Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	From: Jason, To: Pattir, Re: FloJo Photo Op [partial] (1 page)	3/10/93	b(6)
002. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (2 pages)	3/11/93	b(6)
003. memo	From: Kim Tilley, To: Hillary Rodham Clinton, Re: Briefings for Thursday March 11th [partial] (1 page)	3/10/93	b(6)
004. memo	From: Kim Tilley, To: Hillary Rodham Clinton, Re: Briefings for Thursday March 11th [partial] (1 page)	3/10/93	b(6)
005. schedule	Schedule for Hillary Rodham Clinton, Draft #1 [partial] (1 page)	3/11/93	b(6)
006. schedule	Schedule for Hillary Rodham Clinton, Draft #1 [partial] (1 page)	3/11/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Thursday March 11 [1993]

2014-0483-S
sb329

RESTRICTION CODES

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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THURSDAY MARCH 11TH

PHOTOCOPY
PRESERVATION

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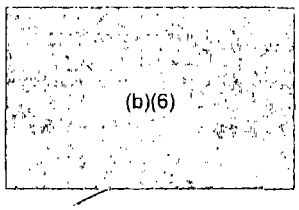
To: Patti
Fr: Jason
Re: FloJo Photo Op
Date: March 10, 1993



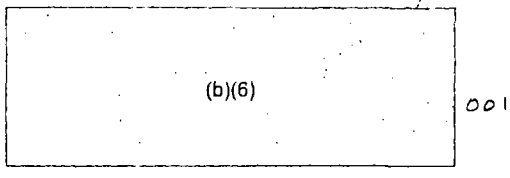
Tomorrow Florence Griffith Joyner will announce the findings of the annual Louis Harris survey on "American Health Habits." FloJo is going on morning shows and doing other interviews, and this photo op would be a good way to get a part of the publicity.

Bob and Maggie thought it would be a good idea to do this photo op in order to promote the image of Mrs. Clinton as our nation's leading health advocate.

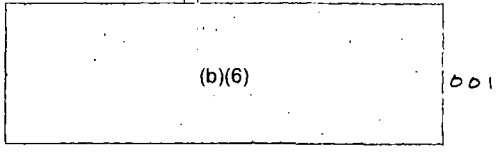
9:00 would be a great time; we only need 10 minutes.

The contact person is Wendy Ruhlin; her number is 828-8816. Home #: 703-823-4620.

Allredrick Joyner

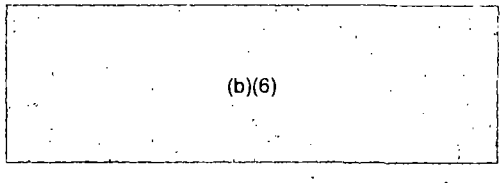


Wendy Ruhlin.



11 will be going
WH - 2F
5:45AM.

Philip Justin Smith



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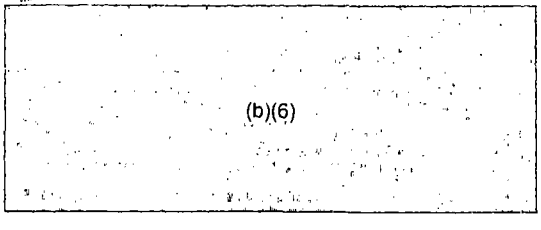

STRICTLY EMBARGOED UNTIL MARCH 11 – 11:00 A.M. (EST)

Contacts: Geoffrey D. Fenton, (708) 948-3436
Mark M. McHale, (202) 828-8849

**Americans' Health Habits Turn For Worse:
Weight Up; Nutrition, Exercise Down, Survey Says**

Washington, D.C., March 11, 1993 -- At a time when the nation can least afford it, Americans are slipping in several important health habits, according to a new nationwide survey.

During 1992, Americans gained weight, ate less carefully than in 1991, and exercised no more than they did a decade ago, according to the 1992 Baxter Survey of American Health Habits. The survey was conducted by Louis Harris and Associates, which has been tracking health habits for 10 years.

The 1992 survey is sponsored by Baxter International, working in partnership with hospitals nationwide. Because the cost of preventing illness is much less than the cost of treating it, the company is working with nearly 2,000 hospitals -- one out of every three community hospitals across the country -- to launch local programs to get Americans to improve their health habits.

The most significant improvements made recently in health behavior across the nation are in areas such as seatbelt use and the use of smoke detectors, where good habits are required by law, the survey reports. When it comes to voluntary health habits, the nation is at best holding the line, and at worst slipping from gains made in the early- to mid-1980s.

- more -

"The survey is a worrisome sign that we're becoming careless about preventative health care," said Vernon R. Loucks, chairman and chief executive officer of Baxter International, headquartered in Deerfield, Ill. "This is disturbing because personal health is one of the few areas of our lives over which we each have direct control. If we individually don't take steps to protect ourselves, we sacrifice what is probably our single best opportunity to contain health-care costs.

"That's why we are working with hospitals across the country to make sure this essential information about health behavior and risk reaches the American public."

The survey suggests that an aggressive information campaign by hospitals, as well as the careful use of financial incentives, might produce real improvements in the nation's health habits. Taking the initiative, more than 1,800 hospitals are launching programs this week to educate their communities on better health habits. These programs include local news briefings, community meetings, hospital publications and other efforts.

Survey Index Reports Main Trends

According to the survey index -- a measure of the proportion of Americans who have engaged in 11 preventative health behaviors over the past 10 years -- the biggest gains in health habits were made in 1984 and 1985. Improvements continued through the late '80s, but have been relatively flat since 1989. The index fell one point in 1992, the first drop since 1987.

The benchmark for the index was established in 1983, the first year that these questions on preventative health were asked by Louis Harris and Associates. From 100 in 1983, the index rose to 108 in 1985, reached 113 in 1988, rose gradually to 117 in 1991, and fell to 116 in 1992.

Bad News; Good News

The survey examines behaviors in important areas of preventative health care. Among its findings:

- **Exercise.** Only 33 percent of Americans now get strenuous exercise three times a week or more, down four percentage points from 1991.
- **Weight.** Sixty-six percent of Americans are overweight -- up from 63 percent in 1991, and 58 percent in 1983.
- **Eating Patterns.** Only 44 percent of Americans try hard to avoid cholesterol, and only 51 percent try hard to avoid fat. Both figures are down six percentage points from 1991. The proportion of Americans trying hard to eat enough fiber is down six points from 1983. The proportion trying hard to avoid too much sodium is down seven points from 1983.
- **Smoking.** Good news: Seventy-six percent of Americans are nonsmokers -- an all-time high.
- **Drinking.** Eighty-eight percent of Americans drink moderately or not at all; fully 40 percent say they never drink alcohol, an increase of six percentage points over 1983. Forty-eight percent say that on a day when they drink, they have no more than three drinks. That's down from 53 percent in 1983, and down slightly from last year.
- **Drug Use.** Ninety-five percent of Americans say they never use illegal drugs. Only one percent say that at present they use illegal drugs frequently.
- **Stress.** Thirty-three percent of Americans say they feel under great stress at least several days a week. And only 58 percent say they get seven to eight hours of sleep a night, down from 64 percent in 1983. Over the past decade, stress levels have risen constantly for those aged 18 to 49, and held steady for those 50 and over.
- **Seatbelt Use and Driving Habits.** Seatbelt use has risen dramatically. Seventy percent of Americans say they use seatbelts at all times when in the front seat of a car, up from 19 percent in 1983. Only 17 percent say they drive after drinking, down from 30 percent in 1983. But only 49 percent say they obey the speed limit all the time. This represents a seven-point drop from 1983.
- **Checkups.** Americans are eager to have their health evaluated in a professional setting. Eighty-four percent have at least annual blood pressure screenings. And although only 44 percent of Americans try hard to avoid cholesterol, 56 percent have their cholesterol level measured at least once a year.

-more-

Key findings (continued)

- **Women's Health**. Women are conscientious about health screening. Eighty percent of women report having a Pap smear at least every other year, which is up from 75 percent in 1983. Forty-nine percent of women say they examine their breasts for signs of cancer at least once each month -- up 12 percent from 1983. But only 40 percent of women over 65 examine their breasts -- cause for concern, since the risk of breast cancer increases with age.

  Forty-four percent of women overall have a mammogram at least every other year. For women aged 40 and over -- the group for which mammography is recommended -- roughly two-thirds report having the test at least every other year, which means one-third of all American women in the same age group are not being screened as often as they should be.

- **AIDS, Other Serious Illnesses**. Two-thirds of Americans say they are taking steps to avoid getting AIDS, although only one-fifth say they worry that they are personally at risk of getting it. Overall, Americans seem ready to take steps to reduce their risk of getting a serious disease even if they don't feel they're personally at risk. While fewer than one-third worry about hypertension and heart disease, over half take steps to avoid them.

- **Health Attitudes**. Americans want to change their health behavior. Seven of 10 smokers say they want to quit smoking. More than four in 10 Americans say they want to learn more about good nutrition, and the same number say they would like to lose weight. Over half of those who say they do not exercise regularly want to start.

- **Motivation to Change**. Most of those surveyed (45 percent) say their strongest motivation to adopt healthier habits is "to be healthier while alive." One-third say that their strongest motivation is "to feel good about [themselves] today." Only one-fifth say their strongest motivation is "to live longer."

  Fifty-seven percent of Americans think that those with unhealthy habits should pay more for their health insurance. Fifty-one percent think the same people should pay a greater share of their medical bills.

  Sixty-six percent think higher insurance premiums would be at least somewhat effective in getting those with unhealthy habits to adopt better health habits. Thirty-three percent think higher premiums would be very effective.

  Thirty percent of smokers say they would be very likely to quit, and 27 percent say they would be somewhat likely to quit, if they were required to pay significantly more for health insurance.

  An overwhelming majority of Americans (more than 80 percent) think it is "very important" or "absolutely essential" that health insurance pay for preventative services for children, such as prenatal care, immunizations and boosters, and checkups; and for women's health screening, including Pap smears, breast exams and mammograms. Seventy-nine percent think that health insurance should pay for general physical examinations.

-more-

Physicians, Hospitals Seen As Resources

Overall, people who want to change their health habits say they are most interested in advice and counseling from their doctors, according to the survey. Hospitals are often a second choice, underscoring the key roles hospitals are playing in community health-promotion and education.

"These survey results represent disturbing trends in the nation's health behaviors. Fortunately, there are a number of people who want to change their health habits for the better, and they are turning to credible sources of information, including their doctors and local hospitals," said James S. Todd, M.D., executive director of the American Medical Association. "We in the medical arena see ourselves as a catalyst of change and look forward to working within our communities to help people stay healthy."

Programs Suggested for Better Health

Regarding the kinds of health-promotion programs most desired by Americans, the survey results suggest efforts that focus on the quality of life rather than on longevity. Other effective steps, according to the survey, might include health-care financing that gives people an incentive to change behavior through a combination of higher premiums for unhealthy habits and more generous reimbursement of preventative services; and legal sanctions and effective enforcement measures against dangerous behavior in cases where this is appropriate.

The 1992 Baxter Survey of American Health Habits was conducted during December 1992 by telephone interview with a total of 1,251 randomly selected adults. The survey includes a number of questions which Louis Harris and Associates has asked every year for the past 10 years (previously for *Prevention* magazine). Neither the phrasing of these questions nor the survey procedure has changed during that time, so that answers can be compared.

Harris national public cross-sections are weighted to the Census Bureau's latest population parameters on sex, race, age and income. Louis Harris and Associates is responsible for final determination of the topics, question wordings, collection of the actual data, and analysis and interpretation of the report.

Baxter is the world's leading manufacturer and marketer of health-care products, systems and services.

# # #

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SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: THURSDAY, MARCH 11, 1993
FINAL

PREV RON	The White House
9:00 am - 9:10 am	**PHOTO-OP W/**Florence Griffith Joyner HRC's Office Contact: Wendy Ruhlin 828-8816 (W)
9:15 am - 9:50 am	**PVT HEALTH CARE MTG (BRIEFING FOR TAMPA)** HRC's Office **Participants:** Maggie Williams, Patti Solis, Melanne Verveer, Lisa Caputo, Bob Boorstein, Julia Moffett
10:00 am - 11:00 am	**MEDIA TIME/SATELLITE FEEDS** Room 452 OEOB
11:00 am - 12:00 pm	**MEDIA TIME/RADIO** HRC's Office Contact: Neel Lattimore 456-2960
12:15 pm - 12:30 pm	**PVT MTG W/** (b)(6) 002 HRC's Office Contact: Shirley Sagawa 456-2369
12:50 pm	**DEPART** The White House South Portico **EN ROUTE** Capitol Hill Travelling Staff: Kelly Craighead Lisa Caputo Melanne Verveer Chris Jennings

Note: Car ride to Capitol Hill with Dr. Victor Raymond, regarding a briefing on the VA for mtg w/Sen. Rockefeller.

12:55 pm	**ARRIVE** Longworth Bldg
1:00 pm- 1:45 pm	**PVT MTG W/**Rep. Ron Wyden (D-OR) 1111 Longworth Bldg Contact: Bruce Ehrle

225-4811

CLOSED PRESS

2:30 pm - 3:15 pm — **PVT MTG W/**Women Senators
S-126

Format: Sen. Barbara Mikulski opens mtg, welcomes participants & intros HRC, HRC brief remarks on health care reform & womens health. Sen. Mikulski remarks, Sen. Kassebaum remarks, follows in alphabetical order.

Participants: Complete list in briefing book

Contact: Ann Norton
224-4654

PRESS SPRAY ONLY

3:30 pm - 4:30 pm — **PVT MTG W/**Sen. Jay Rockefeller (D-WV) &
Rep. G.V. Montgomery (D-MS)
Rep. J. Roy Rowland (D-GA)
109 Hart Bldg

Format: Informal discussion

Contact: Kathy Kellogg
224-6472

CLOSED PRESS

4:45 pm - TBD — **PVT MTG W/**Sen. Daniel Patrick Moynihan (D-NY)
464 Russell Bldg

Format: Informal discussion

Contact: Eleanor Suntum
224-4451

CLOSED PRESS

7:00 pm - 8:30 pm — **HEALTH CARE MTG**
Roosevelt Room

CLOSED PRESS

Format/Purpose: Health care policy discussion: structuring a purchasing cooperative.

Participants:
The President

HRC
Gary Claxton
Judy Feder
Ira Magaziner
Paul Starr
Walter Zelman

Contact: Maggie Williams
456-1660

Note: (b)(6) 002

RON The White House

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March 10, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Kim Tilley

SUBJECT: Briefings for Thursday, March 11th

The following material is attached for tomorrow's events:

(b)(6) 003

Meeting w/ Victor Raymond

(Victor Raymond is briefing you on Veterans Affairs' issues in preparation for your meeting with Senator Rockefeller and Representatives Montgomery and Rowland. Victor Raymond previously worked for Rep. Montgomery and is now Secretary Jesse Brown's designee to the Health Care Task Force. He will accompany you to the meeting.)

- VA and National Health Care Reform: Issues and Option
- VA Health Care System: Facts and Figures

Meeting w/ Representative Ron Wyden briefing

- AP story re: Rep. Wyden v. Pharmaceutical Companies

Meeting w/ Women Senators briefing

- Bios and Health Care Positions
- Abortion Services Coverage Memo (copy only to HRC)
- Letter from Senator Boxer to HRC
- "Capital Gang" Transcript - Senator Feinstein (NOTE: She defended the Task Force against their "secrecy" charges.)

Meeting w/ Senator Jay Rockefeller/Representatives Montgomery & Rowland briefing

- See Raymond briefing for back-up

Meeting w/ Senator Moynihan briefing

(NOTE: FYI, Senator Moynihan is chairing a Senate Finance hearing today on the "money's worth" of Social Security. The Committee is reviewing a recent analysis that compares the amounts that workers paid into Social Security to the amounts that they can expect to get back in retirement benefits.)

FLEISHMAN HILLARD INC — FAX

1301 Connecticut Avenue, N.W.
Washington, D.C. 20036
Telephone: (202) 659-0330

This Facsimile message is being transmitted from (Circle one):

202.828.4494	202.293.8105	202.296.6119	202.467.4382	202.296.1775
(8th Floor)	*(7th Floor)*	*(6th Floor)*	*(5th Floor)*	*(3rd Floor)*

Forward to: Jason Salomon **Date:** 3/10/93

cc:

Company: White House **Pages to Follow:** 6

Fax #: **Telephone #:**

From: Wendy Ruhlin **Client Code:** 211

NOTE: If all pages are not received, please call: ↑ **Phone:** 828-8816

Comments:

w/ photog!
4-5 people

This facsimile contains information which (a) may be LEGALLY PRIVILEGED, PROPRIETARY IN NATURE, OR OTHERWISE PROTECTED BY LAW FROM DISCLOSURE, and (b) is intended only for the use of the Addressee(s) named above. If you are not the Addressee, or the person responsible for delivering this to the Addressee(s), you are hereby notified that reading, copying or distributing this facsimile is prohibited. If you have received this facsimile in error, please telephone us immediately and mail the facsimile back to us at the above address. Thank you.

Annual

Joy

Florence Griffith Joyner is promoting

fitness

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- See Raymond briefing for back-up

Meeting w/ Senator Moynihan briefing

(NOTE: FYI, Senator Moynihan is chairing a Senate Finance hearing today on the "money's worth" of Social Security. The Committee is reviewing a recent analysis that compares the amounts that workers paid into Social Security to the amounts that they can expect to get back in retirement benefits.)

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BNA WASHINGTON INSIDER

Mar. 2, 1993

LENGTH: 1458 words

BODY:
Tax Policy
WHITE HOUSE OFFICIALS SAY CIGARETTE TAX
HIKE MERITS CONSIDERATION; REACTION MIXED

WASHINGTON (BNA) -- An increase in the federal excise tax on cigarettes merits consideration as a means of financing comprehensive health care reform, according to two top Clinton administration officials.

....

Sen. Nancy Kassebaum (R-Kan), a Republican sponsor of a comprehensive health care reform bill reintroduced this year, indicated March 1 that she is not enthusiastic about a significant federal tax increase on cigarettes to pay for reforms that would reduce health care costs and provide greater access to health insurance.

Asked to comment on the Clinton administration's interest in finding ways to raise revenues that also would promote healthy behavior, such as a possible tax of $2 per pack on cigarettes, Kassebaum said, "a $20 tax on cigarettes would cut down on smoking, I guess, but that's not going to raise that much money, and you better consider it on beer and alcohol, as well."

The senator, who spoke to members of the National Association of Counties about her own health care proposals, said she would wait to see what the president's health care reform task force proposes in May.

COMMITTEE ON FINANCE
UNITED STATES SENATE
SD-205 Dirksen Building
Washington, DC 20510

PRESS RELEASE #H-5
FOR IMMEDIATE RELEASE
March 8, 1993

FINANCE COMMITTEE TO REVIEW "MONEY'S WORTH" OF SOCIAL SECURITY

Sen. Daniel Patrick Moynihan (D.-N.Y.), Chairman of the Senate Committee on Finance, announced today that the Committee will hold a hearing on the "money's worth" of Social Security.

The hearing will begin at 10:00 a.m. on Thursday, March 11 in Room SD-215, Dirksen Senate Office Building.

The Committee will hear the views of the Administration and Social Security experts on a recent analysis that compares the amounts that workers paid into Social Security to the amounts that they can expect to get back in retirement benefits.

The analysis suggests that, under the assumptions used by the authors, workers who retired in the past received or are receiving benefits of far greater value than the Social Security taxes they and their employers paid, but that some workers retiring in the future will not get their money back.

"Social Security is our most important domestic program," Sen. Moynihan said. "It is a duty of this Committee to conduct regular oversight hearings on how the program is faring. We will solicit views on the usefulness of a money's worth analysis of Social Security, and on what, if any, the implications of such an analysis might be for Social Security policy."

Witnesses for the hearing will appear by invitation only and must comply with the following rules.

(1) All witnesses must submit 150 copies of a written statement of their testimony (not to exceed 10 letter sized pages in length), along with a cover page and a one-page summary of the principal points. These statements must be received by the Committee no later than 12:00 Noon on Wednesday, March 10, 1993.

(2) Oral presentations should be limited to a brief discussion (not to exceed five minutes) of the principal points included in the one-page summary. The written statement will be included in the hearing record, so witnesses who testify are asked not to read their written statements.

-more-

Written statements.--Witnesses who are not scheduled to testify, and others who desire to present their views to the Committee, are urged to submit written statements for inclusion in the hearing record. Written statements must be typed and must not exceed 10 pages in length. Five copies should be mailed to Mr. Wayne Hosier, United States Senate, Committee on Finance, Washington, DC 20510, and also to Mr. Ed Mihalski, Minority Chief of Staff, United States Senate, Committee on Finance, Washington, DC 20510. These statements must be received **no later than Tuesday, March 25, 1993**. Please indicate the date and subject of the hearing on the first page of the statement.

Sen. Moynihan urges those who submit statements to provide a diskette containing the statement in a format that can be read by personal computers. Plain ASCII text is preferred, but other formats will also be accepted. Please identify the word processing program used.

#

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AARP FAX TRANSMITTAL

FAX #: 434-3758

DATE: 3 9 93 **TO:** Kim Tilley

WHOSE FAX NUMBER IS 456-2239

FROM: EVELYN MORTON 434-3760

DEPARTMENT: FEDERAL AFFAIRS

NUMBER OF PAGES: 7 **(+ 1 COVER SHEET)**

COMMENTS: _____

Women Senators

ANN 3/10

Robin Lipper - Mikulski 224-7962
Staff Dir, Aging Subc

Purpose: Mik & HLC spoke women's health focus exchange / Mik

→ where women's health issues fit in HC reform
What do they need & build system around these needs
How taking needs into account

Issues
① where women fit into HC ref:
What are the key principles to roll to incl women in H.C.

② Repros h c services | Rep to post Repr. pkg
③ abortion as a part of any h.c bill
④ Prov continuum of long term care services. (LTC nt s/n w nursing home
• needs of caregivers - critical
⑤ HC Ref can be s/n w/ ref insurance market mes model v. social health

Robyn Lipner

2

To live up to its model/done ignore pub hlthcare system
Judy Elders symbolizes this

roots as a social wker & activist
① Qual of hc serv & role of fed govt in qual:
a) Clinical lab imp Act
signed into law - last Admin screwed it up
b) Mammography Quality Standards Act
MD & social research at NIH

1.

New work on these issues
& want to do

Per Chris
- rep
cost - op

Abortion services

March 10, 1993

DRAFT ~~CONFIDENTIAL~~ MEMORANDUM

TO: HILLARY RODHAM CLINTON

FROM: LINDA BERGTHOLD
ROBERT VALDEZ

cc: Chris Jennings
Ira Magaziner
Judy Feder
Atul Gawande

RE: PRESIDENT CLINTON'S MEETING WITH CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES ON THURSDAY, MARCH 11, 1993

Chris Jennings has asked us to prepare a background memo for you in preparation for President Clinton's meeting with the Congressional Caucus for Women's Issues tomorrow.

Members of the benefits coverage working group representing the Congressional Caucus for Women's Issues and Senator Mikulski have indicated serious concerns about the coverage of abortion services in the benefit package and the process for developing options. In President Clinton's meeting with the Caucus on Thursday, we understand that he will be asked specifically about these issues.

BACKGROUND

Our working group was asked to explore all options related to benefit coverage as we proceed through the Tollgates. When the issue of coverage for abortion first came up, several women in our group objected to the fact that we were even considering a "no coverage" option. They said that President Clinton had clearly stated during the campaign that abortion would be covered in the benefit package, and he had not backed away from supporting abortion when this issue confronted Secretary Shalala during preparation for the confirmation hearings.

DETERMINED TO BE AN ADMINSTRATIVE
MARKING Per E.O. 12958 as amended, Sec. 3.3 (c)
Initials: ADB Date 5/16/14

The women's advocates in our group emphasized that anything less than clear support for abortion coverage now would be a "signal" to women that the President was abandoning his original commitment. Following discussion with you, Atul and Judy asked us to continue developing all options for consideration (see our options in Attachment A).

ISSUES

Should abortion be covered in the core benefit package?

The problems with including abortion services in the core benefit package are clear. There are probably not enough votes in the Senate to pass a health care reform package that explicitly includes abortion. Support in the House may also be weakened.

Excluding abortion from the core benefit package has obvious political implications. Women's groups perceive that abortion service guarantees can or will be addressed as part of overall system reform. Some women perceive that abortion has been promised as part of the core benefit package.

If part of the core, should abortion be implicitly covered as part of pregnancy related care or as a surgical procedure or explicitly identified?

Making abortion an implicitly covered service may postpone direct confrontation for a short time, but the first time someone asks "Is abortion covered?" a direct answer will be required. Subjecting abortion services to medical necessity provisions is strongly opposed by the Congresswomen as well, because it allows for too much ambiguity and returns power over the decision to medical providers.

The advocates in our working group have presented **three options** for abortion coverage. The options they have outlined are: 1) Establish a comprehensive reproductive health benefit including family planning, abortion as part of maternity related care, and post-reproductive care; 2) Integrate abortion services into prevention and maternity care; and 3) Cover abortion as part of maternity-related care only. Their options do

not exclude abortion, make it a state issue, or subject it to medical necessity control.

We have developed several options for covering abortion short of making it a core benefit in Attachment A. We have also attached provisions for covering abortion in selected western countries in Attachment B.

SUGGESTED TALKING POINTS

Given the complexity of this issue and the importance of gaining as much time as possible to resolve differences among supporters, we would suggest the following talking points for the President in tomorrow's meeting:

- Reaffirm support for a woman's right to choose and indicate that he and you understand this issue very well.

- Explain the importance of maintaining the integrity of the Tollgate process, which requires that all issues and options be explored until the narrowing process begins.

- Indicate that treating abortion differently from other issues at this time will create a credibility problem both within the Task Force work groups and outside.

- Explain that you want to develop mechanisms that allow all women to have access to the entire range of reproductive services. This may mean creating provisions or programs outside the benefit package.

- Ask for their patience and support during this planning phase. Ask them to work with him to develop options and strategies that will support the passage of the overall health care reform bill and guarantee the woman's right to choose.

ATTACHMENT A
OPTIONS FOR COVERAGE OF REPRODUCTIVE HEALTH SERVICES

Our working group has considered several options related to the coverage of reproductive health services, including abortion. As we prepared our Tollgate papers, we collected information on current coverage of abortion in the U.S. and abroad:

Many European countries cover abortion subject to some conditions (**see Attachment B);**

Data on the coverage of abortion services in U.S. private insurance plans is difficult to obtain. Many private plans implicitly cover these services;

Some HMOs and private insurers cover abortion subject to definitions of "medical necessity" only;

Ten states have laws that require the exclusion of abortion services from at least some private coverage. Only twelve states fund Medicaid abortions for low income women using state funds;

The Hyde Amendment restricts federal funding except in cases where the life of the mother is endangered if the fetus is carried to term.

This patchwork of coverage demonstrates the highly sensitive nature of the coverage and the lack of consensus on financing arrangements in either the public or private sector.

We think that there are four main options for coverage of abortion:

OPTION 1: Exclude abortion services from the core benefit package.

PRO: Mollifies opponents of abortion.

Keeps the focus of health care reform on system change.

CON: Provokes strong attacks by most women's groups and weakens support among critical allies. Would be viewed as a serious breach of commitment by the President.

SUBOPTION A: Make abortion coverage available in a supplemental package, with subsidies for low income women.

PRO: The subsidizing of abortion services for low income women may be acceptable to some women supporters and has good chance of gaining support from moderate groups.

Making abortion coverage a supplemental coverage issue may soften some of the opposition by abortion opponents.

CON: Including abortion in a supplemental package may be seen as backing down from broader support.

OPTION 2: Include abortion services implicitly in the core benefit package as part of maternity related care or outpatient surgery.

PRO: May avoid immediate direct confrontation with opponents of abortion and buy time for building broader support among women's groups.

CON: Strategy becomes apparent as soon as anyone asks, "Is abortion covered or not?"

Raises "medical necessity" issues.

OPTION 3: Mandate states to cover abortion services for low income women.

SUBOPTION A: States could be given the option of covering abortion services.

PRO: Removes issue from central point of attack: federal support for abortion.

Supports states' rights.

CON: Bumping this down to the states will be politically contentious and potentially inequitable.

OPTION 4: Cover abortion services subject to a "medically necessary" provision.

PRO: Treat abortion coverage the same as other services subject to determinations of medical necessity.

CON: Women's groups will strongly object to the language of medical necessity, because of the potentially narrow legal definition of necessity, the violation of privacy concerns, and possibility of abuse by providers.

Within the context of managed competition, providers might withhold these services selectively because of personal convictions. Furthermore, some providers may refuse to provide them altogether by invoking the "conscience clause."

ATTACHMENT B

ABORTION LAWS IN SELECTED COUNTRIES *

Country	First Trimester	Second Trimester	Third Trimester
Austria	12 weeks upon request of the pregnant woman	because of danger to the health of a pregnant woman or eugenic reasons; if the pregnant woman is a minor	because of danger to the health of a pregnant woman or eugenic reasons; if the pregnant woman is a minor.
Belgium	12 weeks upon request	no further information is available	no further information is available
Bulgaria	12 weeks upon request	no upper limit for medical reasons	no upper limit for medical reasons
Canada	medical reasons		
France	10 weeks, upon request, for reason of distress	no limit for therapeutic abortions	
Germany, West	12 weeks in case of rape, distress, or socioeconomic reasons	22 weeks for eugenic reasons	beyond the 22 weeks because of serious physical or mental impairment of the pregnant woman
Great Britain	risk to the life or health; eugenic reasons	no upper legal limit; 28 weeks is prescribed by the Infant Life Preservation Act of 1929	

* Source: "A Comparative Survey of the Laws on Abortion of Selected Countries," Law Library of Congress, April 1990, LL 90-32.

Country	First Trimester	Second Trimester	Third Trimester
Greece	12 weeks upon request	24 weeks for eugenic reasons; 19 weeks for rape, incest; no upper limit to avert grave danger to the health of the mother	no upper limit to avert grave danger to the health of the mother
Italy	90 days upon request	beyond 90 days because of serious threat to the woman's health	beyond 90 days because of serious threat to the woman's health
The Netherlands	upon request because of distress	upper limit is the viability of the fetus	
Poland	health, socioeconomic reasons, rape	no upper legal limit	
Portugal	12 weeks because of injury to the health of the mother; rape	16 weeks eugenic reasons; no upper limit where abortion is the only way to avoid the risk of death or grave injury to the pregnant woman	
Spain	12 weeks in case of rape, grave danger to the life or health of the mother	22 weeks for eugenic reasons; no upper limit to avert grave danger to the life or the health of the mother	

Sweden	12 weeks upon request	18-19 weeks upon authorization of the Department of Social Affairs	over 18 weeks because of serious threat to the health of the pregnant woman
Switzerland	in order to save the life of the mother or to avert a great danger of permanent harm; no time limit set		

*. The beginning of a second trimester has been interpreted by the medical profession to be between 13-14 weeks' gestation depending on the reference point. The definition of the end of the second trimester is also vague, ranging between 27-28 weeks.

THE VA AND NATIONAL HEALTH CARE REFORM: ISSUES AND OPTIONS

- VA is pleased to be on the White House Task Force and very much appreciates the support that the Department has been given.
  - VA understands that times have changed; veterans and their advocates want what other citizens want: predictability in receiving their health care.
  - As a framework for solving the difficulties, managed competition under a global budget may be problematic in some areas where VA could help, serving both veterans and the nation. The difficulties that we have faced in providing a broad range of quality services in a cost effective way are the same difficulties being discussed by members of the Task Force.
- Specific VA considerations:
  - Some veterans want the VA label on their care.
  - Some supporters of the VA want the VA label as well; the Association of American Medical Colleges, Association of Professors of Medicine (VA education mission); the American Federation for Clinical Research, Association of Health Services Research (VA research mission); Department of Defense (VA mission as backup to DoD).
  - Service connected veterans should get all medically necessary health care, probably at no out-of-pocket costs to them. Could require this care to be delivered only at VA.
- Specific White House Task Force considerations:
  - Two outcomes are not acceptable: (1) eliminating the VA system and (2) being pushed aside from the new national system to remain unchanged.
  - Exact structure of the new system is not yet clear, but three potential VA roles exist under managed competition with a global budget:

    VA as Accountable Health Plan (AHP)

    VA as some form of Health Insurance Purchase Cooperative (for veterans as a population group, for geographic areas such as rural, or for special care such as mental health, rehabilitation, etc.) or,

    VA as some combination of both.
- Secretary Brown has said: Only when all veterans who want into the VA system can get in, then VA can perhaps talk about other ideas including non-veterans.
  - He suggests that veterans who are not service-connected disabled, who want in the VA system and who have been turned away because of insufficient appropriations be allowed to bring other resources such as federal and private third party insurance (Medicare or resources under a Clinton plan) to pay for their care.
- You may want to ask Chairman Rockefeller and Chairman Montgomery what they think is possible if all veterans were allowed to choose VA care with their private or governmental resources, either today or in the future under a Clinton reform plan.

A Brief Introduction to the Department of Veterans Affairs Health Care System Facts and Figures

National in Scope – largest centrally-managed, organized and financed health care delivery system in the country

- The most important focus of health care in some communities, especially rural areas, and for some underserved urban populations
- National training resource for health care professions annually training over 100,000 health care workers, including more than 32,000 physicians and dentists who receive specialty training.
- Principal employer in some areas of the country with more than 200,000 full-time equivalent employees
- Conducts medical, prosthetic, geriatric, rehabilitation medicine and health services research.

Globally Budgeted – The VA has an annual budget of more than $14.6 billion in FY'93

- Significant experience in allocating resources and managing the dispersion of expensive technologies.
- Significant experience in developing and applying effective cost-containment strategies

A major provider of health care through an integrated, centrally managed health care system which provides high quality medical care to patients across the continum of care

- Approximately 1 million patients hospitalized yearly in 171 VA hospitals.
- More than 30,000 patients treated yearly in VA nursing homes and nearly 20,000 in domiciliaries.
- Approximately 23 million outpatient visits provided annually in VA facilities.

A major national purchaser of goods and services

- More than 19,000 patients in private/community hospitals through VA contracts
- More than 1 million outpatient visits in the community paid for by VA
- More than 16,000 patients in State nursing homes, 6,000 persons in State domiciliaries and 2,000 patients in State hospitals supported by VA
- More than 25,000 patients in private nursing homes contracted by VA
- More than $840 million worth of pharmaceuticals purchased by VA in FY'92

Special Expertise in VA Health Care

- More than 150 VA medical centers and clinics treat over 75,000 substance abuse patients
- Treatment of the homeless, chronically mentally ill
- Specialized treatment programs for women veterans
- Palliative and hospice care
- Non-institutional, long-term care including Adult Day Health Care, Hospital Based Home Care and Community Residential Care and Respite Care programs
- The largest hospital-based dental care system in the U.S.
- Specialized care for spinal cord and brain injured persons
- Unparalleled experience in treating Post Traumatic Stress Disorders and readjustment counseling

Provides direct health care to approximately one in ten veterans in any given year. There are nearly 27 million veterans today.

- Hospitalized patients are sicker, underemployed and have few alternatives outside VA:
  - Two-thirds report their health status as poor or only fair and two-thirds report disabilities which keep them from working;
  - Half have family incomes below $10,000 a year;
  - Forty percent have a military-related disorder;
  - Only one-third have private health insurance and fewer than 16% are employed full time.
- Outpatients are sicker with little community support:
  - Only 40% work full time;
  - Forty percent report their health status as poor or only fair;
  - Over 30% report disabilities which keep them from working;
  - One quarter have no private heath insurance;
  - Nearly 30% have family incomes less than $10,000 yearly.
- Nursing home users: 90% are dependent on others in at least one of the activities of daily living.

Backup support to the Armed Services in the event of war or national emergency

- During an emergency, up to 30% of the 67,000 VA beds would be made available.
- Principal national backup during Desert Storm

A Profile of Veterans Served by DVA's Health Care System

Hospitalized Patients:

- Two thirds report their health status as poor or only fair and two thirds report disabilities which keep them from working.
- Half have family incomes below $10,000 a year
- Forty percent have a military-related disorder
- Only one third have private insurance and fewer than 16% are employed full time

Outpatients:

- Only 40% work full time
- Forty percent report their health status as poor or only fair
- Over 30% report disabilities which keep them from working at all
- One quarter have no private health insurance
- Nearly 30% have family incomes less than $10,000 yearly

Nursing Home Residents:

- 90% are dependent on others in at least one of the activities of daily living

Overview of How Veterans Use DVA Health Care

- A group of about 1.5 million veterans receive health care solely from DVA during the course of any particular year.
- At least another 1.1 million veterans have more than one source of care but use DVA for a significant percentage of their care during any particular year.
- A number of veterans appear to use DVA care as a "safety net" when they need expensive or specific care that would be otherwise difficult for them to obtain. Evidence of this type of behavior comes from the following:
    * Approximately one third of veterans who are hospitalized in DVA facilities in any one year had never before received care from DVA.
    * Approximately one fifth of veterans who receive DVA outpatient care in any one year had never before received care from DVA.
    * Of all of the episodes of hospitalization for acute nonsurgical care provided to veterans throughout the U.S. in any one year, 14% of the episodes are provided in VA facilities. This same figure is 8% for all hospitalizations for surgery. It is hypothesized that the figure is lower for surgery because there is no incentive to perform unnecessary surgery in DVA as there is in the private sector.

M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Thursday Meeting with Ron Wyden
cc: Melanne, Lorraine, Kim Tilley

March 10, 1993

In response to his invitation, you are scheduled to meet with Ron Wyden (D-Oregon). Staffing him for this meeting will be David Schulke, a well respected and former David Pryor Senate Aging Committee staffer.

BACKGROUND

Congressman Wyden is well known in health reform circles. He is very adept at picking hot topic health issues, moving quickly to address them -- particularly through the press, and introducing relevant legislation. In recent years, he has been at the forefront of such issues as prescription drug cost containment, long-term care private insurance standards, and state flexibility. (All three of these issues have also been strongly advocated by Senator Pryor).

During last year's effort by the House to achieve a Democratic consensus on health reform, Congressman Wyden and Congressman Synar attempted to play the mediator role between the Gephardt/Stark government regulation approach and the Cooper/Andrews/Stenholm managed competition approach. He believes there is some middle ground and he wants to be one of the Members who helps you find it. Although he will work closely with Chairmen Dingell and Waxman, he views himself as a major player as well and hopes you will treat him as one. Apparently, FYI, he was very happy that you mentioned his name in yesterday's meeting with the Energy and Commerce Committee.

LIKELY DISCUSSION

A number of issues may come during your discussion with Congressman Wyden, including: (1) How best to talk about revenues and recapture provisions, (2) How best to target wavering Members and what Wyden's role can be in this regard; and (3) the provision of state flexibility and, somewhat related, the status of the Oregon waiver request. This visit is very important to Congressman Wyden. If it turns out like I believe it will, you will have another strong and helpful ally in the House.

M E M O R A N D U M

TO: Hillary Rodham Clinton March 10, 1993
FR: Chris Jennings
RE: Visit With Senator Moynihan
cc: Melanne, Steve R., Kim

Tomorrow at 4:45, you are scheduled to meet with Finance Chairman Daniel Patrick Moynihan. Likely attendees at the meeting will be Lawrence O'Donnell (Staff Director), Faye Drummond (long-time health policy assistant), and Paul Offner (Faye's staff counterpart and former Ohio Medicaid Director).

BACKGROUND

The Chairman has been one of our best friends on Capitol Hill on a wide range of issues. He has basically stated that he will support virtually any health care proposal the President proposes. At the same time, he has expressed some reservations that the issue is so complicated that it may take more time than the President may think for the Administration to develop and the Congress to digest a comprehensive health reform proposal.

Despite his reservations, the Finance Committee Chairman has supported the Majority Leader's contention that health care reform has its best chance for passage if it can be incorporated into the reconciliation bill. Irregardless of what happens in the budget process, Senator Moynihan -- if treated with the respect that he deserves -- can be counted on to be helpful to "set the stage" in terms of desirable hearings and statements.

On health care, Senator Moynihan is not a detail person. He generally asks broad questions with broad implications, rather than focusing on the many complexities of the health care issue. The primary health oriented issues that he has previously indicated some interest in include: (1) the inadequacy of mental health and substance abuse coverage benefits, and its impact on the homeless population, (2) state-based reform and need for flexibility (he was the lead sponsor of a state-based managed care initiative that was adamantly opposed by Henry Waxman), and (3) the impact of any reform effort on New York's powerful, influential and vulnerable hospital providers.

LIKELY DISCUSSION

The Chairman had to miss the last scheduled meeting with you because he was sick. You may want to acknowledge this and ask him how he is feeling. With Senator Moynihan, even more than most Members, one cannot predict the topic of conversation. He probably will want to make sure you are still on track with your bill and to get a sense as to what direction you are headed. More than anything, I believe, he will be more process oriented and "big picture" oriented than most of your recent meetings.

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005. schedule	Schedule for Hillary Rodham Clinton, Draft #1 [partial] (1 page)	3/11/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Thursday March 11 [1993]

2014-0483-S
sb329

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]

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

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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]

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: THURSDAY, MARCH 11, 1993
DRAFT #1

PREV RON The White House

9:00 am - 9:15 am — **PVT MTG W/Maggie & Patti**
HRC's Office

9:15 am - 9:30 am — **PVT MTG W/Maggie**
HRC's Office

9:30 am - 9:45 am — **PVT MTG W/Ira & Carol**
HRC's Office

10:00 am - 11:00 am — **MEDIA TIME/TV**
Room

11:00 am - 12:00 pm — **MEDIA TIME/RADIO**
Room

Contact: Neel Lattimore
456-2960

12:15 pm - 12:30 pm — **PVT MTG W/** (b)(6)
HRC's Office

Contact: Shirley Sagawa
456-2369

12:50 pm — **DEPART** The White House South Portico
EN ROUTE Capitol Hill

12:55 pm — **ARRIVE** Longworth Bldg

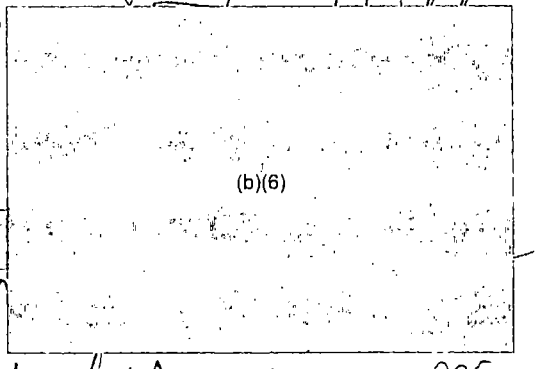
1:00 pm - 1:45 pm — **PVT MTG W/Rep. Ron Wyden (D-OR)**
1111 Longworth Bldg

Contact: Bruce Ehrle
225-4811

2:00 pm - 3:00 pm — **PVT MTG W/Six Women Senators**
S-126

Format: Sen. Barbara Mikulski opens mtg, welcomes participants & intros HRC, HRC brief remarks on health care reform & womens health. Sen. Mikulski remarks, Sen. Kassebaum remarks, follows in alphabetical order.

Participants: Complete list in briefing book



Contact: Ann Norton
224-4654

PRESS SPRAY ONLY

3:30 pm -
4:30 pm

PVT MTG W/Sen. Jay Rockefeller &
Rep. G.V. Montgomery
Rep. J. Roy Rowland (D-GA)
109 Hart Bldg

Format: Informal discussion

Contact: Kathy Kellogg
224-6472

CLOSED PRESS

4:45 pm -
TBD

PVT MTG W/Sen. Daniel Patrick Moynihan
464 Russell Bldg

Format: Informal discussion

Contact: Eleanor Suntum
224-4451

CLOSED PRESS

7:00 pm

HEALTH CARE MTG
Room

Participants:
The President
HRC

Contact: Maggie Williams
456-1660

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The White House

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006. schedule	Schedule for Hillary Rodham Clinton, Draft #1 [partial] (1 page)	3/11/93	b(6)

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FOLDER TITLE:
[HRC Daily File] Thursday March 11 [1993]

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sb329

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]

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: THURSDAY, MARCH 11, 1993
DRAFT #1

PREV RON The White House

9:00 am - 9:15 am **PVT MTG W/**Maggie & Patti
HRC's Office

9:15 am - 9:30 am **PVT MTG W/**Maggie
HRC's Office

9:30 am - 9:45 am **PVT MTG W/**Ira & Carol
HRC's Office

10:00 am - 12:00 pm **MEDIA TIME**
Room

12:15 pm - 12:30 pm 1. **PVT MTG W** (b)(6) 006
HRC's Office

Contact: Shirley Sagawa
456-2369

Shirley

12:50 pm **DEPART** The White House South Portico
EN ROUTE Capitol Hill

12:55 pm **ARRIVE** Longworth Bldg

1:00 pm- 1:45 pm 2. **PVT MTG W/**Rep. Ron Wyden (D-OR)
1111 Longworth Bldg

Chris

Contact: Bruce Ehrle
225-4811

2:00 pm - 3:00 pm 3. **PVT MTG W/**Six Women Senators
S-126

Chris

Format: Sen. Barbara Mikulski opens mtg, welcomes participants & intros HRC, HRC brief remarks on health care reform & womens health. Sen. Mikulski remarks, Sen. Kassebaum remarks, follows in alphabetical order.

Participants: Complete list in briefing book

Contact: Ann Norton
224-4654

PRESS SPRAY ONLY

3:30 pm - 4. **PVT MTG W/**Sen. Jay Rockefeller &

Chris

4:30 pm

Rep. G.V. Montgomery
Rep. J. Roy Rowland (D-GA)
109 Hart Bldg

Format: Informal discussion

Contact: Kathy Kellog
224-6472

CLOSED PRESS

4:45 pm - TBD

5

PVT MTG W/Sen. Daniel Patrick Moynihan
464 Russell Bldg

Chris

Format: Informal discussion

Contact: Eleanor Suntum
224-4451

CLOSED PRESS

7:00 pm

HEALTH CARE MTG
Room

Participants:

Contact: Maggie Williams
456-1660

RON

The White House

THE VA AND NATIONAL HEALTH CARE REFORM: ISSUES AND OPTIONS

- VA is pleased to be on the White House Task Force and very much appreciates the support that the Department has been given.

  - VA understands that times have changed; veterans and their advocates want what other citizens want: predictability in receiving their health care.

  - As a framework for solving the difficulties, managed competition under a global budget may be problematic in some areas where VA could help, serving both veterans and the nation. The difficulties that we have faced in providing a broad range of quality services in a cost effective way are the same difficulties being discussed by members of the Task Force.

- Specific VA considerations:

  - Some veterans want the VA label on their care.

  - Some supporters of the VA want the VA label as well; the Association of American Medical Colleges, Association of Professors of Medicine (VA education mission); the American Federation for Clinical Research, Association of Health Services Research (VA research mission); Department of Defense (VA mission as backup to DoD).

  - Service connected veterans should get all medically necessary health care, probably at no out-of-pocket costs to them. Could require this care to be delivered only at VA.

- Specific White House Task Force considerations:

  - Two outcomes are not acceptable: (1) eliminating the VA system and (2) being pushed aside from the new national system to remain unchanged.

  - Exact structure of the new system is not yet clear, but three potential VA roles exist under managed competition with a global budget:

    VA as Accountable Health Plan (AHP)

    VA as some form of Health Insurance Purchase Cooperative (for veterans as a population group, for geographic areas such as rural, or for special care such as mental health, rehabilitation, etc.) or,

    VA as some combination of both.

- Secretary Brown has said: Only when all veterans who want into the VA system can get in, then VA can perhaps talk about other ideas including non-veterans.

  - He suggests that veterans who are not service-connected disabled, who want in the VA system and who have been turned away because of insufficient appropriations be allowed to bring other resources such as federal and private third party insurance (Medicare or resources under a Clinton plan) to pay for their care.

- You may want to ask Chairman Rockefeller and Chairman Montgomery what they think is possible if all veterans were allowed to choose VA care with their private or governmental resources, either today or in the future under a Clinton reform plan.

A Brief Introduction to the Department of Veterans Affairs Health Care System Facts and Figures

National in Scope – largest centrally-managed, organized and financed health care delivery system in the country

- The most important focus of health care in some communities, especially rural areas, and for some underserved urban populations
- National training resource for health care professions annually training over 100,000 health care workers, including more than 32,000 physicians and dentists who receive specialty training.
- Principal employer in some areas of the country with more than 200,000 full-time equivalent employees
- Conducts medical, prosthetic, geriatric, rehabilitation medicine and health services research.

Globally Budgeted – The VA has an annual budget of more than $14.6 billion in FY'93

- Significant experience in allocating resources and managing the dispersion of expensive technologies.
- Significant experience in developing and applying effective cost-containment strategies

A major provider of health care through an integrated, centrally managed health care system which provides high quality medical care to patients across the continum of care

- Approximately 1 million patients hospitalized yearly in 171 VA hospitals.
- More than 30,000 patients treated yearly in VA nursing homes and nearly 20,000 in domiciliaries.
- Approximately 23 million outpatient visits provided annually in VA facilities.

A major national purchaser of goods and services

- More than 19,000 patients in private/community hospitals through VA contracts
- More than 1 million outpatient visits in the community paid for by VA
- More than 16,000 patients in State nursing homes, 6,000 persons in State domiciliaries and 2,000 patients in State hospitals supported by VA
- More than 25,000 patients in private nursing homes contracted by VA
- More than $840 million worth of pharmaceuticals purchased by VA in FY'92

Special Expertise in VA Health Care

- More than 150 VA medical centers and clinics treat over 75,000 substance abuse patients
- Treatment of the homeless, chronically mentally ill
- Specialized treatment programs for women veterans
- Palliative and hospice care
- Non-institutional, long-term care including Adult Day Health Care, Hospital Based Home Care and Community Residential Care and Respite Care programs
- The largest hospital-based dental care system in the U.S.
- Specialized care for spinal cord and brain injured persons
- Unparalleled experience in treating Post Traumatic Stress Disorders and readjustment counseling

Provides direct health care to approximately one in ten veterans in any given year. There are nearly 27 million veterans today.

- Hospitalized patients are sicker, underemployed and have few alternatives outside VA:
  - Two-thirds report their health status as poor or only fair and two-thirds report disabilities which keep them from working;
  - Half have family incomes below $10,000 a year;
  - Forty percent have a military-related disorder;
  - Only one-third have private health insurance and fewer than 16% are employed full time.
- Outpatients are sicker with little community support:
  - Only 40% work full time;
  - Forty percent report their health status as poor or only fair;
  - Over 30% report disabilities which keep them from working;
  - One quarter have no private heath insurance;
  - Nearly 30% have family incomes less than $10,000 yearly.
- Nursing home users: 90% are dependent on others in at least one of the activities of daily living.

Backup support to the Armed Services in the event of war or national emergency

- During an emergency, up to 30% of the 67,000 VA beds would be made available.
- Principal national backup during Desert Storm

A Profile of Veterans Served by DVA's Health Care System

Hospitalized Patients:

- Two thirds report their health status as poor or only fair and two thirds report disabilities which keep them from working.
- Half have family incomes below $10,000 a year
- Forty percent have a military-related disorder
- Only one third have private insurance and fewer than 16% are employed full time

Outpatients:

- Only 40% work full time
- Forty percent report their health status as poor or only fair
- Over 30% report disabilities which keep them from working at all
- One quarter have no private health insurance
- Nearly 30% have family incomes less than $10,000 yearly

Nursing Home Residents:

- 90% are dependent on others in at least one of the activities of daily living

Overview of How Veterans Use DVA Health Care

- A group of about 1.5 million veterans receive health care solely from DVA during the course of any particular year.
- At least another 1.1 million veterans have more than one source of care but use DVA for a significant percentage of their care during any particular year.
- A number of veterans appear to use DVA care as a "safety net" when they need expensive or specific care that would be otherwise difficult for them to obtain. Evidence of this type of behavior comes from the following:

    * Approximately one third of veterans who are hospitalized in DVA facilities in any one year had never before received care from DVA.

    * Approximately one fifth of veterans who receive DVA outpatient care in any one year had never before received care from DVA.

    * Of all of the episodes of hospitalization for acute nonsurgical care provided to veterans throughout the U.S. in any one year, 14% of the episodes are provided in VA facilities. This same figure is 8% for all hospitalizations for surgery. It is hypothesized that the figure is lower for surgery because there is no incentive to perform unnecessary surgery in DVA as there is in the private sector.

THE WHITE HOUSE
WASHINGTON

Thurs

1. Wyden - Chris doing bef.

2. Women Senators / Paschetti folks doing briefing

Kassebaum
Mikulski
Braun
Boxer
Murray