Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Dr Douglas Wood to Frank Lindsay (1 page)	03/24/1995	b(6)

COLLECTION:
Clinton Presidential Records
Office of the First Lady
Jenifer Klein
OA/Box Number: 12509

FOLDER TITLE:
Correspondence-Other-Maggie Williams' Letters

2014-0536-F
kc1355

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(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

WASHINGTON

August 24, 1995

Gail Chasey Beam
425 Aliso Drive, NE
Albuquerque, NM 87108

Dear Ms. Beam:

Thank you for writing to express your concerns about programs for young children with disabilities. The First Lady shares your commitment to providing children with disabilities the services they need.

At a time when Congress is considering dramatic funding reductions, the President and the Department of Education are working to ensure a continuation of quality programs for children with disabilities. The President opposes the bill that the House has passed that would eliminate funding for early childhood education programs for children with disabilities and other important programs such as training for special education teachers.

The programmatic changes that the President proposed for fiscal year 1996 were designed to improve services to all people with disabilities, including preschool children. I know that you have also heard from Mr. Thomas Hehir, Director of the Office of Special Education Programs at the Department of Education. As Mr. Hehir noted, by reconfiguring the discretionary grant program, the Department believes that it can ensure that states best meet the needs of all children with disabilities. It is important to note, however, that the Administration's proposed consolidations do not include any funding reductions.

Thank you again for sharing your concerns with me.

Sincerely,

Maggie Williams

Maggie Williams
Chief of Staff to
the First Lady

Gail Chasey Beam
425 Alisa Drive, NE
Albuquerque, New Mexico 87108
505/266-5191

February 28, 1995

Post-it® Fax Note 7671	Date 2/28/95	# of pages ▶ 2
To Secy. Riley	From Gail C. Beam	
Co./Dept. US Dept. of Educ	Co.	
Phone # 202/401-3000	Phone # 505/266-5191	
Fax # 202/401-0596	Fax # 505/272-5280	

Secretary Richard Riley
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, D.C., 20202

I would like you to know how very disappointed families and advocates are in the President's 1995-1996 budget proposals for the youngest children with disabilities under the Individuals with Disabilities Education Act (IDEA). This budget proposal includes three devastating changes:

1. NO FUNDING FOR PRESCHOOL SPECIAL EDUCATION for children with disabilities, ages three through five (IDEA Part B, Section 619). Preschool funds have been transferred into the Part B state grant program without an earmark to ensure funding for 3-5 year olds. The combination of these grant programs will result in cuts to programs for preschool children. There must be <u>separate</u> funding at the level of at least $670 million to guarantee appropriate services for these children.

2. THE ELIMINATION OF EARLY CHILDHOOD RESEARCH, DEMONSTRATION AND TRAINING PROJECTS and the transfer of those funds to a block grant. The Early Education Program for Children with Disabilities (EEPCD) has provided state-of-the-art knowledge and methods for over 25 years. This program's budget is only $25 million, and it has been evaluated independently as one of the best examples of research-to-practice in the federal government. The blocking of this program will undoubtedly result in a decreased emphasis on very young children and their families.

3. NO INCREASE FOR INFANT/TODDLER PROGRAM (PART H of IDEA) will result in fewer services to these very young children and their families. Last September, all states finally promised to provide services to eligible children and their families, thus <u>increasing</u> the number of children receiving services. Without the federal commitment, states may find it impossible to keep their promises, putting the program in severe jeopardy across the nation. The funding level needed is $376 million.

Here in New Mexico, where so many children live below the poverty level, and where so many families have to travel great distances to receive services for their young children with developmental problems, the effects of such actions will be suffered widely. Families and advocates are particularly upset that we have not

been able to work with the Department of Education on these issues, despite more than 20 years of successful bipartisan collaboration with previous Administrations. In fact, when I called your office about this matter, I was redirected numerous times, and was finally referred to the Director of EEPCD, the program scheduled for elimination. I then called Judith Heumann's office to try to convey my concerns, and was again referred to the Director of EEPCD. I did ask her staff to let her know that it does not feel responsive to have such calls referred an individual who is not at a decision-making level.

I would appreciate knowing how we can work with you in the future.

Sincerely,

Gail C. Beam

Gail C. Beam

6/13 — 6-7610 - Jenny McCarthy XO

spoke to Edgar at 220a Ed Dept's correspondence office — Office on Special Education responded & he'll have a copy faxed.

401-2981

Presidential Conespondence

Andy 6-7610 XO

#220a 4/10 budget since updated

Gloria 6-5915

will call when ready

Gail Chasey Beam
425 Aliso Drive, NE
Albuquerque, New Mexico 87108
505/266-5191

February 28, 1995

President Bill Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C., 20500

I would like you to know how very disappointed families and advocates are in your 1995-1996 budget proposals for the youngest children with disabilities under the Individuals with Disabilities Education Act (IDEA). This budget proposal includes three devastating changes:

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Here in New Mexico, where so many children live below the poverty level, and where so many families have to travel great distances to receive services for their young children with developmental problems, the effects of such actions will be suffered widely. I urge you to reconsider sacrificing the needs of young children

with disabilities and their families in the interest of budget cutting. Everything we know about these programs tells us that every dollar spent is an investment that is recouped again and again.

Families and advocates are particularly upset that we have not been able to work with the Department of Education on these issues, despite more than 20 years of successful bipartisan collaboration with previous Administrations. In fact, when I called Secretary Riley's office about this matter, I was redirected numerous times, and was finally referred to the Director of EEPCD, the program scheduled for elimination. I then called Judith Heumann's office to try to convey my concerns, and was again referred to the Director of EEPCD. I did ask her staff to let her know that it does not feel **responsive** to have such calls referred an individual who is not at a decision-making level, and who, in fact, probably shares many of my concerns.

Those of us who worked for your election and who continue to support you hope that our appeal on behalf of these families and their young children will be heard. Thank you very much for your interest in this matter.

Sincerely,

Gail C. Beam

Gail C. Beam

Gail Chasey Beam
425 Aliso Drive, NE
Albuquerque, New Mexico 87108
505/266-5191

February 28, 1995

Secretary Richard Riley
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, D.C., 20202

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I would appreciate knowing how we can work with you in the future.

Sincerely,

Gail C. Beam

Gail C. Beam

Training & Technical Assistance Unit
A University Affiliated Program
The University of New Mexico
School of Medicine
Albuquerque, NM 87131-5020
FAX # (505) 272-5280
Confirming Telephone # (505) 272-3000

To Fax # 202-456-6244

No. of Pages (excluding this page) 6

TO: Elli Klein

FROM: Gail Beam

DATE: 5/11/95

RE:

THE WHITE HOUSE

WASHINGTON

April 17, 1995

Mr. David J. Crane
1602 Indiana Bay Drive
Vero Beach, Florida 32963

Dear Mr. Crane:

Thank you for writing to share your innovative suggestions about the use of information-based technology to prevent fraud and abuse and reduce administrative costs in health care programs. As you may know, the Clinton Administration is working to improve the health care system through the use of information technology.

Currently, the Administration's Information Infrastructure Task Force is working to foster the creation of a National Information Infrastructure (NII). Our goal is to use the NII to give consumers and health care providers access to specialists and health information regardless of their location. Further, we anticipate that the NII will significantly reduce the current administrative burdens of our paper-based system.

You suggested using information technology to increase immunization rates for America's children. As part of the President's childhood immunization initiative, the Federal government sent $129 million to states and local health departments to improve existing services. Many of the localities used their funds to create automated record-keeping services to remind providers and parents to immunize children.

I have also forwarded your letter to John Silva, Chair of the NII Task Force's Health Information and Application Working Group. Thank you again for writing.

Sincerely,

Margaret Ann Williams
Assistant to the President and
Chief of Staff to the First Lady

THE WHITE HOUSE
WASHINGTON

Date April 5, 1995

MEMO FROM MAGGIE WILLIAMS

TO: Jen Klein

The attached is for your:

Information _____

Advice _____

Action _____

COMMENTS:
I have no idea what this is about- but why don't you put it in your files.

Withdrawal/Redaction Marker
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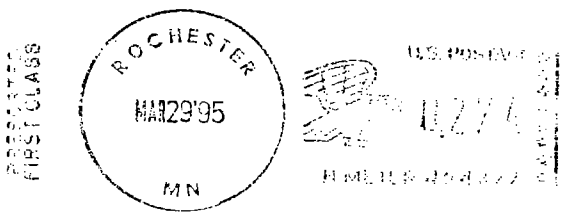
Mayo Clinic
200 First Street Southwest
Rochester, Minnesota 55905

Douglas L. Wood, M.D.



Ms. Margaret A. Williams, The First Lady's Chief of Staff
The White House
Second Floor West Wing
1600 Pennsylvania Avenue NW
Washington, DC 20500

THE WHITE HOUSE

WASHINGTON

Date 6/20

MEMO FROM: MAGGIE WILLIAMS

TO:

Milli Alston	___	Neel Lattimore	___
Pam Barnett	___	Evelyn Lieberman	___
Anne Bartley	___	Diane Limo	___
Liz Bowyer	___	Capricia Marshall	___
Lisa Caputo	___	Ann McCoy	___
Kelly Craighead	___	Alice Pushkar	___
Karen Finney	___	Sarah Ryan	___
Sara Grote	___	Patti Solis	___
Julie Hopper	___	Ann Stock	___
Carolyn Huber	___	Melanne Verveer	___
Jennifer Klein	X	_____	___

The attached is for your:

Information ____

Advice ____

Action X

COMMENTS:

Call me — what is this?

Viatical = gathers funds for a long journey

Org. helps terminally ill people sell their life insurance policies

No response.

Fax Note 7672 | No. of Pages 1 | Today's Date 6-17-94 | Time 11:39 EST

To: Ms. Maggie Williams
Company: The White House/First Lady's Chief of Staff
Location: Wash. DC
Fax #: 202-456-6244 Telephone #: 202-456-1414

From: Mark B. Leeds
Company: Leeds Comm. Assoc.
Location: NYC
Fax #: 212-819-0784 Telephone #: 212-819-0769
Original's Disposition: ☐ Destroy ☐ Return ☐ Call for pickup

Comments: Second Submission (first time to this FAX number) of Letter to Ms. Williams dealing with health care and a particular aspect involving terminally-ill persons and their care and financial self-sufficiency.

Jennifer call me — what is this? Maggie

NVA NATIONAL VIATICAL ASSOCIATION

P.O. BOX 23434 WACO, TEXAS 76702 (817) 772-3688 FAX (817) 772-6026

January 5, 1994

Ms. Maggie Williams, Chief of Staff to
Mrs. Hillary Rodham Clinton
THE WHITE HOUSE
1600 Pennsylvania Avenue
Washington, DC 20500 via FAX: 202-456-2461

Dear Ms. Williams,

We write to request your help and guidance on health care and related issues, and to express our appreciation for Mrs. Rodham Clinton's concern and leadership vis-a-vis health care reform. Controlling runaway costs, providing security to every American family, while maintaining quality medical care and preserving basic choices is so vital to the American people.

We have parallel concerns for AIDS victims, cancer victims and others that are terminally ill. In 1993 the viatical settlement industry paid about $200 million in lump sums of cash to Persons With AIDS (PWA) and other terminally ill individuals, to be used as they saw fit for health care, medications, food, rent, etc., over the remaining 12-24 months of life. Life insurance companies, through accelerated/living benefits programs, paid under $50 million to PWA in '93, to individuals with 3-6 months of remaining life. Through policy cancellations by insurers of terminally ill persons that can no longer afford coverage and miss premiums, the major life insurers save $3 billion (yes, billion!!) a year. Those PWA become destitute and are then cared for at taxpayer expense, so what was once a personal benefit paid for by the individual and an obligation of the life insurance company, is thusly transferred to the public to fund. In most cases, and as can be documented by The National Association of Persons With AIDS and other groups representing minorities, women's interests, seniors and others, the viatical option or choice is the only alternative for terminally-ill persons, short of less generous offers (if any) from insurers and the awful choice of exhausting a lifetime's savings and ultimate poverty. As may be expected the life insurance lobbies at the federal and state levels are inclined to hamper or remove the competitive threat posed by viatical firms, to protect that $3 billion windfall.

We seek to alert Mrs. Rodham Clinton to this matter and enlist the administration's support as part of the overall health care reform. Relatedly, when PWA lose their jobs and group health coverages, the problem is aggravated and the viatical option needlessly precluded. We welcome discussing these concerns and pledge our support for reform.

Mark B. Leeds, NVA Communications Chair MBL: mlf
212-819-0769

THE WHITE HOUSE

WASHINGTON

May 20, 1994

Mr. Douglas D. Jenner
President
Superior Mobile, Inc.
545B East Michigan
Marquette, Michigan 49855

Dear Mr. Jenner:

Thank you for writing about the reductions in Medicare reimbursement rates that your company is facing. I have forwarded your letter to Bruce Vladeck, the Administrator of the Health Care Financing Administration. I have been told that his office is aware of the issues that you raised in your letter and would be happy to work with you to address them.

Please feel free to contact me with any additional questions.

Sincerely,

Margaret A. Williams
Chief of Staff
to the First Lady

545B East Michigan • Marquette, MI 49855
Local: (906) 228-3999
Toll Free: 1-800-852-4090

March 10, 1994

Margaret Williams, Chief of Staff
Office of the First Lady
Old Executive Office Building
1600 Pennsylvania Blvd.
Washington D.C. 20500

Dear Ms. Williams,

Please allow me to introduce my company, Superior Mobile, Inc.. We provide mobile diagnostic services to nursing homes and facilities in the Upper Peninsula of Michigan. These services include mobile x-ray, EKG, pulmonary function exams and ultrasound studies to small hospitals. We have been in business since 1989.

As of January 1, 1994, Blue Cross Blue Shield of Michigan reduced our reimbursible rate by 18%. They plan to do this again next year and the year after. A total of 55% in reduction is expected. Enclosed is a letter that explains in detail what happened in the last six months. Our company will no longer exist after this year.

The reason I am writing you is that there is a rumor that the First Lady may be coming to the U.P. to discuss healthcare. Please brief her about my companies situation.

I would very much like the opportunity to ask Mrs. Clinton a couple of questions and she in turn could relay them to the head of H.C.F.A.

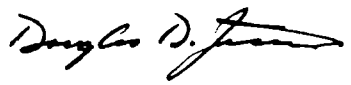
1. If health care services for the elderly are being cut in 1994, what is going to happen in five years when there will be three times as many seniors needing these same types of services?!
2. Since the U.P. is considered "rural" (remote is more the word) H.F.C.A. is making it impossible for some elderly care services to be provided. This is contrary to what health care reform hopes to provide. Shouldn't Medicare and its agencies be working with people like us instead of putting us out of business?

I would be happy to talk about healthcare (in particular, elderly programs) and how it will effect the elderly in the U.P.

If you need more information or have any questions please don't hesitate to call.

906-228-4514 (work)
906-228-3248 (fax)
906-225-5002 (home)

Sincerely,



Douglas D. Jenner
President

DDJ/lmr

THE WHITE HOUSE

WASHINGTON

May 2, 1994

DRAFT

Ms. Mary Jane Moore
4807 Northwest 27th Terrace
Tamarac, Florida 33309-2912

Dear Ms. Moore:

I am so sorry that you did not receive a proper answer to your letter to the First Lady about coverage for prescription drugs under the President's proposal for health reform. You have raised a very important issue, and the President is committed to preserving and enhancing the benefits now available to Americans who are over the age of 65.

You noted in your letter that you are concerned about a monthly $1,500 deductible for prescription drugs. The President's plan does not include any $1,500 monthly deductible. Under the President's plan, Medicare will cover prescription drugs for the first time. Today, some beneficiaries can afford to purchase supplemental coverage for prescription drugs, while many others are forced to choose between medication and food. Under the Clinton plan, after meeting an annual deductible of $250 dollars, beneficiaries will pay 20 percent of the cost of each prescription up to a $1,000 out-of-pocket annual limit. All costs for medication above this limit will be fully covered -- so that you, the beneficiary, pay nothing.

Thank you for writing and again, I apologize. Please feel free to contact me with any further questions or concerns.

Sincerely,

Margaret A. Williams
Chief of Staff
to the First Lady

March 2, 1994

Gary S. Mendoza
Department of Corporations
Office of the Commissioner
3700 Wilshire Boulevard, Suite 600
Los Angeles, California 90010

Dear Mr. Mendoza:

Thank your for your letter about the managed care industry in California and the Department of Corporations' experience as the managed care regulator in the State. I appreciated reading about the role of your department in the development of managed care in California and would be interesting in hearing your views about the implications of this experience for national health reform.

We share your commitment to provide high quality health care at an affordable price. Thank you again for writing.

Sincerely,

Margaret A. Williams
Chief of Staff
to the First Lady

STATE OF CALIFORNIA -- BUSINESS, TRANSPORTATION AND HOUSING AGENCY

PETE WILSON, *Governor*

DEPARTMENT OF CORPORATIONS
OFFICE OF THE COMMISSIONER
3700 WILSHIRE BOULEVARD, SUITE 600
LOS ANGELES, CALIFORNIA 90010

Eve please ask Jennifer Klein to answer for me

IN REPLY REFER TO:

FILE NO: ______ ______

February 1, 1994

Ms. Margaret Williams
Chief of Staff
Office of the First Lady
West Wing
The White House
Washington, D.C. 20500

Dear Ms. Williams:

As the national health care debate unfolds, I think it is important to provide national policymakers with information concerning California's managed care industry and the Department of Corporations' experience as the managed care regulator in California for the past 18 years. I would also respectfully suggest that national health care reform provide states with appropriate flexibility to accommodate those states with strong managed care experience and effective, consumer-oriented regulation, build on these states' successes and consider their regulatory programs as models when designing any national system of regulation.

California has the largest and perhaps the most sophisticated managed health care industry in America. Currently, approximately 16,000,000 Californians (or more than 50% of the State's population) receive their health care from the 38 full-service health care service plans (more commonly referred to as HMOs) operating within the State and regulated by the Department of Corporations. Despite the scope of the Department's responsibilities in this area, the Department's Health Care Service Plan Division currently operates with a budget of less than $5 million and a staff of fewer than 80 people.

CALIFORNIA'S HISTORICAL EXPERIENCE

In the 1960's, major problems in managed care arose when a number of new prepaid health plans were established to provide care to Medi-Cal beneficiaries. In an effort to avoid plan insolvencies and the questionable business practices which could result from inexperienced management operating in an unregulated managed care environment, the California legislature passed the Knox-Mills Health Plan Act in 1965. This Act provided essentially a laissez faire regulatory scheme that proved to be ineffective, and major scandals, including blatant marketing fraud, the unavailability of promised health care services and facilities, and fiscal mismanagement, ensued.

The Waxman-Duffy Act, enacted in 1972, provided greater regulatory authority over plans contracting to provide prepaid Medi-Cal services. Unfortunately, this Act also proved to be inadequate to stem the tide of fraud, abuse, and broken promises from the "bad actor" companies.

This history illustrates the potential problems that the national debate should consider as policymakers seek to assure the public that managed care is a cost-effective, appropriate means to provide quality health care. California's regulatory framework has successfully met this challenge and may provide guidance to the rest of America.

THE DEPARTMENT'S EARLY MANAGED CARE REGULATION

To address these problems and create an environment to foster the responsible growth of managed care, in 1975 the California legislature enacted the Knox-Keene Health Care Service Plan Act ("Knox-Keene Act"), a comprehensive regulatory scheme to promote the delivery of health care to the people of California. The Department promptly and vigorously enforced the Knox-Keene Act to remove the "bad actors" from this industry and to address the major problems of managed care that prompted adoption of the Knox-Keene Act. This effort was successful, and most people have only a dim recollection, if any, of the serious problems which the Knox-Keene Act effectively addressed. Unfortunately, this has not necessarily been the experience in other states. For example, the recent Nunn Committee hearings identified health carriers in other states that had mismanaged funds intended to pay for health care coverage by diverting these funds to questionable investments and activities in the interest of plan management rather than plan enrollees.

THE GROWTH OF MANAGED CARE IN CALIFORNIA

During the past 18 years of steady, predictable regulation by the Department of Corporations, the managed care industry has developed from a fledgling movement to a sophisticated, well-financed industry with a solid overall record of achievement. As I noted before, approximately 16,000,000 people, or more than 50% of California's total population of 31,552,000, receive their health care through a full-service health care service plan regulated by the Department of Corporations.[1] By way of contrast, no more than 4,000,000

---

[1] Although this letter focuses on full-service plans, you should also know that the Department currently regulates 34 dental plans, 8 vision plans, 16 mental health plans and one pharmacy plan. Approximately 23,000,000 Californians are enrolled in these specialty plans.

Californians receive their health care benefits from insurance companies regulated by the Department of Insurance.

This disparity has not been driven by any government mandate. Rather, it is a market-driven, private sector recognition of which system of providing health benefits best delivers the quality, cost-effective care that payors and patients are seeking. Managed care has simply done a better job containing premium cost increases, decreasing hospital admissions and costs and providing more benefits to consumers than nonmanaged care within the State.

KEY FEATURES OF THE DEPARTMENT'S MANAGED CARE REGULATORY PROGRAM

Financial Stability. The Department has established financial reserve requirements (referred to as "tangible net equity") that have successfully ensured the financial viability of health plans in California. While other states have set up guaranty associations, California has resisted this as a costly approach that forces strong plans to underwrite less capable plans. The Department reviews regular financial reports to ensure the plans' ongoing financial viability, conducts periodic financial audits and has the authority to place plans with certain indices of potential trouble on a close watch. The Department can put a plan into receivership or take other enforcement action if the well-being of the enrollees is imperiled.

Plans are required to provide the Department with a complete description of the methods of payment to providers. The Department scrutinizes the plan's various insurance policies and other provisions for extraordinary losses. A plan's administrative costs are capped to prevent unreasonable amounts of enrollee premium from being diverted from the actual provision of health care. If the plan wishes to go into another line of business separate from its health care business, it must seek approval from the Department. Again, this safeguard is designed to prevent health plan premiums from being diverted and the financial strength of the plan from being compromised.

Benefits. The Knox-Keene Act explicitly mandates the scope of services that must be provided or offered to enrollees. Full-service plans are obligated to provide all medically necessary care, including: (a) physician services, including consultation and referral services; (b) hospital inpatient services and ambulatory care services; (c) diagnostic laboratory and diagnostic and therapeutic radiologic services; (d) home health services; (e) preventive health services; and (f) emergency health care services, including ambulance services and out-of-area coverage. In addition, plans can negotiate with employers and individuals to expand this basic package according to their resources and needs.

Quality Assurance. The Knox-Keene Act regulations promulgated by the Department implement the Act's strong emphasis on assuring the quality of care provided to enrollees. These regulations have been enhanced over the years in the direction of stronger requirements, through a collaborative process including input from the health plans themselves.

The institutionalization of quality assurance distinguishes health plans in California from the more traditional means of monitoring the quality of care, which for all practical purposes relies upon state professional licensing boards for policing quality. These licensing boards handle individual professional complaints and enforcement cases which come to their attention, but they do not have the authority to insist upon systematic procedures to assure the delivery of quality care. Quality assurance systems are among the most important features of managed health care, and the historical record in California illustrates their efficacy.

Integrity of Medical Decision-Making. The Department goes to considerable lengths to ensure that medical decisions are not inappropriately influenced by administrative or fiscal considerations. While California HMOs have proven to be cost-effective compared to alternative models of health care delivery, it is critical that these savings be realized without compromising the quality of care. The structures of plans are scrutinized to ensure this protection, and the quality of care that HMO network providers furnish is far more carefully analyzed and assessed than that of traditional fee-for-service providers.

Enrollee Grievance Systems and Disclosures. Every plan is required to have a detailed procedure that allows enrollees to effectively register complaints or grievances against the plan. These procedures include appeals processes that provide for the Department of Corporations to be the final arbiter. There are detailed requirements governing the content of informational materials that must be given to plan enrollees. The text of these documents is carefully reviewed by the Department and changes necessary for full and fair disclosure are regularly insisted upon. Advertising by plans in California is subject to review by the Department, with a heavy emphasis on clear and full disclosure and the absence of deception.

Provider Networks; Contracts and Controlling Corporate Documents. A managed health care plan is frequently woven together by a vast web of contractual relationships. The Department scrutinizes in detail the adequacy of a plan's provider networks, including referral patterns and procedures, to assure the accessibility of these providers to the places of work or residence of the enrollees of the plan. All plan contracts are subject to prior approval by the Department, whether provider contracts, subscriber contracts, contracts for administrative services or solicitor contracts. All are carefully reviewed by the Department to ensure that they are reasonable and satisfy regulatory requirements.

Staffing and Enforcement. The Department relies on a broad spectrum of professional disciplines to carry out its managed care regulatory responsibilities, including medical and other healing arts professionals, financial examiners, attorneys, investigators, health analysts and consumer service representatives. The Department also has a broad range of disciplinary and enforcement powers to exact compliance with the requirements of the Knox-Keene Act. For example, the Department can issue orders prohibiting marketing of a plan's services and can seek civil penalties, and, where appropriate, plan license revocation.

NEW REGULATORY INITIATIVES

As you know, the health care industry is one of the most dynamic in America. The Department has a series of initiatives to respond to ongoing developments in the managed care industry and to keep abreast of market forces.

I have enclosed a copy of an article written by Alain Enthoven (the founder of the Jackson Hole Group) that appeared in the January 17, 1994 edition of The Los Angeles Times. As that article indicates, it is possible to improve the quality of the health care that patients receive and lower the costs of that care through, among other things, integrated delivery networks and the development of better information systems that identify those organizations or entities that provide quality health care.

The Department has formed two task forces to deal specifically with these issues. In September, the Department convened the first meeting of a task force it formed to review the Department's regulatory policies with respect to risk sharing arrangements. Increasingly, medical groups and hospitals are seeking to develop integrated delivery networks to assume greater financial risk for health care services and more effectively manage patient care. This task force has been asked to help the Department develop appropriate operational and financial safeguards to make certain that the public remains protected if the Department's policies in this regard are revised.

Building upon our historical emphasis on the importance of quality care, the Department has convened another task force to help the Department develop performance benchmarks that would increase the ability of the Department, and purchasers of health care, to determine if enrollees are receiving appropriate, quality care. This initiative began in January 1994.

CONCLUSION

As you can see, California has a great deal of experience and success with managed care, and the Department of Corporations has more regulatory experience in this area than perhaps any other state regulatory body in the United States. With this strong record, I believe the

Department can provide important insights during the critical debate on national health care reform, and we would welcome the opportunity to share our experiences with the nation as a whole.

Very truly yours,

GARY S. MENDOZA
Commissioner of Corporations

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Commentary

PERSPECTIVE ON HEALTH CARE

Raise Quality by Lowering Costs

Incentive for providers now is to use the most costly treatment. There's no reward just keeping people healthy.

By ALAIN C. ENTHOVEN and SARA J. SINGER

To improve quality in health care, cut costs. Sounds counterintuitive, but in health care, as in most businesses, quality and economy go hand in hand. One of the biggest misconceptions in the health-reform debate is that if you cut the cost, quality will suffer.

Right now, providers—hospitals, doctors and other practitioners—work in a system in which everyone is rewarded for providing more, not necessarily better, care. This traditional fee-for-service, remote third-party-payer model pays per procedure, regardless of the outcome. In a world such as this, providers, no matter how ethical, have an unavoidable incentive to provide the most costly treatment.

Wide variations in practice patterns among physicians suggest that more procedures are not necessarily related to better outcomes. A medical director of an East Coast health-maintenance organization studied practice patterns and observed a fivefold to tenfold difference in the costliness of practice patterns of different doctors, usually with no evidence of difference in outcomes.

Also, the traditional system does not hospitals purchase expensive equipment even if they cannot fully utilize it, and beds go unfilled while hospitals continue to build capacity. There is no incentive to keep individuals healthy because there is no reimbursement for it. Providers are paid less for pursuing a less invasive, but equally effective, non-surgical treatment.

In the current system, there is no match between resources and needs. This country has trained too many specialists and too few primary-care physicians. A surfeit of specialists is bad for your health and bad for your pocketbook. If there were fewer, we could pay them well and give them full schedules. They could care for the same population at less cost. Because they would be proficient, their work would be of high quality. Because they would be busy, there would be less unnecessary surgery.

To make matters worse, there is no accountability for cost or quality because providers are not paid on the basis of either. Problems in health-care delivery, such as lack of immunizations and other preventive measures, are viewed as isolated issues. They are not. They reflect a systemic problem: No one is accountable for getting the job done.

Even physicians have come to dislike the traditional fee-for-service model because it sets them up in an adversarial relationship with payers. Physicians routinely must respond to calls from lesser-qualified insurance company representatives who question their choice of treatments.

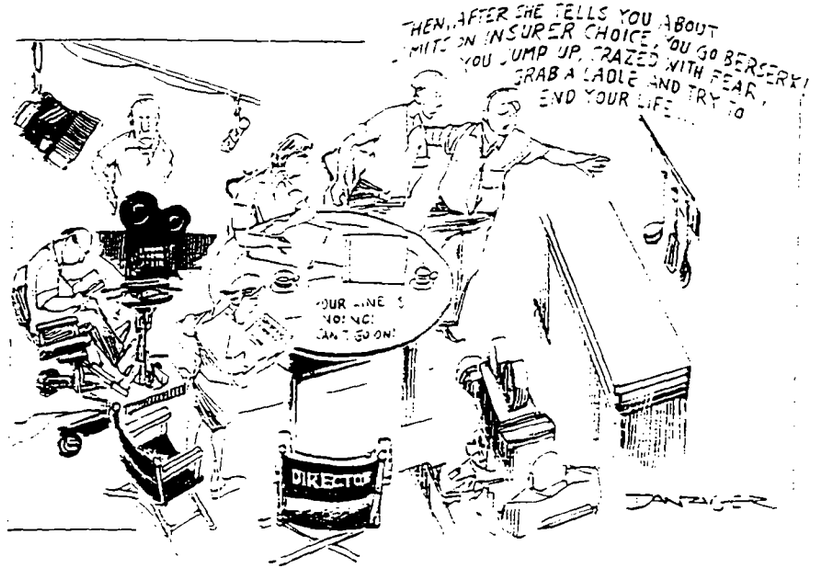
Better care at less cost is possible through integrated financing (that is, insurance) and delivery systems (hospitals and physicians). Under the new rules of the game, all would benefit by keeping individuals under their care healthy, or, once sick, by making them well in the most efficient way possible. Such a system would give providers responsibility for individuals' comprehensive care for a fixed periodic payment set in for the cost of care and, therefore, for the "cost of poor quality," and hold providers accountable for quality outcomes.

With this new set of incentives, accountable health plans would seek to attract committed and responsible physicians. Finding, training and retaining the most qualified group possible in the right quantities and specialty mix for the population served would be key to financial success. Accountable health plans would give doctors incentives to provide high-quality, low-cost care and the tools they need to do so.

Information systems could be used to identify and adopt cost-effective care. Quality management and improvement techniques would be employed routinely. Providers would study variations in practice patterns to determine and adopt what makes sense. They would be held accountable for quality outcomes because the remuneration of the entire group would be at stake. Technological redundancy would be eliminated.

Costly specialized procedures would be concentrated in efficient regional centers where physicians are busy enough to maintain proficiency and achieve administrative economies of scale. There is a well-documented correlation among high volumes, low mortality and low cost. The Pennsylvania open-heart surgery study, for example, studied 35 hospitals doing coronary artery bypass graft operations. The procedure at the hospital with the best risk-adjusted mortality rate cost $21,000; at the worst it was $84,000, and on average was $44,000. If every hospital performed at the level of the most proficient hospital, Pennsylvania alone could save $350 million in one year for this one procedure. A similar result could be true for other states.

We do not mean to suggest that any means of cutting costs is acceptable. Arbitrary cuts put quality at risk. The Clinton Administration's proposal for health-care reform sets unrealistic limits on health-plan premium increases, given the aggressive scheme and time frame for other reforms they propose.



JEFF DANZIGER, Christian Science Monitor

Filming those anti-health-care commercials.

Price controls would limit premium increases to the consumer price index plus 1.5% in 1996, phased down to the index plus zero in 1999. Such targets and better could be met a few years later by a thoroughly reformed competitive system with the strongest possible market incentives, without price controls.

There is a great deal of waste in the health-care system and big opportunities for cutting cost without cutting the quality of care. To realize potential savings, the industry needs time to reorganize, restructure, retrain and install programs of continuous quality and productivity improvement. This cannot happen overnight.

If the Clinton plan succeeded in meeting its cost-containment goals, likely consequences would be arbitrary cutbacks in service and care, then queues and rationing in the form of spending reductions not thought through for lack of time and incentives, especially in the short run. Quality of care would suffer.

In addition, expenditure limitations should not be confused with cost reduction. While a country can limit the cost of treatment, as Britain and Canada have done, by shifting the cost of illness back onto patients in the form of treatments delayed or denied, the only way to reduce the total social cost of illness and its treatment is to improve the efficiency and effectiveness of care delivery. What is best for society is to minimize the cost of illness and treatment.

In general, the rationale that high-quality health care must be expensive is flawed. In fact, often the opposite is true. Mistakes cost lives and dollars. Providers must be given tools and held accountable for doing it right the first time. We believe that this can only be achieved through market forces and accountable health plans.

Alain C. Enthoven is a professor of management at Stanford University's Graduate School of Business and a member of the Jackson Hole Group, an organization of health-care executives and policy analysts. Sara J. Singer is his special assistant.