Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	From David Watkins to White House Staff re: Effective Coordination of Presidential Support (2 pages)	01/27/93	P5
002. memo	From Kathleen M. Whalen to Ira Magaziner re: Former Service on Boards of Directors (1 page)	12/2/93	P5, b(6)
003. note	From Simon to Ira Magaziner re: pay (1 page)	10/26/93	P6/b(6)

COLLECTION:
Clinton Presidential Records
Policy Development
Ira Magaziner (Subject Files)
OA/Box Number: 10019

FOLDER TITLE:
Administrative

Rhonda Young
2006-0770-F
ry511

RESTRICTION CODES

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

January 27, 1993

MEMORANDUM FOR THE WHITE HOUSE STAFF

FROM: DAVID WATKINS
ASSISTANT TO THE PRESIDENT FOR MANAGEMENT AND ADMINISTRATION

SUBJECT: Effective Coordination of Presidential Support

The purpose of this memorandum is to outline the significant support available from the White House Military Office (WHMO). The Military Office can help maximize our efficiency and will simplify support to the President.

The WHMO provides a single point of contact for coordination of military support to the President. Every movement of the President will, in some way, involve military support. From something as simple as a Presidential Jog, to the most complex state arrival, the Military Office plays a vital role in executing our plans. Involving the Military Office early in the planning stages of any event will aid in the smooth execution of that event.

The WHMO office staff can answer questions on the White House Communications Agency, Aircraft or Helicopter support, the White House Staff Mess, the Medical Unit, and the Transportation Agency (cars/vans). They are located in the East Wing and may be reached at 456-2150. A primary point of contact within the Military Office is the duty Military Aide (Milaide). They stand a 24 hour duty and remain overnight in the White House whenever the President does so. They may be reached in a variety of ways; at 395-1747, through the Operations Center at 395-4007, or through the signal switchboard at 757-5000.

The Milaides can provide "One Stop Shopping" for virtually every Presidential event we are planning. As an example, when notified of an Off-the Record Movement (OTR), they will inform all involved parties. These include the Personal Aide (if he is unaware), all WHMO units involved (Press vans, communications, medical personnel, White House TV), the Photographer, and the Press Office. As well, they will remain in constant contact with the Secret Service to coordinate any last minute changes. Off-the-Record movements include such things as Presidential Jogs, low key dinners away from the White House, and any other

low profile movements away from the White House. Close hold events can be passed to the Milaides and they will inform only those parties desired.

The Milaides should act as our single point of contact for all Camp David evolutions and all Presidential travel, both in and out of Washington, DC. Additionally, in conjunction with the WHMO Director of Ceremonies, they should be contacted regarding all official ceremonies at the White House. Their support in these events ranges from reading citations to direct ceremonial support of the President. All staff members should feel free to contact the WHMO office staff or the Milaides at any time regarding the specifics and limits of WHMO support, or the specifics of Milaide coordination.

The White House Military Office has widely circulated a "Welcome Aboard" packet. If you did not receive one, or need more, please contact them at 456-2150.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To Hillary Rodham Clinton and Ira Magaziner from Amy Lee Stewart (14 pages)	06/14/93	P5

COLLECTION:
Clinton Presidential Records
Policy Develoment
Magaziner, Ira (Subject Files)
OA/Box Number: 10019

FOLDER TITLE:
Comments to Draft Plan [5]

Rhonda Young
2006-0770-F
ry558

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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MEMORANDUM

TO: Hillary Rodham Clinton
Ira Magaziner

FROM: Amy Lee Stewart

DATE: June 14, 1993

RE: Health Reform -- Antitrust Review

I have perused various anti-trust related materials (including those produced by the working groups and the legal audit team) provided to me by Dr. Bob Berenson, Greg Lawler, Chris Jennings, and other members of Ira's team. I have spoken with Dr. Berenson, Greg Lawler, members of the House Judiciary Committee's legal counsel staff, Mindy Hatton, of Senator Metzenbaum's staff, attorneys in the D.O.J. Antitrust Division, attorney representatives of the AMA, and Ira Magaziner. I have attended informal meetings of Arkansas doctors and the most recent meeting of the Arkansas Bar Association's Health Law Section. Despite my comparative lack of antitrust expertise, based on the information I have obtained from these writings and discussions, I offer you my gut reactions of the significant antitrust related issues and proposed solutions.

Although a number of groups and individuals have raised antitrust concerns in the context of health care reform, most of these are highly speculative, based on misunderstandings of how health care systems have, in the past, been affected by federal

antitrust regulation and conjecture about what health care delivery systems might look like in the future. Most seem more based on anticipatory fears and reactions to the current complexity of the federal enforcement systems than on actual need to breach the current system in order to achieve greater competitive efficiency.

There are also great political divides among significantly important health care groups (American Hospital Association, American Medical Association, American College of Physicians, American Nurses Association, AARP, and other medical groups and consumer groups) regarding the need for antitrust exemptions or reform in conjunction with global health care reform.

In light of these competing concerns, a few general principles/conclusions logically present themselves:

1. Antitrust laws have served the country well for decades by protecting against egregious infringements on market-based competition.

   - Appropriate selective enforcement is the key to continued effective protection of the public from egregious infringement while balancing pro-competitive effects from innovation by health care providers.

2. Because the misperception of aggressive antitrust enforcement is apparently so frightening, and [mis]perceived as inhibitive of certain pro-competitive (or otherwise beneficial?) combinations, it is, I think, obvious and essential that the federal enforcement agencies (D.O.J. and F.T.C.) quickly develop and make available to the public a set of user-friendly guidelines, including safe harbors and bright lines on which provider systems may rely in making combination decisions. The promise to provide these can be written

into the legislation.

- Because concerned providers often must or simply do contact both agencies over the same combination issues, or providers may unknowingly contact or anticipate review by one agency only to have the other's enforcement apply[1], the D.O.J. and F.T.C. must work together to insure consistent responses to inquiries and situations presented to either or both of them.

3. To the extent that "complication" continues to be an issue to providers after the D.O.J. and F.T.C. make their reliable guidelines, bright lines and safe harbors available to the public, state action immunity can further short-cut federal enforcement risk.

4. Any modifications to the current antitrust regulatory scheme, including bright lines and safe harbors, must be developed with an eye toward their impact, intended or otherwise, as precedents in other areas of current and future antitrust discontent. Exceptions, exemptions (if any), protections, immunities and enforcement assurances must either be applied in all analogous industries, or we must be prepared to present legitimate justifications to explain how the health care industry is not (or will no longer be) analogous to the other [requesting] industry.

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[1] N.B. This memo addresses only federal enforcement efforts. States, of course, remain free to layer appropriate antitrust regulation on top of the federal structure of the Sherman Act § 1 and 2 (prohibiting contracts, combinations and conspiracies in restraint of trade and monopolization and attempts and conspiracies to monopolize), the Clayton Act (prohibiting unlawful discrimination in prices which has the effect of lessening competition, and exclusive dealing and tying arrangements which lessen competition), both of which are primarily enforced by the Department of Justice, and § 5 of the Federal Trade Commission Act, (broadly prohibiting "unfair methods of competition" and "unfair or deceptive acts or practices") which is primarily enforced by the F.T.C.

The Sherman and Clayton Acts also allow for private enforcement suits. To my knowledge no constituency has raised a concern about this private enforcement mechanism, nor do I here.

5. Some antitrust issues have interesting overlaps in the fraud and abuse areas also analyzed for this national reform undertaking (e.g. self referral to physician owned joint-ventures for ancillary health care businesses). It may be possible to gain relief from some anticompetitive or borderline "unfair" activity through fraud and abuse enforcement which has a less antagonistic ring to it than antitrust.

Returning to specifics, five significant areas of antitrust concern probably deserve substantive attention:

1. Mergers of hospitals (especially rural hospitals)
2. Hospital joint ventures (especially high tech)
3. Provider collaborations (especially to set fees)
4. Repeal of McCarran-Ferguson Act.
5. State action immunity

Hospital Mergers

The American Hospital Association, and especially advocates for small and/or rural hospitals, have expressed concerns that as we move toward a vertically integrated health care delivery system in which provider groups are required to function within a strictly (state or federally) controlled budget, small and/or rural hospitals will need to cut costs, and may well need to do so by merging with other hospitals.

As the federal antitrust laws only concern themselves with competition, hospitals which do not compete in the same market (e.g. those 50 or more miles apart or those offering different specialized services) may currently merge without fear of federal

enforcement. Indeed, the federal government only investigated about 10% of all hospital mergers from 1987-1991 and challenged less than 2% since 1989.

Hospitals below a certain size (perhaps 50-75 beds) should also be able to merge without fear of antitrust violation, since their merger would likely create a greater efficiency with insignificant competitive risk.

Conclusion: Both of these situations can, and probably should, be addressed through safe harbors written by the D.O.J./F.T.C., with guaranteed reliability for providers.

All other hospital mergers, of which there are likely to be very few, should continue to be reviewed under the current "rule of reason" analysis for Sherman and Clayton Acts and § 5 of the Federal Trade Commission Act claims, which looks at the balance of efficiencies and competitive effect to determine whether a merger has been or will be primarily anti-competitive.

Conclusion: To address the few remaining concerns of larger, urban and suburban hospitals which might consider merging, two simplifying measures should be instituted, and assured in the legislation:

a) D.O.J. should draft guidelines and examples of mergers which will and will not create enforcement risk.

b) D.O.J. should provide an expedited business review procedure (essentially in place now as a trial program) which would allow a 7-10 day turn around of an answer on which the inquirer could rely if it then acted in accordance with the information it had provided to D.O.J. and D.O.J.'s response.

- If there are truly large hospitals that will want to merge once reform is in place, then this expedited procedure would require devotion of two to four D.O.J. people to this review procedure full-time for the first year or two of transition under the reform system.

- I think that the credibility of the D.O.J. review process could be enhanced in the perception of providers if one or more of the D.O.J. attorneys on the review group were also doctors.

Hospital Joint Ventures/Group Purchasing Arrangements

Hospitals have, over the last decade, begun to recognize that their previously unfettered race toward over-provision of high technology and certain ancillary services is not cost-effective; there is also evidence that it results in lower quality of care to patients, through overutilization of services to justify their purchase and because greater genuinely necessary use or provision of some techniques and services (such as transplant operations) tends to result in higher overall quality as a logical side-effect of greater experience and specialization.

Conclusion: Almost all joint ventures for high technology equipment and ancillary services are already permissible under the basic antitrust statutes. The national trend is already strongly in this direction (an AHA poll last year of 250 hospital administrators showed that more than half did not feel antitrust

laws have inhibited collaborations, and 72% said they are now collaborating or planning to share services with another hospital). Under health care reform we should continue to encourage these cooperative cost-savings measures. The D.O.J./F.T.C. should clarify this with straightforward guidelines and safe harbors on which hospitals may rely. These agencies should also publish examples of the few ventures which would not likely survive antitrust scrutiny (such as those which are actually anti-competitive territorial allocations resulting in capability of exertion of power over price to the detriment of consumers). The same expedited business review procedure described above should be available for joint venture inquiries.

Exemptions/Physician Collaborations

This issue is the single most difficult antitrust problem, both in the current system and under reform. Like the demand for medical malpractice reform, it seems to have an emotional root which runs more deeply than logic and reality justify. It must nevertheless be addressed.

The AMA has presented a white paper (March 1993) which proposes an antitrust exemption for physicians to band together to agree on reimbursement levels [i.e. set prices] which they can propose to third party payors.

In a statement of the AMA to the Senate Subcommittee on

Antitrust, Monopolies and Business Rights, given on March 23, 1993, the AMA, through Dr. Richard Corlin, moderated its stance somewhat, stating, "The AMA does not seek an exemption from the antitrust laws for physicians." Corlin sought instead a "clarification of the antitrust laws." This moderation is, however, little more than word play. Corlin went on to offer a "Physician-Health Plan Negotiations Act of 1993" which would establish safe harbors for physicians who collectively present their views to managed care plans without engaging in price-fixing boycotts, or the threat of boycotts. Corlin concluded that this Act would leave physicians free to combine "to approach payors collectively to provide appropriate input on fees and other payment-related issues."

Corlin also offered the "Managed Care Improvement Act of 1993", which would, inter alia, "provide antitrust immunity for physicians who in good faith participate in collective activities in developing position statements relating to their relationships [including on financial matters] with the plan." Immunity, but not exemption?

In a meeting between the three leading lobbying attorneys for the AMA and members of the D.O.J., Dr. Berenson and Greg Lawler (from the antitrust related working group) which I attended in late May, the AMA representatives again moderated their position, albeit not in writing. At that meeting they stated that they knew they could not get any exemptions or immunities, that the AMA was well

aware of the national trend toward some form of managed care, that it was trying to persuade its membership of the need to participate as leaders in that trend, and that all it needed was some temporary assistance to allow its less-enlightened members room to make the transition from solo practice to group plan delivery systems. These lobbyists also backed off of using the two cases, Southbank and Alston, which the AMA has been presenting to their membership as evidence of the imminent threat of enforcement against any provider collaborations. They never even mentioned Southbank (probably because they have now realized that it does not hold the threat on which they had earlier sounded the false alarm), and they admitted that on the facts of that case, Alston was properly brought by the government. Instead they stated, preposterously, that if you ignore the facts of Alston, there is a substantial enforcement threat.

The AMA lobbyists at this last meeting proposed that there be a short-term (transitional) safe harbor for physicians, in the format of "very loosely integrated networks", who can pick and choose whom to include among competitors, to collaborate, essentially on price setting, as long as the network does not exceed 20% of the market for the services offered by those providers. They indicated that this safe harbor was necessary to allow intransigent physicians to begin coming into the new group delivery system as fee for service providers without feeling as though they were succumbing to governmental pressure, so that

physicians could become the creators of a better, new health care policy, rather than the followers of the government's. They also emphasized, repeatedly, that they were open to discussion and negotiation on this proposal.

The reasoning which I have seen from the AMA representatives with respect to antitrust is suspect at many levels. Their presentations are fraught with conclusions which do not follow from their premises, mis-statements of case facts and holdings, poor logic, inadequate understanding (or deliberate misrepresentations of relevant antitrust regulations) and poor command of the realities of current and future health care delivery systems. The protections they seek, to the extent that they do not involve price fixing and foreclosing competitors from the market, are perfectly legitimate under the current antitrust scheme. Providing "transitional" exemption/immunity/relief for anti-competitive behavior for the rationale they offer neither benefits consumers, nor encourages integration into the kind of reformed, comprehensive, secure, cost effective system which the President's plan seems to envision.

From all that I have read, the AMA, and highly specialized physicians therein, stand nearly alone in this proposal. The American Nurses Association, the American College of Physicians, consumer groups, Senator Metzenbaum, and virtually all economists either oppose it or do not support the AMA in its request.

On the other hand, Ira makes a far more compelling business argument in favor of transitional safe harbors: that third party payors forming health care plans may well exert market (monopsony) power while remaining within their budgets by expanding from one state or region to another using profits derived in one to subsidize initial (or even long term) low cost entry into other markets, pressuring physicians one by one to participate in their plan at unfairly reduced reimbursement rates until the third party payor has gained sufficient numbers of physician participants to foreclose (discipline) any who refuse to participate at those low reimbursement rates, or any newcomers. [N.B. Ira believes this will happen during the first few years of transition but will not happen at all if prevented during that period.] This may or may not affect quality (less likely if we have enterprise liability), but certainly seems unfair to the physicians, and increases the likelihood of development of oligopolies of third party payors, which is likely, in the long run, to hamper rather than enhance cost control, efficiency, quality and satisfaction in the reformed system. [Ira - have I got the argument right?]

Conclusion: Given Ira's business theory, and the obvious need to balance protection of good faith doctors while preventing sheltering of anti-competitive doctors, I am reasonably comfortable with returning to something pretty close to what the AMA ultimately proposed at the May meeting described above (albeit I am not in any way persuaded by the AMA's rationale.] That is, offer, again

through D.O.J./F.T.C. drafting, a safe harbor for physician collaboration where the group has 15-20% or less of the relevant market, the group is sufficiently integrated that each member bears some financial risk in the participation (merely discounting each individual's fees does not constitute risk, but remaining within the Alliance's budget as both fee-for-service and non-fee-for-service plans will be obliged to do may be), and there is absolutely and unequivocally no threat, implied or explicit, of boycott (unlike in Alston). Again, roughly this outline for a safe harbor could be written into the legislation.

If a broader protection becomes necessary in a rural area, I propose case-by-case review through the agencies' expedited review procedures described above rather than pre-determined exemption/immunity.

Please be mindful: it is my perception based on what I have read, what I heard from the AMA lobbyists, and what I have seen informally in recent meetings and visits in Arkansas, that physicians are, on the whole, very agitated about what they perceive to be infringements on their ability to continue to make money which supports them in the lifestyle which they have anticipated and enjoyed over the last few decades. They believe they are being (or will be) sandwiched between managed competition in which they have little power to protect their comfortable income and autonomy and increased taxes which will also reduce their

spending power. They do not believe they will get malpractice reform (which they [wrongly] perceive to be of significant economic value), and they do not understand the value to themselves of enterprise liability. Consequently, they are openly speaking of the need to empower themselves to protect their financial interests by acting as group monopolists. Their misperceptions about taxes, malpractice reform, managed care, antitrust enforcement and their "right" to be over-compensated must all be addressed as much as possible through increased information. Their remaining emotional irrationality cannot, and should not, be addressed by permitting anticompetitive behavior which will undermine the goals of reform.

Repeal of McCarran-Ferguson

There seems to be little dispute (except perhaps from insurance companies) that the McCarran-Ferguson antitrust exemption for state regulated insurance businesses should be eliminated. Thus insurance companies acting as providers of health care services (i.e. by acquiring health care providers) would be subject to the same federal antitrust review as any other health care provider network as they compete with each other. A legitimate state action immunity would presumably still apply to insurance companies undertaking traditional insurance business pursuant to appropriate state regulations.

State Action Immunity

State action immunity arises when (a) the anticompetitive

action must have been taken pursuant to an affirmatively expressed and clearly articulated policy to supplant competition as expressed by the state and (b) the activity was obliged to be undertaken subject to active state supervision. When both these conditions are met, action taken are immune from federal antitrust liability.

A state which seeks to give additional relief to its local health care providers can thus do so by providing a specific policy statement and statutory scheme which includes active state supervision for the activities it seeks to encourage or protect. Maine has recently written such legislation. Although there is some disagreement within the National Association of Attorneys General as to the ability of the Maine statute to so immunize activities of Maine health care providers, attorneys at the D.O.J. as well as Senator Metzenbaum's staff believe it would likely be effective as is or with very little tinkering. It could well be a model for other states, and as such, it or at least the idea of more aggressive efforts to establish such immunizing legislation could be encouraged through precatory language in the President's health care plan as a further relief for the providers who seem now to feel so pressed.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	List of names, members of task force groups (partial) (6 pages)	nd	P6/b(6)
002. note	Discussion with Hillary Clinton (2 pages)	01/28/93	P5
003. memo	From Chris Jennings to First Lady Hillary Rodham Clinton re: background for Congressional meetings (3 pages)	nd	P5

COLLECTION:
Clinton Presidential Records
Policy Development
Magaziner, Ira (Subject Files)
OA/Box Number: 10019

FOLDER TITLE:
Congressional Memos [1]

Rhonda Young
2006-0770-F
ry515

RESTRICTION CODES

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

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DISCUSSION WITH HILLARY CLINTON

January 28, 1993

1. The Administration's health care reform proposal should follow the pattern of earlier major bills and be

   * A **framework** providing a number of major principles

   * A **dynamic policy** that can change as Congressional consideration moves from Committee to Committee over a period of months

2. Most major bills considered by the Ways and Means Committee in recent years have followed this pattern

   * Tax reform from the Reagan Administration in 1985

   * Medicare catastrophic coverage from the Reagan Administration in 1987

   * Medicare physician payment reform legislation passed on a bi-partisan basis with the Bush Administration in 1989

   * The big deficit reduction package with the Bush Administration in 1990

3. If the Administration drafts a detailed bill and sends it to the Congress with a "here's the bill, there's not much time, take it to the Floor quick" approach the bill might fail

   * Many Members would feel excluded from playing a role in the refinement of the bill

   * Interest groups will object that their concerns, even those that are small or reasonable, have been excluded from the hearing and markup process

4. The Committees have a long track record in the health area and have proven they can work on details

   * Major reconciliation bills almost every year during the 1980's resulting in billions of dollars in savings for Medicare

   * Two years of extensive work on broad health reform in 1991 - 92

     -- Over 50 days of hearings and seminars in Ways and Means alone

     -- The Subcommittee reported a comprehensive cost containment bill and the Subcommittee Democrats developed a full employer-based universal coverage plan

5. The framework might include specifications for major areas such as

   * Universal coverage and the timetable for achieving it; time is merely a function of costs

   * Policies to cushion the fiscal impact on small, low-wage businesses

   * Cost containment including a timetable for overall Federal costs

   * Revenue approaches such as a medical VAT, corporate taxes, payroll taxes

   * Policies the Administration would consider off-limits

6. If the Administration proposes major principles and works with the Committees on the details, the process will go smoother and faster than any other approach

TO: First Lady Hillary Rodham Clinton

FROM: Chris Jennings

RE: Background for Tuesday's Congressional meetings

* Congressman Pete (Fortney) Stark is the Chairman of the House Ways and Means Subcommittee on Health. The Ways and Means Committee has jurisdiction over taxes, Medicare Part A (reimbursement primarily for hospitals), and shares (with the Energy and Commerce Committee) jurisdiction over Medicare Part B (reimbursement primarily to physicians and other health care personnel). As such, it is one of the, if not the, most influential health care Committees on the House.

Over the years, Chairman Rostenkowski has given Stark wide latitude in legislating on health care. As a result, the Stark Subcommittee has, for all intensive purposes, been the center of all health care legislating activity for the Committee.

Congressman Stark has become one of the most knowledgeable and (sometimes) feared health care legislators on Capitol Hill. There is no one in Congress who is a more fierce advocate for their own position than Stark and, as a result, he frequently wins more than his share of victories in joint Senate/House legislative conferences. He has not taken this approach without paying a price in terms of his relationships with the Congress, however, and is probably one of the more disliked Members in the Congress.

In terms of health reform initiatives, he has introduced legislation ranging from Medicare-for-all to a play-or-pay to a harsh cost containment initiative (with Congressman Gephardt) used to pay for coverage of pregnant women and children and a prescription drug benefit for the elderly. Most recently, he introduced his own bill merging the Gephardt/Stark provisions with managed competition principles. (He did this even though he was asked by representatives of the President not to do so).

The long leash that Rostenkowski provided in the past has made it extremely difficult for Stark to accept Chairman Rostenkowski's strongly stated desire to embrace the health reform package drafted by the Administration, absent more proactive legislative involvement from the Ways and Means Committee. As Chairman Rostenkowski noted during your meeting, Stark can be extremely difficult but will play an pivotal role in shaping and passing any reform legislation. It is therefore imperative that we maintain as close and constructive a relationship with him as is possible.

* Congressman Henry Waxman is the other "nuts and bolts" health care subcommittee chairman, presiding over the House Energy and Commerce subcommittee. The Energy and Commerce subcommittee has sole Medicaid jurisdiction and shares Medicare Part B jurisdiction with Ways or Means.

Known as a Medicaid guru, Waxman has pushed for increased coverage for poor populations in the absence of a national health care program. Since his main thrust for increased coverage to the indigent has been turning Medicaid coverage options into mandates, Waxman is widely unpopular with states and Governors. Although not well-liked at the state level, he has tremendous respect among consumer interest groups. His biggest concern is that the poor aren't left behind-- he believes you can't achieve success without everyone in system. (He may even support federalizing Medicaid program and sacrificing his own jurisdiction over many of these programs, if it means coverage for more people).

Like Stark, he is viewed on the Hill as an extraordinarily strong advocate for his own point-of-view. But unlike Stark, Waxman has a better concept of where to draw the lines and a greater willingness to negotiate. He has one of the most technically capable staffs on the Hill for health care issues, several of whom are serving on the policy working groups. He supported pay-or-play approaches in the past, but most recently introduced a single-payer bill with Dingell. Chairman Waxman's primary concern, however, is passing an initiative that achieves universal coverage, and he is concerned that political pressures and concerns about taxes could threaten our ability to achieve universal access within a reasonable time frame. Waxman is likely to be less concerned with how it is achieved-- be it a managed competition framework or some other approach-- as long as the system provides universal access and enforceable cost measures. If handled right, Chairman Waxman can be counted on to be a strong ally for us on Capital Hill.

* Pat Williams Chairs the Education and Labor Subcommittee on Labor-Management Relations, which has jurisdiction over ERISA, collective bargaining, and labor law. He has a long-standing interest in health care issues, particularly with regard to rural health.

  As Chairman of this Subcommittee, Williams is very concerned about how health reform will affect employers and workers. He is prepared to make changes in ERISA, but is concerned about the propensity to revisit ERISA by those who understand only its limitations and not the framework of protection it provides workers.

  Williams has not cosponsored any comprehensive reform initiative, despite great pressure from his state to support single payer legislation. He has been repeatedly appointed by the leadership as the labor whip, due to his ability to garner politically viable compromises between labor and management.

  He may raise concerns about ERISA being repealed or severely limited, as there are rumblings of efforts along that line in the working groups. You may want to stress that the working group process allows us to look at the advantages and limitations of everything currently in place. You can acknowledge the discussions held with his staff during the transition about ERISA, and that we appreciate his concern that the protections ERISA affords not be undermined.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	From Alexis Herman and Mike Lux to Mrs. Clinton re: March 12-13 Health Care Hearing Plan (2 pages)	02/10/93	P5
002. memo	From Ira C. Magaziner to Mark Gearon re: Personnel (partial) (1 page)	03/04/93	P6/b(6)

COLLECTION:
Clinton Presidential Records
Policy Development
Magaziner, Ira (Subject Files)
OA/Box Number: 10006

FOLDER TITLE:
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Rhonda Young
2006-0770-F
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RESTRICTION CODES

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

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

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b(1) National security classified information [(b)(1) of the FOIA]
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b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

DRAFT

February 10, 1993

MEMORANDUM FOR MRS. CLINTON

FROM: Alexis Herman and Mike Lux

SUBJECT: March 12-13 Health Care Hearing Plan

As we discussed, the primary goal for this two day hearing would be to inoculate ourselves from charges that we are refusing to listen to all those groups out there that want input. It's important to understand that even with two long days of testimony, we will not be able to schedule everyone we want to schedule.

Hearing Format

The hearing should be two long days, starting at 8:00 AM and ending at 8:00 PM, with no break for lunch both days. We want to give the impression of driving determination to hear everyone out. You, Mrs. Gore, or a cabinet secretary should be there at all times with multiple people listening as much as is possible. Ira Magaziner, Carol Rasco, and Judy Feder should also have seats up front and be there for much of the hearing.

The hearings should be very interactive. Presenters should be given five minutes for their presentation, with ten minutes for q and a. We should have an hour devoted to a given category of testimony. The first forty-five minutes of each hour would be a panel of three presentations, followed by fifteen minutes of overall give and take between the three panelists and whatever principles are there to listen.

Even though our primary goal is political inoculation, we should not lose the opportunity for some public education. Some testifiers should be average people with horror stories, middle class families worried about the future, and senior citizens. These average people should testify during those periods when we believe more people will be watching.

We recommend that we start the first day with introductory

remarks by Mrs. Clinton, followed by three real people's stories, to set the tone for why we need real health care reform and raise the stakes for the interest groups that come afterwards. Similarly, we should end the second day with real people's stories and strong concluding remarks by Mrs. Clinton.

There should be a couple of hours sometime in the hearings for miscellaneous interests to do ten minute blocks of time (five minutes presentation, five minutes q and a.) There are just too many relatively minor players who we don't want or need in larger panels, and they deserve a say. The other twenty hours should be one hour panels, split between major special interests and special issues. We would recommend three fifteen minute presentations -five minutes of statement, ten minutes for q and a - on a panel with fifteen minutes at the end for general discussion with all three panelists.

We recommend the following twenty panels:

Interests	Special Issues/Concerns
Physicians	Rural Health
Hospital Administrators	Long-term Care
Nurses	Inner City Health
Insurance Companies	Workers Compensation
Insurance Agencies	Women's Health
Big Business CEOs	Children's Health
Small Business Owners	Minority Health
Labor Unions	
Consumer Groups	
Disabilities Groups	
Aging Groups	
Pharmaceutical Interests (manufacturers and pharmacists)	
HMOs	

The other issues remaining to be determined are logistical, most importantly:

1. Where do we do the hearing? We believe it is best to keep it in the D.C. area given the nature of it, but what building?

2. How do we pay for it?

These questions need more investigation right away so that we can make a determination next week.