competitiveness, enlightened employers made the transition from traditional health insurance to offering a choice of managed care plans. As a result, they have seen a consistent increase in managed care enrollment with a corresponding reduction in costs. The government could

[1] Group Health Association of America (GHAA), 1994 HMO Performance Report.

experience the same savings by making consumers more cost-conscious, ensuring that plans compete on the basis of price and quality, and actively promoting managed care options.

How Do We Get There?

The ultimate aim should be to reduce the rate of growth in Medicare costs due to mismanagement of the program. This proposal attempts to hold Medicare entitlements to the current percentage of GDP, adjusted for the increasing age and number of beneficiaries. It does not reduce the scope of benefits or deprive beneficiaries of access to well managed health care. It relies on price competition among health plans coupled with a government contribution limited to the GDP target. The proposal also requires health plans to offer a more appropriate set of benefits than the traditional Medicare program (the federal standard HMO package with a prescription drug benefit) so that Medigap insurance is unnecessary for seniors who join health plans. Seniors should be able to choose a health plan with comprehensive benefits while reducing or eliminating the need for supplemental insurance, deductibles, and copayments. A voucher ultimately set at the price of the lowest cost plan in the market area will give seniors access to a full range of plans.[2] The option to stay with traditional indemnity Medicare would still be available.

Promoting Consumer Cost-Consciousness

The money for Medicare vouchers should be appropriated each year, rather than mandated as part of the federal budget. The voucher for Medicare health plans should be initially limited to the amount the government is prepared to spend on traditional Medicare and should ultimately be based on the lowest priced, high quality plan within each market area when the market price falls below the government's adjusted GDP target payment. Seniors who choose a more expensive plan would be responsible for making up the cost difference, be it traditional Medicare or a health plan. To ensure full choice, all

[2] Competitive bidding to set the government contribution has been recommended by Bryan Dowd et al., in "Issues Regarding Health Plan Payments Under Medicare and Recommendations for Reform": The Milbank Quarterly, vol. 70, no. 3, 1992, 423.

plans should participate in a coordinated annual open enrollment. In some areas, especially rural ones, traditional Medicare may be the lowest cost or sole option.

Ensuring Plan Competition on the Basis of Price and Quality

To enable comparison, the Health Care Financing Administration (HCFA), or its designee, should provide information, including quality and price comparisons of traditional Medicare and health plans, by market area on all available plans. Health plans should price and offer a standard benefits package while HCFA does the same for its own traditional Medicare product. Seniors should be given comparative information on out-of-pocket costs for care of common conditions, consumer satisfaction data, etc. Responsible marketing should be encouraged to ensure that seniors understand the options.

Intermediate Steps

To facilitate the transition to managed care, incremental change in the government's contributions to health plans is suggested. Initially, the value of the government voucher for health plans would be the same as that for traditional Medicare. Where more than 20 percent of seniors are enrolled in managed care, the government's contribution in the next year should be based on average health plan prices (excluding traditional Medicare). In the following year, the contribution for traditional Medicare and health plans should be set at the price of the lowest priced, high quality plan.

Stage 1: Fiscal Year 1996

The Secretary of Health and Human Services should establish market areas to calculate the value of the Medicare voucher, as counties are too small for stable prices. The value of the voucher should be capped at the current level of payment adjusted for GDP growth and age of beneficiaries within each market area. Legislation should allow health plans that cost less than the voucher to provide additional benefits or to give consumers rebates. A health plan that costs more than the voucher value should charge seniors the difference. HCFA should simplify its approval requirements so that it is less costly for new health plans to enter the Medicare market.

Stage 2: Fiscal Year 1997

HCFA, or designee, should establish and coordinate an annual open enrollment period to ensure that each individual can choose among all available plans. Voucher payments should be risk adjusted to allow for the extra risks involved in enrolling individuals with chronic diseases. All participating health plans should be required to offer at least the new standard benefits package.

Stage 3: Fiscal Year 2002

If the prices of competitive health plans in the Medicare market consistently exceed the value of the government's voucher, and if traditional Medicare cannot be controlled, the policy should be reexamined with a possible reduction in the scope of benefits, means testing, new controls on volume of services, etc. The cap on the government's voucher should move progressively from the market area to the national level within five years to smooth out price differences among areas. If employers do not encourage retirees to make a cost-conscious choice of Medicare health plan by giving them a defined contribution, then legislative reform of retiree benefits may be required. The federal government should consider relinquishing its responsibility for providing indemnity insurance by asking private indemnity plans to take over this function, as long as there is no restriction on access to providers.

Benefits of Medicare Reform

The phased introduction of premium competition, starting with areas of high managed care enrollments and where Medicare costs have tended to be high, ensures competition and early savings. Over time, there should be a reduction in regional Medicare price and utilization variations. Prices in today's populous high cost areas should come down first, while utilization and prices may go up in those areas (mainly rural) where seniors seem to be underserved. Allowing seniors to make the same responsible choices as the rest of the population will provide greater incentive for plans to improve their cost-effectiveness while maintaining or improving quality. Seniors and the health system as a whole will benefit from an expansion of choice and an end to the cycle of cost shifting.

ENCOURAGING STATE SOLUTIONS FOR ACUTE MEDICAID

Graham Rich, MD, MBA

The dramatic increase in, and unpredictability of, costs in Medicaid programs is a persistent challenge to state governments. The nation spent $82 billion, or 1.2 percent of GDP, on Medicaid in 1994; expenditure is projected to increase to $234 billion, or two percent of GDP, in 2005. States should use the same methods as successful private purchasers of health care to encourage choice and effective price competition for the acute care portion of Medicaid. States are already ahead of Medicare in adopting price competition but have been impeded by the federal waiver process and the lack of health plan availability.

Accelerating the Use of Competitive Managed Care for Acute Medicaid

States that received section 1115 waivers from HCFA have introduced innovations tailored to local needs and preferences. These changes brought variations in eligibility based on income, categorical requirements, new services, and a choice of managed care plans. In an effort to protect the Medicaid population from what it views as ill-conceived or hasty reform, HCFA developed detailed criteria for approval and set goals for implementation. Because criteria and goals can vary from case to case, the approval process may take several weeks, meanwhile state dollars support inefficient and ineffective financing mechanisms. To stop such waste, the 104th Congress should grant states the authority to make the transition to managed care for Medicaid while the federal government focuses on restructuring the Medicare program.

The Federal Contribution

The federal government should give states block grants for the acute Medicaid program based on the number of eligible residents. To facilitate state management of the program, the federal government should specify the rate of growth in the federal capitation rate. If the current GDP growth rate and inflation remain the same, this could be set at 6.5 percent per year in 1996, six percent in 1997, and five percent in 1998. The only

circumstance that would necessitate a reconsideration of these ground rules would be for a drastic change in the number of people eligible for Medicaid.

Minimizing Federal Reporting

Allowing states to define their own solutions puts at risk the comparison of quality, cost, and coverage information essential to enhance consumer choice and aid policy-making at the state and national levels. The problem can be overcome if states follow the example of other purchasers by requiring standardized reporting by health plans (see A Health Accountability System, page 27, and Health System Information, page 32).

INCREASING COST-CONSCIOUSNESS: REFORMING THE TAX TREATMENT OF HEALTH INSURANCE

Alain Enthoven, PhD and Sara Singer, MBA

The fact that employer-paid health benefits are tax-free without limit has been a significant factor in the continuous escalation of health care costs. The tax break is expected to cost the government $90 billion in 1995. This break disproportionately favors people with above average incomes over lower income people who need a more powerful incentive to buy coverage.

The need to motivate responsible, price-sensitive choice of health plan and limit revenue loss to the federal government underlines the advantages of abolishing the tax break and replacing it with a refundable tax credit for individuals purchasing health coverage. This would correct the government-created lack of cost-consciousness by encouraging employer contribution policies that force consumers to be more responsive to the full premium price, thereby promoting competition among health plans. To derive maximum benefit from a tax credit, a choice of plans is necessary. Additionally, it may be appropriate to encourage employers to make their contributions in fixed dollar amounts

that do not vary with choice of plan to ensure that all employees make cost-conscious decisions.

A limit on employer contributions that are tax-free to the employee (a tax cap) is another alternative and would require the application of rules similar to those for the tax credit. However, a fixed tax credit has distinct advantages over a tax cap, including:

- It means portability for individuals, breaking the link between employment and health coverage.
- Both high and low income people would receive the same credit, though the credit could be structured to give low-income more.
- It can be readily characterized as giving something to people, as opposed to a tax cap, which is perceived as taking something away.

Tax Credit Structure

A tax credit could be structured as follows[3]: In 1994, the average family received $4346 in employer-paid health insurance, which allowed them to avoid $1130 in income taxes (i.e., they received a 26 percent premium subsidy).[4] With a tax credit, the average family could still receive up to $1130 in credit on their income tax; which would allow them to purchase or receive up to $4346 in coverage without paying any more in taxes than they do now. If a family purchased or received coverage exceeding $4346, the difference would be treated as taxable income. The tax credit could be adjusted in future years for inflation or other factors. Individuals would claim the tax credit when filing a tax return. Low-income individuals, who do not file a tax return, would claim the tax credit for health benefits when applying for other assistance programs.

[3] For a discussion of tax cap design, see "Managed Competition II," March 1994 or Alain C. Enthoven, "A New Proposal to Reform the Tax Treatment of Health Insurance."

[4] "The Tax Treatment of Employment-Based Health Insurance," Congressional Budget Office. March 1994.

Variation of Tax Credit

In a more complex version, the percentage of premium that a family could claim as a tax credit could be varied with income. The lower the income level, the higher the percentage of the health insurance premium that could be claimed as a tax credit. This solution has problems of complexity, financing, and work disincentives for those at the poverty level, as well as political problems associated with a tax increase. Additionally, the tax credit amount could be adjusted for regional factor price differences, although the added complexity would not be desirable or economically feasible.[5]

It would also be necessary to define rating classes (e.g., individual, couple, single parent with child(ren), and couple with child(ren)) and age categories to calculate the credit. Otherwise, a single credit would be too high for some (healthy young individuals) and too low for others (the elderly and families). Alternatively, by not adjusting the tax credit for age, the generous tax treatment would encourage more healthy young individuals and families to purchase insurance.

A Tax Credit Linked to Group Purchasing

The employment-linked tax exclusion is an important part of the glue that holds insurance purchasing groups together as risk pools. Converting to a tax credit direct to individuals would weaken the glue and threaten the employment-based group purchasing system because good risks will seek better rates elsewhere and pooling will be destroyed. A market based on underwriting at the individual level would perpetuate many or all of today's pathologies for small employers and individuals. The unraveling of the successful employment-based market could lead to a political backlash and a single-payer system.

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[5] Adjusting the tax credit for factor price differences would fairly compensate individuals and families residing in high cost areas. While it would be possible to adjust the tax credit for medical cost variations, this would not be prudent as it would reward areas with inefficient utilization of health care resources and costly excess capacity. It would also be possible not to adjust the tax credit. This would be the simplest approach and would resemble the construction of the recently proposed education deduction. However, a flat tax credit may be too generous in some areas and not generous enough in others.

The tax credit can be structured so as not to dismantle the group purchasing based system. Standards governing the use of a credit would be necessary. For example:

- If your employer offers coverage, the credit should be available only if you buy insurance through your employer. Employers might be mandated to offer, but not necessarily pay for, several coverage options and could do this by contracting with a voluntary, certified purchasing group.
- If you are self-employed, non-employed, or employed by an employer that does not offer health care coverage, you should be able to use the credit only through a voluntary, certified purchasing group that would agree to take all comers and abide by the rules established for the rest of the insurance market.
- If an employer drops coverage, it should be required to offer, but not necessarily pay for, coverage through a purchasing group to provide for its employees. This approach would encourage the formation of voluntary, certified groups for those left out of the employment-based system and ensure the formation of alternative purchasing groups before allowing the dismantling of employment-based purchasing.

Stage 1: A Tax Credit for the Individual Market in 1995

Since there is mounting urgency to reinstate the 25 percent tax deduction for the self-employed, this opportunity should be used to shift from tax exemption to a tax credit for this group. Tax policy changes should start with a tax credit program for the self-employed, non-employed, and employed whose employers do not offer coverage to go into effect in 1995. After three years, the tax credit should be restricted to coverage purchased through a purchasing group. This is attractive for the following reasons:

- A tax credit would give this group a greater tax subsidy than they received under the limited tax deduction. A tax credit would give these people tax-free health benefits while making them price-sensitive. It would eliminate the tax code inequities that the self-employed currently face, without expanding the cost-increasing incentives created by the present tax treatment of health benefits for employed persons.

- Anyone who does not currently receive employment-based health care benefits would benefit from the tax credit without threatening employment-based health care purchasing.
- By tying the tax credit to group purchasing three years after enactment of the tax credit, the formation of purchasing groups would be encouraged without penalizing people who do not have access to group purchasing in the interim.

Stage 2: A Tax Credit for Employer-Based and Group Purchased Coverage in 1998

After successfully implementing a tax credit for individuals, employer-based tax deductions of health benefits should be replaced by a tax credit in 1998 with provisions to avoid unraveling employment-based health care purchasing. This should be done at the same time the tax credit becomes linked to group purchasing—three years after enactment of the tax credit for the individual market—to ensure adequate access to group purchasing arrangements.

Target Goals:

- Tax credit in place for the individual and employer-purchasing markets by 1998.
- At least 75 percent of people claiming the tax credit by the year 2000. If not 75 percent, the policy regarding tax credit eligibility should be reviewed.

MEDICAL SAVINGS ACCOUNTS

Alain Enthoven, PhD and Sara Singer, MBA

The Jackson Hole Group is concerned that Medical Savings Account (MSA) theories, in the forms currently advocated, would undermine the market forces already under way in the health system and would increase tax revenue losses. MSA proposals would allow employers and individuals to contribute to savings accounts (tax sheltered or not) in conjunction with a health insurance policy that has a high annual deductible, such as $3000, referred to as a "catastrophic" policy. Since consumers would have to pay the full

cost of their health care up to the amount of the deductible, this would make them health and cost conscious. In theory, MSAs seem to encourage saving for retirement or other purposes rather than spending money on costly medical care; however, in practice, they would destroy the ability of insurance to spread risks and would jeopardize health plans' ability to compete on cost and quality. It is difficult to make a proper assessment of the impact of different MSA proposals because of their variability. For example, if MSAs were tax deductible, this would create an enormous incentive to purchase a particular type of health insurance and could increase the federal deficit. As a consequence, the Jackson Hole Group is eager to analyze each specific MSA proposal to assess its impact. All of the proposals assume that the health care cost problem is fully attributable to factors that the individual can control and fail to acknowledge that the chronically ill would lose out as the healthy opted to leave risk pools.

MSAs Combined With Catastrophic Coverage Could Damage the Market

With catastrophic policies, people are cost-conscious only until they know their deductible will be reached, after which the cost of more care to them is zero. Since about 70 percent of national health care expenditures are spent on only 10 percent of the population, MSAs with catastrophic policies do not promote cost-consciousness where the majority of expenditures occur.

High deductibles only marginally provide financial incentives to encourage healthy lifestyles and to decrease expenditure on inappropriate medical care. If increasing deductibles had achieved this goal with an indemnity system, then the development of managed care would have been unnecessary. High deductibles discourage people from seeking preventive and primary care since they must pay for these services out of pocket. Delays in seeking care for serious illness increase costs for everyone. MSAs will disrupt the market by favoring catastrophic policies over other forms of health coverage.

According to an example used by the American Academy of Actuaries, if a family pays $5000 for a typical indemnity plan, it could purchase the same policy with a $3000

deductible for about $3,200. The $1800 savings is not enough to cover the $3000 MSA that would need to be paid by someone, either the employer, employee, or the government. If the MSA is tax excludable, it would increase tax losses by $1200 per family.

Anyone who is healthy and wealthy enough to afford the deductible will prefer the MSA, especially if there is favorable tax treatment.[6] This discriminates against the sick, the high risk, and the poor, who will be left in low deductible plans and health plans whose costs will increase as the healthiest people opt out. Experience in the FEHBP program showed that people with the worst risks chose the Blue Cross/Blue Shield low deductible option, while good risks selected the high deductible option. Even if MSAs could be redesigned to encourage healthy lifestyles and preventive care while limiting revenue loss to the federal government, people with cancer, diabetes, heart disease, and other chronic illnesses would face increasingly higher premiums, as the healthy, good risks opt for tax-favored MSAs with catastrophic coverage. Even a sophisticated risk adjustment mechanism would not be able compensate health plans for this degree of adverse selection. However, it is hard to predict the impact of any MSA proposal, as they are all based on theory.

INSURANCE REFORMS AND GROUP PURCHASING

Jay Carruthers and Ellen Wilson

The rising costs of health care over the last decade have affected the large and small group markets in two very different but instructive ways. Cost pressures on large groups have inspired major innovation, including greater use of managed care, incentives for cost-conscious purchasing, and better information for making choices. The same cost pressures when applied to the small group and individual market have had a deleterious effect.

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[6] Section 125 plans create the same problem, although mitigated by the fact that users lose unused funds at the end of each year. This has led many to call for the elimination of Section 125 plans.

Small groups are unable to spread risks, to achieve economies of scale, to benefit from competition, and usually to offer multiple plans. As a result, the small group and individual market is characterized by:

- High premiums or unavailability of coverage to high-risk individuals.
- Steep premium increases (especially for individuals or small groups with individuals who get sick): small and mid-sized businesses faced an average increase of 14 percent over the last twelve months. Over the last three years, it totaled about 57 percent.[7]
- High administrative costs: a carrier's administrative expense, by one estimate, reaches 40 percent of claims in groups of one to four, compared with less than five percent for groups of more than 10,000.[8]
- Segmentation of the market by risk (i.e., health status).
- An inability to influence the development of the market to better meet the needs of small groups and individuals.

If access to, and affordability of, coverage in the small group and individual market is to be improved, the state and federal government must act in concert to implement core uniform standards that foster the development of effective group purchasing.

Group purchasing offers a powerful tool for structuring a competitive, well-functioning market.

- Members are offered a choice of health plans.
- Competition is driven by side-by-side comparisons of health plans based on value (quality and cost).
- Risk is spread more broadly; the ability of health plans to discriminate on the basis of health status decreases.
- Administrative costs are significantly reduced. In addition, health plans avoid the high costs associated with marketing to a multiplicity of small groups.

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[7] Arthur Andersen, " Survey of Small and Mid-Sized Businesses: Trends for 1994."

[8] Congressional Research Service, "Private Health Insurance: Options for Reform," September 20,1990.

However, before group purchasers are effectively able to drive the small group and individual market, certain uniform standards need to be applied across the entire health care market. Standards should be set by the federal government, implemented by purchasing groups through private contracts with health plans, and enforced by the states.

Despite current efforts to give states more power in developing local policy solutions in areas like welfare, there are several reasons why reforming the health system requires federal standards. First, health care markets do not adhere to state boundaries, making it impossible for states to structure rules that apply consistently across markets. Second, the preponderance of large multi-state employers reinforces the need for a federal framework. Moreover, with the rapid change in the delivery of medical services and the proliferation of varying levels of risk- bearing arrangements, state regulations designed to monitor traditional insurance carriers are outdated. Enforcing uniform federal standards, however, would be a logical extension of the state's traditional role as insurance regulator. It is important to note that federal standards could be spelled out without creating a new federal bureaucracy.

State Efforts

Forty-five states have recently adopted some form of insurance reforms as a first important step toward improving access to coverage in the small group and individual market. Results, thus far, have been mixed. Some states have had success eliminating the most blatant forms of risk selection using basic reforms like guaranteed issue of all products, guaranteed renewal, portability, and limits on preexisting condition clauses. Nearly twenty states have gone even further by implementing some form of community rating and experimenting with purchasing groups across the small group and individual market. Private sector initiatives, such as the Cleveland Council of Smaller Enterprises (COSE) and Chamber of Commerce purchasing groups, have expanded access to affordable coverage for their small business members, but criticism has been directed at some of these arrangements for leaving the individual market largely untouched, rarely pooling risk, and in some instances, using medical underwriting to exclude the worst risks.

Despite some progress, states that have carefully crafted insurance reforms are finding their efforts undermined by the growth of self-insured plans. As states increase regulation in the small group and individual market to spread risk more broadly and expand coverage to the poor (e.g., premium taxes), the best health risks opt out of the pool and choose to self-insure (or drop coverage entirely, as was the case in New York). These plans, protected under ERISA, do not have to comply with state laws regulating health insurance. If self-insured plans continue to siphon off the best risks from the small group and individual market, a risk spiral within the state-regulated market is inevitable. The problems surrounding ERISA underscore the difficulty in reforming a voluntary health system with the current division of state and federal regulations. In making limited ERISA reforms, policy-makers should avoid engendering 50 different sets of laws regulating health benefits, nor should they permit states to finance expanded access programs by taxing self-insured plans. Doing so would penalize employers already providing coverage to their employees.

The Role of the Federal Government

A Tax Credit Linked to Group Purchasing: If tax credit eligibility were dependent on purchasing coverage through an appropriate group, as recommended in Increasing Cost-Consciousness: Reforming the Tax Treatment of Health Insurance; page 11, efficient group purchasing efforts on the part of employers would be maintained while providing incentive to create other voluntary certified purchasing groups (defined below). Employees whose employers offered coverage would have to purchase it through them to receive the tax credit. The self-employed, non-employed and employees whose employers do not offer coverage would be required to purchase coverage through a certified purchasing group to receive the tax credit. The individual market would be replaced by purchasing groups that would be able to pool risk sufficiently as people take advantage of the tax credit.

Insurance Reforms: The federal tax credit should be part of an incremental reform package that includes basic insurance reforms. By enacting those insurance reforms at the

federal level that have already been implemented in most states—e.g., limited guaranteed issue of all products, guaranteed renewal, portability, limitations of preexisting condition exclusions, and limited rating restrictions (not community rating)— the most blatant forms of risk selection would be eliminated while providing greater uniformity to the system. These reforms are designed to prevent health plans from discriminating on the basis of health status—a widely accepted principle—and should apply to all health plans regardless of risk-bearing arrangements, whether it is a traditional insurance carrier, a health plan, or an ERISA self-funded plan. The cost of overseeing reforms should be borne equally among all parties in the form of a federal premium tax remitted to the states and other entities created to apply standards.

The Role of the States: Certifying Voluntary Purchasing Groups and Enforcing Standards

The primary responsibility of the states would be to accredit those voluntary purchasing groups that meet the criteria to become Certified Purchasing Groups (CPGs), as well as to enforce compliance with insurance reforms. To receive accreditation and hence enable members to claim a tax credit, a purchasing group would need to adopt certain standards, such as:

- Accepting all who are eligible and wish to purchase coverage through the group.
- Offering a choice of health plans.
- Conducting an annual open enrollment period.
- Experience rate the group as a whole, with adjustments for age, family status, etc .
- Risk adjustment within the purchasing group (developing/adopting an actuarially sound methodology would be left to the purchasing group and participating health plans).
- Surveying members about their experience with their health plans and provide quality related information.
- Assure insurance reform compliance in contracting with health plans.

Many purchasing groups already perform several of these functions and could easily receive state accreditation as a voluntary CPG.[9]

With such federal and state provisions, employers, employees, and individuals should react to existing incentives and market forces to maintain and participate in the appropriate purchasing group. Employers who have been efficiently purchasing health care—primarily large employers who have been major forces of progress and innovation in health care purchasing—will find it in their interest to continue doing so. Employers who are inefficient purchasers, or who have not previously offered coverage, will likely want to offer coverage through a voluntary CPG. Extending access to purchasing groups for all small groups and individuals, in conjunction with the implementation of a standard set of market rules, is a critical step toward structuring an efficient market in which coverage is more accessible and affordable.

Target Goals:

- All fifty states should have at least one voluntary certified purchasing group by 1998—when the tax credit will be given to only those purchasing through the appropriate group. States without a CPG may need to consider offering incentives for their establishment.
- Everyone in the individual and small group market should have access to group purchasing by the year 2000.

[9] When you have individuals choosing among health plans that sell different sets of medical services, there is the threat of risk selection. While insurance reforms and the extension of group purchasing to the small group and individual market attempts to minimize risk selection, in such a complicated and dynamic system the extent to which risk selection will occur is unclear and is something that should be closely monitored. For example, an upper size limit for employer groups has not been placed on CPG eligibility. But if it turns out that predominantly bad risk large groups purchase through CPGs, it may be necessary to impose such a limit.

BENCHMARK BENEFITS

Nancy Ashbach, MD, MBA

The Need for Fair Disclosure and Comparability

Health plans, consumers, pharmaceutical manufacturers, physicians, legislator, the courts, and others have struggled in the past with benefit plan offerings. In particular:

- Consumers have been unclear about the criteria for inclusion of specific benefits in their health plans. This has led to suspicion that managed care plans are motivated to skimp on needed care.
- Consumers have had difficulty comparing health plan offerings with differing benefits.
- Physicians and others have been unclear as to the benefit and technology review processes in health plans, leading them to view the process as secretive and unscientific.
- Health plans have been hampered in their ability to deny coverage for specific interventions clearly and concisely and to support such decisions with cogent reasons.
- Pharmaceutical and technology manufacturers have suspected that such decisions are based upon cost alone and that their products are not receiving a fair and open hearing by health plan policy-makers.
- The courts and legislators have received conflicting advice from interest groups.

It is for these reasons that a benchmark benefits package is needed. This product should be a voluntary, real, and valid offering of all health plans, but need not and should not be the only offering. Plans can and should be able to offer packages both richer and leaner to respond to the needs of purchasers. Many plans have had lengthy experience with the federal HMO benefits package, and we recommend that until the process for revising and improving upon it is in place, it serve as the initial benchmark package.

The process of defining and maintaining the benchmark benefits package should be open, fair, understandable, and for information purposes only. The criteria for additions and deletions should be available and the process should be clear so that coverage decisions

by the health plan would be protected from unreasonable challenge. Physicians, drug manufacturers, consumers, purchasers, health plans, and others who might wish to influence the process of coverage inclusion and exclusion would therefore be able to do so, and the public would be assured of appropriate care being provided and of coverage for expensive therapies not being denied solely because of cost. There should be no opportunity for collusion between health plans for the inclusion or exclusion of benefits. For the purposes of avoiding antitrust law suits, health plans may need to be excluded from the process.

In addition to disclosing criteria for coverage, a standard product must be available for price and quality comparison. In the absence of a voluntary benchmark, plans will vary benefits to satisfy the demands of various customers, and comparability to the consumer will remain elusive. By using a benchmark benefits package as a standard product against which the differing needs and requirements of purchasers can be measured, comparability of benefits and price offerings can be determined.

Assessing Technology

The benchmark benefit package should be that collection of benefits that is most likely to produce health in the population. While the federal HMO benefits package is an excellent starting point, producing health in the population will require ongoing evaluation, revision, and updating of benefits. Technology assessment and cost-effectiveness analysis will be necessary to achieve this objective in a rational way. Currently, such assessments are performed by government, private organizations, and individual health plans. Such efforts are inefficient and duplicative and furthermore do not provide health plans with sufficient justification to offer or deny coverage. In the present environment, such decisions are suspected of being made for cost reasons. As a consequence, benefit decisions are being challenged and made by the courts and legislatures rather than on the basis of sound scientific evidence and efficacy. The absence of an open, clear, fair, and scientific evaluation process is detrimental to all parties.

Technology assessment and evaluation are necessary because:

- Technology in medicine is in a constant state of flux, with new technology entering the market at a staggering rate. The cost of such technology creates a strong economic requirement for a valid assessment process to determine coverage under a typical benefits package.
- Much existing technology has not been evaluated for effectiveness. To date we have had no mechanism for doing so, and many interventions in medicine are covered under existing benefits packages as a result of historical precedent.
- Cost-effectiveness has not been a major element of technology evaluation in the past but will surely become so in the future as group benefits are valued against individual demands.

Additionally, individual coverage decisions on the part of health plans often require an independent evaluation and recommendation, which plans could implement on a voluntary basis. Such individual evaluations would be carried out by experts in the appropriate field of medicine and would be free of vested interests to deny coverage based on cost considerations. Independent expert reviews would support removal of coverage decisions from the legal system, where judges and jurors often rule in favor of coverage if there is uncertainty or urgency.

An Independent Approach

A new, independent organization, the Benchmark Benefits Group (BBG), should be formed to address these needs in the health system. The BBG's proposed functions are outlined in Table 1. It would be private and not for profit, although government collaboration would be possible in key areas, such as technology assessment, clinical trials, Medicare, and Medicaid. Representatives could come from purchasers, consumers, managed care organizations, self-funded employers, academic medical centers, physicians, and the government. Funding for the organization would come primarily from user fees—that is, per capita assessments of the participants and users of the organization's efforts. Special projects funding could come from foundation grants.

Table 1
Functions of the Benchmark Benefits Group

- Definition, updating, and maintenance of the benchmark benefits package using the criterion of production or maintenance of health.
- Recommendation of inclusion or exclusion of new technology into the benchmark benefits package based upon technology evaluation done by recognized groups.
- Recommendations regarding continuation, limitation, or exclusion of existing technology.
- Cost-effectiveness information and recommendations based upon information from competent entities.
- Individual disputed coverage decisions in defined situations. For example, an autologous bone marrow transplantation case for breast, ovarian, or cervical cancer denied as experimental by a health plan would be referred to a group of experts entirely outside the plan for scientific review.

Since technology assessment is currently done in several different organizations, including many managed care organizations, careful consideration would be given to using existing expertise in the private market. This might mean purchasing technology assessment expertise from organizations such as the Emergency Care Research Institute or the Blue Cross/Blue Shield Technology Evaluation Committee or networking current expertise. A principle of the new organization would be to utilize expertise currently available in the private market in the most effective way without in any way regulating or discouraging the innovation of the private market.

A critical element to the success of the BBG will be its independence and autonomy. Many elements of the health care system are characterized by suspicion and doubt as to the methodology regarding coverage decisions in the policy-making and in the individual case. The autonomy of this organization will reassure doctors that an appropriate process exists, with adequate clinical input. It will reassure patients that their interests are being dealt with fairly, and it will reassure new technology providers —e.g., drug and device manufacturers—that a fair process exists, facilitating level playing field competition for all.

Thus, the processes and criteria of the BBG should be open, published, and available for revision as the health care industry develops and matures.

Target Goals:

- 90 percent of health plans offering the benchmark benefits package by 1998.
- 75 percent of health plans utilizing the technology assessment capabilities of the Benchmark Benefits Group by 1998.
- Reconsideration of decisions made in individual cases by the Benchmark Benefits Group upheld by courts in 60 percent of cases by 1998.

A HEALTH ACCOUNTABILITY SYSTEM

Sarah Purdy, MD

A New Quality Accountability System for a New Health Care System

The expectation that consumers would be able to choose among competing health plans, on the basis of comparable quality and cost information, has not been realized. This failure is partly due to information about the quality of health care being not as easily available, understood, or compared, as information about costs. Consumers have been inhibited from assuming responsibility for their own health care choices by inadequate information that does not facilitate side-by-side comparison of health plans or encourage participation in decisions about health care and treatment. To evaluate the impact of health care on the population it is necessary to measure the result, or outcome, of the interaction between individuals and health plans—to hold health plans accountable. At present there is a health care quality measurement industry that uses different definitions of quality and differing methodologies to measure quality. We propose a new health accountability system which would not rely solely on these traditional systems of quality assurance which fail to disclose health outcomes or assure consumers of receiving

excellent care by choosing a specific plan. The principles and assumptions upon which the new health accountability system is based are:

- Comparable, reliable, valid quality accountability data must be available to consumers.
- A move toward outcome based accountability data is feasible.
- Purchasers, consumers, and providers may have different information needs. Quality improvement activities should result from internal use of quality data.
- A clear distinction should be made between defining measurement and disclosure requirements and verifying that requirements are observed. Organizations that define data disclosure requirements, and those that audit data, should be independent of each other, with neither being subject to undue influence by the provider or insurance communities.
- Providers, health plans, and researchers create the capability for choices to be made on cost and quality, but group purchasers and individual consumers should have input on the requirements of the system.
- The same data on quality should be demanded by, and be available to, both private and public sector purchasers.
- Uniform data disclosure requirements could lead to the formation of regional and national data bases, which would inform providers, purchasers, and policy-makers.

These principles raise several potentially controversial issues. First, the intention of the system is to compare health plans, not individual providers. Second, there is debate on how to compare the results of care provided by different health plans when the health and demographic characteristics of the populations they serve are not comparable. This issue of severity adjustment, or case mix, requires continuing refinement. Third, the system would require health plans to collect additional information about quality and use some form of standardized record keeping. By cooperating with this, plans would potentially be putting themselves in a position of being unfavorably compared with competitors. Finally, the degree to which consumers want and understand information about quality of health care is still uncertain. However, those whose lives are impacted by health care—patients

and those who represent their interests—must have the dominant input into the quality accountability system.

The health accountability system would also require group purchasers, whether public or private, to provide valid, comparable information to consumers. To achieve this, and avoid further increase in the number of data sets requested by purchasers, collaboration is needed within the health industry.

What Would a Health Accountability System Look Like?

Table 2 outlines the proposed system, which suggests collaborative efforts to address two areas: the research, design, and evaluation of health accountability measures, and the selection and endorsement of uniform data disclosure requirements.

Accountability Measures Clearinghouse

Many groups and individuals have developed considerable expertise in devising and implementing health plan performance measures. Currently, no organization documents all of these efforts and evaluates them, or assists others with questions of methodology or implementation. A collaborative approach would achieve economies of scale, resulting in more funding for such projects, greater availability of information, and a reduction in the duplication of effort. It is proposed that an organization be formed that serves two main functions:

- To act as a clearinghouse for the collation and exchange of information about quality accountability measures and methodology.
- To call attention to the need for research, development, and continual evaluation and improvement of performance measures.

The clearinghouse is not meant to engage in research. It should be a private/public partnership, perhaps set up to collaborate with an existing organization, such as the Agency for Health Care Policy and Research (AHCPR) or a research institution, such as a

university. Funding would come from foundation grants, government agencies, and per capita contributions from the industry.

Table 2
Elements of a Health Accountability System

1. **Accountability Measures Clearinghouse**
   Clearinghouse function, to collate and disseminate information about measures, methodology, and previous experience. Identify areas that need further research.

2. **Health Accountability Foundation**
   Select and endorse uniform data disclosure requirements. Purchaser and consumer dominated board, permanent executive staff, input from other players.

3. **Auditing of Health Plan Data Disclosure**
   Verification that data has been collected, analyzed, and interpreted in a reliable and valid manner.

4. **Selection of Health Plans by Group Purchasers and Consumers**
   On the basis of uniform, comparable data disclosed by plans.

5. **Quality Improvement**
   Assist health plans to be proactive in the improvement of quality, and to respond to the results of the measurement process.

Health Accountability Foundation

A Health Accountability Foundation (HAF) should be established as an independent collaborative body between the private and public sectors. Its responsibilities would include setting quality accountability goals and selecting and endorsing uniform measures of health plan accountability. These measures and the agreed methodology by which they are collected would then form the core of all health plan reporting activity. Care must be taken to ensure that standardization does not quash innovation, and that evolution of the core measures is assured as information capabilities improve. It is important to consider the clinical implications for plans and providers, and to build incentives and feedback mechanisms for quality improvement activities to result from the internal use of quality data. Standard setting should not be isolated from implementation. The experience of the

health plans and the accrediting bodies will be vital to ensuring a link between the foundation and clinical practice.

It is envisaged that the HAF would have a permanent staff of scientists, who would systematically consult with outside experts. They would present recommendations to the foundation's board, whose majority would be represented by purchasers and consumers from the private and public sectors. A mechanism needs to be devised, by which health plans, providers, researchers, the pharmaceutical and technology industry, and the health care quality organizations would have input. The closest existing model for the HAF is the Financial Accounting Standards Board (FASB). The recommendations endorsed by the HAF should be scientifically justified and subject to scrutiny at public hearings. It is important to link health plans into the system, in order to ensure that the data requirements specified by the board inform quality improvement and the furthering of medical knowledge, and are fair and feasible. Data that is valuable to providers is more likely to be included in medical records and incorporated in computerized medical information systems.

Funding of the HAF should preserve its independent status. Funding should be assured, but not dominated by health plans. A possible mechanism would be an annual subscription, and an assessment on the health plan premiums of those plans that choose to participate.

The two private sector initiatives proposed in "Responsible Choices" are the Benchmark Benefits Group and the Health Accountability System. These two functions could work synergistically under a private umbrella organization sponsored by a broad range of participants and involved parties and funded by user fees.

Completing the System

The other criteria for the proposed system can be satisfied by well-established mechanisms already in place. Because organizations like the National Committee for Quality

Assurance and the Joint Commission on Accreditation of Healthcare Organizations have considerable experience in accrediting plans and providers, they could play a major role in auditing the process and facilitating quality improvement activities. The organizations that focus on internal quality improvement, such as the Institute for Healthcare Improvement, would be an obvious medium for the quality improvement role. Continuing education of physicians and other health plan staff members is important to each stage of the process. There will be considerable overlap between the components, and continuous feedback to the clearinghouse and HAF functions will be necessary.

Target Goals:

- Comparable information about the quality of care provided by health plans should be available to 100 percent of consumers purchasing through groups by 1998.
- Preliminary health plan data on condition specific outcomes by 1998.

HEALTH SYSTEM INFORMATION

Robyn Lunsford, MSE, Nancy Ashbach, MD, MBA and Sarah Purdy, MD

Why Is Coordinated Health Data Needed?

Making responsible choices will require that better information be available on who is insured, what it costs, and whether better health is the result. As the system changes, data must be collected faster and from different sources: per capita expenditures by health plans, for example, are becoming more valuable than the numbers of physician visits and hospital days. Attempts at federal health care reform last year showed that the data available was not sufficiently timely or accurate. In fact, inadequate data on consumers' responses to price competition tilted some proposals toward price controls. Congressional Budget Office estimates of the cost of various bills were hampered by their inability to evaluate the effects of undocumented improvements that were under way and differences in inflation rates from community to community. In order for policy-makers to address the problems of attaining universal coverage while containing the cost of health

care, they must have data about the numbers and characteristics of the insured and uninsured and the cost of different delivery systems. Though multiple sources of health care data are available, one of the major obstacles is how to access, analyze, and compare this disparate information.

Why Are the Current Data Inadequate?

- Multiple data sets are not comparable or accessible from one source: For example, information about coverage and utilization of services is collected in the annual National Health Interview Survey (NHIS), but it does not provide information about household income or costs.
- Data regarding costs and coverage is not timely: e.g., the information from the NHIS takes twelve months to process. The National Medical Expenditures Survey is completed only once every ten years.
- The validity and accuracy of some sources of health data has been questioned; e.g., the medical care component of the consumer price index (CPI) does not measure costs borne by third-party payers, hence it reflects price to the consumer, not true overall cost.
- Data are not available in useful formats: e.g., it would be very helpful to have data sorted by state to deal with issues such as Medicaid reform.

ted with the existing data sets and with setting up an alternative dged by federal agencies[10] and at the state level. We have set out some basic principles for the development of a coordinated system in the following sections.

What Should Be Collected?

Data will be required in four basic areas in the health system:

1. Cost—What is the per capita cost of health care, to third-party payers and to the individual?

[10] Physician Payment Review Commission, Annual Report, 1994.

2. Coverage—Who is and is not covered by the health insurance system?
3. Vital Health Statistics—Morbidity, mortality, reportable diseases.
4. Quality—What are the measures of quality of services provided?

Quality of services (health status, outcomes, and consumer satisfaction) was covered in: A Health Accountability System; page 27). This section focuses on the data needs of cost, coverage, and vital statistics.

The process of collection should be guided by some basic principles:

- Confidentiality of records and privacy rights of individuals must be preserved. Use a unique, encrypted identifier.
- Data must be exchanged electronically, either directly or indirectly.
- Data must represent the minimum required to serve the basic needs of the health system.
- The information needs of the health system will change as the payment system changes.
- Data collection must be timely.
- The aim of the uniform data system should be to reduce administrative cost in the health care system.
- Determination of which data elements are collected should be driven by a clear mission—to improve the health of the population.
- Data should be collected at the state level, and then aggregated nationally.

Cost: Information is needed on per capita costs for all covered individuals in the health care system. The purpose of information at this level is to determine the per member costs of health care—those borne by the health plan and those borne by the individual. It will be necessary during a period of transition to reconcile the methodology of data collection between capitated systems and fee-for-service systems. It will be the responsibility of a federal entity (see page 35) to define appropriate standards to integrate information from the two payment systems.

Coverage: Information will be required from health plans and self-insured groups with respect to numbers of enrollees (including dependents) and member demographics. Timely information on enrollment and disenrollment will be needed. Statewide information will be required both on the insured population, which should be available through health plans, and on the uninsured population. Data on the characteristics of both groups, such as employment or lack thereof, income, and demographics, should be collected. The basic questions to be answered in this context are: "Who is covered?" "Is their coverage adequate?" and "Who is not covered and why?"

Vital Statistics: The new health data system should continue to collect information on morbidity, mortality, reportable diseases, births, and other issues, possibly including immunizations. Such information should be collected in a standardized way and integrated with information collected by providers and health plans for purposes of comparability and to reduce administrative costs in the health care system.

How Can the Goal Be Accomplished?

We propose the creation of a federal entity to collect uniform, timely, accurate health system cost and coverage data. Although some may oppose either a new federal entity or a uniform approach, we believe that the availability of such data is a goal that justifies a federal presence. Private industry collaboration alone will be neither comprehensive nor rapid enough. An apolitical Bureau of Health Statistics, analogous to the Bureau of Labor Statistics, should be established by Congress and report to Congress on progress toward the goal. It should be separate from all purchasers, including Medicare. The Bureau would be advised by a Health Data Commission, to be composed of a broad group of members with expertise in information systems, health care financing, health economics, and other scientific and technical fields. We propose that the Bureau of Health Statistics take responsibility for reporting on cost, coverage, and vital statistics. Information on quality reporting will fall within the purview of the Health Accountability Foundation. The creation of the Bureau of Health Statistics and the Health Data Commission will

require federal legislation and reporting of the chosen data elements by all parts of the health care delivery system as well as by states.

Target Goals:

- Health data system should be functioning by the end of 1996.
- Data on costs of health services should be available quarterly.
- Data on coverage should be available annually, and within the first three months of the following year.

CONCLUSION

"Responsible Choices" recognizes that the health care market is moving rapidly toward reform and offers proposals to foster this restructuring. Private purchasers are driving the market and causing health plans to compete on price and quality. However, not all purchasers are exerting this force on the market. As the largest purchaser of health care in the U.S., the federal government has tremendous potential to drive improvement in the market which it has not yet exercised. Small groups and individuals have limited access to group purchasing arrangements that pool risk, provide choice, and achieve administrative savings that would enable them to be active, value purchasers of health care.

This demonstrates that market mechanisms alone are not solving all of the problems. "Responsible Choices" depends on the willingness of government and the private sector to work together to improve the American health system. Federal involvement is necessary to bring public programs into line with the private sector, increase consumer cost-consciousness, establish a fair market, promote group purchasing that offers the small group and individual market access to reasonably priced health coverage, and provide information. "Responsible Choices" recommends a tax credit as the means for bringing structure to the market. Without the tax credit device, bringing order to the health care market will be much more complicated and require considerable regulation.

For its part, the private sector must be willing to be more accountable. Benchmark benefits and quality reporting are the first steps that the private sector should take to voluntarily hold itself accountable. Implementing these policies would bring comparability to the market and provide information enabling consumers to make informed decisions and drive competition. If the private sector cannot follow through, it may be necessary to link these proposals to the tax credit by requiring health plans to price and offer the benchmark benefits package and report on quality in order to receive tax credit eligibility for their plan.

"Responsible Choices" does not address the issue of achieving universal coverage but recognizes that other primary problems must be solved first, such as building a better marketplace so consumers and purchasers can make informed decisions. Other important issues, such as malpractice and antitrust, are not taken up directly since they are being actively addressed by others and dealt with in the market. These proposals are the necessary incremental steps forward in containing costs and fostering effective public and private purchasing. With these reforms in place, there will be more data and the capability to effectively and efficiently deal with those left out of the system. The elements of this proposal can be put in place rapidly and will accelerate the reforms already taking place in the market.

We welcome, and encourage any comments you have on this draft document. If you have comments, questions or need any further information please call, fax or write:

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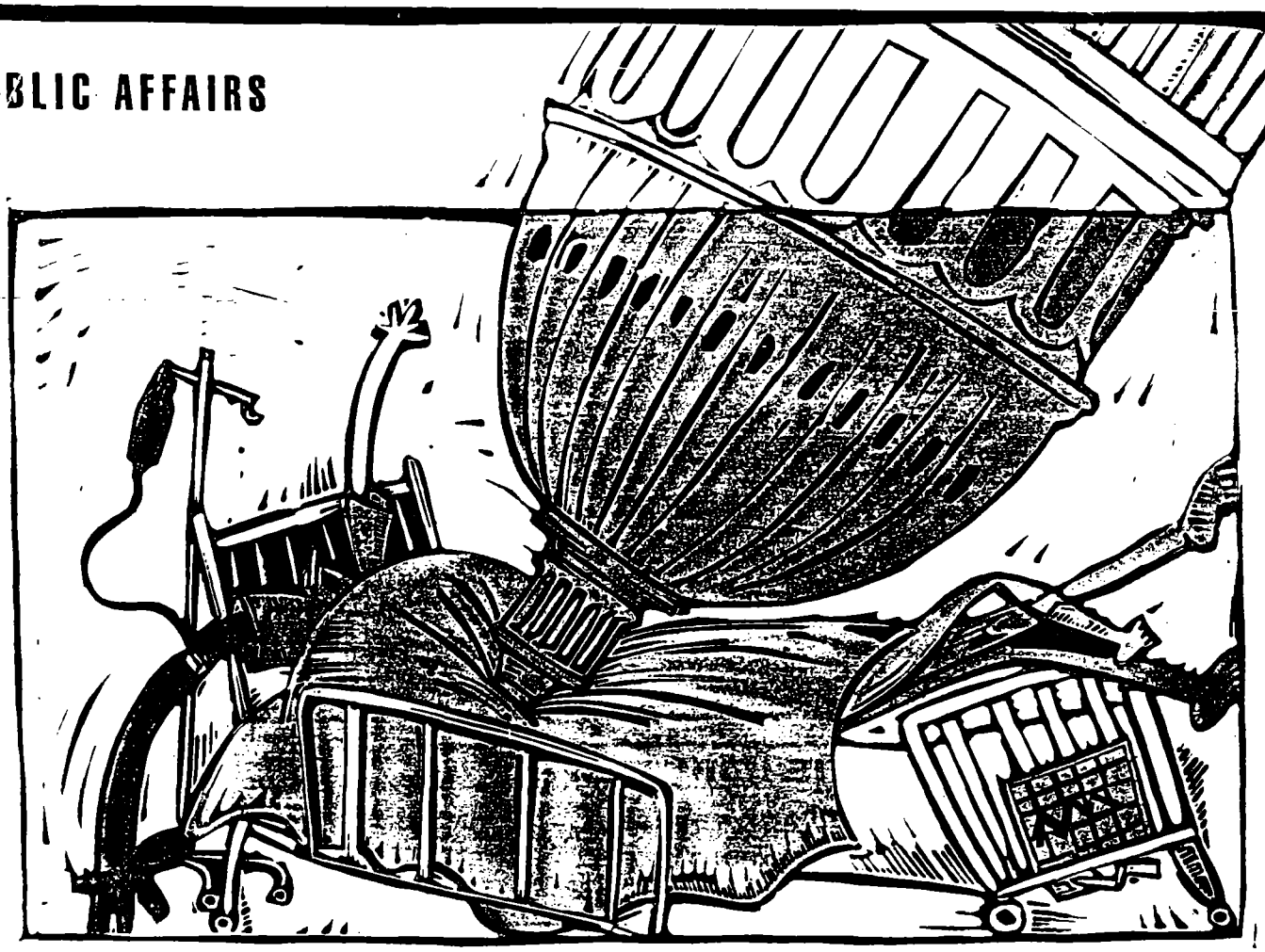


A Triumph of Misinformation

Most of what everyone "knows" about the demise of health-care reform is probably wrong—and, more important, so are the vague impressions people have of what was really in the Clinton plan

by James Fallows

BY the time the Clinton health-care-reform plan was abandoned, in September, everyone knew how terrible it was. It had been hatched in secret by an egghead team that knew a lot about policy details but had no grasp of political reality. The Administration had wasted time and missed deadline after deadline for presenting the plan to Congress, causing the plan to miss its best opportunity for passage—during the President's brief honeymoon period, in 1993. The scheme was fatally overcomplicated. The proposed legislation, 1,342 pages long, was hard for congressmen to read and impossible for anyone except the plan's creators, Hillary Rodham Clinton and Ira C. Magaziner, to understand.

The Clinton plan would have imposed sweeping changes on one seventh of the national economy, with consequences far greater than Congress could possibly consider before casting a rushed vote. It represented a regulation-minded, top-down, centralized approach at a time when the world was moving toward decentralization and flexibility—and when the supposed health crisis was solving itself anyway. The more people learned about this plan, the less they liked it, and it finally died a natural and well-deserved death.

Or so goes the conventional wisdom, as relayed in countless newspaper and magazine postmortems of the health-care struggle. The critiques were usually accompanied by veiled jabs at Hillary Clinton—what will she do with her time now that health care's gone?—and outright ridicule of Magaziner, who was portrayed as the smartest person with the dumbest plan since Robert McNamara and the Vietnam War.

But suppose that what everyone knows is wrong. This happens all the time in politics. Barely a year ago, for example, everyone in Washington knew that Congress was absolutely certain to pass a health-care program by now. The leaders of the Administration's health-care-reform effort, Hillary Clinton and Magaziner, believe that everyone is wrong again now. I heard them elaborate this view in September and October, during a series of

Illustrations by Randall Enos

"No one understood this, but the average American patient would have had more choice under the Clinton plan than they now will."

long background conversations. "Background" means that I agreed to check with them on any material I wanted to quote directly. The gist of their views, however, was on the record. It is no surprise that they view the reform plan as something other than an overcomplicated bureaucratic nightmare. The surprise is how much more convincing their version of reality is than the prevailing one.

These conversations began at Magaziner's suggestion. He and I were friends in graduate school, more than twenty years ago, and he was obviously betting that I'd listen to him more sympathetically than other reporters would. I am biased, in that I like and respect Magaziner. But until these meetings I had had no contact with him during his time as health czar, and I have not always agreed with his ideas. (His worst achievement: helping bring a no-requirements curriculum to Brown University, when he was the student-body president in 1969.) In this case the facts seem to be on his side.

Let's consider each count in the conventional bill of indictment against the Clinton-Magaziner plan.

FIRST count: *The plan was hatched in secret.* During the 1992 presidential campaign Bill Clinton talked frequently about his interest in health-care reform and gave a signal about the reform approach he preferred. In a speech in September he recommended "competition within a budget." To the health-care cognoscenti this indicated an approach different from the main Republican and Democratic proposals of the time.

The most familiar Democratic approaches were "single-payer" and "play-or-pay." Single-payer, which was endorsed during the 1992 Democratic primaries by Senator Robert Kerrey, of Nebraska, meant a Canadian-style or Medicare-style system. Private doctors and hospitals would provide care, but the government would take over all medical payments, financing them with a big new medical tax. All Americans would be covered. Play-or-pay, supported by many Democrats, required companies either to buy health insurance for their workers or to pay into a public fund, which would insure workers not covered by their companies. People who were not working would not be insured. An approach popular among Republicans relied on new tax breaks to encourage people to buy health insurance on their own. Some politicians from both parties endorsed a "managed competition" scheme, separate from all these.

Clinton's reference to "competition within a budget" fit a proposal laid out in the fall of 1992 by Paul Starr, a Princeton professor, in a short book called *The Logic of Health Care Reform*. This book came closer than any other document to anticipating the ultimate shape of the Clinton-Magaziner bill.

In Starr's plan, which was a variation on a managed-competition scheme, all Americans would be covered—even if they were out of work, even if they had "pre-existing conditions." The cost of coverage would be paid mainly by companies, which would contribute to the insurance premiums for each of their workers. The government would subsidize coverage for those who were unemployed or worked for small firms. Private insurance companies would offer coverage, as they do now, but the government would "manage" the way they competed for business. Each company would come up with a list of standard benefits, which it would have to offer at the same price to all customers. That is, the insurers could not turn down people who were already sick, or charge fifty-five-year-old applicants more than thirty-year-olds. Each year people could compare the offers and choose the plan they liked best—including a fee-for-service plan that let them go to their family doctor. From the customer's point of view, the system would work like the "open enrollment" policy at many corporations, in which employees can choose a new health plan each year. The government would set an overall limit on the amount of money that could be spent on medical care each year, while giving insurance companies and health plans latitude to spend the money as they thought best. This limit was the "budget" in Clinton's reference to "competition within a budget."

With numerous changes of detail and emphasis, the plan that Starr explained in his book and that Clinton alluded to in his campaign became the plan the Clinton-Magaziner task force unveiled in 1993. The most important difference lay in what was meant by "within a budget": the bill that Clinton presented would have limited total spending not directly, by fiat, but indirectly, by limiting the amount that insurance premiums could rise each year. The process of working out these details and emphases kept Magaziner and some 500 task-force members busy round the clock during the Administration's first few months.

ACCORDING to today's conventional wisdom, these meetings doomed the reform effort before it really began, for it was here that Magaziner and his fellow nerds cooked up their unrealistic schemes. But did the process seem weird, secretive, and isolated at the time? Yes, but in only one limited and revealing way.

On matters of substance, the task force went out of its way to hear a variety of views. Most members of the task force were policy or budget officials borrowed from other parts of the government, but the group also included outside scholars and experts, plus several doctors and nurses. There were no representatives of organized outside interests—no delegate from the American Medical Association, no one from the Pharmaceutical Manufacturers of America—but the task force met frequently with outside groups and above all with senators, representatives, and their staffs. By early May, *Congressional Quarterly* reported, the task force had met with 572 separate organizations. "We had a couple of hundred meetings with the congressional leadership and individual members," Magaziner says now. "People were saying that it was the biggest outreach effort ever in laying the groundwork for a bill."

Indeed they were saying so. A *Congressional Quarterly* headline on May 22 read, "CLINTON TASK FORCE ALL EARS ON THE SUBJECT OF OVERHAUL." The article said,

> Most members of Congress give the president high marks for laying the political groundwork necessary for his proposal to get the careful considera-

tion of both parties. . . . Clinton has been playing the health-care issue with an eye to keeping everyone at the table, at least at the outset.

In late September of 1993, when Hillary Clinton appeared before five congressional committees in three days to explain the rationale behind the bill, not a single legislator complained about "closed" or "secretive" deliberations: not Robert Dole, not Robert Packwood, not John Danforth—Republican senators who all later came out against the bill. Senator John Breaux, of Louisiana, a conservative Democrat who supported a competing reform plan, praised Hillary Clinton for the "truly remarkable" consultations the task force had carried out.

So when did the task force become "secretive"? Complaints inevitably arose when Magaziner and his assistants stopped soliciting outside advice and started announcing decisions. Those who disagreed felt that they hadn't been listened to. "Some people say they were excluded because in this case we didn't agree with them," Hillary Clinton told me. "But I think that a fair assessment is that we listened to everybody—and then made recommendations based on what we thought made the most sense."

The larger problem was with the one group that truly was excluded from the deliberations—the Washington press and, by extension, the public in whose interest it is supposed to act. During the brusque early weeks of the Clinton Administration, when George Stephanopoulos was walling reporters out of the White House press office and the Administration thought it could use talk shows to take its message directly to the public, over the heads of the daily press, Magaziner was told by the White House communications office that he and his associates should not talk to reporters about what ideas they were considering for the new bill. Instead they were supposed to refer all queries to the communications office. This didn't stop leaks, of course, but it gave Magaziner a lasting reputation among reporters as a man who liked to operate in the dark. Hillary Clinton is known within the Administration for a combative attitude toward the press. But she now says that the news blackout on emerging details of the health bill was a major mistake.

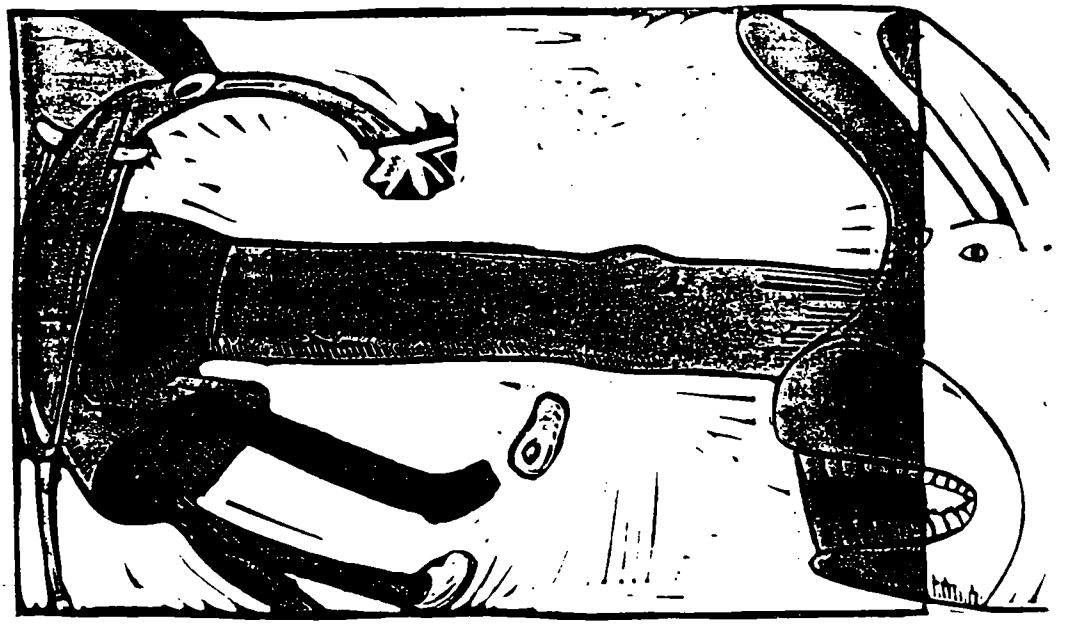
"Even though we had a process unlike any other that has drafted a bill," she told me, "—more open, more inclusive—we got labeled as being secretive because of . . . our failure to understand that we should be more available to the press along the way. That was something we didn't do well. . . . We were not aware of how significant it is to [shape] the inside story in Washington, in order to make the case . . . for whatever your policy is."

Secrecy toward reporters was stupid. But reporters are now acting as if it were something worse: closed-mindedness about ideas.

SECOND count: *The plan was politically naive.* Everyone now knows that the health-care reformers drew up their master plan without taking the slightest interest in what most Americans thought or felt. In reality, though, the plan suffered because the Administration was too attentive to shifting political moods.

Even before Inauguration Day, Magaziner was churning out memos about the right way to pitch the plan to editorialists and interest groups, about the likely Republican arguments and how to rebut them, about the connection between a health-care bill and a re-election campaign in 1996. Week in and week out his memos to Bill and Hillary Clinton contained head counts of likely Senate and House votes—who was leaning, who could be pressured and pushed. In his conversations with me Magaziner seemed to spend half his time sizing up the legislators he had had to deal with: Senator X was in thrall to Bob Dole because of personal problems, Congressman Y had to start out opposing the bill because of donations from Interest Group Z.

Two fundamental decisions about the plan had much less to do with policy than with judgments of political reality. One involved handling the single-payer challenge. A Canadian-style single-payer system has two big virtues. It is simple to administer, since doctors, hospitals, and patients no longer have to worry about dozens of insurance companies with scores of different payment plans. The single-payer approach also guarantees that everyone in the country has medical coverage. But Clinton was dead set against a single-payer plan, arguing that it would require sweeping new taxes and would, in effect, abolish the entire medical-insurance industry. This left the political problem of how to deal with the hundred or so members of the House who supported some kind of single-payer plan.



Without them, no health bill of Clinton's could possibly pass.

Congress also contained a large number of supporters of market-reform and managed-competition plans. The main advantage of such plans is that they change the incentives of medical practice so that doctors, patients, and hospitals are more conscious of costs when making medical decisions. To get a plan passed, Clinton had to show that it would reform the medical market.

"We had to try to bridge the chasm" between these groups in drawing up the plan, Magaziner told me. "If we were serious about universal coverage, we felt, then the single-payer people would buy off even if they didn't like managed competition. We felt we were doing enough of the market reforms that the reform people would buy off too. And, by the way, we also thought that that was the best policy."

But by June of 1993 one of the main market-reform legislators, Representative Jim Cooper, of Tennessee, made clear that he wouldn't buy off. He recommended seeing to insurance reforms first and getting around to universal coverage in a few years. The single-payer group, of course, was not going to agree to that. "At that point," Magaziner said, "we knew that the only way we could try to bridge the chasm was to start a little bit left of center and try to negotiate toward the center."

"Left of center" meant proposing a benefits package a little more generous than what the Administration really wanted, setting the employer's share of total costs a little bit higher, making the limits on insurance premiums a little bit tighter. When the Republican Party lost interest in negotiating, this strategy became a liability, because it made the Clinton plan look more extreme than it was meant to be.

The other purely political calculation concerned sales strategy. Throughout his campaign Bill Clinton had emphasized the overall cost of medical care as a central evil of the U.S. system. Americans spend about twice as much money per capita on medical care as people in other developed nations, with results that are not twice as good. Whenever he was asked about cutting the budget deficit or taming the entitlements monster, Clinton said that the first and most important step was to control health-care costs. This approach won the support of business, since health-insurance costs had for years been rising faster than any other business expense. (From 1948 to 1990, Paul Starr points out, business spending on health coverage rose by an average of 15.6 percent a year.) Through most of 1993, while the plan was being developed and unveiled, major business groups like the U.S. Chamber of Commerce and the National Association of Manufacturers supported its general outlines and accepted even its "employer mandates," which would require companies to pay most of the cost of coverage for their employees. But by the summer of 1994 the Administration was selling the plan mainly as a matter of fairness and security. Its slogan was "Health Care That's Always There."

In theory the Administration could have kept stressing both aspects of its plan—that it would make individuals more secure while reducing the strain on business. The peculiar logic of health-care economics, as revealed in most other developed countries and in American group-care systems, is that when everyone is covered, it becomes easier to control overall costs.

The Administration's political experts, however, recommended a more streamlined sales approach. Clinton's pollster, Stanley Greenberg, produced results in 1993 showing that no one believed that a government health-care plan could ever save money. Although opinion polls taken through the end of 1993 showed that most people supported the idea behind Clinton's plan (once pollsters explained what the idea was), most people also believed that the plan would drive costs up, not down. Therefore the more the Administration emphasized its cost-control themes, the less believable it would become. "The polls showed that people will trust the government to guarantee them security," Magaziner told me. "They will not believe that the government can control costs."

As Republican opposition to the bill increased in 1994, Democratic strategists decided that "security" would be a more effective, partisan rallying theme. "You have to mobilize people, and it's hard to mobilize people around words like 'cost containment' or 'universal coverage,'" Hillary Clinton told me. "So if we didn't convince the middle class that universal coverage meant *them*, we wouldn't get the political support. . . . If you talked about how they could lose their job, how they are one divorce or one pre-existing condition away from losing coverage, then perhaps they would get engaged." By the end of the struggle this sales approach made the Administration even more vulnerable to Republican charges that it was putting out a bighearted, softheaded, typically liberal plan.

One other enormously important, and almost purely political, decision sealed the fate of the bill. Magaziner and Hillary Clinton had hoped to present the bill to Congress a few months after the Inauguration, in the spring of 1993. Thanksgiving had nearly come before they were actually ready to present a finished bill. That delay had little or nothing to do with the nuances of policy. It had everything to do with political necessity—and of a sort that everyone knew was sensible at the time.

Hillary Clinton now says that the news blackout on emerging details of the health-care-reform bill was a major mistake.

THIRD count: "*The First Lady's whiz-kids wasted precious months.*" This was how *The Economist* stated the next objection. Rather than getting busy and presenting the plan when the Administration still had a dewy glow, the health team sat around until it was too late.

The Administration's original strategy was to rush the health plan through as part of its first budget-reconciliation bill. That would have meant having detailed health proposals ready by April at the latest, and the task force had been geared toward meeting that deadline. The genius of this approach, little noticed by the public, is that it would have allowed the health plan to pass with a simple majority vote.

Congressional politics has quietly moved into the "supermajority" system that Lani Guinier was widely denounced for seeming to recommend. In theory it takes fifty-one votes to get a bill through the Senate. In reality it takes sixty votes to end a filibuster, so Bill Clinton knew that the Senate's forty-plus Republicans could stop nearly any legislation they chose.

They could not stop budget bills. These come to the floor under rules that limit debate, and with only a fifty-one-vote majority required for passage. So if the health-care plan could be made part of the budget bill, the Administration could get it acted on quickly, with enough of its own party's votes to see it through.

The Senate's majority leader, George Mitchell, endorsed this strategy, but its de facto parliamentarian, Robert Byrd, objected, scuttling the plan. The Administration then decided that it would introduce the health-care plan as soon as the budget bill passed. But passage was the rub. The budget bill, with its big deficit-reduction package, was seen by everyone in Washington as a major early test of the Administration's strength. (The struggle over the bill is the subject of Bob Woodward's book *The Agenda*.)

The budget fight dragged on much longer than Bill Clinton had hoped or planned. As it became obvious that the final budget vote would be very close (on August 6 it finally passed the Senate 51–50, with Vice President Al Gore casting the deciding vote), the Administration wanted to avoid any extraneous controversy that might affect it. Clinton had been scheduled to make the final decisions about the health-care plan in late May. Because of fears that leaks about his choices would complicate the budget vote, the decisions were put off—a delay that had ripple effects lasting the rest of the year. Without Clinton's decisions, the task force could not prepare detailed legislation; without legislation, it could not start negotiations with congressmen and their staffs. Without final choices on what would be in the package, it could not prepare budget estimates; without those estimates, the Treasury and the Congressional Budget Office could not vet the plan.

By the fall the budget fight was over—but then NAFTA became the issue of the moment. Clinton had been scheduled to spend most of the month of October traveling and speaking about the health-care

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plan. As he was flying to his first event, a labor convention in California, news came that U.S. soldiers had been killed in Somalia. Clinton flew back to Washington after his speech and spent most of the month dealing with Somalia and NAFTA; he canceled all the other health-care events.

Despite the delays and missteps, when the President finally unveiled the plan, in September of 1993, it seemed to have a good chance. "The reviews are in and the box office is terrific," the political analyst William Schneider wrote just after it was presented. "President Clinton's health care reform plan is a hit. . . . The more people read and hear about the plan, the more they seem to like it."

Six weeks after the Inauguration, Magaziner had written a memo to Bill and Hillary Clinton saying that if health-care-reform legislation was not presented and passed immediately, it probably could not be passed during "your first term." With Republican midterm gains in Congress, it now appears that this prediction will be borne out. But the delay was neither negligent nor intentional. It is a reminder of how quickly events spin out of a President's control, and how rare it is for him to be able to advance his own agenda rather than respond to someone else's emergency.

FOURTH count: *The plan had delusions of grandeur.* Now we move to the substance of the plan, which has been described as a regulatory rat's nest, a nightmare of overambitious social engineering, and a sweeping solution where modest reforms would do.

The reality is that very little in this plan was new or unprecedented, and that it was barely more complex or comprehensive than most other plans.

According to the peculiar logic of health-care economics, when everyone is covered, it becomes easier to control overall costs.

When people complained that the plan was grandiose, they had three features in mind: universal coverage (everyone would be insured, whether working or not), community rating (everyone in a given region would pay the same premium for coverage, regardless of age or pre-existing conditions), and employer mandates (forcing businesses to cover much of the insurance cost).

All these ideas have been part of the health-care-reform debate for years. Universal coverage and community rating sound like bleeding-heart concepts, but they are based on tough economic reasoning. The idea behind both is that piecemeal reform of a health-care system can be worse than no reform at all.

The fairness argument for universal coverage is obvious. Even people who are poor deserve care when they are sick or hurt. This is why every developed nation except the United States offers universal care. The economic argument has become almost as familiar. Even people without health insurance ultimately receive treatment, when they show up in emergency wards; hospitals cover the cost by padding charges for everyone else. This backhanded form of coverage is neither economically efficient nor humane. As recently as the fall of 1993 Bob Dole was saying that universal coverage was a "non-negotiable goal of reform."

Community rating is a closely related idea. Every health-care-reform scheme in America is concerned with holding down costs. In most businesses market competition does the job, but competition in the health-insurance area often works in a perverse way. Insurance companies have tended to compete not by improving the incentives, habits, and nature of medical treatment—which in the long run is the only way to limit expenses—but by becoming choosier about whom they will insure. If they can limit their coverage to young, healthy people and rule out those who are already sick, then they can offer coverage at a lower price, without having done anything to improve the efficiency of care.

This is what has happened to the health-insurance business in the past generation. In the old days Blue Cross offered coverage to everyone in the same geographic area at the same price. Now younger, healthier people can get cheaper coverage—which many of them skip anyway, figuring they don't need it—while prices rise for those most likely to need care. Fewer of them can afford to buy it, more must take advantage of the cruel and inefficient fallback of emergency-room coverage, and overall costs keep going up. The young, healthy people eventually become old and sick, and are caught too.

This cycle is known as adverse selection, and it has been talked about in the health-care-reform business for years. Community rating is the main response. It is designed to average each person's medical costs over the course of his or her whole life and to make sure that people have coverage at the times of their lives when it's most necessary. In proposing community rating the Clinton team was hardly making waves.

Even the part of the plan that sounded strangest and most radical, its "mandatory alliances," is already familiar to millions of Americans under a different name. Anyone who works for a big company or a state or federal agency knows about the open-enrollment system for selecting health insurance. The company or agency negotiates with HMOs, insurance companies, and local medical networks that want to offer coverage to its employees. Once a year employees choose which plan they want. The employer then deducts money from their paychecks, adds its own share, and passes the money on to the medical providers.

This, with small variations, is also how the task force's mandatory alliances would have worked. They would have taken bids from insurance companies, HMOs, and other health providers and then let each household choose the plan it liked best. Each provider would have been required to set a price for a standard benefits plan, so that customers could make easy price comparisons among the offerings. The alliances would not, as has often been assumed, have tried to provide medical care themselves, through big new government clinics.

The most ominous-sounding aspect of the new alliance system was its "mandatory" nature. Everyone would have been obliged to choose and buy a standard benefits plan from an alliance. (Contrary to repeated claims by opponents of the bill, people would have been free to buy any extra coverage they wanted, or get any additional treatment from any doctor they chose, as long as they did it with their own

money. Employers would also have been free to offer additional coverage.) The health-care task force argued that the alliances had to be mandatory in order to create the community-rating effect. Otherwise, young, healthy people would stay out of the system, and the pernicious cycle of adverse selection would begin. An exception was made for employees of very large companies, who would still have been able to buy through their own firms' open-enrollment plans. The reasoning was that a General Motors or an AT&T had a work force large and diverse enough to constitute a community-rating pool all by itself. Everyone would have been forced into a pool one way or another.

Some health-care-reform plans have no mandatory component. Several versions of managed competition, for instance, would set up alliances like those in the Clinton bill but not require anyone to buy from them. It is virtually impossible, though, to achieve universal coverage without some element of compulsion. (Medicare offers universal coverage for those over sixty-five, but everyone who works is compelled to pay a Medicare tax.) Moreover, Magaziner argued, for most people the mandatory system would in practice mean more choice and freedom than they now enjoy.

When he ran a small business in Rhode Island, Magaziner said, he covered all health-insurance costs for his employees but could give them only two plans to choose from. Handling the bidding and paperwork for a broad range of plans would have been impossible. "If there had been an alliance, I could have paid my dues to the alliance and let people choose among all the plans." The alliances in the Clinton bill would have been required to offer customers a choice among all plans that met basic certification requirements. In big cities a dozen or more plans might be available. The minimum offering would be three kinds of coverage, including at least one fee-for-service plan that would permit a family to stay with the independent doctor it had been using.

After the plan was withdrawn, Uwe Reinhardt, an economist at Princeton University, told *The New York Times*, "No one understood this, but the average American patient would have had more choice under the Clinton plan than they now will. If you work for a particular company, your choice of HMOs is whatever that company offers you." Some critics argued that the Clinton plan would destroy the market for coverage beyond the plan's basic benefits, and that as a result people would find it difficult to buy as much coverage as they might like. But that is different from the widespread belief that extra coverage would be against the law—and for most people the range of choice would probably be broader under Clinton's plan.

Far from concocting a system that would look and feel radically different from what Americans were accustomed to, the task force believed that it was changing the surface of health care as little as possible while altering its underlying economic structure. The alliance system, despite its strange name, was meant to look familiar to people who already had coverage. The employer-mandate system of finance, in which companies would bear most of the health-insurance costs, reflected the fact that 90 percent of the people who now have insurance (excluding those on Medicare) get it through their employer. The employer mandate is a de facto tax but a well-established one, and a familiar concept in health-policy circles. Many Republicans, including Robert Packwood and Richard Nixon (!), have over the years endorsed employer-mandate plans.

Indeed, none of the individual elements of the Clinton plan was a shocking new entrant into the health-care debate. The plan's system for controlling expenditures, through premium caps that limited how fast the cost of basic coverage could rise, departed from Paul Starr's recommendations. But it closely resembled a plan offered by a group of congressional moderates that included the Republican senators John Danforth and Nancy Kassebaum.

To say that the resulting package of proposals was "too complex" is like saying that an airplane's blueprint is too complicated. The Medicare system is complex. So is every competing health-care-reform plan. Most of the 1,342 pages of Clinton's Health Security Act (which I have read) are either pure legal boilerplate or amendments to existing law. Conventional wisdom now holds that the sheer bulk of the bill guaranteed its failure. The NAFTA bill was just as long, and so was the crime bill that passed last summer. If the health bill had been shorter and had not passed, everyone would know that any proposal so sketchy and incomplete never had a chance.

FIFTH count: *It was a coercive approach to one seventh of the economy—and to a problem that was solving itself.*

Much of the problem for the plan seemed, at least in Washington, to come not even from mandatory alliances but from an article by Elizabeth McCaughey, then of the Manhattan Institute, published in *The New Republic* last February. The article's working premise was that McCaughey, with no ax to grind and no preconceptions about health care, sat down for a careful reading of the whole Clinton bill. Appalled at the hidden provisions she found, she felt it her duty to warn people about what the bill might mean. The title of her article was "No Exit," and the message was that Bill and Hillary Clinton had proposed a system that would lock people in to government-run care. "The law will prevent you from going outside the system to buy basic health coverage you think is better," McCaughey wrote in the first paragraph. "The doctor can be paid only by the plan, not by you."

To say that the resulting package of proposals was "too complex" is like saying that an airplane's blueprint is too complicated.

George Will immediately picked up this warning, writing in *Newsweek* that "it would be illegal for doctors to accept money directly from patients, and there would be 15-year jail terms for people driven to bribery for care they feel they need but the government does not deem 'necessary.'" The "doctors in jail" concept soon turned up on talk shows and was echoed for the rest of the year.

These claims, McCaughey's and Will's, were simply false. McCaughey's pose of impartiality was undermined by her campaign as the Republican nominee for lieutenant governor of New York soon after her article was published. I was less impressed with her scholarly precision after I compared her article with the text of the Clinton bill. Her shocked claim that coverage would be available only for "necessary" and "appropriate" treatment suggested that she had not looked at any of today's insurance policies. In claiming that the bill would make it impossible to go outside the health plan or pay doctors on one's own, she had apparently skipped past practically the first provision of the bill (Sec. 1003), which said,

> Nothing in this Act shall be construed as prohibiting the following:
> (1) An individual from purchasing any health care services.

It didn't matter. The White House issued a point-by-point rebuttal, which *The New Republic* did not run. Instead it published a long piece by McCaughey attacking the White House statement. The idea of health policemen stuck.

So did the idea that one seventh of the national economy would be transformed overnight. Of the vast American commerce in health care, more than 40 percent is already paid for by the federal government, mainly through Medicare. Under the Clinton plan the rest of the money would still go through most of the insurance companies, HMOs, doctors, hospitals, and laboratories that are receiving it now.

THE final element in the conventional wisdom is that this cumbersome, flawed plan was in any case unnecessary, because the health-care problem was going away. Medical costs rose by "only" 5.9 percent in 1993—yet that was more than twice as fast as wage growth and almost twice as fast as the overall inflation rate. Over the past several decades medical costs have risen about three percent faster than the overall inflation rate; in 1993 the gap was 2.9 percent.

"There is no persuasive evidence that we are in either a stabilized or an improving health-care-financing environment," Hillary Clinton told me. "In fact, many of the problems will only continue to get worse. The problems that middle-class Americans care the most about—like what doctor they can see—will likely become appreciably worse, because many will be forced into managed care over which they have no say. Employers will make those decisions. They will pay more for fewer benefits. How deeply this sinks in and how much it motivates political action, I don't know."

IF this plan did not perish because it had been designed in intolerable secrecy, or because its designers knew nothing about politics, or because it was full of unacceptable new ideas, or because it was so much more complex than any predecessors, then what happened to it?

The Administration's view, for which, again, there is ample evidence, is that it went down because of two zero-sum games, one political and one economic. Health-care reform became a battle in which some would win and others would lose—and Clinton lost.

Through most of 1993 the Republicans believed that a health-reform bill was inevitable, and they wanted to be on the winning side. Bob Dole said he was eager to work with the Administration and appeared at events side by side with Hillary Clinton to endorse universal coverage. Twenty-three Republicans said that universal coverage was a given in a new bill.

In 1994 the Republicans became convinced that the President and his bill could be defeated. Their strategist, William Kristol, wrote a memo recommending a vote against any Administration health plan, "sight unseen." Three committees in the House and two in the Senate began considering the bill in earnest early in the year. Republicans on several committees had indicated that they would collaborate with Democrats on a bill; as the year wore on, Republicans dropped their support, one by one, for any health bill at all. Robert Packwood, who had supported employer mandates for twenty years, discovered that he opposed them in 1994. "[He] has assumed a prominent role in the campaign against a Democratic alternative that looks almost exactly like his own earlier policy prescriptions," the *National Journal* wrote. Early last summer conservative Democrats and moderate Republicans tried to put together a "mainstream coalition" supporting a plan without universal coverage, without employer mandates, and without other features that Republicans had opposed. In August, George Mitchell, the Democratic Party's Senate majority leader, announced a plan that was almost pure symbolism—no

employer mandates, very little content except a long-term goal of universal coverage. Led by Bob Dole and Newt Gingrich, Republicans by September were opposing any plan. "Every time we moved toward them, they would move away," Hillary Clinton says.

"We always knew that in the end people's trust of the President and First Lady would be crucial," Ira Magaziner says. "The debate was going to be complicated, and that trust factor was very important." Whitewater eroded the trust factor. The President looked beatable, and he lost.

Economic factors counted too. Doctors had fought bitterly against Medicare in the early 1960s, but for the most part they sat this battle out. If they weren't controlled by the government, they would be controlled by insurance companies, which in some ways were worse. But other interest groups had more to lose. Health-insurance agents would be put out of business. Health-insurance companies could have their premiums capped. For-profit hospitals thought they would lose money. Manufacturers of medical equipment thought that market growth might slow. Large businesses that did not already offer health care for workers knew the employer mandate would cost them money. (These were mainly corporations like PepsiCo and General Mills, which own restaurant chains whose part-time workers are uninsured.)

During the 1992 campaign the Clinton war room excelled at answering negative charges immediately, before damaging impressions could set in. But even flatly untrue attacks on the health plan went unanswered—direct-mail campaigns saying that everyone would have to go to a government clinic, daily doses of misinformation from Rush Limbaugh, TV advertisements fanning McCaughey-style fears of jail terms for people who wanted to stick with their family doctor. Last March *The Wall Street Journal* found that a panel of citizens preferred the provisions of the Clinton plan to the main alternatives—when each plan was described by its contents alone. But when pollsters explained that the preferred group of provisions was in fact "the Clinton plan," most members of the panel changed their minds and opposed it. They knew, after all, that Clinton's plan could never work. ❁

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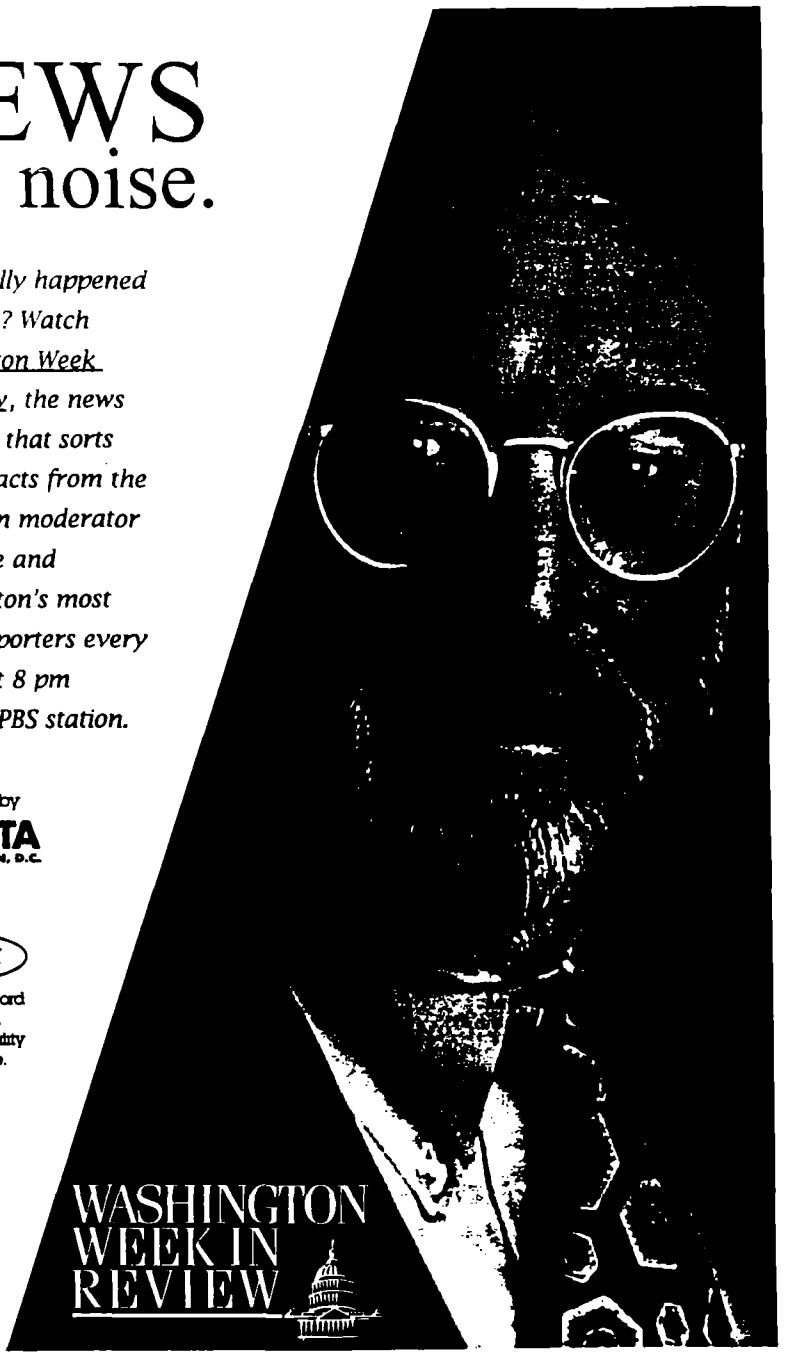

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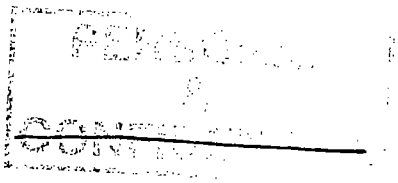

THE WHITE HOUSE

November 3, 1995

Mrs. June Freeman
9 Southern Pines Drive
Pine Bluff, Arkansas 71603

Dear June:

Thank you for your letter and for your good wishes about my trip to Beijing. It was a tremendous honor to speak to so many women from around the world who share our commitment to human rights.

I also very much agree with the point you made in your letter that we need to focus on wellness to prevent disease before it starts. Just this spring, the Clinton Administration launched a year-long Medicare Mammography Campaign to educate older women about the importance of detecting breast cancer early and about Medicare coverage of mammography services. Unfortunately, only about forty percent of women on Medicare take advantage of the Medicare mammography benefit. For most women, a mammogram puts their mind at ease. Those few who do have breast cancer can identify it early and get the treatment they need. We hope that our campaign will encourage older women to get regular mammograms.

I also truly enjoyed your son's newsletter. These kinds of outreach efforts, both local and national, help educate people about how to take care of themselves now to avoid serious and costly illnesses later.

Thank you again for writing and for your commitment to helping Americans lead healthier lives.

With best wishes, I am

Sincerely yours,

Hillary

Hillary Rodham Clinton

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9 Southern Pines Drive
Pine Bluff, Arkansas 71603
501 534-1305

August 20, 1995

Dear Hillary,

I hope by the time this reaches the White House that you will have been able to complete your plans for attending the women's conference in China. I believe we need a presence there in the person of an outspoken advocate of human rights.

I've been thinking of your role as first lady, in light of your interest on health issues. I'd like to see you focus on <u>wellness</u>, to get people to work toward preventing illness. If people ate well and practiced other measures that promoted their well being, physical and mental, how wonderful that would be for all of us. You could do it. No matter if one is sick or poor wellness is an obtainable goal. Please think about it.

My oldest son is a physician, another is the editor of the enclosed publication, one that I believe is very well done. Emlen is a fairly recent issue. David, a Yale graduate by the way, has been putting this out for the past two years. The interest lies in prevention. Hope it has some value to you.

Always,
June Freeman

THE WHITE HOUSE

WASHINGTON

January 31, 1995

Mr. Nick Franklin
Senior Vice President
Public Affairs
FHP International Corporation
9900 Talbert Avenue
Fountain Valley, California 92708

Dear Nick:

Thank you for writing to me about FHP's Medicare program. I enjoyed meeting you at the recent breakfast at the White House, and I appreciate your following up on our discussion. I've asked Carol Rasco to look into the issues you raised and have passed along your invitation to my scheduler for consideration.

As we continue working to improve our health care system, I am grateful for your support. I hope you'll stay involved.

Sincerely,

Bill Clinton

Your letter was great
Thanks—

cc: Carol Rasco
Billy Webster
cc this letter to
HRC, Erskine, Leon
BJ

~~To Jen + Chris Jennings —~~
Please review letter and
evaluate claims in it for me.
Thanks — H

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FHP
HEALTH CARE

FHP International Corporation
Public Affairs Department
9900 Talbert Avenue
Fountain Valley, CA 92708
714.378.5767

January 12, 1995

William Jefferson Clinton
President of the United States
The White House
Washington, DC

Dear Mr. President:

I enjoyed the opportunity to meet you at the breakfast you hosted for members of the Democratic Leadership Councils at the White House on December 7, 1994.

You asked me to write to you and let you know how FHP is able to save Medicare beneficiaries and the federal government money under FHP's Medicare risk contract with the Health Care Financing Administration (HCFA), while providing beneficiaries with a broader range of benefits, including prescription drug coverage. I trust the following provides the information you requested.

I should begin with a brief background of the Company and its Medicare business. FHP International Corporation is a federally qualified health maintenance organization which began 33 years ago in Long Beach, California. Over the years, the Company has expanded and now serves people in 11 states and the Pacific Islands of Guam and Saipan. Over 1.7 million individuals today receive all of their health care from FHP. Our customers, or members, include the employees of over 5,000 small, medium, and large corporations; Medicaid recipients; military dependents; federal, state, county, and city employees; and nearly 350,000 Medicare beneficiaries.

FHP receives a capitated payment, a fixed amount of money every month, for each of its members and in return contracts to provide all of that member's health care needs irrespective of the cost or intensity of care. Approximately 20% of our members receive their care through our staff-model network of over 60 company-operated medical centers and five hospitals. The balance of our members receive their care through private physicians and hospitals with whom FHP has contracted.

Under our Medicare contract with the federal government, HCFA pays FHP an amount equal to 95% of what HCFA would otherwise pay to the fee-for-service physicians and hospitals in that geographical area. FHP in turn provides all of the benefits required under Medicare.

In addition, FHP provides outpatient prescription drugs and other benefits not covered by Medicare, including covering hospital and physician deductibles. For this FHP charges $5 for a prescription, $5 for an office visit, and charges no premium. The results are impressive. For example, the 5% savings to the federal government for our 350,000 Medicare members amounts to more than $60 million per year. Because FHP charges no premium and adds benefits over and above the standard Medicare benefits, we save each of our 350,000 Medicare members an average of more than $1,200 a year. These direct savings to our Medicare members total more than $348 million a year.

Through these efficiencies, FHP is removing over $400 million a year of unnecessary and wasteful health care costs from the health care system for our Medicare members alone. As evidence of the senior population's acceptance of this program, our Medicare membership grew on average 21% each year over the last five years.

We are able to accomplish these results by applying a series of basic principles which we have learned over the years, and which are readily applicable to the nation as a whole as we seek to provide health care to all Americans in a cost-effective way:

I. We remove the financial barriers to seeking early care. We know that if there are limited benefits, pre-existing condition exclusions or deductibles, many people will defer seeing the doctor until the disease or problem becomes unbearable. By the time they see the doctor, it is likely that more expensive procedures and possible hospitalization will be required. We know that if we remove the financial barriers to seeking early care we are often able to stabilize or correct the problem before it gets out of hand, and thereby avoid more expensive treatment later on. Not only does this save money, but it is a higher quality of medical care since no one wants to be sick or in the hospital if he or she can avoid it. The use of a hospital is the most expensive part of medical care, and FHP's use of hospital bed days is one of the lowest in the country.

II. Access to an individual's primary care physician on weekends and in the evenings is very important to the control of health care costs. If their doctor is not available, then typically, the patient will wind up in the emergency room of a hospital. Emergency room care is very expensive and is used by hospitals as a major source of admissions. Many of FHP's medical centers are open in the evenings and on the weekends. The centers are full-service medical centers which include both primary care doctors and specialists, a pharmacy, minor surgery, laboratory, x-ray, physical therapy, and even child care while the patient is receiving medical care.

III. Under the HMO Act, every federally qualified health maintenance organization must provide a minimum level of benefits as prescribed in the act. Except for outpatient drugs, this benefit level is all inclusive; but FHP adds prescription drugs to every one

of its benefit packages. This is particularly important for Medicare beneficiaries since many do not have the funds to fill a prescription. Without a drug benefit, the prescription would likely either not be filled or would be filled and spread over a longer period of time than is therapeutically required to cure the illness. From experience we know that the additional cost of a drug benefit is more than offset by lower hospital use and lower utilization of health care.

IV. The incentive for the physicians must be aligned with the HMO's and the nation's incentives to reduce costs while simultaneously improving quality. Under the fee-for-service system, providers are paid based on services performed. This incentive has lead to abuses and over utilization. At FHP, our staff and contract physicians have incentives to provide members with rapid access and to deliver high quality care. These incentives not only control costs, but also enhance quality—to do otherwise would result in lawsuits and loss of members. Holding back on appropriate utilization would also, as discussed earlier, actually result in eventual higher health care costs.

Our efforts to control costs while delivering high-quality care have had impressive results. Over the past months, our efforts to assure the highest standards of quality have been recognized by a number of organizations. The National Committee for Quality Assurance has awarded our plans in Arizona, New Mexico, Southern California, and Utah with unqualified certifications of quality care. The American College of Surgeons recognized FHP's exceptional quality of care in treating our members who have cancer.

V. FHP's Medicare program is community rated. This is an essential part of the program's success. Under a community rating system, HCFA pays FHP the same monthly amount, adjusted for age, for each member in each geographical area served by FHP, irrespective of the Medicare member's health. At any time, some of our Medicare members will be sick and some will be well. The key is that we have enrolled a large number of Medicare beneficiaries so that the cost of caring for the ill members can be spread over our entire 350,000 Medicare population, making health care on average affordable for any one individual.

VI. Physician choice is important, but not in the way most people think of it. Having the absolute, unchecked freedom to seek the services of any doctor, including expensive specialists, at any time and at any frequency, is not a prerequisite to receiving quality health care. One of the reasons FHP is so popular with its Medicare members is that we have carefully screened, credentialed, and regularly recredential each of our in-house and contracted physicians. We inquire into their malpractice history, their technical competence, where they went to school, where they trained, the amount of their training and experience, and the status of their licensure. When an FHP member selects one of our physicians, the member can have confidence in the level of care they will receive. This is not necessarily the case in the unmanaged, fee-for-service system.

Mr. President, my colleagues at FHP and I are convinced that HMOs offer the best solution to controlling the growing cost of health care, generally, and Medicare, in particular, while assuring coordinated high-quality care. The number of Americans in HMOs has grown steadily in recent years with more than 25 percent of Americans receiving health care through a managed care plan. The savings to the private sector have been significant, with health costs growing at the lowest level in years (indeed, for many employers, costs have actually declined with no loss in quality). Yet only some ten percent of Medicare beneficiaries receive their care through HMOs.

FHP is convinced that the Medicare program and beneficiaries can realize similar cost savings while assuring coordinated quality of care. We have been excited by the recognition managed care has been receiving from Members of the Congress as a way to address the Medicare programs problems. The biggest challenge will be to encourage beneficiaries to try something which for many of them will be new.

Our surveys, like those of the other Medicare HMOs, demonstrate enormous satisfaction by our Medicare patients with the quality, cost and additional benefits they receive. We are sure, given the chance, other beneficiaries would be similarly satisfied.

We would be pleased to work with you and others in your Administration to bring the beneficial cost and quality results of managed care to a greater number of Medicare beneficiaries. Also, we would be delighted for you to visit our medical and corporate headquarters campus in Southern California the next time your travels bring you to the West Coast. I think you will be very impressed with what you see.

Thank you for asking me to provide you with this information and for your leadership on health care issues. If you have any questions or if I can be of any further assistance, please do not hesitate to call me directly at: 714-378-5631.

Sincerely,

Nick Franklin
Senior Vice President,
Public Affairs

cc: Carol H. Rasco, Assistant to the President for Domestic Policy

g:\klein\whitehse.bf