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001a. letter	From: Hillary Rodham Clinton, To: Constituent [partial] (2 pages)	11/10/95	b(6)
001b. note	From: Staffer, To: First Lady, Corerspondence Log [partial] (1 page)	nd	b(6)
001c. letter	From: Constituent, To: Hillary Clinton [partial] (2 pages)	8/18/95	b(6)

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
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HRC
HC CORR 95-S

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HC Corres

HC

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INITIALS: DDB DATE: 12-9-13

March 7, 1995

MEMORANDUM FOR FILE

FROM: Judithanne Scourfield

SUBJECT: Elizabeth Cook letter

At Jennifer Klein's suggestion, Ms. Cook's letter was forwarded to HHS's Executive Secretariat Claudia Cooley today. A copy of the HHS response will be sent to Ms. Klein.

THE WHITE HOUSE

WASHINGTON

March 21, 1995

Ms. Elizabeth J. Cook
1245 Manzona Way
San Diego, California 92139

Dear Ms. Cook:

Thank you for writing about the lack of Medicare coverage for acupuncture and massage therapies. I have forwarded your letter to Claudia Cooley, the Executive Secretariat of the Department of Health and Human Services, who can address your specific concerns.

I am happy to learn that these treatments have helped you. As you know, the President and I firmly believe that an emphasis on disease prevention is essential both to promote health and to contain health care costs.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

Mrs. Clinton

Over the years I have received significant health benefit from treatment with massage and acupuncture. In addition, these licensed practitioners of natural medicine have provided me with valuable information and insights into the effects of lifestyle and diet on my health. These services have been provided at reasonable cost and in a very professional manner.

My question to you today, is why does Medicare not help pay for these services? They are effective, reasonably priced, and I believe help keep me well in a preventative manner?

Thank you very much in advance for any efforts you can make to help in this important matter.

THE WHITE HOUSE

April 14, 1995

Mr. Jack Sheinkman
President
Amalgamated Clothing
and Textile Workers Union
15 Union Square
New York, New York 10003-3377

Dear Mr. Sheinkman:

Thank you for sending me a copy of Professor Merton Bernstein's national health care proposal. The President and I very much appreciate your past support and continuing interest in our efforts to reform the health care system.

As the President said in his State of the Union address, he remains firmly committed to continuing the fight to guarantee that every American has health insurance and to contain health care costs. This year, we will work with the Congress to take the first steps toward achieving these goals.

Thank you again for writing. I have forwarded Professor Bernstein's proposal to our health policy staff for their review.

Sincerely yours,

Hillary

Hillary Rodham Clinton

AMALGAMATED CLOTHING AND TEXTILE WORKERS UNION
ACTWU

JACK SHEINKMAN
President

ARTHUR LOEVY
Secretary-Treasurer

BRUCE RAYNOR
Executive Vice-President

AFL-CIO, CLC
15 UNION SQUARE • NEW YORK, N.Y. 10003-3377
TEL (212) 242-0700 FAX (212) 255-7230

February 6, 1995

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mrs. Clinton:

Attached is a copy of my friend, Professor Merton Bernstein's national health care proposal adapted according to him to today's circumstances.

(1) It proposes competitive bidding among self-formed groups of private insurers and providers to determine each state's private single payer. Private administration would remove the curse of "big government". It also provides for a non-tax method of providing funds, although it contemplates using a tobacco tax for a small portion of the money required for universal coverage and banning pre-existing conditions.

(2) It proposes shifting $50 billion of current expenditures for non-health-insurance medical services (such as workers' comp., homeowners, and auto and truck insurance) to health insurance. The money would purchase more than it now does because of eliminating a great deal of paper shuffling and health insurers pay much less than these other insurers for the same diagnoses.

I trust that this proposal will be of assistance to you in your significant efforts dealing with health care.

With warm regards,

Sincerely,

Jack Sheinkman
President

January 20, 1995

RX FOR UNIVERSAL PRIVATE SINGLE PAYER HEALTH CARE WITHOUT NEW TAXES

by

Merton C. Bernstein*

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* Professor of Law, Washington University. Author of *The Future of Private Pensions* (Free Press-Macmillan 1964) and co-author, with Joan Brodshaug Bernstein, of *Social Security: The System That Works* (Basic Books 1988). Principal Consultant to the National Commission on Social Security Reform (1982-83) and delegate to the White House Conference on Aging (1995).

Support for universal health insurance is itself almost universal -- and so is opposition to new taxes to pay for it. Extending coverage and eliminating the exclusion of pre-existing conditions cost vast sums. So, the trick becomes to achieve about $100 billion in savings from money already being expended and to use those savings to pay for the 39 million people who now lack assured medical care from either private insurance or public programs. And substantial sums also must be found to bring insurance within the reach of small companies who account for the major bloc of uncovered employees. Further, public antipathy to a public bureaucracy to administer unused health care means private mechanisms must do that job.

A universal health plan can succeed -- economically and politically -- without federal government administration and tax increases. Two measures - not yet seriously considered - can make this happen: (1) competitive bidding to select a single <u>private</u> health insurance administrator for each state or region and (2) redirecting into health insurance $50 billion already being spent on the medical care portion of several kinds of liability insurance.

Competitive bidding among groups of insurers to select a single private administrator/payor in each state or region (parts of some populous states or contiguous areas of more than one state) would capture over $100 billion in savings (the Office of Technology Assessment and the Congressional Budget Office estimates) by eliminating sales and promotion costs and claims processing expenses for both insurers and health care providers. Higher taxes on tobacco products command great popular support; they can generate as much as $18 billion a year (the 1994 House Health Care Subcommittee proposal). Most small businesses already pay for workers' compensation and automobile and truck insurance. Using the portion of

premium now paid for medical care more efficiently in health insurance would ease the burden for more small businesses to cover their employees.

Together, the measures proposed here would provide the sums needed to provide universal coverage and eliminate exclusions for pre-existing conditions. Supplemented by additional reforms, such as prohibiting costly conflicts of interest among providers,[1] we can assemble the funds needed for universal coverage without increasing total medical care outlays.

COMPETITIVE BIDDING TO BECOME A STATE'S PRIVATE SINGLE PAYER SAVES MORE THAN $42 BILLION

Both proponents and opponents of a single-payer system have assumed that it must be (1) government operated, (2) would not achieve economies through competition, and (3) would require increased taxes. Those assumptions are baseless. A privately-operated single payer selected in each state or region selected by competitive bidding would produce vast savings. Private administration would make a consolidated payer politically acceptable and harness the accumulated know-how and cost-consciousness of private enterprise. The savings achieved can be translated into payments for the new system without imposing new taxes or raising existing taxes.[2]

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[1] For example, studies show that physicians with an ownership interest in diagnostic centers and test labs prescribe those services more than non-owners. Prohibiting provider conflicts of interest can save large sums.

[2] Other than on tobacco.

Competitive bidding is the time-honored way of obtaining goods and services at lowest cost. Using that device to select among groups of private insurers to determine which private entity would be the unified "single-payer" insurer for health care services in each state or region would yield enormous savings on insurer sales and promotion outlays and administrative costs. In 1994, the Office of Technology Assessment put overall savings at $100 billion.

Private insurers and providers would form health insurance groups to bid against one another to become the insurer/administrator of a state or regional program for a stated period of years. Limiting any group's national market share and the duration of its contracts would assure many competing organizations. Limiting the portion of the national market of any single participating company would further assure that many companies would vie for the role. Contract periods should be staggered so that each year contracts in some states come up for bid.

The successful bidder would face no competitor during its contract term and so need not include the prodigious costs of promotion (advertising and commissions) in its bid or subsequent charges. That provides a major saving over current practice and proposals where all insurers must include promotion costs in their premiums because they must constantly compete with rival insurers for patrons.

The proponents of managed competition claim that insurer plans would compete on price and quality, the latter to be shown by published reports of provider track records. Data on outcomes do not necessarily identify the best providers. For example, deaths may occur most frequently at the hands of the provider that gets the most tough cases. Even assuming that mortality rates, for example, do somehow show the efficacy of a provider's services, experience

lends little support that potential consumers will choose a provider based on such information. The more than $124 billion spent annually by private enterprise for advertising and the ever-present advertising by health insurers attest that U.S. enterprises favor that device when competing. Health plans now huckster their wares on billboards, airwaves, and direct mail as they battle for market share. We can avoid those growing non-health-care costs and apply the funds they consume to coverage or lower premiums.

The state (or regional) single payer would insure the payment of all providers for a state (or region's) residents who would receive the same coverage without distinction by source of payment. This would eliminate the enormous and expensive non-medical record-keeping now necessary for each insured and each patient. Uniformity of coverage would also make the single payer and all providers expert in what is covered and what it costs.

States could experiment with fee-for service, HMO's, preferred providers and whatever other devices each one thought most promising. They could even specify in their invitations to bid whatever combination of such arrangements they desired - providing some with fee-for-service coverage, some HMO coverage, some PPO coverage. If a state legislature thinks the additional cost of such variety is worth the price, or possibly more efficient than a uniform method for all, it could pursue its preferences. I am persuaded that uniform coverage makes the most sense because all of us are subject to the same hazards and uniformity achieves the greatest efficiency But, enabling the states to experiment with a variety of methods would counter the opposition to "one-size-fits-all" arguments and enable the nation to experiment with

various kinds of coverage and combinations. Any insurer or insurer-provider combination could join forces with any other insurers and providers to form a group to bid on a state's package.

A single payer's contract with a state or region would run for a specified number of years. Records of premiums and payout must be matters of public record to enable other insurers to compete and to assure providers that they are getting a fair shake from insurers and vice-versa. A few years under a contract would be necessary to enable all concerned to gain experience and also to spread health problems, such as flu epidemics, over a period long enough to provide the balm of averaging costs.

Invitations to bid should be made sufficiently long in advance of a new contract period to enable providers and insurers to form their groups. Federal and state anti-trust laws must apply so as to avoid collusion between prospective bidders.

The coverage must enable participants and patients to move from state to state and keep coverage. National law might have to specify the method(s) of reciprocity so that each affected state's insurer would get a proportional amount of a year's premium and a proportional share of the year's obligations for participants and patients who move in any year.

State or Regional Arrangements

Some states are so large and populous that they may wish to segment the areas served so as to conform to local circumstances. Others may wish to establish uniform rates and therefore combine urban and less populated areas. Some states may desire to form regional arrangements with contiguous states for all or a portion of their population so as to fit varying circumstances

of population and transportation. They should be free to make such arrangements through interstate compacts.

A clearinghouse for information should be maintained for the convenience and use of all states, especially less populous and less affluent states. To minimize objections to a national government role, the federal government could provide the Council of State Governments with funds to establish such an institution or the states could provide the necessary funds. After such an institution gets started, its services might be available to states on some fee basis decided by states that decide to participate.

The essentials of this proposal are: simplification in the interests of low cost, affordability and simplicity; sufficient variability among the states to enable experimentation; a minimal role for the federal government once it enables the system to get going.

Paying for Single Payer

The current single-payer proposal depends upon taxes assessed primarily upon participants. The proponents argue quite sensibly that the taxes would cost most participants less than they now pay. But a tax is a tax and hard to sell, all the more so because many participants will not readily recognize that employer payments probably come from their pay package anyhow. I strongly urge a different approach.

The initial stage of a private single-payer program should use a "maintenance of effort" principle. That means that whatever an enterprise now pays (measured by recent years' premiums made proportional to current employment) it would continue to pay for a time (as a condition of eligibility for deductibility). Each state would ascertain that amount by requiring

reporting on state corporate, partnership, and individual tax returns. The total thus ascertained would be translated into an estimate of what coverage that amount would buy in a single payer market. The state could apportion some of that amount to its expenses to administer the program. Or the federal government might assume that cost or some part of it, as it does in the unemployment compensation program. Some less populous states might find such help necessary. On the other hand, some states may find to advantageous to combine their efforts with neighboring states or contract with an organization like the Council of State Governments.

The amount that the state ascertains would enable it to offer a specified package would constitute the maximum amount it would pay to a successful bidder. But the bidders would be invited to offer to do the job for less, with the lowest bid the winner. The state could then use any surplus for expanding its package of coverage or lowering premiums.

I urge that the system move toward a contributory basis, at least for the currently employed, as in Social Security, and charging premiums, as in Medicare. Such an arrangement gives the participants two competing stakes: as potential patients, they desire to maximize coverage; as purchasers, they desire to pay as little as possible. Giving all or most participants such competing stakes should encourage balance between cost and coverage.

As described in the next section, most enterprises and individuals already pay premiums for medical care insurance in non-health insurance coverages such as workers' compensation and automobile. Applying the medical portion of such premiums to health insurance would help pay their health insurance premiums, but getting more medical services for each dollar paid. Such payments also reduce the cost problem of enterprises that now do not provide health insurance.

These initial arrangements would make it clear to residents and businesses in all states that they pay for covering the employees of "free riders". They then could decide whether they wish to continue to do so or require some or even an equal contribution from the "free riders" or provide some explicit subsidy. States could decide the conditions for free-rider status, possibly permitting it for only a limited start-up period for an enterprise.

The maintenance-of-effort phase would be limited to several years. During that initial period, each state could decided how it wished to proceed thereafter. They could choose premium rates that varied by industry, thereby reflecting the differing hazards of different employments. Or a state may decide that it is more rational to proceed as the single-payer now proposes, utilizing tax revenues tailored to the circumstances of such a system.

It would be wise to enact the initial phase for say six years and provide for debate and voting on modifications to assure debate on the next phase and to assure people that whatever the initial stage, it is not set in stone.

HHS, the Council of State Governments, the National Governors' Association, and individual states should set aside funds to study what states do and assess their outcomes after a period long enough to reach some conclusions about the comparative merits of various approaches.

Single payer with adequate record keeping also should enable the public and policy makers to see where the money is going. That should provide a reasonable basis for decisions about curtailing or expanding various aspects of each state or region's program.

That initial stage, if coupled with adequate information, also ought to enable states to decide how to make the cost burdens more equitable. Many substantial enterprises and their employees now subsidize the free-rider segment of the economy. That does not seem fair or good for competitiveness over the long haul.

The maintenance-of-effort approach would apply also to public programs for the initial phase. With more complete tracking of costs and financial support than now exist, better decisions about the proper sharing of burdens should be feasible. So, if it appears that the portion of payments now allocable to Medicaid pay for substantial numbers of employee of enterprises that pay less than comparable enterprises for their employees, a state could decide to require more from such companies.

Single payer is the nation's best bet for assuring universal coverage and also reducing health care costs to individuals, families, enterprises, the states and the federal government because it produces the greatest economies. As this short presentation shows, single payer can be launched state-by-state, use private entities, harness competition, and encourage experimentation without the political burdens of new taxes and an enlarged public bureaucracy which now prevent the serious public consideration of this most promising alternative.

In sum, under this proposal, enterprises, home owners, and automobile and truck owners and operators (private and commercial) would pay to the health insurer essentially the same medical care premium they now pay to liability insurers. The health insurer would provide coverage for medical care now shunted over to other insurance coverages. Health insurance would cover the costs of preventive measures and injuries and illness regardless of cause. Those

enterprises and individuals engaged in activities causing injury and illness (e.g.,automobiles and trucks) would pay more than those who do not. The costs of such hazards would register in enterprise prices, exerting pressure to eliminate or reduce the more harmful, the more costly activities. All would pay the health insurance premium reflecting their activities. Non-health insurers would be required to reduce their premiums to reflect that they no longer provide the medical care component.

REDIRECTING THE MEDICAL CARE PORTION OF NON-HEALTH INSURANCE PREMIUMS

Most non-health liability insurance includes medical care components. Today, expenditures for advertising, commissions, claims processing, litigation (mostly preparation for litigation and settlement negotiations), and administration consume up to 50% of the premiums paid for non-health insurance coverages. Redirecting to health insurance the medical care component of premiums for workers' compensation, personal and commercial automobiles and trucks, homeowners, temporary disability, malpractice, and products liability insurance policies would eliminate a substantial portion of advertising, commission, and claims processing and litigation costs. All health services to any individual or family would flow from one private insurer rather than many.

This would accomplish vast savings by:

- Eliminating the need to determine which insurance and insurer, from among possibly dozens, should pay;
- Eliminating millions of transactions between insurers and medical care providers;

- Eliminating or reducing commissions;
- Reducing insurance company advertising costs;
- Substituting lower-outlay health insurance for higher-cost non-health medical care insurance.

THE EXAMPLE OF WORKERS' COMPENSATION - OVER $12 BILLION IN SAVINGS

Employers expend some $63 billion for workers' compensation coverage, including approximately $17.6 billion paid out for medical benefits (1992 data). Redirecting that $17.6 billion (and the accompanying mark-up of about 33% to approximate the premium cost) to a system of universal coverage would buy a great deal more in medical services than those sums obtain now.

For starters, of 4.6 million workers' compensation claims administered by major private insurance companies in 1988-89, 3.5 million were for "medical [care] only" benefits (see Attachment B). In such cases, clerks typically verify the claimant's eligibility by ascertaining whether the claimant worked for the insured company on the date of the claimed injury; then they authorize payment for virtually all claims. Performing this simple task for 3.5 million claims costs some $270 million, about 27% of the $1 billion in benefits paid. As few such cases result in denials, the expenditure of $270 million is utterly wasteful. Redirecting the $1.3 billion spent on "medical only" workers' compensation claims into national health care would capture practically all of the $270 million to pay for medical services.

But there are bigger fish in that pond.

The remaining 1.1 million injured employees claim not only medical care but lost wages. Such claims require determination of liability in order to make the associated medical costs eligible for payment by the workers' compensation carrier. Again, most such cases get settled. The pattern tends to be that small claims (the most numerous kind) get settled quickly with little attention to their merits while large claims take longer. Bargaining occurs over the amount of lost-wage compensation; but medical billings are, for the most part, paid once the compensation claim is agreed upon. (Claimant lawyers' fees are a percentage of the compensation payment; the medical care costs do not figure into lawyers' fees.)

The 1.1 million workers' compensation claims reported by the National Council on Compensation Insurance that involve both compensation and medical benefits produced payments of $8.6 billion for medical services at a cost of about $1.1 billion in private insurer administrative expenses. (Those figures do not include outlays in several major states and publicly-administered workers compensation programs that go through the same rigamorole.)

If all workers' compensation medical services and the portion of premium allocable to them were folded into health insurance coverage, about $2 billion would be saved on paper shuffling and added to the funds available to pay for medical services.

But that's not all. Workers' compensation experts estimate that workers' comp pays, on average, twice as much as health insurance does for the same diagnoses.[3]

[3] Minnesota Department of Labor & Industry, Industrial Strength Medicine: A Comparison of Workers' Compensation and Blue Cross Health Care in Minnesota (1990) p. iii (Executive

Applying all of the $17.6 (plus its premium costs another $6 billion) billion of workers' compensation medical care benefit payments to health insurance could add up to $12 billion net gain to pay for needed medical services.

Some seek to preserve workers' comp medical apart from health insurance because employees do not pay the co-insurance and deductibles under workers' comp that they do in health insurance. The utility of such payments is debatable. Whatever the merits, adjustments can be made so that employees do not lose those savings. Some employer groups claim that their relationship with workers' compensation enables them to work with physicians to get employees back to work quickly. But all health providers know that it's good medicine to restore all capabilities as quickly as possible. Even assuming that some need employer urging, such communications can continue.

In sum, rerouting the medical care now paid by workers compensation and the funds now spent for them into whatever health care plan we adopt would help achieve universal coverage.

TRANSFERRING MORE THAN $50 BILLION FROM THE MEDICAL CARE COMPONENTS OF LIABILITY INSURANCE

Insurance Information Institute data (Attachment A) show some $37.1 billion in annual medical care benefit payments (not premiums) by automobile insurance (personal and commercial), general liability, medical malpractice, commercial multi-peril, homeowners and workers' compensation. Assuming that the benefit payout comes to about 75% of premium for

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Summary). In Missouri, worker's comp pay 50% more than Medicare for the same diagnosis.

those programs (a very conservative estimate), redirecting their premiums for the medical portion of such insurance would make more than $50 billion available to the universal coverage health insurance system.

Combining the portion of premium allocable to medical services in all insurances would save (1) the transaction costs of ascertaining which kind of insurance and which insurer should pay, (2) how much should be paid, and (3) the transfer costs to move funds from one insurer to another or even several others. This is no small matter. Ascertaining which insurer or insurers should pay and how much has become so complex that intricate articles provide diagrams showing how to run the maze. Running the traps costs time and money better spent on medical services. Even more importantly, rerouting would substitute the more efficient health insurance for other insurance programs which, like workers' compensation, pay more than health insurance for the same diagnoses.

The next question, then, is, how to get the money from there (other plans) to here (health insurance).

ADMINISTERING THE PROPOSAL

The health insurance package would cover medical services regardless of who or what causes the injury or illness. Those of us who, for example, own cars or operate businesses will continue to pay the medical care costs for each such activity -- but to our health insurer. Individuals and businesses would have ample incentive to do this because that would reduce their health insurance premium.

Employers also would remit the amounts payable by employees (on their personal cars and homes) through withholding, just as they do Social Security FICA contributions and union dues. To simplify this process, such payments could be made uniform among, for example, all automobile and truck owners. Rental vehicles would be subject to the same rates so that the contribution could not be avoided by renting. Truck rates could vary according to tonnage - the greater the weight, the greater the potential for damage to the drivers and occupants of other vehicles.

The portion of premium payable for medical services is readily broken out of total premium because it goes into ascertaining total premium in the first place. To simplify the procedure and minimize costs, each industry's rate for the medical component of liability insurance would be applied to all employers in each industry, including those who self-insure. Employers would pay those amounts to the health insurer rather than the liability insurer.

Some will surely argue that rate standardization reduces the beneficent hazard-reducing effect of insurance experience rating. Whether experience rating does promote improved safety practices remains questionable. Some analysts argue that often it produces employer resistance to paying benefits rather than added efforts to improve safety. Rather than debate the issue, rate reductions should be available for specified safety devices, e.g., air bags and anti-lock brakes on cars. More importantly, the major portions of liability insurance, for economic losses, would continue as now with whatever experience rating applies. So, if experience rating works as advertised, it would continue to do so.

TO COVER ALL WE MUST SAVE LOTS

Only if new health care arrangements produce enormous savings over current arrangements can we achieve a program that provides universal coverage and bans the exclusion of pre-existing conditions. The savings achieved by the proposals made here are demonstrably available. Indeed, unless we utilize these savings, we cannot afford any plan that can rightly be called universal.

The massive inefficiency of current arrangements offers the opportunity for massive savings enabling us to pay for assured health care for all. Here is a practical way to substitute efficiency for inefficiency, thereby getting more health care without spending more. And it won't take new taxes, beyond kicking Mr. Butt.

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Attachments: A - Summary of medical care payments under various insurance coverages.

B - 1992 National Council on Compensation Insurance report on workers' compensation.

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Attachment A

Medical Care Payments
Under Property/Casualty Insurance
1992

		Insurance Companies	Alternative Markets	Total
			$ Billions	
1.	Workers Compensation	$ 10.6	$7.0*	$17.6
2.	Auto Insurance (Includes personal and commercial)	11.5	1.0	12.5
3.	General Liability	2.0	1.1	3.1
4.	Medical Malpractice	0.4	0.4	0.8
5.	Commercial Multi Peril	1.0	0.1	1.1
6.	Homeowners	2.0	0.0	2.0
	TOTAL	$27.5	$9.6	$37.1

*Includes state funds.

Source: The Insurance Information Institute in response to inquiry by Reader Services Librarian, School of Law, Washington University, January 20, 1994.

WORKERS COMPENSATION EXPERIENCE - COUNTRYWIDE - ULTIMATE REPORT BASIS benefits and payments

		DEATH			PERMANENT TOTAL			MAJOR		
STATE •	POLICY PERIOD	NO. OF CASES	INDEMNITY	MEDICAL	NO. OF CASES	INDEMNITY	MEDICAL	NO. OF CASES	INDEMNITY	MEDICAL
ALABAMA	5/87 4/88	82	5,620,436	2,612,327	70	18,079,442	11,665,468	1,561	84,426,517	68,459,460
ALASKA	4/88 3/89	23	3,313,104	380,961	8	1,243,765	3,469,967	254	23,316,545	13,066,045
ARIZONA	3/88 2/89	53	5,342,672	886,400	15	2,021,262	1,543,104	2,298	151,043,903	93,780,284
ARKANSAS	4/88 3/89	78	4,311,257	541,663	38	1,862,543	1,128,868	995	40,116,622	31,625,046
COLORADO	3/87 2/88	67	5,612,530	565,996	215	51,340,139	4,490,159	2,771	163,613,073	56,281,163
CONNECTICUT	1/88 12/88	48	14,048,390	1,069,237	44	31,290,284	3,756,668	4,204	347,566,916	100,278,057
DELAWARE	3/88 2/89	5	1,762,469	21,900	17	4,719,746	2,436,506	202	17,464,276	15,555,000
DIST. OF COL.	2/88 1/89	7	1,867,136	102,518	11	8,076,766	2,080,936	386	32,703,435	15,747,853
FLORIDA	10/88 9/89	201	15,300,852	10,783,238	1,667	328,560,747	56,479,205	9,757	819,332,096	418,346,282
GEORGIA	1/88 12/88	145	8,952,971	1,640,506	102	22,605,859	10,392,901	5,624	272,819,659	160,814,541
HAWAII	6/87 5/88	27	1,065,025	344,706	251	8,200,360	4,054,218	1,028	43,856,177	20,183,004
IDAHO	3/88 2/89	16	950,154	58,066	6	2,836,016	1,653,093	179	11,395,710	2,603,038
ILLINOIS	4/88 3/89	160	17,757,067	1,085,974	124	26,425,690	7,469,956	7,133	474,794,156	144,765,048
INDIANA	12/87 11/88	104	7,612,739	371,151	26	2,316,882	5,467,472	1,503	48,100,337	41,798,327
IOWA	3/88 2/89	61	7,203,148	250,374	25	2,715,181	1,666,484	1,082	55,258,434	21,926,816
KANSAS	1/88 12/88	70	6,324,540	788,706	20	806,066	2,324,719	1,823	65,724,146	33,527,287
KENTUCKY	1/88 12/88	44	3,705,364	1,159,049	54	9,211,535	4,795,139	2,349	89,506,394	73,566,871
LOUISIANA	4/87 3/88	151	12,067,268	1,495,019	102	14,968,809	5,610,800	3,700	254,079,446	113,232,133
MAINE	6/88 5/89	20	2,937,075	111,192	136	9,007,182	1,978,404	2,117	273,222,880	38,920,446
MARYLAND	4/88 3/89	65	8,509,071	1,381,722	15	2,380,326	1,736,328	1,191	117,435,084	37,125,470
MASSACHUSETTS	7/88 6/89	44	18,611,533	386,423	37	22,714,467	25,838,142	10,822	925,472,712	121,328,836
MICHIGAN	4/88 3/89	133	10,746,703	1,132,740	93	15,561,530	9,533,272	4,074	382,733,269	102,977,058
MISSISSIPPI	1/88 12/88	107	2,939,918	1,706,303	31	2,233,718	2,439,417	1,481	53,454,947	62,851,568
MISSOURI	1/87 12/87	92	8,472,330	536,358	31	3,334,604	6,571,055	2,010	78,206,706	46,640,210
MONTANA	11/87 10/88	18	2,891,314	71,471	13	2,477,622	757,685	608	47,344,975	19,277,750
NEBRASKA	2/88 1/89	31	5,953,094	281,182	4	1,182,033	264,761	671	37,066,786	19,901,365
NEW HAMPSHIRE	4/87 3/88	19	1,915,341	133,665	27	2,151,385	193,311	1,453	92,568,686	35,408,642
NEW JERSEY	1/88 12/88	128	14,721,086	703,514	65	17,528,953	16,631,368	2,740	139,928,968	57,499,255
NEW MEXICO	1/88 12/88	37	3,601,311	137,334	76	7,498,415	3,125,324	1,182	76,708,393	36,765,761
NORTH CAROLINA	1/88 12/88	124	11,186,752	1,794,355	53	10,260,020	4,323,213	2,344	107,501,852	66,885,656
OKLAHOMA	6/88 5/89	81	6,982,425	984,040	102	5,831,958	2,935,068	1,194	66,304,538	44,863,478
OREGON	1/88 12/88	62	12,185,698	2,395,370	229	56,700,396	22,054,077	2,902	159,194,028	80,766,161
PENNSYLVANIA	3/88 2/89	201	42,563,733	3,538,756	867	268,653,122	178,651,945	4,190	570,428,220	175,979,500
RHODE ISLAND	1/87 12/87	11	2,023,551	205,839	35	9,250,898	804,444	2,127	162,021,485	33,163,809
SOUTH CAROLINA	1/88 12/88	62	4,240,148	343,722	20	2,297,626	579,049	2,276	90,431,029	35,200,148
SOUTH DAKOTA	1/88 12/88	14	2,207,493	48,896	2	240,200	531,295	143	8,107,119	4,731,920
TENNESSEE	1/88 12/88	92	5,053,378	1,466,617	40	3,078,617	5,418,936	3,684	148,923,766	72,514,150
TEXAS	1/88 12/88	452	59,522,739	4,790,802	691	41,041,436	62,786,423	21,134	590,158,630	390,926,338
UTAH	5/88 4/89	23	2,684,546	243,412	30	1,512,516	2,620,337	716	17,588,584	23,732,330
VERMONT	4/88 3/89	9	595,241	30,308	2	375,408	14,520	333	16,100,486	9,606,179
VIRGINIA	2/88 1/89	63	6,159,382	1,163,117	77	20,225,152	10,000,596	2,433	150,840,577	88,878,387
WISCONSIN	1/88 12/88	76	5,612,732	574,418	52	6,591,505	3,789,894	1,784	105,478,650	55,268,205
TOTAL		3,306	365,133,716	48,319,327	5,523	1,049,410,181	494,064,647	120,458	7,418,340,012	3,086,748,877
TOTAL*		3,100	320,807,514	44,758,671	4,639	776,037,313	312,976,196	116,066	6,830,447,516	2,895,214,377

* EXCLUDING DELAWARE AND PENNSYLVANIA

• CALIFORNIA, MINNESOTA AND NEW YORK NOT AVAILABLE

WORKERS COMPENSATION EXPERIENCE COUNTRYWIDE : ULTIMATE REPORT BASIS

		MINOR			TEMPORARY TOTAL			NON COMP & CONTRACT	
STATE	POLICY PERIOD	NO. OF CASES	INDEMNITY	MEDICAL	NO. OF CASES	INDEMNITY	MEDICAL	NO. OF CASES	MEDICAL
ALABAMA	5/87-4/88	1,995	15,638,065	22,865,523	22,673	22,514,360	45,653,436	73,835	16,395,079
ALASKA	4/88 3/89	901	8,944,791	8,333,578	4,089	6,190,659	11,398,514	12,138	5,160,018
ARIZONA	3/88-2/89	3,034	10,534,856	24,117,194	15,231	18,356,459	39,052,440	92,641	37,356,685
ARKANSAS	4/88 3/89	2,992	23,547,361	30,825,830	8,938	16,105,424	27,226,198	53,640	12,315,545
COLORADO	3/87 2/88	3,243	27,063,986	31,559,915	19,757	21,501,956	37,581,349	85,156	28,040,020
CONNECTICUT	1/88-12/88	4,927	38,919,371	29,725,437	50,854	50,558,066	51,988,308	75,266	20,782,829
DELAWARE	3/88-2/89	354	3,033,667	3,380,300	3,261	6,795,813	7,483,859	N/A	2,929,548
DIST. OF COL.	2/88-1/89	452	1,718,366	2,780,362	3,318	3,945,706	7,040,115	8,082	3,328,602
FLORIDA	10/88-9/89	3,250	29,496,410	48,445,870	37,919	74,808,539	184,980,964	199,489	87,115,089
GEORGIA	1/88-12/88	5,105	26,724,716	37,218,220	22,976	43,987,652	78,863,073	166,313	49,983,252
HAWAII	6/87 5/88	2,826	10,172,185	9,222,767	10,028	7,961,807	11,615,436	16,586	6,239,089
IDAHO	3/88 2/89	1,446	17,226,104	12,045,402	5,644	10,768,424	17,168,394	24,834	6,680,899
ILLINOIS	4/88 3/89	22,343	138,303,145	91,555,532	54,126	120,628,191	112,311,252	234,538	56,946,559
INDIANA	12/87-11/88	4,237	20,704,880	27,391,334	28,277	42,272,250	62,996,919	198,469	37,279,991
IOWA	3/88-2/89	3,513	23,124,559	19,178,705	18,714	21,605,210	29,062,172	67,059	11,907,257
KANSAS	1/88 12/88	3,614	21,770,003	18,814,695	10,015	19,316,972	22,716,106	66,362	14,513,861
KENTUCKY	1/88-12/88	1,816	9,079,347	10,917,680	12,814	19,592,758	36,434,862	68,516	19,030,895
LOUISIANA	4/87 3/88	1,036	5,094,571	11,118,013	13,463	22,238,281	55,668,277	57,447	21,635,406
MAINE	6/88-5/89	551	7,919,600	9,941,213	12,068	26,848,021	36,269,483	33,981	9,978,488
MARYLAND	4/88-3/89	4,941	41,664,879	30,056,410	19,164	40,287,613	41,260,655	61,669	16,794,718
MASSACHUSETTS	7/88-6/89	4,718	29,669,984	9,660,011	52,661	268,123,982	100,543,858	114,520	26,150,261
MICHIGAN	4/88-3/89	2,729	21,889,249	17,672,269	38,041	95,756,291	115,289,058	180,505	47,151,856
MISSISSIPPI	1/88 12/88	1,816	12,383,227	14,628,837	12,077	14,009,226	32,296,957	56,287	13,427,539
MISSOURI	1/87 12/87	13,383	67,433,500	46,898,975	31,072	44,433,014	42,686,504	100,692	18,391,603
MONTANA	11/87-10/88	727	6,677,294	3,363,869	3,005	6,523,756	15,037,437	16,674	6,653,342
NEBRASKA	2/88-1/89	1,498	11,293,864	9,577,089	6,637	10,736,199	16,769,489	44,293	9,163,439
NEW HAMPSHIRE	4/87-3/88	290	1,566,569	1,977,316	12,071	13,874,914	17,708,539	32,908	7,455,235
NEW JERSEY	1/88-12/88	22,767	193,820,061	115,798,190	35,408	72,842,172	57,736,948	163,520	42,763,395
NEW MEXICO	1/88-12/88	1,539	15,046,033	21,129,069	4,044	7,889,026	17,614,122	21,358	8,695,413
NORTH CAROLINA	1/88-12/88	6,740	40,997,421	38,168,989	21,212	32,827,984	44,835,163	171,456	36,701,298
OKLAHOMA	6/88-5/89	7,563	59,231,724	34,618,037	8,117	21,949,400	18,289,555	49,984	12,949,348
OREGON	1/88-12/88	8,359	56,635,316	70,864,347	25,413	44,072,518	57,428,920	97,750	22,852,473
PENNSYLVANIA	3/88-2/89	8,357	101,039,216	65,696,100	69,282	235,497,808	222,874,406	N/A	87,644,972
RHODE ISLAND	1/87-12/87	401	1,473,789	1,257,034	9,550	11,374,358	10,436,536	19,700	3,557,151
SOUTH CAROLINA	1/88-12/88	5,490	27,818,487	17,848,771	9,406	18,980,709	18,910,546	78,960	14,808,382
SOUTH DAKOTA	1/88-12/88	773	6,217,467	5,690,576	2,648	5,946,800	6,721,687	15,816	3,304,620
TENNESSEE	1/88-12/88	5,610	39,242,858	33,525,025	21,569	34,069,572	50,898,822	114,685	29,761,963
TEXAS	1/88-12/88	33,924	422,402,936	289,371,117	70,429	433,152,372	353,611,462	279,401	82,726,604
UTAH	5/88-4/89	710	4,411,226	3,855,223	8,717	10,414,778	20,210,000	55,927	11,950,195
VERMONT	4/88-3/89	523	5,041,642	3,444,967	5,253	9,548,195	8,788,505	15,925	3,229,675
VIRGINIA	2/88-1/89	2,669	14,789,074	21,300,057	21,607	34,350,327	66,050,364	127,187	35,779,788
WISCONSIN	1/88-12/88	7,252	43,906,977	41,694,573	48,844	57,975,329	79,411,190	157,392	33,565,837
TOTAL		210,414	1,663,668,776	1,347,334,421	870,392	2,079,732,891	2,290,921,880	N/A	1,023,098,219
TOTAL*		201,703	1,559,595,893	1,278,258,021	797,849	1,837,439,270	2,060,563,615	3,510,961	932,523,699

* EXCLUDING DELAWARE AND PENNSYLVANIA

• CALIFORNIA, MINNESOTA AND NEW YORK NOT AVAILABLE

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	From: Hillary Rodham Clinton, To: Constituent [partial] (2 pages)	11/10/95	b(6)

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

FOLDER TITLE:
HRC health Care Correspondence 95 - S

2014-0159-S
sb301

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

THE WHITE HOUSE

November 10, 1995

[redacted] 0019

Dear [redacted] 0019

Thank you for writing to share your concerns about the elimination of congregate care facilities for the mentally retarded. I certainly agree that state residential services provide many people with the care they need. I am delighted to hear that your son's care has worked out so well.

The Clinton Administration is attempting to help states provide the most appropriate services for people with disabilities, not to undermine institutions that are already giving valuable, high quality care. The Justice Department's enforcement of the Civil Rights of Institutionalized Persons Act (CRIPA) is focused on enforcing patient's rights and ensuring that individuals get the services they need, not on closing institutions.

I know that you have also heard from Carol Rasco on this issue, and I have asked her to keep me up to date on your discussions. Thank you again for writing. Best regards to you and your family.

Sincerely yours,

Hillary

Hillary Rodham Clinton

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. note	From: Staffer, To: First Lady, Corerspondence Log [partial] (1 page)	nd	b(6)

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

FOLDER TITLE:
HRC health Care Correspondence 95 - S

2014-0159-S
sb301

RESTRICTION CODES

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0016

-- 8/18/95 from [redacted] (b)(6) re the Department of Justice activities in field of residential services for the mentally retarded, as described in 8/8/95 ***NY Times*** article. With a disabled 27-year-old son who has resided in an "institution" for 10 years, she is particularly concerned. She asks for your response to her question, "Is the Clinton administration really pushing the deinstitutionalization agenda?"

Carol Rasco received copy of this letter.

✓ See
✓ To Carol Rasco ~~or~~ and Jan Klein per HRC to draft response

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001c. letter	From: Constituent, To: Hillary Clinton [partial] (2 pages)	8/18/95	b(6)

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

FOLDER TITLE:
HRC health Care Correspondence 95 - S

2014-0159-S
sb301

RESTRICTION CODES

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(b)(6) 001c

August 18, 1995

Mrs. Hillary R. Clinton
1600 Pennsylvania Avenue
The White House
Washington, D.C. 20500

Dear Hillary:

This letter is prompted (in part) by a New York Times article published August 8, 1995 (copy of which is enclosed) concerning the Department of Justice activities in the field of residential services for the mentally retarded.

I write to express my sorrow and outrage at the unfair use of federal monies being used to push and fund a one-sided philosophical agenda of "care in the community" for all disabled individuals. In the past two years, I have been to Washington once and (b)(6) has been 10 times in an effort to provide information about and express our alarm concerning the activities by powerful, federally funded groups (The Arc, UCP, the Consortium, DD Councils, P&As, UAPs, the DOJ) whose agenda for disabled citizens is to close congregate care facilities for the mentally retarded. Both of us have visited members of Congress and I visited the White House staff and (b)(6) the Department of Justice and the Department of Human Services in an effort to convey our concerns.

After the New York Times article was published, friends from Arkansas and across the nation have called me, "Is the Clinton administration really pushing the deinstitutionalization agenda?" Please tell me how I should respond.

The President has appointed Mr. Patrick to head the Civil Rights Division at Justice. Using CRIPA, the suits which DOJ attorneys bring against state institutions for the mentally retarded serve to undermine the States' abilities and willingness to continue providing care for its most vulnerable citizens, the profoundly retarded. Because of these suits, the States' responsibilities under the parens patriae concept are in decline and valuable resources, our nation's congregate care facilities, are being eliminated from the continuum of care options for retarded citizens and their families.

(b)(6) 001c

[redacted] (b)(6) 001c

From birth, he has depended on others to provide for his most basic needs; and it will always be so. For the past 10 years [redacted] (b)(6) has resided in an "institution". During that time, his caregivers have remained virtually the same and his care has been competent and without interruption. Stable staffing patterns are a key to his stability. I believe that the majority of disabled people, especially physically challenged persons and mildly/ moderately retarded individuals, can live in small community settings. I also believe that our son and many other profoundly retarded/medically fragile persons need the care only offered by a congregate care facility.

Our nations' institutions are a desperately needed option for severe and profoundly retarded people and also for medically fragile individuals. It makes me physically ill to think that our president's policies are destroying this option. I ask the question posed earlier in this letter: "Is the Clinton administration really pushing the deinstitutionalization agenda?"

Your response to my letter will be appreciated.

Very truly yours,

[redacted] (b)(6) 001c

cc: Ms. Carol H. Rasco

NEW YORK TIMES 8/8/95

U.S. Joins Effort to Transfer Retarded Into Group Homes

By JONATHAN RABINOVITZ

NEW HAVEN, Aug. 7 — A Federal court convened today to consider the fate of Connecticut's sole large institution for the mentally retarded, with the Clinton Justice Department pushing toward a goal that previous administrations have rejected: the transfer of hundreds of residents into the community.

If the Justice Department succeeds, it could lead to the closing of the Southbury Training School, home to 843 retarded adults.

The case is part of a national push by the Justice Department's civil rights division to expand community housing for the retarded — rather than just improve existing aging institutions — that could result in the closing of more than a dozen institutions in at least eight states.

Both the Reagan and Bush Administrations had opposed attempts by advocates to scale back institutions and expand community services.

"We used to be at loggerheads with the Justice Department," said Curtis L. Decker, executive director of the National Association of Protection and Advocacy Systems, which represents nonprofit agencies that assist the retarded. "We would be going into court saying, 'Develop a phase-out plan for the institution,' and the Justice Department would be forcing the state to take the same money and fix it up. Now, we view them as an ally."

At the heart of the new policy is an argument that large institutions are inherently more dangerous to residents than smaller settings in the community and that they represent a form of illegal segregation and discrimination against the disabled.

Indeed, today an expert on the medical care of the retarded, Dr. Renee C. Wachtel, testified that several Southbury residents had died because of inadequate treatment and that a review of 15 residents' records showed that serious medical problems went unattended.

The Clinton Administration's initiative carries some political risk, coming as the Republican Congress is trying to reduce Federal intervention in state programs.

But the Justice Department's new approach toward the retarded is part of a more aggressive role by the civil rights division after 12 years of Republican restraint. Civil rights advocates say the division has stepped up its enforcement in areas such as voting rights, housing discrimination and affirmative action, as well as disability rights.

In some respects, the policy shift on institutions is not radical. Since horrifying conditions were discovered in many institutions in the 1970's, almost two-thirds of the institutionalized retarded population has been moved into community settings, the result of years of litigation by advocacy groups.

But the Justice Department's initiative comes as the drive for deinstitutionalization confronts a difficult hurdle.

Many residents who remain in institutions are the most severely disabled and the most challenging to relocate.

Several states and a network of parents who want their retarded children to stay in institutions have argued that the Justice Department is overstepping its authority.

"They think institution is a bad word," said Sarah E. Bondy, president of the Southbury parents' group, the Home and School Association. "But most of the people in institutions today need to be protected — there's a limit to how much they can improve."

So far, the law has not guaranteed the retarded the right to community placement. The Supreme Court in 1982 ruled only that institution residents have a constitutional right to be free from harm and restraint. Since then, lower courts have issued conflicting decisions about when it is appropriate to order expanded community services.

Viewing Institutions As Discriminatory

Now, the Justice Department is trying to establish a more expansive interpretation of the rights of retarded people, and it has started to use the Americans with Disabilities Act of 1990 to argue that institutionalization may be considered unnecessary segregation, a form of illegal discrimination against the disabled.

"It's a very bold and progressive position," Michael Perlin, a professor at New York Law School and an expert in disability-rights law, said. "The precedents are mixed, the Americans with Disabilities Act is untested, and public sentiment is certainly not entirely supportive."

Indeed, the official Justice Department position is that the current policy does not reflect any change.

"Since the beginning of institutional reform litigation, the Department has supported community placement," said Loretta King, the deputy assistant attorney general in the Civil Rights Division.

Statements Provide Signs of Sea Change

But other statements by the department suggest otherwise. In a letter to Maryland officials, David Deutsch, a senior trial lawyer in the department, wrote that the department had "a new policy of encouraging community placement where appropriate."

And in a speech to advocates last year, Deval L. Patrick, the head of the Civil Rights Division, said that in the two previous administrations, "policies of the division effectively narrowed the rights of persons with mental disabilities."

"The division," he said, "determined that individuals with mental disabilities only had rights to services necessary to insure their safety and rejected even modest efforts to expand community placement."

over

Since then, the department has moved to expand community placements in at least eight states. It forced Washington, D.C., to transfer all retarded residents at one nursing home into community programs. In Tennessee, it won placement for about 200 retarded residents at one institution and is seeking to downsize two others. In Pennsylvania, it worked with advocates and the state to close the Embreeville Center in Coatesville. The department's efforts to expand community placement also may lead to the closing of institutions in California, Alabama, Oregon, New Mexico and Wisconsin.

And in a telling symbol of the change, the Justice Department last year re-entered a 25-year-old landmark case in Alabama, after withdrawing from it during the Bush Administration. The department has joined with advocates for the retarded to seek a court order for community placement of residents of Alabama's five institutions.

Many advocates say the new policy is actually a return to the 1970's, when the department first addressed the often horrifying conditions in institutions for the retarded at the request of several judges.

But in the 1980's, when many expected the department to expand its involvement, it retreated. Only in the final years of the Bush Administration did the department tentatively explore expanding community placements in a few cases.

Southbury Case Illustrates New Role

The Southbury Training School case is an example of the policy change by the Clinton Administration.

When Connecticut reached a consent decree with the Justice Department in 1986 to upgrade the institution, advocates and state officials were disappointed that it did not follow the pattern established by Southbury's sister institution, the Mansfield Training School, which was phased out after advocates for the retarded filed a lawsuit over conditions there.

The Reagan Justice Department did not require community placement for Southbury. Instead, it asked the state to meet certain ratios of staff to residents, improve training, add services and make a host of repairs. When advocates for the retarded tried to intervene, the Justice Department blocked their effort.

At that time, Barry Bosworth, the president of the Connecticut Association for Retarded Citizens, called the consent decree a "regressive document." The state's Attorney General, Joseph I. Lieberman, now a Senator, described the Justice Department as "an enemy of retarded citizens."

Mr. Lieberman said he agreed to the arrangement to avoid costly litigation and promised that the state would reduce the population on its own. Indeed, Southbury's population is 843 today compared with 1,200 in 1986.

But the Clinton Administration's new approach raised questions about Southbury. In a June 1994 letter to the state, the Justice Department wrote that Southbury was "a very dangerous place." And it called for Southbury's population to be reduced by at least half, among other measures.

One year later, when the state had refused to comply, the Justice Department sought to have the state declared in civil contempt for failing to provide safe conditions. It argued that "the most effective remedy" for residents' problems was "to end their forced segregation and isolation."

In her testimony today, Dr. Wachtel recommended a court-appointed monitor to oversee Southbury and called for a substantial reduction in its population.

In its brief, the Justice Department also asked the court to consider the Americans with Disabilities Act, or A.D.A.

"The A.D.A.'s essential aim is the integration of persons with disabilities into the mainstream of American life," the brief states. "Unnecessary harmful segregation of persons with mental retardation in isolated, removed institutions violates the A.D.A.."

But some say that the act was not intended as a tool for deinstitutionalization. James P. Welsh, assistant state attorney general, argued in court papers that a change in attitude in the Justice Department should not mean a change in the 1986 consent decree.

Little Difference On Safety and Abuse

The state also rejected the idea that institutions are inherently harmful. Statistics for abuse and neglect show Southbury as having fewer incidents than group homes in Connecticut, the brief says, and it notes that the rate of accidents and injuries was virtually the same.

The state maintained today that it has made progress at Southbury.

Judge Ellen B. Burns of Federal District Court here must decide whether the state has lived up to the consent decree.

Both supporters and critics of Southbury say that an order for a substantial reduction in its population would make keeping it open financially difficult and could force its closing. Many say this could happen nationally if the Justice Department is successful.

It is difficult to predict the outcome in these cases.

Last month, a Federal court in Pennsylvania rejected the department's claim that the state had violated the constitutional rights of residents at its Ebensburg Center. Judge D. Brooks Smith wrote that the state was not obligated to improve the lives of the retarded, but only to provide a minimal level of care, and that the state had done that.

Still, critics of institutions say that Justice's involvement shifts the debate.

"It brings the very heavy weight of the Federal government not only in terms of resources, but as a symbol," Mr. Decker, the advocate, said. "It says that we are talking about the civil rights of people with disability."

THE WHITE HOUSE

March 14, 1995

John R. Stafford
Chairman, President and
Chief Executive Officer
American Home Products Corporation
Five Giralda Farms
Madison, N.J. 07940

Dear Mr. Stafford:

I very much enjoyed speaking with you and Mrs. Stafford at the United Cerebral Palsy dinner. Thank you for writing to follow up on our conversation about the Vaccines for Children Program. I am particularly interested in your views on how to protect investment in research and development on new vaccines against childhood disease.

I have forwarded your letter to my scheduling office for their consideration. You will be hearing from them directly.

Sincerely yours,

Hillary

Hillary Rodham Clinton

AMERICAN HOME PRODUCTS CORPORATION
FIVE GIRALDA FARMS
MADISON, N.J. 07940
(201) 660-5008

JOHN R. STAFFORD
CHAIRMAN, PRESIDENT AND
CHIEF EXECUTIVE OFFICER

January 25, 1995

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mrs. Clinton:

Let me thank you once again for being so generous with your time to help the New York United Cerebral Palsy. As you know the dinner was a great success, obviously, in large part, due to your presence. On a personal note, Mrs. Stafford and I enjoyed being with you, and I especially appreciated the chance to talk a bit of shop during dinner. I do hope you and your family come back to Martha's Vineyard where, as I'm sure you know, you are very welcome.

With your permission I would like to reiterate some of the points we discussed concerning the impact of the Administration's Vaccines for Children (VFC) program. As I told you, American Home Products' recent acquisition of American Cyanamid included its vaccine division, Lederle-Praxis Biologicals (LPB). At present, only two major vaccine manufacturers are American-based, but American research, including substantial contributions by LPB, has led the world in vaccine innovation.

With the advent of biotechnology, many more new vaccines are now feasible. Our company introduced three new vaccine products during the first four years of the decade, including a vaccine to prevent bacterial meningitis in infants, a less reactive version of pertussis vaccine to address parent concerns about side-effects, and a new combination vaccine that halved the number of injections necessary to protect against four major childhood diseases. These are products that would not have been possible just a few years ago without the benefit of biotechnology; other vaccines in our pipeline have the capacity to revolutionize disease prevention and to save billions in medical and other costs.

Vaccine innovation, however, is currently at risk in the United States because of the VFC program. The legislation permits essentially unlimited purchases of childhood vaccines by state and federal governments at extremely low, statutorily-fixed prices. If not amended

substantially to limit public purchases, the VFC program will completely destroy our private market, which is the sole source of revenue supporting its research and development efforts.

Even prior to enactment of VFC, the economics of the vaccine business were extremely difficult. (A principal reason why only two U.S. based companies are in the vaccine business.) In fact, American Home Products made a decision several years ago not to remain in the childhood vaccine market, at least in part, because of concerns over excessive government purchases. With the LPB acquisition we are once again in a position which requires us to assess this market. Our greatest concern is the ability to continue the outstanding research program of LPB.

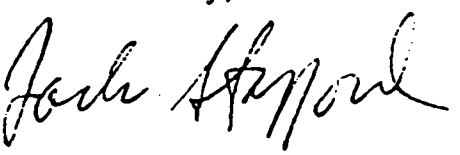
I shared with you the exciting prospect of a vaccine to protect children against otitis media (chronic ear infection that can cause deafness), which is the single largest reason for infant pediatric visits. Obviously, this product offers the potential of tremendous savings for the nation. Without substantial capital investment and continued clinical research, however, LPB will not be able to move this vaccine from the product pipeline into pediatricians' offices. Already LPB officials tell me that progress toward approval of the otitis media vaccine has been delayed by a year or more by uncertainties engendered by the VFC program. This is understandable because uncertainty is the absolute enemy of stable investment. But the loss to the country, in terms of both unnecessary illness and lost opportunities for savings, from just one year of delay is a tragedy.

I would like to request a meeting with you and the White House staff to discuss how the VFC program might be revised to support our shared goal of improved childhood immunization without undermining vaccine research and development. We can, no doubt, provide for today's needy children without depriving tomorrow's children of the promise of greatly enhanced prevention and freedom from disease through new vaccines.

Of course, I would also welcome an opportunity to discuss other areas of the pharmaceutical and biotechnology research-based industries if you or your staff should desire to do so.

Thank you again for the opportunity to be with you at last week's dinner, and I look forward to continuing our dialogue in a meeting anytime at your convenience.

Sincerely,



JRS:MH

-- 2/9/95 from **Sherry Stolberg**, thanking for reception - a wonderful gracious event.

Also, thanks for efforts to improve health care delivery. As a physician assistant and P.A. education, she appreciates your continual focus on the plight of patients in a system that does not serve all equally. Despite special interest lobbying and scare tactics, the basic issues remain - cost, quality and access. And health care reform is going on, although not as comprehensively or as equitably as we would like.

Despite personal and political attacks you have seen, she takes heart that you carry on with same standards of excellence. You are an inspiration to smart women with power who want to contribute both to their families and to society.

She encloses an article which may interest you about a woman with breast cancer.

Respond
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Send copy of article to Pam for H.C filing + to Lisa C for filing pw HRC

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IN RETROSPECT

My father, Hillary, and me

Patricia A. Connor, MS, CHA, PA-C

My father cried as he watched Hillary Rodham Clinton testify before Congress about health care reform last year. I was puzzled by this at first, but as I gave it more thought, I choked up too.

You see, it had been an unusual year in my life—at least I hope that it was unusual. More than a year ago, a postcard arrived encouraging me to come in for the follow-up mammogram that is routine after breast biopsy. (The biopsy specimen from my left breast had been interpreted as normal.)

Soon after that mammogram, however, I started my way through the maze of being a *real* patient. I had been a patient before, with typical maladies—tonsillitis, urinary tract infections, infertility, migraine headaches, an occasional bout of mild depression—but this journey would teach me a lot more than any previous experience had.

You may have guessed the punch line. Although the mammogram was read as normal, it did not look that way to me when I studied it while waiting to see the breast specialist. When I asked my questions—about the two lumps instead of one, whether the biopsy bisected the mass, or was that just a funny shadow—he paused, then said something about a "radial scar" and needing to talk to my surgeon.

I am a card-carrying baby boomer who still enjoys a run on a spring morning and who maintains the illusion of being part of the youth movement. I am 40 years old, but I would certainly never have a serious illness, I believed. It turned out that I had stage II interductal carcinoma of the breast.

Within six weeks of receiving the postcard, I had a mastectomy and the first of four rounds of chemotherapy. I lost my hair, eyelashes, and eyebrows; felt incredibly fatigued; worked half-time; developed styes in one eye that caused intermittent diplopia for months; had reconstructive breast surgery; started a course of tamoxifen citrate; and began menopause. In the same year, I also started a new job, ended a relationship, and, recently, was laid off.

Did I mention intermittent depression? That came back, too.

I also spent an enormous amount of time wondering about what constitutes femininity. If you are bald, have had a

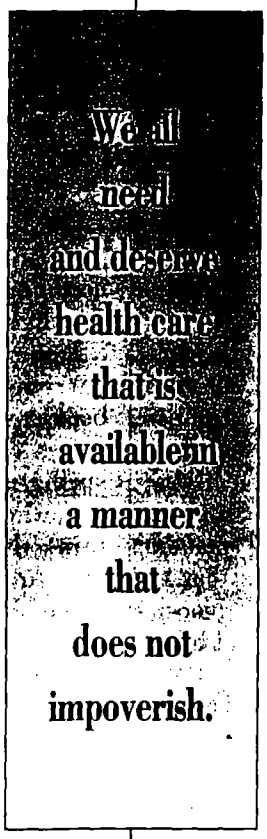
Ms. Connor is in pediatric practice as a physician assistant at Fitzsimons Army Medical Center, Aurora, Colo. She is chair of the editorial board of *JAAPA*.

mastectomy, and do not have hormones that work, are you still feminine?

What did I learn during this time? I learned about hope and, as do most people who confront their mortality, I learned how precious life is. And I learned how wasteful many of the things that we do are.

I also learned a lot about what it takes to negotiate the health care maze. I am a rather savvy consumer; with much excellent support, I found a cadre of superb and truly kind clinicians to take care of me. They did just that: They *cared* for their patient. I also had many of the values in my life affirmed: My family was wonderful, prayer helped, and my friends were generous and kind beyond words.

At the hospital, when my surgeon called to say that the pathology report indicated no lymph node involvement, I saw a double rainbow outside. And I saw another double rainbow the day that my dressings were removed and I went home.



What does this have to do with Hillary? I lost my health insurance at the one-year anniversary of the diagnosis. In the job change before the diagnosis, I was difficult to insure because of preexisting conditions. But with the preexisting condition from hell, I became impossible to insure—even though my oncologist proclaimed me well and I resumed running.

To say that I was raised by a very protective Irish Catholic father and that I am a prized only daughter probably understates my situation. All my father ever wanted was to keep me from harm, to have his daughter grow up to be an ambassador to the United Nations and be appreciated by the rest of the world. I think the sight of Hillary testifying to Congress as a competent, bright, committed woman of my generation vindicated many of his dreams for me. My father would not describe himself as a feminist, yet he is undoubtedly a militant one. In his mind, Hillary passed what I would call the father test.

So what about being uninsured? What about my preexisting condition? And what about being an essentially healthy baby boomer who, like everyone else, is mortal? What about being a health care provider who cannot get health care?

I applied, and was accepted, for the state's program of health insurance for the uninsurable, which is a godsend but not a bargain. I was able to pay the premiums while I looked for a new job. My search for a job took a new spin: I narrowed the field of possibilities to large institutions that could carry my risk and offer me a health insurance policy that did not have a clause about preexisting conditions. What I wanted was the same health insurance that members of Congress have.

Richard D. Krugman, dean of the University of Colorado School of Medicine, Denver, says that health care reform is about containing costs, providing access, and maintaining quality, and that we will probably end up with two of those three reforms. It is just that nobody knows which two.

I am taking my tamoxifen and antioxidant vitamins and trying to live a sensible, balanced life that is focused on the "life" part. My hair is back, soft and curly, and that helps allay some of my despair about not being feminine.

I found a job as a physician assistant in the adolescent medicine clinic at Fitzsimons Army Medical Center, making me a civilian employee of the U.S.

Department of Defense who has access to the same benefits package that other employees of the federal government do. The catch is that Fitzsimons is among those military facilities on the list for possible closing, but I've dealt with uncertainty before. The problem has been that the process of arriving here was such a scramble, adding a dimension of insecurity to my recuperation that seemed unfair. I was able to afford the state's plan for the uninsurable, but not everyone who needs the program can. Like millions of other essentially healthy and productive patients, I did not want to be a burden or face bankruptcy.

I had hopes that health care reform would happen in a way that would provide security for patients coping with life-threatening or debilitating illness. It seems that reform has moved ahead—but only in the private, corporate world, where the emphasis continues to be on the bottom line. True, sick people are expensive, but all people eventually get sick. We cannot remain oblivious to potential mortality by excluding it as a preexisting condition. A humane society must offer other options.

The double rainbows I described have been good omens for many wonderful awakenings this past year. I just hope that the good fortune they have brought me doesn't run out before Congress awakens to the need for change. We all need and deserve health care that is available in a manner that does not impoverish. It seems to me that this ought to be possible. □

HCF

The Washington Post/ Health 2/21/95

Maple Leaf Lag

As Their Vaunted National Health Care System Falters, Canadians Seek Private Providers

By Anne Swardson
Washington Post Foreign Service

TORONTO

During the U.S. debate on health care reform last year, supporters of national health insurance often held up the Canadian system as a model. One major advantage, they said, is that health care in Canada is free.

But when Canadians visit the doctor these days, they are increasingly doing something that might surprise those supporters. Often they are reaching for their wallets.

In Calgary, people pay up to $900 for cataract surgery if they choose to bypass three-month-long waiting lists and have the procedures done in semiprivate clinics.

In Ontario, Canada's most populous province, parents pay out of their own pockets to have their young children vaccinated for hepatitis B.

In the province of Nova Scotia, patients pay their doctors for supplies such as syringes and surgical tape.

One of the guiding principles of Canada's national health system has long been that essential medical services are provided equally to everyone, with no charge to individuals for medical care other than the high taxes that make the system possible. Now, however, the government is trying to pare large budget deficits, in part by cutting back on spending, and patients increasingly pay the difference.

"It has been a hallmark of Canadian health care that you should not be able to purchase better care just because you're rich," said Michael Rachlis, a health policy consultant and coauthor of a new book on reforming the Canadian system. Rachlis said studies have shown that "whenever you increase private financing, you make the rich and healthy better off and the poor and sick worse off."

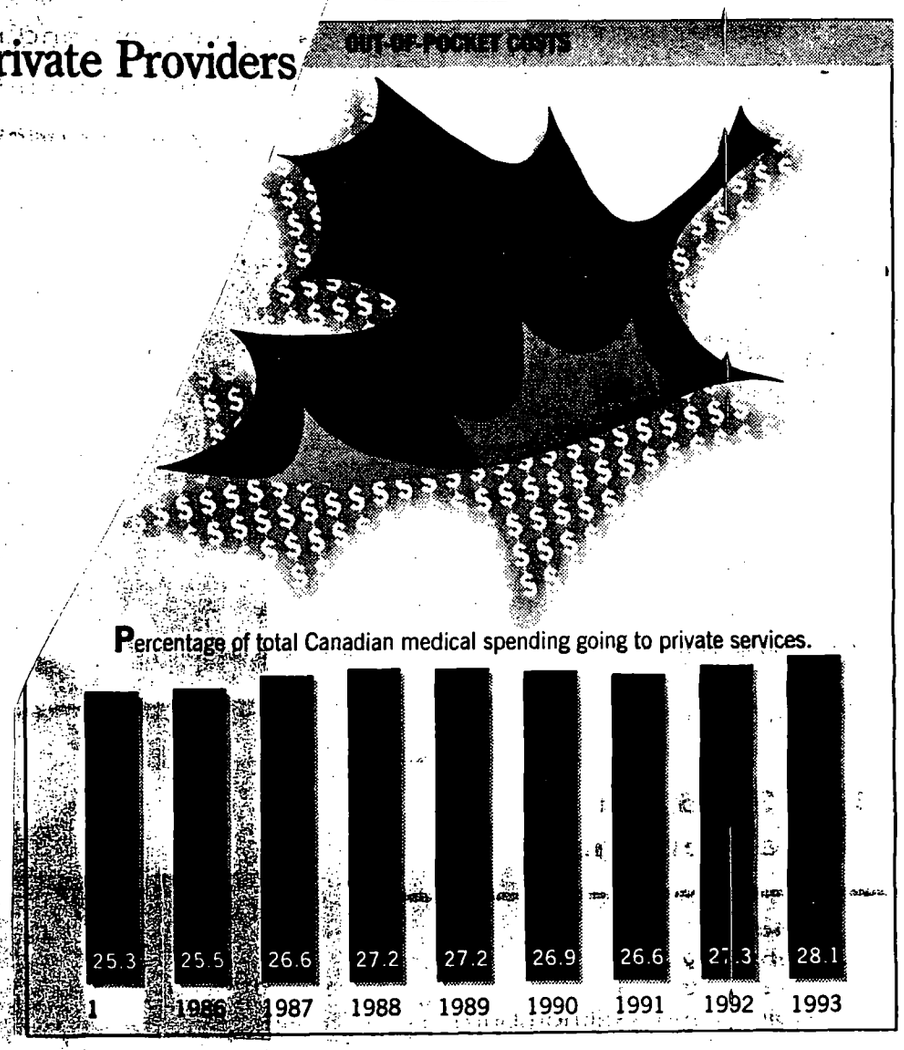
While Canada's national health insurance still covers the vast majority of patients and treatments, the proliferation of private services has led to fears—strongly shared by the government of Prime Minister Jean Chretien—that Canada is headed toward a "two-tier" amalgamation of unequal health care based on wealth.

"We have a national responsibility to ensure that there are not hospitals for the rich and hospitals for the poor. We don't want to find ourselves in the situation they have in the United States," Chretien said at a news conference last month.

Health Minister Diane Marleau has warned that she will cut federal subsidies to provinces that fail to crack down on clinics requiring patients to pay.

"I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate . . . outside the publicly funded and publicly administered system presents a serious threat to Canada's health care system," Marleau said in a letter to provincial health ministers warning them about the clinics.

During the acrimonious health reform debate in Washington last year, the Canadian care system was often compared to



Medicare, the health plan for senior citizens in the United States. Canadian doctors practice privately, hospitals are nonprofit and patients are free to choose their own doctor or hospital. After a patient is treated, the physician and hospital are paid a fee that is set by negotiation between the government and medical groups.

The cost of health care is shared by the Canadian national government and the 10 provinces. But costs have never been entirely funded by the government. The provinces, which administer the delivery of health care, pay about half the total cost of $51 billion. The federal government pays another quarter. Most of the remainder, about $14 billion, comes from individuals or private insurers.

These payments usually cover items—such as drugs, dental care, cosmetic surgery and private hospital rooms—that are not covered by the public health system.

Of more concern to defenders of the system is the recent growth of fee-charging private or semiprivate clinics that perform services that formerly were only done in hospitals for free.

The province of Alberta, for instance, is home to seven such clinics, which charge for cataract operations, abortions and other services. The clinics are semiprivate: The government pays for the doctors' fee and patients pay a "facility fee." More than half of the 5,000 Calgary residents who undergo cataract operations each year choose to pay $500 to $900 and get the operation quickly rather than waiting three months or more to have the surgery in a hospital without cost, according to Terry Stewart, a doctor who runs one of the clinics.

Stewart, who is medical director of the Outpatient Anesthesia Clinic in Calgary, said the clinics actually ease pressure on the public system because they reduce the demand for expensive hospital services. They can save money for patients too, he said, citing the case of a child who needs tubes in his ears to combat ear infections. The tube procedure in Stewart's clinic costs $31.50; the antibiotics a parent would otherwise pay for while waiting three months for a "free" operation in a hospital would cost at least twice that.

In other instances consumers have no choice if they want the service. In Ontario, for example, the provincial health plan generally does not cover vaccinations for hepatitis B. Yet many pediatricians recommend children receive immunization against the disease starting at birth; the series costs about $50.

And in Nova Scotia, more and more doctors are requiring patients to reimburse them for expenses such as wound dressings, syringes, sutures, certain instruments, sick notes to employers and in one case even the office nurse's salary. These charges are being levied because the province is reducing the fees it pays to doctors for treating patients by 12.5 percent over three years as a cost-saving measure, said Robert Kimball, a doctor and president of the Medical Society of Nova Scotia.

"The fee system now has become downright skimpy, and the physician has had to become more of a businessman and recover costs from patients. We can't recoup any other way," Kimball said.

The Canadian system remains far removed from the free-market American health system, where major corporations own hospitals and the government has little impact on prices. But the Canadian move toward medical capitalism has engendered strong feelings here, where the health system has been a source of national pride and a way for Canadians to differentiate themselves from Americans.

Canadians say they are willing to pay to save their system. A poll by COMPAS Inc. of Ottawa recently found that 58 percent of respondents were willing to pay a small user fee for visits to the doctor rather than experience further reductions in services.

Jane Fulton, professor of ethics and health policy at the University of Ottawa, is one of the few experts in the field who says it may take a two-tier health system to bring Canada to fiscal soundness. Canada's overall debt and deficit are proportionately among the highest in the developed world.

"There need to be steam vents in the Canadian health-care system, and private clinics in Alberta are steam vents," Fulton said.

Besides, she contends, Canada already has a two-tier medical system, with the second tier located south of the 49th parallel. Canadians—either visiting in the United States or coming down to specifically seek medical treatments—spend an estimated $1 billion, she said, on U.S. medical care each year. ■

The proliferation of private services has led to fears that Canada is headed toward a 'two-tiered' health care system based on wealth.

THE WHITE HOUSE

WASHINGTON

February 27, 1995

Mr. John Swope
President
Chubb LifeAmerica
One Granite Place
P.O. Box 515
Concord, New Hampshire 03302

Dear Mr. Swope:

Thank you for responding to my staff's request for your thoughts on health care reform. As you noted, we must continue to fight for health security for the millions of hardworking Americans who have no insurance or who are just one pink slip or illness from losing it, and we must contain health care costs. As you also pointed out, we can and should work together this year to take the first steps toward these goals.

As the President said in his State of the Union address, this year we can pass meaningful insurance reform so that Americans do not lose coverage if they lose a job or if a family member falls ill. We can ensure that small businesses can buy insurance at more affordable rates through voluntary purchasing pools. We can expand the tax deduction for self-employed workers. We can help families provide long-term care for a sick parent or a disabled child. And, in time, we can find a way to make sure that America's children have affordable health care.

I appreciate the support and thoughtful advice that you and others at Chubb Life have offered throughout the debate on health care reform. I look forward to continuing to work with you.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

CHUBB LifeAmerica

One Granite Place, P.O. Box 515, Concord, NH 03302
(603) 226-5276

John F. Swope, CLU
President

November 17, 1994

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

Dear Mrs. Clinton:

I was pleased to hear from Karen Guss of your staff last week and am forwarding some immediate summary comments on health care reform as she requested.

Chubb Life has reaffirmed its support of the "Vision Statement" that the Health Insurance Association of America developed two years ago. This vision includes achieving universal coverage building upon the employer based system we have today. It also includes the less sweeping, if perhaps more attainable, goals of reforming the insurance market, including limiting use of pre-existing condition exclusions to achieve portability.

The goal of providing all Americans access to health care is an ambitious one in and of itself. To provide basic coverage (however this may be defined) should be the first step without being concerned that inevitably some Americans will enjoy greater benefits than others. This "inequality" seems to be basic to human nature and has occurred in every society devised by humankind, though not always based on money. It would also seem to make sense to attack the problems of the uninsured and job lock of those who are insured with minimum disruption of those parts of the current system that are working. A simple requirement that employers provide medical insurance would naturally generate opposition from employers not currently providing the benefits, a fairly narrow constituency. But, when it was combined with sweeping changes to existing benefit plans, a formidable alliance of interests was added to the opposition.

Unfortunately, it now appears that any mandate is unlikely. It may not even be possible to use other approaches to the same end, but they should be explored. For example, build on the minimum wage by requiring at least some amount per hour be applied to health benefits for the employee. This would, in effect, apply a mandate to those employers not providing benefits, but have little or no effect on those currently doing so. Tying the requirement to the familiar concept of the minimum wage would make it less confusing to the public.

At least for the working population, the problem of access to health care is inextricably linked or perhaps an outgrowth of the cost of health care. While spreading the cost over the entire population minimizes each individual's cost (as well as minimizes the possibilities of gaming the system), it does nothing to control the total cost to society. To do this, we must link health care decisions closely with the self interest of those that pay the bills. This, obviously, includes the individual and, under an employer based system, must also include the employer. Relying on an employer to select the most efficient financing mechanism and the individual to use it most effectively would be the most promising path to follow. The government is not the best mechanism for controlling costs, particularly since this function can interfere with the functions only government can provide, setting and enforcing standards and regulating the system.

In health care, as in many other aspects of life, America seems to be having difficulty balancing rights and responsibilities. To be effective, I believe that any system we devise must balance and link the rights and responsibilities of each party involved. These include the individual, the health care provider, the health care financing mechanism (insurer, HMO, or other entity) and the employer.

It now does not appear that we can achieve all of our objectives during the next session of Congress. Incremental reforms should be possible. We should make sure that whatever reforms we consider will move us closer to the goal of universal coverage, not further away, and closer to the goal of wisely employing our medical resources, not encouraging further over utilization.

Chubb Life and many other insurers are committed to reform and could be useful resources in dealing with problems that any reform proposals will generate. We would welcome an opportunity to meet with you or your staff to further discuss what in many respects is a shared agenda. Thank you for your response and interest in our views.

Sincerely,

John F. Swope

JFS/psw

cc: Karen Guss

CHURCH
LifeAmerica
One Granite Place, PO Box 515, Concord, NH 03302-0515

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