

THE WHITE HOUSE

WASHINGTON

January 26, 1993

MEMORANDUM FOR THE FIRST LADY AND CHAIRPERSON, HEALTH  
CARE TASK FORCE

THE SECRETARY OF DEFENSE  
THE SECRETARY OF THE TREASURY  
THE SECRETARY OF COMMERCE  
THE SECRETARY OF LABOR  
THE SECRETARY FOR HEALTH AND HUMAN SERVICES  
THE SECRETARY OF VETERANS AFFAIRS  
DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET  
THE CHIEF OF STAFF  
ASSISTANT TO THE PRESIDENT AND CHIEF OF STAFF  
FOR THE FIRST LADY  
ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY  
ASSISTANT TO THE PRESIDENT FOR ECONOMIC POLICY  
ASSISTANT TO THE PRESIDENT AND DIRECTOR OF  
COMMUNICATIONS  
ASSISTANT TO THE PRESIDENT AND DIRECTOR FOR  
LEGISLATIVE AFFAIRS  
ASSISTANT TO THE PRESIDENT AND DIRECTOR OF  
PUBLIC LIAISON  
ASSISTANT TO THE PRESIDENT AND DIRECTOR FOR  
INTERGOVERNMENTAL AFFAIRS

FROM: IRA MAGAZINER *IRM*  
Senior Adviser for Policy Development

SUBJECT: Health Care Task Force

Attached is a draft work plan for the Health Care Task Force. Please review it and send your comments with your Task Force designee. The first meeting of the Task Force Working Group will be held on Wednesday, January 27, at 2:00 p.m. in Room 213 of the Old Executive Office Building.

Please designate someone as your official representative to this working group and ask them to attend the meeting. Your designee should be prepared to spend a significant portion of their time on this effort over the next 100 days.

Please also review the staffing chart (exhibit 3) of the draft work plan and identify people from within your department who can be assigned full-time to the Task Force for the next 100 days (longer for the outreach and coordination teams and for policy team leaders). We must fully staff up by early next week if we are to meet our schedule.

I know that you are all very busy and that some of you are still learning your departments. However, our schedule is very tight, as the President has committed publicly to the 100-day deadline for submitting comprehensive health care legislation.

We will phone you Tuesday afternoon or Wednesday morning to ask for the name of your designee.

We need your help to fulfill this commitment.

Attachment

**PRELIMINARY WORK PLAN FOR THE INTERAGENCY  
HEALTH CARE TASKFORCE**

**PRELIMINARY WORK PLAN FOR THE INTERAGENCY**

**HEALTH CARE TASKFORCE**

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## BACKGROUND

The United States is in the midst of a health care crisis.

Health care costs are high and growing rapidly (14 percent of GDP in 1992, expected to reach at least 18 percent by 2000). Rising health care costs are placing a tremendous burden on individuals, businesses, and governments and are erasing gains in living standards.

Rising costs are also causing firms to drop or cut health care benefits and preventing people with pre-existing conditions or serious medical needs from getting insurance. At least 35 million people do not have insurance; many others have inadequate coverage; still others are at risk of losing coverage.

To meet the objectives of controlling costs and ensuring universal access, we must move immediately to restructure the nation's health care system.

### The Campaign Health Care Plan

The health care plan outlined by President Clinton during his campaign contained the following principles for providing universal access to affordable, high quality health care for all Americans.

- A National Health Board would set a standard comprehensive benefits package for all Americans.
- All employers would be required to pay a percentage (perhaps 75-80 percent) of the cost of a standard plan for their employees and dependents. Hence most people would continue to have largely employer-financed coverage. The federal government would assist small companies in the early years so that this requirement would not cause undue hardship.
- State-based Health Insurance Purchasing Cooperatives (HIPCs) would manage competition among private health care plans on behalf of at least small businesses and individuals who lack negotiating clout. Businesses not included in HIPCs would negotiate with providers to offer the basic package directly to their employees, much as they do today.
- Specifically, these HIPCs would negotiate premiums, distribute information and marketing materials to consumers, and risk-adjust premiums to prevent adverse selection. Consumers would choose among these plans during an open enrollment period.
- The unemployed and other non-workers would be entitled to buy a plan on a subsidized basis through the HIPCs.

By building on our existing employer-based system, this scheme would minimize the disruption and public cost associated with expanded access. It favors consumer choice and private provider competition in allocating health services.

The plan (often described as managed competition with global budgets), would provide a new market structure within which competition could work to ensure efficient care delivery and control costs.

- Insurance reforms (standard benefits, no medical underwriting, community rates) would provide individuals freer choice of plans. HIPCs and large companies would drive tough bargains with insurers eager to sign up the consumers they represent.
- The reforms would stimulate competition on price and quality among insurers; prevent risk selection and encourage insurers to promote efficiency.
- Consumers would be given incentives to choose efficient plans. This could be done through mechanisms such as: requiring consumers buying more expensive plans to pay for added costs above a "benchmark" premium, rather than employers; or taxing these added payments if made by companies for employees.
- Insurers would be held responsible for controlling costs. They would likely replace uncontrolled fee-for-service systems with new payment mechanisms (e.g., capitated payments, salaried doctors). These systems would likely hold providers accountable for managing the volume and quality of care.

While this competition and consumer incentives would likely slow the growth of health costs, global budgets, enforced by the National Health Board, would guarantee results.

- Per capita state budgets would put a limit on HIPC spending, limiting premiums if competitive bidding falls short. The budgets also would limit premium costs outside HIPCs. The budgets would be set to bring health care inflation in line with overall economic growth over time.
- States where competition among plans is not possible or desired may regulate provider fees in order to meet the budget.

### Likely Criticisms

Any comprehensive health reform plan will be controversial. Some criticisms would apply to any plan; others are specific to the type of managed competition with global budgets proposed by President Clinton. Criticisms are likely to center on the following arguments:

1. Cost containment would be ineffective and have perverse results.
  - Little evidence exists that managed care networks will produce efficiencies and thus deliver the cost containment we require; the result will be reliance on existing perverse behaviors (e.g., risk selection, claims denials) to meet global ceilings.

- Limiting spending on health care through global budgets will lead to service rationing, and interfere with quality improvements and consumers' traditional freedom to spend.
2. Universal coverage would involve redistribution of income and disrupt satisfactory arrangements for many Americans. The result would be to increase rather than reduce many Americans' costs of care.
- Community rating of insurance premiums would raise costs for currently insured populations who are young, male and healthy.
  - "Recapture" or other taxes needed to apply private savings toward access would tax healthy currently insured people.
  - Taxation of benefits above the nationally mandated package would put a burden on some working middle class families.
  - Requirements to purchase coverage would lower disposable incomes for individuals who have gone without health insurance.
3. The plan would be cumbersome:
- Consumers would have to deal with new and unfamiliar agencies ("purchasing cooperatives") and choose from among plans they feel ill-equipped to evaluate.
  - Unanticipated barriers to service would be erected when people are sick.
  - Unanticipated financial obligations would be imposed on people who wanted to use providers not included in their plan.
4. Many small businesses may fiercely resist the proposal.
- Even with subsidies for low-wage or newly insuring employers, our plan would impose premium requirements that small business groups and other critics will challenge as:
    - A "payroll tax".
    - A threat to current jobs.
    - A threat to small business development and job creation.

In designing our reforms, we must take cognizance of these potential criticisms. We need to allow states flexibility to use alternative models that may make sense for them.

In developing the reform strategy, we will work closely with Congress and the health care community to ensure that we are effectively addressing their policy and political concerns.

**This work plan is preliminary. It will be revised many times as we progress.**

## WORK MODULES

The goal of the interagency taskforce is to prepare comprehensive health care reform legislation in the next 100 days. This will require detailed policy work and a significant outreach effort. This preliminary work plan dimensions the work to be done.

### POLICY ANALYSIS

There are at least seven areas of analysis necessary to form the comprehensive health care reform package.

1. Defining the structure for the new American health care system proposed in the campaign -- Managed Competition Within a Budget.
2. Planning the phase-in of guaranteed universal health insurance under the new system.
3. Defining options by which health care cost increases can be controlled during the next few years as the new system phases in.
4. Developing ways for the federal government to finance the new system, capturing private health care savings to cover universal access and possibly contribute to deficit reduction.
5. Devising programs to make short-term improvements in preventive care and in care for underserved populations.
6. Defining programs for improving long-term care.
7. Analyzing the economic impact of current health care policy versus our proposed policies.

#### 1. Managed Competition Within a Budget

The model that President-elect Clinton has proposed for health care in the United States does not exist anywhere in practice. The campaign proposal, while sensible conceptually, needs significant definition. Some of the key questions which must be answered are:

- What constitutes a reasonable guaranteed benefits package? If the chosen package is too thin, a multi-tier health care system will develop based on income; if it is too comprehensive, cost increases may be difficult to control.

- How should budgets and the associated premium caps be set? Who should set them? How should they differ by state? Should there be different capitations based on the health status of individuals and how should they be determined? Should there be a reinsurance system and how should it work? How should rates of increase be determined from year to year?
- How should a state global budget be set and enforced? How can the plan discourage the evolution of an elite system which "busts the budget?" How should taxation for benefits above the guaranteed package be implemented?
- How will the state purchasing cooperatives work? Will certain companies be required to participate? Will Medicaid be folded in? Will individual choice of insurance plans be preserved through the HIPC?
- How will states monitor the solvency and reliability of insurers and enforce community rating? How will states guarantee competition while preventing "fly-by-night" insurers from adversely affecting consumers? How will states be sure that insurers are not finding new ways to compete through underwriting?
- How will quality of care be measured and improved? How will quality be ensured without burdensome micromanagement of health care processes? How can the system move towards meaningful outcome measurements? How can "best practice" information be collected and disseminated efficiently? How can we be sure that cost control does not lead to lower quality care?
- How will administrative savings be realized? How do we create universal quality and reimbursement forms? How do we create an efficient patient information system? How do we reconcile the desire of different health care insurers to control costs and utilization in their own way with the need for simplification of provider paperwork?
- How will the malpractice system work? What review mechanisms will be built into health networks themselves? Under what circumstances will lawsuits be tolerated? Will there be caps on awards? How will malpractice insurance be sold?
- What restrictions, if any, will be placed on the type of relationship which can exist between insurer and provider? Will providers be free to affiliate with multiple insurers? Will hospitals be permitted to deny use rights to physicians not participating in affiliated plans of that hospital?
- How will drug price increases be controlled? Will this be done nationally? How can we ensure that innovation is not stifled?
- Will states be permitted to fold their workers compensation health care systems into the new health care system? How would this work?

- How will the employer mandates be enforced? Will companies be required to cover part-time employees? What will happen to current retiree commitments? How will seasonal employees or employees on layoff be handled? Will individual insurance memberships be portable?
- To what extent will insurers be permitted to offer packages which differ from the nationally guaranteed package? If they can, how can complexity and its extra costs be avoided?
- How will the national and state boards be constituted? How can we assure that they will be representative bodies? How will their activities be limited by law? Do we envision the boards or legislatures or some other mechanisms as agents of system change?
- How much flexibility will states be given to operate systems other than managed competition as long as they stay within the global budget? Will a small state be allowed to operate a Canadian-style single payer model system if it chooses?
- Can doctors, hospitals and nursing homes opt out of the system entirely and work on a fee-for-service or own insurance basis and be free of spending caps? If so, then might we be creating an elite system for those who can afford to pay more? If not, then are we denying people basic freedoms?
- How will we ensure an adequate supply of primary care professionals for the new system?
- What will be the underlying ethical guidelines for the system? Will rationing be explicitly condoned or prohibited for certain tests and procedures? Will living wills or other similar mechanisms be required or encouraged? Will ethical review panels be required for provider or insurer groups, etc.
- How should the DOD and VA systems be integrated with the new national health care system?

These are only a small number of the key questions which will need answering about the new system we will be creating. The transition team has done a good job of exploring answers to some of these and other related questions, but a tremendous amount of work is yet to be done.

The issues raised by these question can be addressed by the following work modules:

- The Benefits Package
- Budgets and Caps and How they will function
- Insurance Reforms, Organization of the HIPC and state oversight of Health Networks
- Health Care Quality Assurance
- Administrative savings, Reimbursement Systems, and Patient Information Systems
- Malpractice Reform

- Drug Price Controls
- Organization of Employer Mandates and Subsidies to Employers
- Organization and Mandate for the National Board
- Ethical Guidelines for the System
- Integration of VA and DOD Health Care
- Health Care Workforce Development

## 2. Controlling System Cost Increases in the Short Run

Comprehensive reform of the health care system will require time to implement. However, the current upward trajectory for health care costs suggest that actions must be taken more quickly to control costs in order not to imperil economic progress.

There are no easy options. We must explore the options which do exist and draw up proposals to control the costs of health care while a new system is being instituted. The President may or may not choose to adopt such measures, but if he does, they should be part of the comprehensive bill.

Relatively little work has been done by the transition team on this topic. Some options which should be explored are:

- Various means to institute cost controls.
- Ways to extend Medicare rate regulation to private insurance systems or to institute some other form of all payer rate regulation.
- Ways to accelerate the move to managed competition within a budget.
- Ways to introduce global budgets or caps soon even if managed competition takes more time to phase-in.
- Ways to elicit voluntary controls from the health care industry.
- Ways to provide incentives for states and private entities to manage care more efficiently.
- Ways to use tax incentives or penalties to influence utilization and price of health care services.
- Other means not yet identified to control costs.

Any policy option we choose would likely be temporary, and so phase-in and phase-out mechanisms must be created for each option.

Each of these options is complex and will lead inevitably to a series of unintended consequences. Our analysis must explore detailed options for implementation to identify risks and to design "fall back" mechanisms as appropriate.

In addition to economic and cost analyses, we should conduct extensive legal and political analysis of each of these options since most will require regulatory legislation and congressional approval against fierce lobbying.

### 3. Phasing-in Universal Coverage

The transition team and most Democratic policy analysts associated with the campaign have done much work in this area. As a result, there is a comprehensive body of analysis upon which to build this part of our work.

Embedded in all of this work, however, are a series of assumptions which represent policy choices. Most access proposals include assumptions on increasing Medicaid reimbursement schedules, extending subsidies to people between 100 percent and 200 percent of the poverty level, subsidizing small companies as they begin covering their employees, etc. These must be decoded and separated into discrete pieces for proper decision making.

Access proposals also include crucial assumptions on cost and utilization of care by those now uninsured and underinsured and about how the insurance market will change as access is phased-in. These assumptions must be examined so that a range of possible cost outcomes can be projected and risk properly evaluated.

Cost savings realized from universal access should be calculated and weighed against the extra costs associated with greater utilization. These calculations can only be made in ranges, but we must understand the boundaries of potential impacts.

Finally, we should create a model which will allow us to analyze alternatives for phasing-in universal coverage with implications for population served, cost to the system, budget impacts for states and the federal government, demographics, demand for providers in under-served neighborhoods, etc.

Depending on definitions and program structure, universal access could mean \$30 billion or \$90 billion of additional annual expenditure by the government by 1997. Despite a good start, we have a great deal more work to do to choose our program design and schedule.

### 4. Federal Financing

As we design both the short- and long-term programs, we should develop options for recapturing some private sector savings for funding universal access and possibly for deficit reduction.

Most system savings under almost any set of policy options will be generated in the private sector. We must decide what level of recapture we want to affect. Then we must choose among a number of options on how to do it. Some possibilities are:

- Allowing insurance premiums to go up somewhat faster than intended and taxing the premiums.

- Raising a corporate tax to capture part of the savings corporations will realize from slower premium growth.
- Taxing benefit plans offering coverage above a certain level.
- Reducing uncompensated care payments.
- Instituting higher taxes on alcoholic beverages, tobacco products, pollutants, guns or other products which contribute to health problems.
- Creating a tax on non-critical service usage.
- About 20 other alternatives.

These recapture mechanisms are crucial to realizing positive effects from health care reform for the federal budget. They will be complex to design economically as they must be efficient and equitable.

They also will be hard to design politically. We will need to create program designs which link private sector savings to the capture mechanisms and which link the capture mechanisms to funding of universal care. Methods of linkage will be part of the formulation of each option.

Finally, we will need CBO scoreable revenue estimates for each of the options we develop.

##### 5. Short-term Improvements

There are many relatively inexpensive extensions of care which we can recommend to be implemented immediately. These will be both good health policy and will also assist us in designing a package with broad appeal.

Some possibilities include:

- Immunization programs.
- Enhanced funding for community health centers in disadvantaged communities.
- An AIDS program.
- More funds for women's health research.
- Increased assistance to pregnant women and young children now receiving inadequate care.
- Preventative health programs.

- A dozen others from campaign documents and reports of "think tanks."

We should create a detailed analysis of each measure which would include:

- Demonstration of need for the program.
- Population to be served.
- Precedent for the program, if any, in states, cities or other countries.
- Implementation mechanisms which maximize total program dollars spent for consumer benefit, not for administration.
- Total costs under a variety of program options.
- Likely supporters and opponents of the program.
- Those who will benefit and those who will be penalized by the program.
- Former legislative proposals which resemble the proposal.

We should follow a common format so that we can weigh the advisability and impact of each of these programs against one another, should we not be able to propose them all.

## 6. Long-term Care

While fully funding long-term care would be costly, a comprehensive health reform package without some provisions for addressing long-term care problems may be flawed economically, socially and politically.

We should research and present a series of long-term care options, some of which address full phase-in of long-term care insurance and others of which provide shorter-term, less expensive means of addressing problems now experienced by the frail elderly and disabled.

Some include:

- Establishment of a contributory insurance scheme for people to pre-fund long-term care. This could include tax incentives and/or mandates for individuals to contribute or raises in social security taxes or cuts in COLAs with diverted funds used entirely for long-term care, or a variety of other options.
- Increased access to home care as an alternative to nursing home and hospital care including waivers to allow funding for homemaker services.
- Increased funding for community senior centers to enhance their ability to provide health, transportation and food services for neighborhood elderly.

- Increased drug coverage under Medicare.
- The AARP, Gray Panthers and The Roosevelt Group have a number of other proposals on the table for enhancing long-term care. We should analyze them and prepare to include some in our deliberations, should the President choose to do so.

## 7. Economic Impact

Since any major health reform is almost by definition also a major economic program, we should analyze the economic effects of current policy as well as the effects of our recommended policies.

This analysis should include:

- A definition of the current impact of the health sector on the economy and anticipated impacts if current trends continue.
- An analysis regarding the transition issues as we move from the current situation to the one contemplated by the reforms. In particular, we should consider such issues as the nature and impact of efforts to reduce the rate of growth of health costs; and the form and significance of efforts to transfer cost savings. In general public policy has not considered transitional issues and effects with sufficient care. With a program this big, we should try.
- A definition of all the distributional tradeoffs that will occur so that we can answer "who is better off and worse off" questions that normally accompany budget or tax changes.
- A description of the economy that will result as a consequence of the reforms.

This analysis should include the effects of growing health care costs on GDP growth, personal income growth, wages, the cost levels of U.S. companies, corporate profits, etc. This analysis will also be useful for the public campaign the President might have to lead if one of the more active cost control options is followed.

Finally, as President Clinton asked, the analysis should include a comparative presentation of why U.S. costs are so much higher than costs of our major competitor nations. This will be useful both for our background planning and for the public campaign.

## OUTREACH

In addition to policy work, the taskforce should plan serious outreach activities. The policy work cannot be done in a vacuum.

### Constituency Liaison

A significant outreach effort will be required to secure views from the enormous number of groups interested in health care.

At last count, there are at least 150 interest groups who have weighed in each time health care reform has been discussed, not including individual companies or state or local lobbyists who visit Washington. There are also many health care policy experts and ordinary Americans who will wish to be heard.

We should develop a capability to receive these inputs on a systematic basis. Many may be useful. These people will also help us as sounding boards for ideas and they will help give us information on the political "lay of the land."

This activity should be conducted systematically with regularly organized sessions, formal mechanisms for the submission and review of memos and papers, organized assessments of who are potential supporters, etc. Since time is short, this activity must begin quickly.

We must also reach out to citizens' groups around the country to be sure that not only the most powerful and loudest lobbyists have impact on our process.

### Congressional and Intergovernmental Liaison

We should involve key representatives from relevant congressional committees, and from the governors and mayors as soon as possible in our process. Interaction with these groups should also be systematic and frequent so that we don't proceed too far down paths which are "non-starters" for them. This will also help us build support for the eventual program.

### Communications Effort

Reforming the health care system will involve government-led changes on a scale not attempted since Social Security. People are calling for massive change, yet their support for individual plans is very weak. We should convene focus groups to conduct research conducted to test the political appeal of options under discussion. We should establish a communications effort to begin the process of educating the public about the nature of the problem and the kinds of change required. The public campaign for health reform could involve a health care summit, First Lady visits and satellite tours across the country, a well-produced half hour infomercial, and other strategies. Once the President decides on the proposal, the communications group would proceed with the marketing of the plan.

### Taskforce Coordination

The taskforce must accomplish a complex task in a short period of time. Efficient coordination will be essential.

## Coordinated Analysis of Fiscal, Health and Economic Impacts

Currently the federal government has numerous, overlapping data collection and analysis groups who will weigh in on health reform. HHS has two different groups who can do analysis of costs and savings, business and economic impacts, and health care effects -- one in HCFA's Office of the Actuary and another in the Agency for Health Care Policy Research. In addition, Treasury, Labor, Commerce and OMB can -- and will -- analyze some aspects of health reform. Finally, Congressional Budget Office and Congressional Research Service have their own analytic capacities.

In order to avoid having conflicting and competing assessments of different reform ideas, the transition team had already begun the process of coordinating these different analytic capacities. The analytic operations also need to be coordinated so that individual issue area task groups can produce analyses with common assumptions and methods.

### Legal and Drafting Group

Because this will be a complex bill or set of bills, we will need a legal group who can explore questions of regulatory authority, jurisdiction, interaction with existing bodies of law, potential legal challenges to provisions, etc. We don't want to find legal problems with our proposals too far down the line.

Both our potential short-term cost controls and our long-term reform of the system are likely to make some people very angry. We must be sure that our proposals are not preempted or overturned due to legal problems.

We should create a legal team to monitor all policy development.

We must have a legislative drafting team which begins work early in order to capture accurately and comprehensively, the full intent of the policy proposals. We must have sufficient time to avoid sloppy drafting. Although some drafting flaws can be worked out in Congress, the administration could lose control of the process if drafting is not done thoroughly before the bill is submitted.

### Audit Group

We should have an audit team which checks all numbers used in our analysis. The function of this team is to challenge numbers to be sure that they are accurate. They also should make clear all assumptions so that decision makers understand the risks inherent in the numbers upon which policies are formed.

### The Contrarians

Midway through the process, we should create a group of outsiders to the process including health care consumers, providers and policy experts to serve as "devils advocates" to our proposals. They should be asked to cast a critical eye on our work so that we can

improve it or at the very least, understand better our plan's weaknesses.

### Task Force Coordination

Since this is a major undertaking, we will need to plan for the coordination of the taskforce itself. The taskforce will involve representatives from the Domestic Policy staff, the First Lady's staff, HHS, OMB, Treasury, Commerce, Labor, Veterans Affairs, DOD, The National Economic Council, White House Congressional Affairs, White House Communications, White House Public Affairs, White House Intergovernmental Relations and possibly other groups.

A number of work teams must operate in parallel. Coordination will be essential.

## ORGANIZATION OF THE TASKFORCE AND SCHEDULE

While tasks and groupings will change as we proceed, I suggest initially organizing the taskforce into nine clusters and 30 task groups within those clusters. (Exhibit 1) Each cluster should have a coordinator as should each task group. Schedules, work plans, presentation dates, and monitoring formats should be set up for each group.

A small core group of cluster leaders, departmental representatives and some key outside reviewers should form the strategy group which pulls together the work of the cluster task groups and which prepares successive drafts of the ultimate report and legislation.

The schedule (Exhibit 2) is organized according to a "toll gate" model. "Toll gate" organization models are used in corporations for complex planning or product development projects which must be accomplished at an accelerated pace. "Toll gates" are a series of reviews, each of which has specific defined criteria which must be met by a work group.

The seven successive reviews serve as interim deadlines for each cluster group. The group must pass each of these reviews in order to proceed with its activities. In this way, problems can be identified and dealt with in an iterative fashion.

The first two "toll gates" involve charter definition and broadening of scope to be sure all important ideas are pursued and all relevant contracts will be made. The middle "toll gates" involve rigorous analytic hurdles and result in a narrowing of options and eventual selection among options.

The last few "toll gates" include:

- Increasingly rigorous numbers checks by auditors and actuaries to ensure that all numbers used and assumed "add up" and are relevant.
- Legal reviews to make sure that all proposals meet the test of potential legal challenge.
- Political reviews to ensure feasibility.
- Outside constituency reviews in a controlled manner.

Throughout the reviews, of course, the President, First Lady, Vice President, Domestic Policy Advisor and Cabinet Secretaries will be driving the substance of policy formation.

The following rough schedule assumes a 100 day submission date for the bill after the inauguration. "Toll gates" and a more detailed work plan will be defined by the week of February 1. The detailed work plan to be done the week of February 1 will spell out a weekly "to accomplish" task list for each work group.

The schedule is tight, but can be met.

**EXHIBIT 1****ORGANIZATION****THE CLUSTER TEAMS**

<b>Cluster I - The Long-term Plan</b>	
Team IA	The Benefits Package
IB	Budgets and Caps and How they will function
IC	Insurance Reforms, Organization of the HIPC and state oversight of Health Networks
ID	Health Care Quality Assurance
IE	Administrative savings, Reimbursement Systems, and Patient Information Systems
IF	Malpractice Reform
IG	Drug Price Controls
IH	Organization of Employer Mandates and Subsidies to Employers
II	Organization and Mandate for the National Board
IJ	Ethical Guidelines for the System
IK	Integration of VA and DOD Health Care
IL	Health Care Workforce Issues
<b>Cluster II - Short-Term Costs Control Plans</b>	
Team IIA	Cost Controls
IIB	Rate Regulation
IIC	Acceleration of Managed Competition and Global Budgets
IID	Use of Incentives of Various Sorts
<b>Cluster III - Phasing-in Universal Coverage</b>	
<b>Cluster IV - Federal Financing Options</b>	
<b>Cluster V - Short-term Initiatives</b>	
<b>Cluster VI - Long-term Care</b>	
<b>Cluster VII - Economic Impacts</b>	
<b>Cluster VIII - Liaison</b>	
Team VIIIA	Congress
VIIIB	Constituency Groups
VIIIC	State and Local Government
VIIID	Communications
<b>Cluster IX - Management of Taskforce</b>	
Team IXA	Numbers Audit
IXB	Legal Audit
IXC	Drafting

## EXHIBIT 2

### SCHEDULE

<b>Week of:</b>  January 18	<ul style="list-style-type: none"><li>• Choose and assemble cluster leaders.</li><li>• Review all transition materials and debrief transition teams.</li><li>• Approve schedule and preliminary work plan.</li></ul>
January 25	<ul style="list-style-type: none"><li>• Prepare detailed work plan for each task group.</li><li>• Secure staff for all teams.</li><li>• Conduct first task force meeting.</li><li>• Form strategy core group from taskforce.</li></ul>
February 1	<ul style="list-style-type: none"><li>• <u>Toll Gate 1</u> - each task group presents a detailed work plan outlining the questions they expect to explore, who they will contact, what data they seek, what their output will look like, etc..</li><li>• Analysis begins.</li></ul>
February 8	<ul style="list-style-type: none"><li>• Development of outreach plan; review of outreach lists; development of systems for funnelling outreach submissions to task groups.</li><li>• Preparation of Congressional liaison plan.</li><li>• Task groups continue analysis.</li></ul>
February 15	<ul style="list-style-type: none"><li>• <u>Toll Gate 2</u> - each task group presents a revised work plan, a statement of issues, an outline of options, a more detailed methodology for answering all questions needed to "flesh out" the options, etc.</li><li>• Outreach meetings begin.</li><li>• Analysis continues.</li></ul>
February 22	<ul style="list-style-type: none"><li>• Formation of legal and drafting groups -- development of work plan for background legal research on legislative issues.</li><li>• Formation of audit group. Development of formats for audits.</li><li>• Outreach continues.</li><li>• Analysis continues.</li></ul>

**EXHIBIT 2 - SCHEDULE (CONT'D)**

<b>Week of:</b>	
<b>March 1</b>	<ul style="list-style-type: none"> <li>• <b>Toll Gate 3</b> - formal presentation to President, Domestic Policy Advisor, etc. -- goal is to be sure that range of options and conduct of outreach effort are broad enough and in general line with their wishes. Preparation of this presentation will force synthesis of task group work.</li> </ul>
<b>March 8</b>	<ul style="list-style-type: none"> <li>• Meetings between task groups and audit and legal teams to communicate formats and expectations.</li> <li>• Outreach continues.</li> <li>• Analysis continues.</li> </ul>
<b>March 15</b>	<ul style="list-style-type: none"> <li>• <b>Toll Gate 4</b> - presentation of draft recommendations and full analysis supporting the recommendations. Aim is to make recommendations for narrowing options and to make explicit all analysis, logical links and assumptions explored which support conclusions.</li> <li>• Detailed numbers audits.</li> <li>• Detailed legal analysis.</li> <li>• Outreach continues.</li> </ul>
<b>March 22</b>	<ul style="list-style-type: none"> <li>• Detailed numbers audits continue.</li> <li>• Detailed legal audits continue.</li> <li>• Review of drafts by outreach people.</li> </ul>
<b>March 29</b>	<ul style="list-style-type: none"> <li>• <b>Toll Gate 5</b> - presentation of draft proposals as audited. Meetings of strategy group to integrate task group work into a comprehensive set of proposals.</li> <li>• Meetings with outreach people to review political viability of approach.</li> </ul>
<b>April 5</b>	<ul style="list-style-type: none"> <li>• Meeting with President and others to review Toll Gate 5 draft and comments of political outreach groups. Highlighting of major unresolved issues, options which need to be changed, expected problems, etc.</li> <li>• Begin preparation of communication plan.</li> </ul>
<b>April 12</b>	<ul style="list-style-type: none"> <li>• Draft revisions and additional analysis based on presidential meetings.</li> <li>• Controlled floating of draft ideas to selected outside individuals and groups.</li> <li>• Legislative drafting begins.</li> <li>• Additional numbers audit.</li> </ul>

**EXHIBIT 2 - SCHEDULE (CONT'D)**

<p><b>Week of:</b></p> <p><b>April 19</b></p>	<ul style="list-style-type: none"> <li>• <b><u>Toll Gate 6</u></b> - Final draft of program prepared for presidential review -- should reflect close to finished definition of program. Final unresolved issues get resolved. Discussion of communication plan.</li> <li>• <b>Legislative drafting continues.</b></li> <li>• <b>Controlled floating of program continues.</b></li> <li>• <b>Congressional discussions commence in earnest.</b></li> <li>• <b>Final legal audit.</b></li> <li>• <b>Final numbers audit.</b></li> </ul>
<p><b>April 26</b></p>	<ul style="list-style-type: none"> <li>• <b>Final legislative drafting.</b></li> <li>• <b>Congressional consultations continue.</b></li> <li>• <b>Communications plan finalized.</b></li> </ul>
<p><b>May 3</b></p>	<ul style="list-style-type: none"> <li>• <b><u>Toll Gate 7</u></b> - final review of legislation and communications plan. <b>Legislation ready for submission.</b></li> </ul>

## STAFFING

We need a large number of capable people to work with us these next 3 1/2 months, and we need them quickly. The staff requirements chart (Exhibit 3) gives an initial estimate of numbers. Most participants exist in departments already.

While the sheer numbers probably seem daunting, remember that in all policy initiatives, there are dozens of often "faceless" staffers who do the detailed work for the secretaries and deutes who show up to meetings.

In this case, however, I don't want them to be "faceless." I want to be able to manage them in a "hands on" fashion, questioning their assumptions, helping set their work plans and tracking down the sources of all their numbers.

Many major federal initiatives have hundreds of people working separately in a variety of departments. For such a comprehensive initiative, this will be a relatively small staff.

While most of the staff we will use already work for the government, we need to bring in a number of others quickly to marshal the knowledge and creativity now resident in the private sector and in the states.

These people could be hired by HHS or OMB either on a temporary or continuing basis.

We could also secure volunteered services from consulting groups.

The project must be fully staffed by February 5, 1993.

**EXHIBIT 3**

**STAFF REQUIREMENTS**

<b>POSITIONS</b>	<b>APPROX. # PEOPLE</b>	<b>PLACE OF EMPLOYMENT</b>
Staff Director	1	Domestic Policy
Project Coordination (VIID)	3	Domestic Policy, HHS
Data Coordination	8	HHS, OMB, Treasury, CBO, CRS,
Sub Total	12	Labor, Commerce
<b>Team IA Benefits Package</b>	<b>3</b>	<b>HHS, Labor, Commerce, Treasury</b>
IB Budgets and Caps	3	OMB, HHS, Treasury
IC HIPC Organization	2	OMB, HHS
ID Quality Assurance	4	HHS
IE Administrative Savings	3	OMB, HHS
IF Malpractice	3	HHS
IG Drug Prices	3	HHS, Commerce
IH Employer Mandates/Subsidies	3	HHS, Commerce, OMB, Treasury
II Organization of Boards	2	HHS, OMB
IJ Ethical Guidelines	2	HHS
IK Integration of DOD/Veterans	3	HHS, Veterans, DOD
IL Health Care Workforce Issues	3	HHS, Labor
Sub Total	34	
<b>Team IIA Cost Controls IIB</b>	<b>3</b>	<b>CEA, OMB, HHS</b>
Rate Regulation	3	HHS, OMB, CEA
IIC Acceleration of New System	3	HHS
IID Incentives	2	HHS, Treasury, CEA
Sub Total	8	
<b>Team III Universal Coverage</b>	<b>5</b>	<b>HHS, OMB</b>
<b>Team IV Federal Financing</b>	<b>5</b>	<b>OMB, Treasury, CEA</b>
<b>Team V Short-term Initiatives</b>	<b>5</b>	<b>HHS</b>
<b>Team VI Long-term Care</b>	<b>5</b>	<b>HHS</b>
<b>Team VII Economic Impacts</b>	<b>3</b>	<b>CEA</b>
<b>Team VIIIA Congress</b>	<b>3</b>	<b>White House, HHS</b>
VIIIB Constituency Groups	5	White House, HHS
VIIIC State and Local Gov't	3	White House, HHS
VIIID Communications	1	White House, HHS
Sub Total	12	
<b>Team IXA Legal</b>	<b>3</b>	<b>Domestic Policy, Justice, HHS</b>
IXB Audit	3	Consultants (pro bono)
IXC Drafting	3	HHS, Congress
Sub Total	9	
<b>Total</b>	<b>98</b>	

**Health Care Task Force Working Group**

**AGENDA**

**January 27, 1993**

1. Opening Remarks by the First Lady
2. Discussion of Work Plan -- Substance
3. Discussion of Work Plan -- Teams and "Toll Gates"
4. Discussion of Work Plan -- Outreach
5. Staffing
6. Schedule
7. Communications and Message
8. Next Steps

Task Teams - Program Development

1. New System Organization *Zellman*
  - A. Budgets and Caps
  - B. HIPC Organization
  - C. Organizations of Boards, Federal and State Oversight
  - D. Insurance Reform
  
2. New System Coverage *DAVE ROSENBERG  
SPENCER ALTMAN*
  - A. Benefits Package
  - B. Employer Mandates
  - C. Unemployed Coverage
  - D. Medicaid Integration
  
3. New System Infrastructure and Support *Tom Pyle*
  - A. Quality Assurance
  - B. Administration, Reimbursement, and Patient Information Systems *CHAPMAN*
  - C. Malpractice and Tort Reform
  - D. Preparation of Health Care Workers *SATCHER*
  
4. Integration of Government Health Programs into New System *SARAH COOPER  
HHS*
  - A. Medicare *SARAH COOPER*
  - B. DoD *ED MARTIN DOD*
  - C. Veterans
  - D. *Federal Employees system*
  
5. Ethical Foundations of New System
  
6. Short-Term Cost Controls *PAUL STARR*

*- Workers' Comp.*

7. <sup>Public</sup> Federal Financing *MANNA WELLS*
8. Health Policy Initiatives for Underserved Populations and Preventative Health *Jocelyn Elbert*
  - A. AIDS *SARAH ROSENBERG*
  - B. Women's Health
  - C. Underserved Regions -- Rural, Inner city
  - D. Immunizations Programs
  - E. Other
9. Long-Term Care *FRANCO TORRES Gil ROBYN STONE*
10. Economic Impacts *DAN CUTLER*
11. Quantitative Analytic Support *W. THORPE*
12. Legal Audit Group
13. Numbers Audit Group
14. Drafting Group *ANNE GAWANDE*
15. MENTAL HEALTH

The "Toll Gates"  
Policy Substance

Toll Gate 1 (February 13)

Each task group presents a detailed work plan outlining the questions they expect to explore, who they will contact, what data they will seek, what their output will look like -- discussion aims to ensure methodology is thorough and broad enough.

Toll Gate 2 (February 15)

Each task group presents a revised work plan, a statement of issues, an outline of options, a more detailed methodology for answering all questions needed to "flesh out" the options -- discussion aims to ensure that options considered are broad enough and that methodology is thorough enough to cover the options.

Toll Gate 3 (March 1)

Synthesis of work for a presentation of options to the President and Task Force members. This concludes broadening phase. All serious options are put "on the table." This is final check to be sure that sufficient breadth has been achieved.

Toll Gate 4 (March 15)

Each task group narrows options and makes draft recommendations, making explicit all analysis, logical links and assumptions which support conclusions.

Toll Gate 5 (March 29)

Synthesis of revised draft recommendations into a comprehensive set of proposals for presentation to the President and the Task Force to receive direction. Presentation should seek decisions on key issues so that proposals can be drafted.

Toll Gate 6 (April 19)

Further draft of program -- with numbers, legal, and political audits complete. Final unresolved issues get resolved. Contrarian review.

Toll Gate 7 (May 3)

Final review of legislation. Final audits of synthesized proposals.

Health Care Task Force Working Group

**Proposed Meetings**

Week of February 1	Toll Gate 1 Review	4 hours
Week of February 15	Toll Gate 2 Review	4 hours
Week of March 1	Toll Gate 3 Review	8 hours
Week of March 1	Task Force Meeting	2 hours
Week of March 15	Toll Gate 4 Review	4 hours
Week of March 29	Toll Gate 5 Review	8 hours
Week of April 5	Task Force Meeting	4 hours
Week of April 19	Toll Gate 6 Review	8 hours
Week of April 19	Task Force Meeting	8 hours
Week of April 26	Toll Gate 7 Preparation Meeting	As long as necessary
Week of May 3	Toll Gate 7 Review	As long as necessary
Week of May 3	Task Force Meeting	8 hours

**Task Teams  
Outreach and Politics**

Work plans to be prepared for discussion and revision at each "Toll Gate"

1. Congressional Liaison
2. Constituency Outreach
3. Intergovernmental Liaison
4. Political Coalitions
5. Communications

HEALTH CARE WORKING GROUP

STAFFING

I. NEW SYSTEM ORGANIZATION

Chair: Walter Zelman

Outside Consultants:

Gary Claxton, Rick Kronick, Lois Quam, Lynn Etheredge, Larry Levvitt, Rick Curtis

A. Budgets and Caps *Larry Levvitt + Sherry*

<u>Department</u>	<u>Contact</u>
Veterans	Patricia O'Neill
OMB	Randy Lutter Panashar Patel
HHS	George Schieber Nancy Delew
CEA	Sherry Glied
Treasury	TBD

B. HIPC Organization - *Rick*

<u>Department</u>	<u>Contact</u>
Veterans	Patricia O'Neill
OMB	Steve Bandeian
Treasury	Randy Hardock
HHS	Peter Hickman Jim Lubitz Leslie Greenwald

*Who has to purchase thru HIPC?  
How will HIPC select plans?  
Issue of self-insured*

C. *Gov Summary* Organization, Boards, Federal and State Oversight: *Walter (for now)*

<u>Department</u>	<u>Contact</u>
OMB	Jack Langenbrunner
Treasury	Alicia Munnell

**D. Insurance Reform**

*Mary Claxton*

Department

Contact

Treasury

TBD

HHS

Leslie Greenwald  
Peter Hickman  
Jim Lubitz

*Workers' Comp.*

Justice

Greg Vistnes

Labor

Bette Briggs  
Dan Maguire

CEA

Debbie Lucas

*E. Purchasing Co-ops beyond Mgmt Comp. - Lois*

*? F. Phys./Pat. relationship w/in Mgmt'd Comp.  
See rec'd*

**II. NEW SYSTEM COVERAGE**

Chair: Judy Feder - HHS, Atul Gawande - HHS

**A. Benefits**

<u>Department</u>	<u>Contact</u>
Treasury	TBD
Veterans	Bob Roswell
Labor	Steve Finan
Commerce	TBD
HHS	Pam Short Linda Bergthold
OPM	TBD
Outside Consultants	Diane Rowland Bob Valdez Shoshanna Sofaer

**B. Employer Participation**

<u>Department</u>	<u>Contact</u>
HHS	Alan Monhait
Treasury	Randy Hardock
Labor	Dan Maguire
CEA	Darryl Willis
OMB	Bob Anderson
Commerce	TBD
Outside Consultant	Alan Kreuger

**C. Coverage of Unemployed/Low-Income Populations**

<u>Department</u>	<u>Contact</u>
HHS	David Cooper Julia Paradise Elmer Smith Steve Clauser

Veterans	Beth Smith
Treasury	Randy Hardock
OMB	Cheri Rice
CEA	Andrew Lyon
Labor	Joe Hight
Outside Consultants	Diane Rowland Shoshanna Sofaer
Commerce	Sherry Courtland

**III. NEW SYSTEM INFRASTRUCTURE AND SUPPORT**

Chair: Tom Pyle, Tom Chapman?

**A. Quality Assurance**

<u>Department</u>	<u>Contact</u>
HHS	Henry Krakauer Goldfield Risa Lavizzo Mourey Barbara Gagel Linda Demlo
DOD	COL Timothy McKee CPT Paul Tibbits, M.D.
Veterans	John Williamson Bill Mudd
Outside Consultants	Alan Hillman Kathy Lohr Paul Epstein

**B. Administration, Reimbursement, and Patient Info Systems**

<u>Department</u>	<u>Contact</u>
OMB	Paul Kuzmack Bruce McConnell Shannah Koss McCollum
HHS	Henry Krakauer Tim Hill Dierdre Duzor
Justice	Greg Vistnes
DOD	John Silva
PPRC	Roz Lasker
Commerce/NIST	Dennis Steinauer

**C. Malpractice and Tort Reform**

<u>Department</u>	<u>Contact</u>
HHS/ASPE	Beth Hadley
Justice	TBD

HHS/AHCPR Kathleen Hastings  
Jacqueline Besteman

HHS Alan Hillman  
Caroline Taplin  
Bob Berenson  
Glen Aukerman  
Nancy Baum

**D. Preparation of Health Care Workers**

<u>Department</u>	<u>Contact</u>
HHS	Fitzhugh Mullen Marc Rivo Marla Solomon Marcy Gross
Labor	Frank Wilson
Veterans	Elizabeth Short Fortunato Kennedy
DOD	Lucretia McClenney-Elliott
Medicare	Tom Ault
Outside Consultant	Linda Aiken

**IV. INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS**

Chair: Steve Bandeian - OMB

**A. Medicare**

<u>Department</u>	<u>Contact</u>
OMB	Andy Swire Bob Kazden
HHS	Barbara Cooper Ira Burney
Outside Consultants	Peter Boland Mike Hix Pete Welch

**B. DOD**

<u>Department</u>	<u>Contact</u>
OMB	Jim Fish
DOD	Steve Lilly Joel Slackman COL Ed Miller, M.D. COL Robert Claypool
VA	Art Hamershlag Jose Coronado
HHS	Barbara Cooper
Outside Consultant	Chuck Phelps

**C. Veterans**

<u>Department</u>	<u>Contact</u>
OMB	Todd Grams
Veterans	Alline Norman Karen Walters
DOD	Ken Cox
HHS	Tom Hertz

**D. Federal Employees (FEHBP)**

<u>Department</u>	<u>Contact</u>
Labor	Diane Svenonius Bob Copeland
OMB	Bob Wyler
OPM	Curt Smith Abby Block

**V. ETHICAL FOUNDATIONS OF NEW SYSTEM**

Chair: TBD

<u>Department</u>	<u>Contact</u>
Justice	TBD
HHS	TBD
Outside Consultants	NIH Ethicist Charlie Dockerty? Art Kaplan? John Galenski? David Wickler?

## VI. SHORT-TERM COST CONTROLS

Chair: Paul Starr

<u>Department</u>	<u>Contact</u>
CEA	Howard Leathers Kim O'Neill
OMB	Len Nichols Randy Lutter Jack Langenbrunner Shannah Koss Rich Kuzmack
Labor	Bette Briggs Mark Wilson
Justice	TBD
HHS/HCFA	Steve Sheingold Ira Burney Kathy Buto George Greenberg Nancy McCall Ken Thorpe Tim Hill
Treasury	James Ukockis
Veterans	Louise Rodriguez
MIT	Peter Diamond Steve Zuckerman
DOD	John Silva
Commonwealth Fund	Karen Davis
Congress	CBO, PPRC, PROPAC, CRS Lisa Potetz

**VII. PUBLIC FINANCING**

Chair: Marina Weiss - Treasury

<u>Department</u>	<u>Contact</u>
Treasury	Randy Hardock Alicia Munnell Jim Duggan
CEA	Kevin Berner
HHS	Fred Hellinger Roland King Joe Antos Paul Jackson
OMB	Andy Swire Parashar Patel
Veterans	Victor Raymond
External	Vic Miller

**VIII. HEALTH POLICY INITIATIVES FOR UNDERSERVED POPULATIONS AND PREVENTIVE HEALTH**

Chair: Sarah Rosenbaum - White House?, Mark Smith?

<u>Department</u>	<u>Contact</u>
Veterans	Susan Mather
OMB	TBD
HHS	Bonnie Lefkowitz Ron Carlson
Labor	Ruth Shinn
White House	Sarah Rosenbaum
Commerce	Nampeo McKenney
CEA	Lucy Allen
Veterans	Ken Link
DOD	Larry Sobel
Outside Consultants	Diane Rowland Mark Smith

**IX. MENTAL HEALTH**

Chair: Dr. Bernie Arons - OVP

<u>Department</u>	<u>Contact</u>
Veterans	TBD
DOD	Peter Brock
HHS	Alan Leshner Sharman Stephens
HUD	TBD
OVP	Charlotte Hayes
Media Affairs	Bob Boorstin
Outside Consultants	

**X. LONG-TERM CARE**

Chair: Robyn Stone - HHS

<u>Department</u>	<u>Contact</u>
Treasury	Terry Jacobs
CEA	Debbie Lucas
Veterans	Marsha Goodwin Mary Beth Smith Thomas Yoshikawa, MD
OMB	Mark Wasserman Sarah Brentlinger
HHS	Robyn Stone Peter Kemper Mary Harahan Steve Clauser Nancy Miller
House Aging	Richard Veloz
Outside Consultants	Fernando Torres-Gill Brenda Veazoy  Steve McConnell Gary Claxton Bruce Vladick Karen Davis Pat Butler

**XI. ECONOMIC IMPACTS**

Chair: David Cutler - CEA

<u>Department</u>	<u>Contact</u>
CEA	Sherry Glied
Treasury	Alicia Munnell
OMB	Len Nichols Bob Anderson
Labor	Mark Wilson
HHS	Ken Thorpe
Commerce	David Kass
Outside Consultants	Alan Kreuger

## XII. QUANTITATIVE ANALYSIS

Chair: Ken Thorpe - HHS

<u>Department</u>	<u>Contact</u>
HHS	Office of Actuary AHCPR National Center for Health Jim Mays Gordy Trapnell
CEA	David Cutler Sherry Glied
Treasury	Janet Holtzblatt
OMB	Ron Nichols Bob Anderson Randy Lutter
Labor	Richard Hinz
Commerce	(Chuck Nelson - Census)
Outside Consultants	Urban Institute Rand
Congress	CBO - Chuck Seagrave, Nancy Gordon, Paul Vanderwater Joint Tax - Louise Sheiner

**XIII. LEGAL AUDIT GROUP**

<u>Department</u>	<u>Contact</u>
Labor	Dan Maguire

**XIV. NUMBERS AUDIT GROUP**

External group.

**XV. DRAFTING GROUP**

Chair: Atul Gawande - HHS, Shirley Sagawa - White House

<u>Department</u>	<u>Contact</u>
Treasury	Marina Weiss Randy Hardock
Labor	Betty Briggs
OMB	Steve Bandeian
DOD	John Casciotti

THE WHITE HOUSE

WASHINGTON

July 2, 1993

Memo to Roslyn Kelly

FROM: Diane Limb

Subject: Health Care Issues

Per our telephone conversation, attached is the memo I mentioned to you. Although it says that correspondence should be forwarded to the Office of Domestic Policy, it is actually going to Room 410/412 OEOB, which is the new health care correspondence office. The extension for that office is 2813.

Individuals wishing to speak with someone regarding health care are being directed to Health Care Communications at X2566. Health Care Communications is set up in the War Room and is operating under Jeff Elder.

Please contact me if you have further questions.

THE WHITE HOUSE  
WASHINGTON

June 29, 1993

MEMORANDUM TO THE STAFF

FROM: MAGGIE WILLIAMS  
SUBJECT: Health Care

As you all know, the Health Care Task Force and the health care reform working groups no longer exist. Calls related to health care are being directed to Health Care Communications at (202) 456-2566. Health Care Communications is located in the War Room. The fax number is (202) 456-2362.

Correspondence is being directed to:

Office of Domestic Policy  
ATTN: Health Care Correspondence  
Old Executive Office Building  
Room 410  
Washington, DC 20500

Standard language for outgoing correspondence should include the following paragraph:

At this point, the Health Care Task Force and the health care reform working groups have terminated. You should forward in writing any policy suggestions or opinions to the Office of Domestic Policy at the White House.

file: Toll Gate 1

TOLL GATE SCHEDULE FOR 2/10

ROOM 474

TIME	WORK GROUP
8:30	IA: NEW SYSTEM ORGANIZATION: BUDGET AND CAPS
8:45	IB: NEW SYSTEM ORGANIZATION: HIPC ORGANIZATION
9:00	IC: NEW SYSTEM ORGANIZATION: ORGANIZATION, BOARDS, FEDERAL AND STATE OVERSIGHT
9:15	ID: NEW SYSTEM ORGANIZATION: INSURANCE REFORM
9:30	IIA: NEW SYSTEM COVERAGE: BENEFITS
9:45	IIB: NEW SYSTEM COVERAGE: EMPLOYER PARTICIPATION
10:00	IIC: NEW SYSTEM COVERAGE: COVERAGE OF UNEMPLOYED /LOW-INCOME POPULATION
10:15	IIIA NEW SYSTEM INFRASTRUCTURE AND SUPPORT: QUALITY ASSURANCE
10:30	IIIB: NEW SYSTEM INFRASTRUCTURE AND SUPPORT: ADMINISTRATION, REIMBURSEMENT, AND PATIENT INFORMATION SYSTEMS
10:45	IIIC: NEW SYSTEM INFRASTRUCTURE AND SUPPORT: MALPRACTICE AND TORT REFORM
11:00	IIID: NEW SYSTEM INFRASTRUCTURE AND SUPPORT: PREPARATION OF HEALTH CARE WORKERS
11:15	IVA: INTEGRATION OF BOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS: MEDICARE

11:30	IVB: INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS: DoD
11:45	IVC: INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS: VETERANS
12:00	IVD: INTEGRATION OF GOVERNMENT HEALTH PROGRAMS INTO NEW SYSTEMS: FEDERAL EMPLOYEES
12:15	V: ETHICAL FOUNDATIONS OF NEW SYSTEM
12:30	VI: SHORT TERM COST CONTROLS
12:45	VII: PUBLIC FINANCING
1:00	VII: HEALTH POLICY INITIATIVES FOR UNDERSERVED POPULATIONS AND PREVENTIVE HEALTH
1:15	IX: MENTAL HEALTH
1:30	X. LONG TERM CARE
1:45	XI: ECONOMIC IMPACT

NOT SCHEDULED:  
QUANTITATIVE ANALYSIS  
LEGAL AUDIT  
NUMBERS AUDIT  
DRAFTING GROUP