

WITHDRAWAL SHEET

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Collection: Domestic Policy Council, Carol Rasco
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File Folder: Health Care [2]

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Date: 8/16/04

DOCUMENT NO. & TYPE	SUBJECT/TITLE	DATE	RESTRICTION
1. List	Re: Healthcare Reform Meeting, 1p (partial)	n.d.	P6/B6
2. Note	To Roz, 1p (partial)	n.d.	P6/B6
3. List	Re: Confirmations, 2p (partial)	n.d.	P6/B6
4. List	Cabinet members, 4p (partial)	1/22/03	P6/B6

RESTRICTIONS

P1 National security classified information [(a)(1) of the PRA].

P2 Relating to 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].

PRM Personal records misfile defined in accordance with 44 USC 2201 (3).

B1 National security classified information [(b) (1) of the FOIA].

B2 Release could disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA].

B3 Release would violate a Federal statute [(b)(3) of the FOIA].

B4 Release would disclose trade secrets or confidential commercial financial information [(b)(4) of the FOIA].

B6 Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA].

B7 Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA].

B8 Release would disclose information concerning the regulation of financial institutions [(b)(9) of the FOIA].

B9 Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA].

THIS FORM MARKS THE FILE LOCATIN OF ITEM NUMBER 1-2
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THE FOLLOWING PAGE HAS HAD MATERIAL REDACTED. CONSULT THE
WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER FOR FURTHER
INFORMATION.

file meeting folder

**HEALTHCARE REFORM MEETING
WITH PRESIDENT CLINTON**

**January 25, 1993
1:00 p.m. - Roosevelt Room**

DOB SS#

The Honorable Al Gore
Greg Simmon
Charlotte Hayes

The Honorable Donna Shalala
Judith Feder
Kenneth Thorp
Atul Gawande
Karen Davis

John D. Donahue

The Honorable Ron Brown

Jonathan Sallet

The Honorable Les Aspin

The Honorable Leon Panetta
Alice Rivlin

The Honorable Laura D'Andrea Tyson
David Cutler

The Honorable Lloyd Bentsen
Marina Weiss

The Honorable Jesse Brown
Dr. Victor P. Raymond

P6/(b)(6)

THE WHITE HOUSE
WASHINGTON.

Ron

list of HHS contractors

Karen DAVIS

P6(b)(6)

[REDACTED]

ROZ

VP. will attend
with

Geeg Simon

OR
Charlotte Hayes.

[Faint handwritten notes]

[Faint handwritten notes]

[Faint handwritten mark]

[Faint handwritten mark]

(B)

To refer to MKT

(A) ~~Individuals.~~
(B) Small business owners.

(A) Linda Gyles →

See 1PM.

THIS FORM MARKS THE FILE LOCATIN OF ITEM NUMBER 3
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INFORMATION:

Confirmations

HTS.

Secretary Shalala will attend.
And.

Judith Feder
Kenneth Thorp.
Atul Gawande
Karen Davis.

P6/(b)(6)

Also coming for 2:30pm. w/ Carol,
Kevin Thurm

P6/(b)(6)

Wahor

Sec. Reich CANNOT attend. His Rep is.

John D. Donahue

P6/(b)(6)

Commerce

Sec Blawie will attend with.

JONATHAN Sallet

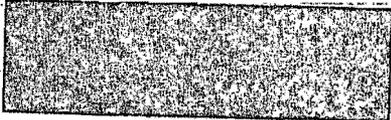
P6/(b)(6)

Rosslyn

Secretary Jesse Blum will attend with

Dr. Victor P. Raymond

P6/(b)(6)



Blum

Roz

PRIORITY TASK FOR MONDAY!

The following offices of the following Department Secretaries need to be called as a follow up call/message to them by Carol Rasco, Domestic Policy Advisor on Sunday in order to CONFIRM their attendance at the meeting on Health Care Reform today, Monday, January 25 at 1:00 p.m. in the Roosevelt Room of the White House, West Wing. You need to get the name of their designee(s) - hopefully ONLY HHS will bring more than one designee and let them volunteer that instead of asking if they have more than one. Also, for the designees (and the Secretaries/Directors if information not already on file) we must have: FULL NAME (first, middle, last); date of birth; social security number. These names and the vital information will all be compiled on a list to turn in to WAVE center by 11:30 p.m. hopefully in order to have smooth clearance for 1:00 p.m. meeting. I will need to go over the format of that information turned in to WAVE.

Again, I did not have the name of the room when I spoke to people over the weekend so please stress to them the room is the Roosevelt Room.

Attached is a list from Christine Varney that is the most up to date information we have for secretaries, phone numbers. ~~This is her ONLY copy of the list, we need to make sure when the copier is running again to get her original back to her.~~

LIST OF DEPARTMENTS:

VICE PRESIDENT Gore (I spoke to Roy Neel, chief of staff)
Designee:

HHS: Secretary Shalala (I spoke to Shalala personally)

Labor: Secretary Reich (I left message on Reich's machine)

Commerce: Secretary Brown (I left message on Brown's machine)

Veterans: Jesse Braun (I talked with Braun personally)

Defense: Secretary Aspin (I spoke with Aspin personally) *Wendy*
You are to call Judy Bernan at P6/(b)(6)

OMB: Director Panetta (I spoke with Panetta personally as well as his designee Alice Rivlin)
The call still needs to go here for the room designation and the clearance information.

*Diana Neenan
4840*

Treasury: Secretary Bentsen (I spoke with him personally as well as his designee) They still need the room and clearance info. Please call the designee, Marina Weiss, and ask her to get info on room to Bentsen. She can be reached at one of these two numbers this a.m.: Finance Comm. is 224-4200 where secretary is

Dave Burton

622-1447

622-2210 Nancy
622-0090

Donna; Treasury Dept. is 622-1260 and Marina will be with Alicia Minell. Make sure anyone taking the message knows to let Bentsen know the room.

- ✓ NEC: Make sure Bob Rubin has this on his calendar. His designee, Bo Cutter, should also be reminded. No clearance necessary.
- ✓ Council of Economic Advisors: Laura Tyson (I spoke only with her designee, David Cutler, who will be here but needs to know the room and clearance info obtained. HE is the one to be tracked down on this as he was going to check it out with Laura since I did not reach her.)

THIS FORM MARKS THE FILE LOCATIN OF ITEM NUMBER 4
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Chief of Staff

Name:
Work:
Home:
Fax:

Personal Secretary

Linda Kaufman
(202) 523-3331
P6/(b)(6)
(202) 523-3330

CABINET LEVEL

Chief of Staff: The Honorable Thomas F. McLarty

Home:
Work:
Chief of Staff

Personal Secretary

Name:
Work:
Home:
Fax:

Council of Economic Advisors: The Honorable Laura D'Andrea Tyson

Home: [Redacted]
P6/(b)(6)

Work:
Chief of Staff

Personal Secretary

Name: Tom O'Donnell
Work: (202) 395-5042 VceMail: (202) 457-5613
Home: P6/(b)(6)
Fax:

Alice Williams Elizabeth Williams ("Liz")
(202) 395-5042 (202) 395-5107

OMB: The Honorable Leon Panetta

Home:
Work:
Chief of Staff

Personal Secretary

Name: John Angel
Work: 395-6190
Home:
Fax: 395-5730

Diana Marino (Lydia)
395-4844 (395-4840)

Trade Representative: Mickey Kantor

Home:
Work: (202) 395-3911
Chief of Staff

Personal Secretary

Name: Debbie Shon
Work: (202) 395-3204
Home: P6/(b)(6)
Fax: (202) 395-3911

Steve Engleberg
(202) 395-3204
(202) 395-3911

Work: 219-8274
Home:
Fax: 219-7659

219-8274
P6/(b)(6)
219-7659

State: The Honorable Warren Christopher

Home:
Work: (202) 647-5291
Chief of Staff

Personal Secretary
Carline Ackerman
647-9574

Name: Lionel Johnson (Acting)
Work: 647-9572
Home:
Fax: 647-0122

Transportation: The Honorable Federico Pena

Home:
Work:
400 7th St. SW
Suite 10-200
Washington, D.C. 20590
Chief of Staff

Personal Secretary
Joyce Craley

Name: Steve Kaplan
Work: 356-1111
Home:
Fax: 356-3956

Treasury: The Honorable Lloyd Bentsen

Home:
Work:
Chief of Staff

Personal Secretary
Leslie Williams (Conf. Asst.)
622-0190

622-0000

Name: Gave Burton (Exec. Asst.)
Work: 622-0287/622-0425
Home:
Fax:

United Nations: The Honorable Madeleine Albright

Home: [Redacted]
Work: (202) 736-4536
Chief of Staff

Personal Secretary
Rick Inderfurth
(202) 736-4536

Name: Jo Fuhrer
Work: (202) 736-4536
Home:
Fax: (202) 736-4550

[Redacted] P6/(b)(6) [Redacted]
(703) 736-4550

Veterans Affairs: The Honorable Jesse Brown

Home: [Redacted]
Work:

Name: Anne Elliot
Work: 586-6210/586-1400
Home: P6/(b)(6)
Fax: 586-7644

EPA: The Honorable Carol Browner

Home:
Work:
Chief of Staff

Personal Secretary
Cheryl Montgomery (Acting)

Name: Ann Hardison
Work: 260-7960
Home:
Fax: 260-3684

(703) 519-8374

HHS: The Honorable Donna Shalala

Home: [REDACTED]
Work:
Chief of Staff

Personal Secretary

Name: Kevin Thurm (or Sarah Kovner)
Work: 690-8204
Home: P6/(b)(6)
Fax: 690-6154

HUD: The Honorable Henry Cisneros

Home:
Work:
Chief of Staff

Personal Secretary
Bert Benavides (Linda Benjamin)
708-0417

Name: Bruce Katz
Work: 708-2713
Home:
Fax: 708-2476

Interior: The Honorable Bruce Babbitt

Home:
Work: 208-7351
Chief of Staff

Personal Secretary
Barbara Atkinson
208-7351

Name: Fred Duval
Work: 208-7351
Home: Mayflower Hotel
Fax: 208-6956

P6/(b)(6)
208-6956

Labor: The Honorable Robert Reich

Home: [REDACTED]
Work: 219-8274
Chief of Staff

Personal Secretary
Debby Goldberg

Name: Kitty Higgins

DETERMINED TO BE AN ADMINISTRATIVE MARKING Per E.O. 12958 as amended, Sec. 3.2 (c)
Initials: RW Date: 8/15/04

CONFIDENTIAL

CONFIDENTIAL

24-Hour Contacts for Cabinet Members

DRAFT COPY: JANUARY 22, 1993 ADDITIONS TO BE MADE

Agriculture: The Honorable Mike Espy

Home: [REDACTED]
Work: (202) 720-5539 direct line
Chief of Staff

Personal Secretary

Name: Ron Blackley

Sharon Harris

Home: [REDACTED]
Work: (202) 720-3631
Fax: (202) 720-2166

[REDACTED] P6/(b)(6)
(202) 720-3631
(202) 720-2166

Commerce: The Honorable Ronald H. Brown

Home: [REDACTED] P6/(b)(6)
Work:
Chief of Staff

Personal Secretary

Name: Rob Stein (or Eric London)
Work: 482-2112
Home: [REDACTED] P6/(b)(6)
Fax: 482-2741

Barbara Schmitz
482-2112

Defense: The Honorable Les Aspin

Home: [REDACTED]
Work: (703) 695-5261
Chief of Staff

Personal Secretary

Name: Rudy DeLeon (Spec. Asst)
Work: (703) 697-8388
Home: [REDACTED] P6/(b)(6)
Fax: (703) 697-9080

Judy Berman
(703) 695-5261

Education: The Honorable Richard Riley

Home: [REDACTED]
Work: (202) 401-1181
Chief of Staff

Personal Secretary

Name: Billy Webster
Work: 401-1110
Home: [REDACTED] P6/(b)(6)
Fax: 401-0596

Pat Pierson
401-3006

Energy: The Honorable Hazel O'Leary

Home: [REDACTED]
Work:
Chief of Staff

Personal Secretary

To: Wave Center
From: Rosalyn / Carol Ruseo - DPC
Phone: 456-8849

TRANSMISSION REPORT

THIS DOCUMENT (REDUCED SAMPLE ABOVE)
WAS SENT

** COUNT **
2

*** SEND ***

NO	REMOTE STATION I. D.	START TIME	DURATION	#PAGES	COMMENT
1	202 395 5349	1-25-93 12:38	1'03"	2	

TOTAL 0:01'03" 2

XEROX TELECOPIER 7020

THE WHITE HOUSE

WASHINGTON

MONDAY, FEBRUARY 8, 1993

INFORMATION

MEMORANDUM FOR THE FIRST LADY

FROM: Howard Paster *P*

SUBJECT: Health Policy Task Force

I. SUMMARY

House Republican Leader Bob Michel has decided to cooperate with the proposal that each of the four Congressional Leaders designate someone to work with the Task Force. Unlike the other three, however, Representative Michel has not designated himself. Rather, he has asked that we work with Representative Dennis Hastert (IL-14), who is the head of an existing study group on health policy in the House Republican organization.

II. DISCUSSION

Representative Michel was reluctant to participate personally because he does not have the same intense level of expertise of the other leaders. I am satisfied of his good intentions and recommend Ira contact Representative Hastert in the next few days.

Representative Hastert was first elected in 1986. His district straddles the line between metropolitan Chicago and rural Illinois. It is one of the most Republican belts of territory in the country. Representative Hastert is one of his party's most fervent opponents of taxes. He crusaded in 1989-1990 to end the earnings tax on social security recipients. Another pet project is to end state regulation and taxation of trucks, in order to open up the trucking business. A third cause of his is attacking the IRS for rounding down the COLA on the dependent exemption. He is the Ranking Republican Member on the Commerce, Consumer and Monetary Affairs Subcommittee of the Government Operations Committee and he also sits on the Energy and Commerce Committee.

cc: *Carol* Rasco
Ira Magaziner
Lorraine Miller

cc: Sarah

File: Health care

CHARLES B. RANGEL, NEW YORK
CHAIRMAN

JACK BROOKS, TEXAS
PORTNEY H. PETER STARK, CALIFORNIA
JAMES H. SCHEUER, NEW YORK
CARRISS COLLINS, ILLINOIS
FRANK J. GUARINI, NEW JERSEY
DANTE B. FASCELL, FLORIDA
WILLIAM J. HURDHEB, NEW JERSEY
MEL LEVINE, CALIFORNIA
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LAWRENCE J. SMITH, FLORIDA
EDOLPHUS "ED" TOWNS, NEW YORK
JAMES A. TRAFICANT, JR., OHIO
KWEISI MFUME, MARYLAND
NITA M. LOWEY, NEW YORK
DONALD M. PAYNE, NEW JERSEY
ROMANO L. MAZZOLI, KENTUCKY
RON DE LUGO, VIRGIN ISLANDS
GEORGE J. HOCHBRUECKNER, NEW YORK
CRAIG A. WASHINGTON, TEXAS
ROBERT E. ANDREWS, NEW JERSEY

Sara Rosenbaum →

U.S. House of Representatives

SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
ROOM H2-234, HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, DC 20515-6425

COMMITTEE PHONE 202-226-3040

February 5, 1993

LAWRENCE COUGHLIN, PENNSYLVANIA
RANKING MEMBER

BENJAMIN A. GILMAN, NEW YORK
MICHAEL G. OXLEY, OHIO
F. JAMES BENDERBRENER, JR., WISCONSIN
ROBERT K. DORNAN, CALIFORNIA
TOM LEWIS, FLORIDA
JAMES M. INHOFE, OKLAHOMA
WALLY HERGER, CALIFORNIA
CHRISTOPHER SHAYS, CONNECTICUT
BILL PAXON, NEW YORK
WILLIAM F. CLINGER, JR., PENNSYLVANIA
HOWARD COBLE, NORTH CAROLINA
PAUL E. GILLMOR, OHIO
JIM RAMSTAD, MINNESOTA

EDWARD M. JURTH
STAFF DIRECTOR
MELANIE T. YOUNG
MINORITY STAFF DIRECTOR

Hillary Rodham Clinton, Esquire
Chair
President's Task Force on Health Care Reform
The White House
Washington, D.C. 20500

cc: *Sra*
Capitol
Melanne
Shirley
Howard

Dear Hillary:

Congratulations on your appointment by the President to be chair of the Health Care Reform Task Force. The stature and commitment you bring to this assignment reassures those of us in the Congress who strongly support fundamental health care reform, particularly the need to expand quality health care services to the poor and to victims of alcoholism and drug abuse.

As Chairman of the Select Narcotics Committee, I have been concerned for some time that treatment for substance abuse problems is a major unmet need in our health care system. The prevalence of drug and alcohol dependence in our country is undeniably high, and substance abuse is truly an equal opportunity disease, respecting neither age, race, sex nor socio-economic status. Yet many people who need drug or alcohol treatment cannot get it, because private treatment is too expensive and publicly funded programs are full.

I recognize that, in these times of tight budgets, cost is a paramount concern in considering what benefits to cover in health care reform. There will be those who argue that we cannot afford to pay for comprehensive substance abuse treatment. To the contrary, we cannot afford the cost of not covering substance abuse treatment. In their appearance before the Ways and Means Committee just over one year ago, President Bush's top economic advisors -- OMB Director Dick Darman, Treasury Secretary Nicholas Brady and Council of Economic Advisors Chairman Michael Boskin -- agreed that \$300 billion a year is not an unreasonable estimate of what drugs and alcohol cost our society in

(noted as correction of February 5 letter)

Hillary Rodham Clinton, Esquire
Page 2

terms of lost productivity, lost revenues, and increased governmental spending for criminal justice, health care, welfare and other programs. Substance abuse can be treated effectively at low cost. It would be penny wise and pound foolish to adopt health care reforms that provide coverage for the expensive care needed to treat the adverse medical consequences of substance abuse -- such as drug-exposed babies, drug overdoses, AIDS, TB and other infectious diseases -- without providing coverage for substance abuse treatment that could significantly reduce the need for more costly medical services in the first place. It also would be political tragedy to take on the difficult problem of health care reform without addressing the need for expanded and improved drug and alcohol treatment.

Furthermore, because of the uniqueness of substance abuse services, alcohol and drug abuse service should be kept separate from other mental health benefits. I recognize that substance abuse is often defined as a mental disease or disorder under standard classifications of disease and diagnostic manuals. Clearly there are overlaps between mental health and substance abuse treatment services and providers. I am concerned, however, that such classifications fail to take into account the significant differences that exist both in the types of treatment that are available and appropriate for substance abusers on the one hand and the mentally ill on the other as well as in the service providers who are recognized to treat substance abusers versus the mentally ill. Regardless of whether health reform proposals establish a separate benefit for substance abuse services or cover such services under mental health benefits, it is vitally important to clarify the types of substance abuse services that are covered and the practitioners who are eligible to provide such services. Otherwise, substance abusers could be denied access to the most appropriate and least expensive treatment or be denied access to treatment altogether.

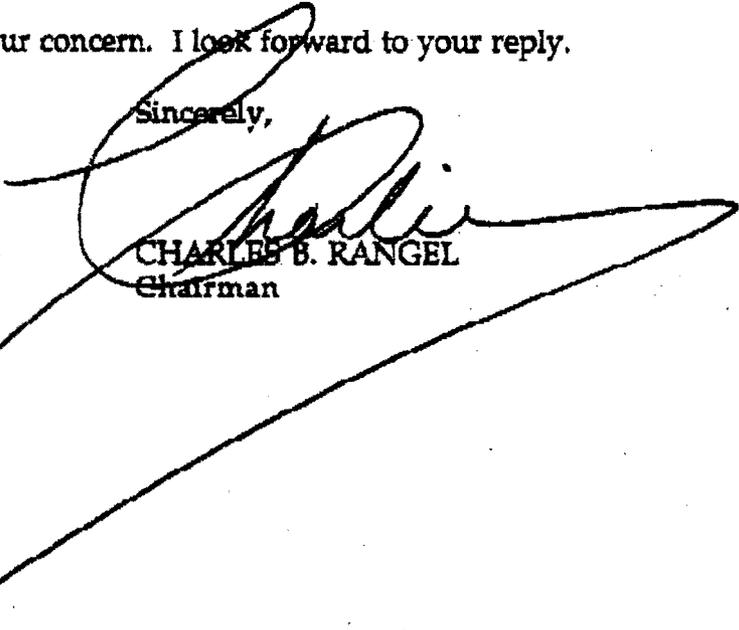
Enclosed is a proposal for coverage of comprehensive substance abuse benefits in health care reform legislation. This benefit proposal has been developed by a coalition of national organizations with broad expertise in substance abuse services. I include it for your review not as the final word on the subject but as a starting point for your consideration of the serious issues that must be addressed in designing appropriate coverage for addiction treatment and prevention.

Hillary Rodham Clinton, Esquire
Page 3

I know you share a sincere desire to expand and improve substance abuse treatment services and to ensure access to such services for all those who need and want help in overcoming their dependence on alcohol and drugs. I look forward to working with you to include appropriate coverage for substance abuse services in any health care reform package the Administration proposes. With everything that is at stake in health care reform, it would be all too easy for substance abuse treatment to get lost in the shuffle. We cannot afford to miss this opportunity to provide hope for the millions of Americans who cannot now get the help they need to escape addiction.

Thank you for your concern. I look forward to your reply.

Sincerely,



CHARLES B. RANGEL
Chairman

Enclosures

The White House

Health Reform Delivery Room



Phone: 202-456-2566
Fax: 202-456-2362

Facsimile Cover Sheet

To: CAROL RASCO

Fax #:

From: CHRISTINE HEENAN

Date:

Comments:

Number of pages including cover: 6

CHILDREN AND FAMILIES

The Health Security Act will provide security and comprehensive coverage for the 8.8 million American children who now have no health insurance.

Over the last decade, the amount the average American family spent on health care more than doubled from \$1,742 to \$4,296. Health care costs are projected to double again by the year 2000 if nothing is done. In addition, family coverage through the workplace is rapidly eroding: only 33 percent of employer-sponsored health plans paid for health insurance coverage of spouses and dependent children in full in 1990--compared to 40 percent just a decade ago.

- Thirty percent of all children under the age of two and 50 percent of some inner-city children, have not been immunized against preventable childhood disease.
- One in five American children had no contact with a doctor in 1992.

Health care reform will help provide children and families with comprehensive benefits and piece of mind, and will include specific initiatives aimed at keeping children healthy.

- The benefits package will include prenatal care, immunizations, regular checkups and preventive services for children, vision and hearing care, and preventive dental for children.
- The Health Security Act will guarantee every American family health insurance protection not linked to their job, health, income or age.
- American families, and not their employers or insurance companies, will choose their own plans from their local health alliance.
- The Clinton plan will continue to support specific service targeted at high risk community, migrant, family planning, and maternal and child health services.

09/23/98 09:44 AM Final 2:CG

**CHILDREN AND FAMILIES AND HEALTH CARE:
Questions and Answers**

Q: My spouse, my children and I all have our own doctors. Under the new system will we still be able to see different doctors?

A: Yes. Allowing people to choose their own doctor is a hallmark of American medicine. The Clinton plan preserves this right and expands it by giving consumers a broader range of health plans from which to choose. Under the President's plan, no longer will consumers be restricted to a single plan offered by their employer. Instead, they will choose from a variety of health plans with access to a selection of doctors. Those wishing to see doctors outside their plan can do so, but will have to pay more.

Q: Will my benefits or my family's benefits be reduced?

A: No. The comprehensive benefit package in the Clinton plan will be based on the best of today's plans and will be guaranteed to all Americans. Most Americans will see a broader range of choices among health care plans covering a greater variety of services than they have today.

Q: Will my family's health care be limited in any way?

A: Those who oppose reform often raise the specter of rationing of health care to scare consumers and undermine reform. The truth is that health plans competing on the basis of service and quality to attract and retain patients, will have every incentive to provide necessary care on a timely basis. In addition, the alliances will protect consumers and enforce quality standards.

Q: Will I still receive my health insurance through work?

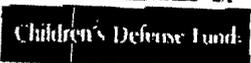
A: Most Americans obtain their insurance through their jobs. Under the Clinton plan, employers will continue to contribute to the cost of their employees' health insurance. Under the new system, rather than the employer choosing an insurance plan, employees will choose their own plans from among those offered through health alliances.

Q: What happens if I lose my job or change my job?

A: You'll still be covered. Your family's health insurance coverage will no

EMBARGOED FOR RELEASE
9:00 a.m. (EST)/Thursday, March 3, 1994

CONTACT:
Stella Ogata (513) 784-6043 or 6044 (Cincinnati)
Nicole Chrysostom (202) 662-3612 (Washington, D.C.)



ALARMING NUMBER OF CHILDREN DENIED PRIVATE HEALTH INSURANCE

Universal Coverage, Comprehensive Benefits, and Employer Mandate Needed to Stem Declining Coverage For Children

CINCINNATI, Ohio -- Barely half of the nation's children will be covered by health insurance through their parents' employers by the year 2000 if current trends continue, according to a new report released today by the Children's Defense Fund. The Health Insurance Crisis for America's Children also documents that the problem of children without insurance from any source is mainstream -- nearly two out of three are from non-poor families, three quarters are White, and nearly seven out of ten are from married-couple families.

CDF said that the percentage of children who were covered fell from 64.1 percent in 1987 to 59.6 percent in 1992. Had this decline not occurred and the percentage of children covered stayed at the 1987 rate, more than three million additional children would have had employer-based insurance in 1992. The report also concludes:

- o The five-year trend (1987-1992) was a continuation of the previous ten years when children also lost employer-based insurance at the rate of nearly one percent a year.
- o The drop in employer-provided coverage is not because of a drop in employment. In 1987, 91% of children lived in a family with at least one working member, and over 64% had employer-based insurance. By 1992, 91% of children still lived in a family with at least one working parent, but only 60% were insured through those employers.

"For two decades, employer cost-cutting and the rising cost of health insurance have forced millions of children out of the private health insurance system and children's health and the public treasury are left to pick up the tab," said CDF President Marian Wright Edelman. **T**oo many employers have ignored their responsibility for the well-being of their employees' families. Families who work too often lose care for their

25 E Street, NW
Washington, DC 20001
Telephone: 202 628-1377
Fax: 202 628-3310

-more-

children and we need to change the system to make sure that every American child has health security that can never be taken away."

Despite the rapid decline of employer-based health coverage of children, the number of children who were covered by some health insurance remained relatively flat for the five-year-period covered by the report (1987-1992). According to CDF, the primary reason was growth of the government's Medicaid program to cover more poor and near-poor children. However, the report points out that Medicaid will not continue to grow to compensate for declining private coverage, and that the growth that has occurred shifts costs to the public. Moreover, the static situation left almost one in eight American children (8.3 million) uninsured throughout the year in 1992. Millions more children had insurance for some but not all of the year.

"Only by guaranteeing health insurance for every American can we assure every child and pregnant woman the health care they need," Edelman said. "We need universal coverage with comprehensive benefits through a plan that is affordable for families."

While almost every state has alarming numbers of children who are uninsured, some states have extraordinarily high rates. In Texas, New Mexico, the District of Columbia, and Oklahoma more than one in five children has no health insurance throughout the year. In contrast, fewer than seven percent of the children in Connecticut, Minnesota, North Dakota, and Rhode Island have no insurance. Ohio ranks twelfth in the nation, with 224,029 (eight percent) of its children uninsured.

CDF released the report on the opening day of its 14th annual conference, which kicked off today in Cincinnati with a presentation by Hillary Rodham Clinton via satellite from Washington, D.C. The First Lady spoke to over 2,400 conference attendees about the President's plan for health care reform and its effects for children.

The conference runs for three days and draws child advocates, religious leaders, educators, and parents from every state. Conference speakers include U.S. Attorney General Janet Reno, Ohio Governor George Voinovich, Director of the Office of National Drug Control Policy Lee Brown, Rep. Robert Matsui (D-Calif.).

-more-

and Rep. Tim Roemer (D-Ind.).

The theme of CDF's conference is "Leave No Child Behind," and the focus of many workshops and plenary sessions is on the crises American children face in the areas of health and welfare, gun violence, teen pregnancy, and family and community breakdown.

"Ohio is an ideal setting for CDF's annual conference because it is a typical state that has taken a bipartisan lead on some very critical programs for children, especially on Head Start," said CDF-Ohio Director Mark Real. "Over 400 Ohioans are participating in the conference, including the Governor and key legislative leaders. What's noteworthy is that support for children is coming from all parts of Ohio and from leaders of both parties," Real said.

At a luncheon Saturday, CDF will recognize outstanding efforts on behalf of children at a special awards luncheon. Sarah and Jim Brady will receive an award for their tireless efforts against violence and work to win passage of the Brady bill. Joseph Marshall, executive director of the San Francisco-based Omega Boys Club, will be recognized for his organization's innovative approach to giving inner-city youth alternatives to drugs and violence by providing scholarships to teens who "stay clean." Dr. Barry Zuckerman, chairman of the Department of Pediatrics at Boston City Hospital, will be honored for his pioneering efforts to meet the special health needs of high-risk children. And, the *Detroit Free Press* will receive an award for its trailblazing "Children First" initiative which advocates on behalf of Detroit's children and has altered how many journalists view their commitment to the communities they serve.

The Children's Defense Fund exists to provide a strong and effective voice for the children of America who cannot vote, lobby or speak for themselves. Its goal is to educate the nation about the needs of children and encourage preventive investment in children before they get sick, drop out of school, suffer family breakdown, or get into trouble. CDF works to ensure that every child has a healthy start, a head start, a fair start, and a safe start, and to see that no child is left behind. CDF is a private, nonprofit organization supported by foundations, corporations, and individuals.

13 May 1993

MEMORANDUM TO CAROL RASCO

FROM: MOLLY BROSTROM FOR CHRISTINE HEENAN
RE: MEETING REQUEST YOU RECEIVED FROM THE MENNONITES - file

The Mennonites have requested a meeting with you to discuss the health insurance system operated by the Mennonite Mutual Aid Association. Christine and I do not believe you need to meet with the Mennonites on this issue.

Background

At the request of Andie King with Congressman Gephardt's office, I set up a meeting for Walter Vinyard and members of the Mennonite Mutual Aid Association (whom he represents) with Gary Claxton on April 12.

Forty three thousand Mennonites located in rural areas of 19 states are currently insured by the Mennonite Mutual Aid Association (MMAA). They would like to continue to do so under the new system. The ease or difficulty of allowing them to do this is contingent in part on whether or not we allow big business and other associations to self-insure. It is complicated by the fact that if we allow the Mennonites to self-insure, we could have a host of other associations and fraternal benefits societies requesting the same.

Gary's initial thought was that this level of detail would be worked out in regulations. Walter Vinyard believes that would be a mistake. Vinyard thinks we want to minimize Congress' tinkering with our plan--if Congress is convinced to add a provision helping the Mennonites (which their "white cap" reputation could make likely), this may open a floodgate of special provisions.

On Friday, Gary Claxton is meeting with the Church Alliance; they also would like to continue to insure their members under the new system. Gary and I are going to discuss the two situations after the meeting and I will pass on any further information.

VINYARD & ASSOCIATES

COLUMBIA SQUARE
505 THIRTEENTH STREET NW
WASHINGTON DC 20004-1109
(202) 637-6638

PLEASE DELIVER IMMEDIATELY

Ms. Carol H. Rasco
ATTN: Rosalyn

FAX NO. 456-2979

Roz
Pls. have
Christine
Neenan review
this & advise
me.
CHR

From: WALTER D. VINYARD, JR.

No. of Pages 6
(Excluding This Cover Sheet)

Date: 5/6/93

Time: _____

Recipient's Telephone _____

Please notify us immediately if there has been any problem receiving this telecopy.

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VINYARD & ASSOCIATES

COLUMBIA SQUARE
555 THIRTEENTH STREET NW
WASHINGTON DC 20004-1109
(202) 637-6836

May 6, 1993

Ms. Carol H. Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, D.C.

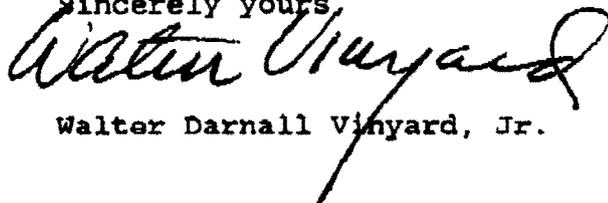
Dear Ms. Rasco:

On behalf of 43,000 Mennonites and related Anabaptists in the United States, we respectfully request a meeting with you to discuss the health insurance system operated by Mennonite Mutual Aid Association.

A copy is enclosed of our submission to the Health Care Task Force.

We hope the Administration will resolve the Mennonites' questions before the new universal health insurance plan is submitted to Congress.

sincerely yours,



Walter Darnall Vinyard, Jr.

WDV:css

VINYARD & ASSOCIATES

COLUMBIA SQUARE
555 THIRTEENTH STREET NW
WASHINGTON DC 20004-1000
(202) 637-0000

April 21, 1993

Mr. Gary Claxton
Health Care Task Force
The White House
Washington, D.C. 20500

Dear Gary:

As you suggested in our meeting on April 12, we are submitting this request on behalf of Mennonite Mutual Aid Association (MMAA). MMAA operates in a unique historic and theological context as a health insurer for Mennonites. MMAA would like to continue to operate within the new universal health system as an insurer solely for Mennonites.

We do not know many details about the new system which the Administration will propose in May. From what is known, it would seem that MMAA might function as an approved "closed" health plan meeting certain financial and quality standards and providing legally required benefits solely to Mennonites. Mennonites should be able to elect out of the large, regional purchasing groups in order to join MMAA.

In the alternative, MMAA might be able to function as a separate, dedicated approved health plan available only to Mennonites through the health insurance purchasing cooperatives in states where MMAA operates. During the transition period to a new system, MMAA ought to be permitted to continue providing coverage independently.

MMAA can help the Administration fulfill its goals. The preponderance of Mennonites live in rural areas where the concept of large purchasing groups may be more difficult to implement. Currently MMAA insures 43,000 Mennonites located in rural sections of Arizona, California, Colorado, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Nebraska, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota and Virginia.

MMAA bears the risk of insuring Mennonite and related Anabaptist believers. MMAA is the insurer; it does not purchase coverage from another organization. MMAA offers comprehensive, high quality major medical plans to Mennonites, emphasizing cost containment and managed care. This is accomplished by: direct

VINYARD & ASSOCIATES**Mr. Gary Claxton**

page - 2 -

April 21, 1993

contracting with hospitals and special service organizations; creation of PPO networks; precertification; large case management; reasonable and customary evaluation; challenging both physician and hospital prices on a claim by claim basis; and steering Mennonites to selected efficient providers where a formal PPO/HMO arrangement does not exist. Because of this experience we believe MMAA could offer any required benefit package the Administration proposes.

MMAA also provides Mennonites with premium assistance for persons unable to afford full premium cost as well as for dependents with physical or mental disabilities; catastrophic aid; emergency aid for health related expenses not covered by insurance; adoption expenses; community grants; wellness programs; AIDS educational materials; Nurse in the Congregation (a health ministry for the church); medical ethics materials; and advance medical directives (living wills). Some literature on MMAA programs is enclosed for your review.

The historic and theological context of MMAA

In the sixteenth century the Anabaptist movement began to see the church as a community where property and possessions were used to meet the needs of others. This is not charity, but rather a belief that two or more individuals should help each other achieve their respective goals. Individuals could own private property so long as it was used to the glory of God and the common good; human rights ought to have precedence over property rights. For example, in the Swiss Brethren congregation at Strassburg in Alsace during 1557, applicants for membership were asked whether they were willing to devote all their possessions to the church and its needs if necessity required, and not to fail any member that was in need if they were able to render aid.

Mennonite mutual aid programs had their origins during 1623. Over time Mennonites developed fire insurance associations, mutual stock buying and breeding companies, hospitalization plans, as well as agricultural and educational improvement societies. Mennonite tradition and history are filled with all manner of mutual aid practices. Mutual aid is considered an essential way of incorporating Christian faith into social relations. It is a practice central to Mennonite theology.

In the late 1940's, the Mennonites of North America experienced a renewal and rediscovery of this earlier vision. MMAA was formed as part of the attempt to give practical expression to this rebirth. The following are some examples of how MMAA attempts to carry out Mennonite beliefs:

VINYARD & ASSOCIATES

Mr. Gary Claxton

page - 3 -

April 21, 1993

- MMAA is accountable to the Mennonite Church. It is governed by a Board of Directors elected by the Mennonite membership. The Church influences MMAA's goals, planning and products;

- risks underwritten by MMAA are broader than those accepted by commercial insurance companies;

- ethical guidelines reflecting moral judgments based on Mennonite beliefs govern and restrict MMAA's investment policies. No funds are invested in defense, alcohol or tobacco industries. Instead MMAA investments help to meet basic human needs such as housing, food, transportation, as well as gas and electric power;

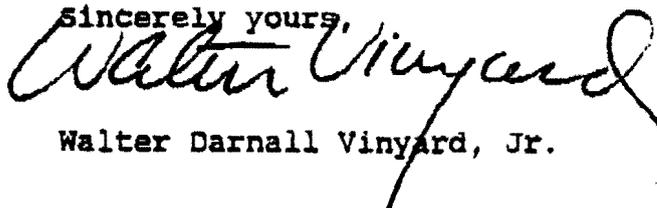
- to encourage church growth MMAA provides first mortgage loans to established churches at a reasonable interest rate; and

- selection and compensation of MMAA management and staff plus overhead costs are greatly influenced and limited by Mennonite beliefs on stewardship.

In light of this historic and theological context, MMAA adopted in May 1992 guiding principles for responding to the health care crisis (copy attached). These appear compatible with what we have learned so far about the Administration's objectives.

We appreciate your consideration of our request on behalf of MMAA. Please let us know if you have any questions or if any further information would be helpful.

Sincerely yours,



Walter Darnall Vinyard, Jr.

WDV:css

**Guiding Principles for
Responding to the Health Care Crisis**
Adopted by Mennonite Mutual Aid
May 1992

Our country and our church face a crisis in health care. We do not have an integrated system which coordinates the provision of health care in a fair manner for all. Consumers, providers, and insurers compete rather than cooperate for mutual benefit.

While the insurance products currently offered by Mennonite Mutual Aid and other insurers are unfortunately outside the reach of 10-15 percent of families and individual they reflect what is economically and politically feasible at the time. However, we long for a system which is more inclusive, just, effective and efficient, and invite the church along with other insurers and providers to struggle with us in the search for solutions.

As the national debate over health care advances, many alternatives, legislative and otherwise, are proposed. While we do not have clear answers, the Board and Staff of MMA propose that the following principles guide the search for solutions.

We desire a health care system that

1. **provides access to a basic level of care to everyone, everywhere in the United States**
 - **emphasizes health care as a social good**
 - **guarantees access to basic preventive, curative, supportive and emergency care for all regardless of ability to pay**
 - **places the curing of individuals in the larger context of caring for one another**

2. **recognizes our mortality and the limits of our financial resources**
 - **acknowledges our mortality -- accepts death as an inevitable part of life**
 - **recognizes that financial resources we have to spend on health care are limited and that we cannot continue to spend without jeopardizing other social goods**

3. **emphasizes prevention of illness and health promotion**
 - encourages individual responsibility for a healthy lifestyle and for use of the health system
 - emphasizes health education, wellness promotion, illness prevention and community-based primary care
 - assures preventive and basic curative services for pregnant women, nursing mothers, and children through the age of 18 years
 - recognizes the legitimate role of the government in promoting medical research and in setting standards for housing, nutrition, environmental safety and sanitation

4. **controls cost and spending while emphasizing quality care**
 - promotes quality over quantity of life, discourages use of expensive technology to prolong life where death in a very short while is inevitable
 - simplifies the process of health care administration
 - reduces the burden of malpractice litigation; frees providers from practicing expensive and medically unnecessary defensive medicine
 - frees (reduces regulatory and cultural barriers) non-physician health workers to assume a more active role in supporting and caring at the community level
 - assures fair compensation and adequate opportunity for professional growth and development for health care workers

Creation of such a system will require not only political reform, but transformation to a new way of thinking about health care. The crisis in health care is cultural, ethical, and theological as well as political and economic. Emphasizing caring over curing, honestly accepting our mortality, and openly acknowledging the need to ration health care resources are not tasks which will come easily to our society. However, significant reform is not possible without an alteration of these and other basic values and assumptions which provide the foundation of the current health care system.

DPC Program Staff

EXECUTIVE OFFICE OF THE PRESIDENT

27-Oct-1993 12:19pm

TO: (See Below)

FROM: Jeffrey L. Eller -
Office of Media Affairs

SUBJECT: Where to get the legislation and the book

October 27, 1993

TO: Interested Parties

FR: Health Care Delivery Room

RE: WHERE TO GET:

HEALTH CARE REFORM LEGISLATION

**and HEALTH SECURITY, THE PRESIDENT'S REPORT TO THE
AMERICAN PEOPLE**

The President's Health Security Act, legislation to reform America's health care system to guarantee every American comprehensive health care benefits that can not be taken away, will be released at Noon today (10/27). The President's letter to The Honorable Thomas S. Foley, Speaker of the House of Representatives, and to The Honorable George J. Mitchell, Majority Leader of the United States Senate, will also be released at that time. Additionally, The President's Report to the American People, describing the President's

plan for health security for every American will be made available today.

These documents are immediately available from a wide variety of sources and technologies as listed below:

TELEPHONE:

U. S. Government Printing Office (202)
783-3238

The White House Bill
(1300 pages)
order # 040-000-00634-6
The cost is: \$45

The President's Report to America
order # 040-000-00633-8

The cost is: \$5

Books will be in stock at the GPO bookstore, 710 North Capital Street NW, after 12 noon today (10/27/93). Or you may order from the GPO via phone with VISA or MASTER CARD. Normal delivery time is two to four weeks. Express delivery is an extra cost option.

**National Technical Information Service(703) 487-4650
NTIS(800) 553-NTIS**

President's Report to America
PB94-102860
The cost is: \$5

The Health Security Act
PB94-102878
The cost is: \$45

Normal delivery time ranges from overnight, at an

additional charge, to one business week.

COMPUTER ACCESS:

Americans Communicating Electronically
ACE

Via the Internet, please send a message to:

health@ace.esusda.gov

You will be sent back an email message, the Health Care
FAQ, listing many electronic sources and methods for
retrieving Health Care Information at no charge.

FedWorld Bulletin Board
321-8020

(703)

data format is: N-8-1, full duplex
ANSI emulation

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Telenet fedworld.gov

There is no charge for the FedWorld BBS.

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Distribution:

TO: Sheryll D. Cashin
TO: Manager Infomgt

EXECUTIVE OFFICE OF THE PRESIDENT

27-Oct-1993 10:04am

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs
SUBJECT: Health Care Update

RE: PRESIDENT'S HEALTH SECURITY PLAN UPDATE

1. KEY ISSUES FROM THIS MORNING'S NEWS:

o CAPS: The morning news focuses on the caps and suggests that the system could require dramatic changes -- the implication is that the system will run out of money. This charge does not reflect key elements of the plan that make this contingency highly unlikely. Our goal must be to reinforce the President's commitment to health security -- to guarantee every American comprehensive health benefits that can never be taken away. NOTE: TALKING POINTS FOLLOW, more information to come later.

o IMPLEMENTATION: The President's plan will be fully implemented by the end of 1997. There is some confusion because FISCAL 1998 was mentioned at last night's briefing. For clarity and accuracy, you should say the bill will be fully implemented by the end of 1997. There have been changes in the pace of the implementation within the three years, but the full implementation deadline remains the end of 1997.

o INDIVIDUAL PAYMENTS: There are reports this morning about a limit on individual payments at 3.9 percent of income, implying that everyone will pay 3.9 percent of their income for health care. WRONG. The 3.9 percent cap was needed to protect some low income individuals who would not qualify for insurance discounts. Most Americans will pay only between 1 - 2 percent of income. For most Americans who are now insured, this will be the same or less than they are currently paying

for the same or better benefits. (The other numbers you might hear, relate to the fact that health insurance costs will be split, with employers paying at least 80 percent and individuals paying 20 percent. In the context of income, low income people will be protected by the 3.9 percent cap and most Americans will pay only between 1 - 2 percent.)

Page Two

CAPPED ENTITLEMENT FOR HEALTH CARE DISCOUNTS

The President's Health Security Plan provides insurance discounts to small businesses and low income families and individuals to help them afford health security. To ensure the most

responsible financing possible and to ensure against the kinds of out-of-control and automatic spending increases we've seen in government programs historically, the President's plan sets limits on the amount of these discounts that could be provided before a trigger forces Congress to take action. These caps represent the President's strong commitment to financial responsibility, to a sound plan that will ensure every American is guaranteed comprehensive benefits that can never be taken away.

The President's plan includes extraordinary protections and safeguards to ensure against the need for additional funding. The President's plan includes a 15 percent cushion, \$45 billion over five years, built in for protection. And, the legislation allows funds from this cushion to be carried over, allowing the reserve to build over time. (For perspective, consider that models found that a massive and highly unlikely 2 percent annual increase in unemployment would mean the need for an additional \$4 billion in discounts over one year. The 'cushion' provides \$12 billion of protection in one year -- three times more than would be needed for even a situation as unlikely as this.)

It is extremely unlikely that the scenario our opponents are creating will ever come to pass -- there are too many protections and too many safeguards in the President's plan. The President's plan relies on our existing system -- a private system funded primarily with private funds. All of the health care plans within the system will be required to meet a solvency requirement, a strict test of financial strength, to be allowed to treat patients. And, the President's plan relies on solid and conservative assumptions that will make it highly unlikely that additional funding would be needed. The President's plan is designed to stop the automatic spending increases we've been forced to confront in the past, instead designing a mechanism that demands accountability and responsibility from our elected representatives.

Inflation is built into the system, so the cap can not be overrun simply by general inflation.

Consider the source of these questions about the President's plan: the insurance industry has

spent millions to scare people about the President's plan. Why? Because the President would make it illegal for the insurance companies to indiscriminately raise rates, to drop coverage for sick people, to limit the amount of benefits they'll provide, to refuse coverage to people with pre-existing conditions, and other abuses. The insurance industry doesn't want to lose that ability to indiscriminately raise rates or take away coverage.

The President is determined to ensure that every American is guaranteed comprehensive benefits that can never be taken away. The Health Security Plan transmitted to Congress today will keep that commitment.

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