Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Edward Frankie to Christopher Jennings re: Genetic Discrimination Executive Order (2 pages)	01/14/2000	P5
002. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	12/02/1999	P6/b(6)
003. fax	Jonathan Stein to Chris Jennings (partial) (1 page)	12/02/1999	P6/b(6)
004. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	12/06/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Faxes)
OA/Box Number: 16777

FOLDER TITLE:
Faxes - DPC December 1999 [Binder] [1]

Racheal Carter
2011-0747-S
rc329

RESTRICTION CODES

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

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

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

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

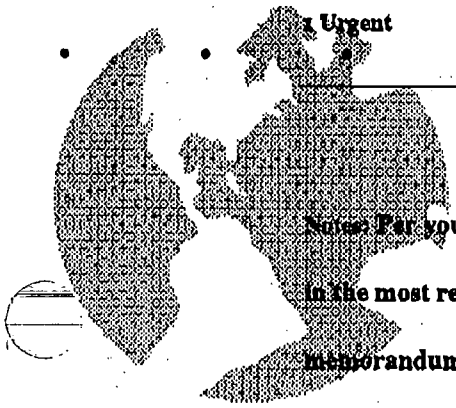
b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Edward A. Frankle, Esq.
General Counsel
NASA
Washington, DC 20546
(202) 358-2450

facsimile transmittal

To:	Christopher Jennings, Deputy Assistant to the President for Health Policy	**Fax:**	202-456-5557
From:	Edward A. Frankle	**Date:**	1/14/00
Re:	Genetic Discrimination Executive Order	**Pages:**	Cover plus 1
CC:			

☒ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle



Notes: Per your request, NASA has reviewed the draft Executive order. The changes made in the most recent version address most of NASA's concerns. As explained in the enclosed memorandum from our medical staff to me, the current version presents no problem regarding the vast majority of our employees and has only small, but acceptable impacts on the astronaut corps as it currently exists. We do feel that when the time comes to begin selecting crews to go on long duration missions, such as to Mars or the moon, other problems may well arise. Those issues are, at least, several years in the future and are best addressed when they arise in a full factual context. Therefore, recognizing that policy on this important topic will and must evolve as we learn more about the use of genetic information, NASA has no objection to the issuance of the version of the Executive order distributed for comment on January 12, 2000. Thank you for the opportunity to comment and participate in this review.

Edward A. Frankle

CONFIDENTIAL

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: RLR DATE: 06/29/11

National Aeronautics and
Space Administration
Headquarters
Washington, DC 20546-0001

Reply to Attn of:

JAN 14 2000

UH

TO: G/General Counsel

FROM: UH/Director, Office of Health Affairs

SUBJECT: Proposed Executive Order to Prohibit Discrimination in Federal Employment Based on Predictive Genetic Information

1. We have reviewed the revised draft of the proposed Executive Order. We believe that compliance with this order will not negatively impact our operations for our ground-based workforce, for those workers engaged in underwater activities, and for those individuals engaged in atmospheric flight operations.

2. With respect to operations in space, there is potential liability. Space is the most extreme and unforgiving environment into which humans have ever ventured. In space, small crews of people are utterly dependent on each another for survival, and failure of one for any reason may mean disaster for all. We have depended on strict selection standards to minimize the risk of medical problems during space missions and have been well served by this practice. For short duration missions, the proposed Executive Order will probably not negatively impact operations. During long duration missions, however, genetic traits that were latent at launch may manifest as disease, endangering not only the individual but also the entire crew. Inability to use predictive genetic information for flight assignment in this context may therefore represent a prohibitive risk.

3. We believe that an exception to this proposed Order applicable to the Astronaut Corps may ultimately be necessary to protect the health and safety of long duration space crews. We can, however, comply with the proposed order without untoward effect at present, for short duration space flight missions.

Richard S. Williams, MD

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton (partial) (4 pages)	12/10/1999	P6/b(6)
002a. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	12/11/1999	P6/b(6)
002b. schedule	Schedule for Hillary Rodham Clinton (partial) (2 pages)	12/12/1999	P6/b(6)
003. schedule	Schedule for Hillary Rodham Clinton (partial) (2 pages)	12/13/1999	P6/b(6)
004. letter	Becky Ogle to Chris Jennings (partial) (1 page)	12/13/1999	P5, P6/b(6)
005. schedule	Schedule for Hillary Rodham Clinton (partial) (2 pages)	12/16/1999	P6/b(6)
006. briefing paper	re: US Healthcare Systems v. Pennsylvania Hostpital Insurance Co. (PAPPAS) (5 pages)	12/13/1999	P5
007. schedule	Schedule for Hillary Rodham Clinton (partial) (2 pages)	12/17/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Faxes)
OA/Box Number: 16777

FOLDER TITLE:
Faxes - DPC December 1999 [Binder] [3]

Racheal Carter
2011-0747-S
rc331

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

456-5237

Chris,

Thanks for taking the time to review this and to see whether or not we can provide Secretary Herman the opportunity to present it on Friday. It is significant in the fact that the first report to the President recommended passage of the WIIA and now he is signing it and accepting the second report that lays out implementation plans, as well as other recommendations that are very important to the employment of people with disabilities. There is nothing controversial in the report, P6/(b)(6)

P6/(b)(6)

[004]

The significance of the Task Force is it's ability to work in a cross-agency way on issues such as implementation. We were going to put a directive or recommendation in the report that called on the President to direct Donna Shalala to expedite the grant and infrastructure funds to the states, but Jeanne asked us not to. We had also intended to ask that the WIIA be revisited to bring it to where we were w/Medicare, but I think OMB objected or someone did so it got taken out too.

Anyhow, I have enclosed for your review highlights of the Task Force report to the President, especially the parts of the Health Care and Income Committee report where they talk about the implementation of the WIIA. This is working so I would suggest not creating another entity to do this, in fact, I beg of you not to create another entity. It is difficult enough getting them to all work together in this arena without asking them to step into another. Turf has been established and I think everyone is comfortable with the boundaries.

Let me know what you think. I really want to hand this report over to the President and get it out the door. We are way past due.

Thanks,

Becky Ogle

DRAFT 12/13/99 — INTERNAL USE ONLY
DRAFT BRIEF IS UNDER REVIEW AT SG's OFFICE

The Facts:

- Basile Pappas subscribed to a Pennsylvania HMO through his wife's ERISA covered health plan. In 1991, he visited his HMO doctor, Dr. Asbel, complaining of neck and shoulder pain. The doctor gave him a steroid injection and sent him home. Pappas' condition worsened drastically overnight. The next morning he was admitted to the emergency room at Haverford Community Hospital, paralyzed from the chest down. The emergency physician, Dr. Rikter, diagnosed Pappas as suffering a neurological emergency and arranged for him to be transported to Thomas Jefferson University Hospital, a facility capable of providing immediate, specialized treatment for the particular condition that Pappas suffered

- When Dr. Rikter asked the HMO to preauthorize emergency treatment for Pappas at Jefferson, the HMO refused because Jefferson was not a network facility. Instead, the HMO gave Rikter the name of 3 other area hospitals where Pappas could be treated that were in the HMO network. The HMO's denial of the preauthorization request appears to have been in error, because a plan document states that pre-authorization is not required in an emergency.

- Once the HMO refused to authorize treatment at Jefferson, a delay ensued as Rikter arranged for Mr. Pappas to be sent to one of the 3 network hospitals. That evening, Pappas underwent surgery at a network hospital, but he was left a permanent quadriplegic.

- Although Dr. Asbel, the primary care doctor, was an HMO provider, it appears that neither Dr. Rikter, the ER doctor, nor Haverford Hospital, where Pappas were seen by Rikter, were part of the HMO network.

The Litigation:

- Pappas and his wife sued Dr. Asbel and Haverford Hospital in state court for negligence. The Pappases did not assert any claim (direct or vicarious) against the HMO (perhaps believing, in 1992, that any such claim would be preempted by ERISA). Haverford filed a third party complaint against the HMO, joining it as a defendant and seeking to recover from the HMO whatever sums Haverford was found to owe the Pappases Haverford did not assert any independent claims against the HMO.

- The state trial court granted summary judgment to the HMO against Haverford, on grounds that Haverford's third-party complaint was preempted by ERISA. The court

characterized the complaint as alleging that the HMO failed to pay a benefit claim or preapprove a procedure which are matters of plan administration.

- After summary judgment, Haverford's insurers settled the Pappases' claims against Dr. Asbel and Haverford. The court substituted Haverford's insurers as the real parties in interest. Since settling their claims, the Pappases have not been parties to the litigation.

- An intermediate state court reversed the trial court's grant of summary judgment, holding that ERISA was not implicated in the negligence claims. Rather, the court viewed these claims as involving general health care regulation, a matter which is traditionally left to the states and not preempted. The intermediate court further noted that no denial of benefits was involved in this case, as Pappas eventually received treatment.

- The Pennsylvania state supreme court affirmed the intermediate court in a divided opinion. The majority broadly held that negligence claims against an HMO do not "relate to" ERISA plans and thus are not preempted. Further, the court read Travelers as establishing that ERISA does not preempt state laws governing the provision of medical care and as implicitly overruling Pilot Life.

- The HMO petitioned the Supreme Court for review. The respondents in the Supreme Court are Haverford Hospital's insurers.

The Government's Position:

- The SG has final say over the government's brief, which recommends that the Court hold the case until Pegram is decided, or alternatively, that the Court take the case now. This recommendation is a slight change from the Department of Labor's recommendation, which was to take the case now.

- If the Court takes the case now, it would be heard and decided in the same term as Pegram, by June 30, 2000. If the Court holds the case it could, after deciding Pegram, refuse to review Pappas (unlikely); accept Pappas for review and schedule it for next term (between October 2000 and June 2001) (possible); or accept Pappas, vacate the state court judgment and remand to the state court for a decision consistent with Pegram (the most likely outcome if the Court holds the case). In the last scenario, the Court would not decide the preemption issue in Pappas and the Court's decision in Pegram, which presents fiduciary questions, may or may not shed light on the preemption issue.

- As mentioned, on the merits the SG's draft brief argues for preemption. The brief states that it is "undisputed" that the HMO here made a benefit decision denying preauthorization of treatment at an out of network hospital, and that the denial did not

involve the exercise of medical judgment. Because the HMO was acting in a plan administration capacity when it denied coverage, the brief argues that ERISA preempts the state law negligence claims against the HMO. In laying the foundation for this argument, the brief notes that case law and the claims regulation (current and proposed) treat benefit denials involving a significant component of medical judgment as plan benefit decisions that may be challenged only under ERISA.

- The draft brief argues that the state supreme court decision below conflicts with Pilot Life, as well as with numerous federal appellate decisions. The brief further argues that the question whether ERISA preempts state negligence claims against an HMO is an issue of national importance that the Court should clarify.

- The draft brief notes in a footnote (n.4) that DOL has supported amending ERISA to provide better remedies for the negligence of plan administrators in making benefit decisions.

Opposing Views:

- No amicus briefs were filed in the Supreme Court at the petition stage, i.e., on the question of whether the Court should accept the case for review. If the Supreme Court takes the case on the merits, amicus briefs will surely be filed on the preemption question, including by the government. In the Pennsylvania state supreme court, below, the AMA (with the AMA Specialty Society Medical Liability Project and the Pa. Medical Society) and the Pa. Trial Lawyers Association filed amicus briefs arguing that ERISA does not preempt a state law action against the HMO for negligence.

PBOR Implications:

- The HMO's negligence in this case caused Pappas to suffer an egregious harm -- permanent quadriplegia. To the extent Pilot Life controls this case, however, the government and the parties are bound by that law. This case thus highlights the need for Congress to enact PBOR which either narrows ERISA preemption or expands ERISA remedies.

- Under existing law, the HMO could have been reached under state law theories which were not asserted in this case. For instance:

    - If Dr. Asbel, the primary care doctor, were a network provider, Pappas could have sued the HMO for vicarious liability based on Asbel's malpractice, and for direct liability based on the HMO's negligent selection of Asbel as a provider.

DRAFT 12/13/99 — INTERNAL USE ONLY
DRAFT BRIEF IS UNDER REVIEW AT SG's OFFICE

- Some courts have permitted a service provider (such as Haverford Hospital) to assert an independent claim against an HMO alleging negligent misrepresentation about plan coverage, without running afoul of ERISA preemption.

- It is important to remember that the Pappases have been compensated. This case involves claims by the insurers of Haverford Hospital, where emergency room treatment was rendered, against the HMO for reimbursement of the settlement amount paid to the Pappases.

Background:

- The immediate issue before the Supreme Court is whether to grant the petition for review in this case. The parties filed their briefs asking the Court to accept or reject the case. The Court then issued an order inviting the government to file a brief expressing its views on whether the Court should take this case. There is no formal deadline for this filing, but the Solicitor Generals' Office intends to file the government's brief in Pappas by Friday, December 17, 1999. The SG's draft brief recommends that the Court hold Pappas until it decides Pegram, or alternatively, that the Court accept Pappas for review.

  - If the Court **holds** Pappas, it could do one of three things after it decides Pegram:

    (1) refuse to take Pappas for review (unlikely);

    (2) accept Pappas for review on the merits of the preemption question and schedule it for the next Supreme Court term (between October 2000 and June 2001) (possible); or

    (3) accept Pappas for review, but vacate the decision of the Pennsylvania state supreme court below, and remand for further proceedings consistent with the Supreme Court's decision in Pegram. This is the most likely outcome if the Court decides to hold the case. It would mean that the Supreme Court would not decide the preemption issue. It would also mean that the Court's decision in Pegram may or may not provide guidance on the preemption issue. Both cases involve HMOs and may perhaps raise a subsidiary issue of whether the plan benefit is membership in the HMO or, as the government argues, coverage for specific kinds of medical care. On the merits, however, Pegram involves fiduciary questions, so a decision in that case may shed no light on the preemption question raised by Pappas.

  - If the Court takes Pappas now it would hear and decide Pappas in the same term as Pegram, by June 30, 2000.

- The merits issue presented by this case is whether ERISA preempts state law claims arising from an HMO's denial of a plan participant's request for emergency treatment at a specialized hospital that was out-of-network. In making a recommendation, the government's brief explains why the decision below was wrong and previews its position on the merits. The government's position on the merits is that the state law negligence claim against the HMO is preempted by ERISA.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Janis Dubow to President Clinton re: phone number (partial) (1 page)	12/17/1999	P6/b(6)
002a. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	12/18/1999	P6/b(6)
002b. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	12/19/1999	P6/b(6)
003. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	12/20/1999	P6/b(6)
004. schedule	Schedule for Hillary Rodham Clinton (partial) (6 pages)	12/21/1999	P6/b(6), b(7)(E)
005. briefing paper	re: US Healthcare Systems v. Pennsylvania Hospital Insurance CO. (PAPPAS) (5 pages)	12/17/1999	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Faxes)
OA/Box Number: 16777

FOLDER TITLE:
Faxes - DPC December 1999 [Binder] [4]

Racheal Carter
2011-0747-S
rc332

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

DRAFT 12/17/99 (1:30) — INTERNAL USE ONLY
SG TO FILE BRIEF TODAY

US HEALTHCARE SYSTEMS v. PENNSYLVANIA HOSPITAL INSURANCE CO. (PAPPAS)

Background:

- The Solicitor Generals' Office plans to file the government's brief in Pappas **TODAY**, Friday, December 17, 1999. The brief recommends that the Court hold Pappas until it decides Pegram, or alternatively, that the Court accept Pappas for review.

- The **immediate issue** before the Supreme Court is whether to grant the petition for review in this case. The parties already filed their briefs asking the Court to accept or reject the case. The Court then issued an order inviting the government to file a brief expressing its views on whether the Court should take this case.

  - If the Court **holds** Pappas, as the government recommends, it could do one of three things after it decides Pegram:

    (1) refuse to take Pappas for review (unlikely);

    (2) accept Pappas for review on the merits of the preemption question and schedule it for the next Supreme Court term (between October 2000 and June 2001) (possible); or

    (3) accept Pappas for review, but vacate the decision of the Pennsylvania state supreme court below, and remand for further proceedings consistent with the Supreme Court's decision in Pegram. This is the most likely outcome if the Court decides to hold the case. It would mean that the Supreme Court would not decide the preemption issue. It would also mean that the Court's decision in Pegram may or may not provide guidance on the preemption issue. Both cases involve HMOs and may perhaps raise a subsidiary issue of whether the plan benefit is membership in the HMO or, as the government argues, coverage for specific kinds of medical care. On the merits, however, Pegram involves fiduciary questions, so a decision in that case may shed no light on the preemption question raised by Pappas.

  - If the Court **takes** Pappas now it would hear and decide Pappas in the same term as Pegram, by June 30, 2000.

- The **merits issue** presented by this case is whether ERISA preempts state law claims arising from an HMO's denial of a plan participant's request for emergency treatment at a specialized hospital that was out-of-network. In making a recommendation, the

DRAFT 12/17/99 (1:30) — INTERNAL USE ONLY
SG TO FILE BRIEF TODAY

government's brief explains why the decision below was wrong and previews its position on the merits. The government's position on the merits is that the state law negligence claim against the HMO is preempted by ERISA.

The Facts:

- Basile Pappas subscribed to a Pennsylvania HMO through his wife's ERISA covered health plan. In 1991, he visited his HMO doctor, Dr. Asbel, complaining of neck and shoulder pain. The doctor gave him a steroid injection and sent him home. Pappas' condition worsened drastically overnight. The next morning he was admitted to the emergency room at Haverford Community Hospital, paralyzed from the chest down. The emergency physician, Dr. Rikter, diagnosed Pappas as suffering a neurological emergency and arranged for him to be transported to Thomas Jefferson University Hospital, a facility capable of providing immediate, specialized treatment for Pappas' condition.

- When Dr. Rikter asked the HMO to preauthorize emergency treatment for Pappas at Jefferson, the HMO refused because Jefferson was not a network facility. Instead, the HMO gave Rikter the name of 3 other area hospitals where Pappas could be treated that were in the HMO network. The HMO's denial of the preauthorization request appears to have been in error, because a plan document states that pre-authorization is not required in an emergency.

- Once the HMO refused to authorize treatment at Jefferson, a delay ensued as Rikter arranged for Mr. Pappas to be sent to one of the 3 network hospitals. That evening, Pappas underwent surgery at a network hospital, but he was left a permanent quadriplegic.

- Although Dr. Asbel, the primary care doctor, was an HMO provider, it appears that neither Dr. Rikter, the ER doctor, nor Haverford Hospital, where Pappas was seen by Rikter, were part of the HMO network.

The Litigation:

- Pappas and his wife sued Dr. Asbel and Haverford Hospital in state court for negligence. The Pappases did not assert any claim (direct or vicarious) against the HMO (perhaps believing, in 1992, that any such claim would be preempted by ERISA). Haverford filed a third party complaint against the HMO, joining it as a defendant and seeking to recover from the HMO whatever sums Haverford was found to owe the Pappases Haverford did not assert any independent claims against the HMO.

DRAFT 12/17/99 (1:30) — INTERNAL USE ONLY
SG TO FILE BRIEF TODAY

- The state trial court granted summary judgment to the HMO against Haverford, on grounds that Haverford's third-party complaint was preempted by ERISA. The court viewed the complaint as alleging that the HMO failed to pay a benefit claim or preapprove a procedure, matters of plan administration which are preempted.

- After summary judgment, Haverford's insurers settled the Pappases' claims against Dr. Asbel and Haverford. The court substituted Haverford's insurers as the real parties in interest. Since settling their claims, the Pappases have not been parties to the litigation.

- An intermediate state court reversed the trial court, holding that ERISA did not preempt the negligence claims. The court viewed the claims as involving only general health care regulation, an area that does not implicate ERISA and is traditionally left to the states.

- The Pennsylvania state supreme court affirmed. The court broadly held that negligence claims against an HMO do not "relate to" ERISA plans and thus are not preempted. It viewed Travelers as narrowing ERISA's preemptive scope, and opined that delivery of emergency care in a dilatory fashion implicates the quality of the care, which is not preempted.

- The HMO petitioned the Supreme Court for review. The respondents in the Supreme Court are Haverford Hospital's insurers.

The Government's Position:

- The SG has final say over the government's brief. The brief suggests that the Court hold the case until Pegram is decided, or alternatively, that the Court take the case now. This recommendation is a slight change from the Department of Labor's draft brief, which recommended that the Court take the case now.

- If the Court holds the case it could, after deciding Pegram, refuse to review Pappas (unlikely); accept Pappas for review and schedule it for next term (between October 2000 and June 2001) (possible); or accept Pappas, vacate the state court judgment and remand to the state court for a decision consistent with Pegram (the most likely outcome if the Court holds the case). In the last scenario, the Court would not decide the preemption issue in Pappas and the Court's decision in Pegram, which presents fiduciary questions, may or may not shed light on the preemption issue. If the Court takes the case now, it would be heard and decided in the same term as Pegram, by June 30, 2000.

- As mentioned, on the merits the government's brief argues for preemption. The brief treats the HMO's denial of preauthorization as a benefit determination and argues that state-law negligence claims against the HMO are preempted, because coverage decisions

DRAFT 12/17/99 (1:30) — INTERNAL USE ONLY
SG TO FILE BRIEF TODAY

are governed exclusively by ERISA,. The brief observes that there is no evidence of record that the HMO exercised any medical judgment in refusing to preauthorize or that the HMO acted other than in its role as plan administrator when it denied coverage. The brief also notes that case law and DOL's claims regulation (current and proposed) treat benefit denials that involve a significant component of medical judgment as plan benefit decisions that may be challenged only under ERISA.

- The government's brief argues that the state supreme court decision below conflicts with Pilot Life, as well as with numerous federal appellate decisions. The brief further argues that the question whether ERISA preempts state negligence claims against an HMO is an issue of national importance that the Court should clarify.

- The government's brief notes in a footnote (n.5) that DOL has supported amending ERISA to provide better remedies for the negligence of plan administrators in making benefit decisions.

Opposing Views:

- No amicus briefs were filed in the Supreme Court at the petition stage, i.e., on the question of whether the Court should take the case for review. If the Supreme Court takes the case on the merits, amicus briefs will surely be filed on the preemption question, including by the government. In the Pennsylvania state supreme court, below, the AMA (with the AMA Specialty Society Medical Liability Project and the Pa. Medical Society) and the Pa. Trial Lawyers Association filed amicus briefs arguing that ERISA does not preempt a state law action against the HMO for negligence.

PBOR Implications:

- The HMO's negligence in this case caused Pappas to suffer an egregious harm -- permanent quadriplegia. To the extent Pilot Life controls this case, however, the government and the parties are bound by that law. This case thus highlights the need for Congress to enact PBOR which either narrows ERISA preemption or expands ERISA remedies.

- Under existing law, the HMO could have been reached under state law theories which were not asserted in this case. For instance:

    - If Dr. Asbel, the primary care doctor, were a network provider, Pappas could have sued the HMO for vicarious liability based on Asbel's malpractice, and for direct liability based on the HMO's negligent selection of Asbel as a provider.

DRAFT 12/17/99 (1:30) — INTERNAL USE ONLY
SG TO FILE BRIEF TODAY

- Some courts have permitted a service provider (such as Haverford Hospital) to assert an independent claim against an HMO alleging negligent misrepresentation about plan coverage, without running afoul of ERISA preemption.

- It is important to remember that the Pappases have been compensated. This case involves claims by the insurers of Haverford Hospital against the HMO for reimbursement of the settlement amount paid to the Pappases. Haverford rendered emergency care to Pappas but allegedly was negligent in arranging his transfer to a network hospital for surgery,

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	01/20/2000	P6/b(6)
002. fax	Valerie Washington Akers to Chris Jennings re: SSNs and DOBs (partial) (1 page)	01/20/2000	P6/b(6)
003. letter	S. Daniel Abraham to President Clinton (partial) (1 page)	01/17/2000	P6/b(6)
004. memo	Rosemary Hart to Christopher Jennings re: Executive Order to Prohibit Discrimination (2 pages)	01/21/2000	P5
005. schedule	Schedule for Hillary Rodham Clinton (partial) (1 page)	01/24/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Faxes)
OA/Box Number: 20141

FOLDER TITLE:
Faxes - DPC January 2000 [Binder] [4]

Racheal Carter
2011-0747-S
rc337

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

U.S. Department of Justice

Office of Legal Counsel

Washington, D.C. 20530

January 21, 2000

To: Christopher C. Jennings
Deputy Assistant to the President for Health Policy

From: Rosemary A. Hart
Robin A. Lenhardt

Re: Executive Order to Prohibit Discrimination in Federal Employment Based on Genetic Discrimination.

This memorandum sets out the substantive comments on the draft executive order that have been advanced by various components within the Department of Justice. We apologize for the delay in getting them to you. As we explained to your assistant, Devora, obtaining comments from the numerous components within the Department proved to be a more difficult task than we had anticipated.

For the most part, the changes we have suggested are minor. We believe that they would improve the draft order, but emphasize that a decision not to accept our suggested revisions would not preclude the Department of Justice from supporting the final order. Our components have been uniform in their willingness to sign on to the draft.

If you have any questions or concerns, please contact us at either 514-2027 (Rosemary) or 514-1762 (Robin).

Suggested revisions to the 1/18/00 draft:

1. 1-202. Add a provision permitting disclosure in response to a congressional subpoena.

2. 1-202(d)(3). This subsection permits an employing department or agency to disclose protected genetic information "under legal compulsion of a Federal court order." We note, however, that many legal actions, such as proof of paternity, take place primarily in state courts. We therefore suggest that you revise that phrase to read "under legal compulsion of an order issued by a court of competent jurisdiction." This language

tracks the language of the Privacy Act and would allow a state court to issue a disclosure order, where such disclosure is appropriate.

3. 1-301(a). This exception to employer procurement of protective genetic inform ation is not uniform in its references to applicants and employees. We ask that you am end the introductory sentence of this provision to read that "[t]he employing departmen or agency may request or require information defined in 1-201(e)(1)(C) with resp ct to an applicant **or employee** who has been given a conditional offer. . . ." This wou d make the language of subsection 1-301(a) consistent with that of subsection 1-301(a)(3).

4. 1-301(a)(3). We recommend that you substitute the word "would" for the wor "could." The amended subsection would read "such current disease, medical c ndition or disorder **would** prevent the applicant or employee from performing the esse tial functions of the position held or desired." We think that permitting employers to request protected information only when it is clear that a "current disease, med cal condition, or disorder" would prevent an employee from performing his or her job is more consistent with the Rehabilitation Act and other applicable law.

5. 1-301(d)(3). This subsection explains that the order would not limit the statuto y authority of an agency to "collect protected genetic information as part of a law ful program, the exclusive purpose of which is to carry out identification purposes " We are concerned that, as currently drafted, this provision would not be read to em brace the operations of the National DNA Index System (NDIS), a database maintain d by the Federal Bureau of Investigation pursuant to authorization found in the Viol nt Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, 108 tat. 1796, whose primary, but not exclusive, purpose is to store DNA records subm itted by criminal justice agencies for law enforcement purposes. We therefore recomm end that this provision be amended to read "the **primary** purpose of which is to carry ou t identification purposes."

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: SSDI recipients (1 page)	07/28/2000	P6/b(6)
002. paper	re: Talking Points (6 pages)	07/28/2000	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Faxes)
OA/Box Number: 20143

FOLDER TITLE:
Faxes - DPC July 2000 [Binder] [5]

Racheal Carter
2011-0747-S
rc361

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[redacted]

Talking Points

[redacted]

Internal Use Only

Background: *The nation-wide class action lawsuit filed against us in 1993 has been settled. As you may know, the plaintiffs originally challenged the adequacy of the managed care appeals process and HCFA's protection of enrollees' due process rights through its contractors.*

- We share a commitment with the plaintiffs to ensure the adequacy of the managed care appeals process, including ensuring that beneficiaries receive adequate notice, and are afforded fair process rights when their health care coverage is being terminated. These shared values led us to proceed with settlement discussions.

- Using the basic direction given by the President in the Consumer Bill of Rights and Protections, we took the responsibility to conduct a public process for developing a set of appeals that will balance the interests of our beneficiaries with the operational concerns of the organizations with which we contract.

- We seek a process that is fair, efficient, and imposes a minimum of burden and lost time in decision-making.

- Given the potential range of proposed solutions, we believe that this settlement and our proposal are very sensible. By agreeing with plaintiffs to issue the proposal as a Notice of Proposed Rulemaking (NPRM), we have moved the decision-making process concerning these key patient protections into the public rulemaking arena where all affected parties can contribute to the final product.

- We would like to acknowledge the plaintiffs for their willingness to settle for reasonable notice and appeal procedures that in some ways differ substantially from those they had been seeking to have ordered by the court.

- Many aspects of the protections arising out of this process already exist in the context of the Medicare+Choice appeals process that applies in the case of an appeal from a termination of hospital services, which Medicare+Choice organizations are already expected to follow.

- HCFA believes that the underlying principles and specific approaches which we hope to use in fashioning Medicare+Choice provider notices and beneficiary appeal procedures will provide a useful foundation for further reforms in our fee-for-service program where the increased use of prospective payments systems creates similar situations where one payment embraces a number of services that a beneficiary may wish to appeal. In fact, some current litigation raises some of the same concepts that were at issue in the Grijalva matter. We look forward to working with the providers in the fee-for-service system to take a new look at the appeals process and to fashion a system, which is fair, efficient, and imposes a minimum of additional burden.

DRAFT #3 -- 7/28/00 11:41 AM

Background

As you may recall, Grijalva v. Shalala is a 1993 nation-wide class action lawsuit brought by beneficiaries who were enrolled in risk-based HMOs under Medicare's old managed care program. The plaintiffs challenged the adequacy of the managed care appeals process and whether the Health Care Financing Administration (HCFA) failed to enforce that its contractors afforded enrollees due process rights when the contractors denied, reduced or terminated health care coverage. For a variety of reasons, the Department appealed a lower court decision in favor of the plaintiffs to the Supreme Court where the lower court decision was vacated and remanded. After that, HCFA met with plaintiffs' counsel to see if we could agree on an approach to meeting their goals and HCFA's. Over the past 8 months, HCFA – in close consultation with the Assistant Secretary for Planning and Evaluation, the Office of General Counsel, Department of Justice, as well as other Department offices – discussed these issues with plaintiffs. We have reached and equitable settlement.

Pursuant to a court order, HCFA must sign and file with the court by July 24 a final settlement agreement in Grijalva v. Shalala.

Overview

Q. What is the Grijalva case?

A. Grijalva v. Shalala is a 1993 nation-wide class action lawsuit brought by beneficiaries who were enrolled in risk-based HMOs under Medicare's old managed care program. The plaintiffs challenged the adequacy of the notice and appeals process provided when HMOs denied coverage of services or terminated such coverage.

Q. What are some of the key elements of the settlement agreement?

A. The primary element of the settlement agreement requires that we publish a notice of proposed rulemaking (NPRM) addressing notice and appeal procedures for Medicare+Choice organizations (M+COs) that would:

- Require that M+C organizations provide advance written notice of appeal to enrollees at least four days prior to the proposed termination date of certain institutional provider services, such as SNFs, HHAs, and CORFs.

- Establish an independent review entity (IRE) that would be available to perform an expedited review of the M+C organization decision to terminate services prior to the effective date of the termination. An enrollee would be required to file a request for such review no later than by noon of the day immediately following the receipt of the above advanced notice.

- Provide that an IRE decision is final and binding as to whether coverage of service should terminate or continue, and that the enrollee has a right to continued coverage until noon of the day following the IRE's decision.

The enrollee would not be required to use the IRE appeals process and could use other appeal processes available under the M+C organization regulations; however, the right to continued coverage during the appeals process would not pertain.

The settlement agreement provides that HCFA will make its best efforts to publish the NPRM by December 31, 2000, and give plaintiffs rights to return to court if a final rule responding to comments on the NPRM is not published by December 31, 2002.

Q. Why did the Government agree to a settlement and cave in to the plaintiff's demands?

A. The Clinton Administration has always supported the right of Medicare beneficiaries to appeal decisions by their HMOs. Through this settlement, HCFA has taken into account both the President's Consumer Bill of Rights and the claims presented in the lawsuit. We believe that the settlement balances the need for advanced termination notice in provider settings with the potential for burden on M+C organizations. The court's original Grijalva order included numerous items that we did not believe were appropriate and that were not included in the eventual settlement, including:

- Obligating M+C organizations to continue covering services indefinitely until an appeal is resolved, all after the services have been determined not to be covered (including not just the services in HHA and SNFs that will be addressed in the NPRM, but other types of services).

- "In person" hearings with decision-makers before the 1st level-reconsideration, and a description of this procedure to be included in the written beneficiary notice of denial.

- A requirement that the notice beneficiaries include a description of the additional evidence that would support the enrollee's case, including access to utilization review screens.

- A prohibition on renewing a contract with an M+CO that failed to comply with notice, and appeal requirements, or which retaliated against a doctor supporting expedited review.

Q. What type of providers are affected by the Grijalva settlement?

A. If the NPRM were finalized as proposed, the final rule would affect skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities treating M+C enrollees.

Q. When will the terms of the settlement become effective?

A. HCFA has agreed to implement the terms of the settlement in the following manner:

1. We will employ our "best efforts" to publish an NPRM by December 31, 2000; and promulgate a Final Rule by no later than December 31, 2002. This process will allow the public, including M+C organizations who will have primary responsibility for implementation of the new requirements, to have an opportunity to comment on these new proposed provisions.

2. All required notices will be published in the Federal Register as part of the Paperwork Reduction Act clearance process.

3. HCFA has agreed to issue instructions or make arrangements necessary to explain how to implement other aspects of the agreement (e.g. through, manual instructions, OPLs, protocol changes, handbook or publication) by no later than June 30, 2001.

Q. Are provisions for denials, reductions and terminations all covered within the scope of this settlement?

A. No. Under the settlement, our proposed rule would cover only notice and appeal rights relative to terminations of coverage or discharges from certain provider types.

Potential Impact on M+C Enrollees and Plans

Q. How will the Medicare+Choice organization enrollees be affected by the Grijalva settlement?

A. If the rules in the notice of proposed rulemaking (NPRM) are finalized as proposed, when an M+C organization has authorized coverage of an ongoing course of treatment for an enrollee, proper advanced written notice of termination would need to be provided to each enrollee. An enrollee would be provided a written notice of a decision to terminate provider services four days in advance of termination.

Q. What will the advanced termination notice provide?

A. As part of the NPRM, we will propose to require that the advanced written notice provide specific information regarding the reasons why provider services either are no longer medically necessary or covered, the specific basis for that decision, as well as information about the enrollee's right to file for an immediate independent review and the procedures for how to file an appeal.

Q. Who will be responsible for issuing the advanced termination notices?

A. We will propose that providers issue the notice to the enrollees and that M+C organizations are ultimately financially responsible for the cost of the enrollees care and services until notices are given.

Q. Will an advanced notice of termination be required even if an enrollee agrees that services should terminate?

A. Yes. The NPRM will propose to require that notice be given regardless of whether the enrollee agrees that provider services should end.

Q. Will M+C organizations be liable for continued coverage during an appeal to the IRE?

A. Yes, but note that the time interval that will be proposed under the settlement agreement essentially coincides with the current expedited review process used by M+C organizations. Therefore, to the extent that the term of coverage decision is adequately supported by the plan's documentation, there will no additional costs.

Q. Under this settlement agreement will providers have to follow separate notice and appeal procedures in fee-for service Medicare and in the Medicare+Choice program?

A. Historically, the notice and appeals provisions associated with fee-for-service Medicare have varied considerably from those used in Medicare managed care. These differences stemmed in large measure from the basic natures of the two systems--Medicare's traditional appeals procedures were based on claims for individual items and services that had already been provided, whereas in a managed care system decisions can often be individually appealed before services are furnished. The increased use of prospective payments systems in our fee-for-service program creates similar situations where one payment embraces a number of services that a beneficiary may wish to appeal, and our long-range strategy is to achieve greater uniformity in both underlying principles and specific approaches that apply in original Medicare and the Medicare+Choice program.

The Grijalva settlement agreement represents an important step in these long-term efforts. We believe that the notice and comment rulemaking process that we will use to fashion the Medicare+Choice provider notices and beneficiary appeal procedures will be very useful in informing similar changes that we are contemplating in fee-for-service Medicare. We look forward to working with the providers in the fee-for-service system to take a new look at the appeals process and to fashion a system which is fair, efficient, and imposes a minimum of additional burden.

Q. Why is HCFA settling this case, after successfully getting the Ninth Circuit's decision and the district court's order vacated? Aren't the plaintiffs back where they started when they first filed this case in 1993?

A. While we have always agreed with plaintiffs' goal that Medicare managed care enrollees be afforded adequate protections when their HMO decides that services should be terminated, we felt it was important that decisions on how best to meet this goal be made by HCFA with input from interested parties, and not dictated by a single district court judge. At the time the district court rendered its decision, HCFA already had in the works a new regulation that would provide for an "expedited" review process when delays could be harmful to the enrollee's health. The publication of this final rule was a significant step in addressing the concerns that caused plaintiffs to file this lawsuit. HCFA also has long believed that it would be desirable to provide enrollees in nursing homes, or receiving home health services, with a right to an independent review of an HMO decision to terminate such services. The district court order that we were successful in having vacated, however, would have applied such a right far more broadly, and would have required HMOs to pay for services indefinitely even after a decision had been made that they were no longer covered. We did not think that the terms of the court's order were reasonable, or could be practically implemented. Moreover, HCFA potentially would have been subject to the district court's approval any time we felt that a change was warranted in the procedures spelled out by the court.

After the district court order was vacated, we met with plaintiffs' counsel to see if we could agree on an approach to meeting their goals that met both their needs and HCFA's. After extensive discussions, we arrived at the agreement filed with the court today July 31. Under this agreement, in addition to taking certain steps to enforce current requirements, we agreed to publish a notice of proposed rulemaking by the end of this year in which regulations would be proposed that would provide for an external independent review of SNF and home health termination decisions before termination occurs. This proposal will be subject to public notice and comment, and we expect to receive comments from beneficiaries, providers, HMOs, and other interested parties. We made no commitments in this agreement as to the contents of the final rule, which is expected to be published by the end of 2002.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	Chris Jennings to Pat Griffin (1 page)	12/12/1994	P5
001b. memo	David Nexon to Chris Jennings (1 page)	12/08/1994	P5
001c. report	re: Health Care and the 1994 Election (12 pages)	n.d.	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21536

FOLDER TITLE:
Chris Jennings Memos

Racheal Carter
2011-0747-S
rc847

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Pat Griffin

From: Chris Jennings

Date: December 12, 1994

Re: Polling Data Analysis by Senator Kennedy'soffice

cc: Steve R., Janet M.

It is my understanding that Senator Kennedy is likely to come in to see the President sometime early this week. Nothing he will say is likely to surprise anyone. (For example, I am certain that he will weigh in strongly against alienating the Democratic base through major cuts in social programs, particularly Medicare outside the context of a significant investment toward health reform.)

Although he will be introducing a comprehensive (universal coverage) bill early in January, he will not urge the President to do the same. In fact, he will not even urge him to go back to the Mainstream bill (which is where his staff was a few weeks ago). He will say, however, that it would be a major mistake for the President to forego an opportunity to initiate and lay claim to getting credit for some modest health reform proposal. (He probably would favor insurance reforms, a kids program, etc.).

For your information, I am enclosing a memo that David Nexon sent to me late last week. It concludes that, notwithstanding the current stereotypical perception of polling results as it relates to health care, the polling data does not bear it out. In short, as I read the attached:

Although the President's health care proposal was and will continue to be used as a metaphor for "big government" programs (and, as such, has contributed to a negative perception about the President), health care reform and the President's definition of it (containing costs and covering citizens) remian impressively popular with the Democratic and Independent voters he will need in 1996. I assume Senator Kennedy's coversation will be structured around this theme.

Lastly, do you want me to help with Janet (or Steve) with the drafting of the POTUS briefing memo?

December 8, 1994

TO: Chris Jennings

FR: David Nexon

RE: Analysis of poll data on the role of health care in the 1994 elections/implications for Democratic strategy.

Attached is the poll analysis we discussed. The data strongly re-affirms the view that health care continues to be one of the Democrats' best issues, but it also suggests that the President needs to act forcefully to re-identify himself with the issue in a positive way.

HEALTH CARE AND THE 1994 ELECTION: EVIDENCE FROM THE POLLS AND IMPLICATIONS FOR DEMOCRATIC STRATEGY

Summary

--Health care is a critical issue for the Democrats. It was the most salient single issue in the election and is among the voters' top priority for action in the new Congress. Health care is particularly important to the groups who will determine Democratic success in 1996--Democrats, Independents, and voters who did not go to the polls in 1994 but can be motivated to turn out in a Presidential election year.

--To make the health care work for the Democrats in 1996 the President must regain the initiative on the issue.

--The public continues strongly to support the central elements of the President's plan--universal coverage and cost control--but the scare tactics of the plan's opponents have left the public frightened of a possible government take-over of the health care system. This factor, combined with increased cynicism and distrust for government, may have temporarily dampened the public's appetite for plans labelled comprehensive reform.

--The poll data shows convincingly that, contrary to the usual analysis, health care as a discrete issue was an electoral plus for Congressional Democrats. The Democrats failure to pass health care, however, may have helped crystallize resentment about "politics as usual in Washington," and the disinformation spread by opponents of the President's plan may have contributed to an image of the Democrats supporting "big government".

--The DLC poll shows strong ambivalence about the proper role for government. Surprisingly, however, in view of the way the poll has been interpreted, it does not indicate that health care reform harmed the Democrats at the polls, nor does it even demonstrate that it affected voters' views of the President--and the poll shows continued high levels of support for key elements of the President's health plan.

--To seize the high ground on the health care issue, the President needs to continue to visibly fight for his principles: universal coverage and cost containment. He also needs to disassociate himself from the unfavorable

images that were unfairly attached to his own plan. He can best correct his image problems on this issue and position himself for the 1996 election by coupling continued advocacy of universal coverage and cost containment with a specific proposal for a down payment program that includes the elements "we can all agree on"-- insurance reform and subsidies to help working people and families with children afford the coverage they need.

--The President needs to resist any attempt to put him in the position of proposing Medicare cuts to be used for deficit reduction or a middle class tax cut or any use other than health care reform. Protection of Medicare and Social Security, which are linked together in the public mind, are wedge issues that can be immensely valuable to the Democrats at the polls--if we don't squander the opportunity.

Analysis

1. Health care is a critical issue for the Democrats

Health care was the single most salient issue in the 1994 campaign.

Three separate polls (Voters News Service, Kaiser/Harvard, and Public Opinion Strategies/HIAA) all showed the voters reporting that the single most important issue deciding their 1994 vote for Congress or that one of the two most important issues was health care (33% of all voters said it was one of the two most important issues in the Kaiser poll). The fact that health care was more salient to the voters than crime or welfare or tax cuts is especially remarkable in view of the relatively low level of discussion of health care during the campaign compared to these other issues.[1]

Health care is among the voters' top priorities in the new Congress

VNS, Kaiser, and a Yankelovitch poll all found that more voters listed health reform as the top priority for the new Congress than any

---

[1]There was some evidence in the POS poll of increased discussion of health care in the final few weeks of the campaign.

other issue. In the Kaiser poll, 40 percent listed it as one of the top two priorities.[2]

The DLC poll, which asked the question differently than the other polls (a forced choice rather than an open-ended question), found that voters ranked health care second out of twenty-two options as their choice for the single highest priority for the new Congress, just behind protecting Social Security and Medicare. When choices for either the single highest priority or one of the top few priorities are combined, the two health-related issues ranked third (controlling health care costs/ 53%) and seventh (insure everyone has health insurance/46%).

If anything, support for action seems to have grown since the election. A CBS health poll conducted November 27-28 found that health care was the top priority for the new Congress (19%). Crime was second (13%). Nothing else was above single digits, including welfare, the deficit, unemployment, taxes, and immigration. The poll also found that 62% said Congress should pass health reform in 1995 (although only 22% thought Congress would actually act).

Health care is particularly important among the groups who will determine Democratic success in 1996--Democrats, Independents, and 1994 non-voters who can be mobilized in a Presidential election year. Support for describing health reform as a top priority for the new Congress was substantially stronger among those who voted Democratic (53%) than it was among those who voted Republican (38%), although it was one of the top two priorities for both groups.[3] In the DLC poll, support for ranking universal health care as the single top priority was almost as high among Independents (14%--higher than any other issue) as it was among Democrats (18%). By contrast, only 4% of the Republicans thought universal health insurance was an equally high priority. When choice of the top priority and the top few priorities were grouped, the two health care issues were ranked fourth and fifth for independents and second and third for Democrats, compared to only eleventh and seventeenth for the Republicans (out of 22 choices).

---

[2]Crime was second with 31%; taxes, the deficit, education, the economy, and foreign policy were all below 20%.

[3]Kaiser.

Interestingly, for the whole sample and for Democrats and Independents, the top ranked issue was protecting Social Security and Medicare (it ranked third even for Republicans). Nonvoters ranked the priority of controlling health care costs even higher than Independents, and were about the same as the independents on the universal coverage issue.

2. To make the issue work for the Democrats in 1996, the President must regain the initiative. Health care is potentially one of the Democrats' strongest issues. As discussed above, it is highly salient for voters, and it is most salient with the voters we need to win in 1996--our Democratic base, independent swing voters, and off-year non-voters who can be mobilized in a Presidential election. Although, as we shall see, the voters most concerned about health care voted Democratic in 1994, there is evidence across the political spectrum that the pounding the President's plan took means that the President must act decisively to re-identify himself with the issue in a positive way.

When asked who should take the lead in developing a health care reform plan next year, 56% of the voters said members of Congress, and only 18% said the President. Even among Democratic voters, the proportion saying the Congress should take the lead was 45% to 20%.[4] When asked whether the Federal government or state governments should take the lead in changing the health care system, 54% said the state governments and only 32% said the Federal government (Democratic voters were about evenly divided--46% to 44%).[5] When asked who is to blame for the failure of health reform, the most recent poll data shows that 30% blame the President, while 33% blame the Congress or the Republicans in Congress.[6]

The lesson is not that the President should stay away from the issue: we can't afford to forfeit it to the Republicans. Instead, he needs

---

[4]Kaiser.

[5]Kaiser.

[6]POS. The question was loaded to place the blame on the President, but there was a significant increase in the proportion blaming him between September (22%) and November (30%), illustrating the failure of the Democrats to use the issue as effectively as they should have.

to take control of it again.

3. The voters still strongly support the key elements of the President's plan, but they are cynical about government and fearful of a government takeover of the health care system.

Support for the essential elements of the President's plan--universal coverage and cost control--remains high. As noted above, the DLC poll found these two objectives were ranked as very high priorities by voters, especially by Democrats, Independents, and non-voters. When the Kaiser poll asked whether voters were willing to pay more in premiums or taxes to guarantee health insurance coverage for all Americans--a question loaded against universal coverage--51 percent of the voters said they would (including 69 percent of Democratic voters and 43 percent of Republican voters), while only 39 percent said they would not. Interestingly, prohibition of pre-existing conditions, while it has broad support, is not as salient as more fundamental reforms. Only 18 percent of voters choose it as the most important way of improving private insurance.[7]

The scare tactics of the last year, however, have increased concerns about the nature of any plan proposed. Cynicism about government in general also makes it important to clearly explain that any proposal is not a government take-over of the health care system and is not excessively bureaucratic. The proportion of people wanting "radical reform" declined from 45% in January of 1992 to 22% in October, 1994.[8] A plurality of voters say they favor making modest changes in the health care system compared to enacting a major reform bill (25%), although those who voted Democratic continue to favor major reform (45% to 28%).[9] When the question is proposed in terms of major reforms versus small reforms, however, 48% favor major reforms over small reforms (29%). Of the 31 percent of voters who said they were less supportive of major reform on election day than six months ago, the top reason cited was, "The

---

[7]Kaiser.

[8]POS.

[9]Kaiser.

government wouldn't do it right."[10] The top worry cited by voters about what might happen if the Congress takes action on health reform is that "there will be too much government bureaucracy," ahead of reduction in quality or loss of choice.[11]

4. Contrary to the usual analysis, health care <u>as a discrete issue</u> was an electoral plus for Congressional Democrats--more so than any other issue. The Democrats failure to pass health care, however, may have helped crystallize resentment about "politics as usual in Washington," and the disinformation spread by opponents of the President's plan may have contributed to an image of the Democrats supporting "big government".

This result is especially striking in view of: (1) the tremendous pounding the interest groups and press had given the plan and the President over health care; (2) the relative lack of attention health care received during the election; and (3) the large numbers of voters that had an unfavorable view of the Clinton plan by the end of the debate.[12] What seems to have been going on is that voters who want health care reform--particularly those for whom it is a highly salient issue--continue to identify the Democrats as the party with a commitment to action. These voters who see health care as an important plus for the Democrats are either Democratic base voters, who we will need to mobilize in 1996, or independent swing voters, who we will need to attract. Voters who saw the health reform as a negative for the Democrats, on the other hand, were typically predisposed to vote Republican, anyway, or were more interested in other issues than health reform.

The VNS poll found that voters who said health care was the single most important issue in the election went for the Democrats 60% to 40%. When the broader group of voters who chose health care as one or the two most important issues deciding their vote is considered, Republican voters were as likely to identify health care as one of the two most

---

[10]Kaiser.

[11]Kaiser.

[12]The POS poll did find indications that the salience of health care increased during the last few weeks of the election.

important issues as Democratic voters.[13] But among key independent swing voters, those said health care was one of the two most important issues determining their vote overwhelmingly voted Democratic (44% of these voters who chose the Democrats felt health care was a key issue in deciding their vote compared to only 23% choosing the Republicans). President Clinton also had disproportionately high approval ratings among voters who said that health care was the most important issue affecting their vote (56% approval versus 35% disapproval).[14]

The indirect impact of health care may have been more negative, because the failure to pass health reform fed the voters' anger about the perceived failure of the Democrats to bring about change and the continuance of "business as usual" in Washington. POS reported that 59% of voters said their vote had to do with "sending a message" to the President and said that, in response to an open-ended follow-up questions, the broad theme that emerged was "get something done," with health care often cited as a failure to get something done (although, crime, the economy, and "stopping business as usual" were more frequently mentioned as the message voters wanted to send). Greenberg's poll for the DLC found, on a forced-choice question, that 56% of independents said they were trying to send a message about being dissatisfied with things in Washington. When given a list of things they might be sending a message about, "politics as usual" was most frequently cited (45%).

5. The DLC poll shows strong ambivalence about the proper role for government. Surprisingly, however, in view of the way the poll has been interpreted, it does <u>not</u> indicate that health care reform harmed the Democrats at the polls, nor does it even demonstrate that it affected voters' views of the President--and the poll shows continued high levels of support for key elements of the President's health plan.

The DLC poll includes a number of questions that seem to position people as "voting to change a government that spends too much and accomplishes too little and to shift public discourse away from big

---

[13]Kaiser.

[14] POS.

government solutions," in the words of the study's author.[15] On the other hand, there also seems to be strong support for government activism and maintaining or even expanding government's role, as well as responses that suggest that the "big government" issue may not have been important in the voting decision. For example:

– questions asking for endorsement of phrases that the candidate the voter chose in the elections was "against big government," and "for government that will do more for less" ranked only 13th and 14th respectively out of 17 choices. Independents looked more like Democrats on the first question and more like Republicans on the second question.

--When asked which of a pre-selected set of changes were most important for the Federal government (multiple responses allowed), the statement "The government should be made smaller so it will cost less and do less" was the least frequently selected (25%) of seven alternatives. Independents looked slightly more like Democrats than Republicans on this statement.

--57% of voters agreed that it is the responsibility of the government to take care of people who can't take care of themselves--and Independents were far closer to Democrats than Republicans on this issue.

--69 percent of voters (including 69 percent of independents) agreed that "We have important problems that the government must play a bigger role to help solve."

--And when asked what should be the top priorities of the new Congress and President, preserving those flagship programs of big government, New Deal liberalism--Social Security and Medicare--was the most frequently selected option as the single highest choice or top few choices out of 22 possibilities (62% of the total sample, 64 % of the Independents, and 70% of Democrats). Even among the Republicans, it had the third highest priority (51 percent).

There is no question that the public is ambivalent about the role of

---

[15]In my view, the evidence that these attitudes were a significant factor shaping the vote is actually quite weak, but there is no question that the views themselves are held by a large segment of the electorate.

government and cynical about its effectiveness, but these negative attitudes seem to be coupled with a high level of demand for government activism to solve problems and a continued belief in government responsibility to help those who need help and maintain entitlement programs benefitting the middle class.

The most relevant questions for this discussion, however, are not the public's overall attitudes about government but how these attitudes translated into attitudes on health reform, how health reform affected perceptions of the President and the Democrats, and, in turn, how these perceptions affected the vote. In view of the emphasis that the funders of the study have placed on health reform as the linchpin of the 1994 election, it is striking how little evidence there is in the study to support their interpretation. The whole argument is essentially pinned to two connected questions.

These questions actually have no direct connection to voting choices. Instead, the survey asked voters if they have felt disappointed about Bill Clinton since he took office in 1993. But Greenberg points out that in focus groups "independent voters in revolt against politics declined the easy connection with Bill Clinton." And when voters were asked to choose from among phrases that described the candidate that they selected, responses relating to the President received the lowest response of the 17 alternatives. Among those who chose these responses, "supports the President" was actually chosen by more voters (17%) than opposes the President (15%). Among the Independents, the margin was 14% to 12%. This is really quite a remarkable finding in view of the concerted Republican attempt to make the President the issue and the way so many Democratic candidates ran away from him.

Fifty-four percent of those polled said they felt disappointed with Bill Clinton. On this response, there was no unique profile to independents, 55% of who answered affirmatively. Instead, as is typical of questions with a partisan dimension, they fell almost exactly midway between Republicans (73%) and Democrats (35%). Interestingly, the same pattern applies to approval of Clinton's performance as President: 74% of Democrats approved; 52% of independents approved; and only 27% of Republicans approved.

If respondents said they were disappointed with Clinton, they were

then asked to choose from among nine phrases the ones that best reflected their feelings of disappointment (multiple choices were allowed). The second most frequently selected response (49%/first with Independents at 48%) was "Clinton proposed big government solutions, like health care reform." It is an elementary rule of questionnaire construction that only one question should be asked at a time. This question asks both about big government solutions and about health care reform. It is impossible to know whether the respondent is concerned about health care reform or about big government solutions, or even if he accepts the characterization of health care reform as a big government solution. Moreover, given the vagaries of the way people respond to poll questions, some of these people may well have been disappointed that Clinton did not pass health care.

It seems plausible from other survey data that opponents of health care reform were able to make the inaccurate characterization of health reform as a big government take over of the health care system stick with some voters. And it seems reasonable that some of this misunderstanding of the Clinton plan may have impacted negatively on the President's image with at least some voters--but you can't prove it from this question. And, as discussed earlier, all the other evidence in the survey--and three other surveys as well--strongly suggests that health reform as a discrete issue helped the Democrats. The key question now is how the President can best make this issue work as strongly as possible for the Democrats--because it can be one of the most important issues helping us win in 1996.

6. To seize the high ground on the health care issue, the President needs to continue to visibly fight for his principles and to disassociate himself from the unfavorable images that were unfairly attached to his plan. He can best correct his image problems on this issue and position himself for the 1996 election by coupling continued advocacy of universal coverage and cost containment with a specific proposal for a "down payment program that includes the elements Republicans have said they support.

As noted earlier, the key priority should be to get the President re-identified with the health care issue in a positive way. This has both a positive and a negative component. On the positive side, the President must be seen as pro-active and fighting for his principles. On the negative side, the President needs to disassociate himself from the idea that he is

proposing a bureaucratic, big-government take-over of the health care system.

Recommendation:

--The President should reaffirm and keep reaffirming his support for comprehensive reform founded on the principles of universal coverage and cost containment. He needs to be perceived as fighting for what he believes in and as being on the side of working families. As part of continuing advocacy of comprehensive reform, the President can comfortably reaffirm his support for employer mandates (with protection for small businesses) and premium limits, since those remain popular with the public and are a credible way of achieving universal coverage and cost-containment. Moreover, they are positions that are well-suited to reinforcing Clinton's image as a President willing to take on the special interests in defense of the ordinary working American.

--The President does not need to re-introduce or re-develop a comprehensive reform program at this time, since everyone recognizes that the Republican Congress will not enact it, but he does need to put forward a downpayment program that will keep him a leading player on this issue and will hold the Republican's feet to the fire.

--The President should defuse fears about his old program and keep himself in the public eye on this issue by proposing a program for enactment in this Congress that "we can all agree on" as a first step to comprehensive reform--and challenge the Republicans to enact it. The program should include:

o insurance reform (pre-existing condition limitations, guaranteed issue, guaranteed renewability, modified community rating).

o subsidies for those who can't afford coverage, with emphasis on working families and coverage for all children.

o a start on long-term care for seniors.

This approach puts the President on the high ground on the issue. It challenges the Republicans to do what they said they were going to do in their seven-point Senate agenda and in the legislation they introduced last

year. It removes the residual taint of last year's attacks by endorsing essentially the same things Republicans have already proposed. If the Republican fail to act, they will be blamed for gridlock (and their own pollsters are telling them it would be a mistake for them not to pass anything). If the Republicans do pass a plan with any of these elements, the President can claim credit and ask the voters to send him back in 1996 so that he can finish the job.

The Republicans would like the President to stay away from the health care issue, because they know it is still a potential winner for the Democrats. Their pollsters are telling them that their best strategy is to ignore health care this year and focus on issues that they think work best for them: welfare, crime, tax cuts, spending cuts. In 1996, the Republicans would pass a modest, noncontroversial insurance reform to satisfy the public's demand for action. **If the President does not take the initiative on the health care issue--to keep it in the public eye and to identify it with him in a positive way again--he will play into the Republicans' hands.**

7. No Medicare cuts in the budget, except for health reform.

The President should avoid proposing Medicare cuts for any purpose except financing health reform (which must include a seniors' component). The Republican will be proposing huge reductions to try to balance their tax schemes. As the DLC poll shows, defending Medicare and Social Security is immensely popular with the voters--especially Democrats and Independents. The Republican cuts open an enormous opportunity for a "wedge issue" that can help us win an electoral victory in 1996--just as the Republicans lost the Senate in large measure over Social Security cuts in 1986. The Democrats would be foolish to blur this issue by proposing their own Medicare cuts, whether in the form of new cuts or so-called "extenders", for deficit reduction, tax cuts, or any other purpose.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Meeting Attendance list re: SSN and DOB (partial) (3 pages)	04/09/1993	P6/b(6)
002. memo	Chris J. to Steve R. re: Republican Members and Staff Meetings/Contacts (2 pages)	04/09/1993	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Meeting Attendance [2]

Racheal Carter
2011-0747-S
rc546

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PRIVILEGED AND ~~CONFIDENTIAL~~

Steve E. - FYI

M E M O R A N D U M

TO: Steve R. April 9, 1993
FR: Chris J.
RE: Republican Members and Staff Meetings/Contacts

Steve, as you will be able to tell by the attached list, we have been busy scheduling and holding meetings with Republican Members and staff from both Houses during the last two months. I believe the list will give Howard and you more than ample room to say that any future meetings with Republicans are simply a continuation of our past practice of consultation -- (even though the Republicans, particularly the Senate Members, have been complaining about their adequacy).

A couple last notes. I have been trying for weeks to find a way to extract Chafee and his moderates from the rest of the Republicans. The First Lady has desired to have a meeting with Senator Chafee, but has hesitated from calling to initiate one. (She does not want to appear to be going around the Minority Leader). Ira has tried too, but Chafee has repeatedly indicated he does not wish to meet with him at this time.

In addition, Senator Chafee's office (Christy Fergeson on a very confidential basis) has called to indicate that she believes their could be a constructive working relationship with at least a group of Members from the Republican Health Care Task Force. Most recently, though, she and her boss -- probably because they too fear alienating Senator Dole -- have taken the position that we should wait to have active Member-level discussions on the Senate side AFTER we have a better sense about what direction we want to go. (The reason why they are taking this position, no doubt, is that they do not have any desire to appear to be "bought off" so early in the process). Also, they still feel that having a larger number of Republicans to negotiate, at this point, places them in a much more powerful negotiating position.

Based on my numerous "off-the-record" conversations with senior staff of Chafee's office (Christy Fergeson), Danforth's office (Peter Leibold), Kassebaum's office (Andrew Patzman), and Senator Jefford's office, their is a great desire to work with us, but their is also a great fear about how it will be perceived by the rest of the Republicans. At a recent Members meeting, a comment about how "Republicans would get more than a good night's sleep if we go to bed with the Administration on health care" was made and well received by most of the Members present.

Obviously, if we have any chance of passing health care reform this year, we will have to have Republicans on board. Based on our record of meetings to date, I think we should have no problem defending a closer working relationship.

Lastly, I want to point out that, although Senate Republican Members have not been coming to meetings recently, it is not because we did not want them there. I have consistently pointed out to Shiela that our Democratic Senators are being briefed by Ira and are being done so in large numbers. Shiela always says, though, that if it is just Ira or other work group members, it will be just staff.

Hope this information is helpful. Call me up with any questions.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	Ron Klain to Mary Gore re: Mental Health Parity (1 page)	05/03/1996	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 23743

FOLDER TITLE:
Mental Health Parity [5]

Racheal Carter
2011-0747-S
rc850

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Ron Klain

05/03/96 07:14:33 PM

To: Mary E. Gore/OVP
cc: Skila S. Harris/OVP
Subject: Poll Numbers on Mental Health Parity

Here are the polling numbers we discussed on your balcony. As I mentioned to you, Dick Morris included, as part of his weekly polling of American opinion, two questions about the mental health parity provision:

1. General support vs. opposition: Support 70% Oppose 23%

2. Then, voters were given a list of arguments against the provision (i.e., cost, federal mandate, cures uncertain), and re-asked about their position.
   The result: Support: 65% Oppose 28%

These so-called "after argumentation" results are especially strong; for example, Morris has an operating principle that a new idea that survives argumentation with a 55/35 approval (i.e., net +20 points) is one worth having the President endorse; the parity provisions' score after argumentation (net +37 points) is exceptional.

These results were presented to the President and his senior political advisers last night. I hope that they had some effect. I still think it is likely that some compromise will be forced upon us in exchange for winning passage of this bill, but your very successful public efforts have really helped strengthen our hand.

Chris

F. Y. I.

But for your eyes only

Sheila

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Jonathan Stein to Harriet Rabb re: SSI and Medical Assistance and Disabled Children (2 pages)	10/16/1997	P5
002. card	Business card re: phone number (partial) (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 23759

FOLDER TITLE:
Miscellaneous 1997 [13]

Racheal Carter
2011-0747-S
rc562

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

File SSI/ Medicaid

COMMUNITY LEGAL SERVICES, INC.

1424 CHESTNUT STREET
PHILADELPHIA, PA 19102
215-981-3700
FAX 215-981-0434

October 16, 1997

Harriet Rabb
Chief Counsel
U.S. Dept. of Health and Human Services
615F Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: SSI and Medical Assistance
and
Disabled Children

Dear Harriet,

Following our phone call last week we have not been able to receive from HCFA any assurance that the two problems we articulated to you, their acting chief counsel and then to HCFA program staff would be satisfactorily addressed at this time. As a result we are giving you notice that we will initiate class action litigation against Secretary Shalala and HCFA unless an immediate remedial response is forthcoming.

The two problems needing resolution, and set forth in more detail in the enclosed letter of October 10, 1997 to Judith Moore, Deputy Director of HCFA's Center for Medical and State Operations, are:

(1) the failure of HCFA to implement, via instructions to state Medicaid agencies, the grandfathering provision providing for continuous, uninterrupted Medicaid eligibility for any children terminated from SSI child disability benefits, Sec. 4913, Balanced Budget Act; and

(2) the planned implementation policy of allowing states to require an entirely new application for Medicaid for children already cut from SSI since July 1, 1997, most of whom were cut in violation of HCFA policy mandating automatic eligibility redeterminations to keep people on Medicaid even prior to the Balanced Budget Act amendment.

We and co-counsel have already filed a class action against the Georgia Medicaid agency which has now admitted to that at least 1,700 disabled children cut from SSI were also cut from Medicaid without any inquiry to determine whether they remained eligible under another provision of the Act. The failure of HCFA to issue implementing instructions and HCFA's plan to implement a re-application policy that will further impede Medicaid eligibility constitute violations of Section 4913 and other federal law.

You may reach us at (215) 981-3742 (or -3773) to remedy these issues without the need for litigation.

Sincerely yours,

JONATHAN M. STEIN
General Counsel

RICHARD P. WEISHAUPT
Senior Attorney

cc: Secretary Donna Shalala
Nancy Ann Min Deparle, HCFA
Judith D. Moore, HCFA
Bob Jay, HCFA Acting General Counsel
Chris Jennings, Domestic Policy Counsel, The White House
Senator Edward Kennedy
Mrs. Eunice Kennedy Shriver
Claudia Schlosberg, National Health Law Program
Marty Ford, The Arc
Herb Semmel, National Senior Citizens Law Center
Chris Koyanagi/Rhoda Schulzinger, Judge Bazelon Mental Health Law Center
Marilyn Holle, Calif. Protection and Advocacy

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. note	re; Publications Authored by David Satcher (2 pages)	n.d.	P2
001b. article	re: David Satcher (2 pages)	08/1996	P2
001c. note	re: David Satcher (1 page)	n.d.	P2
001d. article	re: Violence Prevention (2 pages)	1996	P2
001e. article	re: David Satcher (3 pages)	03/1995	P2
001f. article	re: Health Reform (7 pages)	10/26/1994	P2
001g. note	re: David Satcher (1 page)	n.d.	P2
001h. paper	re: Administrative Claiming for School Based Services in Medicaid (3 pages)	n.d.	P2
001i. article	re: The CDC and the NMA (4 pages)	n.d.	P2
001j. note	re: David Satcher (1 page)	n.d.	P2
001k. article	re: National Conference on Family Violence (5 pages)	03/1994	P2
001l. article	re: Two Views on the Problem of Emerging Infectious Diseases (2 pages)	n.d.	P2

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 23759

FOLDER TITLE:
Miscellaneous 1997 [16]

Racheal Carter
2011-0747-S
rc851

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001m. note	re: David Satcher (1 page)	n.d.	P2
001n. article	re: CDC Targets New and Recurring Health Risks (4 pages)	03/1994	P2
001o. note	re: David Satcher (1 page)	n.d.	P2
001p. article	re: The Paradox of Tobacco Control (2 pages)	02/1994	P2
001q. article	re: David Satcher (3 pages)	01/1994	P2

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 23759

FOLDER TITLE:
Miscellaneous 1997 [16]

Racheal Carter
2011-0747-S
rc851

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PUBLICATIONS AUTHORED BY

DAVID SATCHER, M.D., Ph.D.

Contents of Volume I:

- Articles and publications that are asterisked as being requested on Dr. Satcher's curriculum vitae.

- Articles and publications that may or may not have been requested, but which have been screened and identified as containing commentary needing special attention.

  Sections of articles with content of potential concern have been highlighted and have been flagged with a red tab. A sheet with a short explanation covers each of the articles that have sections needing special attention.

Contents of Volume II:

- Articles that have not been specifically requested but which are available, have been reviewed for content, contain no obvious potential issues needing special attention.

Note:

- No factual problems
- Comparison with a book popular in some circles could lead to question(s) .

sease will be available throughout the world. How their availability is constrained by al and population-based factors caused by the profound cultural changes of having so many more people live in a healthy state to a much older age.

Individuals will be able to calculate the probability of the adverse impact of various lifestyle choices in order to decide the value to them of effecting changes in their lifestyle (although it may take an additional generation before they fully understand and can make objective choices as a routine part of their daily life). Society, too will be able to make such calculations, and taxes, proportionate to their societal costs, will be levied on selected products and services, such as tobacco or motorcycle licenses, which account for a disproportionately high increase in monitoring, treatment, or trauma costs.

Trauma care will continue to be the realm where medical professionals actively run the care, but even here, the desires and the will of the individual will play a much more active role in the decisions that are made at critical junctures. Much of this care will be provided via telemedicine to community-based health care sites or to people in their own homes, and there will be a dwindling of activity in the emergency rooms and in the hospitals to focus on only the most ill or traumatized patients.

David Satcher, MD
Director
Centers for Disease Control and Prevention

As I seek to project myself well into the 21st century, I would begin by making some assumptions about the status of things at that time as compared to now, and I

insulin-dependent diabetes, or type 2 diabetes, can be prevented by interventions of physical activity and nutrition. The same is true for several other chronic diseases.

Assumption 2: New technological developments will improve our abilities to target prevention activities.

Certainly, the enhancement of communication networks will expedite our ability to implement prevention strategies throughout the country and the world. The new technologies involved in genetic engineering and genetic mapping will allow us to better target our prevention strategies to individuals who have significant risk for certain illnesses. For example, today we recommend screening tests such as colonoscopies based primarily on age. However, with genetic mapping we will be able to assess individual risk for colon cancer and to target colonoscopies to those persons who are high risk.

For people who are very low or no risk, it means that we can completely eliminate the colonoscopy or space colonoscopy much wider in time than we do for those at significant risk based on their genetic make up. This would not only save inconvenience and discomfort for persons who go through this procedure, but will also save money for the health care system.

As we learn more about the genetic factors involved in breast cancer we will be able to better target mammography to populations at high risk at different ages. This targeting will help us to detect breast cancer much earlier, preventing much of the pain and suffering from this disease. It will also allow us to significantly reduce the cost that is now involved in a broad scale mammography screening program.

Assumption 3: Microorganisms will continue to emerge, adapt, and change in such a way as to expedite their survival.

Despite our development of new antibi-

status among people we will see a continu- crease in violence and injuries. Like- nvironmental hazards will increase. s, the issue of urgent threats to health will continue far into the 21st century, unless there are drastic changes which take place in the human equation before that time. Certainly, public health in the 21st century must be global in perspective, and we must act with the global interest in mind in order to protect the health of the people in our own country.

All of the assumptions above will necessitate maintaining a strong and rigorous science base in public health, one that includes not only quality laboratories, but also excellent training programs to assure the availability of multidisciplinary scientists including: basic scientist, epidemiologist, clinical scientist, and behavioral scientist, to name a few. In addition to strong rigorous science, we must also develop new partnerships in public health, taking advantage of resources in every level and segment of community. The community planning coalition which has been developed as a part of our HIV/AIDS prevention strategy must become commonplace throughout public health as we attempt to intervene and prevent problems.

Partnerships within government as well as public-private partnerships and with non-governmental or volunteer organizations must become a part of the fabric of public health in the 21st century. Finally, we must make optimal use of the evolving information technology which we have at our disposal. This information technology will be critical in the early detection of and response to disease outbreaks in the 21st century. Scientists must be able to communicate with each other rapidly throughout the world; the best of expertise must be brought to bear upon a problem whenever it occurs in the world, and a response which

("memes") Speci in the fi microbiology, it will become possible to create a whole new panoply of replicating and evolvable nucleotide based agents (viruses). These will not be constructed by simply inserting or replacing a gene in a "natural" virus (as is done today), but by engineering entirely new classes of organisms from scratch. These artificial viruses will be used to deliver specific genetic information (genes) to selected target cells in vivo for therapeutic or prophylactic purposes. Some will be intentionally transmissible, to spread desirable genetic information (to somatic, not germinal cells) through entire populations.

Not long thereafter, autonomous cellular organisms will be artificially constructed. From the genetic sequencing of mycoplasma, hemophilus, and other prokaryotes, it is now known that the minimal genome size for autonomous cellular life is only a few hundred thousand nucleotides, as few as 250 genes. Artificial bacteria will be engineered for all sorts of industrial needs, ranging from chemical catalysis to food synthesis. Artificial bacteria may be designed to colonize the human gut and mucosal surfaces.

Of course, the technology for creation of entirely new viruses or bacteria will pose serious dangers. Rogue nations or apocalyptic groups will seek to weaponize the technology for biowarfare or bioterrorism. And certainly, well-intentioned biobungling will be an ever-present threat.

Paradoxically, perhaps the first real danger of the new science of predictive evolvability will not be in the biological sciences but in the perverse generation of transmissible and evolvable computer programs. Today's computer viruses are not

(Continued from page 37)

to one where they simply provided assistance when needed. Similarly, non-trauma, non-emergency medicine in the future will be conducted primarily by each individual caring for himself or herself. Medical professionals will be consulted for unusual or complicated situations or in the rare instances when procedures or operations are necessary. Most of these consultations will be conducted via telecommunications rather than in person.

The most common first line contact for an individual will be with a nurse or medical assistant (an evolution of the physicians assistant), who in turn can serve as the link to a much smaller number of physicians, since each specialist physician can manage a population of some several hundred thousand people. In some instances, medical professionals may become more involved in actively "providing" care, similar to their role today, for conditions where individuals are unable to successfully take care of themselves, such as early on in the treatment of chemical dependencies and some mental disorders, or for those who repeatedly fail to properly manage their condition to avoid adverse medical outcomes.

Better predictions of illness and risk assessment, based on genetic predisposition and environmental factors, will allow wellness care to home in on monitoring for each person the medical conditions which they are most likely to develop. Sophisticated high-tech, minimally invasive monitoring technologies will provide reliable methods for detecting these conditions early enough to offset or, more likely, to cure, those conditions which might occur in the first 90 years or so of life.

Highly effective cures for such entities and the cancers, diabetes, and heart disease will be available throughout the world. However, their availability is contrary to what would follow that with how I feel these assumptions will affect what we will be doing, the delivery of medical care and of essential of public health services.

Assumption 1: The balance of attention and expenditures for health care in this country will have shifted significantly from treatment to prevention.

Today we spend almost $1 trillion a year in our health care system, mostly for the purpose of providing high tech medical care, with less than 1 per cent of that invested in population-based prevention. Well into the 21st century, the dual pressures from cost containment and concern for quality will have shifted that balance, and we will be investing much more heavily into prevention.

Many managed care organizations are leading the way in this regard, but this phenomenon will be experienced much more broadly throughout the health care system in this country. The relationship between public health and medicine will have changed significantly, as medicine increasingly will turn to public health to participate in the training/education of future physicians and for working with enrolled populations and implementing community-wide strategies for prevention and control of diseases.

Not only do we know that many of the complications of chronic illnesses such as diabetes can be prevented with quality health care, we also know that much of non-insulin-dependent diabetes, or type 2 diabetes, can be prevented by interventions of

otics and new vaccines, the struggle between man and microorganism will continue well into the 21st century. Among other things, this means that we need to develop global systems of surveillance and response to outbreaks of new or existing microorganisms.

To the extent that we detect outbreaks early wherever they occur throughout the world, we will be able to better control these microorganisms. At the same time, of course, we need to work on controlling the behavior of humans, both providers and patients, so as to minimize the risk of antibiotic-resistant microorganisms which frequently results from the inappropriate and overuse of antibiotics.

Assumption 4: There will be continuing changes in human behavior and demography which challenge our ability to control urgent threats to health—emerging infectious diseases, environmental hazards, and injuries.

From all indications, we will see the continuing development of mega cities so that by the years '20 to '25 there will be perhaps as many as 20 cities in the world with populations in excess of 20 million.

The overwhelming majority of these cities will be in the developing countries or in countries where poverty is a major factor of life. This great increase in the density of population, accompanied by difficulties in providing the necessary sanitation, will lead to environments where microorganisms will be able to incubate and to spread rapidly. If we add to that the great improvements that are continuing to take place in travel, it is very easy to see that the global threat of emerging infections will continue to be a factor.

It also is likely that with continuing and growing inequality in the socioeconomic status among people we will see a continuing increase in violence and injuries. Likewise, represents a worldwide coordinated effort on the part of people throughout the world must be more evident.

Col. Donald S. Burke, MC,USA
Associate Director
Emerging Diseases
And Biotechnology
Walter Reed Army Institute
Of Research

We are on the cusp of revolution in bioinformatics, a revolution that will grow out of studies of the molecular evolution of microbes. Computer analysis of sequence changes during real-life evolution will be used to generate reliable models of complex adaptive systems. The outcome will be science of "predictive evolution," in which the fundamental mathematical laws governing evolution will be formulated, proven, and used to consciously guide evolutionary processes.

The revolution will uproot fundamental biological concepts, much as Newtonian mechanics was overturned by quantum physics. Although the laws of "predictive evolution" may be derived from study of microbial genetics, these newly discovered rules will be sufficiently robust to govern evolvability of all forms of information, from bits to human language, not just nucleotide-based information. The insights will profoundly affect every sphere of human endeavor, even leading to an improved understanding of the evolution of cultural units of information ("memes"). Specifically,

Note:

- Gun lobby interest

Violence Prevention Is as American as Apple Pie

The biggest barriers we face in violence prevention are fear, frustration, and a sense of failure. Violence is a problem of such enormous proportions and complexity that it is easy and all too common to feel overwhelmed upon confronting it. The toll in deaths, disabilities, and shattered lives cannot be measured in simple economic terms, and when the toll is measured the numbers are so large that we cannot comprehend their real impact. It is no surprise that even the most committed community workers frequently give up hope of ever bringing peace to their neighborhoods; indeed, many give up even hope itself.

In spite of this, there are two very important reasons for being optimistic about our chances for making a difference in this arena. The first reason is that we are bringing many divergent ideas, people, disciplines, and voices together. Every study in this volume represents a marriage between a program born in the passionate conviction of the community that something has to work, with the equally strong conviction of the scientists that we have to find out what that something is. Each study represents the application of science to a community-based intervention with the goal of making that intervention evaluable. And each paper is written by authors from at least two different disciplines. They include sociologists, epidemiologists, psychologists, anthropologists, and educators. The challenge now is to hear the voices—from rich and poor, black and white, liberal and conservative, pro-gun and gun-control; to hear the fears and hopes, suggestions and criticism, and to learn and move forward together in new partnerships of strength.

The second reason for optimism is that we can bring science to bear on this problem and tap into its extraordinary potential for making the world a better place, showing us new ways to approach old problems. Science is empowering communities to make peace that will last in ways that will work.

Given the great perceived urgency for addressing this problem, it is no surprise that many people feel we must act right away, without taking time to await the results of calculated scientific trials. Urgency leads people to think there will be—indeed, that there must be—an answer that is simple and readily discoverable.

Yet the results that are beginning to come forth suggest that the answer will not be so simple. Discoverable, yes; simple, no. But, like the really healthy diet, it looks like the answers to youth violence prevention will represent a balance of ingredients. Take apples, for example. Apples are nutritious. One apple provides approximately 80 calories of complex carbohydrates, essentially no fat and no sodium, 3 grams of fiber, more than 10% of the recommended daily intake of vitamin C for everyone except pregnant and lactating women, and small but useful amounts of other vitamins and minerals.[1,2] Our mothers told us, and our mothers were usually right, "an apple a day keeps the doctor away." Even so, apples, in spite of proven nutritional value and mother's recommendation, are not enough. A healthy diet requires a balanced input of diverse foods.[3] The same is true for preventing violence.

When we look closely at violence we see that it is actually a variety of problems and will require a variety of actions. In our nation, homicide and suicide are among the leading causes of mortality;[4] and we stand apart from other industrial nations in the frequency and burden of fatal interpersonal violence.[5] Violence against women, child abuse, elder abuse, youth violence, and self-directed violence—common groupings based on the injured victim—are each complex problems. They share some origins and characteristics, but manifest different patterns of occurrence, different risk factors, and present different opportunities for prevention.

The public and the public health community are responding. The Centers for Disease Control and Prevention (CDC), state and local health departments, schools of public health, and other public health organizations are engaged in numerous activities to develop and implement effective interventions, programs, and policies for preventing violence. These efforts are being carried out across the country in partnerships with, among others, schools, medical care providers, businesses, law enforcement agencies, judges, and community residents.[6]

We must recognize that violence prevention, like a healthy diet, requires diversity of input. There is no single simple solution. The monotonous application of limited strategies, even effective strategies, like eating only apples, will be insufficient. Some of the interventions currently being evaluated will be shown to be effective, but, acting in isolation both in space and time, their benefit will be small and of uncertain permanence.

To overcome these problems, we must begin to think about violence prevention as we do a healthy diet. Rather than search for the one or the few strategies that might bring magical success, we need to assemble the multiple strategies that maintain health. Although currently we lack the knowledge to construct a violence-prevention model with the precision of the nutrition pyramid, we can suggest the components most likely to be important.

Interventions must encompass individual and social factors. Violent behaviors are influenced not only by characteristics of individuals, but also by—moving out from the individual—characteristics of families, such as cohesion and parenting practices; characteristics of peers, such as delinquent behaviors; characteristics of schools, such as teacher practices and school atmosphere; characteristics of community organizations, such as the frequency and type of youth activities; and characteristics of

 Youth Violence Prevention: Descriptions and Baseline Data from 13 Evaluation Projects is a supplement to *American Journal of Preventive Medicine* Volume 12, Number 5.

the larger society, such as economic opportunity, misuse of firearms, or media exposure.[7] Violence-prevention efforts to date ...e emphasized individually oriented strategies, directed toward ...nts in school or patients in clinical settings. These ...oaches should be continued, but need to be complemented by activities designed to modify exposures at the family, peer, community, and societal level.

All age groups must be addressed. Violence-prevention needs, like dietary needs, vary across the ages. Violence-prevention projects for new parents and children are needed to minimize child maltreatment and maximize children's development of prosocial values. Early education enrichment, such as preschool, promotes social and intellectual development, providing a buffer against antisocial and violent influences. Adolescents need educational and employment opportunities that will connect them with the social system and assure their economic success. Many adolescents and young adults need help in learning how to engage in and maintain healthy, nonviolent relationships with the opposite sex. School- and community-based efforts are needed for both parents and youth that reinforce prosocial values, hold individuals accountable for violent behavior, and provide treatment to modify antisocial behavioral patterns.

Scientific evidence must be applied. Empirical evidence should support every decision, and where it is lacking, it must be sought. The most difficult and controversial aspect of the problem of violence in our society concerns the involvement of firearms in these events. CDC and others within the public health community have been criticized for applying science to understand the role that firearms play in the occurrence and severity of assaultive injuries. Firearms are the implement of death in 70% of homicides and 60% of suicides.[8] Ignoring the involvement of firearms in these deaths precludes scientific understanding and ...tional response. In fact, firearms are only one of many factors ...t CDC is examining in trying to understand how to prevent ...olence; the motivation for studying the role of firearms stems from the desire to prevent violence and injuries and not from preventing lawful ownership and use.

In sum, the approach to violence prevention must be diverse and scientific. We need to avoid unitary approaches, draw from and develop a range of workable interventions, and mobilize new partnerships representing diverse sectors of our population. Complementary strategies, addressing multiple target groups, applied in diverse settings must be assembled into a nutritious whole, a substantial and balanced diet that can help us as a nation grow healthy and strong in peace.

David Satcher, MD, PhD
Kenneth E. Powell, MD, MPH
James A. Mercy, PhD
Mark L. Rosenberg, MD, MPP

REFERENCES

1. Human Nutrition Information Service. Nutritive Value of Foods. Home and Garden Bulletin Number 72. U.S. Department of Agriculture. June 1991.

2. Food and Nutrition Board. Recommended Dietary Allowances, 10th Edition. Commission on Life Sciences, National Research Council. National Academy Press, Washington DC, 1989.

3. Nutrition and Your Health: Dietary Guidelines for Americans. Home and Garden Bulletin No. 232. U.S. Department of Agriculture and U.S. Department of Health and Human Services. December 1995.

4. National Center for Injury Prevention and Control. 1992. Ten leading causes of death. Atlanta, GA: Centers for Disease Control and Prevention, 1995.

5. Fingerhut LA, Kleinman JC. International and interstate comparisons of homicide among young males. JAMA 1990;263:3292–5.

6. Powell KE, Hawkins DH (Editors). Youth Violence Prevention: Descriptions and Baseline Data from 13 Evaluation Projects. Am J Prev Med 1996;12(5)Supplement.

7. Tolan PH, Guerra NG. What works in reducing adolescent violence: an empirical review of the field. Boulder (CO): Center for the Study and Prevention of Violence, 1994.

8. National Center for Injury Prevention and Control. Injury mortality: national summary of injury mortality data, 1986–1992. Atlanta, GA: Centers for Disease Control and Prevention, 1995.

school, maintain employment, and function as a contributing member of society while another with the same IQ fails in school and requires supervised living and social support? Motivational and emotional variables certainly contribute to these differences in lifestyle. Traits such as poor self-esteem, low expectancy of success, overdependence on external cues, and an "I can't do it" attitude are common in retarded individuals as a result of frequent encounters with failure and personal rejection. Experiences that increase their exposure to success can bolster self-confidence and determination, leading to better performance. In these cases, the "treatment" for mild retardation involves education and training regimens that encourage full use of individual potential by removing psychological barriers.

The question, then, is not how we can "cure" mild mental retardation but how we can encourage those in this category to use fully the intelligence they possess. Comprehensive early childhood intervention for children and families in poverty is one promising strategy. Head Start, for example, has been highly successful in improving the physical well-being and school readiness of poor children by providing health, educational, mental health, and family support services and opportunities for parental involvement. One year of preschool, however, cannot be expected to inoculate children against the ravages of poverty for the rest of their lives. Because children reared in poverty can experience so many developmental threats before they reach age 4, intervention must begin earlier, preferably during the prenatal period. To continue the momentum toward success made during preschool, comprehensive services for children and families should continue during the critical time of transition to elementary school. Other means of prevention and enrichment include universal access to health care, improved nutrition, a cleaner environment, quality schooling, safe neighborhoods, good child care, and services that support families in their roles. Such changes will benefit the entire society, not just those at risk of mild retardation. While these improvements cannot be expected to slice the prevalence of mental retardation in half, they might very well slice the proportion of those who do poorly in school and in life regardless of their intelligence level. □

Edward Zigler
Department of Psychology
Yale University
New Haven, Conn

References

1. *A Proposed Program for National Action to Combat Mental Retardation.* Washington, DC: President's Panel on Mental Retardation; 1962. Publication 0-669325.
2. *MR '71: Entering the Era of Human Ecology.* Washington, DC: President's Committee on Mental Retardation; 1972. Publication 0-453-940.
3. Burack JA, Hodapp RM, Zigler E. Issues in the classification of mental retardation: differentiating among organic etiologies. *J Child Psychol Psychiatry.* 1988;29:765–779.
4. Zigler E, Hodapp RM. *Understanding Mental Retardation.* New York, NY: Cambridge University Press; 1986.
5. Zigler E, Balla D, eds. *Mental Retardation: The Developmental–Difference Controversy.* Hillsdale, NJ: Erlbaum; 1982.
6. Ellis NR, Cavalier AR. Research perspectives in mental retardation. In: Zigler E, Balla D, eds. *Mental Retardation: The Developmental–Difference Controversy.* Hillsdale, NJ: Erlbaum; 1982:121–152.
7. Fisher MA, Zeaman D. Growth and decline of retardate intelligence. *Int Rev Res Ment Retard.* 1970;4:151–191.
8. Luria AR. *The Mentally Retarded Child.* New York, NY: Pergamon; 1963.
9. Spitz HH. *The Raising of Intelligence: A Selected History of Attempts to Raise Retarded Intelligence.* Hillsdale, NJ: Erlbaum; 1986.
10. Zigler E. Familial mental retardation: a continuing dilemma. *Science.* 1967;155:292–298.
11. Zigler E. Developmental versus difference theories of mental retardation and the problem of motivation. In: Zigler E, Balla D, eds. *Mental Retardation: The Developmental-Difference Controversy.* Hillsdale, NJ: Erlbaum; 1982:163–188.
12. Benton D. Vitamin and mineral intake and human behaviour. In: Smith AP, Jones D, eds. *Handbook of Human Performance.* London, England: Academic Press; 1992;2: 25–47.
13. Schoenthaler SJ, Amos SP, Eysenck HJ, Peritz E, Yudkin J. Controlled trial of vitamin-mineral supplementation: effects on intelligence and performance. *Pers Individual Differences.* 1991;12:351–362.
14. Flynn J. The mean IQ of Americans: massive gains 1932 to 1978. *Psychol Bull.* 1984;95:29–51.
15. Infant Health and Development Program. Enhancing the outcomes of low-birthweight, premature infants. *JAMA.* 1990;263: 3035–3042.
16. Garber HL. *The Milwaukee Project: Preventing Mental Retardation in Children at Risk.* Washington, DC: American Association on Mental Retardation; 1988.
17. Ramey CT, Campbell FA. Poverty, early childhood education, and academic competence: the Abecedarian Project. In: Huston AC, ed. *Children in Poverty: Child Development and Public Policy.* New York, NY: Cambridge University Press; 1991:190–221.
18. Herrnstein RJ, Murray C. *The Bell Curve: Intelligence and Class Structure in American Life.* New York, NY: Free Press; 1994.
19. Zigler E, Seitz V. Social policy and intelligence. In: Sternberg R, ed. *Handbook of Human Intelligence.* New York, NY: Cambridge University Press; 1982:586–641.
20. Zigler E, Styfco SJ. Using research and theory to justify and inform Head Start expansion. *Social Policy Rep.* 1993;7:

Annotation: The Sociodemographic Correlates of Mental Retardation

In a series of three articles in this issue of the Journal,[1–3] investigators at the Centers for Disease Control and Prevention (CDC), the Georgia Division of Public Health, and Emory University provide new data on an old question: namely, the link between mental retardation in children and various sociodemographic characteristics of the children's families. These reports, together with a related article from CDC's National Center for Health Statistics in this same issue,[4] are important in defining the scope of the problem and in identifying children (and their families) who might benefit from early health and educational intervention programs.[5,6]

Recent publications, including *The Bell Curve*,[7] have heightened sensitivity and concern regarding the relationship between sociodemographic factors (especially race) and cognitive ability (or intelligence). Therefore, it is important that we make every effort to put into proper perspective the important articles dealing with this problem that are included in this issue of the Journal. Because there is some disagreement among professionals about the meaning of the terms *mental retardation* and *IQ*, as well as about the measurement of cogni-

Editor's Note. See related articles by Kramer et al. (p 312), Murphy et al. (p 319), Yeargin-Allsopp et al. (p 324), and Drews et al. (p 329) in this issue.

tive ability in general, the authors of the first three articles are cautious in the interpretation of their findings. For example, Murphy and colleagues state, "We recognize that an IQ test is a measure not of innate intelligence but of performance on a set of skills defined by a specific test instrument and considered relevant to intelligence by the prevailing culture."[1]

Although the method of case ascertainment for mental retardation used in the Georgia study is not synonymous with the prevalence derived from conducting cognitive testing on all children in a given population, the relative prevalence of mental retardation among the various sociodemographic subgroups of children is similar to that found in studies where investigators tested all subjects.[8,9] Thus, these results can be viewed as valid estimates of the relative prevalence of mental retardation within the racial and educational subgroups studied.

The investigators began with a descriptive epidemiologic survey.[1] In this component of their studies, they observed higher prevalence rates of both mild (IQ = 50–70) and severe (IQ < 50) mental retardation among Black 10-year-old children compared with White children of the same age. Because Black and White populations in the United States generally differ with regard to social, economic, cultural, and behavioral factors that affect health, the authors analyzed data from the case–control component of the study to attempt to uncover factors that might explain the Black–White difference.[2] They were able to demonstrate that about one half of the excess of mild mental retardation among Black children was related to a disproportionately high burden of adverse socioeconomic risk factors among the Black mothers, such as low education and residence in neighborhoods with low median family incomes.

The investigators also considered a number of possible explanations for the residual difference in mild mental retardation between Black and White children. These included lack of information on other possible confounding variables; the higher prevalence of certain adverse medical and environmental factors in the Black population (e.g., anemia, lead); intergenerational social, educational, and economic deprivation among Blacks; and differential access to the skills and knowledge assessed in cognitive tests. Although genetic factors have been shown to account for a fair share of the *individual variability* in IQ scores,[10,11] *group differences* raise ecological questions not amenable to the same analysis, and the authors did not speculate on whether genotypic variation may have contributed to those they observed.

In pursuing the search for other sociodemographic risk factors for both mild and severe mental retardation, the authors identified low maternal education (defined as less than 12 years) as the strongest risk factor in their data, independent of the six other factors (including race) that they examined. Mothers with less than 12 years of schooling at the time their children were born were four times more likely to have their children diagnosed as mildly retarded by age 10 years than were mothers with 13 or more years of education.[3] Although the data are not shown in that article, children of both Black and White mothers with less than 12 years of schooling were at almost equally high risk (Pierre Decouflé, ScD, Developmental Disabilities Branch, National Center for Environmental Health, personal communication).

Overall, 54% of children with mild mental retardation in the Georgia study were born to mothers with less than a high school education.[3] Together with the observed elevated risk in this group, the results point to a large portion of mild mental retardation that is potentially preventable. The specific correlates of a low maternal education that directly affect children's cognitive ability could not be identified in this study, but the work of other investigators in the child development field suggests a number of possibilities.[12,13] These include the physical and socioemotional characteristics of the home environment and the quantity and quality of parent–child interactions.

The investigators also clarified the source of the Black–White differential in cases of severe mental retardation. They found that the disparity was confined to the isolated form of the condition in which no other severe neurologic impairment is present.[3] This isolated form of mental retardation is strongly linked with maternal education level. Thus, as is the case with mild mental retardation, the Black–White difference in the severe form may be at least partly an effect of sociodemographic factors other than race.

From a national perspective, three interesting facts emerge about low maternal education. First, of all births in the United States in 1990, about 22% were to women with less than 12 years of education. Second, low maternal education crosses racial and ethnic boundaries. In 1990, White women had 367 196 such births; Hispanic women, 309 054; and Black women, 190 105. Third, low maternal education is not confined to teenage mothers. Of women who gave birth in the United States in 1990 without finishing high school, about 65% were 20 years old or older at delivery.

In another article in this issue of the Journal,[4] data from the third National Health and Nutrition Examination Survey (NHANES III) show that children aged 6 through 16 years from both Black and Mexican-American families and from families with lower incomes or lower education levels had lower mean scores on each of four tests of cognitive functioning. The sociodemographic differences in cognitive ability uncovered in these studies suggest that in certain groups environmental factors raise barriers against optimal intellectual development. Indeed, a recent report from the Carnegie Corporation goes beyond questions of intellectual function and underscores the importance of early (birth to 3 years) experiential and social factors in brain development.[14] The report emphasizes long-lasting effects of early environmental experiences on both brain structure and cognitive function.

I believe that this nation can make a difference in the lives of children by helping to facilitate their early health and learning environments. Thus, in addition to the fine work done by other organizations, CDC is mobilizing resources for a demonstration program aimed at promoting the cognitive, communicative, and behavioral development, as well as the health, of children born to women with fewer than 12 years of education. This effort (Project BEGIN) seeks to determine whether an expanded version of a previously proven early-intervention model[15] can be successfully implemented in diverse community settings and be of decided benefit to participating children and their families.

This early-intervention model is a comprehensive and particularly intensive program, consisting of home visits with the families from birth to age 3 years; enrollment of the child in a full-day, year-round child development center during the second and third years; and parent group meetings throughout the 3-year program. CDC's commitment to the conduct of rigorous, high-quality research together with a neutral stance regarding the effectiveness of early-intervention programs are critical to the success of this new endeavor. Due to the generosity of the Robert Wood Johnson Foundation, CDC has been assisted by a number of

localities in developing the plan for this community intervention project. Because our children are one of the nation's most important resources, we have made this project a priority at CDC. □

David Satcher
Centers for Disease Control and Prevention
Atlanta, Ga

References

1. Murphy CC, Yeargin-Allsopp M, Decouflé P, Drews CD. The administrative prevalence of mental retardation in 10-year-old children in metropolitan Atlanta, 1985 through 1987. *Am J Public Health.* 1995;85:319–323.
2. Yeargin-Allsopp M, Drews CD, Decouflé P, Murphy CC. Mild mental retardation in Black and White children in metropolitan Atlanta: a case–control study. *Am J Public Health.* 1995;85:324–328.
3. Drews CD, Yeargin-Allsopp M, Decouflé P, Murphy CC. Variation in the influence of selected sociodemographic risk factors for mental retardation. *Am J Public Health.* 1995;85:329–334.
4. Kramer RA, Allen L, Gergen PJ. Health and social characteristics and children's cognitive functioning: results from a national cohort. *Am J Public Health.* 1995;85:312–318.
5. Ramey SL, Ramey CT. Early educational intervention with disadvantaged children—to what effect? *Appl Prev Psychol.* 1992;1:131–140.
6. Ramey CT, Campbell FA. Poverty, early childhood education, and academic competence: the Abecedarian experiment. In: Huston AC, ed. *Children in Poverty. Child Development and Public Policy.* Cambridge, England: Cambridge University Press; 1991; 190–221.
7. Herrnstein RJ, Murray C. *The Bell Curve. Intelligence and Class Structure in American Life.* New York, NY: The Free Press; 1994.
8. Birch HG, Richardson SA, Baird D, Horobin G, Illsley R. *Mental Subnormality in the Community.* Baltimore, Md: Williams & Wilkins; 1970.
9. Broman S, Nichols PL, Shaughnessy P, Kennedy W. *Retardation in Young Children. A Developmental Study of Cognitive Deficit.* Hillsdale, NJ: Lawrence Erlbaum Associates; 1987.
10. Plomin R, DeFries JC. Genetics and intelligence: recent data. *Intelligence.* 1980; 4:15–24.
11. Bouchard TJ Jr, Lykken DT, McGue M, Segal NL, Tellegen A. Sources of human psychological differences: the Minnesota study of twins reared apart. *Science.* 1990; 250:223–228.
12. Wachs TD, Gruen GE. *Early Experience and Human Development.* New York, NY: Plenum Press; 1982.
13. Gottfried AW, ed. *Home Environment and Early Cognitive Development. Longitudinal Research.* Orlando, Fla: Academic Press; 1984.
14. Carnegie Task Force on Meeting the Needs of Young Children. *Starting Points: Meeting the Needs of our Youngest Children.* New York, NY: Carnegie Corporation; 1994.
15. The Infant Health and Development Program. Enhancing the outcomes of low-birthweight, premature infants: a multisite, randomized trial. *JAMA.* 1990;263:3035–3042.

Annotation: Physicians' Attitudes and Decision Making Regarding the Withdrawal of Life Support

During the past few decades, there have been dramatic changes in both the treatment of critically ill patients and in attitudes about how decisions about care should be made. The development of sophisticated technologies has increased the ability to prolong life, which is usually of clear benefit. However, there is growing acceptance of the notion that in some cases treatment may merely prolong the dying process or lead to survival with a very poor quality of life. Indeed, it is now nearly 20 years since Karen Ann Quinlan ceased breathing on the night of April 15, 1975,[1] and the ensuing court case thrust decision making about withdrawal of life support into the public arena.

Formerly, choices about life-sustaining treatment were seen primarily as medical decisions for physicians to make. The debates about criteria for withdrawing life support led to clearer recognition that such decisions cannot be based only on objective facts but must always reflect value judgments about issues such as the meaning of life and death, the quality of life, and the proper use of technology. Therefore, in parallel over the past 20 years, the principle of patient autonomy has steadily gained ground. Court decisions, statutes, and professional standards have supported the right of competent patients to make decisions to forgo treatments, either directly or through the use of advance directives (living wills and health care proxies).[2]

Despite the clear guidelines, empirical research has shown that many factors prevent adherence to patients' preferences about care at the end of life.[3] This situation affects public health not only because care thought to be inappropriate can cause suffering for patients and families but also because the inappropriate prolongation of treatment uses health care resources for unwanted care. Little is known, however, about the extent to which actual treatment decisions vary from patient preferences. For many reasons, this topic is very difficult to study. One problem is that research would need to uncover patient preferences that may never have been explored; another problem is that these decisions are made when patients and their families are in crisis. One way to address the issue is to look at physician responses to hypothetical situations and ask them about how they would treat terminally ill patients. The research conducted by Christakis and Asch,[4] reported in this issue of the Journal, is important because it demonstrates that physicians' characteristics affect both attitudes and practices related to the withdrawal of life support. Although the response rate to their survey was lower than that usually reported in this Journal, the article is an important contribution because it is one of the first to provide data on the relationship of attitudes to practice.

Christakis and Asch presented hypothetical vignettes and asked physicians to indicate treatment choices in order to study responses to the most clear-cut type of case: a terminally ill, comatose patient who had previously stated, and whose family currently indicated, that under the circumstances presented they would want life supports withdrawn. Nevertheless, responses varied; many physicians chose to give life-sustaining treatments. In addition, unlike many previous studies that examined only attitudes, this study asked physicians to report on their actual practices. Professional characteristics such as specialty and work setting, personal characteristics such as age and religion, and the attitudes manifested in the responses to the vignettes were associated with the number of times the respondents said they had withdrawn life support during the last year.

Editor's Note. See related article by Christakis and Asch (p 367) in this issue.

Health Reform and the Health of the Public

Forging Community Health Partnerships

Edward L. Baker, MD, MPH; Robert J. Melton, MD, MPH; Paul V. Stange, MPH; Mimi L. Fields, MD, MPH; Jeffrey P. Koplan, MD, MPH; Fernando A. Guerra, MD, MPH; David Satcher, MD, PhD

REGARDLESS of the direction or timing of the reform of the health care financing system, the nation's health status may not substantially improve without simultaneous reform of the public health system. Reducing administrative complexity and redundancy and, most important, assuring that all US citizens have access to quality medical care will do little to influence the true determinants of ill health: unsafe environments, unhealthy personal behaviors, and biologic, genetic, and socioeconomic factors.[1-3] These determinants account for more than 1 million deaths per year and untold levels of preventable morbidity and expensive (avoidable) health care in the United States.[4] Thus, the concept of health system reform should not be restricted primarily to medical care; it should also encompass strengthening the practice of public health and stimulating new systems of integration among all organizations within a community whose missions have an impact on the health of the public, many of which will be neither providers of clinical services nor traditional health departments.

From the Public Health Practice Program Office (Dr Baker) and Office of the Director (Dr Satcher), Centers for Disease Control and Prevention, Atlanta, Ga; Department of Health, Monterey County, Salinas, Calif (Dr Melton); Association of Schools of Public Health, Atlanta, Ga (Mr Stange); Department of Health, State of Washington, Olympia (Dr Fields); The Prudential Center for Health Care Research, Atlanta, Ga (Dr Koplan); and the Metropolitan Health District, San Antonio, Tex (Dr Guerra).

Reprint requests to Public Health Practice Program Office, Centers for Disease Control and Prevention, 1600 Clifton Rd, Mailstop E20, Atlanta, GA 30333 (Dr Baker).

What we attempt to do in this article is provide a background and a framework for examining how the health of the public can be improved during a period of substantial change in the health system and focus on issues that must be addressed. Our goal is not only to broaden the range of the debate, but also to sharpen it so that key participants—including policymakers, private insurance companies, physician groups, hospitals, and state Medicaid officials—can appreciate fully that a refocused and revitalized governmental public health system is a sine qua non for achieving the favorable financial and health status outcomes of reform.[5] We present a redefinition of public health practice that extends well beyond the usual governmental efforts and aggressively seeks out and embraces the skills and resources of many new nontraditional players. While in no way diminishing the importance of public health agencies, we foresee a significantly greater participation by the private sector, particularly the personal medical care system, in the practice of public health in the future.

See also pp 1292 and 1297.

Finally, our entire discussion is based on observations of a health system that has already begun to reform, albeit at a rate that has increased dramatically in the last year. Several key trends evolving in the marketplace have shaped our thinking. First, there is increasing support for managed care systems by both state Medicaid programs and large private insurers.[6] Second, the 5300 community hospitals in the United States are beginning to emerge as an important force in public health practice. These hospitals employ 3.5 million people and constitute the single largest category of national health spending (44%, or $305 billion, in 1991).[7] Third, formal partnerships allying governmental public health agencies with managed care providers and hospitals are absolutely vital if the health of the public is to improve as we move through the reform era.[8] Through these and other related developments, we see the personal health care system broadening its focus beyond individual services to include the health of the entire community.

THE PUBLIC HEALTH SYSTEM AT A CROSSROADS

During this century, life expectancy has increased markedly—from less than 50 years at the turn of the century to more than 70 years (79 years for women and 72 years for men) in 1990.[9] This increase, resulting from great historical advances against infectious diseases as well as contemporary gains against heart disease, has derived in large part from public health interventions. These essential public health services (Table), traditionally coordinated by our nation's federal, state, and local governmental public health agencies, are distinctive because their focus is *populations* or *communities as a whole*, and they are designed to assure the existence of conditions in which people can live healthier lives.[10] Many of these programs are es-

tablished by law to protect the health of the entire community. They are organized to prevent epidemics and the spread of disease; protect against environmental hazards; prevent injuries and disabilities; promote and encourage healthy behaviors and mental health; respond to disasters and assist communities in recovery; and assure the quality and accessibility of health services. In short, the vision of public health is healthy people in healthy communities.

Notwithstanding mandates and historical successes, the vitality of the public health system has been undermined in the last two decades by escalating pressures on state and local governments to provide medical care for the poor and uninsured. As a consequence, and to its serious detriment, "public health" has become confused with "publicly funded" or "charity" medicine. Public health should be seen as the crucial population-based practice in which the scientific base for defining problems, developing interventions, and measuring results is epidemiology and in which the philosophical base continues to be social justice in the application of scientific knowledge.[11,12] Moreover, however necessary the support for indigent care has been, it has had the unintended and unfortunate effect of reducing the viability of essential or "core" communitywide public health programs targeted to the same populations. The erosion of core public health funding during this time (from 1.2 cents of the national health dollar to 0.9 cent)[9] has had predictable negative consequences, certain to worsen unless substantial corrective action is taken. The nation has struggled, for example, to mount effective programs against re-emerging age-old problems such as tuberculosis and sexually transmitted diseases. Handgun-related violence has surged, and pregnancies among teenagers (and even younger children) are much too frequent. Highly publicized epidemics of waterborne and food-borne illness have occurred recently, with substantial morbidity and associated cost, because of inadequate systems of early detection of emerging problems and insufficient environmental protection.[13] Workplace hazards are insufficiently controlled, resulting in fatal injuries, occupational diseases, and disability, and causing substantial losses in productivity. In short, the support for indigent medical care has exacted a huge toll in lost opportunities for preventing morbidity and mortality in vulnerable populations and for promoting optimum health conditions for the entire community.[14]

This seriously deteriorated state of our public health system has profound negative implications for individual physicians, hospitals, and networks of managed care. As changes in medical care financing (eg, capitation) create incentives for providers to keep their patients as healthy as possible, private medical providers and the hospitals with which they are affiliated can succeed ultimately only if the governmental public health agencies are strong partners. The missions of these agencies and medical care providers should converge into one for which there is shared responsibility, maintaining optimal health for every member of every community.

As the health system changes—regardless of the pace or the ultimate structure of medical care financing—the responsibilities of governmental public health agencies will not diminish. If anything, their importance will increase substantially. Many patients previously treated in publicly funded facilities—such as hospital emergency departments, health department clinics, community health centers—will be treated by private providers. However, who will assure that the child who is privately treated for lead-based paint poisoning has the lead hazard removed from his home? Similarly, who will assist the private provider in the difficult long-term management of individuals undergoing therapy for multiple-drug–resistant tuberculosis? Who will argue for the public health perspective in debates on safety devices (eg, seat belts) or the benefits of smoking cessation? If an outbreak of food-borne illness occurs within the community, or if a "mystery" disease suddenly strikes children in an elementary school, who will respond? Who will detect early patterns of emerging health threats before emergency departments and physicians' offices are overwhelmed with sick patients?

Moreover, reshaping the private medical care financing and delivery system (even with incentives that encourage prevention) will not shift the ultimate accountability for protecting the health of the community away from governmental health agencies. Even assuming universal coverage for medical care and a sophisticated epidemiologic perspective by care providers, the sum of all their efforts will not constitute complete public health readiness. When health emergencies strike a community, the citizens will pressure the local governmental health officials, not the administrators or medical leadership of the managed care organizations, community care networks, or hospitals, for action on behalf of the community as a whole.

Thus, in the face of an already-occurring and certain-to-continue restructuring of medical care organizations, the public health system has reached a crossroads. Although the public health system has an undeniably pivotal role in the overall health system, that role is not well understood by many medical care providers. Moreover, its performance has been weakened by years of general financial neglect. We have arrived at this point of urgency partly as a result of indigent care obligations; in addition, the strapped financial condition of many state and local governments has not encouraged investment in the infrastructure of their public health systems. At the same time, to meet the challenges of a rapidly evolving health system, public health agencies will need to change significantly in the ways in which they are organized and operate and, most important, interact with the private business of medical care.

Essential Public Health Services

- Monitor health status to identify and solve community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships and action to solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and assure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent workforce—public health and personal care
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

REFOCUSING AND REVITALIZING PUBLIC HEALTH

Refocusing and revitalizing public health must begin with a consideration of its *core values* and *core functions*, followed by an analysis of how those functions will be carried out under a reformed health system. Reform of a governmental institution such as a public health agency requires changing the ways in which the government and the community it serves interact.[15] This process has been referred to as "reinventing public health."[9] Further, as the Institute of Medicine indicated, "[T]he future of public health depends on redefining and restoring the role of health agencies at all levels of government to a position of respect."[10(pp41-42)] Two principal values historically important to public health practice should be integral elements of a revitalized public health mission: prevention and "community."

The prevention of disease or injury is accomplished primarily through health protection and health promotion. Health protection focuses on assuring a safe

environment (eg, food, air, and water supplies, housing, and workplaces) and is achieved primarily through federal, state, and local governmental enforcement programs. Health protection also occurs through the combined efforts of clinical medicine (eg, childhood and adult immunization, treatment of sexually transmitted diseases) and public health agency case-finding and case-management efforts (eg, tuberculosis). The emphasis of health promotion is encouraging "healthy" behaviors (eg, proper nutrition, safe-sex practices). Public health agencies have frequently played leadership or catalyst roles in community health promotion programs; but, depending on the problem, program success actually results from the collaboration of multiple public and private organizations (eg, promoting self-examination to detect breast cancer involves local chapters of the American Cancer Society and the medical society, as well as other groups).

"Community" appears in many diverse forms. It might be thought of as a geographically coherent place that is the scene of both work and home life. Community can also be defined in terms of institutions through which people are involved in shared decisions, shared values, and the reinforcement of values.[16] Thus, a community might be a congregation, a school, or a neighborhood organization. In this sense, the process of strengthening or developing the institutions of community is very much a part of the process of improving public health. In recent years the United States has experienced a disintegration of the larger sense of community, with the concurrent proliferation of competing special interest communities.[17] Thus, the task of reinventing public health not only involves changes in governmental organizations, but also means rebuilding consensus and values among citizens that affirm the importance of the community as a whole.

The federal government has fostered an enormous increase in contracting with nonprofit organizations and has contributed significantly to the strengthened community presence of these organizations.[18] For example, the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic has spawned the development of community-based nongovernmental organizations throughout the nation. However, similar organizations also exist for a wide spectrum of other specific health-related concerns (eg, homelessness, drunk-driving prevention, and environmental protection). Consequently, the landscape in which health departments must now operate has been permanently altered by the rapidly increasing presence and political sophistication of these groups. Reform of public health means addressing the challenges and opportunities presented by community-based organizations as they coexist with the local governmental public health agency. It also means successfully encouraging these organizations to cooperate effectively in promoting better health for the entire community.

COMMUNITY HEALTH PARTNERSHIPS—TOWARD A NEW PUBLIC HEALTH PRACTICE

Financial and programmatic constraints of government at all levels in the 1990s require health departments to aggressively seek partnerships, coalitions, and shared resources wherever possible to achieve objectives, rather than rely on hierarchical, bureaucratic approaches that may have worked in a different political and budget environment. Public school systems, governmental agencies in nonhealth areas (eg, justice, welfare, housing), churches, hospitals, institutions of higher learning, and the wide array of community-based nonprofit organizations exemplify the types of partners with which innovative local governmental agencies have collaborated. For example, in the Chicago, Ill, area, the Mt Sinai Hospital Medical Center has helped stimulate the creation of the Westside Health Partnership, which includes four hospitals, 150 physicians, free-standing community health centers, the Chicago Department of Public Health, the Illinois Departments of Public Health and Public Aid, and community-based organizations. In the last 2 years, more than 7000 clients—young pregnant women and their children—have been seen, and immunization levels and prenatal care utilization rates have increased.[19] In New York City, the pediatric trauma division at Harlem Hospital, together with the City Board of Education and the New York State Department of Parks, developed a program of safety instruction beginning at third grade, both in the classroom and on the streets. The incidence of pedestrian injury and gunshot trauma has decreased significantly since 1989 through community programs and school curricula on guns and violence, letters to parents on gun safety, and training of school and hospital teams in stress management.[20] In 1992 the Dekalb County, Georgia, Board of Health proposed successfully to Antioch Baptist Church North, which was developing a single-room-occupancy facility for low-income individuals, that a block of rooms be set aside specifically for tuberculosis patients requiring directly observed therapy. A reduced daily census at the state's Northwest Georgia Regional Hospital resulted from this state-supported program.[21]

THE PROCESS OF CHANGE

As health reform proceeds, we envision a process whereby many public health agencies will reduce their role in the direct provision of personal health services to economically and medically indigent populations, transferring this role to managed care and other private providers. Concentrating on population-based services to the entire community will become the primary focus of public health agency efforts. This process has already begun. For example, in California the public health agencies in Yolo and Mendocino counties no longer provide comprehensive personal health services, having contracted with and transferred clinical services provision to private sector agencies. Community-wide services (eg, case finding for control of sexually transmitted diseases) continue to be managed directly by the local health agency.

As agency function changes, so will organizational structure. Public health agencies that want to thrive will inevitably transact more of their business through legally constituted partnerships with other public and private entities, as well as through publicly accountable nonprofit corporations (eg, public benefit corporations). These new partnerships will focus on three areas; (1) Providing information to the community derived from assessment of health status, health needs, disease threats, and health services. This role incorporates the traditional public health activities of disease and injury surveillance and epidemiologic investigation, but broadens them to include topics such as behavioral risk factors, environmental hazards, and major health determinants. (2) Leading the community in planning and mobilization of governmental and nongovernmental resources for health. (3) Assuring the availability of quality individual, family, and public health services to the entire community, including a proactive emphasis on health protection and promotion and capacity to respond on an emergency basis to unanticipated diseases, conditions, and events threatening community health.

These essential public health services are comparable with those proposed by the Institute of Medicine in its 1988 report, *The Future of Public Health*[10] (ie, assessment, health policy development, and assurance of quality health services). Although the principles remain the same, the context has changed since the 1988 report was issued. As reform of the nation's health care system continues to evolve, public health system improve-

ment is even more imperative now than 6 years ago.

Providing Health Information to the Community

The leaders and members of every community should have easy access to the broadest possible array of health information to make sound public health policy decisions and prudent personal choices, including information on health status (eg, rates of illness and injury from specific causes), health risks (eg, levels of environmental hazards and extent of healthy behaviors), and major health determinants (eg, socioeconomic factors, ethnicity, education), in a personally meaningful fashion. This information should be contained within a "community health report card"—a profile of the health of the community. The American Public Health Association has recently pioneered an analogous effort, creating the nation's *Public Health Report Card*.[22] Report cards have been proposed to monitor the performance of the personal health care system.[21,24] Their utility can be readily extended to include monitoring the effectiveness of public health services designed to protect and improve the health of a population as a whole. Their production should become a central consideration in the design of all health information systems.

"Health data institutes" (a form of "health database organization" with public-private governance recently proposed by the Institute of Medicine[25]) should be established within every state and charged with the design and production of community health report cards. Using data generated by managed care providers, public health agencies, community hospitals, and other sources, provided through new electronic networks, these institutes would provide extensive, up-to-date community health information. Availability of such information would improve the ability of governmental public health agencies, hospitals, managed care organizations, and others to monitor the effectiveness of communitywide health programs, to detect epidemics more efficiently, and to respond to growing public interest in health information.

In some states, the process of creating integrated health information systems has already begun. For example, a Data Institute created under Minnesota's health reform plan, MinnesotaCare, began integrated data collection activities in January 1994. The institute is governed by a Health Data Commission and includes representatives from hospitals, insurance companies, consumers, group purchasers, health professionals, and governmental health agencies. The system will serve a dual function: to facilitate health care quality assurance, cost analysis, and consumer choice and to guide programs designed to protect and improve the health of the entire community. From the outset, this personal care–oriented data system has been planned to link with other data sets from the state and private sector, including those that measure public health status within the state (eg, vital records and communicable disease reporting).[26]

Leading in Health Planning and Mobilizing the Community for Health

Regardless of the course of reform of the personal health care system, members of every community will continue to expect governmental leadership in developing plans and policies for responding to acute health emergencies and chronic threats to public health. As managed care systems cover a larger percentage of a population, health planning will become increasingly important as communities seek to develop strategies to reduce preventable illness and injury, thereby reducing unnecessary (and costly) utilization of personal health care services. The development of these prevention strategies can be enhanced if the local public health agency can lead its partners (eg, private medicine, voluntary organizations, schools, interested citizens, churches) through a periodic, structured, rigorous examination of community health status and available resources. Through broad-based participation in the process of planning and policy development, all parties can better understand what they need to do to mobilize to build a safer, healthier community.

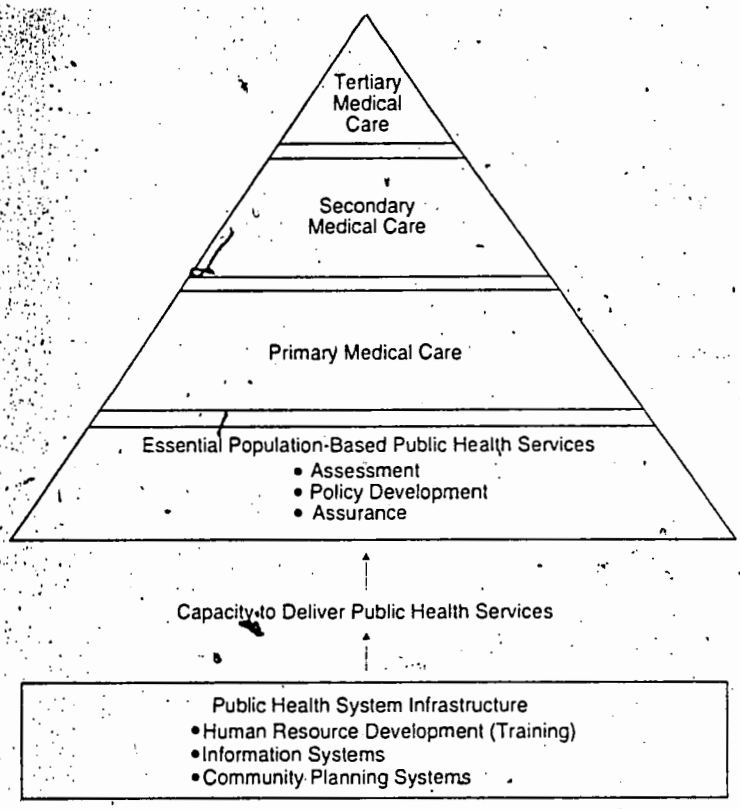
An excellent example of leadership in health planning exists in Sarasota, Fla, where the local health department is leading a comprehensive effort, Healthy Sarasota 2000. Using tools developed by the Centers for Disease Control and Prevention (CDC) and other health organizations, the community identified its major health problems and formed coalitions to address them. The process was guided by a health leadership council consisting of representatives from the health department, local hospitals and other health care providers, schools, businesses, and churches. Directly resulting from this strategic planning effort has been a detailed community health improvement plan, including specific resource requirements, which was based on an analysis of the years of potential life lost and the direct and indirect economic costs of excess morbidity and mortality attributable to its major health problems.[27] In 1993, the state of Washington enacted health reform legislation that built directly on a statewide, but community-oriented, health planning process. The legislation has specific provisions and resources designed to strengthen public health system capacity. The blueprint for capacity building, a Public Health Improvement Plan, will be delivered to the legislature in December 1994.[28]

As part of this community planning process, the local public health agency must help focus discussions about complex societal issues that have a major impact on a community's health. These include such concerns as homelessness, drug addiction, and handgun-related violence—problems for which prevention and control efforts may not have been seen in the past as being within the agency's purview and that will require confronting the fundamental determinants of health: income, education, and other social factors.[1-3,20,30]

Two other difficult areas in which the local public health agency has a critical role to play—both because it will manage or have access to increasing amounts of communitywide data and because it can potentially offer a neutral forum in which health professionals and citizens can deliberate—are rationing of medical care resources and explanation of "risk."[31-33] These issues call for decision making with both scientific and ethical components. For example, increasingly, public choices will have to be made about the equitable allocation of limited medical resources. A prime example of this has been Oregon's successful request for a Medicaid waiver.[6] Second, we are all constantly challenged by stories in the popular media about risks to health, which are sometimes simplistic and misleading. As a consequence, the public veers between being jaded about a plethora of risks in the environment and confusion and anxiety about what is truly important. In both of these areas, rationing and risk assessment, the local public health agency, as the center and principal "source of epidemiologically-based thinking and analysis"[34(p1268)] in the community, has an important role to play in directing balanced debates that incorporate science as well as community ethics and values.

Assuring the Availability of Quality Community Health Services

Currently, public agencies at the state and local levels are involved in assuring the availability of quality health services by influencing (or regulating) their provision by the private sector or delivering them as a "provider of last resort." This function—serving the community as the guarantor for health—is a fun-



Public health: the foundation of a national health system.

damental role of government.[10] It is important, however, to distinguish clearly between overseeing the quality of the elements of the medical care system (eg, facility and professional licensure), which is primarily a state regulatory function, and our principal concern, which is related but quite different: the promotion of creative ways in which the local "governmental presence in health"[7(p119)] can work collegially with representatives of local medical care providers and other community organizations to identify gaps in the continuum of responsibility for care and services for vulnerable populations and collectively identify ways to close them.[36] In this regard, one critical role public health agencies have traditionally played is worth highlighting: They manage "enabling" services for medically vulnerable or underserved populations, which include outreach, language translation, transportation, advocacy, case management, triage, and referral. Under any reformed health system, the community must continue to receive such services, which are designed to connect those most in need of health services with available sources of care.

Monitoring the quality and availability of community health services will be accomplished, in part, through developing and enforcing guidelines, regulations, and standards. Just as guidelines are needed to monitor personal health services, those defining effective and appropriate essential public health services are also urgently needed. An important component of these guidelines, those for clinical preventive services, is a work in progress.[37] In certain respects, however, governmental health agencies may face a conflict of interest in situations where they retain responsibility for delivery of personal health services and also attempt to serve as watchdog, monitoring the delivery of such services by other providers in the community. If this situation is not avoided, these agencies could be confronted with instances in which they must monitor (and sanction) other health providers potentially competing in the health marketplace. Because the agency could not monitor itself, a double standard of oversight would occur.

As the health system evolves, many traditional population-based public health functions (eg, inspection of restaurants, monitoring of drinking water and air quality, and inspection of worksite hazards) must continue. In many instances governmental agencies will still provide these services, although communities may find it cost-effective to contract out some of them to the private sector, while retaining public sector oversight. Responding to epidemics of communicable disease, environmentally induced disorders, health problems caused by natural disasters, and other health-related emergencies will continue to be a central responsibility of state and local governmental agencies. There is a wide chasm, however, between this vision of public expectations and the current ability of these agencies to perform adequately.

BUILDING COMMUNITY CAPACITY

Rebuilding the public health foundation and capacity—its infrastructure (Figure)—must concentrate on providing communities with the tools and systems they need to determine what their health problems are and what resources are available to enable them to take the lead in addressing them. These tools and systems relate to three primary areas: information, training, and community health planning.

Information Systems

In its recently released report, *Health Data in the Information Age: Use, Disclosure, and Privacy*, the Institute of Medicine describes the importance of information on the health of the population as a whole, not just of those who use the health care system, and states further that "the need for information on both end results (the outcomes) of care as well as on the processes of care poses great challenges to database developers. The current push for health care reform has made clear to many that the success of reform options—as well as the ability to assess the effect of a reformed system on the health of the public—depends on access to the kinds of data that too often are unavailable."[25(p1)] In the face of these challenges, important efforts are under way in the public and private sectors that offer promise that information system capacity for public health purposes is being developed.

For example, during the last 2 years, managed care organizations have been in the forefront working to develop the Health Plan Employer Data and Information Set (HEDIS 2.0). Developed under the auspices of the National Committee for Quality Assurance, a nonprofit accrediting body for managed care organizations, HEDIS 2.0 will be used to produce "report cards" for consumers. It includes selected public health indicators within its range of quality measures (eg, childhood immunization rates, prenatal visits during the first trimester, and the incidence of low birth weight).[21] During 1994, the National Committee for Quality Assurance is implementing a major 1-year Report Card Pilot Project that will attempt to "establish the infrastructure to produce a Report Card and to produce Report Cards for participating health plans."[21]

This consumer- and business group–driven private initiative will establish an important connection point with public health agencies for sharing information. Thus, this information system capacity that is being created by the private sector for quality assurance and marketing purposes could, through timely collaboration with government, augment the weak public sector capacity.

In a related fashion, the CDC is vigorously promoting electronic information sharing between state public health agencies and itself, and it is also seeking to stimulate similar connectivity among public health partners within states. With the sponsorship and support of the Robert W. Woodruff Foundation, an information network is being implemented that will connect the Georgia Division of Public Health, the state's 19 district health departments, and the CDC. This project, known as the Georgia Information Network for Public Health Officials, will provide local officials easy access to computer-based analytic tools that allow health status evaluations of an individual community and of the state as a whole; offer guidelines for delivering preventive health services, such as immunizations and cancer screening; and provide environmental and occupational health regulations. All agencies will also be able to communicate through computer with each other, the Emory University School of Public Health, the CDC, and the Georgia Division of Public Health. Eventually, the network will be expanded to include all local health departments, relevant voluntary agencies, and primary health care providers. This network will, in turn, be expanded nationwide.

Training Networks

Public health faces a massive retraining challenge over the next decade as a result of the changing role of public health agencies and the increasing interest by private sector organizations in community health. Increasingly, successful organizations of any nature are committing themselves to ongoing enhancement of knowledge, skills, and abilities.[38,39] In addition to the skills of professional staff, opportunities should also be available to improve the leadership skills of those individuals in health agency leadership positions. The CDC, through the Public Health Leadership Institute, managed by the Western Consortium for Public Health, and the states of Missouri, Illinois, Ohio, Florida, and California have developed or are planning such programs. Given the enormity of the task, long-distance learning methods offer much promise. Through satellite-based delivery of training courses, computer-assisted instruction modules, cable-television "narrowcasting," and self-study courses, training can be provided at a distance from the training source,[40] forming the basis for a national Public Health Training Network. As ventures are formalized between public health agencies and the private medical community, joint training activities—a local public health learning network—will become an important feature of local "partnering for health."

Community Health Planning

As a consequence of the health reform debate, communities everywhere are becoming engaged in active debate about health issues. However, the dialogue is often limited and, at times, unproductive. In part this occurs because many communities do not have the capacity to engage in an orderly planning process that brings together community leaders, focuses attention, and yields a shared plan of action. The responsibility for improving health ultimately must be shared by the entire community and will inevitably involve the formation of public-private partnerships. Health care organizations benefit when they shift to shared partnership roles—and so does the community.[41] Clearly recognizing this, the hospital industry supports a general shift in management orientation from planning service delivery to comprehensive population-based community health planning. Central to this strategy is a community health assessment and the recruitment of partners "drawn from the ranks of prominent community organizations, such as school boards, public health agencies, and elected officials."[8]

A number of planning models have been developed, and are in widespread use, that encourage the public health agency to take a leadership role in planning. These include Healthy Communities 2000: Model Standards,[42,43] the Assessment Protocol for Excellence in Public Health,[44] and the Planned Approach to Community Health.[45] The Healthy Communities Program, created by the World Health Organization, uses a diverse community coalition to enable the community to assess its own health priorities and develop effective health promotion programs.[45] Finally, grassroots planning initiatives are occurring as well. American Health Decisions, a national consortium that encourages the development of citizen networks and broad participation in health policymaking, is operating in 21 states.[46] The local public health agency has an important role to play in "unlocking the energy" of local citizens and community health institutions, such as hospitals, as a local vision of public health improvement is developed. The institutions, for their part, should not view their planning efforts separately from those of government.

Financing

In view of the magnitude of the challenge and inherent difficulties in financing any infrastructure program, multiple directions should be explored. First, evaluating publicly funded categorical programs for the financial support that could be extracted by reducing administrative inefficiencies and increasing the flexibility in the use of existing funds is critical. Current programs mandated by Congress to address specific disease problems (eg, HIV/AIDS) have frequently required separate, duplicative administrative systems at the local level and have often hampered the ability of health officials to allocate their aggregate federal and state resources to areas of greatest community need. A federal public health funding philosophy that strengthens the ability of communities to direct resources to problems of highest priority and specifically allows flexibility in using a portion of these funds for investment in capacity building should be adopted.

Second, Medicaid programs, which are at the center of virtually all state-based reform initiatives, should be encouraged to begin investing in the information system, workforce development, and community planning technologies that constitute the public health infrastructure. The vulnerable populations for whom these programs finance medical care are virtually the same as those whom public health agencies have identified as "high risk." Innovative managed care programs sponsored, for example, under "1915 Freedom of Choice" or "1115" statewide demonstration waiver programs could, with little impact on an initiative's overall financing structure, provide an important source of support for upgrading the capacity of the state and local public health agencies—their governmental partners—to accomplish their joint mission: improving population health status in a cost-effective manner. A redirection of a fraction of a state Medicaid budget would represent a major new source of capital for public health infrastructure support.

Third, it behooves nonprofit community hospitals and public health agencies to explore joint business ventures. The agencies may need support, for example, to establish a sophisticated information and data system that, when operational, could be integrated with that of the hospital, thus expanding the public health practice data universe. These hospitals (and other health-related

nonprofit organizations) are increasingly under scrutiny by governmental agencies to demonstrate their continued eligibility for valuable tax exemptions under the "community-benefit standard."[47] Mutually beneficial community hospital–public health agency infrastructure support opportunities should be plentiful when local ingenuity is applied. Local governmental agencies must also be entrepreneurial in developing new resources—that is, searching beyond typical channels of public financial support.

Finally, although proposals to alter medical care financing clearly dominated its recent session, the Congress did begin to consider legislation to strengthen the public health system. However, as the reform process continues next year, assuring more complete congressional understanding of the unique contributions the public health system makes to our nation's health and elevating its strengthening to the *center* of decisions about health system financing are imperative.

CONCLUSION

Health system reform presents an unprecedented opportunity to refocus and reinvigorate the system of protecting and improving the health of the public. The process must be centered on the fundamental values of prevention and community. It will require a commitment by governmental agencies to work in partnership with a wide array of nongovernmental groups, and the local public health agency must be adequately equipped to monitor health problems, provide timely information to citizens, take a leadership role in assisting the community to determine its priorities and mobilize all available resources to address them, and assure the availability of quality, communitywide services. To achieve this goal, the infrastructure, or capacity, of the public health system must be strengthened through the creation or enhancement of information systems, learning networks, and community planning techniques. In this way, comprehensive health system reform—medical care reform together with public health reform—can measurably benefit the health of the public.

We wish to acknowledge the review of Jo Ivey Boufford, MD, and the assistance of Margot Parra in manuscript preparation.

References

1. Aday LA. *At Risk in America—The Health and Health Care Needs of Vulnerable Populations in the United States*. San Francisco, Calif: Jossey-Bass Inc Publishers; 1993.
2. Adler NE, Boyce WT, Chesney MA, Folkman S, Syme SL. Socioeconomic inequalities in health: no easy solution. *JAMA*. 1993;269:3140-3145.
3. Angell M. Privilege and health—what is the connection? *N Engl J Med*. 1993;329:126-127.
4. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA*. 1993;270:2207-2212.
5. Lundberg GD. American health care system management objectives: the aura of inevitability becomes incarnate. *JAMA*. 1993;269:2554-2555.
6. Iglehart JK. Health care reform: the states. *N Engl J Med*. 1994;330:78-79.
7. Iglehart JK. The American health care system: community hospitals. *N Engl J Med*. 1993;329:372-376.
8. Rice JA. *Community Health Assessment: The First Step in Community Health Planning*. Chicago, Ill: American Hospital Association; 1993.
9. Lee PR. Reinventing public health. *JAMA*. 1993; 270:2670.
10. Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press; 1988.
11. Foege WH. Preventive medicine and public health. *JAMA*. 1993;270:251-252.
12. Beauchamp DE. Public health as social justice. *Inquiry*. 1976;13:3-14.
13. Berkelman RB, Bryan RT, Osterholm MT, LeDuc JW, Hughes JM. Infectious disease surveillance. *Science*. 1994;264:368-370.
14. Gordon L. Public health is more important than health care. *J Public Health Policy*. 1993;14:261-264.
15. Osborne O, Gaebler T. *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*. Reading, Mass: Addison-Wesley Publishing Co; 1992.
16. Bellah RN, Madsen R, Sullivan WM, Swidler A, Tipton SM. *Habits of the Heart: Individualism and Commitment in American Life*. New York, NY: Harper & Row Publishers Inc; 1985.
17. Bellah RN, Madsen R, Sullivan WM, Swidler A, Tipton SM. *The Good Society*. New York, NY: Vintage Books; 1992.
18. Smith SR, Lipsky M. *Nonprofits for Hire: The Welfare State in the Age of Contracting*. Cambridge, Mass: Harvard University Press; 1993.
19. Greenspan B. A public-private partnership. Presented at National Conference on Models for Managing Health: The Realities of Building a Healthier Community; April 22, 1994; Washington, DC.
20. Shoemaker WC, James CB, King LM, Hardin E, Ordog GJ. Urban violence in Los Angeles in the aftermath of the riots: a perspective from health care professionals, with implications for social reconstruction. *JAMA*. 1993;270:2833-2837.
21. Schilling R. Narrative report. Presented to the Centers for Disease Control and Prevention; July 1, 1993; Atlanta, Ga.
22. *America's Public Health Report Card*. Washington, DC: American Public Health Association; 1992.
23. *HEDIS 2.0: Executive Summary*. Washington, DC: National Committee for Quality Assurance; 1993.
24. Zablocki E. Employer report cards. *HMO Magazine*. March/April 1994;33:27-32.
25. Institute of Medicine. *Health Data in the Information Age: Use, Disclosure, and Privacy*. Washington, DC: National Academy Press; 1994.
26. Minnesota Dept of Health. *Minnesota Integrated Data Initiative to Support Health Care Reform*. Minneapolis: State of Minnesota; 1993.
27. Oberle MW, Magenheim MJ, Baker EL. *Healthy People 2000* and community health planning objectives. *Annu Rev Public Health*. 1994;15:259-275.
28. Washington Health Care Commission. *Final Report*. Olympia: State of Washington; 1992.
29. Hurwitz JC. Toward a social policy for health. *N Engl J Med*. 1993;329:130-133.
30. Susser M. Health as a human right: an epidemiologist's perspective on the public health. *Am J Public Health*. 1993;83:418-426.
31. Eddy DM. Rationing resources while improving quality: how to get more for less. *JAMA*. 1994; 272:817-824.
32. Abelson PH. Toxic terror; phantom risks. *Science*. 1993;261:407.
33. Keeney RL. Decisions about life-threatening risks. *N Engl J Med*. 1994;331:193-196.
34. Keck CW. Creating a healthy public. *Am J Public Health*. 1992;82:1206-1209.
35. Pickett G. The future of health departments: the governmental presence. *Annu Rev Public Health*. 1980;1:297-321.
36. Fielding J, Halfon N. Where is the health in health system reform? *JAMA*. 1994;272:1292-1296.
37. US Preventive Services Task Force. *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions*. Baltimore, Md: Williams & Wilkins; 1989.
38. Cleveland H. *The Knowledge Executive*. New York, NY: EP Dutton; 1989.
39. Senge PM. The leader's new work: building learning organizations. *Sloan Manage Rev*. Fall 1990:7-23.
40. Borow W. Medical television: prescription for progress. *JAMA*. 1993;270:1601-1602.
41. Flynn BC. Partnerships for health. *Healthcare Forum J*. 1994;37:55-56, 73.
42. *Healthy Communities 2000: Model Standards*. 3rd ed. Washington, DC: American Public Health Association; 1991.
43. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: US Dept of Health and Human Services; 1990. DHHS publication PHS 91-50212.
44. American Public Health Association, Association of Schools of Public Health, Association of State and Territorial Health Officials, US Dept of Health and Human Services, Public Health Service, Centers for Disease Control, US Conference of Local Health Officers. *Assessment Protocol for Excellence in Public Health*. Washington, DC: National Association of County Health Officials; 1991.
45. Katz MF, Kreuter MW. Community assessment and participation in disease prevention and health promotion. In: Scutchfield FB, Keck WC, eds. *Principles of Public Health Practice*. In press.
46. Crawshaw R. Grassroots participation in health care reform. *Ann Intern Med*. 1994;120:677-681.
47. *Statement Before the Subcommittee on Select Revenue Measures of the House Committee on Ways and Means*. 103rd Cong, 1st Sess (December 14, 1993) (testimony of Robert S. McIntyre, director, Citizens for Tax Justice).

Note:

- Tobacco lobby might see page 494 highlights differently and take issue with the "sinister" reason cited for tobacco's community support of African American communities.

Medicaid school board claims BL

ADMINISTRATIVE CLAIMING FOR SCHOOL BASED SERVICES IN MEDICAID

Today, you are scheduled to meet with representatives of national education groups to discuss the issue of administrative claiming under Medicaid for school based services and the guidelines that HCFA released to clarify its current policy.

DOCUMENTATION OF ABUSES

A new report from GAO's criminal division scheduled to be released in early April focuses on states and outside consultants using schools to game the system rather than schools claiming inappropriately for services. This report will detail that in a survey of seven states, only 4 out of every 10 dollars claimed by schools are being returned to the schools to reimburse them for the services they are providing. (There is also a separate report being prepared by GAO's research division that is also scheduled to be released in early April.)

In addition, a December 1999 GAO report that surveyed 10 states indicated a five-fold increase in claims over the past four years ($82 million to $462 million).

- Two of the states surveyed, Illinois and Michigan, accounted for most of the increases in administrative cost claims over this period of time.
    - In Illinois, claims increased from $82 million in 1997 to $145 million in 1998 – a 77 percent increase.
    - In Michigan, claims increased from $79 million in 1996 to $227 million in 1997 – a 187 percent increase.
- In four out of the 10 states surveyed, a portion of the Federal reimbursement for services provided at schools is retained in the state's general revenue funds.
    - In FY 1998, Federal dollars contributed about $8 million in Illinois to the state general revenue funds.
    - In FY 1998, Federal dollars contributed about $47 million in Michigan to the state general revenue funds. Since Michigan schools began claiming for administrative costs, the state has retained almost $106 million of Federal Medicaid payments.

SUMMARY OF HCFA ACTION

5/21/99: HCFA released a State Medicaid Director letter that states that: (1) Medicaid will no longer approve matching payments for bundled payments for school based services; (2) Medicaid will only pay transportation costs for children with special transportation needs; and (3) HCFA will issue guidance on approved administrative claiming procedures under Medicaid.

2/15/00: HCFA released their guidance on approved administrative claiming services under Medicaid for an informal comment period. It was posted on the web and distributed through Medicaid directors. The comment period was supposed to close on 3/3, but was extended until 3/4.

3/10/00: Briefing on the guide for the Senate side

3/17/00: Briefing on the House side

CONTROVERSY OVER HCFA GUIDELINES

The education groups were alarmed by the parameters for administrative claiming in the 2/15 guidance and have begun to lobby the White House and the Hill. Their major concerns include:

- **Tone.** The guide is difficult to understand and seems to be designed to discourage even appropriate administrative claiming.
- **Differentiating administrative costs and service costs.** This section is unclear and should be restructured.
- **Includes new policy.** The guide promulgates new regulations (specifically in the area of cost allocation), rather than limiting itself to clarifying current policy, and violates APA.
- **Who can claim.** The guide limits reimbursement for administrative claiming in support of EPSDT to services delivered by providers participating in the Medicaid program.
- **What is reimbursable.** The guide limits Medicaid payments for services in schools to services that are not already paid for by other providers.

SUMMARY OF LEGISLATIVE ACTION

6/17/99: Hearing in front of Senate Finance Committee.

10/99: Amendment on school based services attached to HR 1180 (WIIA) as an offset (score of $70 million). It addressed bundling and transportation in a manner consistent with the HCFA guidelines and asked HCFA to issue uniform guidelines on administrative claiming.

3/15/00: House Budget Committee approved a "Sense of the Congress" amendment stating that the draft guidelines released by HCFA in February promulgated new rules rather than clarifying current rules, and should be revised or abandoned.

4/5/00: Hearing scheduled in front of Senate Finance Committee.

MEETING PARTICIPANTS

FEDERAL:

Jeanne Lambrew
Barbara Chow
Judy Heuman
Andy Rotherham
Tim Westmoreland

OUTSIDE GROUPS:

Dan Fuller	Director of Federal Programs, National School Board Administrators
Michael Resnick	Associate Executive Director, National School Board Administrators
Connie Milito	Director of Government Relations, Hillsborough County Public Schools
Gordon Ambach	Executive Director of the Chief State School Officers
Jeffrey Smink	Legislative Director for the Chief State School Officers
Jerald Newberry	Director of Health Information Network for the National Education Association
Michael Casserly	Executive Director of the Council of Greater City Schools
Audrey Gamm	Specialized Services Officer for Chicago City Schools
Gordon Wrobel	National Association of School Psychologists

GUEST EDITORIAL

THE CDC AND THE NMA—PARTNERSHIPS TO CONTROL TOBACCO IN THE AFRICAN-AMERICAN COMMUNITY

David Satcher, MD, PhD, and Robert G. Robinson, MSW, DrPH

In less than a year, the National Medical Association (NMA) will celebrate its centennial anniversary, marking 100 years of professional service to the American people. This organization of African-American and other racial and ethnic physicians, and their families, has been a beacon of professional leadership for its members since 1895. Through its Journal, the NMA offers unwavering guidance in the application of medical science to promote and improve the health of America's African-American population. The legacy on which pioneering leaders founded the NMA almost 100 years ago is one in which its membership and the entire country can take extreme satisfaction. Yet, as we prepare for the turn of the century, we continue to encounter unacceptable disparities in the health of our most vulnerable populations. African Americans and other communities of color are disproportionately at risk with respect to health and social well being. It is incumbent on representative bodies such as the NMA to continue to help close the health-care gap. It is also critical that federal agencies such as the Centers for Disease Control and Prevention (CDC) form partnerships and assist in this mission.

Today, we are on the threshold of many new and exciting ventures in the area of public health, many of which target preventive aspects of health care. These public health ventures are especially critical for African Americans and others who suffer disproportionately from preventable disease, disability, and death. For too long, we have focused on disease, giving more attention to treating and curing disease than to preventing poor health. Moreover, too many Americans are complacent about the risk factors that contribute to disease. In the case of the number one preventive risk factor—tobacco—this complacency is compounded by the addictive nature of the substance.

In July 1993, I assumed the directorship of two strategic agencies in the fight against disease—the CDC and the Agency for Toxic Substances Disease Registry. Both of these mission-driven agencies are committed to preventing disease. I have established five priorities that will help ensure our commitment to achieve this goal of prevention:

- continued support of state and local health departments,
- developing, maintaining, and improving capacity to respond to urgent threats to health,
- creating a nationwide prevention network and program,
- promoting women's health issues, and
- using cross-cutting approaches to developing new partnerships.

Each of these initiatives has overriding significance for the number one preventable cause of death in America today: tobacco use. The Surgeon General has called tobacco—which causes more than 400 000 deaths annually—the nation's most serious public health threat.[1]

Unfortunately, disproportionate rates of the disease and death caused by tobacco use occur in the African-American community, which has the highest rates of tobacco-related cardiovascular and cancer incidence, rates that translate into approximately 45 000 annual tobacco-related deaths.[2] From 1950 through 1990, the rate of increase in lung cancer mortality was

From the Centers for Disease Control and Prevention. Requests for reprints should be addressed to Robert G. Robinson, MSW, DrPH, CDC, Office on Smoking and Health, 4770 Buford Hwy, NE, Atlanta, GA 30341.

higher for African-American men than for white men. Indeed, lung cancer mortality for African-American men increased nearly sevenfold during this period. Lung cancer mortality for African-American men surpassed that for white men in 1963 and was directly attributable to greater increases in smoking rates for African-American men than those increases for white men. Disturbingly, among African-American women, lung cancer surpassed breast cancer as the leading cancer-related cause of death in 1990.[3]

Currently, an estimated 46 million adult Americans smoke cigarettes, of which about 6 million are African Americans.[4] The good news is that smoking rates among African-American youth are significantly lower than smoking rates among white youth. African-American youth, aged 12 to 17 years, have a prevalence of 3.2% compared with 11.6% for white youth[5]; moreover, only 4.4% of African-American high school seniors smoke, but 22.9% of their white counterparts smoke (Institute for Social Research, University of Michigan. Unpublished data. 1993).

Yet, the situation for adults, particularly African-American men, remains critical. Between 1990 and 1991, after two decades of decline, smoking prevalence among African Americans actually increased from 26% to 29% (CDC. Unpublished data. 1994). This increase is unconscionable and unacceptable. With the availability of such a vast body of scientific evidence attesting to the risks associated with smoking, how can we explain an increase in prevalence? One can point to a variety of explanations, not the least of which is the insidious advertising and promotional campaigns targeting African-American and other vulnerable communities, the difficulties faced by African-American smokers who wish to quit, and the effective penetration of the African-American community by the tobacco industry resulting from industry support of community-based programs, organizations, and elected officials.[6]

In 1991, the tobacco industry spent more than $4.6 billion advertising tobacco products, making tobacco one of the most heavily advertised products in America.[7] Significant expenditures find their way into the African-American community, through either billboard and print advertising or promotional campaigns. The latter is especially revealing because the tobacco industry has engaged in a dramatic shift in advertising expenditures from traditional mass media advertising that is required by law to carry rotational health warning labels, to nonmedia advertising and promotion that in some cases do not require federally mandated health warnings. Such promotional expenditures represented more than three out of every four advertising dollars spent by the cigarette industry in 1991.[7] In addition, there are four to five times more billboards in African-American communities than in white communities, and the majority of these contain tobacco- and alcohol-related images.[8] The tobacco industry states that smoking is a matter of free choice. However, when communities are inundated with images over which they have no control, this is hardly a matter of free choice.

Research shows that African Americans are highly motivated to quit smoking, they make more serious attempts to quit than white smokers, and they are strongly concerned about the social and health consequences of smoking.[9] Why then are African-American adults still smoking in such large numbers?

One reason may be related to the fact that physicians are less likely to counsel African Americans than white smokers to quit smoking. Reports from national surveys indicate that 34.4% of adult African-American smokers—compared with 38.2% of white smokers—who visited a physician or other health-care professional in the previous year received advice to quit.[10] The importance of physician advice to clients has been an established fact for some time, particularly if more than brief counseling is involved.[11] Relatedly, multiple studies have shown that a brief intervention by health-care providers during routine office visits coupled with an office system that promotes cessation advice can result in chemically validated 1-year cessation rates of up to 15% of all smokers in the practice.[12] However, research also indicates that culturally relevant counseling protocols may be needed for the African-American smoker. African-American smokers who quit are significantly more likely to relapse than their white counterparts.[9]

The tobacco industry's support of the African-American community has been strategic and deliberate. This fact is especially evident by the high numbers of African Americans who work in tobacco-related industries. African-American tobacco farmers, for example, have been a significant proportion of this segment of the working force, even though in recent decades their decline has been disproportionately higher than the decline in white tobacco growers. African Americans also have had significant representation in tobacco industry blue- and white-collar jobs, particularly in managerial positions. Indeed, the tobacco industry's record in employing African Americans is considerably more positive compared with other business sectors.[6]

Similarly, the tobacco industry has provided finan-

cial support to an array of community interests, including sponsoring educational and cultural events, supporting elected officials, and funding multiple civic and social organizations. Such support has provided inroads for higher levels of tobacco advertising, particularly of brands high in tar and nicotine, in African-American media and communities. In addition, community leaders have been silent regarding the harmful effects of tobacco use, a silence that has only begun to be broken over the past 5 years. Thus, the tobacco industry has encouraged African-American communities with dollars for their silence, while targeting them with cigarette brands that contain the most lethal doses of addiction and death.[6]

The importance of community leader involvement in countering this influence was evidenced in Philadelphia in 1990.[6] African Americans were instrumental in organizing one of the most successful coalitions in history to force the removal of a new cigarette (Uptown) developed especially for them. The Philadelphia-based Coalition Against Uptown cigarettes succeeded in getting the R.J. Reynolds Company to remove a high-tar, high-nicotine menthol cigarette from the market. This campaign proved the epitome of successful community organization. A combination of African-American-led tobacco control activism; media advocacy about tobacco-related health problems called on all members of an ethnic community to take control of which products are allowed entry into their community; and the coordinated efforts of diverse agencies encompassing health, research, church, and civic interests forced R.J. Reynolds to remove this cigarette from production. Other communities also have rallied around the elimination of tobacco marketing. Detroit and Baltimore are both noted for their efforts to restrict cigarette advertising on billboards.

The CDC currently is supporting several initiatives to improve the capacity of African-American physicians and leaders to promote tobacco prevention and control and to become advocates for decreased dependency on the tobacco industry. The Association of Schools of Public Health is developing physician-based protocols for smoking cessation intervention among African-American clients that use the *Pathways to Freedom* program. Similar initiatives are planned for the Hispanic community. The CDC is collaborating with the American Lung Association in its work with African-American Clergy and the American Cancer Society in its initiative to disseminate the *Pathways to Freedom* program in 15 states. Support also is being provided to African-American, Native-American, Hispanic, and Asian tobacco control advocates to assess their respective communities' infrastructure related to tobacco control and to report the results of their assessments at the next World Conference on Tobacco and Health. Legends, a 1993 public service campaign targeting the African-American community, was developed and implemented by the CDC's Office on Smoking and Health, with the active partnership of the NMA. The next Surgeon General's Report on tobacco and health will focus on the implications of tobacco use among communities of color. The CDC, in funding 33 states to build their capacity in tobacco control, strongly emphasizes the need for diversity and for including traditionally underrepresented communities in tobacco control coalitions. Finally, the CDC is hoping to support an initiative that will target national organizations whose primary constituencies are communities of color, youth, women, and blue-collar or agricultural workers to broaden the base of the tobacco control movement and strengthen the forces of those committed to a tobacco-free society.

As a public health agency, however, the CDC cannot operate in a vacuum. All of these issues are interrelated to the community and its leaders and their capacity to identify and mobilize around issues that affect the well being of the community. The NMA is ideally situated to provide significant tobacco control leadership for the African-American community and strengthen its partnership with CDC. This partnership can help remove the barriers to counseling clients about the deleterious health effects of tobacco use and provide quit-smoking advice. Most important, the NMA can call on African-American leaders and organizations to develop a strategy to free themselves from dependency on the tobacco industry.

The challenges to the CDC and the NMA are immense. More research on tobacco use among youth and communities of color will bolster our understanding. More progress to control the ability of vendors to sell cigarettes illegally to youth will help deter smoking. Increased tobacco excise taxes, a critical element to support health-care reform, will result in more attempts by adults to quit smoking. We must be ready to help the smoker succeed.

In addition, policy initiatives of particular relevance to the African-American community need development and support. Such initiatives include regulating tobacco advertising and promotion and developing strategies to help replace financial support from the tobacco industry for community-based programs. The most positive trend is that communities of color continue to mobilize

to increase their voice and capacity for acting to promote and protect the health of their citizens. As a proven leader in health-care reform and health promotion, the NMA can play a key role in intensifying these efforts. We are a long way from achieving a smoke-free society, but through partnerships our journey is made easier.

Literature Cited

1. US Department of Health and Human Services. *Preventing Tobacco Use Among Young People, a Report of the Surgeon General.* Atlanta, Ga: US Dept of Health and Human Services; 1994.
2. Centers for Disease Control and Prevention. Smoking—attributable mortality and years of potential life lost—United States, 1988. *MMWR.* 1991;40:62-70.
3. Centers for Disease Control and Prevention. Mortality trends for selected smoking-related cancers and breast cancer—United States, 1950-1990. *MMWR.* 1993;42:857-866.
4. Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 1991. *MMWR.* 1993;42:214-217.
5. Substance Abuse and Mental Health Services Administration. *National Household Survey on Drug Abuse: Population Estimates, 1992.* Rockville, Md: US Dept of Health and Human Services; 1993.
6. Robinson RG, Pertschuk M, Sutton C. Smoking and African Americans: spotlighting the effects of smoking and tobacco promotion in the African-American community. In: Samuels SE, Smith MD, eds. *Improving the Health of the Poor.* Menlo Park, Calif: The Henry J. Kaiser Family Foundation; 1992:123-181.
7. Federal Trade Commission. *Federal Trade Commission Report to Congress for 1991: Pursuant to the Federal Cigarette Labeling and Advertising Act.* Washington, DC: Government Printing Office; 1994.
8. Centers for Disease Control and Prevention. *African Americans and Smoking—At a Glance.* Atlanta, Ga: US Dept of Health and Human Services; 1991.
9. Royce JM, Hymowitz N, Corbett K, Tyler DH, Orlandi MA. Smoking cessation factors among African Americans and whites. *Am J Public Health.* 1993;83:220-226.
10. Centers for Disease Control and Prevention. Physicians and other health care professional counseling of smokers to quit—United States, 1991. *MMWR.* 1993;42:854-857.
11. Kotteke TE, Battista RN, DeFriese GH, Brekke ML. Attributes of successful smoking cessation interventions in medical practice: a meta-analysis of 39 controlled trials. *JAMA.* 1988;259:2883-2889.
12. Glynn TJ, Manley MW. *How to Help Your Patients Stop Smoking: A National Center Institute Manual for Physicians.* Bethesda, Md: US Dept of Health and Human Services; 1991. NIH publication 92-3064.

Note:

- The 20 to 30 percent quoted has been called into question. Source ? Back-up for statement
- Sex education statement can be taken out of context.
- Gun lobby might not like firearm comment.

[redacted]

(National Conference of Family Violence (1994 Mar. 11-13: Washington, D.C.)

National Conference on Family Violence: Health and Justice

Conference Proceedings
March 11-13, 1994
Washington, DC

Sponsored by the
American Medical Association

Funded by the
National Institute of Justice
Centers for Disease Control and Prevention
Ford Foundation
Robert Wood Johnson Foundation
Maternal and Child Health Bureau

David Satcher, MD, PhD
Director, Centers for Disease Control and Prevention; and
Administrator, Agency for Toxic Substances and Disease Registry

A man's home is his castle. How many times have we heard this? We have so many ways to talk about home: keep the home fires burning, a woman's place is in the home, I'll be home for Christmas ... if only ... If only what? If only my family was like everybody else's – safe, loving, secure. For too many women and children, a loving and safe family is only in their dreams.

People in most American families get past interpersonal problems to find comfort, security, love, and the nurturing of bodies and souls in their families. But for many others, the interpersonal problems are too great, and their homes become places where they are victimized, either physically or psychologically, or both. Some don't survive. In 1991, 5,745 women in the United States were victims of homicide. Six of every 10 of these women were murdered by someone they knew. About half of the women who knew their assailants were killed by a spouse or someone with whom they had been intimate. The numbers themselves astound us, but that is nothing compared to seeing a neighbor – a child or a woman whom you see at church, in the stores, in the yard, or at PTA – dead at the hands of one whose role was to protect.

Violent deaths represent less than 1% of assaults on women. Estimates of assaults on women by partners or cohabitants range from 1.8 million to almost four million per year. More than 1800 women are estimated to be forcibly raped each day in the United States. Other estimates show that 20 to 30 percent of women treated in emergency rooms are there because of physical abuse by a partner.

These deaths, injuries, and psychological and physical abuse are difficult to understand, but we must strive to understand. The urge to simply turn away from this type of violence is great. As a society, we have done that for many years. The reasons for this national silence are many and diverse. You will hear many reasons throughout the course of this meeting. As we grapple with extremely difficult questions that revolve around ethical, legal, medical, and practical decisions about preventing family violence, we should keep in mind a few basic facts about family violence in our society.

First, we must carefully examine how we regard the family in our culture and the roles of the members of the family. This is fundamental to how we regard the victims of family violence. One of the first questions that confronts us is: What constitutes a family? Regardless of what people believe or want the American family to be, we who work in violence prevention know that people who come together to give to each other those qualities of home that are found in a family – such as love, companionship, children, fulfillment of basic needs – these unions foster bonds that are just as strong as traditional families, and they can be just as destructive if the relationship becomes violent. But because these relationships are inherently intimate and private, we are reluctant as a society to intervene in the violence. We must overcome that reluctance.

We need to continually monitor and assess how society perceives the roles of women and children. Too often women are still viewed as a secondary citizens and children as property of the parents. Over the last 30 years our country has opened many doors in business and education for women. But as with other segments of the U.S. population, we have a long way to go. Many women cannot make enough money to support themselves and their children. This hard economic fact keeps many women in an abusive, even life-threatening, situation because she has no place else to go.

And while we find ways to help them, we must hold batterers and abusers accountable for their actions. The Family Violence Prevention Fund puts this very succinctly – "There is no excuse."

Even more importantly perhaps are the children. They are the potential victims and potential future abusers. Therefore, they warrant our intensive efforts. As parents and members of communities and in our roles that we perform professionally, we must make sure that children are firmly rooted in the positive values of our society. What children learn about their role in society and their opportunities may well be shaped by what they see in the movies and on television rather than what they learn from extended families and their own immediate community. We can change this.

We need to continually monitor and assess how society perceives the roles of women and children. Too often women are still viewed as a secondary citizens and children as property of the parents.

And while we find ways to help them, we must hold batterers and abusers accountable for their actions. The Family Violence Prevention Fund puts this very succinctly – "There is no excuse."

We are very concerned about the cycle of violence that begins with child abuse and children witnessing violence in the home, that continues into adolescence as children learn that violence is the way to react to conflict and stress. Ultimately, this leads to abuse or victimization in adulthood that turns once more on the children. We can break this cycle. We have ways to help – home visitation for families who are at risk for child abuse; protocols and methods for getting women out of abusive situations; mentoring, conflict resolution, and a host of other interventions for youth who are violent. We can do this.

But we need to do more. We must teach our children fundamental respect for others because we are human beings. We don't shoot someone for their jacket. We don't strike out in violence because we don't like the way someone looks or talks. There are better ways to settle disputes than with a gun. We must give them the tools that will help them withstand the pressures that life will bring them. Many other fundamental societal problems contribute to violence: poverty, lack of opportunity, drug and alcohol abuse, and unemployment, to name a few. As a society, we have to find answers to these problems, but we can also give youth the tools to help them deal with their problems, like self-esteem, education, and a desire to contribute to society.

At CDC we are conducting 16 evaluation projects in communities that are looking at the impact of promising interventions to prevent youth violence. Some of these projects are designed to evaluate single strategies, such as curriculum in schools or mentoring. Others are looking at how a combination of interventions – such as mentoring combined with teaching job skills and placing adolescents in jobs – will affect youth violence. These latter projects are also looking at how the interaction of a number of community organizations, including churches, affects the ultimate outcome of preventing violence. We need stronger family support programs, including welfare reform. And we need more well-coordinated community-wide efforts.

We don't help to prepare young people for the family. That's partly reflected in the fact that we have so little sex education going on in the schools. When we say sex education people think of just sexual intercourse and not what does it mean to be a man or woman and how should men and women relate to each other in society.

Young men need to rethink their attitudes toward women. In a survey of 1700 boys and girls in the seventh to ninth grades, 20% answered that a man on a date had a right to sexual intercourse without the woman's consent if "he spent a lot of money on her." We can and we must improve school-based health education. And a major part of the health care reform proposal is school-based health care. School-based health education must focus on family life and sexualtiy: What it means to be a boy or girl, man or woman. We must teach our children and we must protect our children. This is primary prevention.

In our society we also have glamorized violence. Dr. Rodriguez and I were at the World Health Assembly in Geneva in May. And one of the areas where we, as a nation, took the greatest beating was in that people in other countries complained that we have so glamorized violence that it is having a very adverse effect on young people all over the world. We can and we must improve public education and the marketing of nonviolent behavior. Just as we have marketed violent behavior, we can market nonviolent behavior.

Another fundamental societal issue that we must confront is the proliferation of firearms in the United States. Over the last 10-20 years, we have seen the homicide rates rise dramatically in our country as well as the rate of ownership of guns. A recent CDC report predicts that cross-over of two important injury causes: firearms and motor vehicles. The death rates associated with motor vehicle crashes in the United States are coming down after years of intensive work in this area. At the same time, death rates associated with injuries from firearms are rising dramatically. In six states and the District of Columbia, firearms are already responsible for more deaths than motor vehicles.

Family violence is affected by this increase in the same way as youth violence and other violence in public places. In a recent study by Arthur Kellermann and his colleagues that was funded by CDC, homes with guns were found to be the scene of a homicide almost three times more often than similar homes without guns. Virtually all these homicides involved a family member or intimate acquaintance. We need to develop strategies that will address injuries and deaths caused by firearms in the same aggressive

manner that we tackled injuries and deaths related to motor vehicles.

Our task in this meeting is to examine how we who work in the two areas of health and justice can work together to solve the problem of family violence. As we deal with this issue, we will have to acknowledge how these two disciplines fit into the societal milieu that underscores family violence. This may not be very comfortable. Both the justice and the medical system have some black marks against them. But we can overcome this also. We can start by recognizing that family violence is a crime with very definite health consequences. We can start by recognizing that children have a fundamental right to be safe and to nurtured. And that women have the right to live free from the threat of violence and that they have the right to function in society in the same manner as men.

From these fundamental rights will come our responsibilities. We have the power to make sure women and children are safe. We have incredible power to help both the victims and the perpetrators. What may stand in our way is our reluctance and that of society to intervene – because of all the issues that we will discuss today and tomorrow. As physicians, nurses, police officers, and judges, we are accustomed to taking charge of situations, and we want to be the solution. With family violence, though, none of us will be able to do much alone. We have to learn how to be an effective team. People's lives depend on it.

Although there is a great deal we know we can start with, we still have much to learn about family violence. For example, the numbers that you will hear sometimes seem contradictory. Nearly everyone acknowledges that the numbers are only a tip of the iceberg because these problems are under-reported. The lack of true information about all aspects of family violence is telling itself: We have not cared enough as a society to even carefully describe the problem – the first step in changing the situation.

At the Centers for Disease Control and Prevention, we are beginning a new program in family and intimate violence. We are excited about this opportunity to join many of you in this audience who have been working in this area for a long time. Our focus in this program will be on traditional public health methods, such as surveillance to monitor the problem, analysis of risk factors, development and evaluation of interventions, and public and professional education. We are currently developing mechanisms to work in each of these areas.

We can and we must improve surveillance. We must improve the diagnosis of domestic violence, the reporting, the referrals. And we must do that together – all of us – the public health, health care, justice system – together we must develop the systems and the surveillance which allow us to monitor the magnitude of this problem. If we can't do that, we can't evaluate our interventions.

We will develop ways to describe and track the problem of family and intimate violence to obtain the information we need to determine how often it occurs, who are at greatest risk, how many people are affected, and whether the problem is improving or worsening over time. This information is crucial to targeting resources and determining whether our prevention efforts are working.

We will also work to increase our knowledge of the causes and consequences of family violence. Because of its intimate and personal nature, this a difficult problem to study. Consequently, much remains unknown about the factors that increase or decrease the likelihood that men will behave violently toward women, factors that endanger women or protect them from violence, and the physical and emotional consequences of such violence for women and children. Better knowledge of these risk factors will help us develop new prevention strategies.

A major priority for us at CDC is to determine what works. Although a number of existing interventions to prevent family violence are being used and are perceived as useful, we actually know very little about their effectiveness and their impact on victims of violence. Therefore, we will evaluate interventions, particularly those that are designed to prevent violence before it happens. We also believe that, because this is a problem deeply rooted in societal beliefs and behaviors, that we must work with and in communities to effectively solve the problem. Therefore, we will also evaluate how interventions are implemented in communities and what effect strong participation by the community has on the effectiveness of a prevention program. We will also work

We can and we must improve surveillance. We must improve the diagnosis of domestic violence, the reporting, the referrals. And we must do that together – all of us – the public health, health care, justice system – together we must develop the systems and the surveillance which allow us to monitor the magnitude of this problem.

The lack of true information about all aspects of family violence is telling itself: We have not cared enough as a society to even carefully describe the problem – the first step in changing the situation.

with state health departments to set up the necessary support for community programs to thrive.

We will also work to inform the public about family violence and ways to prevent it. In 1992, the Family Violence Prevention Fund sponsored a nationally representative survey of 1000 men and women aged 18 and over. Three companion surveys oversampled African Americans, Latinos, and Asian Americans. Fifty-seven percent of the respondents said they had witnessed a potentially violent circumstance. In this survey more people had directly witnessed an incidence of domestic violence than muggings and robberies combined. While the majority of respondents believed this violence to be wrong, there was ambivalence about what could or should be done until a woman actually suffered an injury. While we can take heart that it appears that family violence is perceived as unacceptable, this is not enough.

We must let the public know what can be done to remedy the situation. We will also work with professionals who deal with victims of violence, as we are doing in this conference, to continually refine how we act to prevent this problem.

As we develop our recommendations today and tomorrow, we must keep these societal conditions foremost in our minds. It is not simply enough to develop recommendations in papers that will serve as a record to the world that we care. We must go back to our communities to be active agents of change. We have the power to make this happen – and we must do it. A former Secretary of Health and Human Services, John Gardner, used to say, "Life is full of golden opportunities, carefully disguised as irresolvable problems."

Thank you.

Two Views on the Problem of Emerging Infectious Diseases

DAVID SATCHER AND ANTHONY S. FAUCI

Priorities in public health are constantly evolving. As the nation's prevention agency, the Centers for Disease Control and Prevention (CDC) must ensure that its prevention and control programs keep pace with the numerous and changing health problems that threaten all segments of our diverse society. To strategically address these public health issues, CDC has identified four priority areas: (i) strengthen core public health functions; (ii) develop, maintain, and enrich the capacity to respond to urgent threats to health; (iii) develop a nationwide prevention network and program; and (iv) promote women's health. Leading the list of urgent threats to health are new and emerging infections.

The spectrum of infectious disease is changing rapidly in conjunction with dramatic changes in our society and environment. Worldwide, population growth is explosive with expanding poverty and urban migration; international travel is increasing; and technology is rapidly changing—all of which affect our risk of infection with the countless microbial pathogens with which we share our environment. Despite historical predictions to the contrary, we remain vulnerable to a wide array of new and resurgent infectious diseases.

Satcher

Our vulnerability to emerging infections was dramatically demonstrated in 1993. In that year alone, we witnessed the largest waterborne disease outbreak ever recognized in this country. The source was an urban municipal water supply contaminated with a *Cryptosporidium* sp.—an intestinal parasite that causes prolonged diarrheal illness in the immunocompetent and severe, often life-threatening, disease in the immunosuppressed. Also in 1993 the emerging bacterial pathogen *Escherichia coli* O157:H7 caused a multistate food-borne outbreak of hemorrhagic colitis and hemolytic uremic syndrome (HUS) with at least four HUS-associated deaths in infected children. Finally, a previously unknown hantavirus was identified as the etiologic agent of hantavirus pulmonary syndrome. This infection, which was linked to exposure to infected rodents, has primarily affected otherwise healthy young adults—mortality approaches 60%.

Moreover, in recent years our antimicrobial drugs have become less effective against many infectious agents, and experts in infectious diseases are concerned about the possibility of a "postantibiotic era." In our communities, drug-resistant pneumococci are being recognized with increasing frequency and threaten our ability to adequately treat middle ear infections in children and community-acquired pneumonia in adults. In our hospitals, vancomycin-resistant enterococci have emerged, and concerns are increasing that the same resistance patterns may evolve in staphylococci.

Three recent reports by the Institute of Medicine document the urgent need to end years of complacency toward infectious diseases and to begin immediately with enhanced vigilance to address emerging infectious disease threats. To meet this urgent need, we must improve public health infrastructure at the local, state, and federal levels and adjust public health policy to foster a well-coordinated and systematic approach among clinical and public health professionals to prevent and control new and resurgent infectious diseases. Further, we must recognize that the health of the American people is inextricably linked to the health of people in other nations, infectious diseases can and do spread rapidly around the

David Satcher is the director of CDC. Anthony S. Fauci is the director of NIAID.

globe, and global surveillance for emerging infections is vital to public health.

In partnership with local and state public health officials, other federal agencies, medical and public health professional associations, infectious disease experts from academia and clinical practice, and international and public service organizations, CDC has developed a plan that will help direct our efforts to safeguard this nation from the threat of emerging infectious diseases. This plan, "Addressing Emerging Infectious Disease Threats: A Prevention Strategy for the United States," is summarized elsewhere in this issue of *ASM News*.

The President's Health Security Act of 1993 addresses the need for universal health-care coverage as well as the need to enhance community-based public health strategies. As we proceed with health-care reform, priority must be given to strengthening partnerships among health-care providers, microbiologists, and public health professionals to detect and control emerging infectious diseases. As the nation's prevention agency, CDC looks forward to working with its many partners to address the challenges of emerging infectious disease threats.

David Satcher

New or emerging infectious diseases have had an extraordinary impact on society throughout history. In the Middle Ages, plague killed a quarter of Europe's population in 4 years. In this century, the influenza pandemic of 1918 claimed millions of lives worldwide. In the past two decades alone, we have seen the emergence of Legionnaires' disease, toxic shock syndrome, Lyme disease, Ebola fever, and human immunodeficiency virus-related disease, among others. Most recently, we have witnessed the emergence of a hantavirus in the United States. Other infectious organisms, such as those that cause tuberculosis, malaria, and common bacterial infections, have developed drug resistance, often making treatment difficult or impossible.

Factors such as rapid air travel between remote tropical areas and crowded commercial centers, increased mobility of formerly isolated populations, human settlement in formerly uninhabited tropical areas, changes in human behavior, and wars or natural disasters that disrupt diet and sanitation all increase opportunities for infectious diseases to spread more quickly—and to more individuals—than ever before. Clearly the threat from new or emerging microbes is real and potentially catastrophic.

A problem that is inherent in the establishment of a meaningful commitment to resources for the support of basic biomedical research as a critical tool in our never-ending struggle against emerging infectious diseases is the difficulty in convincing the general public and their elected representatives that the threat is real. Our task is made more difficult because polio, typhoid fever, and diphtheria, among others—once major killers in this country—are now rare. Much of the general public assumes that infectious diseases are largely relics of the past. Furthermore, when we are immersed in public health crises that already exist, it is not easy to garner support for a future public health threat.

Fauci

There are two main scientific, complementary approaches to the problem of identifying and responding to new and emerging microbes: surveillance and basic research. One example of surveillance would be sentinel outposts that examine serologies and evolving patterns of disease at the perimeter of tropical rain forests.

Basic biomedical research, the specific mission of the National Institutes of Health (NIH), is the mainstay of the approach of the National Institute of Allergy and Infectious Diseases (NIAID) to emerging infectious diseases. There is no better argument for the continued support of basic biomedical research than the threat of new or emerging infectious diseases. The revolution in molecular biology spawned largely by basic research supported by NIH, the work on animal viruses such as the murine retroviruses, and the decades of research on the regulation of the immune system—among so many other endeavors—enabled the biomedical research community to be well positioned to meet the scientific challenges of the AIDS epidemic. Ongoing basic biomedical research prepares us to battle new or emerging microbes through improved diagnostic techniques, advanced molecular virology, better vaccine development, better adjuvants for vaccines, faster and more precise serological tests, improved monoclonal antibodies, and better ways to clone, sequence, and study viruses. Our ability as a nation to defend ourselves against new or emerging microbes is very closely related to the state of our basic biomedical research.

Infectious disease challenges of the future cannot be met without unwavering commitment to basic biomedical research. As part of this commitment, one goal of NIAID is to develop a research and training infrastructure aimed at building a critical mass of investigators with expertise in infectious diseases, field research, medical entomology, and epidemiology, as well as a scientific support structure capable of responding expeditiously to infectious disease emergencies.

Anthony S. Fauci

Note:

- Highlight can be taken out of context.

Reprinted by the
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

from U.S. MEDICINE, March 1994, Vol. 30, Nos. 4-8

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC Targets New and Recurring Health Risks

By David Satcher, M.D., Ph.D.
Director
Centers for Disease Control and Prevention

Dr. David Satcher

In the following article, written for U.S. MEDICINE, Dr. David Satcher, director of the Centers for Disease Control and Prevention, discusses the prevention and epidemiologic challenges facing his agency in an era of health care reform and increasing morbidity and mortality from violence.

Since assuming directorship of the Centers for Disease Control and Prevention in November 1993, I have become more committed than ever to fulfilling this organization's role as the nation's primary agency for prevention.

The vision of CDC is one of "Healthy People in a Healthy World," which precisely aligns with my personal goals as a physician, researcher and educator. I now have the privilege and opportunity to work with a world-class professional staff at CDC, to continue our mission of delivering better health to the world.

The administration clearly has articulated that prevention is essential to its plan for health reform and has indicated its commitment to prevention and public health by requesting a large increase in CDC's fiscal year 1994 budget.

Challenges To Prevention

Achieving our goals in prevention has become increasingly complicated because of the complex issues facing public health in the 1990s. Injuries from violence have taken too large a toll, particularly among our young people, as well as on people in our inner cities, in our rural communities, and in our suburbs. Prevention tools must be applied to solve our violence problems, which have reached national epidemic proportions.

The public health community must assess the problem; develop public policy to prevent it and devise programs to assure the success of interventions to prevent violence.

New and re-emerging infectious diseases challenge current technology and treatment, bringing the nation face-to-face again with enemies once considered endangered foes.

Environmental toxins need to be assessed and addressed as potential risks to the health of American neighborhoods. Scientific inquiry will be greatly challenged to find which toxins pose risks and how they can best be managed.

With the advent of health care reform, the incentives and the demand for preventive interventions will increase. We must be prepared to implement nationwide health information and surveillance systems for assessment and monitoring of health, to develop the most appropriate policies, and to assure access and quality of services and public education to protect and promote good health for everyone.

Building Nationwide Prevention Programs

Other current challenges to prevention fit into more traditional categories:

- ✔ Increased efforts to immunize America's youngest children.
- ✔ Epidemiologic and laboratory research related to infectious diseases.
- ✔ Research, in field and laboratory, to identify initiatives to prevent birth defects.
- ✔ Program activities to prevent breast and cervical cancer and smoking-related illness.
- ✔ Epidemiology on a global scale.

The CDC Epidemic Intelligence Service (EIS) is a unique two-year, post-graduate program of service and on-the-job training for health professionals interested in the practice of epidemiology. Our recruitment efforts resulted in the 1993 class of 69 officers, composed of 52 per cent women and 20 per cent racial and ethnic minorities.

In fiscal year 1993, officers responded to 78 requests for epidemiologic assistance.

Worldwide, CDC collaborated with 12 other nations to prevent and control disease and injury through the establishment of field epidemiology training programs which enabled these countries to better meet their public health needs at the national, provincial and local levels.

Responding To Urgent Threats To Health

✔ ***Immunization of children.*** Last year survey conducted by CDC focused major attention on the problem of low immunization rates—too many of our nation's children go unvaccinated. A more recent survey shows that while some improvement in coverage had occurred from 1991 to 1992, the problem of low immunization coverage remains.

Childhood immunization represents a cost-effective means of protecting children against disease.

The Childhood Immunization Initiative (CII) has made immunization of children one of the nation's highest priorities. In 1993, the National Immunization Program was created as a high-level organization within CDC, reporting organizationally to my office. Its purpose: to increase momentum toward higher immunization coverage levels and the protection of children younger than 2 years of age.

The unprecedented resources provided in the fiscal year 1994 budget mean that CDC can accelerate its efforts and target 90 per cent coverage among 0 to 2-year-olds by 1996 (1998 for hepatitis B), rather than the year 2000 as initially planned.

✔ Congress increased the immunization budget for CDC to $528 million in fiscal year 1994, an increase of more than $187 million over fiscal year 1993.

✔ CDC released $289 million in grant funds to 63 immunization programs throughout the United States and U.S. territories.

Global eradication of polio. The World Health Organization (WHO) initiative to eradicate polio by the year 2000 has made substantial progress during 1993. The entire Western Hemisphere remained free from polio, and marked reductions in reported polio cases occurred in most other regions of the world.

Strategies to eradicate polio, such as national immunization days, were initiated in China, Vietnam and the Philippines and continued in Egypt, resulting in a decline in polio in these countries. CDC supports this initiative by providing technical, laboratory and programmatic assistance to WHO and polio-endemic countries.

In addition to ending the risk of importations of polio into the United States, more than $225 million in polio vaccine and administration costs will be saved in the U.S. after global eradication is achieved and vaccinations are stopped.

New and Emerging Infectious Diseases Challenge CDC Researchers

Despite predictions earlier this century that infectious diseases would soon be eliminated as a public health problem, they remain the major cause of death worldwide and a leading cause of illness and death in the United States. Since the early 1970s, the U.S. public health system has been challenged by a myriad of newly identified pathogens and syndromes (e.g. *Escherichia coli* O157:H7, hepatitis C virus, human immunodeficiency virus (HIV), Legionnaires disease, Lyme disease and toxic shock syndrome).

New hantavirus strain identified. A team of CDC biomedical researchers isolated and grew in the laboratory the virus responsible for the hantavirus pulmonary syndrome cases that occurred in 12 states and killed 27 people during 1993. The virus is carried in blood, urine and fecal material of mice. Patients inhaled the airborne virus in locations where mice droppings were found.

This hantavirus often strikes with terrifying swiftness and causes fatal lung disease. While the virus was identified as the cause of the disease in June 1993, this further step should eventually enable scientists to develop simple, rapid diagnostic tests, investigate effective treatments in the lab and potentially produce a vaccine against this emerging health threat.

E. coli O157.H7 infection in hamburgers traced. E. coli O157.H7 was discovered only 11 years ago, but has emerged as a major cause of food poisoning. Last year, one of the most serious outbreaks of foodborne disease in the United States occurred in Washington state and eventually emerged in three other states. Sources of E. coli O157 include undercooked ground beef and raw milk. Most of these cases were traced to contaminated ground beef served at a hamburger chain.

Tuberculosis re-emerges; drug resistant strains emerge. Despite a steady decline, tuberculosis (TB) once again has come to the forefront as a significant public health problem. From 1985 through 1992, TB increased by 20 per cent throughout the general population, with childhood cases increasing by 35 per cent. The resurgence of TB was fueled by the AIDS epidemic, immigration from high-TB prevalence countries, homelessness, and poverty.

In 1992 alone, 26,273 cases of TB were reported, and the disease is hitting minority groups hardest. From 1985 through 1990, TB cases increased among non-Hispanic blacks by 27 per cent and among Hispanics by 55 per cent, while showing a 7 per cent decrease among non-Hispanic whites.

CDC formed a national task force with other federal agencies and public health organizations to combat the TB problem, including the appearance of TB strains resistant to known treatments for the disease. The task force has developed and released a national plan to prevent multi-drug resistant TB.

The War On Violence— A Global View

At the World Health Assembly in Geneva in May 1993, delegates from Africa and Asia told American delegates that violence in America was affecting their children. They criticized our movies as glamorizing violence.

CDC must stay focused on combating violence as a global issue, as well as dealing with this threat on our own soil.

In order to more effectively combat violence with the epidemiologic tools which are available to the health community, the National Center for Injury Prevention and Control (NCIPC) was formed in June 1992. NCIPC has strengthened the national capacity to monitor trends and evaluate effectiveness of interventions to prevent unintentional injuries, such as the use of bicycle helmets to prevent bicycle-related head injuries.

The center must confront some tough violence issues head-on.

For instance, a recent CDC study revealed that in 1990, 4,200 teenagers were killed by firearms, resulting in the highest firearm death rate for 15-19 year-olds ever recorded for the United States. Comprehensive national statistics on firearm deaths have been compiled since the late 1960s. Guns caused one in every four deaths of young people 15-19 and 20-24 years of age and were responsible for more deaths than all natural causes.

Areas where the center made progress include:

✔ NCIPC funded three cooperative agree-

ments with community-based organizations to evaluate the effectiveness of a combination of violence prevention strategies (i.e. mentoring and job training, reducing youth violence and the resulting injuries and deaths).

✔ The center has refocused the national debate on firearms from the political to the public health arena and has given impetus to programs to prevent death and disability due to violence as well as unintentional injuries such as automobile crashes, falls, fires, and drownings.

✔ Each year 20,000 people die from homicide and 30,000 from suicide. Youth violence is a particular concern, with homicide the second leading cause of death for young people ages 15 to 34 and the leading cause of death for both young black men and women in that age group. CDC strategy has been, and will continue to be, to scientifically determine the factors that put people at risk for violence or protect them from it; to disseminate information about current programs for preventing violence, and to evaluate potential interventions for violence prevention.

Potential Threats From The Environment

Cryptosporidium exposure traced. CDC epidemiologists, working with state and local health departments, traced outbreaks of serious illness to environmental exposures to *Cryptosporidium* in drinking water. Though the parasite is uncommon, in the last 10 years the protozoan has been recognized more frequently throughout the world as causing waterborne outbreaks in the United States and England. In a recent Milwaukee outbreak, 370,000 people became ill in a single month after drinking water contaminated with *Cryptosporidium*, and about 50 died.

The intestinal parasite inhabits the intestines of humans, cattle and many other animals and is generally spread through contaminated food and water; it can be removed from water only through filtration.

Lead poisoning and America's children. Lead poisoning is the number one environmental threat to the health of children in the United States and is totally preventable. CDC announced a new and lower "threshold of concern" for lead levels in blood which should initiate accelerated levels of action, ranging from individual treatment, to case-management, to community prevention activities.

CDC efforts toward the elimination of lead poisoning are part of the Department of Health and Human Services' five-year national effort to reduce lead exposure in housing, food, water, soil and the work place.

Environmental health. Other health threats relate to environmental toxins potentially emanating from various sources which may threaten many communities in this country. Minorities are overly represented in communities where toxic waste dumps are located. Because of these potentially urgent threats to health, CDC is committed along with our colleagues at the state and local levels to a process of continued quality improvement in knowledge and skills, laboratories, communication, training, and a productive work force at every level of the public health community.

CDC Programs Fight Chronic Disease

Though the health community has made progress in combating chronic disease and premature death, we are falling short in several areas, including reducing health disparities among certain racial, economic and ethnic groups.

✔ CDC programs to prevent chronic diseases actively reach out to Americans who would not otherwise have opportunities for prevention. Given what we now know about the role of tobacco use, physical inactivity, and nutrition in the origin of chronic diseases which account for over half of the deaths each year in our nation, CDC is developing effective prevention strategies to combat cardiovascular disease, birth defects, diabetes mellitus, cancers of some types, and injuries of all kinds.

✔ CDC developed two programs in 1993 directly addressing the disproportionate burden of diabetes borne by African Americans, along with a comprehensive community organization program addressing diabetes as a public health problem in rural as well as urban communities.

✔ The prevention block grant, which funds many activities related to chronic diseases, has increased by 61 per cent since its founding in 1988—from $89 million to $143 million in 1993.

✔ New research has been developed to examine the risk factors for the high infant mortality rate for black infants. Black infant mortality is twice that for whites and the gap is increasing. In this quest, CDC now has cooperative agreements with eight schools of public health or departments of preventive medicine.

CDC Maps Genetic Structure Of Smallpox

Smallpox destroyed millions of lives before its eradication in 1977. CDC molecular biologists now have determined the DNA sequence of one complete smallpox virus genome, and in collaboration with Russian scientists, have sequenced parts of five other smallpox strains.

The work is a significant achievement that provides a valuable archive of the virus and insight into the components responsible for its virulence.

Scientists have debated the proposed destruction of the remaining smallpox virus samples which are held at the CDC and the Research Institute for Viral Preparations in Moscow.

The World Health Organization (WHO) has received a technical committee report on the sufficiency of the sequence data and is considering the debated issues to make recommendations on the proposed destruction for ratification by the United Nations World Health Assembly which meets in May 1994.

Folic Acid Lowers Risk Of Birth Defect

CDC has worked with the Food and Drug Administration (FDA) on proposals that folic acid, a B-vitamin, be added to some food products to lower the risk of neural tube birth defects (NTDs), spina bifida and anencephaly, which occur in about 2,500 live-birth cases.

CDC research was the basis for the Public Health Service recommendation that all women of childbearing age in the United States who are capable of becoming pregnant should consume 0.4 mg of folic acid per day to reduce their risk of having a child affected by spina bifida or other neural tube defects.

HIV/AIDS Battle Continues

✔ The revision of the AIDS surveillance case definition had an immediate and powerful impact on the number of reported

• AIDS cases in 1993. From January 1 through December 31, 1993, more than 100,000 cases of AIDS were reported to CDC, representing a more-than-100-per-cent increase over cases reported in 1992. By the end of 1994, the cumulative number of U.S. AIDS cases is projected to reach 415,000 to 535,000 and result in 330,000 to 385,000 deaths.

✔ In 1993, five external review panels of experts in the field of HIV prevention suggested program modifications and proposed solutions to potential problems CDC faces in preventing the spread of HIV infection. These strategies examined monitoring the AIDS epidemic, developing partnerships for prevention, preventing risk behaviors among students, promoting knowledge of one's serostatus, and improving the public's understanding of the HIV epidemic.

✔ CDC published scientific information that confirmed the fact that latex condoms used consistently and correctly during every sexual intercourse are an effective barrier in preventing HIV transmission. CDC also formally announced a major prevention initiative and marketing campaign focusing on people 18-25 years of age which promotes sexual abstinence and the use of condoms to prevent HIV infection.

The prevention marketing initiative is the first government-supported information effort designed to reach sexually active young people with specific messages regarding condom use and efficacy.

Smoking: A Top Prevention Issue

✔ The use of tobacco is still our leading preventable cause of death and disease. As a component of an overall tobacco control initiative, CDC promoted efforts to reduce tobacco use among women and also supported a variety of programs to help pregnant women to stop smoking.

CDC is funding 10 state programs to encourage cessation of smoking during pregnancy. In 1994, CDC will award up to 12 grants to state health departments to develop aggressive tobacco prevention and control programs.

Priorities For Women's Health

Women's health priorities included several major areas where CDC has invested resources and makes a difference in the health of women:

✔ The National Breast and Cervical Cancer Early Detection Program, now in its third year, has awarded grants to 45 states. Its 1993 budget was set at $72.5 million.

With these grants, states now participate at some level to provide community-based screening services to women at risk, to expand outreach services to women at risk, and to improve quality assurance measures for screening mammography and cervical cytology.

The goal of the program is to reduce breast cancer deaths by 30 per cent and cervical cancer deaths by more than 90 per cent through increased mammographic and Pap testing. Breast cancer is the most common cancer in American women and is second only to lung cancer as a cause of premature mortality.

✔ Research studies continue on HIV/AIDS, specifically to improve prevention efforts for women.

✔ A multidisciplinary coalition of 30 public and private professional organizations and advocacy groups has initiated increased awareness of the impact of sexually transmitted diseases on women's health.

✔ CDC funded state and local injury control projects for preventing unintentional injuries. Recent CDC studies have examined the relationship between cancer and the occupational exposure of women to chemicals and pesticides, along with other health conditions like tuberculosis, asthma and hearing loss.

Future Challenges And Opportunities

In 1994, we will focus our energy on targeting the problems of inner cities and other underserved communities. The problem of violence and related injuries represent the leading causes of years of potential life lost in this country. Violence must be approached as not just a criminal justice problem but as a health problem that is measurable, has definable risk factors, and is amenable to intervention strategies such as conflict resolution and firearms restrictions, especially for teenagers.

Likewise, substance abuse and HIV/AIDS will be better targeted in these most vulnerable populations.

In addressing new responsibilities in prevention, CDC must develop new partnerships to amplify its own efforts. Our traditional partners of state and local health departments and schools of public health remain critical to the nation's good health. However, together, we must now reach out to develop new community partnerships that can best impact the most vulnerable populations of rural towns and inner cities.

Among these new partners must be the church, school systems, the criminal justice system, and other community-based organizations.

Note:

- Possible target for tobacco lobby

The Paradox of Tobacco Control

Under the best of circumstances, knowledge brings about changes in behavior and public policy. When thinking about what we know and what we have accomplished in the realm of smoking and health, we perceive a paradox. Decades of careful medical research have documented the hazards of smoking. Social scientists continue to investigate and define the factors that impede efforts to prevent the use of tobacco. We know that nicotine is an addictive substance and that our children are very vulnerable to this addiction. We know that smoking is the single greatest cause of death in the United States.[1] Yet, we are still plagued by an entirely preventable problem, and this is the paradox of tobacco control.

To better understand this paradox and perhaps be better able to reconcile what we know and what we do, we have developed a framework that provides an organized approach to categorizing tobacco control efforts. Interventions to prevent and control tobacco use can be organized within six categories: those that (1) prevent the onset of tobacco use, (2) treat nicotine addiction, (3) protect nonsmokers from exposure to environmental tobacco smoke (ETS), (4) promote nonsmoking messages while limiting the effect of tobacco advertising and promotion on young people, (5) increase the price of tobacco products, and (6) regulate tobacco products.

Articles in this issue of THE JOURNAL highlight the challenges facing us in preventing the onset of tobacco use, protecting nonsmokers from exposure to ETS, and limiting the effect of tobacco advertising and promotion on young people, and add to our knowledge about treating nicotine addiction. Not addressed are such policy issues as the impact of price on tobacco consumption and whether product regulation, such as warning labels or generic packaging, can reduce tobacco use.

Klonoff and colleagues[2] explore the critical issue of minors' access to tobacco and present disturbing data on the ability of minors to purchase single cigarettes. Not only do minors have greater success than adults at purchasing single cigarettes, but Klonoff and colleagues report that these illegal sales occur in minority neighborhoods at twice the rate observed in white neighborhoods.

Evidence continues to accumulate that ETS is not innocuous. In their analysis of hair samples from neonates and their mothers (active smokers, passive smokers, and a nonexposed control group), Eliopoulos and colleagues[3] report a significant level of nicotine and cotinine not only in the hair of infants whose mothers smoked, but also in infants of mothers who reported having been exposed to ETS while pregnant. We expect this finding will be heavily criticized by the tobacco industry (as have most peer-reviewed reports of ETS) and that contrary evidence, most likely from tobacco industry–sponsored symposia, will be cited. The public policy debate over the effects of ETS will benefit from review of the article by Bero et al[4] who examined the articles presented at industry-sponsored symposia and compared them with the peer-reviewed literature on ETS. Bero et al found that the industry-sponsored articles were more likely to be reviews that reached conclusions contrary to independent scientific consensus, were typically from non–peer reviewed journals, and more likely to be written by tobacco industry–affiliated authors.

The analysis of tobacco advertising patterns and uptake of smoking by women described by Pierce and colleagues[5] adds to the growing body of literature on the impact of tobacco advertising on tobacco consumption. They conclude that the ad campaigns accompanying the introduction of the Virginia Slims and other women's brands in the 1960s were associated with the initiation of smoking among teenaged girls. Smoking by teenaged girls continues to be a major public health problem. One in four 17- to 18-year-old females are past-month smokers. Seventeen percent of female high school seniors are daily smokers (as well as 17% of male high school seniors.)[6]

Three of the articles in this issue address practical clinical concerns about treating nicotine addiction. Because most of the 46 million smokers[7] in the United States would like to quit smoking,[8] new data on achieving smoking cessation should be appreciated. These articles analyze the effectiveness of nicotine replacement systems, specifically the nicotine patch.

Hurt and colleagues[9] found that cessation rates at 8 weeks and at 1 year were twice as high for persons randomly assigned to receive the nicotine patch, low-intensity physician intervention, and nurse follow-up than for the placebo patch control subjects. Successful cessation may well be dependent on tailoring our follow-up efforts to the needs of our patients. Kenford and colleagues[10] found that the best predictor of cessation at 6-month follow-up was not smoking at all during the first 2 weeks of a quit attempt, suggesting that a clinician's most intensive support (pharmacologic and/or behavioral) should be in the first 2 weeks. Orleans and colleagues[11] in their investigation of nicotine patch use by low-income elderly persons came to the sobering conclusion that both providers and patients have problems with the nicotine patch. About half of the elderly interviewees reported not having received initial advice about how to use the patch from either their physician or pharmacist, and half reported continuing to smoke while using the patch. Even so, no adverse outcomes were reported, and 29% gave a nonbiochemically confirmed report of successful cessation at 6-month follow-up. More effective and consistent physician counseling might be anticipated if medical schools heed the advice of Fiore and colleagues[12] and incorporate smoking cessation education in their curricula.

At least 40 000 books and articles and 22 Surgeon General's reports on tobacco and health have added to our understanding of tobacco use and our abilities to ameliorate its harms. As we have continued to learn about tobacco, its effects, and how to

From the Office of the Director (Dr Satcher) and Office on Smoking and Health (Dr Eriksen), Centers for Disease Control and Prevention, Atlanta, Ga.

Reprint requests to Centers for Disease Control and Prevention, 1600 Clifton Rd NE, Mailstop D-14, Atlanta, GA 30333 (Dr Satcher).

control its use, we have witnessed some progress: the number of tobacco-attributable deaths has been slightly reduced,[13] per capita cigarette consumption is at its lowest level since World War II,[14,15] and the number of former smokers (43 million) is nearly that of current smokers (46 million).[7] In fact, among men alive today, more are former smokers than current smokers.[7]

Yet the paradox continues. While our nationwide efforts to control tobacco use may be viewed by some as a public health success story, smoking is responsible each year for more than 400 000 deaths and more than 5 million years of potential life lost.[13] Furthermore, the most recent data on smoking prevalence provide no basis for optimism. The decline in smoking rates enjoyed during the past 25 years appears to have stalled. The 1991 smoking prevalence estimate of 25.7% is virtually no different from the previous year's estimate of 25.5%.[7] If current trends persist, we will not meet one of the nation's health objectives—a smoking prevalence of no more than 15% by the year 2000.[16]

The outlook for smoking among children and adolescents is even worse. When comparing the use of alcohol, cigarettes, and other drugs, only cigarette use did not decline substantially among high school seniors between 1981 and 1991.[17] During the last decade, smoking among white teens has scarcely declined at all.[18] An estimated 3000 young people, mostly children and adolescents, become regular smokers each day.[19] This represents about 1 million new smokers each year who partially replace the approximate 2 million smokers who either quit or die each year.[13,19] Since most children can buy cigarettes whenever they want to[20]—even though the sale of tobacco products to minors is illegal in all 50 states—it is clear that the war against the onset of tobacco use has not been won.

To resolve the paradox of tobacco control, the responsibility for change must be shared by all. The federal government is increasingly involved in tobacco control through the US Department of Health and Human Services and other government agencies. In 1994, every state will have a tobacco-control program funded by the Centers for Disease Control and Prevention, the National Cancer Institute, or dedicated state excise taxes (as in California). The US Department of Health and Human Services will soon publish *Preventing Tobacco Use Among Young People*,[6] the Surgeon General's 23rd report on smoking and health, but the first of these reports devoted to the study of tobacco and youth. The Centers for Disease Control and Prevention will release guidelines for schools on preventing tobacco use and addiction among young people, and we will sponsor a national town meeting on this topic. The US Department of Health and Human Services is finalizing regulations to implement provisions of the Synar Amendment, which will strengthen the laws limiting the sale of tobacco products to minors.

In addition to the symbolic step of having made the White House smoke-free, the current administration has proposed quadrupling the excise tax on cigarettes—from 24 cents to 99 cents—an action of great significance to public health. Not only will this action raise much-needed revenue for health care, but it should also contribute to a major reduction in cigarette consumption. We expect that, as a result of an increased cigarette tax, the annual decline in smoking prevalence will begin again. The leveling off, which began in 1991, corresponded with an increase in the availability of discount cigarettes and cost-saving promotions sponsored by the tobacco industry.[7] There is reason to expect that by providing a financial incentive, the proposed tax increase will encourage current smokers to quit and teens never to start, rather than merely encourage smokers to smoke fewer cigarettes.[21] The greatest effect is expected on teen smoking behavior, since teens are the most sensitive to changes, both up and down, in the price of cigarettes.[22] Furthermore, the US Department of Agriculture has predicted that substantial progress in tobacco control can be accomplished with a relatively minor impact on the economy of tobacco farm regions. The US Department of Agriculture estimates that a 30% drop in tobacco production will reduce the total economic activity in any tobacco-growing area by less than 3%.[23]

But even more important to tobacco control than federal action are the continued commitment and involvement of physicians and other health care professionals; health care, civic, business, educational, and religious organizations; and the US public. Only through a broad-based approach to preventing tobacco use can we hope to end the staggering toll of needless disability and death. The paradox of tobacco control is one contradiction that must come to an end.

David Satcher, MD, PhD
Michael Eriksen, ScD

1. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA*. 1993;270:2207-2212.
2. Klonoff EA, Fritz JM, Landrine H, Riddle RW, Tully-Payne L. The problem and sociocultural context of single-cigarette sales. *JAMA*. 1994;271:618-620.
3. Eliopoulos C, Klein J, Phan MK, et al. Hair concentrations of nicotine and cotinine in women and their newborn infants. *JAMA*. 1994;271:621-623.
4. Bero LA, Galbraith A, Rennie D. Sponsored symposia on environmental tobacco smoke. *JAMA*. 1994;271:612-617.
5. Pierce JP, Lee L, Gilpin EA. Smoking initiation by adolescent girls, 1944 through 1988: an association with targeted advertising. *JAMA*. 1994;271:608-611.
6. US Dept of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, Ga: US Dept of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. In press.
7. Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 1991. *MMWR Morb Mortal Wkly Rep*. 1993;42:230-233.
8. Thomas RM, Larsen MD. Smoking prevalence, beliefs, and activities by gender and other demographic indicators. Princeton, NJ: The Gallup Organization Inc; 1993.
9. Hurt RD, Dale LC, Fredrickson PA, et al. Nicotine patch therapy for smoking cessation combined with physician advice and nurse follow-up: one-year outcome and percentage nicotine replacement. *JAMA*. 1994;271:595-600.
10. Kenford SL, Fiore MC, Jorenby DE, Smith SS, Wetter D, Baker TB. Predicting smoking cessation: who will quit with and without the nicotine patch. *JAMA*. 1994; 271:589-594.
11. Orleans CT, Resch N, Noll E, et al. Use of transdermal nicotine in a state-level prescription plan for the elderly: a first look at 'real world' patch users. *JAMA*. 1994; 271:601-607.
12. Fiore MC, Epps RP, Manley MW. A missed opportunity: teaching medical students to help their patients successfully quit smoking. *JAMA*. 1994;271:624-626.
13. Centers for Disease Control and Prevention. Cigarette smoking-attributable mortality and years of potential life lost United States, 1990. *MMWR Morb Mortal Wkly Rep*. 1993;42:645-649.
14. Miller R. US cigarette consumption, 1900 to date. In: Harr W, ed. *Tobacco Yearbook*. Bowling Green, Ky: Cockrel Corporation; 1981.
15. US Dept of Agriculture. *Tobacco Situation and Outlook Report*. Washington, DC: US Dept of Agriculture, Commodity Economics Division, Economic Research Service, TS 224; September 1993.
16. Public Health Service. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives: Full Report, With Commentary*. Washington, DC: US Dept of Health and Human Services, Public Health Service; 1991. US Dept of Health and Human Services publication PHS 91-50212.
17. National Center for Health Statistics. *Health United States, 1992*. Hyattsville, Md: US Public Health Service; 1993. US Dept of Health and Human Services publication PHS 93-1232.
18. Centers for Disease Control. Cigarette smoking among youth—United States, 1989. *MMWR Morb Mortal Wkly Rep*. 1991;40:712-715.
19. Pierce JP, Fiore MC, Novotny TE, Hatziandreu EJ, Davis RM. Trends in cigarette smoking in the United States: projections to the year 2000. *JAMA*. 1989;261:61-65.
20. Centers for Disease Control. Accessibility of cigarettes to youths aged 12-17 years—United States, 1989. *MMWR Morb Mortal Wkly Rep*. 1992;41:485-488.
21. US Dept of Health and Human Services. *Smoking and Health in the Americas*. Atlanta, Ga: US Dept of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1992. US Dept of Health and Human Services publication CDC 92-8419.
22. Grossman M, Sindelar JL, Mullahy J, Anderson R. Policy watch: alcohol and cigarette taxes. *J Econ Perspect*. 1993;7:211-222.
23. Gale F. Tobacco economies: what's ahead? *Agricultural Outlook*. September 1993:27-31.

American Medical
NEWS
American Medical Association
JANUARY 24/31, 1994

Insurers race to bring HMOs to New York

Making up for lost time in fight to lock up market of 27 million

First of a series

Big 5 insurers and local players are competing to bring managed care to the nation's largest city, until recently a bastion of fee-for-service medicine.

Next issue: The big insurers go head-to-head in markets around the country.

By Greg Borzo
AMNEWS STAFF

At the end of 1992, 83% of Aetna's enrollees working for small and midsize employers in the New York City area were covered by indemnity plans. By September 1993, 84% were in managed care plans.

• • •

Just a year ago, insurers in New York were complaining that physicians would not join their managed care networks. Today, physicians — particularly specialists — are complaining that they can't sign up because many panels are filled.

• • •

Oxford Health Plans took six years to build its New York-area HMO enrollment to 100,000 — but just 12 months, in 1992-93, to reach 200,000.

• • •

And Aetna reports that once-closed doors are opening to their managed care business. "Even new indemnity business includes plans to convert to managed care," said David M. Alpeter, senior vice president of New York operations.

• • •

These dramatic reversals illustrate New York City's sudden interest in managed care. Most of the Big Five insurers — Prudential, Aetna, CIGNA, Travelers and Metropolitan Life — have stepped up the marketing of their managed care products and are developing their own provider networks. Meanwhile, strong regional players have a big head start on the market.

Nationally, the same pattern is becoming dramatically apparent, as the big insurers go head-to-head in one market after another. They are creating their own accountable health plans in anticipation of reform; and with or without reform, they aim to control significant chunks of regional markets. Their efforts aren't going unchallenged, however, as local managed care players are gearing up to defend their turf.

The new climate portends potentially dramatic changes for physicians. Specialists are being hit the hardest. Those not aligned with managed care networks are

See NEW YORK, page 25

Inside: more on reform

Get off reform fence, Celeste warns

Support president now to win influence over final plan, he urges

By Janice Somerville
AMNEWS STAFF

PALM BEACH, Fla. — The AMA and other groups straddling the fence must jump off or risk losing all bargaining power when President Clinton's final health reform bill is drawn up, warned Richard Celeste, the president's chief pitchman for the plan.

"There's a time and a place to express reservations. If you want a voice later, you'd better get in the front row of supporters now," he said.

The comment drew groans from many of the state medical society leaders and lobbyists who gathered to hear him address the AMA's 20th Annual State Health Legislation Meeting. This year's conference, the largest ever, drew nearly 150 to the Breakers resort Jan. 5-8.

Since Clinton announced his plan, the AMA has tried to appear supportive overall but has been frequently dragged down by the weight of its reservations. Most recently, the AMA came under attack from Clinton after watering down support for an employer mandate, expressing support for a mandate on individuals as well at its interim meeting last December. The AMA also opposes premium caps and charges that the plan lacks sufficient tort reform and antitrust relief.

Others urge AMA to fight for key goals

Celeste implied that the AMA could not expect to use its support as a bargaining chip to achieve those goals.

Many interest groups have a major "yes, but" problem, he said, referring to those, like the AMA, who support the basic goals of Clinton's plan but oppose key details. He said the president would be looking to see which groups offer a "clear yes" during the next two to three months.

Now or never

This winter marks a crucial period for the Clinton selling team. Several congressional committees have begun hearings, while Clinton is gearing up for a major public education campaign to swing support. Unless special interest groups line up solidly behind the plan, however, it has little chance of success, most observers believe.

Celeste, a former two-term Ohio governor, heads the Democrats' National Health Care Campaign. With a skeleton staff of about a dozen and a $4 million budget, he's become a tireless campaigner for the plan, logging about 200,000 miles last year building grass roots support.

While the meeting's topic was state legislation, and attendees agreed that states will continue to lead reform efforts, the real attention was on national reform. Speakers generally agreed that reform is inevitable, although most likely it will be incremental. Like Celeste, many offered advice on how the AMA should proceed in coming months.

John Iglehart, editor of *Health Affairs*, told the audience, "The time has come for you to be political. The dialogue thus far has been civil, intellectual, not overtly political. But the president and his administration are taking off the gloves."

He said the AMA had been restrained long enough. "Ira [Magaziner] promises. Oh, does he promise," he said of Clinton's chief health adviser.

See AMA, page 31

Member Matters

Starting this week, AMA's membership newsletter will appear as a tear-out supplement in the center of the fourth issue of *AMNews* each month. Look to *Member Matters* for short reports of AMA actions on reform and other key issues.

Inside this week

Unhealthy education

Lessons of the tobacco industry's youth anti-smoking message. In Health.

Prevention seen as best AIDS hope

The Clinton administration faces an HIV epidemic larger and more diverse than ever before. As Clinton's second year in office begins, AMNews reviews his efforts to reshape the government's response to AIDS. Second of three parts.

By Laurie Jones
AMNEWS STAFF

WASHINGTON — When Gwendolyn B. Scott, MD, began treating HIV-infected children 10 years ago, she had a handful of patients.

Now, the pediatric AIDS program she heads, at Jackson Memorial Hospital-University of Miami School of Medicine, treats 350 patients and follows another 200 children at risk.

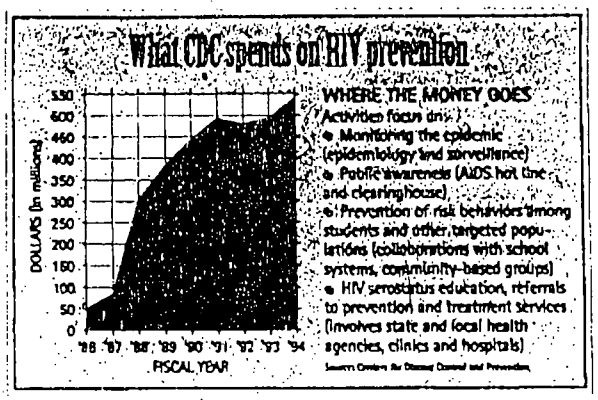
Each new child she sees is a reminder to Dr. Scott that every case could have been prevented. "I look at these young mothers and think, why is no one reaching them? Prevention is really the only tool we have, but I see so many people still involved in risky behaviors. There is this overwhelming need for education about HIV, and that need just hasn't been filled."

Advocates urge explicit, targeted education programs

Twelve years into the AIDS epidemic, physicians and activists say they are looking to the Clinton administration for bold, decisive action to prevent further spread of the human immunodeficiency virus. With major research and treatment breakthroughs likely to be years away, prevention is increasingly viewed as an underutilized weapon.

"We are way behind the curve regarding prevention," said Paul Kawata, executive director of the Minority AIDS Council. "Millions of people are at risk, and the challenges are growing exponentially. We have a long way to go just to catch up."

Prevention efforts have lagged, AIDS activists argue, because the Reagan and Bush administrations squelched most efforts to discuss any prevention strategy besides abstinence. States and communities using federal funds did not protest because they, too, feared political backlash.



"HIV prevention involves thinking about sex and drugs, and many political leaders would rather not think about sex and drugs," explained Don Des Jarlais, MD, director of research at the Chemical Dependency Institute of New York's Beth Israel Medical Center. But as the epidemic has spread, "there's been gradual progress in attitude at the state and local level. The fact that AIDS didn't go away — and if you ignored it, if anything it got worse — helped convince some people that prevention is worth trying."

■ You have a role in the CDC's new HIV campaign. Page 20

The administration has responded in AIDS experts' concerns by revamping the federal prevention approach. Communities will gain greater autonomy over federally funded education programs, and the Centers for Disease Control and Prevention has launched an ad campaign that for the first time explicitly refers to condom use.

But growth in financial support has been far less dramatic. CDC's budget for HIV-related prevention activities rose 9% in fiscal year 1994, to $543 million — the second smallest annual percentage increase since the agency began funding HIV prevention separately in 1986. It compares with a 21% increase, to $1.3 billion, for research by the National Institutes of Health this year, and a 66% increase, to $579.4 million, for patient services under the Ryan White Act.

"They're moving in the right direction, but there is no question we need more funding for prevention," said Jeffrey Levi, director of public policy for the AIDS Action Council.

Administration officials would not comment on its budget proposal for fiscal 1995. Conceded CDC Director David Satcher, MD, PhD: "I don't think we've done enough yet regarding prevention to tell you the truth. The whole idea is we've got to do more, and we're beginning to do that."

Locally targeting high-risk groups

About 75% of the CDC's HIV prevention efforts go to information and education, with $407 million budgeted this year. Nationwide information projects include the national AIDS hot line and clearinghouse, and America Responds to AIDS, an educational media campaign that also promotes awareness of the hot line.

Other budgeted expenditures cover surveillance ($90.2 million), population-based research (40.8 million) and basic science research ($5 million).

More than 60% of information and

See AIDS, page 26

ACOG backs training nonphysicians for abortions

By Diane M. Gianelli
AMNEWS STAFF

WASHINGTON — In a historic nod to the reality of the times, the American College of Obstetricians and Gynecologists is recommending that nonphysicians be trained to perform abortions.

The decision by the group's executive board apparently makes ACOG the first national doctors' group to endorse nonphysician abortion training. The move is sure to deepen an ongoing professional debate over what has become the nation's most common — and controversial — outpatient surgical procedure.

The ACOG board voted earlier this month to encourage programs that would train not only more physicians but other licensed health professionals to provide abortions.

"I think the ideal would be that physicians would be performing them," said ACOG President-elect William C. Andrews, MD. "But as a pragmatic thing, if there are not physicians who are trained or willing to do the procedure, other options have to be considered.

Major policy shift tied to dwindling supply of providers

"I think it's an access to care issue."

The National Abortion Federation, which lobbies on behalf of providers, welcomes ACOG's move. Several years ago, NAF issued a report noting the dwindling supply of physicians willing to perform abortions. It attributed the decline to a variety of factors, including provider harassment, the "graying" of the provider population and the fact that relatively few ob-gyn residency programs routinely trained physicians to do abortions anymore.

So in addition to beefed-up abortion training in residency programs, NAF suggested training physician assistants, nurse midwives and nurse practitioners to do abortions.

The ACOG proposal did not detail which groups should be trained to perform abortions or how they might be supervised. But associations representing the groups most likely to be involved reacted cautiously to the development.

The American Academy of Physician Assistants said it was "committed to the principle that a physician assistant should be allowed to perform any medical task, including abortion, delegated by a physician under whose supervision the task will be performed."

The National Assn. of Nurse Practitioners in Reproductive Health would "certainly support members who wished to pursue specialized training in this area," a spokeswoman said. "We continue to advocate for well-prepared physicians to work along with us."

The American College of Nurse Midwives said that if its members were appropriately trained and wanted to perform abortions, they could. But "[just] because someone is willing to delegate a task to us . . . doesn't mean we should have to do it. We should make that decision for ourselves," a spokeswoman added.

See ABORTION, page 26

Infant mortality commission is axed; budget cuts blamed

By Wayne Hearn
AMNEWS STAFF

As Congress prepares to debate health system reform, it has quietly shut down an office devoted to an avowed reform goal: health promotion and disease prevention.

The National Commission to Prevent Infant Mortality last autumn saw its request for $460,000 axed from the 1994 federal budget, a victim of the push to "downsize" government. Its last official day of business was Dec. 31, although staffers were still answering the telephone into early January.

The commission is credited with helping call attention to the nation's deplorable infant mortality rate, 21st among developed countries at 9 deaths per 1,000 live births. Its primary purpose was to monitor the issue for Congress and recommend action, which it did in its 1988 report, *Death Before Life: The Tragedy of Infant Mortality.*

Public health experts say the commission's work helped persuade legislators to expand federal prenatal and infant-care programs, mainly within Health and Human Services.

The commission also developed its own programs and helped to forge public-private partnerships and multigroup coalitions. Examples are the National Health/Education Consortium, a program involving nearly 60 health and education groups, and the National Consortium for African-American Children, which brings together black groups from the health, education, business and religious communities.

It also started the Resource Mothers Development Project, a national project to encourage the widespread use of "resource mothers," outreach workers versed in prenatal and child care who visit at-risk families at home.

The 16-member congressionally appointed commission comprised members of Congress, HHS, medicine, education, state government and the public. The panel had a staff of 11.

Key information clearinghouse

Other federal agencies and private organizations are expected to divvy up

See INFANT, page 27

R.I.P.

National Commission to Prevent Infant Mortality

Born: 1987
Died: 1993

Purpose
- Advise Congress on effective strategies
- Provide data to health professionals and community organizers
- Foster collaborative programs between public and private sectors

Accomplishments
- 1988 Report to Congress, 'Death Before Life: The Tragedy of Infant Mortality,' a national overview with recommendations
- 1989 National Health/Education Consortium formed for health professionals and educators
- 1991 Resource Mothers Development Project launched; promotes home visits to families at risk
- 1992 National Consortium for African-American Children created

Abortion

Continued from page 3

The issue of nonphysicians performing abortions divides the physician community for several reasons.

First, there is the quality question. many feel physicians are uniquely trained to provide the best care for patients seeking abortions. There also is the issue of turf. With nonphysicians seeking to expand their scope of practice, a trend accelerated by the health reform debate, some physicians are especially reluctant to cede yet another piece of their traditional domain to a midlevel practitioner.

But since few physicians are willing to perform abortions, they might be relieved to allow others to do it.

Even if physicians were willing to give up their hold on the procedure, it's unclear, how many midlevel practitioners would enter the fray.

Having seen physicians picketed at work or at their homes, and even shot by abortion foes, many may not be willing to subject themselves or their families to that kind of risk.

Legal restrictions could pose even more of a roadblock. Forty-three states and the District of Columbia have laws specifically barring anyone but physicians from doing abortions. *Roe v. Wade*, the 1973 Supreme Court ruling that legalized abortion, reinforced that stance by giving states explicit permission to enact "doctors-only" laws.

Time to change the law?

Many in the abortion-rights community say that was a response to the need for safety in a procedure that had long been illegal and was often performed under unsanitary conditions by unskilled people. A trained midlevel professional under the supervision of a physician should be allowed to do uncomplicated abortions, they say.

Some state lawmakers already have been approached about removing the doctors-only restrictions on abortion. But some physicians oppose that idea.

When some PAs expressed the hope last summer that a recent Arizona law would be interpreted to allow them to perform abortions, Brian L. Finkel, DO, a Phoenix physician who specializes in abortion services, balked.

"Abortion surgery is something that is very difficult to do," he said. "It's not done easily, and there's a lot that can do wrong. Even for a senior surgeon like myself, it's not without risk. It can have complications — even in the first trimester."

If something goes wrong, Dr. Finkel said, "the full backdrop of medical training and sophistication must be brought to bear upon the situation."

The state board of medicine did not interpret the law to allow Arizona PAs to do abortions. But those who favor training nonphysician providers point to a 1981-82 study in Vermont, where PAs have been performing abortions since 1972 with complication rates similar to those of physicians.

In fact, PAs in the Vermont Women's Health Center in Burlington now provide the abortion training for University of Vermont residents.

Phillip G. Stubblefield, MD, chief of ob-gyn at Maine Medical Center in Portland, thinks opponents have overstated the complications of early abortions and underestimated the capabilities of such midlevel providers as PAs.

"Physician assistants and other midlevel practitioners can be properly trained to do a thoroughly competent job in performing abortions," he said.

ACOG expects further debate

The ACOG board knows its recommendation, which is now the group's official position, won't please all its members. Some worry about the quality issue and fear "that there may be an increase in morbidity," said ACOG President Richard S. Hollis, MD. Others, of course, don't believe physicians should perform abortions at all.

"We'll never have unanimity in our membership," Dr. Hollis said. "I doubt one can ever change anybody's deep conviction about this subject. It comes down to a matter of trying to work out something that is agreeable, is less distasteful, but yet, by the same token, provides for the needs of American women under the present law."

David V. Foley, MD, is one ACOG member disappointed by the board's new stance.

When physicians treat a pregnant woman, he says, they in fact have two patients. Abortion "takes the life of one of them."

He also questions whether nonphysician providers are competent to perform abortions. He suggests that midlevel providers "aren't going to want to do this operation any more than members of ACOG do."

Passing the buck?

ACOG board members interviewed agree that violence and harassment by anti-abortion activists is a major reason why many physicians are opting out of the provider pool. And they admit to concerns that their new position will just pass the problem on to another group of providers.

"I think a worry that hasn't been addressed is what's going to happen to the nurses [or other nonphysicians]. They're going to get harassed, too," said ACOG Immediate Past President Richard F. Jones, MD.

"It's not that doctors don't understand and don't care," he said. "But people start picketing your office and throwing bombs, ... So it's not a matter so much of our passing the buck to somebody else. It's a matter of saying, 'Hey, if you want to help us with this problem, please do.'"

Dr. Jones said ACOG had no intention of coercing midlevel professionals into doing abortions. On the other hand, he said, ACOG has no right to say, "We're not going to do it, but you can't do it either."

The AMA has not been asked to study the issue of nonphysician abortion providers, said trustee William E. Jacott, MD. Its official position is that abortion is a medical procedure that should be performed by a "duly licensed physician."

The AMA does endorse the idea of routinely including abortion training in medical residency, however. At its Interim Meeting in December, AMA delegates adopted a resolution supporting efforts to specifically require residency programs to provide abortion training, provided individuals could opt out for reasons of conscience.

Provider shortage questioned

There are those who feel that the provider shortage dilemma is overstated. Just because every community does not have an abortion provider doesn't mean women don't have access to abortions, they say. They compare the situation to communities that don't have neurosurgeons or kidney transplant centers.

"I think this is a tempest in a teapot," said Norman Gant, MD, executive director of the American Board of Obstetrics and Gynecology. "The hysteria may be correct in that fewer and fewer doctors are performing [abortions]. But it doesn't mean that fewer and fewer doctors are trained to do them.

"Anybody I know who graduates from a residency program can do a first-trimester abortion," because, he said, all graduates know how to do a D&C — a procedure frequently used to terminate pregnancy.

But the NCAP's Fitzsimmons predicts that the provider shortage "is going to get crucial in next five to 10 years." He said the average provider is "relatively old — in their 40s and 50s — and we don't see young ones ready to fill their shoes."

And he expects few newcomers to the field. "My gut tells me if I were a medical student and getting to my third year, why in the world would I pick this field? When I read all the stories, I wouldn't want picketers in front of my house or my office."

AIDS

Continued from page 3

education funding is for grants administered through state and local health departments. Many AIDS advocacy groups hailed the policy change, implemented with the fiscal 1994 budget, that shifts decisions about how to spend that money away from the CDC. In a process called "participatory community planning," health departments will work with other government agencies, community groups and people at high risk for HIV to develop targeted prevention and education projects.

Such a community-based approach has gained favor among public health experts in recent years as HIV has spread into diverse populations. According to a 1993 National Research Council report: "Much of the attention given to the epidemic has focused on national estimates and national needs. Ultimately, however, the epidemic and its impacts and the responses to it are experienced in specific locales, and responses are shaped by the resources, traditions and leadership of the specific communities."

Other nations' experiences have added weight to the argument, Dr. Des Jarlais said. In Australia, after several years of community-based efforts targeting gay men and intravenous drug users, the rate of HIV infection dropped from fourth highest in the developed world in 1983 to sixth in 1991.

"The idea is to really meet the needs of high-risk groups in a given community," said James W. Curran, MD, CDC associate director for HIV/AIDS. "We expect a whole range of projects using everything from health communication strategies to condom distribution to linkage to substance-abuse treatment for IV drug users."

Dr. Curran named an Atlanta group, Outreach Inc., which uses peer educators to work with high-risk black men and women, as an example of the type of project CDC hopes for. "We believe this kind of peer-based approach is a key to HIV prevention," he said.

Explicit, targeted messages are essential to affecting how people will act, said M. Roy Schwarz, MD, the AMA's senior vice president for medical education and science. But assessment studies are needed to determine which methods work best, he said. "In 12 years of this epidemic, we have not turned the tide of behavior. Why do young people continue to practice unprotected sex? Is it denial? If so, what's the best way to work against that?"

Some money for assessment follow-up will be included in the grants, CDC officials said.

Prevention experts face a formidable challenge. CDC studies show that by age 20, 86% of males and 77% of females have had sexual intercourse. A 1992 study, published in the *American Journal of Public Health*, found that only 6% of heterosexual males in San Francisco with multiple sex partners reported always using condoms, compared with 48% of gay and bisexual men. In a 1992 study published in *Family Planning Perspectives*, only 20% of sexually active women said their male partners used condoms.

Approaches that have been successful in persuading gay males to practice safer sex may not work with young heterosexual women, IV drug users or even young gay males, who, according to several recent studies, are less likely to use condoms than older men.

And even the same risk groups sometimes benefit from different approaches in different locales, say prevention experts. That's why they consider local, targeted efforts so important.

Slick promotion of condom use

At the national level, the CDC earlier this month unveiled a slick, $800,000 campaign of public service announcements aimed at men and women age 18 to 25. Most of the ads say that abstinence is the only sure way to avoid contracting the virus. But they add that those who are sexually active should use latex condoms "consistently and correctly."

While officials acknowledged some people may object to the ads, they said, they had to get the message out. "Our philosophy is we're not going to let political, religious or cultural differences stand in the way of providing young adults the information they need to protect themselves," Dr. Satcher said.

Representatives of more than 100 national and community-based organizations, such as the United Way, National Minority AIDS Council and National Episcopal AIDS Coalition, attended the campaign's unveiling.

"The big step forward is not just the ads, and I can't emphasize that enough," said Health and Human Services Secretary Donna E. Shalala, PhD. "It's the connections and cooperative relationships with community organizations and the kind of planning that's going to take place in this concentrated effort."

Those who oppose the government's approach argue it's too simplistic, giving the false impression that condoms offer foolproof protection against HIV.

"The advertisements promote promiscuity and a false sense of security, which put at risk the very lives of those most likely to be influenced by them," said Monsignor Robert N. Lynch, general secretary of the National Conference of Catholic Bishops. "The public would be best served, and the incidence of HIV infection diminished, by a campaign promoting a responsible attitude toward sexuality as the most serious of human interactions, not a casual recreation."

Others warn that focusing strictly on high-risk groups will promote complacency among those at low risk.

But officials are banking that the efforts will raise general awareness at a time when the public often seems tired of the subject.

"This is part of breaking the denial that still exists in many people of all ages — that this problem doesn't affect all of us," said Kristine M. Gebbie, RN, national AIDS policy coordinator.

Breaking through that denial may be the most daunting challenge for prevention experts, said Dr. Scott at the University of Miami. "We definitely need new and innovative ways to deliver the message. I don't know if people have become apathetic, or perhaps they didn't listen in the first place."

Next: Big gains for research and treatment funding. Will coordination follow?

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	From: Pat Griffin re: Meeting with Senate Majority Leader Mitchell (3 pages)	05/17/1994	P5
002. memo	From: Pat Griffin re: Meeting with House and Senate Health Care Leadership (5 pages)	05/24/1994	P5
003. memo	From: Pat Griffin re: House Democratic Cacus Meeting (2 pages)	05/24/1994	P5
004. memo	Chris Jennings and Steve Ricchetti to Hillary Rodham Clinton re: Proposed Schedule for Congressional Consultative Meetings (3 pages)	06/01/1993	P5
005. memo	Chris J. and Lynn M. to Hillary Rodham Clinton and Jeff Eller re: Health Care University (11 pages)	06/28/1993	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21536

FOLDER TITLE:
POTUS Memos 1st Term [1]

Racheal Carter
2011-0747-S
rc853

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Christine

*** * * * PRIVILEGED AND ~~CONFIDENTIAL~~ * * * ***

MEMORANDUM

TO: Hillary Rodham Clinton June 1, 1993
FR: Chris Jennings/Steve Ricchetti
RE: Proposed Schedule for Congressional Consultative Meetings and Pre-introduction Briefings for a Scheduled June 23rd Release Date
cc: Distribution

In discussions with the staff of the House and Senate Majority Leaders, it has become clear that it is advisable to implement a two step Congressional outreach process **after** the first cut on final policy decisions has been made. With this in mind, the attached schedule of consultative meetings and pre-introduction briefings was developed.

The first series of meetings would be detailed policy discussions with Members of Congress, the purpose of which would be to advise Members of the initial decisions made and to obtain their political reads and suggestions for improvement. The second series of briefing sessions would be used to describe the President's final decisions on the plan and to help make the Members more comfortable in explaining it to their constituents and local media. This would occur immediately prior to the unveiling of the proposal.

Four Points About Timing, Consultation, Communications and Hearings:

(1) **Timetable Needs to be Finalized.** As the attached list clearly illustrates, the necessary amount of consultation can only take place if we squeeze it into a very brief period of time. **If the policy is delayed beyond this week, however, it will be literally impossible to have a sufficient amount of time to conduct adequate consultations prior to June 23rd.** Should the policy be unavailable, we need to immediately revisit and restructure what is already a very ambitious timetable.

(2) **Substantive Consultation Must Occur.** We understand the concerns about leaks and the general frustration with working with many Members of Congress. However, it would be extremely counter-productive to attempt to release a package in which the Members have little or no investment.

It is important to remember that consultations will be significantly more fruitful and constructive when we have a policy as a basis for discussion. To protect the process from problematic leaks, all discussions can be accurately characterized as purely exploratory, with no FINAL decisions yet made.

If we do not engage in significant consultation, the Congress will almost invariably wilt in the face of the inevitable concerns that will be raised. Moreover, the Members -- particularly those in the House -- have made it clear that they believe that this legislation will be "dead on arrival" if unless substantive consultations occur as the President makes his final decisions. **Lastly, it is important to note that those Members who advise no further consultation are generally those who are afraid of being -- or perceived as being -- coopted.**

(3) **Senator Daschle's Outreach Proposals Should Be Implemented.** We believe that Senator Daschle's suggestions for a message/whip group and a focus group are very constructive. We believe that we should get started on these meetings as soon as the Members return from recess regardless of the final decision on the timing of the unveiling. These meetings can be interspersed with the attached schedule of consultative meetings OR conducted on a separate track.

(4) **Appropriate Witnesses Should Be Prepared for Inevitable Hearings.** Immediately after the unveiling, numerous Committees will request that the Administration supply witnesses for their inevitable series of hearings. We need to carefully consider where we should testify first, who we believe are the most appropriate people to send, and begin to develop the message(s) we want delivered.

SCHEDULE FOR CONGRESSIONAL CONSULTATIVE MEETINGS AND BRIEFINGS

CONSULTATIVE MEETINGS:

Sunday, June 6th:

House Leadership and Committees of Jurisdiction Staff
IM, JF
(To help staff prepare members for meeting with First Lady)

Senate Leadership and Committees of Jurisdiction Staff
IM, JF
(To help staff prepare members for meeting with First Lady)

June 8th:

House Leadership and Chairmen of Committee of Jursidiction
HRC, IM, JF
Location: White House
(To brief Members and set up consultative process)

Foley
Gephardt
Bonior
Rostenkowski
Stark
Dingell
Waxman
Ford
Williams

Senate Leadership and Chairmen of Committees of Jurisdiction
HRC, IM, JF
Location: White House
(To brief Members and set up consultative process)

Mitchell
Ford
Pryor
Daschle
Moynihan
Kennedy
Rockefeller
Riegle
Mikulski
Breaux

PERSONAL AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton/Jeff Eller
FR: Chris J., Lynn M.
RE: HEALTH CARE UNIVERSITY
Through: Ira, Steve, Melanne, Jerry K., Karen P.
cc: Distribution

June 28, 1993

Senator Daschle and other Members of Congress (such as Majority Leader Gephardt) have repeatedly raised concerns about the limited education level of Members as it relates to health care. The Senator has promoted the establishment of a kind of "health care university" for Members of Congress. He and Congressman Gephardt both believe the "classes" should be **open to Members of both parties.**

Jeff E. has suggested expanding the congressionally-oriented health care university concept to educate and train appropriate Administration representatives. Other Members, in particular Senator Pryor, have repeatedly emphasized the need to have designated (and Administration-educated) advocates situated throughout the country to serve as credible "talking heads" to combat the predictable organized opposition that the Administration and nervous Congresspersons face.

We believe that establishing a health university-like entity (from now on referred to -- at least temporarily -- as **health care briefings**) has great potential to meet the goals outlined above. An effective educational outreach effort would help ensure a consistent Administration health care reform message and be invaluable for those who are testifying at hearings and briefing Members of Congress. In addition, if done well, it would:

(1) Reinvigorate the "need for action" mentality that, until very recently, had been effectively fanning the flames of desire for comprehensive health reform in the Congress;

(2) Ease Congressional concerns about, and raise Member comfort levels with, the President's proposal to address the problems;

(3) Better enable perspective Congressional supporters to explain, defend, and sell the President's proposal; and

(4) Be utilized to help educate surrogates in home Congressional districts.

Achieving success in briefing Administration, Congressional, and other influential individuals will depend on the ability of the health care briefings to: (1) communicate our message in a simple, understandable way; (2) utilize staff resources most effectively; and (3) be responsive to the information needs and time constraints of those we will rely on to support the President's health reform initiative. To develop and implement an effective educational briefing process we will have to successfully:

- **Target the Issues**
- **Target the Best Personnel to Make Presentations**
- **Establish a Staff/Intake and Scheduling Process**
- **Prepare the Briefing Materials and Presentations**
- **Brief and Train the Briefers**
- **Develop a Workable Timetable.**

This memo provides our recommendations on how best to meet these requirements. It has been reviewed and approved by Ira and the Administration's health reform legislative affairs team (headed up by Steve Ricchetti and Jerry Klepner). After you and Jeff review the proposal, it would be advisable to have it also reviewed by the Senate Democratic Policy Committee (Senator Daschle) and the House Democratic Caucus (Gephardt's designee and Chair of the Caucus -- Congressman Hoyer).

If the President is going to unveil his package by not later than late September, the implementation of the start-up recommendations for the health care briefings must occur almost immediately. At the end of the memo is a worplan timeline that has been prepared to help with scheduling.

One last point: the health care briefing concept proposed in this memo can also be utilized for many other purposes as well. We have yet to talk in depth with Mike Lux and Bob B. on this, but John Hart has expressed a good deal of interest in it being extended to certain select and influential intergovernmental (state and local) audiences.

TARGET THE ISSUES

The briefings should convey a simple, concise message and be responsive to what we know to be **the major thematic priorities and interests of the majority of the Congress.** As a first cut, we propose limiting the briefings to no more than 10 broad-based issues:

(1) **An Overview of the Plan, its Design and its Philosophy;**

(2) **Consumers in the New System;**

(3) **Cost Containment and Budgets;**

(4) **Savings, Costs and Financing;**

(5) **Small and Large Businesses in the New System;**

(6) **Health Care Providers in the New System;**

(7) **Federal/State Roles;**

(8) **The Elderly in the New System;**

(9) **Rural Communities and the New System; and**

(10) **Urban Communities, Underserved, and the New System.**

Issues such as Medicare, Medicaid, Veterans, Federal Employees Health Benefits, medical malpractice, anti-trust, quality, public health, benefits, etc. would be incorporated into the above mentioned categories. Special and more detailed briefings on these and the whole range of other issues would be provided to Administration representatives, Congressional Members and staff on an as-needed and requested basis. (A detailed issues list has been prepared for specialized briefings and is included in the appendix.)

TARGET THE BEST PERSONNEL TO MAKE PRESENTATIONS

Briefing Members of Congress always has the potential for great benefits, as well as great risks. The key is for Members to leave the presentations both impressed with the substance of the information given and the competence (and likeability) of the presentors.

Included in the definition of a competent Congressional briefer is to know -- going in -- what are the historic sensitivities of the Members present; in other words, to know what to say and how to say it, and to know what not to say. If the personnel chosen meets these criteria, the benefits to these briefing are almost boundless. If, on the other hand, Members leave presentations with a sense that briefers are either incompetent, arrogant, condesending, and/or disrespectful, an effort with the best of intentions could well turn out to be a total disaster. All of this is to say that the personnel chosen for Congressional briefings is critically important.

Policy Expert Resources

Within the White House health care working groups and the Departments (in particular, HHS), the Administration has an impressive array of health care policy experts who could serve in briefing roles extremely well. (In most cases, Ira and Judy -- in particular -- have been, and likely will continue to be, very well received.) Having said this, the other briefers that we will need must be evaluated carefully -- keeping in mind not only how competent they are, but how well they will be received by different collections of Members. (We have prepared a tentative staff resource list linked to the ten topics previously mentioned, but it is undergoing final review by Ira and HHS; in any event, it will be a continually updated list based on their performance and Congressional reception.)

Legislative/Policy Resources

We strongly advise that those most familiar with the Congress and their predilictions -- the Administration's Legislative Affairs staff -- play a major role in briefing the Members and the staff on this issue. The White House and Departmental Legislative Affairs staff (particularly at HHS) have strong and long-standing relationships with the Members and staff that should be utilized to the benefit of the Administration's health reform effort.

At every briefing, there should be one Legislative Affairs Administration representative who has equal status to the policy presenter. This is absolutely necessary to best assure that no situation gets out of hand, that there is a politically sensitive individual always present, that there are careful notes of the meeting, and that responsive follow-up occurs.

ESTABLISH A STAFF/INTAKE AND SCHEDULING PROCESS

The scheduling of the university and other requested briefings should be coordinated out of the War Room. This work should be closely coordinated with the Department of Health and Human Services' Office of the Assistant Secretary for Legislation (ASL and other Departments as necessary). In addition, if desirable and appropriate, we should work closely with the House Democratic Caucus and the Senate Democratic Policy Committee to help coordinate topics, schedules, and rooms. The schedule of all briefings should be updated daily, provided to Steve Ricchetti/Chris J./Jerry K./Karen P., and announced at the morning Communications meeting.

To ensure that the briefing operation is a success requires an experienced and politically sensitive staff person who can work closely with the Congressional Leadership and Administration personnel in meeting the scheduling and substantive needs of the Members. We propose that Steve Edelstein take on this role (in addition to his other responsibilities) and work with Lori Davis and other staff at HHS to assist him. Depending on the volume of and desire for briefings, additional staff (perhaps a full-time intern who is mature and responsible) may be required.

PREPARE THE BRIEFING MATERIALS AND PRESENTATIONS

In order to ensure the delivery of a consistent, simple, understandable message, we need to prepare educational materials and the presenters in advance of the briefings that all staff can and should use. Educational materials should include charts, graphs, detailed outlines to guide presentation, questions and answers as appropriate. These materials and presentations should be user friendly and targeted to specific audiences.

Working with the initial approval of Ira and Judy, as well as the Legislative Affairs staff, Steve E. will assign one policy expert to each of the issues chosen for briefings to take the lead in preparing the substance of the briefing materials and their presentation. He will make certain that each presentation is finalized on time and in the best format possible. The Communications staff will review and edit the briefing materials for clarity, directness, and consistency of message.

The presentations will also be screened by Legislative Affairs staff to ensure that they meet the needs of the audiences. (They will know who is attending because we propose to limit the size of each briefing to between 25-35 Members and have them signed up in advance of the briefing; we believe that such a small structure will best assure a less lecture-like atmosphere and better encourage a give and take constructive discussion.)

Each "class" will be structured to briefly outline the problem(s) with the current system, how the President's proposal addresses the problem(s) (if relatively non-controversial), and the rationale behind the Administration's proposal. The briefings will be designed to last no longer than 60 minutes: 20-30 minutes (at most) of presentation and 30-40 minutes for questions and answers. On an as needed basis, these classes will be repeated to enable interested Administration representatives and Members of Congress the opportunity to learn about (and be comforted by) the substance and rationale behind our proposals.

Substantive and detailed presentations about the most controversial policy recommendations -- if they are even available -- of the President's proposal should be avoided. There is great concern among the Congressional Leadership that controversial recommendations -- such as financing, exact cost containment mechanisms, etc -- could lead to public and potentially problematic disclosure. Instead, the two Majority Leaders have suggested that we detail the **options** we are considering to address the most challenging issues.

BRIEF AND TRAIN THE BRIEFERS

Communications staff will be needed to provide guidance to all briefers on how to orally deliver their presentations in an easily understandable manner. In addition, before each presentation, the Legislative Affairs staff from either the White House or the appropriate Department (usually Jerry Klepner's shop) will brief the presenters on who will be in the audience, what issues are particularly sensitive, what issues to highlight/avoid, and how best to present complex, potentially controversial materials to them. As mentioned previously, Legislative Affairs staff will accompany and participate in all briefings with the Congress to assure that Member response is closely monitored and documented, and to assure that appropriate follow-up occurs.

DEVELOP A WORKABLE TIMETABLE

We need to make a final decision as to when it would be most appropriate and useful to commence the health care seminars. Senator Daschle originally envisioned the "classes" beginning only after the legislation had been introduced. Majority Leader Gephardt believes it is advisable to hold a series of briefings into one or two days of presentations in an attempt to hold a dry run -- presenting options not final decisions -- in an effort to begin to work out the kinks and determine what briefing format will work the best in September.

There are arguments on both sides of the appropriate start-up timeframe issue, but we assume that Senator Daschle will defer to Congressman on this issue. Should this be the case, the "dry-run" briefings could commence as soon as late July or early August. Both strongly believe, however, that this not occur until we are comfortable with the materials and presenters before we go to the Hill.

Lastly, Congressman Gephardt has initiated an invitation for the First Lady to speak before the House Democratic Caucus soon after she returns from her July trip (roughly the 21st). The concept behind this presentation is for Mrs. Clinton to reinvigorate the Members into, once again, feeling that health care reform is a political and economic imperative.

One last point: If we proceed with the establishment of the health care briefing formats, we must make certain that the Committee Leadership is well aware that these presentations are not substitutes for the normal detailed consultations that will take place with them. To assure them that this is not the case, we must schedule and conduct regular briefings with the Chairmen and their staff. If we do not do this, they are likely to view these briefing forums as an insulting gesture. THIS WOULD NOT SIT WELL AND WOULD BE UNWISE.

WORKPLAN TIMELINE

Activity	6/27 7/5	7/12 7/19 7/26	8/2- 8/30	9/6 9/13 9/20 9/27
Target Issues	¦-------¦			
Target Personnel	¦----------¦			
Finalize Staffing	¦-------¦			
Prepare Briefing Materials		¦----------¦		
Brief the Briefers		¦---------¦	(on how best to communicate/ legislative prep)	¦---------¦ (communication and leg. prep continues)
Hone the Message			¦----------¦	
HRC CAUCUS PRESENTATION		¦--------¦		
CONGRESSIONAL BRIEFINGS			¦---¦ Dry run 1st briefing before recess	¦----------¦ RETURN TO briefings and continue them even after introduction on a bipartisan basis.

APPENDIX
HEALTH CARE UNIVERSITY
DETAILED LIST*

Coverage

- Working Population
- Part-time Workers
- Nonworking Population
- Medicaid
- Early Retirees
- Undocumented Persons

Benefits Package

- Cost sharing
- Preventive Services
- Mental Health
- Abortion
- Updating benefits through Board

New System Design

- National Health Board
- National Administration
- State role
- Regional Health Alliances/
- ERISA/Corporate Alliances
- Health plans
- Rural
- Urban
- Risk adjusters
- Inter-alliance trust fund

Long-term Cost Containment

Transition

- Insurance Reforms
- Short-term cost controls
- State phase-in
- Enforcement

Costs and Financing

Structure of mandate
Cost of reform
Other Revenue Sources

Quality Management and Improvement

Performance Report
Accountability
CLIA
Practice Guidelines

Information Systems/Administrative Simplification

Medical Malpractice

Anti-trust

Fraud and Abuse

Medicare

- Managed care (AAPCC reform)
- Point of service option
- Prescription drug benefit
- Waiver option - Medicare integration

Medicaid

- Managed care incentives
- Maintenance-of-effort
- Budgets
- Eligibility requirements
- Wrap-around benefits

Long-Term Care

Disabled

Prescription Drugs

Other Federal Programs

Veterans Affairs
FEHB
Indian Health
Military: DoD/CHAMPUS

dical Research Initiatives

HS

Essential Providers
Population-based Prevention

Workforce Development/Medical Education

Primary Care Incentives
Graduate Medical Education
Academic Health Centers

Ethics

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Chris Jennings to Paul Ellwood (partial) (1 page)	11/18/1996	P2, b(6)
002. letter	Chris Jennings to Arnold Epstein (1 page)	11/19/1996	P2, b(6)
003. letter	Christopher Jennings to J. Barlow Herget re: address (partial) (1 page)	11/18/1996	P6/b(6)
004. letter	Christopher Jennings to Glenn Hutchins (1 page)	11/15/1996	P2, b(6)
005. letter	Christopher Jennings to Congressman Earl Pomeroy (partial) (1 page)	11/18/1996	P2, b(6)
006. letter	Christopher Jennings to Susan Prokop re: address (partial) (1 page)	11/15/1996	P6/b(6)
007. letter	Christopher Jennings to Laurie Sullivan (partial) (1 page)	11/18/1996	P2, b(6)
008. letter	Christopher Jennings to Senator John Warner (partial) (1 page)	12/06/1996	P2, b(6)
009. letter	Christopher Jennings to Walter Zelman re: address (partial) (1 page)	11/18/1996	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8990

FOLDER TITLE:
Response Letters [1]

Racheal Carter
2011-0747-S
rc606

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

November 18, 1996

Paul M. Ellwood, M.D.
President
Jackson Hole Group
P.O. Box 350
Teton Village, WY 83025

Dear Dr. ~~Ellwood~~ Paul:

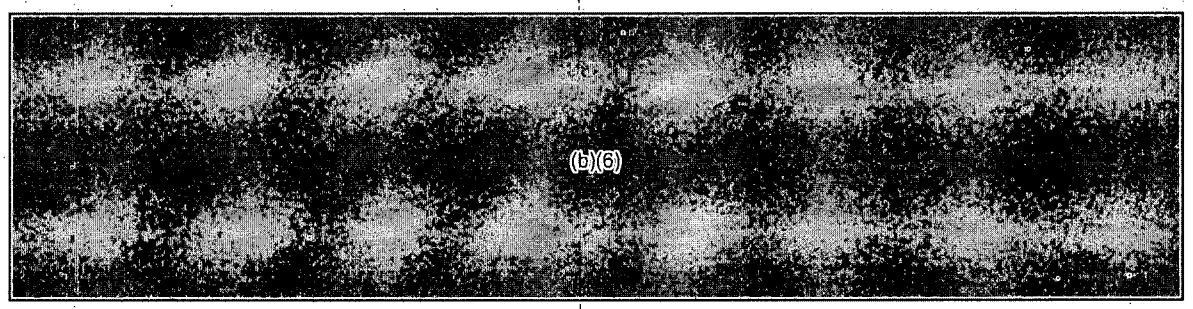
Thank you for your letter in support of John Crosby to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Mr. Crosby's background and credentials are currently being reviewed. Clearly, he would have much to contribute to the Advisory Commission. You can be assured that his candidacy is being given every due consideration.

As always, I welcome your views, and I hope that we can count on your continued support for the Commission and its goals.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development



[001]

THE WHITE HOUSE

WASHINGTON

November 18, 1996

Congressman Earl Pomeroy
1533 Longworth Building
Washington, DC 20515

Dear Congrssman Pomeroy: Earl:

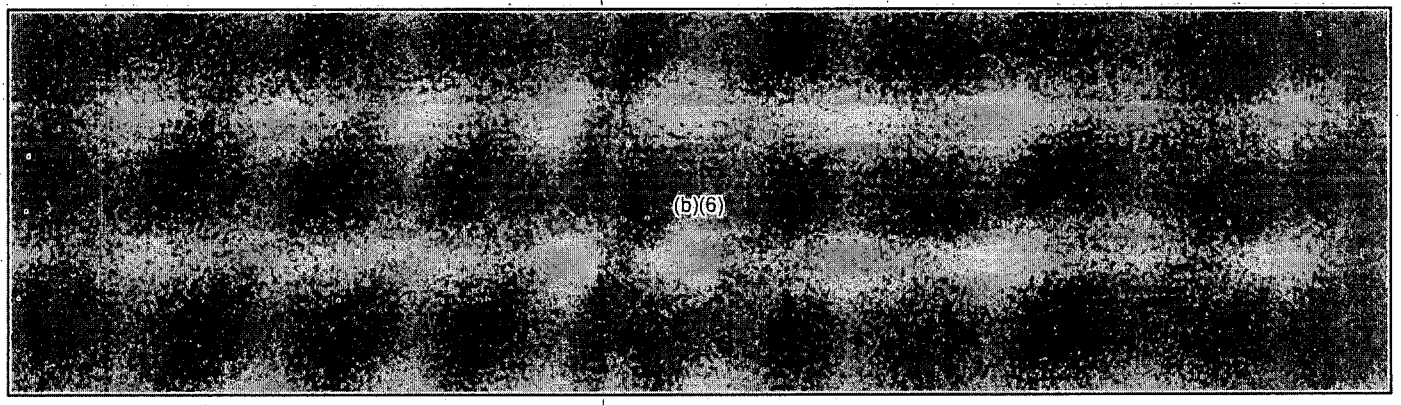
Thank you for your letter in support of Kathleen Sebelius to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Ms. Sebelius' background and credentials are currently being reviewed. Clearly, she would have much to contribute to the Advisory Commission. You can be assured that her candidacy is being given every due consideration.

As always, I welcome your views, and I hope that we can count on your continued support for the Commission and its goals.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development



[005]

THE WHITE HOUSE

WASHINGTON

November 18, 1996

Laurie Sullivan
Law Offices
Verner, Liipfert, Bernhard, McPherson and Hand Chartered
901 – 15th St., NW, Suite 700
Washington, DC 20005-2301

Dear Ms. ~~Sullivan~~ Laurie

Thank you for your letter in support of Sheila Leatherman to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Ms. Leatherman's background and credentials are currently being reviewed. Clearly, she would have much to contribute to the Advisory Commission. You can be assured that her candidacy is being given every due consideration.

As always, I welcome your views, and I hope that we can count on your continued support for the Commission and its goals.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development

(b)(6)

[007]

THE WHITE HOUSE

WASHINGTON

December 6, 1996

Senator John Warner
225 Russell Senate Office Building
Washington, DC 20510-4801

Dear Senator Warner:

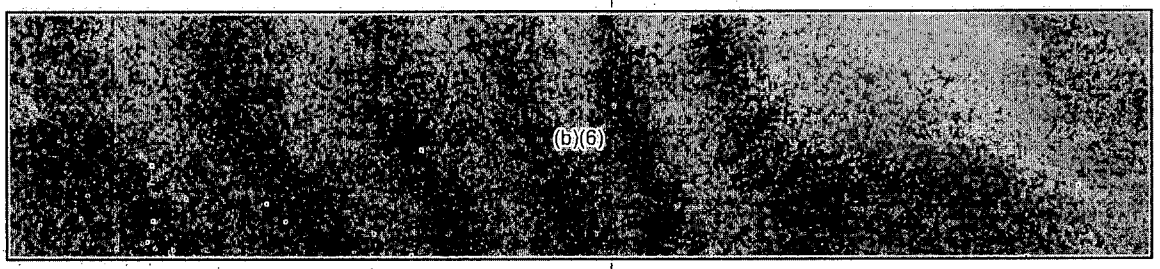
Thank you for your letter in support of Ms. Phyllis Cothran to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Dr. Cothran's background and credentials are currently being reviewed. Clearly, she would have much to contribute to the Advisory Commission. You can be assured that her candidacy is being given every due consideration.

As always, I welcome your views, and I hope that we can count on your continued support for the Commission and its goals.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development



[008]

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	Joseph Minark to Jeanne Lambrew re: tobacco stuff (partial) (1 page)	09/05/1997	P6/b(6)
002. press release	re: phone number (partial) (1 page)	09/17/1997	P6/b(6)
003. paper	re: Public Liaison Satcher Plan (2 pages)	n.d.	P2
004. paper	re: Dr. David Satcher (4 pages)	10/03/1997	P2

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 14654

FOLDER TITLE:
Surgeon General Nomination [1]

Racheal Carter
2011-0747-S
rc609

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PUBLIC LIAISON SATCHER PLAN:

I. Short Term Piorities

A. Prior to announcement (focus will be on healthcare groups and companies that might carry some weight with Committee members of interest).

1. Support letters from the following national health groups.

Am. Medical Assn.*	Nat. Medical Assn
Am. Acad. Of Family Physicians*	Am. College of Physicians
Am. Med. Women's Assn	Am. College of Ob/GYNs
Am. Academy of Pediatrics	Am. Hosp. Assn.
Assn. Of Am. Medical Colleges*	Assn. Of Academic Health Centers
Am. Nurses Assn	Black Nurses Assn
Am. Assn. Of Health Plans*	Health Insurance Assn. Of Am
Am Public Health Assn	Healthcare Leadership Council*

Pharmceutical and Research Manufacturers Assn*

BioTech Industry Council NARD

Pharma NACDS

2. Support Letters from the following companies.

Eli Lily*	IBM (VT site)*
Avon	Merck — only those
Baxter	McDonalds* he is close to.
Gerber	Smith Kline.

Other companies involved in CDC's immunization, breast cancer, etc programs

3. Other important early letters.

Junior League*	Boy Scouts
YWCA	Rotary*

Education and School Board groups*

4. Letters of Support from state groups prior to announcement.

Tn Medical Society*	MeHarry
Vanderbilt	Univ of Tennessee

All Tennessee health groups will be approached, but a special focus wil be placed on those who communicate regularly with Sen. Frist.

Morehouse

Case Western* Vermont Medical Society*

University of Vermont

Emory AAFP Bob Graham

Emory - Bill Foege

Additional state focus will be on healthcare groups, companies and academic medical centers in the states of the committee members.

5. Potential validators prior to announcement.

C. Everett Koop*
Fmr. Sec. Louis Sullivan*
Fmr. Sen. Kassebaum*
Ken Shine - IOM
Nancy Dickey - AMA pres.*
Governor Sundquist*
Lamar Alexander
Fmr. Sen Hatfield
Lonnie Bristol*

6. Other commitments prior to announcement

A. AMA commitment to do Hill visits on behalf of the nomination within the week of the announcement

B. JAMA and New England Journal of Medicine Editorials

C. Op ed piece by TN Medical Society

B. Post Announcement

1. Broadbased support effort to include:

All other health groups
Disability and Mental Health groups
African-American groups
Religious Groups
State and local groups, i.e. Nat. Assn. Of Counties
Police Groups
Senior Groups
Labor
Injury Prevention groups
Children's health groups
Breast Cancer coalitions

2. Individuals support letters from his friends and associates. (What about athletes?)

II. Longer Term strategy will be requests for letters from group members in key states, additional op ed pieces, national group briefings to keep the groups focused and active.

ENDORSEMENTS OF DR. DAVID SATCHER

as of October 3, 1997

Medical Associations

American Medical Association
American Academy of Family Physicians
National Medical Association
National Hispanic Medical Association
Tennessee Medical Association
American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Public Health Physicians
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Nuclear Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventative Medicine
American Dental Association
American Gastroenterological Association
American Medical Group Association
American Medical Women's Association
American Osteopathic Association
American Psychiatric Association
American Society of Cataract and Refractive Surgery
American Society of Clinical Pathologists
American Society of Internal Medicine
American Society of Pediatric Nephrology
American Society for Reproductive Medicine
American Society for Transplant Physicians
California Medical Association
College of American Pathologists
Congress of Neurological Surgeons
Society of Nuclear Medicine
Interamerican College of Physicians and Surgeons
~~California Medical Association~~

Nurses

American Nurses Association

American Association of Nurse Anesthetists
National Black Nurses Association

Hospitals

American Hospital Association
National Association of Public Hospital and Health Systems
National Association of Children's Hospitals
The Hospital and Health System Association of Pennsylvania

Pharmaceutical Companies

Merck
Smith Kline Beecham Pharmaceuticals
Zenecca Inc.
Wyeth-Lederle Vaccines and Pediatrics

Businesses

American Airlines
American Association of Health Plans
American Greetings
Avon
Ford
Phoenix Healthcare Corporation

Academic Health Centers

Association of American Medical Colleges
Meharry Medical College
Morehouuse School of Medicine, Dr. Louis W. Sullivan
The Rollins School of Public Health of Emory University
Vanderbilt University Medical Center
University of Washington School of Public Health and Community Medicine
University of Pittsburgh Graduate School of Public Health
Mississippi State Medical Association
University of North Carolina School of Public Health, Chapel Hill, North Carolina
Harvard University Medical School, Cambridge, Massachusetts

Allied Health Groups

American Cancer Society
American Public Health Association
National Association for Public Health Policy

Associations of Schools of Public Health
Community Health Resources
Council of State and Territorial Epidemiologist
National Association of County and City Health Officials
National Association for Public Health Policy
National Family Planning and Reproductive Health Association
National Black Child Development Institute
National Association of People With AIDS
AIDS Action Council
National Mental Health Association
American Lung Association
National Task Force on AIDS Prevention
American Diabetes Association
Intercultural Cancer Council
Coalition for Health Funding
U.S. Department of Health and Human Services Hispanic Employee Organization

Education

Claflin College, Orangeburg, South Carolina
National Alliance of Black School Educators
Voorhees College, Denmark, South Carolina
West Virginia State College, Institute, West Virginia
Mississippi Valley State University, Itta Bena, Mississippi
Coppin State College, Baltimore, Maryland
St. Paul's College, Lawrenceville, Virginia
South Carolina State University, Orangeburg, South Carolina
Langston University, Langston, Oklahoma
Tuskegee University, Tuskegee, Alabama
University of California, San Francisco, California

Disability Groups

March of Dimes Birth Defects Foundation
National Multiple Sclerosis Society

Youth Groups

College Democrats of America

Fraternities and Sororities

Alpha Phi Alpha Fraternity, Inc.
Phi Beta Sigma Fraternity, Inc.
Zeta Phi Beta Sorority, Inc.

Delta Sigma Theta Sorority, Inc.

Women's Groups

Joint Action Committee for Political Affairs
National Black Women's Health Project
National Asian Women's Health Organization

Senior Groups

National Council of Senior Citizens

Religious Groups

Bay of Hope Christian Church
Shiloh Baptist Church of Washington

Civil Rights Groups

National Association for the Advancement of Colored People
National Urban Coalition

Law Enforcement Groups

National Association of Blacks in Criminal Justice
National Organization of Black Law Enforcement Executives
American Correctional Association
Family Violence Prevention Fund

Individuals

Sister Mary Alice Chineworth, OSP

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: Dr. David Stacher (3 pages)	n.d.	P2
002. memo	Chris Jennings to Patsy Thomason et al re: David Satcher (5 pages)	07/08/1997	P2
003. memo	Peter Erichsen to John Podesta et al re: David Satcher (21 pages)	08/15/1997	P2

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 14654

FOLDER TITLE:
Surgeon General Nomination [2]

Racheal Carter
2011-0747-S
rc856

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Surgeon Gen
NLR

Privileged and ~~Confidential~~

DR. DAVID SATCHER
Candidate for Assistant Secretary for Health and Surgeon General (PAS)
Department of Health and Human Services

Dr. David Satcher has been the Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR) since November 1993. He was previously vetted by this office in July 1993. [1]

Dr. Satcher is extensively published in a wide variety of professional and popular journals and periodicals. [2]

Condoms in Schools

A November 20, 1996, article in the ABORTION REPORT indicated that Dr. Satcher praised a report on Sexually Transmitted Diseases (STDs) by the National Academy of Science's Institute of Medicine. The article stated, "The report's recommendations are 'certain to spark debate' about the role of schools in sex education, disease prevention and treatment. The study said schools should offer 'age-appropriate' education and clinical services to help prevent, diagnose and treat students infected with STDs." The study also said that while schools "should emphasize abstinence, they should also provide condoms." A September 26, 1993, article in the NEW YORK TIMES indicated that Dr. Satcher said "he is comfortable with whatever is effective in dealing with problems like teen-age pregnancy and AIDS, including new Surgeon General Jocelyn Elders' support for condom distribution in schools." The article quoted Dr. Satcher as saying, "My attitude is that we really have to provide people in this country with the information they need to protect themselves from this virus. And we can't let political, cultural or religious differences interfere with that."

In the interview, Dr. Satcher stated that with regard to teens, the first step should be sex education to stress the importance of sex and relationships and to emphasize abstinence. To support people who choose abstinence, Dr. Satcher recommends programs such as peer counseling so that teens who choose not to be sexually active will not feel isolated. However, for teens that are sexually active, he feels strongly that they should be protected and should,

---

[1]This is an update of an earlier public record vet written in 1993. Please see attached for additional issues and biographical information. Please note that this is a limited review of the public record for articles and other items mentioning Dr. Satcher and not a comprehensive review of issues involving the CDC during his tenure as its Director.

[2]Dr. Satcher's writings were reviewed, and are the subject of a separate memorandum prepared by, the Domestic Policy Council. His speeches and other writings are being reviewed by HHS.

Privileged and ~~Confidential~~

DR. DAVID SATCHER
Candidate for Director, Centers for Disease Control (CDC),
U.S. Department of Health and Human Services

David Satcher has been the President of Meharry Medical College (Meharry) in Nashville, Tennessee since 1982. Prior to his appointment at Meharry, Dr. Satcher was Professor and Chairman of the Department of Community Medicine and Family Practice at the Morehouse School of Medicine in Atlanta. From 1977 to 1979, he served as a professor and Interim Dean of the Charles R. Drew Postgraduate Medical School in Los Angeles.

Dr. Satcher's career also includes the following posts: Director, King-Drew Sickle Cell Center in Los Angeles, 1974 to 1979; Assistant Professor of Epidemiology, School of Public Health, U.C.L.A. School of Medicine, 1974 to 1976; Associate Director of the King-Drew Center, 1973 to 1975; and Director of the Community Outreach Program at the Martin Luther King, Jr. General Hospital in Los Angeles. Dr. Satcher received a B.S. from Morehouse College in Atlanta in 1963 and an M.D. and Ph.D. from Case Western Reserve University in 1970.

Dr. Satcher has been widely praised and credited for his leadership at Meharry. The most notable event of his tenure was the 1992 merger of Meharry's Hubbard Hospital (Meharry-Hubbard) with Metropolitan General Hospital (Metro General), Nashville's largest public hospital. According to an article in The Memphis Commercial Appeal, the merger was a "landmark event in the city's race relations." Until 1985, Meharry's doctors, virtually all of whom are African American, were not permitted access to Metro General. Dr. Satcher led a three year campaign to join operations of the two hospitals in order to save both of them. Metro General's facilities were deteriorating and Meharry-Hubbard had not been profitable since it opened in the mid-1970s. The plan drafted by Dr. Satcher promises to save the city money because Meharry would basically donate its facilities and services on the condition that the center would serve as the school's teaching facility, thereby ensuring that Meharry receives all necessary accreditations.

In a 1991 Washington Post article, Dr. Satcher called Meharry "possibly the most needed institution in the country today" because of its mission of serving African Americans and indigent people. He appears in the public record as a strong supporter of a national focus on special health care needs for poor people. In The Memphis Commercial Appeal, Dr. Satcher was quoted as saying "we must make health promotion and prevention a priority" so that indigent people can "receive preventive health care and education in their communities, rather than last-ditch treatment in hospital emergency rooms." In the article, Dr. Satcher advocated an emphasis by

universities on training African American health professionals, who, according to a statistic attributed to Dr. Satcher, are twice as likely as non-African Americans to serve the poor.

There is little information in the public record regarding Dr. Satcher's views on AIDS and HIV policy. A 1990 Memphis Commercial Appeal article reports that Dr. Satcher believes that fear, misinformation and lack of access to health care are hampering efforts to prevent the spread of HIV, especially among African Americans.

On the issue of health care access, Dr. Satcher appears to advocate a strong national system that provides universal coverage. A 1991 Memphis Commercial Appeal article reported that, during a health care conference, Dr. Satcher "urged lawmakers to consider the Canadian system, which, though not perfect, at least provides basic coverage to all."

A review of the available public record does not reveal any information that would disqualify Dr. Satcher from serving as Director of the Centers for Disease Control or that reflects negatively on his qualifications for the position.

July 12, 1993

Surgeon Gen
nom
NHH

MEMORANDUM

July 8, 1997

TO: Patsy Thomason, Peter Erichsen, Stacy Reynolds

FR: Chris Jennings

RE: Review of the Literature Written By Dr. David Satcher

Following up on our meeting, this memo summarizes all of these issues in literature written by Dr. Satcher that we thought could potentially be controversial during his upcoming confirmation hearings. Like many well-renowned public health officials, Dr. Satcher has written on a number of controversial topics, such as the need for more sex education and the harmful impact of tobacco.

Dr. Satcher makes some statements which, taken out of context, could suggest that he may have controversial solutions to the problems that he raises. When reviewing his positions in context, however, he does not advocate any views on issues which are particularly radical for the public health community. It is important to note, though, that on certain issues Dr. Satcher does not write extensively about his proposed public health solutions to the problems he addresses.

As we have discussed, we did not review what Dr. Satcher has said on all of these issues or what he has done to address them as the Director of the Center for Disease Control (CDC). However, after reviewing his writing extensively, I do not believe that his published work contains any information that would prevent him from successfully serving as the next Surgeon General or prevent him from being confirmed by the Senate.

The following is a list of the potentially controversial issues in Dr. Satcher's writings.

Sex Education

Dr. Satcher has written a number of articles which discuss the importance of sex education. These articles contain quotes which, when taken out of context, could be perceived as being too proactive with regard to sex education programs in schools. In one article, he writes: "We don't help to prepare for young people for the family. That's partly reflected in the fact that we have so little sex education going on in the schools." Dr. Satcher also clearly believes that any effort to improve sex education should include an active discussion about the importance of

condoms in preventing HIV. In several articles, Dr. Satcher discusses the Prevention Marketing Initiative, a sex education program launched by CDC under his leadership. He describes the program as follows: "The Prevention Marketing Initiative is the first government supported information effort designed to reach sexually active young people with specific messages regarding condom use and efficacy."

One could speculate that, given these views, Dr. Satcher might advocate a controversial policy of broad distribution of condoms in the schools. Dr. Satcher never explicitly writes his position on this issue. According to public health experts, the CDC program does not advocate such policies, and has not been considered controversial.

Response to Writings That Could Be Taken Out of Context

While Dr. Satcher clearly believes that promoting the use of condoms should be an important component of any sex education campaign, he also mentions the importance of stressing abstinence. He writes that "CDC has formally announced a major prevention initiative and marketing campaign focusing on people 18-25 years of age which promotes sexual abstinence and the use of condoms to prevent HIV infection." He also writes that sex education means something broader than just preventing sex: he defines it has a larger discussion of family values and in particular how men and women treat each other. In one article he writes: "When we say education people think of just sexual intercourse and not what does it mean to be a man or woman and how men and women relate to each other in society."

Firearms as a Critical Component of Violence

In a number of articles, Dr. Satcher writes that firearms are a leading contributor to the problem of violence in the United States. In one article, he writes: "the most difficult and controversial aspect of the problem of violence in our society concerns the involvement of firearms in these events." Dr. Satcher clearly recognizes that this is a controversial claim as he writes: "CDC and others within the public health community have been criticized for applying science to understanding the role that firearms play in the occurance and severity of assaultive issues."

He does not, however, back down from his claim. These quotes can no doubt be taken out of context, and one could certainly speculate that as a next logical step Dr. Satcher might advocate controversial policies regarding limiting or banning of guns. However, it is important to note that nowhere in the literature does he explicitly advocate for any such policy.

Response to Writings That Could Be Taken Out of Context.

By and large, Dr. Satcher does not discuss his views on gun control. He does state at one point, however, that the motivation for studying the role of guns in violence prevention is motivated by public health concerns <u>not</u> to prevent lawful ownership. "In fact, firearms are only one of many factors that CDC is examining in trying to understand how to prevent violence; the motivation for studying the role of firearms stems from the desire to prevent violence and injuries

and not from preventing lawful ownership and use." Thus again if Dr. Satcher's writing is viewed holistically, rather than highlighting selective quotes, his views on the role of firearms should not be perceived as particularly controversial.

Limiting Tobacco

Dr. Satcher also writes about the negative impact of tobacco and recommends a series of steps to reduce cigarette smoking. However, his criticisms as well as his proposed solutions are not any more far reaching than any of the recommended strategies for reducing cigarette smoking that have been advocated by the Administration.

Dr. Satcher recommends "promoting non-smoking messages while limiting the effect of tobacco advertising and promotion on young people." He also is a proponent of increasing the price of tobacco product which he believes will encourage current smokers to smoke less. At one point, Dr. Satcher writes that he advocates the "regulation of tobacco products." However, he never suggests that we should ultimately aim to ban tobacco products.

Response to Writings That Could Be Taken Out of Context

Dr. Satcher's main emphasis is how to reduce the availability and use of tobacco products by young people. In fact, he emphasizes CDC's approach to reduce smoking among young people. This strategy includes releasing guidelines for schools on how to prevent tobacco use and addiction among young people.

Dr. Satcher's writing on tobacco also takes into consideration the impact that efforts to reduce cigarette smoking would have on the tobacco industry. He claims that his proposed efforts to reduce tobacco use would not have a dramatic impact of Americans living in communities economically dependent on tobacco. He cites a U.S. Department of Agriculture study which estimates that a 30 percent drop in tobacco production would reduce total economic activity in any tobacco-growing area by less than 3 percent.

The Impact of Tobacco on the African American Community

While Dr. Satcher does not advocate radical views on limiting tobacco, he does criticize the tobacco community for excessively targeting their promotional campaign to the African-American community. In one article, he writes: "one can point to a variety of explanations, not the least of which is the insidious advertising and promotional campaigns targeting the African-Americans and other vulnerable communities." Dr. Satcher goes onto criticize that this campaign has indeed been intentional, claiming that "the tobacco industry's support of the African-American community has been strategic and deliberate." These claims may be perceived as more controversial than his underlying views on tobacco.

As the Director of CDC, Dr. Satcher has worked to reduce the impact of tobacco in African American communities, focusing part of the anti-tobacco campaign on educating African American physicians and community leaders to promote tobacco prevention and control.

Minority Issues

A good portion of Dr. Satcher's writings are focused on the unique concerns of the African American community in the health care system. He has done a great deal of research on a number of diseases that predominately impact the African-American community, such as sickle cell anemia and hypertension.

Dr. Satcher has also written extensively on his strong belief that our health care system is failing African Americans, leading to their lower health status. A number of his articles discuss the nature of this failure stating that, "the lack of emphasis on comprehensiveness, the lack of incentives for preventive intervention, the barriers to access, and the underrepresentation of African-Americans and other minorities in the health professions all combine to create what the American Medical Association recently referred to as a 'racist' health care system -- a system that disproportionately fails African-Americans and other minorities."

Throughout his writing, Dr. Satcher outlines various remedies to improve the presence of African Americans in the medical community as well as the overall health status of African Americans. These solutions include: increasing the number of minority physicians; increasing research funds, particularly for research on the unique health needs of minorities; supporting historically black medical schools; improving the comprehensive nature of our health care system. He also discusses the need for more primary care and family medical services in certain communities, particularly inner city communities. He also cites this as a major reason that we need more minority physicians and the institutions that promote them. African American doctors, he notes, are more likely to practice in many of our underserved, largely minority communities -- those communities that, according to Dr. Satcher, our current health care system is failing.

Response to Writings That Could Be Taken Out of Context

While increasing minority participation in the nation's health care system is a primary goal of Dr. Satcher's nowhere in his writings does he call for some of the more controversial remedies such as quotas to achieve his goal. In fact, so far as we can tell, he does not even mention the role affirmative action plays in increasing minority participation.

Other Discussions of Race

While Dr. Satcher does not have particularly controversial solutions to improve the health status of minorities, it is important to note that some of his early writings explicitly claim that America is a racist society and that this racism has important implications in the health care system. In one article in the early 1970s, Dr. Satcher writes: "We live in a racist society, and all around us the forces of racism help to determine the course of our lives and the nature of our relationship. Unfortunately, racism knows no geographic academic boundaries. One need only

look casually at the medical profession to see how potent a force racism has been in its development." Dr. Satcher also likens the nature of the white-physician-black patient relationship to a "master-servant relationship" where blacks feels inhibited to express their dissatisfaction or question aspects of medical care. None of this language is in his later writings.

Article on the Sociodemographic Correlates of Mental Retardation

In one article, Dr. Satcher analyzes the relationship between mental retardation in children and the various sociodemographic characteristics (particularly race) of the children's families. This article was written in the context of the highly charged debates about the relationship between sociodemographic characteristics and cognitive ability raised by Charles Murray in *The Bell Curve.*

Dr. Satcher points to a study in Georgia which finds some correlation between mental retardation and sociodemographic factors and concludes that there is physical and social characteristics of the home environment that have an impact on development. In fact, he argues that "the results [of the study] point to a large portion of mild mental retardation that is potentially preventable.

Response to Writings That Could Be Taken Out of Context

However, unlike Charles Murray, Dr. Satcher does not use the correlation between mental retardation and sociodemographic characteristics to make any generalizations about racial groups. Instead, he uses this article ultimately to advocate for more early intervention and learning to improve the environment that poor, often minority children grow up in. Dr. Satcher's conclusions are not particularly controversial, but because this topic is so sensitive, we wanted you to be aware that he had engaged in this dialogue.

Conclusion

As mentioned previously, I do not believe that any of these issues are controversial enough to compromise Dr. Satcher's ability to be confirmed. Of course, this memo only reviews his written work. I am aware that you are reviewing his statements on a wide range of issues as well as his record at the CDC. If there are major issues that have been raised in this aspect of your review process on which you would like a second opinion, please feel free to call me at 6-5560.

Surg. Gen
Nom
NHK

THE WHITE HOUSE

WASHINGTON

August 15, 1997

MEMORANDUM FOR JOHN PODESTA, CHUCK RUFF, PATSY THOMASSON AND CHRIS JENNINGS

FROM: Peter Erichsen PE

SUBJECT: David Satcher

Attached are (1) the final version of our review of the public record for accounts of Dr. Satcher's career, together in most cases with comments by Dr. Satcher from a follow-up interview, (2) the 1993 public record vet and (3) the limited review of Dr. Satcher's publications performed by Chris Jennings's office.

3

Do I have right document?

Privileged and ~~Confidential~~

DR. DAVID SATCHER
Candidate for Assistant Secretary for Health and Surgeon General (PAS)
Department of Health and Human Services

Dr. David Satcher has been the Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR) since November 1993. He was previously vetted by this office in July 1993. [1]

Dr. Satcher is extensively published in a wide variety of professional and popular journals and periodicals. [2]

Condoms in Schools

A November 20, 1996, article in the ABORTION REPORT indicated that Dr. Satcher praised a report on Sexually Transmitted Diseases (STDs) by the National Academy of Science's Institute of Medicine. The article stated, "The report's recommendations are 'certain to spark debate' about the role of schools in sex education, disease prevention and treatment. The study said schools should offer 'age-appropriate' education and clinical services to help prevent, diagnose and treat students infected with STDs." The study also said that while schools "should emphasize abstinence, they should also provide condoms." A September 26, 1993, article in the NEW YORK TIMES indicated that Dr. Satcher said "he is comfortable with whatever is effective in dealing with problems like teen-age pregnancy and AIDS, including new Surgeon General Jocelyn Elders' support for condom distribution in schools." The article quoted Dr. Satcher as saying, "My attitude is that we really have to provide people in this country with the information they need to protect themselves from this virus. And we can't let political, cultural or religious differences interfere with that."

In the interview, Dr. Satcher stated that with regard to teens, the first step should be sex education to stress the importance of sex and relationships and to emphasize abstinence. To support people who choose abstinence, Dr. Satcher recommends programs such as peer counseling so that teens who choose not to be sexually active will not feel isolated. However, for teens that are sexually active, he feels strongly that they should be protected and should,

---

[1]This is an update of an earlier public record vet written in 1993. Please see attached for additional issues and biographical information. Please note that this is a limited review of the public record for articles and other items mentioning Dr. Satcher and not a comprehensive review of issues involving the CDC during his tenure as its Director.

[2]Dr. Satcher's writings were reviewed, and are the subject of a separate memorandum prepared by, the Domestic Policy Council. His speeches and other writings are being reviewed by HHS.

therefore, be shown the proper use of latex condoms. Dr. Satcher noted that he is a father and that he feels this way professionally and personally. Dr. Satcher stated that this approach is not judgmental. He said they work with local communities and encourage more focus on funding local community groups. However, he said the CDC does not fund programs that only provide one prong of their two prong approach (abstinence and protection). He stated that they will not fund programs that discriminate against people who are sexually active.

Satcher Produced Televised Announcements Featuring Condoms

Many articles criticized the CDC and Dr. Satcher for producing and defending a series of televised public service announcements regarding condoms and the transmission of HIV which were eventually taken off the air by Health and Human Services (HHS) Secretary Donna Shalala. A December 7, 1993 article in USA TODAY quoted a CDC spokesman as saying the announcements would "be very different than anything you've ever seen before." The article indicated that Dr. Satcher was "very much in favor" of the plan for more explicit and targeted announcements. The article quoted Dr Satcher as saying, "We've got to be more aggressive. What are we going to tell our children and grandchildren when they ask us why we allowed political, cultural and religious differences to prevent us from attacking this problem." According to the article, Dr. Satcher further argued that fighting AIDS meant "talking frankly about drugs, sex and condoms." A January 4, 1994, transcript from a CNN newscast indicated that previous AIDS prevention announcements had been criticized "for being too vague about barrier protection for sexual intercourse." The transcript went on to say, "Many of the new spots are frank, but not particularly graphic." The transcript indicated that Dr. Satcher said the new ads struck a proper balance "between sensitivity about sex and the public's need to know about protection." A January 31, 1994, article in the ARIZONA REPUBLIC stated, "The problem is, some of [the announcements] are utter trash. So trashy, in fact, that the intended message is not communicated." The article reported that the announcements were eventually pulled off the air by HHS Secretary Shalala. A February 1, 1994, article in the INSIDE REPORT ON AIDS indicated that Dr. Satcher said that the "uproar over the CDC's recent condom message deflected attention from the campaign's equal emphasis on abstinence." The article quoted Dr. Satcher as saying, "Message number one is abstinence. That's good science. But our surveys tells [sic] us that only 20% of those between ages 18 and 25 are not having sex. So message number two says if you are sexually active, use latex condoms. They work. Unfortunately, the first message got lost in the uproar over the second message."

Dr. Satcher stated in the interview that he does not recall the Secretary ever pulling any public service announcements by the CDC. He stated that during his tenure all ads were approved by the Secretary before being aired. He suggested that these ads might have been produced prior to his becoming the head of the CDC. Dr. Satcher said the only controversy he recalled was an incident relating to an ad which was going to feature the Red Hot Chili Peppers. He said that ad was pulled prior to air because it became known that there was some scandal

relating to the artist (he believed it was something to do with domestic violence or sexual assault). As to the comment about favoring more explicit and targeted announcements, Dr. Satcher did not recall the comment. He said he does favor targeted ads, but was not sure what was meant by more explicit. He noted that he does believe ads should include homosexuals, which some people do not want to include, but he does not think sex should be shown no matter what the sexual orientation.

CDC Criticized for Insufficient Emphasis on Abstinence

An April 3, 1996, article in USA TODAY, reported that Dr. Satcher said, "[O]ur [sex education and AIDS] programs deal with abstinence. But we also must deal with the fact that for those people who are sexually active, they need to know how to protect themselves from [infection with the HIV] virus. There are those people because of their religion or politics who might disagree with that and say we should only be talking about abstinence. Well, that's almost like saying we don't really care about those people who are active. We can't afford to take that attitude." A February 1, 1997, article in the TULSA WORLD stated that Representative Tom Coburn (R-Okla.), a physician, charged that the CDC had "missed the mark in the fight against sexually transmitted diseases" and argued that the agency's message on condoms "falls far short of what it should be" because it "fails to emphasize that while condoms can offer protection from certain disease, they leave users at risk for others." Representative Coburn reportedly said that the CDC did not emphasize sexual abstinence enough and that "[y]ou can't be irresponsible sexually and get away with it." According to the article, Representative Coburn suggested that the agency lacks a "real world perspective."

Dr. Satcher stated that he and Representative Coburn have mutual respect for each other and says Representative Coburn was supportive of him and his candidacy, even though they disagree. He said they have similar basic ethics, but that they have different backgrounds and this difference accounts for their different views. Dr. Satcher said he thinks it is the right response to make it clear that condoms are not 100 percent effective against STDs, but he believes they have a role in containment. See discussion above for more regarding abstinence.

Proponent of Sex Education in Schools

A February 18, 1995, article in the CHAPEL HILL HERALD quoted Dr. Satcher as saying, "I think we ought to be very aggressive in helping teen-agers deal with the challenge of teen-age pregnancies." He further stated that teen-agers "should also be targeted for AIDS prevention" because "[t]hey are making some sex decisions which are in fact deadly choices." A October 1, 1994, article in EDITOR AND PUBLISHER MAGAZINE stated that Dr. Satcher reported that the CDC "found that young people who receive sex education early on are less likely to be sexually active early and much less likely to engage in high-risk sexual behavior." Given these statistics, Dr. Satcher said "the opposition to sex education in this country is astounding." A May 21, 1994,

article in the ETHNIC NEWSWATCH stated that Dr. Satcher explained that AIDS could be prevented but "[w]e are busy fighting against sexuality education in our schools and against making condoms easily available to sexually active persons."

See above.

CDC Criticized for AIDS Education for Heterosexuals

A May 16, 1994, transcript by the FEDERAL NEWS SERVICE of a National Press Club luncheon at which Dr. Satcher spoke indicated that Dr. Satcher was asked about the spread of AIDS to "the general population." Dr. Satcher responded that "we have reason to feel that we're making some progress in this country in terms of the spread of AIDS. We believe that the epidemic, based on the last few years, is tapering off." He indicated, however, that "the fastest-growing group of persons in this country diagnosed with AIDS in recent years have been women. . . . And so [the prevalence of the disease is] becoming more heterosexual. And the type of education that we need for our teenagers especially is the heterosexual education. I think to a great extent the gay community has done a pretty good job of curtailing this problem in some communities. . . . We've got to be more targeted with our programs." A May 2, 1996, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that the CDC "denied allegations that, to get federal funding for AIDS programs, the CDC exaggerates the threat of AIDS to heterosexuals." The article stated that a WALL STREET JOURNAL article reported that the CDC deliberately overstated the risk of heterosexual AIDS and failed to direct the bulk of its AIDS funding toward the highest-risk populations: gay men and intravenous drug users. A May 3, 1996, article in the HOUSTON CHRONICLE, stated that Dr. Satcher "felt the agency made the right decision in targeting the general population with information about AIDS even though gays and intravenous drug users are the most affected." Dr. Satcher reportedly said, "How does a woman know her mate is not bisexual or an intravenous drug user."

Dr. Satcher stated that he wrote a letter responding to the Wall Street Journal article, as did Dr. Koop and others. He said recent numbers show that the WSJ was wrong. Dr. Satcher said he believes the reason America has been more successful than other countries in addressing the AIDS epidemic is because the approach was to address all people. He said the message was to be careful even though engaging in heterosexual relationships. Dr. Satcher said he stands behind this approach and noted that people take sex much more seriously today than they did 10 years ago. He also reiterated the statement about a woman not knowing if her partner is an intravenous drug user or otherwise at risk for AIDS. However, Dr. Satcher stated that all this does not mean that certain groups with higher risk should not be targeted. He said these high risk groups can be targeted while still educating the general population.

Criticized for Study of Unlicensed AIDS Drugs in Africa as "Double Standard"

On May 9, 1997, the PLAIN DEALER reported that Dr. Satcher, at a hearing before the House Government Reform and Oversight subcommittee, defended a study of unlicensed drugs for the treatment of AIDS, which was conducted by the CDC in Africa, against criticism that it "employ[ed] a 'double standard' in poorer countries." The article indicated that the study was set up such that HIV-infected mothers in Cote d'Ivoire, Ethiopia and South Africa were given new and promising drugs while women in the control groups were given placebos, rather than "a successful antiviral drug AZT, as they would in the United States." Dr. Satcher reportedly argued that the study was proper because the control group was being treated according to "the realities of the 'accepted standard of care' in poor countries," noting the "'cost and complexity' of giving AZT in developing countries where it is not generally available." However, according to the article, Sidney Wolfe, Health Research Director of Public Citizen, argued that this policy "exposes newborns in Africa, Asia and the Caribbean to unnecessary deaths from their mothers' HIV infections." He was quoted as saying, "In essence, U.S.-funded researchers are conducting experiments abroad that would never pass ethical muster in the U.S."

In our interview, Dr. Satcher stated that this study was done according to World Health Organization (WHO) recommendations. He explained that earlier studies had been done which concluded that a certain AZT regimen was the preferred course of action for pregnant women who are HIV positive. However, WHO complained that while this regimen was good for the U.S., it was not feasible in third world nations where prenatal care is virtually non-existent and people cannot afford such expensive drugs. Therefore, this study was an effort to find something that could work in these undeveloped nations. He explained that there was no reason to do a study which they could not use in the future. He further noted that they have a relationship with these countries which has developed over the years. As to Mr. Wolfe, Dr. Satcher stated that he was a friend, although they disagree on this issue.

HIV Prevention Progress Disputed

On July 13, 1994, the ORANGE COUNTY REGISTER reported that Representative Gerry Studds (D-Mass.) challenged Dr. Satcher's assertion that there had been progress in preventing HIV infections. Dr. Satcher was quoted as saying, "I happen to believe that the fact that the numbers are not going up suggests that we probably are making some progress with our community (prevention) programs." Noting that the number of young people with HIV was increasing despite a "dip" in the numbers of adult, homosexual men infected, Representative Studds reportedly "retorted" to Dr. Satcher's statement by saying, "Do you really believe that? Every number I've ever seen, every community that we're concerned about, has increased."

Satcher's Response to Theory On AIDS Transmission By Potentially Contaminated, Experimental Hepatitis B Vaccine

On June 26, 1997, the BUSINESS WIRE reported that Dr. Satcher withdrew his invitation to meet with Dr. Leonard Horowitz, author of Emerging Viruses: AIDS and Ebola--Nature, Accident or Intentional? to discuss AIDS as a possible outcome of contaminated vaccines. The "controversial" book purportedly "documents [the fact that] the CDC and Food and Drug Administration (FDA) helped manufacture a vaccine that might have transmitted AIDS worldwide." The article stated that "[i]n an official letter to Dr. Horowitz in which he withdrew his invitation to meet, Dr. Satcher stated the 'CDC believes that scientific evidence is the foundation for sound public health policies' and that Dr. Horowitz's allegations 'do not appear to be based on credible, evidence-based information.'" The article also stated, "Regarding Dr. Satcher's inability to see any 'credible evidence-based information' in Dr. Horowitz's writings, the author replied, 'If he did, he would also see himself and his agency are now fully exposed. And since rumor has it that President Clinton is considering Dr. Satcher for the Surgeon General post, putting on the 'Emperors [sic] new clothes' suits him fine--a black man who can watch his own people and millions of others die without seeing anything."

Dr. Satcher, in the interview, explained that he withdrew the invitation to meet with Dr. Horowitz after he had arranged a meeting for Dr. Horowitz with the National Medical Association (NMA), the Nation of Islam and others, including three of the best scientists from the CDC. This meeting took place in Washington, DC, and was a response to the Nation of Islam threatening to call a moratorium on all vaccines based on Dr. Horowitz's claim that all vaccines are contaminated. Although Dr. Satcher did not attend the meeting, he believed that it had accomplished what he wanted because it was decided that Dr. Horowitz's claims were not based on credible scientific evidence and it did not appear that the Nation of Islam would call for a moratorium. Therefore, Dr. Satcher was advised that meeting with Dr. Horowitz would accomplish nothing further and would merely promote Dr. Horowitz's book. As to Dr. Horowitz's response, Dr. Satcher called it an outburst and said it was unprofessional. He said he had no response to it, but noted that more white people get immunizations than African-Americans so the comment did not really make sense insofar as it suggested that Dr. Satcher, as an African-American, was watching his own people die from the allegedly contaminated vaccines without doing anything about it. Dr. Satcher stated that it is his style to be open and communicative, so normally he would have met with Dr. Horowitz, but he believed his advisors were right in saying the meeting would only serve to promote the book.

CDC Reported to Favor Needle Exchange Programs

On March 7, 1995, the ASSOCIATED PRESS reported that internal CDC documents showed that "[g]overnment scientists have twice urged a reluctant Clinton administration to lift the ban on federally funded needle-exchange programs to help slow the spread of AIDS." The article

stated that although "Clinton health chiefs contend[ed] that they [did not] have
that giving drug addicts clean needles can fight the AIDS virus while not increa
allow lifting the ban, "two internal reports from the [CDC] released by AIDS activists . . . say
otherwise." The article quoted from one report which said, "We conclude that the ban on federal funding of NEPs (needle-exchange programs) should be lifted." The article stated that this report was signed by Dr. Satcher in December 1993, as head of the CDC. The article also noted that a second CDC report had more evidence, including a needle-exchange program in Tacoma, Washington that showed decreases in hepatitis, "a liver virus spread similarly to AIDS." That report noted that it "demonstrates more clearly than any previous research that use of NEPs is associated with decreases in blood-borne infections." The news article said that the CDC reports and attached memos from the National Institutes of Health "emphasize that needle-exchange 'data are quite limited.'" The second report also "acknowledg[ed] new figures from Montreal that show needle-exchange participants there had HIV rates three times as high as other addicts." The article concluded by noting that Health and Human Services Assistant Secretary Philip Lee "decided not to act" and considered the CDC reports as "one part of the decision-making process" which he did not consider strong enough evidence to enable him to approach Congress on the funding issue.

An August 13, 1994, transcript of the CNN program HEALTH WORKS stated that "CDC insiders" privately supported needle exchange programs to combat the spread of infectious diseases among intravenous drug users. The article reported that Dr. Satcher "has made a formal recommendation, but won't say what it is." Dr. Satcher reportedly said, "I don't think [commenting] would be appropriate. What I will say is that we have finished the study [of needle exchange programs]. We looked at our results and we are, we have communicated that and we're discussing those results in the department, where to go from here." A December 6, 1994, article in the SAN FRANCISCO CHRONICLE stated that the CDC refused to release the report. The article stated that "officials are keeping the lid on the report, despite frequent requests" and that a Public Health Service official said, "Officially, the matter is still under review."

Dr. Satcher stated in the interview that people are critical of the CDC's work on needle exchange, but he stated that it is the department that has to make a decision, the CDC just evaluates the issue. He said the studies show needle exchanges are effective and show no evidence of increasing drug use. He further stated that the NIH consensus conference on this issue reviewed a number of studies and reached the same conclusion that needle exchange programs reduced HIV with no indication of increasing drug usage. However, Dr. Satcher did state that the available studies reveal differences in the effect on drug usage. He said some show no effect on drug usage, others show a decrease since it increases the ability to get people into drug treatment programs, but at least two studies suggest that it would increase drug usage. He said the NIH consensus conference considered all of these studies. Dr. Satcher noted that he recently spoke to the NAACP and said his speech included talk about the epidemic growing in minorities and women and talk about the Connecticut study on needle exchange programs, but

nothing about the political aspect of the issue. When asked about his opinion, he stated that he supports the Secretary's communication to Congress that there is a place for needle exchange programs, but that they are still considering what role the programs should play. Dr. Satcher added that personally he hopes they can lift the ban. He stressed that he understands the political sensitivity of this issue and the importance of the appropriate airing of such issues. As to whether the statutory requirements for lifting the ban have been met, Dr. Satcher said the Secretary's communication did not deal with the question of the effect on drug usage and he suggested that the Secretary will probably recommend the use of needle exchange programs only where drug treatment programs are available. He did not voice an opinion on whether the requirements have, in fact, been met.

As to the release of the CDC studies, Dr. Satcher stated that he did not know how they got out. He said the CDC had submitted the studies to Dr. Phil Lee and that there were several people in both HHS and the CDC that handled the studies, as well as the researchers themselves. He stated that he does not think government can hide anything and said he did not feel particularly bad that these studies got out. He said the studies were not released, but that similar studies have been published, particularly noting the Connecticut study.

Controversy over HIV Testing of Newborns without Notification of Results

A May 20, 1995 article in the WASHINGTON POST reported that 45 States, using CDC funding, tested newborns for HIV, but did not disclose the information to the mother or her doctor. Representative Gary Ackerman (D-N.Y.) introduced a bill to compel any state requiring infants' HIV tests to disclose the results to the mother. The article indicated that Dr. Satcher visited Representative Ackerman in his office and requested that Representative Ackerman "abandon his bill." Representative Ackerman refused to withdraw his support for the bill. According to the article, Dr. Satcher said he might then consider withdrawing the tests altogether rather than disclose the results. The article said that Dr. Satcher was troubled by the analogy between the HIV study and the "Tuskeegee 'experiment.'" The Tuskeegee experiment was a CDC study of some 400 illiterate African-American men with syphilis who "were observed -- but not treated-- by Public Health Service physicians as they deteriorated and eventually died, having been told only that they had 'bad blood.'" The article quoted a professor of pediatrics as saying, "The maintenance of anonymous test results at a time when treatment and prevention are readily available will be recorded in history as analogous to the Tuskeegee 'experiment.'" The article stated that the CDC then suddenly "announced it was immediately suspending its HIV testing for newborns throughout the country." The article concluded, "The CDC could have continued the tracking, added disclosure of results, and been free of the taint of the Tuskeegee 'experiment.' But instead the politicized CDC has chosen to fold -- extricating itself from accountability."

The June, 1997, ATLANTIC MONTHLY published an article which criticized the treatment of AIDS and HIV as an exception to traditional epidemiology practices in which infectious diseases would be tracked by using at least some combination of routine testing, reporting to local health authorities, tracing of people in contact with the disease, and notification of the potentially infected people. The article argued that privacy concerns voiced by AIDS activists and others who have called for the special treatment of the AIDS epidemic were either not as great as these activists would argue or were out-weighed by public health concerns. One example given in the article was the CDC-funded study in which newborn babies were subjected to blind testing for HIV infection. The article noted that after Representative Ackerman's bill led the CDC to suspend the infant-testing program, Representative Ackerman and Representative Tom Coburn (R-OK) succeeded in drafting and passing new legislation known as the "Baby AIDS Compromise." This legislation reportedly required state health-care workers to provide voluntary HIV testing and counseling to pregnant women who had not previously been tested. States would then be subject to the loss of some federal AIDS funding or to the requirement of implementing mandatory testing on infants if they fail to meet certain goals with respect to the voluntary testing program.

Dr. Satcher explained in the interview that the newborn testing was part of a community, population-based screening to study the magnitude of the epidemic. He said AIDS poses a public health dilemma and they need a way to study the magnitude reliably without violating privacy. He stated that the study was a blind screening of the discarded blood of newborns. He explained that after blood samples were used to test for other things, the identifying marks were removed and the samples discarded. The study took those discarded samples and tested them for HIV. Since the samples had no identifying marks, there was no way to identify the source and, therefore, no way to notify the mother of the results. Dr. Satcher said the blinded newborn screening was the best way to monitor the epidemic since it tested samples that were representative of the population, rather than self-selected samples. His concern about voluntary screening (where mothers are given the option of HIV testing) is that the people who tend to volunteer for HIV testing are those who are less likely to test positive. Thus, self-selecting reduces the efficacy of such screening in monitoring the epidemic. Unfortunately, Dr. Satcher said, he has been unable to adequately explain the value of the blinded screening to most people, including Representatives Ackerman and Coburn. According to Dr. Satcher, Representative Ackerman will not be happy with any study without notification of results and Representative Coburn wants mandatory screening. Dr. Satcher has concerns about both options (the former will not be representative and the latter might deter people from seeking prenatal and neo-natal care). Dr. Satcher voiced optimism about a plan that has been suggested, but not yet approved. The plan would give women the option of voluntary testing so that they could get the results if they want them and conduct the blinded study as well. This way, he said, the women have the option of getting the results and counseling and the blinded study should not cause a problem.

CDC Failed to Provide Informed Consent

A July 2, 1996, article in the WASHINGTON POST stated that, prior to Dr. Satcher's appointment to head the CDC, nearly 1500 infants were enrolled in a measles vaccination study without providing information to the parents that the vaccine was not licensed in the United States. Dr. Satcher reportedly said, "A mistake was made. It's a terrible error. It's going to hurt -- hurt in research and hurt in treatment." The article further quoted Dr. Satcher as saying, "We have to be uniquely sensitive . . . because of the history [of the Tuskeegee Experiment]." He reportedly said that people in the African-American and Hispanic communities had doubts "about how to trust the government."

Against Restraints on Tobacco Advertisements for Adults

A May 16, 1994, transcript by the FEDERAL NEWS SERVICE of a National Press Club luncheon at which Dr. Satcher spoke indicated that Dr. Satcher was asked his position on whether or not the government should prohibit all advertising of tobacco products. Dr. Satcher responded, "Well, I don't think the answer to this problem is in a restraint of trade, I think our nation values several things and some of the freedoms we value are important and we don't have to engage in trade offs. . . . So in this case I don't think it's regulation. Obviously I think it's appropriate to prohibit the sale or marketing of tobacco to teenagers. The problem we are having is enforcing those laws that we already have."

For Higher Tobacco Taxes

A September 9, 1994, article in the ROCKY MOUNTAIN NEWS, regarding a proposed increase in the cigarette tax, noted that "[s]ome have argued that cigarettes can save money by killing people before they reach old age." Dr. Satcher reportedly responded, "We find it difficult to come to the point of valuing death." Dr. Satcher said that 80 percent of the nation's medical costs were linked to tobacco or alcohol and that "[w]e know that increasing the cost of cigarettes will lower the death rate." A February 23, 1994, article in the TIMES UNION reported that Dr. Satcher urged an increase in the federal excise tax on tobacco and said, "Tobacco use tends to go down as the price goes up. Tobacco control represents a compelling drama of profits vs. health."

CDC Study of Exposure to Second-Hand Tobacco Smoke

An April 24, 1996 article from the FEDERAL DOCUMENT CLEARING HOUSE indicated that the CDC reported that "[a]lmost nine out of every 10 non-smoking Americans are exposed" to second-hand tobacco smoke. Dr. Satcher reportedly said, "This study documents for the first time the widespread exposure of people in the U.S. to environmental tobacco smoke. This new information will be critical in estimating the extent of related disease and developing effective public health strategies."

Priorities of the CDC

An article in the February 1, 1994, INSIDE REPORT ON AIDS indicated that Dr. Satcher enumerated four "evolving priorities" for the CDC: 1) protecting "core" public health functions; 2) enhancing the ability to respond to urgent public health threats; 3) developing nationwide prevention strategies similar to those for HIV; and 4) women's health issues.

Broadening CDC's Mission: Violence and Drugs as a Public Health Issue

A January 26, 1994, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that Dr. Satcher stated that the CDC needed to "combat social ills like teen violence as fervently as it fights the AIDS epidemic." The article quoted Dr. Satcher as saying, "[T]he threats to the public's health over the last 20 years have not come from infections nearly so much as from substance abuse and violence. The CDC has been slow to adapt to that. This is a historic departure." A March 1, 1994, article in the LOS ANGELES TIMES reported that Dr. Satcher said, "Violence is a global issue and we are a Third World country when it comes to violence. We at CDC believe violence is a public health problem, and that we can prevent a lot of it by educating people about firearms." A March 22, 1994 article in the ORANGE COUNTY REGISTER reported that Dr. Satcher told participants at a conference sponsored by the American College of Preventative Medicine that "Guns in the hands of teen-agers are more of a threat today by far than even cholera in drinking water."

A January 29, 1996, article in the PITTSBURGH POST-GAZETTE stated that some lawmakers wondered if the CDC mission had become too broad. According to the article, the lawmakers reasoned that if violence prevention research and AIDS education were cut, there would be more money for responding to infectious disease outbreaks. An April 3, 1996, article in USA TODAY, indicated that the CDC had "drawn criticism from those who believe the agency's scientists should stick to bugs and stay away from social issues." In response to those critics, Dr. Satcher reportedly said, "Public health is much broader than medicine." He continued, saying that public health has a wider goal of "keeping people healthy." The article indicated that Dr. Satcher said, "If what's wrecking people's health is 'a virus or bacteria, public health targets that problem. If the problem is human behavior, I think we have to target that problem . . . . Whether we're criticized or not, we have to follow the science.'"

Dr. Satcher, in the interview, noted that the CDC's work on violence prevention has been controversial. He said the NRA has been critical, saying the CDC favors gun control. Dr. Satcher denied that the CDC favored anything and said they do objective research without taking a position. He said their research concluded that easy access to firearms is a risk factor for youth violence. He said people may use their research to support one side or another, but that they only do the science. They are not trying to get a law passed. Dr. Satcher went on to state that even if science goes against your position, you have to respect the science. He said

violence and guns are political issues, therefore people will fight if research view. Dr. Satcher stressed that science should come before advocacy and c sometimes, if you move too fast to advocacy, people fail to hear the science. Notin[illegible] are laws regarding concealed weapons, including one place that requires them, Dr. Satcher [illegible] stated that they have not adequately looked at the issue of concealed weapons. He said people are not necessarily interested in researching this topic.

As to allegations that violence and guns are not public health issues, Dr. Satcher affirmed his statements about the effects of violence and guns on public health and relied upon statements by peer review groups, the New England Journal of Medicine and JAMA which also characterize violence and guns as public health issues.

Gun Control as Important as AIDS Prevention; Position Criticized by Lott, et al.

A June 28, 1995, article in the ATLANTA JOURNAL AND CONSTITUTION reported that Dr. Satcher was broadening the CDC's role in addressing violence. The article reported that Dr. Satcher said, "We are the national prevention agency. How do we prevent our children and teenagers from having access to guns and taking guns to school?" A January 26, 1994, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that Dr. Satcher said, "We feel that guns in the hands of teens in this country represent as much of a public health problem" as AIDS. A March 31, 1995, report in the ASSOCIATED PRESS stated that Dr. Satcher said that the government needed to "tighten regulation of weapons, particularly guns."

A January 29, 1996, article in the PITTSBURGH POST-GAZETTE indicated that "the National Rifle Association [(NRA)] and a small but vocal group of doctors have charged that the CDC's research on violence is biased against gun ownership." A May 2, 1996, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that the NRA, with support from "influential members of Congress," had "attacked the CDC's research on gun violence as propaganda for gun control." Another article in the May 2, 1996, ATLANTA JOURNAL AND CONSTITUTION noted that "Congressional defenders of gun ownership" accused the CDC of using this research as a "pretext for a campaign to make firearms socially unacceptable in America." An April 1997 article from the REASON FOUNDATION indicated that 10 Senators, including then-Majority Leader Bob Dole and current-Majority Leader Trent Lott, wrote, "This [firearm] research is designed to, and is used to, promote a campaign to reduce lawful firearms ownership in America." Dr. Satcher reportedly responded that this criticism "did not bode well for the country's future." He reportedly said, "If we question the honesty of scientists who give every evidence of long deliberation on the issues before them, what are our expectations of anyone else? What hope is there for us as a society?"

On May 4, 1996, the WASHINGTON TIMES reported, "Claims that the CDC mixes politics and science have escalated since it funded two studies . . . that showed there was a five times

greater risk of suicide and a three times greater risk of homicide in homes with guns." These studies reportedly drew fire from the NRA and top Senate Republicans, including then-Majority Leader Bob Dole (R-Kansas) and then-Majority Whip Trent Lott (R-Miss.), who called for reducing or eliminating funding for the CDC division responsible for the studies.

See above.

Satcher Comments on Universal Health Care and Public Health Issues Deemed "Too Political"

A September 16, 1994, editorial column in the ATLANTA JOURNAL AND CONSTITUTION indicated that Dr. Satcher had criticized the media as "too much interested in sensational stories, like the so-called flesh-eating bacteria that may affect only 100 people worldwide, and too little interested in dull-but-important health-related stories, like efforts to wipe out smallpox and polio." The editorial continued, "But in the course of his criticism, Dr. Satcher crossed into territory that will one day prove to be dangerous ground for the Centers for Disease Control. He urged journalists to keep up the pressure on Congress to reform health care and to tell the real story about how badly universal health coverage is needed. In his advocacy, Dr. Satcher is an inch away from hauling himself and his agency into the political arena. . . . Where there is no clear-cut physiological, biological, or environmental cause that can be isolated conclusively, as there isn't with much of the new agenda of the Centers for Disease Control, the agency leaves its franchise to play in the policymakers' park. . . . If the issue is how to eliminate smallpox or polio, Dr. Satcher's and his colleagues' expertise is beyond challenge. If it's how to deal with violence in America, their opinion may be no more useful than yours." A September 29, 1994, letter to the editor in the ATLANTA JOURNAL AND CONSTITUTION regarding the editorial stated, "I don't think the CDC considers anything as 'dangerous ground.' How else would one explain why the CDC would funnel $800,000 of taxpayers' money to underwrite a program for a homosexual group called the National Association of Black and White Men Together (BWMT)? One grant of $200,000 was partly used for what BWMT says are 'Hot, Horny and Healthy' workshops that include 'condom races.'"

Regarding the editorial, Dr. Satcher responded that it is always dangerous to criticize the media. He explained that this column came about after he met with the editorial boards of the Atlanta Journal and Constitution. He said his statement was not made to the public. Regarding the statement about universal health care, Dr. Satcher stated that he was saying the cost of health care was going up exponentially and that access to health care is one of public health's responsibilities. He noted that the National Institutes of Health definition of the responsibilities of public health are (1) leadership in policy; (2) assessment; and (3) assurance. He said the last responsibility includes access to care. Regarding the statements about violence, Dr. Satcher said the editor of the Atlanta Journal believes the CDC should stick with bugs and not get into violence and, therefore, has been critical of the CDC's work on violence.

After I read him the excerpt from the letter to the editor, Dr. Satcher responded that some people criticize any funding for gay groups. He did not recall the grants to BWMT or the workshops and "condom races" described in the letter. He said the U.S. Conference of Mayors often made those decisions to fund fringe groups. However, he would not rule out the possibility that the CDC made the decision. He stated that in 1994 the CDC decided they needed to do a better job getting information to high-risk groups and, therefore, would fund groups with good programs even if they did not agree with the group's overall aims.

Children's Vaccinations Program Criticized in GAO Report

Published sources indicated that the General Accounting Office (GAO) released a report in 1994 which criticized the federal childhood vaccination program. A July 20, 1994, article in the LOS ANGELES TIMES regarding the vaccination program, quoted Dr. Satcher as saying, "We will have in place all necessary systems to order, purchase and deliver vaccine in a safe and efficacious way. We are confident that we will be ready to go [on October 1, 1994]." Senator Dale Bumpers (D-Ark.) reportedly said that the Administration would be "foolish in the extreme" to proceed on schedule. A September 30, 1994, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that the GAO report criticized the CDC's lack of a formal system to track the vaccination program's cost and effectiveness. A November 15, 1994, ASSOCIATED PRESS report indicated ongoing criticism of the program. One Philadelphia doctor contended, "It's kind of a stupid program, not attacking the right issues." Dr. Satcher reportedly acknowledged that "there are still some things to iron out. But I think we're making significant progress."

A July 10, 1995, article in the INFECTIOUS DISEASE WEEKLY indicated that some members of Congress intended to dismantle the program "in view of a new report from the [GAO] who found that the program was misconceived and mismanaged." The article indicated that Dr. Satcher "clashed with critics at a hearing of the House Commerce Committee's Subcommittee on Health and the Environment," regarding the criticism found in the GAO report. A June 17, 1995, report on the PR NEWSWIRE stated there were "several sharp exchanges" during the hearing. According to the article, Representative Richard Burr (R-NC) asked Dr. Satcher how many additional children had been immunized through the program. Dr. Satcher reportedly replied, "I'm not going to play games, there's no way to know." The article further stated that Representative Scott Klug (R-WI) "also took the agency to task" over a CDC-sponsored immunization conference in Los Angeles. Representative Klug noted "that 13,500 children could have been immunized" with the money spent (more than 1 million dollars) to send 238 staff members to stay at the Beverly Hills Century Plaza Hotel for the five-day conference. The article stated that "even traditional supporters of the CDC, like Representative Ron Wyden (D-OR), expressed dismay at the program's disarray, saying that his confidence in the CDC 'was shaken' and that the mismanagement of the [vaccination] program was a 'prescription for failure.'"

Dr. Satcher stated that this program has been controversial, noting that he has gotten past four congressional hearings on the program (and did very well). He said vaccinations are at an all time high and noted that Senator Bumpers has been one of the strongest supporters of vaccinations. Dr. Satcher suggested that Senator Bumpers was hurt by not being consulted by the Administration in developing the program and that this might account for some of his criticism.

As to Representative Klug's criticism that the money used for the conference could have immunized 13,500 children, Dr. Satcher responded that the question is, "How many children were immunized because of it?" He explained that the conference was to bring together community leaders to increase the reach of the immunization program.

Injectable Polio Vaccine

A September 21, 1996, article in the INTERNATIONAL HERALD TRIBUNE indicated that the CDC had shifted from an oral polio vaccination to an injectable version for the first two doses of the four-dose regimen. The article stated that "a coalition of minority advocacy groups immediately criticized the policy shift. The groups said the increased cost and other differences between the two vaccines would leave thousands of disadvantaged children unprotected."

Gulf War Illnesses

Published sources indicate that Senator Tom Harkin (D-Iowa) and Dr. Satcher jointly released a study of illness associated with military service in the Persian Gulf War. A January 8, 1997, article in the FLORIDA TIMES-UNION stated that the study "blasted the Pentagon" for "inadequately investigating sick Persian Gulf war veterans." A February 23, 1997, article in the TELEGRAPH HERALD indicated that Senator Harkin stated, "While there still is much mystery associated with Gulf War illnesses, this study exposes one clear, inescapable truth - Persian Gulf War veterans are far more likely to suffer from a wide variety of illnesses than non-Persian Gulf veterans." A January 8, 1997, transcript of NATIONAL PUBLIC RADIO'S MORNING EDITION reported, however, that Dr. Satcher, who joined Senator Harkin at the press conference "did not agree with (Senator Harkin's) conclusion." The reporter stated that Dr. Satcher said "instead of relying simply on what veterans said over the telephone, the researchers really need to study people in doctors' offices in order to get convincing information." A January 8, 1997, AP WORLDSTREAM report quoted Dr. Satcher as saying, "In some ways, the complaints . . . are similar to what we've heard from veterans of other wars."

When asked about the Gulf War illnesses, Dr. Satcher noted the press conference with Senator Harkins, saying the purpose of the press conference was to release a CDC-University of Iowa study in which a telephone survey was conducted. The survey revealed that Gulf War veterans reported more illnesses than the general population, but did not show any single illness

or set of illnesses. Dr. Satcher said the complaints were similar to those heard from veterans of other wars. According to Dr. Satcher, the CDC is conducting clinical studies to follow-up on the results of the telephone survey and that those studies are in progress. Dr. Satcher specifically noted two studies in which the CDC was involved. One was a Mississippi study of birth defects which concluded that there was no significant difference in the incidence of birth defects in babies born to Gulf War veterans as compared to the general population. The second was a study by Dr. Bill Reeves (sp?) in Pennsylvania which compared the illnesses to Chronic Fatigue Syndrome. Dr. Satcher stated that he believes this is the extent of his public statements on the Gulf War Syndrome. He said he had followed the President's committee looking into the issue and commended their work, but said he had not spoken publicly about it.

Intelligence of Minorities

On March 29, 1995, the ASSOCIATED PRESS noted that the CDC was starting a federal program to help at-risk children develop better mental skills. The article reported that "the racial findings hold particular interest because of the controversy over whether intelligence is racially based," noting that the book The Bell Curve created a furor when it was published in 1994 by arguing that African-Americans score lower on IQ tests and that the difference controls their destiny. Dr. Satcher said, "It is important that we make every effort to put (these studies) into proper perspective." A co-author of the study said that "the new studies knock down arguments that race plays a bigger role than preventable socioeconomic problems."

A March 30, 1995, article in the TIMES UNION stated that two CDC-sponsored studies had concluded, "Children born to women who are poor, uneducated, black or Latino are more likely than others to be mildly retarded." The article said that the "federally funded studies confirm what many psychologists and social workers have been saying for years: Deprivation and social hardship can stunt human intelligence." The article stated that the studies "were attacked by others, who say the conclusions cannot be trusted, because they are racist and lead to discriminatory treatment of minority children." The article indicated that Dr. Satcher wrote an editorial accompanying the studies. Dr. Satcher reportedly wrote, "As America becomes more diverse, greater efforts need to be directed toward improving access to economic and educational opportunities and removing obstacles such as poor health and the possible effects of discrimination and racism." He concluded, "We believe much of the excess prevalence of mild mental retardation is preventable."

In the interview, Dr. Satcher stated that he has a history with the pediatrician who did the study (he is a friend of her family) and had heard about the research before he came to CDC. He said the CDC refused to release the study until he came to the CDC and looked into it. He stated that he decided the study, while somewhat controversial, was good science and could help prevent children from being labeled. He stated that the study showed that some mental retardation was preventable and could give an opportunity to improve the health of children.

Because he was sensitive to the issues raised in The Bell Curve, Dr. Satcher stated that he wrote an editorial to be released with the study to make clear what the study does and does not say.

Health Care for Undocumented Immigrants

A December 14, 1994, article in the DALLAS MORNING NEWS indicated that government health officials said that cutting off preventive medical services to undocumented immigrants "would increase everyone's risk of getting sick." The article quoted Dr. Satcher as saying, "To deny access to preventive services to people who are in this country means that we increase the risk for everybody in this country."

Dr. Satcher stated that he still believes that undocumented immigrants should receive medical services. He said public health is just that. Dr. Satcher said they should get treatment because we should not want undocumented immigrants to be the focus of some epidemic, but we also should want them to receive it so that they will not create an epidemic in non-immigrant or legal immigrant populations. However, he stated that he understands that it is difficult for states to carry the burden. Dr. Satcher stated that he does not believe he has made any public statements about this issue since 1994, noting that his only occasion for discussing it at that time was a trip to the Texas boarder in which the question was asked.

Personnel and Facility Problems at CDC

A June 15, 1995, article in the ATLANTA JOURNAL reported that an internal investigation process "began in 1993 with a scathing report on CDC staffing" from the Office of Personnel Management (OPM). According to the article, 100 of the 6500 CDC employees were overpaid. The article further stated that the OPM report "found 'a total breakdown of staffing operations' at the CDC and cited it for several hundred violations of federal personnel laws," including the "appointment or promotion of 'unqualified' employees and noncompetitive promotions of 'pre-selected' employees." The article noted that OPM's Regional Director said the CDC had corrected these violations. According to the June 16, 1995, HEALTH LINE, these personnel problems, including the overpayment of employees, "coincides with the CDC's public outcries over decaying laboratories that need replacing, and the need for a beefed-up national surveillance system to detect new and emerging diseases."

International Role of the CDC

A May 26, 1994, article in the BALTIMORE SUN stated that Dr. Satcher said that out of necessity; "the new definition of public health must be global," and that the "increased incidence of tuberculosis, the spread of the AIDS virus and growing violence are worldwide threats." In a June 28, 1995 article in the ATLANTA JOURNAL AND CONSTITUTION, Dr. Satcher reportedly said that the "CDC does not have a mandate for international health, yet whenever there's an

international health problem, we get called." A March 2, 1997 article in the NEW YORK TIMES, which dealt with newly emerging infectious diseases, quoted Dr. Satcher as saying, "There is no such thing as doing public health in isolation anymore. You can't stop public health efforts at the [borders] of the U.S. and still protect Americans."

Dr. Satcher stated that all public health is local, but must have a global perspective. He stated that people travel, organisms travel. For example, he pointed to the hepatitis A outbreak in school lunches. When asked about sending tobacco or other items deemed dangerous here to foreign countries, Dr. Satcher said this was a concern. He said we are not just protecting ourselves, foreign countries must protect against us. He did not know the regulatory scheme required to deal with tobacco and said it was not his area to deal with.

Women's Health Issues

An April 27, 1994, UNITED PRESS INTERNATIONAL report indicated that Dr. Satcher said, "We feel women's health has been neglected in many ways and we want to focus on dealing with that history of neglect." The article stated that Dr Satcher "blamed the neglect of women's health in part on the lack of women in the health professions." Dr. Satcher reportedly said, "In order to be successful, we need more women and minorities in leadership positions." An October 2, 1994, article in the CHICAGO TRIBUNE stated that the CDC planned "a special office to ensure that women's health issues get government attention." The creation of a special office was "part of a government response to criticism that women's health has been underfunded and ignored."

In addressing the neglect of women's health issues and the distrust of the minority communities, Dr. Satcher has proposed increasing the numbers of women and minorities in the health care professions. I asked Dr. Satcher about this in his interview. Dr. Satcher responded that he believes that the medical profession should reflect the population they serve. He said he encourages minorities (he specifically listed African-Americans, Hispanics and Native Americans) and women to become interested and involved in science and medicine. He believes integration is important. Dr. Satcher noted that during his tenure at CDC, he has appointed six center directors and that one-third of them have been women and one-third have been minorities. He believes there should be no discrimination.

Chronic Fatigue Syndrome

A May 3, 1996, article in the HOUSTON CHRONICLE indicated that the CDC had been "criticized in a current book about chronic fatigue syndrome." The article indicated that Dr. Satcher responded that "researchers have been unable to find any evidence that these problems are transmitted from one person to another" and noted the CDC's quick response in other situations like those involving the ebola virus and the hantavirus.

On Racial Issues in Nashville

On December 21, 1992, the COMMERCIAL APPEAL reported that the "a
a black police officer by fellow white officers . . . left Nashville pondering wh
the 'Athens of the South' ha[d] tarnished." The article quoted Dr. Satcher as sa
racism is a part of our society wherever I've been. I think as a nation, we still ha much to do. Nashville is probably better than some places I've been, but certainly we have a lot to do." The article reported that Dr. Satcher believed that the Mayor and Police Chief "responded appropriately and rapidly to last week's incident." Dr. Satcher said, "Now we've got to put these issues on the table and talk about it."

On September 7, 1992, JET reported on the Nashville City Council's approval to merge two of its hospitals, "eliminating one of the vestiges of a racially divided health care system." Dr. Satcher said, "This wasn't racial (sic) issue, but at best a financial issue . . . Common sense and good will have prevailed over racial division." Dr. Satcher further noted that, "[a]t a time of considerable pessimism about race relations in this county, this is a step worth noting . . . racial divisiveness makes as little sense politically and economically as it does morally."

Tuskegee Apology

On May 15, 1997, the GANNETT NEWS SERVICE reported that Dr. Satcher was "singled out" and "credited for quietly pushing for an apology" related to the Tuskegee Syphilis Study. The article quoted Benjamin Payton, President of Tuskegee University as saying, "The reality is this wouldn't have been brought to this point without the behind-the-scenes assistance of key individuals inside the Centers for Disease Control and the (U.S. Department of) Health and Human Services."

Dr. Satcher stated that he had a lot to do with the Tuskegee apology, but said a lot of other people did too. He said he had not gotten engaged with the question of the slavery apology. He explained that he became involved in the Tuskegee apology because the distrust resulting from the Tuskegee experiment still plays a role in health care. He said there were three things that he felt were important in the Tuskegee apology: (1) continuity of responsibility by the government and by the CDC (even though the study was conducted by another administration and a different CDC director, the current Administration and CDC director still bear the responsibility for the study, just as they get the credit for the good that happened such as the eradication of polio); (2) important to say that the study was wrong; and (3) important to show committed to seeing that it never happens again. Dr. Satcher stated that he would have to think through the slavery apology and come to a similar conclusion on it before recommending it. He said the President's commitment to race in a multiracial environment was a good move, saying it was needed regardless of whether there is an apology. He said it helps to have a dialogue and

that it is heading in the right direction. Dr. Satcher indicated that he would be more interested in working on what to do after an apology if there was one.

Meharry Accreditation

An article in the February 11, 1995, NEW YORK TIMES about Dr. Henry Foster noted that Dr. Satcher had preceded Dr. Foster as President of Meharry Medical College, leaving that post in 1993 to go to the CDC. The article further noted that Meharry had lost its accreditation in 1990 due to declining business at its teaching hospital. The article explained that this situation was addressed by the merging of the teaching hospital with the city-owned Metropolitan General Hospital.

Dr. Satcher stated that the merger will not be complete for another year, but that they have made progress toward accreditation.

Death of Hospital Patient

A July 31, 1993, article in the COMMERCIAL APPEAL stated that a female patient, age 69, disappeared from her hospital room at Meharry-Hubbard Hospital, where Dr. Satcher was then-President. Despite a search for the patient, it was not until sixteen days after she disappeared that her decomposing body was found in an undeveloped floor of the Hospital where she had fallen into a crevice. Dr. Satcher reportedly said that medical records showed the woman was treated properly and that there was no need for restraints to keep her in her room. He said, "It's possible to do everything right and still have things go wrong." A July 30, 1993 article distributed by the GANNETT NEWS SERVICE stated that members of the woman's family criticized the hospital for not protecting the woman and "for not conducting a thorough enough search of the hospital after she disappeared."

Dr. Satcher stated that this was a very painful experience which he carries with him. He said he does not know how the woman was able to disappear or how she was not found in the ensuing search. He said they brought in the police and others from outside the hospital, searched the floor where she was later found, etc. He said the elevator was not supposed to stop on that floor, but it apparently did on this occasion since the stairs were blocked and it was the only way to get to the floor. Dr. Satcher stated that this was an isolated incident and no such thing had happened before, but he said it should not have happened at all. However, Dr. Satcher said they reviewed the medical file and agreed that before the woman disappeared, there was no indication medically that she should have been restrained.

July 24, 1997

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: Satcher Nomination (5 pages)	09/02/1997	P2
002. paper	re: Satcher Nomination (4 pages)	n.d.	P2
003. paper	re: Questions and Answers for David Satcher (2 pages)	n.d.	P2
004. paper	re: Questions for Dr. Satcher (7 pages)	n.d.	P2

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings
OA/Box Number: 14654

FOLDER TITLE:
Surgeon General Nomination [3]

Racheal Carter
2011-0747-S
rc857

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

September 2, 1997
b:sglst9.2

CONGRESSIONAL OUTREACH LIST FOR SATCHER NOMINATION

- Public Liaison
- Personnel
- Counsel

(1) Leadership

- Majority Leader Lott (R-MS)
  Minority Leader Daschle (D-SD)
  Republican Conference Secretary Coverdell (R-GA)

- Speaker Gingrich (R-GA)
  Minority Leader Gephardt (D-MO)

(2) Senate Committee Leadership

Cochran

- Senator Jeffords (R-VT)
- Senator Kennedy (D-MA)
- Senator Specter (R-PA)
- Senator Harkin (D-IA)

(3) Home State Congressional Delegations

- Senator Frist (R-TN)
- Senator Thompson (R-TN)
- Representative Gordon (D-TN), Dean of Delegation
- Representative Tanner (D-TN)

- Senator Coverdell (R-GA)
- Senator Cleland (D-GA)
- Speaker Gingrich (R-GA), Dean of Delegation
- Representative McKinney - represents nominee's home district

- Senator Shelby (R-AL)
- Senator Sessions (R-AL)
- Rep. Callahan (R-AL), Dean of Delegation
- Rep. Bob Riley (R- AL) - represents nominee's town of birth

(4) House Committee Leadership

House Ways and Means Committee

- Representative Charles Rangel (D-NY)
- Representative Bill Archer (R-TX), Chairman
- Representative Pete Stark (D-CA)
- Representative William Thomas (R-CA), Chairman

House Commerce Committee

- Representative John Dingell (D - MI)
- Representative Thomas Bliley (R-VA), Chairman
- Representative Sherrod Brown (D-OH)
- Representative Michael Bilirakis (R-FL), Chairman

House Appropriations Subcommittee on Labor, HHS

- Representative David Obey (D-WI)
- Representative John Edward Porter (R-IL), Chairman
- Representatives Stokes (D-OH)

House Government Reform and Oversight

- Representative Waxman (D-CA)
- Representative Towns (D-NY)
- Representative Shays (R-CT), Chairman

(5) Other Senate Labor Committee Members

- Senator Coats (R-IN)
- Senator Gregg (R-NH)
- Senator DeWine (R-OH)
- Senator Enzi (R-WY)
- Senator Hutchinson (R-AK)
- Senator Collins (R-ME)
- Senator Warner (R-WA)
- Senator McConnell (R-KY)

- Senator Dodd (D-CT)
- Senator Mikulski (D-MD)
- Senator Bingaman (D-NM)
- Senator Wellstone (D-MN)
- Senator Murray (D-WA)
- Senator Reed (D-RI)

(6) Other Supportive Members

- Senator Bumpers (D-Ark.)
- Senator Byrd (D-WV)
- Senator Cochran (R-MS)
- Senator Bond (R-MO)
- Senator Stevens (R-Alaska)
- Senator Inoyue (D-Hawaii)

- Rep. Pelosi (D-CA)
- Rep. Linder (R-GA)
- Rep. Hoyer (D-MD)
- Rep. Lowey (D-NY)
- Rep. Delauro (D-CT)
- Rep. Miller, Dan (R-FL)
- Rep. Sanders (I-VT)
- Rep. Dickey (R-Ark)
- Rep. Morella (R-MD)
- Rep. Coburn (R-OK)

TIMELINE BEGINNING THE DAY OF THE ANNOUNCEMENT

The following is a proposed time line that begins the day of announcement of the intent to nominate.

ANNOUNCEMENT DAY (A = DAY)

WH Announcement

- Key Press Statements from outside validators - AMA, Family Physicians, etc.
- Press conferences held by key Congressional supporters.
- Press statements from key members of Congress - leadership, Senator Labor Committee members, Tennessee and Georgia delegations

Begin Senate Process

- Send questionnaire to the Hill
- Send courtesy visit letters to the Hill
- Call to schedule visits

A DAY + 1

- Senate Floor - statements during morning business
- House floor - one minutes statements
- Courtesy Visits - with Leadership, Jeffords, Kennedy.
- Key outside groups hold Press Conference - AMA, Family Physicians, etc.

A DAY + 2

- Nominee meet with TN Congressional Delegation - Press availability
- Nominee meet with CBC - Press Availability?
- HBCU Presidents - Press Conference
- Courtesy Visits continue

Dr. Satcher

Satcher Nomination
Press Plan

Chris - Satcher has not seen this - we can discuss later -

I. Audiences

A. Senate Labor Committee members

B. Senators

C. General Public

II. Key Message

A. Dr. Satcher is the best man for the job. He is a well known, mainstream public health professional, with experience in medicine and management.

III. Initial Media Strategy

A. Announcement date that highlights his position as a successful CDC Administrator. Possible combination with annual vital statistics report. (See attached calendar for possible dates.)

B. Daily press availabilities with supportive Senators, possibly other key supporters (AMA, etc.) followed by a "no interview" policy as he resumes his duties at CDC.

C. Media opportunities determined primarily by CDC-related press opportunities. Surrogates to take lead role on nomination-related questions whenever possible.

D. Regional and minority press strategy to be determined with ASL.

Satcher Nomination
Key Dates

NOTE: Scheduling CDC vital statistics report requires three days advance notice

September 9 Possible announcement date

September 10 Possible announcement date
NIH adolescent survey released

September 11 Possible announcement date
MMWR: AIDS surveillance (T)
MMWR: 1995 teen pregnancy data (state by state) (T)
MMWR: Minority immunization rates for 1996 (T)

September 12 Satcher/Congressional Black Caucus meeting (?)
Administration tobacco announcement (T)

September 15 Anti-immunization activists in DC

September 17 ACT-UP needle exchange protest

September 18 Satcher speech to National Sickle Cell conference - Washington, DC
MMWR

September 25 MMWR

September 26 Satcher speech to ASTHO - Phoenix, Arizona

September 27 Satcher speech to LA Pediatric Society - San Diego, California

September 29 Satcher to attend National Business and Labor Awards for Leadership on HIV/AIDS

NOTE: Nomination-related press events:

A-1 All surrogate statements complete in case of leak

Announcement Day – Satcher statement at announcement event

A + 1 Satcher press availability with Senate supporter(s) or key groups after courtesy visit

A+2 Satcher press availability with TN delegation or CBC after courtesy visit

Satcher Nomination
Key Decisions

Announcement Date

Surrogates*

Role of CDC public affairs staff

Key talking points (with ASL)

Key Validators (with ASL)

* Surrogate possibilities include Secretary Shalala; Claire Broome, CDC; Helene Gayle, CDC; Rahm Emanuel; Bruce Reed; Chris Jennings; Dr. Bill Foege, Emory University; Dr Robert Graham, AAFP; Dr. Lonnie Bristow; Mr. Alfred Haynes.

~~Dr Satcher~~
Surgeon Nomination
NTBK

Questions and Answers for Dr. David Satcher's nomination as Surgeon General and ASH.

1. Q What are your views on needle exchange? What is the Department's current position?

A: I believe that to realize our goal of effective HIV prevention, it is vital that we identify and evaluate sound public health strategies to address the epidemics of HIV and substance abuse.

I support the Administration's position on needle exchange, which was summarized in Secretary Shalala's February,1997 report to Congress. That report concluded that needle exchange programs "can be an effective component of a comprehensive strategy to prevent HIV and other blood borne infectious diseases in communities that choose to include them."

I also share the Administration's position on federal funding of NEPs. As you know, currently there is a Congressionally imposed ban on federal funding for needle exchange programs unless the Secretary determines that certain conditions have been met.

Although the Department continues to look at the issue, the Department has not yet concluded that the conditions set forth by Congress have been met. We will continue to support research into this question and work with Congress on this important issue. However, local communities remain free to use non-Federal funds to support such programs if they so choose.

I believe that we should continue to support and review research. In the meantime, it is appropriate for local communities to take the lead on needle exchange programs.

Let me also say that I fully support the Clinton Administration's position to prevent the use of illicit drugs, prosecuting drug pushers, reducing the number of hard-core drug users, and increasing drug treatment options.

2. Q: But didn't you in 1993 support lifting the ban on federal funding?

A: I believe you are referring to a CDC staff paper reviewing a University of California study that I forwarded to the principal deputy assistant secretary for health, at her request, in December, 1993. That report was an attempt to review and summarize research initiated by the previous Administration and funded by CDC and others.

Although the staff paper recommended lifting the ban on federal funding, my cover note specifically states that the paper **did not** receive final concurrence of the National Institutes of Health, the Substance Abuse Mental Health Services Administration, the Health Services and Resources Administration, and the Food and Drug Administration.

I believe strongly that, in addressing the epidemics of HIV transmission and substance abuse, we should be guided by what science tells us. And, as Surgeon General and Assistant Secretary for Health, I would not recommend a change in the Administration's policy in the absence of a scientific consensus from the key public health agencies .

It is also important to note that the CDC staff paper acknowledges that "it is extremely difficult to quantitatively assess the impact of NEPs on community drug use" -- one of the key tests imposed by the Congress.

While the studies summarized in Secretary Shalala's February, 1997 report showed that needle exchange programs can be an effective HIV prevention strategy, the Administration has not yet found a similar degree of evidence on the question of whether such programs encourage drug use. Therefore, both tests - as mandated by Congress -- have not been met. However, local communities remain free to use non-Federal funds to support such programs if they so choose.

Q. Does this mean you disagree with the CDC staff paper?

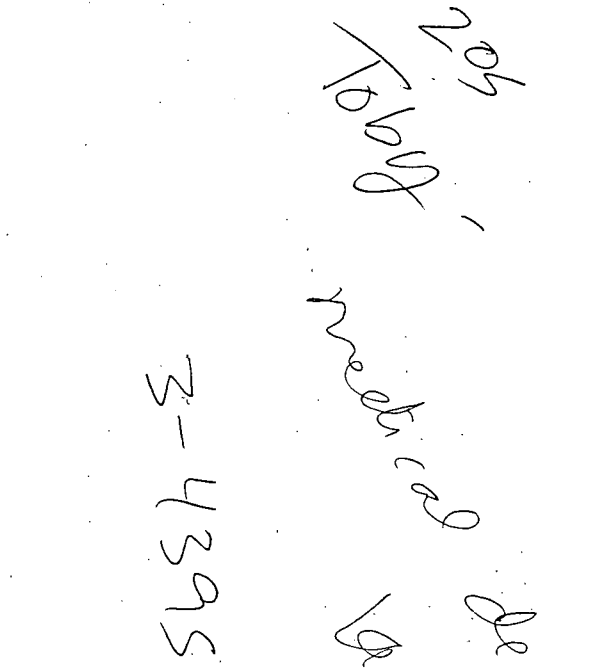
A: This is a very complex issue on which there have been numerous studies. Some of these studies were summarized in the Secretary's report to Congress and some are ongoing. In the existing body of research there is more evidence and more consensus that needle exchange programs are effective in preventing the spread of HIV than on whether such programs encourage illicit drug use. We will continue to support research into this question.

Friday->

Tobacco meeting
Friday

Tue/Weds

6-



Questions for Dr. Satcher

Needle Exchange

Why did your report -- released by AIDS activists in 1993 -- suggest that we remove the ban on federally funding needle exchange programs when there was not sufficient evidence to conclude that these programs did not increase drug use?

What do you believe the Administration should do with regard to federally funding needle exchange programs now?

Gun Control

You have expanded CDC's emphasis on guns as a public health problem. Many, including Majority-Leader Trent Lott, have argued that this research is designed to advocate for greater gun control. Do you think in this campaign that CDC has overstepped the boundaries between science and politics?

What is your position on gun control? What should the Administration be doing to reduce this public health problem?

Sex Education

How can you say that you believe that the primary emphasis in sex education should be abstinence when you have stated that you support condom distribution in schools and "whatever is effective in dealing with problems like teenage pregnancy and AIDS"?

Other Possible Issues

Controversy over HIV Testing of Newborns without Notification Results
Critics have stated that testing newborns for HIV and not informing their parents of the results is analogous to the Tuskegee studies. How can you justify not telling families about the HIV status of their infants?

Tobacco
How far should this Administration/Congress go to limit tobacco?

ILLICIT DRUGS

CHARGE:

Hasn't CDC participated in and even sponsored conferences that promote the legalization of illicit drugs? Aren't Dr. Satcher's views inconsistent or ambiguous at best when it comes to drug legalization?

RESPONSE:

No. Let me be clear on this. Dr. Satcher has zero tolerance for illegal drug use and is adamantly opposed to the legalization of marijuana or any other drug..

Regarding the confusion around CDC participation in March of 1996 in a locally sponsored "Harm Reduction Conference" at Emory University, let me clarify. Although CDC only participated in the local meeting by providing epidemiologic information about HIV and AIDS among injecting drug users, one of the meeting planners released information that was inaccurate, incomplete, and misleading. Once CDC became aware of the misrepresentation and was provided a copy of the material, CDC requested that authors immediately agree to withdraw their false statements and they did.

regarding CDC's views on needle exchange??

BACKGROUND

CDC has participated in meetings that deal with sterile needle exchange programs as part of an overall strategy to reduce the transmission of HIV/AIDS. As the principal agency charged with the responsibility to protect Americans from the spread of HIV and other blood borne infectious diseases, CDC has also supported local community efforts to design prevention programs that address the transmission of HIV among intravenous drug users. However, CDC does not fund needle exchange programs. The intentional use of drugs is wrong and it is a major public health problem as well as a law enforcement concern.

The Administration is strongly on record opposing the legalization of illicit drugs including marijuana. In fact, the Administration has gone to great lengths to oppose Proposition 215 in California and Proposition 200 in Arizona. It is the Administration's and the Department's belief that these wide-ranging initiatives seriously compromise local, state, and federal strategies for public health, drug prevention and treatment, and law enforcement.

unclear from this Q+A what person in this Admin is willing to clearly answer question

~~Does Dr Satcher believe needle exchange~~

Needle exchange should follow this. question

MARIJUANA

CHARGE:

Hasn't CDC sponsored or participated in conferences or research that support the legalization of marijuana?

RESPONSE:

No. CDC has not participated in or sponsored meetings or research directed at the legalization of marijuana. And let me be clear - the Administration opposes the legalization of marijuana or any other drug.

CDC has participated in meetings to review the scientific findings on the medicinal use of marijuana and concurs with NIH that at present there is no scientifically sound evidence that smoked marijuana is superior to currently available therapies for symptoms or treatment side-effects associated with glaucoma, AIDS, cancer or multiple sclerosis.

Until the science indicates the superiority of smoked marijuana to current therapies, Dr. Satcher shares the department's strong opposition to its use as a prescription drug due to the known harmful effects it has on the brain, heart and lungs, the impairment its use causes to learning, memory, perception, judgment and complex motor skills and the known carcinogens the patient would be exposed to during treatment.

In participating in such meetings, CDC is simply fulfilling its responsibility to the American public to ensure that treatment decisions are based upon the best evidence that emerges from the scientific process.

BACKGROUND

A recent independent review conducted for the National Institutes of Health concludes that further study of the medical use of marijuana may be warranted. NIH is reviewing these recommendations.

Regarding the confusion around CDC participation in March of 1996 in a locally sponsored "Harm Reduction Conference" at Emory University, let me clarify. Although CDC only participated in the local meeting by providing epidemiological information about HIV and AIDS among injecting drug users, one of the meeting planners released information that was inaccurate, incomplete, and misleading. Once CDC became aware of the misrepresentation and was provided a copy of the material, CDC requested that authors immediately agree to withdraw their false statements and they did.

AZT TRIALS

CHARGE:

The CDC funded clinical trials of AZT in developing countries in which some HIV infected women were given AZT, but others were given a placebo. This is no different than the infamous Tuskegee study, in which treatment was knowingly withheld from African-American men who had syphilis.

RESPONSE: * state up front the ethical justification for doing this.

These studies --which are funded by NIH and CDC -- are scientifically well-founded, ethical and essential to conduct. In June 1994, a group of international experts convened by the World Health Organization thoroughly reviewed the tests and concluded they were essential and the best way to proceed. ~~Since that time, the studies proposed to meet this need have been evaluated and~~ Since then these studies have been reviewed by the ethical committees of not only the U.S. and European institutions involved but, in every case, by an ethical committee from the countries in which the studies are carried out.

For those reasons, the NIH and the CDC, as well as public health authorities throughout the world and in the countries hosting this research, believe these studies offer the only scientifically valid and ethically acceptable means of developing and evaluating a feasible, effective therapy for these countries. X delete repetitive

We have conducted an extensive review of the process of scientific development and ethical assessment applicable to these trials. The women in the study are fully informed of the nature of the studies. Because of poor economic conditions and low standards of public health care in the participating countries, the women in the studies infected with HIV are not able to afford the considerably more expensive protease inhibitors now available in the United States, and would otherwise have not received treatment. It must not be forgotten why the studies are taking place -- to find a simpler, less costly treatment that can be made available in these developing countries.

Can you clarify
Were the studies done explicitly to deal w/ issues ~~not this~~ of therapy in third world countries.
That is what this seems to suggest. But that's not what we thought?
P.S. Clarify.
we thought studies would not impact people in these countries

CONDOMS

CHARGE:

The CDC is promoting the distribution of condoms in our schools. Why are federal dollars being spent to encourage promiscuous sexual activity among our nation's youth?

RESPONSE:

First and foremost, we strongly believe that abstinence is a key strategy to prevent teen pregnancy. We believe that communities, schools, and parents - not Washington - are best able to determine the needs of children, and that communities must be allowed to design programs that are right for them. But it is simply not acceptable – emotionally, physically, and financially – for young teens to be having sex and having children. We must all send the strongest possible message to teens, as the welfare law signed by President Clinton does, that postponing sexual activity, staying in school, and preparing for work are the right things to do.

To back up this message, as part of our National Strategy to Prevent Teen Pregnancy, we are engaging all of our teen pregnancy prevention and related youth programs in sending a strong abstinence message to teenage boys and girls. In addition, the new welfare law provides $50 million a year in new funding for state abstinence education activities, beginning in FY 1998. All 50 states have applied for this program and will receive funding early in the next fiscal year. Already we are starting to see teen birth rates coming down. Since 1992, teen birth rates have declined by ten percent.[1] ~~Although the reasons for the good news are complex, the recent declines in teen birth rates~~ indicate that public and private-sector programs may be having some success. ~~Since 1993, we have worked to forge a consensus about the importance of both personal responsibility and community~~ involvement. [Note: Statistics not yet released by CDC as of 9/3/97]

But despite the recent decline in the teen birth rate, teen pregnancy remains a significant problem in the nation. Approximately 600,000 teenagers aged 18 and under already have at least one child and each year another 200,000 give birth.[1] For many of these teens, who are sexually active, community based education programs and access to contraceptives can reduce pregnancy rates, STDs and AIDS. While CDC does not directly fund the distribution of condoms, it does provide financial and technical support to every state education agency to plan and implement programs that local officials determine are right for them.

Follow up: Does Dr Satcher believe condoms should be distributed in schools?

[1] Ventura SJ, Mosher WD, Henshaw S. Unpublished tabulation.

GUN VIOLENCE

CHARGE:

(NCIPC)

Dr. Satcher and his National Center for Injury Prevention and Control are promoting a political agenda against gun ownership through wasteful and scientifically biased studies.

RESPONSE:

The CDC does not promote gun control. Its National Center for Injury Prevention and Control simply carries out a mandate to collect data relating to all types of injuries, including accidents, fires and acts of violence.

Former President Bush established the NCIPC in hopes that, just as the federal highway fatality reporting system helps to reduce automobile accident deaths, better information about all types of accidents would lead to improved policing as well as better education and prevention programs that would reduce the number of such incidents.[1]

The NCIPC collects its data through scientific research that is peer-reviewed to ensure its scientific integrity. The budget of the NCIPC amounts to only $49 million a year, which is only about 2 percent of the overall CDC budget ~~of $2.5 billion~~. And of that $49 million, only about $7.5 million is spent on research concerning youth violence, and only 1[illegible]% of that $7.5 million in research deals with firearm-related violence.[2]

10.6%

a bit defensive

can we say a little bit about what NCIPC does that is good--and not controversial

The majority of this program goes to fund:

Follow up question Does Dr Satcher believe ~~the~~ Admin should do more to promote gun control?

[1] CDC Press Office, press release, "National Center for Injury Prevention" June 25, 1992.

[2] U.S. Office of Management and Budget, Budget Request for Fiscal Year 1998.

Questions for Dr. Satcher

Needle Exchange

Why did your report -- released by AIDS activists in 1993 -- suggest that we remove the ban on federally funding needle exchange programs when there was not sufficient evidence to conclude that these programs did not increase drug use?

What do you believe the Administration should do with regard to federally funding needle exchange programs now?

Gun Control

You have expanded CDC's emphasis on guns as a public health problem. Many, including Majority-Leader Trent Lott, have argued that this research is designed to advocate for greater gun control. Do you think in this campaign that CDC has overstepped the boundaries between science and politics?

What is your position on gun control? What should the Administration be doing to reduce this public health problem?

Sex Education

How can you say that you believe that the primary emphasis in sex education should be abstinence when you have stated that you support condom distribution in schools and "whatever is effective in dealing with problems like teenage pregnancy and AIDS"?

Other Possible Issues

Controversy over HIV Testing of Newborns without Notification Results
Critics have stated that testing newborns for HIV and not informing their parents of the results is analogous to the Tuskegee studies. How can you justify not telling families about the HIV status of their infants?

Tobacco
How far should this Administration/Congress go to limit tobacco?

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: Dr. David Satcher (20 pages)	n.d.	P2
002. list	re: contact information (partial) (1 page)	08/08/1997	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 14654

FOLDER TITLE:
Surgeon General Nomination [4]

Racheal Carter
2011-0747-S
rc610

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Privileged and ~~Confidential~~

DR. DAVID SATCHER
Candidate for Assistant Secretary for Health and Surgeon General (PAS)
Department of Health and Human Services

Dr. David Satcher has been the Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR) since November 1993. He was previously vetted by this office in July 1993. [1]

Dr. Satcher is extensively published in a wide variety of professional and popular journals and periodicals. [2]

Condoms in Schools

A November 20, 1996, article in the ABORTION REPORT indicated that Dr. Satcher praised a report on Sexually Transmitted Diseases (STDs) by the National Academy of Science's Institute of Medicine. The article stated, "The report's recommendations are 'certain to spark debate' about the role of schools in sex education, disease prevention and treatment. The study said schools should offer 'age-appropriate' education and clinical services to help prevent, diagnose and treat students infected with STDs." The study also said that while schools "should emphasize abstinence, they should also provide condoms." A September 26, 1993, article in the NEW YORK TIMES indicated that Dr. Satcher said "he is comfortable with whatever is effective in dealing with problems like teen-age pregnancy and AIDS, including new Surgeon General Jocelyn Elders' support for condom distribution in schools." The article quoted Dr. Satcher as saying, "My attitude is that we really have to provide people in this country with the information they need to protect themselves from this virus. And we can't let political, cultural or religious differences interfere with that."

In the interview, Dr. Satcher stated that with regard to teens, the first step should be sex education to stress the importance of sex and relationships and to emphasize abstinence. To support people who choose abstinence, Dr. Satcher recommends programs such as peer counseling so that teens who choose not to be sexually active will not feel isolated. However, for teens that are sexually active, he feels strongly that they should be protected and should,

---

[1]This is an update of an earlier public record vet written in 1993. Please see attached for additional issues and biographical information. Please note that this is a limited review of the public record for articles and other items mentioning Dr. Satcher and not a comprehensive review of issues involving the CDC during his tenure as its Director.

[2]Dr. Satcher's writings were reviewed, and are the subject of a separate memorandum prepared by, the Domestic Policy Council. His speeches and other writings are being reviewed by HHS.

therefore, be shown the proper use of latex condoms. Dr. Satcher noted that he is a father and that he feels this way professionally and personally. Dr. Satcher stated that this approach is not judgmental. He said they work with local communities and encourage more focus on funding local community groups. However, he said the CDC does not fund programs that only provide one prong of their two prong approach (abstinence and protection). He stated that they will not fund programs that discriminate against people who are sexually active.

Satcher Produced Televised Announcements Featuring Condoms

Many articles criticized the CDC and Dr. Satcher for producing and defending a series of televised public service announcements regarding condoms and the transmission of HIV which were eventually taken off the air by Health and Human Services (HHS) Secretary Donna Shalala. A December 7, 1993 article in USA TODAY quoted a CDC spokesman as saying the announcements would "be very different than anything you've ever seen before." The article indicated that Dr. Satcher was "very much in favor" of the plan for more explicit and targeted announcements. The article quoted Dr Satcher as saying, "We've got to be more aggressive. What are we going to tell our children and grandchildren when they ask us why we allowed political, cultural and religious differences to prevent us from attacking this problem." According to the article, Dr. Satcher further argued that fighting AIDS meant "talking frankly about drugs, sex and condoms." A January 4, 1994, transcript from a CNN newscast indicated that previous AIDS prevention announcements had been criticized "for being too vague about barrier protection for sexual intercourse." The transcript went on to say, "Many of the new spots are frank, but not particularly graphic." The transcript indicated that Dr. Satcher said the new ads struck a proper balance "between sensitivity about sex and the public's need to know about protection." A January 31, 1994, article in the ARIZONA REPUBLIC stated, "The problem is, some of [the announcements] are utter trash. So trashy, in fact, that the intended message is not communicated." The article reported that the announcements were eventually pulled off the air by HHS Secretary Shalala. A February 1, 1994, article in the INSIDE REPORT ON AIDS indicated that Dr. Satcher said that the "uproar over the CDC's recent condom message deflected attention from the campaign's equal emphasis on abstinence." The article quoted Dr. Satcher as saying, "Message number one is abstinence. That's good science. But our surveys tells [sic] us that only 20% of those between ages 18 and 25 are not having sex. So message number two says if you are sexually active, use latex condoms. They work. Unfortunately, the first message got lost in the uproar over the second message."

Dr. Satcher stated in the interview that he does not recall the Secretary ever pulling any public service announcements by the CDC. He stated that during his tenure all ads were approved by the Secretary before being aired. He suggested that these ads might have been produced prior to his becoming the head of the CDC. Dr. Satcher said the only controversy he recalled was an incident relating to an ad which was going to feature the Red Hot Chili Peppers. He said that ad was pulled prior to air because it became known that there was some scandal

relating to the artist (he believed it was something to do with domestic violence or sexual assault). As to the comment about favoring more explicit and targeted announcements, Dr. Satcher did not recall the comment. He said he does favor targeted ads, but was not sure what was meant by more explicit. He noted that he does believe ads should include homosexuals, which some people do not want to include, but he does not think sex should be shown no matter what the sexual orientation.

CDC Criticized for Insufficient Emphasis on Abstinence

An April 3, 1996, article in USA TODAY, reported that Dr. Satcher said, "[O]ur [sex education and AIDS] programs deal with abstinence. But we also must deal with the fact that for those people who are sexually active, they need to know how to protect themselves from [infection with the HIV] virus. There are those people because of their religion or politics who might disagree with that and say we should only be talking about abstinence. Well, that's almost like saying we don't really care about those people who are active. We can't afford to take that attitude." A February 1, 1997, article in the TULSA WORLD stated that Representative Tom Coburn (R-Okla.), a physician, charged that the CDC had "missed the mark in the fight against sexually transmitted diseases" and argued that the agency's message on condoms "falls far short of what it should be" because it "fails to emphasize that while condoms can offer protection from certain disease, they leave users at risk for others." Representative Coburn reportedly said that the CDC did not emphasize sexual abstinence enough and that "[y]ou can't be irresponsible sexually and get away with it." According to the article, Representative Coburn suggested that the agency lacks a "real world perspective."

Dr. Satcher stated that he and Representative Coburn have mutual respect for each other and says Representative Coburn was supportive of him and his candidacy, even though they disagree. He said they have similar basic ethics, but that they have different backgrounds and this difference accounts for their different views. Dr. Satcher said he thinks it is the right response to make it clear that condoms are not 100 percent effective against STDs, but he believes they have a role in containment. See discussion above for more regarding abstinence.

Proponent of Sex Education in Schools

A February 18, 1995, article in the CHAPEL HILL HERALD quoted Dr. Satcher as saying, "I think we ought to be very aggressive in helping teen-agers deal with the challenge of teen-age pregnancies." He further stated that teen-agers "should also be targeted for AIDS prevention" because "[t]hey are making some sex decisions which are in fact deadly choices." A October 1, 1994, article in EDITOR AND PUBLISHER MAGAZINE stated that Dr. Satcher reported that the CDC "found that young people who receive sex education early on are less likely to be sexually active early and much less likely to engage in high-risk sexual behavior." Given these statistics, Dr. Satcher said "the opposition to sex education in this country is astounding." A May 21, 1994,

article in the ETHNIC NEWSWATCH stated that Dr. Satcher explained that AIDS could be prevented but "[w]e are busy fighting against sexuality education in our schools and against making condoms easily available to sexually active persons."

See above.

CDC Criticized for AIDS Education for Heterosexuals

A May 16, 1994, transcript by the FEDERAL NEWS SERVICE of a National Press Club luncheon at which Dr. Satcher spoke indicated that Dr. Satcher was asked about the spread of AIDS to "the general population." Dr. Satcher responded that "we have reason to feel that we're making some progress in this country in terms of the spread of AIDS. We believe that the epidemic, based on the last few years, is tapering off." He indicated, however, that "the fastest-growing group of persons in this country diagnosed with AIDS in recent years have been women. . . . And so [the prevalence of the disease is] becoming more heterosexual. And the type of education that we need for our teenagers especially is the heterosexual education. I think to a great extent the gay community has done a pretty good job of curtailing this problem in some communities. . . . We've got to be more targeted with our programs." A May 2, 1996, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that the CDC "denied allegations that, to get federal funding for AIDS programs, the CDC exaggerates the threat of AIDS to heterosexuals." The article stated that a WALL STREET JOURNAL article reported that the CDC deliberately overstated the risk of heterosexual AIDS and failed to direct the bulk of its AIDS funding toward the highest-risk populations: gay men and intravenous drug users. A May 3, 1996, article in the HOUSTON CHRONICLE, stated that Dr. Satcher "felt the agency made the right decision in targeting the general population with information about AIDS even though gays and intravenous drug users are the most affected." Dr. Satcher reportedly said, "How does a woman know her mate is not bisexual or an intravenous drug user."

Dr. Satcher stated that he wrote a letter responding to the Wall Street Journal article, as did Dr. Koop and others. He said recent numbers show that the WSJ was wrong. Dr. Satcher said he believes the reason America has been more successful than other countries in addressing the AIDS epidemic is because the approach was to address all people. He said the message was to be careful even though engaging in heterosexual relationships. Dr. Satcher said he stands behind this approach and noted that people take sex much more seriously today than they did 10 years ago. He also reiterated the statement about a woman not knowing if her partner is an intravenous drug user or otherwise at risk for AIDS. However, Dr. Satcher stated that all this does not mean that certain groups with higher risk should not be targeted. He said these high risk groups can be targeted while still educating the general population.

Criticized for Study of Unlicensed AIDS Drugs in Africa as "Double Standard"

On May 9, 1997, the PLAIN DEALER reported that Dr. Satcher, at a hearing before the House Government Reform and Oversight subcommittee, defended a study of unlicensed drugs for the treatment of AIDS, which was conducted by the CDC in Africa, against criticism that it "employ[ed] a 'double standard' in poorer countries." The article indicated that the study was set up such that HIV-infected mothers in Cote d'Ivoire, Ethiopia and South Africa were given new and promising drugs while women in the control groups were given placebos, rather than "a successful antiviral drug AZT, as they would in the United States." Dr. Satcher reportedly argued that the study was proper because the control group was being treated according to "the realities of the 'accepted standard of care' in poor countries," noting the "'cost and complexity' of giving AZT in developing countries where it is not generally available." However, according to the article, Sidney Wolfe, Health Research Director of Public Citizen, argued that this policy "exposes newborns in Africa, Asia and the Caribbean to unnecessary deaths from their mothers' HIV infections." He was quoted as saying, "In essence, U.S.-funded researchers are conducting experiments abroad that would never pass ethical muster in the U.S."

In our interview, Dr. Satcher stated that this study was done according to World Health Organization (WHO) recommendations. He explained that earlier studies had been done which concluded that a certain AZT regimen was the preferred course of action for pregnant women who are HIV positive. However, WHO complained that while this regimen was good for the U.S., it was not feasible in third world nations where prenatal care is virtually non-existent and people cannot afford such expensive drugs. Therefore, this study was an effort to find something that could work in these undeveloped nations. He explained that there was no reason to do a study which they could not use in the future. He further noted that they have a relationship with these countries which has developed over the years. As to Mr. Wolfe, Dr. Satcher stated that he was a friend, although they disagree on this issue.

HIV Prevention Progress Disputed

On July 13, 1994, the ORANGE COUNTY REGISTER reported that Representative Gerry Studds (D-Mass.) challenged Dr. Satcher's assertion that there had been progress in preventing HIV infections. Dr. Satcher was quoted as saying, "I happen to believe that the fact that the numbers are not going up suggests that we probably are making some progress with our community (prevention) programs." Noting that the number of young people with HIV was increasing despite a "dip" in the numbers of adult, homosexual men infected, Representative Studds reportedly "retorted" to Dr. Satcher's statement by saying, "Do you really believe that? Every number I've ever seen, every community that we're concerned about, has increased."

Satcher's Response to Theory On AIDS Transmission By Potentially Contaminated, Experimental Hepatitis B Vaccine

On June 26, 1997, the BUSINESS WIRE reported that Dr. Satcher withdrew his invitation to meet with Dr. Leonard Horowitz, author of Emerging Viruses: AIDS and Ebola--Nature, Accident or Intentional? to discuss AIDS as a possible outcome of contaminated vaccines. The "controversial" book purportedly "documents [the fact that] the CDC and Food and Drug Administration (FDA) helped manufacture a vaccine that might have transmitted AIDS worldwide." The article stated that "[i]n an official letter to Dr. Horowitz in which he withdrew his invitation to meet, Dr. Satcher stated the 'CDC believes that scientific evidence is the foundation for sound public health policies' and that Dr. Horowitz's allegations 'do not appear to be based on credible, evidence-based information.'" The article also stated, "Regarding Dr. Satcher's inability to see any 'credible evidence-based information' in Dr. Horowitz's writings, the author replied, 'If he did, he would also see himself and his agency are now fully exposed. And since rumor has it that President Clinton is considering Dr. Satcher for the Surgeon General post, putting on the 'Emperors [sic] new clothes' suits him fine--a black man who can watch his own people and millions of others die without seeing anything."

Dr. Satcher, in the interview, explained that he withdrew the invitation to meet with Dr. Horowitz after he had arranged a meeting for Dr. Horowitz with the National Medical Association (NMA), the Nation of Islam and others, including three of the best scientists from the CDC. This meeting took place in Washington, DC, and was a response to the Nation of Islam threatening to call a moratorium on all vaccines based on Dr. Horowitz's claim that all vaccines are contaminated. Although Dr. Satcher did not attend the meeting, he believed that it had accomplished what he wanted because it was decided that Dr. Horowitz's claims were not based on credible scientific evidence and it did not appear that the Nation of Islam would call for a moratorium. Therefore, Dr. Satcher was advised that meeting with Dr. Horowitz would accomplish nothing further and would merely promote Dr. Horowitz's book. As to Dr. Horowitz's response, Dr. Satcher called it an outburst and said it was unprofessional. He said he had no response to it, but noted that more white people get immunizations than African-Americans so the comment did not really make sense insofar as it suggested that Dr. Satcher, as an African-American, was watching his own people die from the allegedly contaminated vaccines without doing anything about it. Dr. Satcher stated that it is his style to be open and communicative, so normally he would have met with Dr. Horowitz, but he believed his advisors were right in saying the meeting would only serve to promote the book.

CDC Reported to Favor Needle Exchange Programs

On March 7, 1995, the ASSOCIATED PRESS reported that internal CDC documents showed that "[g]overnment scientists have twice urged a reluctant Clinton administration to lift the ban on federally funded needle-exchange programs to help slow the spread of AIDS." The article

stated that although "Clinton health chiefs contend[ed] that they [did not] have enough evidence that giving drug addicts clean needles can fight the AIDS virus while not increasing drug use" to allow lifting the ban, "two internal reports from the [CDC] released by AIDS activists . . . say otherwise." The article quoted from one report which said, "We conclude that the ban on federal funding of NEPs (needle-exchange programs) should be lifted." The article stated that this report was signed by Dr. Satcher in December 1993, as head of the CDC. The article also noted that a second CDC report had more evidence, including a needle-exchange program in Tacoma, Washington that showed decreases in hepatitis, "a liver virus spread similarly to AIDS." That report noted that it "demonstrates more clearly than any previous research that use of NEPs is associated with decreases in blood-borne infections." The news article said that the CDC reports and attached memos from the National Institutes of Health "emphasize that needle-exchange 'data are quite limited.'" The second report also "acknowledg[ed] new figures from Montreal that show needle-exchange participants there had HIV rates three times as high as other addicts." The article concluded by noting that Health and Human Services Assistant Secretary Philip Lee "decided not to act" and considered the CDC reports as "one part of the decision-making process" which he did not consider strong enough evidence to enable him to approach Congress on the funding issue.

An August 13, 1994, transcript of the CNN program HEALTH WORKS stated that "CDC insiders" privately supported needle exchange programs to combat the spread of infectious diseases among intravenous drug users. The article reported that Dr. Satcher "has made a formal recommendation, but won't say what it is." Dr. Satcher reportedly said, "I don't think [commenting] would be appropriate. What I will say is that we have finished the study [of needle exchange programs]. We looked at our results and we are, we have communicated that and we're discussing those results in the department, where to go from here." A December 6, 1994, article in the SAN FRANCISCO CHRONICLE stated that the CDC refused to release the report. The article stated that "officials are keeping the lid on the report, despite frequent requests" and that a Public Health Service official said, "Officially, the matter is still under review."

Dr. Satcher stated in the interview that people are critical of the CDC's work on needle exchange, but he stated that it is the department that has to make a decision, the CDC just evaluates the issue. He said the studies show needle exchanges are effective and show no evidence of increasing drug use. He further stated that the NIH consensus conference on this issue reviewed a number of studies and reached the same conclusion that needle exchange programs reduced HIV with no indication of increasing drug usage. However, Dr. Satcher did state that the available studies reveal differences in the effect on drug usage. He said some show no effect on drug usage, others show a decrease since it increases the ability to get people into drug treatment programs, but at least two studies suggest that it would increase drug usage. He said the NIH consensus conference considered all of these studies. Dr. Satcher noted that he recently spoke to the NAACP and said his speech included talk about the epidemic growing in minorities and women and talk about the Connecticut study on needle exchange programs, but

nothing about the political aspect of the issue. When asked about his opinion, he stated that he supports the Secretary's communication to Congress that there is a place for needle exchange programs, but that they are still considering what role the programs should play. Dr. Satcher added that personally he hopes they can lift the ban. He stressed that he understands the political sensitivity of this issue and the importance of the appropriate airing of such issues. As to whether the statutory requirements for lifting the ban have been met, Dr. Satcher said the Secretary's communication did not deal with the question of the effect on drug usage and he suggested that the Secretary will probably recommend the use of needle exchange programs only where drug treatment programs are available. He did not voice an opinion on whether the requirements have, in fact, been met.

As to the release of the CDC studies, Dr. Satcher stated that he did not know how they got out. He said the CDC had submitted the studies to Dr. Phil Lee and that there were several people in both HHS and the CDC that handled the studies, as well as the researchers themselves. He stated that he does not think government can hide anything and said he did not feel particularly bad that these studies got out. He said the studies were not released, but that similar studies have been published, particularly noting the Connecticut study.

Controversy over HIV Testing of Newborns without Notification of Results

A May 20, 1995 article in the WASHINGTON POST reported that 45 States, using CDC funding, tested newborns for HIV, but did not disclose the information to the mother or her doctor. Representative Gary Ackerman (D-N.Y.) introduced a bill to compel any state requiring infants' HIV tests to disclose the results to the mother. The article indicated that Dr. Satcher visited Representative Ackerman in his office and requested that Representative Ackerman "abandon his bill." Representative Ackerman refused to withdraw his support for the bill. According to the article, Dr. Satcher said he might then consider withdrawing the tests altogether rather than disclose the results. The article said that Dr. Satcher was troubled by the analogy between the HIV study and the "Tuskeegee 'experiment.'" The Tuskeegee experiment was a CDC study of some 400 illiterate African-American men with syphilis who "were observed -- but not treated-- by Public Health Service physicians as they deteriorated and eventually died, having been told only that they had 'bad blood.'" The article quoted a professor of pediatrics as saying, "The maintenance of anonymous test results at a time when treatment and prevention are readily available will be recorded in history as analogous to the Tuskeegee 'experiment.'" The article stated that the CDC then suddenly "announced it was immediately suspending its HIV testing for newborns throughout the country." The article concluded, "The CDC could have continued the tracking, added disclosure of results, and been free of the taint of the Tuskeegee 'experiment.' But instead the politicized CDC has chosen to fold -- extricating itself from accountability."

The June, 1997, ATLANTIC MONTHLY published an article which criticized the treatment of AIDS and HIV as an exception to traditional epidemiology practices in which infectious diseases would be tracked by using at least some combination of routine testing, reporting to local health authorities, tracing of people in contact with the disease, and notification of the potentially infected people. The article argued that privacy concerns voiced by AIDS activists and others who have called for the special treatment of the AIDS epidemic were either not as great as these activists would argue or were out-weighed by public health concerns. One example given in the article was the CDC-funded study in which newborn babies were subjected to blind testing for HIV infection. The article noted that after Representative Ackerman's bill led the CDC to suspend the infant-testing program, Representative Ackerman and Representative Tom Coburn (R-OK) succeeded in drafting and passing new legislation known as the "Baby AIDS Compromise." This legislation reportedly required state health-care workers to provide voluntary HIV testing and counseling to pregnant women who had not previously been tested. States would then be subject to the loss of some federal AIDS funding or to the requirement of implementing mandatory testing on infants if they fail to meet certain goals with respect to the voluntary testing program.

Dr. Satcher explained in the interview that the newborn testing was part of a community, population-based screening to study the magnitude of the epidemic. He said AIDS poses a public health dilemma and they need a way to study the magnitude reliably without violating privacy. He stated that the study was a blind screening of the discarded blood of newborns. He explained that after blood samples were used to test for other things, the identifying marks were removed and the samples discarded. The study took those discarded samples and tested them for HIV. Since the samples had no identifying marks, there was no way to identify the source and, therefore, no way to notify the mother of the results. Dr. Satcher said the blinded newborn screening was the best way to monitor the epidemic since it tested samples that were representative of the population, rather than self-selected samples. His concern about voluntary screening (where mothers are given the option of HIV testing) is that the people who tend to volunteer for HIV testing are those who are less likely to test positive. Thus, self-selecting reduces the efficacy of such screening in monitoring the epidemic. Unfortunately, Dr. Satcher said, he has been unable to adequately explain the value of the blinded screening to most people, including Representatives Ackerman and Coburn. According to Dr. Satcher, Representative Ackerman will not be happy with any study without notification of results and Representative Coburn wants mandatory screening. Dr. Satcher has concerns about both options (the former will not be representative and the latter might deter people from seeking prenatal and neo-natal care). Dr. Satcher voiced optimism about a plan that has been suggested, but not yet approved. The plan would give women the option of voluntary testing so that they could get the results if they want them and conduct the blinded study as well. This way, he said, the women have the option of getting the results and counseling and the blinded study should not cause a problem.

CDC Failed to Provide Informed Consent

A July 2, 1996, article in the WASHINGTON POST stated that, prior to Dr. Satcher's appointment to head the CDC, nearly 1500 infants were enrolled in a measles vaccination study without providing information to the parents that the vaccine was not licensed in the United States. Dr. Satcher reportedly said, "A mistake was made. It's a terrible error. It's going to hurt -- hurt in research and hurt in treatment." The article further quoted Dr. Satcher as saying, "We have to be uniquely sensitive . . . because of the history [of the Tuskeegee Experiment]." He reportedly said that people in the African-American and Hispanic communities had doubts "about how to trust the government."

Against Restraints on Tobacco Advertisements for Adults

A May 16, 1994, transcript by the FEDERAL NEWS SERVICE of a National Press Club luncheon at which Dr. Satcher spoke indicated that Dr. Satcher was asked his position on whether or not the government should prohibit all advertising of tobacco products. Dr. Satcher responded, "Well, I don't think the answer to this problem is in a restraint of trade, I think our nation values several things and some of the freedoms we value are important and we don't have to engage in trade offs. . . . So in this case I don't think it's regulation. Obviously I think it's appropriate to prohibit the sale or marketing of tobacco to teenagers. The problem we are having is enforcing those laws that we already have."

For Higher Tobacco Taxes

A September 9, 1994, article in the ROCKY MOUNTAIN NEWS, regarding a proposed increase in the cigarette tax, noted that "[s]ome have argued that cigarettes can save money by killing people before they reach old age." Dr. Satcher reportedly responded, "We find it difficult to come to the point of valuing death." Dr. Satcher said that 80 percent of the nation's medical costs were linked to tobacco or alcohol and that "[w]e know that increasing the cost of cigarettes will lower the death rate." A February 23, 1994, article in the TIMES UNION reported that Dr. Satcher urged an increase in the federal excise tax on tobacco and said, "Tobacco use tends to go down as the price goes up. Tobacco control represents a compelling drama of profits vs. health."

CDC Study of Exposure to Second-Hand Tobacco Smoke

An April 24, 1996 article from the FEDERAL DOCUMENT CLEARING HOUSE indicated that the CDC reported that "[a]lmost nine out of every 10 non-smoking Americans are exposed" to second-hand tobacco smoke. Dr. Satcher reportedly said, "This study documents for the first time the widespread exposure of people in the U.S. to environmental tobacco smoke. This new information will be critical in estimating the extent of related disease and developing effective public health strategies."

Priorities of the CDC

An article in the February 1, 1994, INSIDE REPORT ON AIDS indicated that Dr. Satcher enumerated four "evolving priorities" for the CDC: 1) protecting "core" public health functions; 2) enhancing the ability to respond to urgent public health threats; 3) developing nationwide prevention strategies similar to those for HIV; and 4) women's health issues.

Broadening CDC's Mission: Violence and Drugs as a Public Health Issue

A January 26, 1994, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that Dr. Satcher stated that the CDC needed to "combat social ills like teen violence as fervently as it fights the AIDS epidemic." The article quoted Dr. Satcher as saying, "[T]he threats to the public's health over the last 20 years have not come from infections nearly so much as from substance abuse and violence. The CDC has been slow to adapt to that. This is a historic departure." A March 1, 1994, article in the LOS ANGELES TIMES reported that Dr. Satcher said, "Violence is a global issue and we are a Third World country when it comes to violence. We at CDC believe violence is a public health problem, and that we can prevent a lot of it by educating people about firearms." A March 22, 1994 article in the ORANGE COUNTY REGISTER reported that Dr. Satcher told participants at a conference sponsored by the American College of Preventative Medicine that "Guns in the hands of teen-agers are more of a threat today by far than even cholera in drinking water."

A January 29, 1996, article in the PITTSBURGH POST-GAZETTE stated that some lawmakers wondered if the CDC mission had become too broad. According to the article, the lawmakers reasoned that if violence prevention research and AIDS education were cut, there would be more money for responding to infectious disease outbreaks. An April 3, 1996, article in USA TODAY, indicated that the CDC had "drawn criticism from those who believe the agency's scientists should stick to bugs and stay away from social issues." In response to those critics, Dr. Satcher reportedly said, "Public health is much broader than medicine." He continued, saying that public health has a wider goal of "keeping people healthy." The article indicated that Dr. Satcher said, "If what's wrecking people's health is 'a virus or bacteria, public health targets that problem. If the problem is human behavior, I think we have to target that problem . . . . Whether we're criticized or not, we have to follow the science.'"

Dr. Satcher, in the interview, noted that the CDC's work on violence prevention has been controversial. He said the NRA has been critical, saying the CDC favors gun control. Dr. Satcher denied that the CDC favored anything and said they do objective research without taking a position. He said their research concluded that easy access to firearms is a risk factor for youth violence. He said people may use their research to support one side or another, but that they only do the science. They are not trying to get a law passed. Dr. Satcher went on to state that even if science goes against your position, you have to respect the science. He said

violence and guns are political issues, therefore people will fight if research goes against their view. Dr. Satcher stressed that science should come before advocacy and complained that sometimes, if you move too fast to advocacy, people fail to hear the science. Noting that there are laws regarding concealed weapons, including one place that requires them, Dr. Satcher also stated that they have not adequately looked at the issue of concealed weapons. He said people are not necessarily interested in researching this topic.

As to allegations that violence and guns are not public health issues, Dr. Satcher affirmed his statements about the effects of violence and guns on public health and relied upon statements by peer review groups, the New England Journal of Medicine and JAMA which also characterize violence and guns as public health issues.

Gun Control as Important as AIDS Prevention; Position Criticized by Lott, et al.

A June 28, 1995, article in the ATLANTA JOURNAL AND CONSTITUTION reported that Dr. Satcher was broadening the CDC's role in addressing violence. The article reported that Dr. Satcher said, "We are the national prevention agency. How do we prevent our children and teenagers from having access to guns and taking guns to school?" A January 26, 1994, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that Dr. Satcher said, "We feel that guns in the hands of teens in this country represent as much of a public health problem" as AIDS. A March 31, 1995, report in the ASSOCIATED PRESS stated that Dr. Satcher said that the government needed to "tighten regulation of weapons, particularly guns."

A January 29, 1996, article in the PITTSBURGH POST-GAZETTE indicated that "the National Rifle Association [(NRA)] and a small but vocal group of doctors have charged that the CDC's research on violence is biased against gun ownership." A May 2, 1996, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that the NRA, with support from "influential members of Congress," had "attacked the CDC's research on gun violence as propaganda for gun control." Another article in the May 2, 1996, ATLANTA JOURNAL AND CONSTITUTION noted that "Congressional defenders of gun ownership" accused the CDC of using this research as a "pretext for a campaign to make firearms socially unacceptable in America." An April 1997 article from the REASON FOUNDATION indicated that 10 Senators, including then-Majority Leader Bob Dole and current-Majority Leader Trent Lott, wrote, "This [firearm] research is designed to, and is used to, promote a campaign to reduce lawful firearms ownership in America." Dr. Satcher reportedly responded that this criticism "did not bode well for the country's future." He reportedly said, "If we question the honesty of scientists who give every evidence of long deliberation on the issues before them, what are our expectations of anyone else? What hope is there for us as a society?"

On May 4, 1996, the WASHINGTON TIMES reported, "Claims that the CDC mixes politics and science have escalated since it funded two studies . . . that showed there was a five times

greater risk of suicide and a three times greater risk of homicide in homes with guns." These studies reportedly drew fire from the NRA and top Senate Republicans, including then-Majority Leader Bob Dole (R-Kansas) and then-Majority Whip Trent Lott (R-Miss.), who called for reducing or eliminating funding for the CDC division responsible for the studies.

See above.

Satcher Comments on Universal Health Care and Public Health Issues Deemed "Too Political"

A September 16, 1994, editorial column in the ATLANTA JOURNAL AND CONSTITUTION indicated that Dr. Satcher had criticized the media as "too much interested in sensational stories, like the so-called flesh-eating bacteria that may affect only 100 people worldwide, and too little interested in dull-but-important health-related stories, like efforts to wipe out smallpox and polio." The editorial continued, "But in the course of his criticism, Dr. Satcher crossed into territory that will one day prove to be dangerous ground for the Centers for Disease Control. He urged journalists to keep up the pressure on Congress to reform health care and to tell the real story about how badly universal health coverage is needed. In his advocacy, Dr. Satcher is an inch away from hauling himself and his agency into the political arena. . . . Where there is no clear-cut physiological, biological, or environmental cause that can be isolated conclusively, as there isn't with much of the new agenda of the Centers for Disease Control, the agency leaves its franchise to play in the policymakers' park. . . . If the issue is how to eliminate smallpox or polio, Dr. Satcher's and his colleagues' expertise is beyond challenge. If it's how to deal with violence in America, their opinion may be no more useful than yours." A September 29, 1994, letter to the editor in the ATLANTA JOURNAL AND CONSTITUTION regarding the editorial stated, "I don't think the CDC considers anything as 'dangerous ground.' How else would one explain why the CDC would funnel $800,000 of taxpayers' money to underwrite a program for a homosexual group called the National Association of Black and White Men Together (BWMT)? One grant of $200,000 was partly used for what BWMT says are 'Hot, Horny and Healthy' workshops that include 'condom races.'"

Regarding the editorial, Dr. Satcher responded that it is always dangerous to criticize the media. He explained that this column came about after he met with the editorial boards of the Atlanta Journal and Constitution. He said his statement was not made to the public. Regarding the statement about universal health care, Dr. Satcher stated that he was saying the cost of health care was going up exponentially and that access to health care is one of public health's responsibilities. He noted that the National Institutes of Health definition of the responsibilities of public health are (1) leadership in policy; (2) assessment; and (3) assurance. He said the last responsibility includes access to care. Regarding the statements about violence, Dr. Satcher said the editor of the Atlanta Journal believes the CDC should stick with bugs and not get into violence and, therefore, has been critical of the CDC's work on violence.

After I read him the excerpt from the letter to the editor, Dr. Satcher responded that some people criticize any funding for gay groups. He did not recall the grants to BWMT or the workshops and "condom races" described in the letter. He said the U.S. Conference of Mayors often made those decisions to fund fringe groups. However, he would not rule out the possibility that the CDC made the decision. He stated that in 1994 the CDC decided they needed to do a better job getting information to high-risk groups and, therefore, would fund groups with good programs even if they did not agree with the group's overall aims.

Children's Vaccinations Program Criticized in GAO Report

Published sources indicated that the General Accounting Office (GAO) released a report in 1994 which criticized the federal childhood vaccination program. A July 20, 1994, article in the LOS ANGELES TIMES regarding the vaccination program, quoted Dr. Satcher as saying, "We will have in place all necessary systems to order, purchase and deliver vaccine in a safe and efficacious way. We are confident that we will be ready to go [on October 1, 1994]." Senator Dale Bumpers (D-Ark.) reportedly said that the Administration would be "foolish in the extreme" to proceed on schedule. A September 30, 1994, article in the ATLANTA JOURNAL AND CONSTITUTION indicated that the GAO report criticized the CDC's lack of a formal system to track the vaccination program's cost and effectiveness. A November 15, 1994, ASSOCIATED PRESS report indicated ongoing criticism of the program. One Philadelphia doctor contended, "It's kind of a stupid program, not attacking the right issues." Dr. Satcher reportedly acknowledged that "there are still some things to iron out. But I think we're making significant progress."

A July 10, 1995, article in the INFECTIOUS DISEASE WEEKLY indicated that some members of Congress intended to dismantle the program "in view of a new report from the [GAO] who found that the program was misconceived and mismanaged." The article indicated that Dr. Satcher "clashed with critics at a hearing of the House Commerce Committee's Subcommittee on Health and the Environment," regarding the criticism found in the GAO report. A June 17, 1995, report on the PR NEWSWIRE stated there were "several sharp exchanges" during the hearing. According to the article, Representative Richard Burr (R-NC) asked Dr. Satcher how many additional children had been immunized through the program. Dr. Satcher reportedly replied, "I'm not going to play games, there's no way to know." The article further stated that Representative Scott Klug (R-WI) "also took the agency to task" over a CDC-sponsored immunization conference in Los Angeles. Representative Klug noted "that 13,500 children could have been immunized" with the money spent (more than 1 million dollars) to send 238 staff members to stay at the Beverly Hills Century Plaza Hotel for the five-day conference. The article stated that "even traditional supporters of the CDC, like Representative Ron Wyden (D-OR), expressed dismay at the program's disarray, saying that his confidence in the CDC 'was shaken' and that the mismanagement of the [vaccination] program was a 'prescription for failure.'"

Dr. Satcher stated that this program has been controversial, noting that he has gotten past four congressional hearings on the program (and did very well). He said vaccinations are at an all time high and noted that Senator Bumpers has been one of the strongest supporters of vaccinations. Dr. Satcher suggested that Senator Bumpers was hurt by not being consulted by the Administration in developing the program and that this might account for some of his criticism.

As to Representative Klug's criticism that the money used for the conference could have immunized 13,500 children, Dr. Satcher responded that the question is, "How many children were immunized because of it?" He explained that the conference was to bring together community leaders to increase the reach of the immunization program.

Injectable Polio Vaccine

A September 21, 1996, article in the INTERNATIONAL HERALD TRIBUNE indicated that the CDC had shifted from an oral polio vaccination to an injectable version for the first two doses of the four-dose regimen. The article stated that "a coalition of minority advocacy groups immediately criticized the policy shift. The groups said the increased cost and other differences between the two vaccines would leave thousands of disadvantaged children unprotected."

Gulf War Illnesses

Published sources indicate that Senator Tom Harkin (D-Iowa) and Dr. Satcher jointly released a study of illness associated with military service in the Persian Gulf War. A January 8, 1997, article in the FLORIDA TIMES-UNION stated that the study "blasted the Pentagon" for "inadequately investigating sick Persian Gulf war veterans." A February 23, 1997, article in the TELEGRAPH HERALD indicated that Senator Harkin stated, "While there still is much mystery associated with Gulf War illnesses, this study exposes one clear, inescapable truth - Persian Gulf War veterans are far more likely to suffer from a wide variety of illnesses than non-Persian Gulf veterans." A January 8, 1997, transcript of NATIONAL PUBLIC RADIO'S MORNING EDITION reported, however, that Dr. Satcher, who joined Senator Harkin at the press conference "did not agree with (Senator Harkin's) conclusion." The reporter stated that Dr. Satcher said "instead of relying simply on what veterans said over the telephone, the researchers really need to study people in doctors' offices in order to get convincing information." A January 8, 1997, AP WORLDSTREAM report quoted Dr. Satcher as saying, "In some ways, the complaints . . . are similar to what we've heard from veterans of other wars."

When asked about the Gulf War illnesses, Dr. Satcher noted the press conference with Senator Harkins, saying the purpose of the press conference was to release a CDC-University of Iowa study in which a telephone survey was conducted. The survey revealed that Gulf War veterans reported more illnesses than the general population, but did not show any single illness

or set of illnesses. Dr. Satcher said the complaints were similar to those heard from veterans of other wars. According to Dr. Satcher, the CDC is conducting clinical studies to follow-up on the results of the telephone survey and that those studies are in progress. Dr. Satcher specifically noted two studies in which the CDC was involved. One was a Mississippi study of birth defects which concluded that there was no significant difference in the incidence of birth defects in babies born to Gulf War veterans as compared to the general population. The second was a study by Dr. Bill Reeves (sp?) in Pennsylvania which compared the illnesses to Chronic Fatigue Syndrome. Dr. Satcher stated that he believes this is the extent of his public statements on the Gulf War Syndrome. He said he had followed the President's committee looking into the issue and commended their work, but said he had not spoken publicly about it.

Intelligence of Minorities

On March 29, 1995, the ASSOCIATED PRESS noted that the CDC was starting a federal program to help at-risk children develop better mental skills. The article reported that "the racial findings hold particular interest because of the controversy over whether intelligence is racially based," noting that the book The Bell Curve created a furor when it was published in 1994 by arguing that African-Americans score lower on IQ tests and that the difference controls their destiny. Dr. Satcher said, "It is important that we make every effort to put (these studies) into proper perspective." A co-author of the study said that "the new studies knock down arguments that race plays a bigger role than preventable socioeconomic problems."

A March 30, 1995, article in the TIMES UNION stated that two CDC-sponsored studies had concluded, "Children born to women who are poor, uneducated, black or Latino are more likely than others to be mildly retarded." The article said that the "federally funded studies confirm what many psychologists and social workers have been saying for years: Deprivation and social hardship can stunt human intelligence." The article stated that the studies "were attacked by others, who say the conclusions cannot be trusted, because they are racist and lead to discriminatory treatment of minority children." The article indicated that Dr. Satcher wrote an editorial accompanying the studies. Dr. Satcher reportedly wrote, "As America becomes more diverse, greater efforts need to be directed toward improving access to economic and educational opportunities and removing obstacles such as poor health and the possible effects of discrimination and racism." He concluded, "We believe much of the excess prevalence of mild mental retardation is preventable."

In the interview, Dr. Satcher stated that he has a history with the pediatrician who did the study (he is a friend of her family) and had heard about the research before he came to CDC. He said the CDC refused to release the study until he came to the CDC and looked into it. He stated that he decided the study, while somewhat controversial, was good science and could help prevent children from being labeled. He stated that the study showed that some mental retardation was preventable and could give an opportunity to improve the health of children.

Because he was sensitive to the issues raised in The Bell Curve, Dr. Satcher stated that he wrote an editorial to be released with the study to make clear what the study does and does not say.

Health Care for Undocumented Immigrants

A December 14, 1994, article in the DALLAS MORNING NEWS indicated that government health officials said that cutting off preventive medical services to undocumented immigrants "would increase everyone's risk of getting sick." The article quoted Dr. Satcher as saying, "To deny access to preventive services to people who are in this country means that we increase the risk for everybody in this country."

Dr. Satcher stated that he still believes that undocumented immigrants should receive medical services. He said public health is just that. Dr. Satcher said they should get treatment because we should not want undocumented immigrants to be the focus of some epidemic, but we also should want them to receive it so that they will not create an epidemic in non-immigrant or legal immigrant populations. However, he stated that he understands that it is difficult for states to carry the burden. Dr. Satcher stated that he does not believe he has made any public statements about this issue since 1994, noting that his only occasion for discussing it at that time was a trip to the Texas boarder in which the question was asked.

Personnel and Facility Problems at CDC

A June 15, 1995, article in the ATLANTA JOURNAL reported that an internal investigation process "began in 1993 with a scathing report on CDC staffing" from the Office of Personnel Management (OPM). According to the article, 100 of the 6500 CDC employees were overpaid. The article further stated that the OPM report "found 'a total breakdown of staffing operations' at the CDC and cited it for several hundred violations of federal personnel laws," including the "appointment or promotion of 'unqualified' employees and noncompetitive promotions of 'pre-selected' employees." The article noted that OPM's Regional Director said the CDC had corrected these violations. According to the June 16, 1995, HEALTH LINE, these personnel problems, including the overpayment of employees, "coincides with the CDC's public outcries over decaying laboratories that need replacing, and the need for a beefed-up national surveillance system to detect new and emerging diseases."

International Role of the CDC

A May 26, 1994, article in the BALTIMORE SUN stated that Dr. Satcher said that out of necessity, "the new definition of public health must be global," and that the "increased incidence of tuberculosis, the spread of the AIDS virus and growing violence are worldwide threats." In a June 28, 1995 article in the ATLANTA JOURNAL AND CONSTITUTION, Dr. Satcher reportedly said that the "CDC does not have a mandate for international health, yet whenever there's an

international health problem, we get called." A March 2, 1997 article in the NEW YORK TIMES, which dealt with newly emerging infectious diseases, quoted Dr. Satcher as saying, "There is no such thing as doing public health in isolation anymore. You can't stop public health efforts at the [borders] of the U.S. and still protect Americans."

Dr. Satcher stated that all public health is local, but must have a global perspective. He stated that people travel, organisms travel. For example, he pointed to the hepatitis A outbreak in school lunches. When asked about sending tobacco or other items deemed dangerous here to foreign countries, Dr. Satcher said this was a concern. He said we are not just protecting ourselves, foreign countries must protect against us. He did not know the regulatory scheme required to deal with tobacco and said it was not his area to deal with.

Women's Health Issues

An April 27, 1994, UNITED PRESS INTERNATIONAL report indicated that Dr. Satcher said, "We feel women's health has been neglected in many ways and we want to focus on dealing with that history of neglect." The article stated that Dr Satcher "blamed the neglect of women's health in part on the lack of women in the health professions." Dr. Satcher reportedly said, "In order to be successful, we need more women and minorities in leadership positions." An October 2, 1994, article in the CHICAGO TRIBUNE stated that the CDC planned "a special office to ensure that women's health issues get government attention." The creation of a special office was "part of a government response to criticism that women's health has been underfunded and ignored."

In addressing the neglect of women's health issues and the distrust of the minority communities, Dr. Satcher has proposed increasing the numbers of women and minorities in the health care professions. I asked Dr. Satcher about this in his interview. Dr. Satcher responded that he believes that the medical profession should reflect the population they serve. He said he encourages minorities (he specifically listed African-Americans, Hispanics and Native Americans) and women to become interested and involved in science and medicine. He believes integration is important. Dr. Satcher noted that during his tenure at CDC, he has appointed six center directors and that one-third of them have been women and one-third have been minorities. He believes there should be no discrimination.

Chronic Fatigue Syndrome

A May 3, 1996, article in the HOUSTON CHRONICLE indicated that the CDC had been "criticized in a current book about chronic fatigue syndrome." The article indicated that Dr. Satcher responded that "researchers have been unable to find any evidence that these problems are transmitted from one person to another" and noted the CDC's quick response in other situations like those involving the ebola virus and the hantavirus.

On Racial Issues in Nashville

On December 21, 1992, the COMMERCIAL APPEAL reported that the "abusive treatment of a black police officer by fellow white officers . . . left Nashville pondering whether its nickname, the 'Athens of the South' ha[d] tarnished." The article quoted Dr. Satcher as saying, "I think racism is a part of our society wherever I've been. I think as a nation, we still have much to do. Nashville is probably better than some places I've been, but certainly we have a lot to do." The article reported that Dr. Satcher believed that the Mayor and Police Chief "responded appropriately and rapidly to last week's incident." Dr. Satcher said, "Now we've got to put these issues on the table and talk about it."

On September 7, 1992, JET reported on the Nashville City Council's approval to merge two of its hospitals, "eliminating one of the vestiges of a racially divided health care system." Dr. Satcher said, "This wasn't racial (sic) issue, but at best a financial issue . . . Common sense and good will have prevailed over racial division." Dr. Satcher further noted that, "[a]t a time of considerable pessimism about race relations in this county, this is a step worth noting . . . racial divisiveness makes as little sense politically and economically as it does morally."

Tuskegee Apology

On May 15, 1997, the GANNETT NEWS SERVICE reported that Dr. Satcher was "singled out" and "credited for quietly pushing for an apology" related to the Tuskegee Syphilis Study. The article quoted Benjamin Payton, President of Tuskegee University as saying, "The reality is this wouldn't have been brought to this point without the behind-the-scenes assistance of key individuals inside the Centers for Disease Control and the (U.S. Department of) Health and Human Services."

Dr. Satcher stated that he had a lot to do with the Tuskegee apology, but said a lot of other people did too. He said he had not gotten engaged with the question of the slavery apology. He explained that he became involved in the Tuskegee apology because the distrust resulting from the Tuskegee experiment still plays a role in health care. He said there were three things that he felt were important in the Tuskegee apology: (1) continuity of responsibility by the government and by the CDC (even though the study was conducted by another administration and a different CDC director, the current Administration and CDC director still bear the responsibility for the study, just as they get the credit for the good that happened such as the eradication of polio); (2) important to say that the study was wrong; and (3) important to show committed to seeing that it never happens again. Dr. Satcher stated that he would have to think through the slavery apology and come to a similar conclusion on it before recommending it. He said the President's commitment to race in a multiracial environment was a good move, saying it was needed regardless of whether there is an apology. He said it helps to have a dialogue and

that it is heading in the right direction. Dr. Satcher indicated that he would be more interested in working on what to do after an apology if there was one.

Meharry Accreditation

An article in the February 11, 1995, NEW YORK TIMES about Dr. Henry Foster noted that Dr. Satcher had preceded Dr. Foster as President of Meharry Medical College, leaving that post in 1993 to go to the CDC. The article further noted that Meharry had lost its accreditation in 1990 due to declining business at its teaching hospital. The article explained that this situation was addressed by the merging of the teaching hospital with the city-owned Metropolitan General Hospital.

Dr. Satcher stated that the merger will not be complete for another year, but that they have made progress toward accreditation.

Death of Hospital Patient

A July 31, 1993, article in the COMMERCIAL APPEAL stated that a female patient, age 69, disappeared from her hospital room at Meharry-Hubbard Hospital, where Dr. Satcher was then-President. Despite a search for the patient, it was not until sixteen days after she disappeared that her decomposing body was found in an undeveloped floor of the Hospital where she had fallen into a crevice. Dr. Satcher reportedly said that medical records showed the woman was treated properly and that there was no need for restraints to keep her in her room. He said, "It's possible to do everything right and still have things go wrong." A July 30, 1993 article distributed by the GANNETT NEWS SERVICE stated that members of the woman's family criticized the hospital for not protecting the woman and "for not conducting a thorough enough search of the hospital after she disappeared."

Dr. Satcher stated that this was a very painful experience which he carries with him. He said he does not know how the woman was able to disappear or how she was not found in the ensuing search. He said they brought in the police and others from outside the hospital, searched the floor where she was later found, etc. He said the elevator was not supposed to stop on that floor, but it apparently did on this occasion since the stairs were blocked and it was the only way to get to the floor. Dr. Satcher stated that this was an isolated incident and no such thing had happened before, but he said it should not have happened at all. However, Dr. Satcher said they reviewed the medical file and agreed that before the woman disappeared, there was no indication medically that she should have been restrained.

July 24, 1997

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fact sheet	re: U.S. Senators (21 pages)	ca. 1994	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting [5]

Racheal Carter
2011-0747-S
rc858

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SENATOR JOSEPH BIDEN

State: Delaware

Election in 1994: No

Priority Health Issues:

Interest in Legal Issues (Antitrust; Malpractice Reform) - Generally supportive of HSA provisions in these areas
Opposes Tax Cap
Concern for Economic Winners and Losers in Reform

Priority Non-Health Issues: N/A

Recent Comments:

Meeting 5/13/94 - Felt abortion should be put on the back burner.

Meeting 5/25/94 - Absolutely opposes caps on economic and non-economic damages but likes limits on legal fees on non-economic damages. Requested separate meeting on fraud, waste and abuse issues which also fall under his committee's jurisdiction.

Strategy: Inside

Principal Contact: POCUS/HOC

Cabinet/White House Contact: [Cabinet Affairs Recommends Reno]

Influential State/Local Officials:

Governor Tom Carper

Influential Groups and Organizations:

Labor
ATLA

Media/Grassroots Efforts Advisable: No

Notes on Strategy: Suggest a meeting with the First Lady to make case for reform and appeal for his vote.

SENATOR BILL BRADLEY

State: New Jersey

Election in 1994: No

Priority Health Issues:

Supports Market Oriented Cost Containment
Concern for Impact on Insurance Industry - Opposes Premium Caps
Concern for Impact on Pharmaceutical Companies - Opposes Price Controls

Priority Non-Health Issues:

China
Pensions
Taxes

Recent Comments:

Strategy: Inside/Outside

Principal Contact: POCUS

Cabinet/White House Contact: Rubin/Altman [Cabinet Affairs Recommends Cisneros/Reich] (Also Susan Thomases; Ken Apfel, HHS; and Joe Minarik, OMB)

Influential State/Local Officials:

Robert Janiszewski, Hudson County Executive
Carol Clark, City Council, E. Orange

Influential Groups and Organizations:

Unions - (CWA; AFSCME; SEIU; 1199)
National Council of Senior Citizens
African American Organizations
Women's Groups
Pharmaceutical Industry

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform
Universal Coverage through Employer Mandate
Middle Class

Notes on Strategy: As evidenced by reaction to lobbying against his "tax-cap-like" cost containment proposal, Senator Bradley seems to be sensitive to union concerns. Pushing hard for universal through employer requirement, regardless of cost containment mechanism seems advisable. Responds to union pressure and personalized letter campaign efforts. Positive Media efforts particularly in conjunction with Lautenberg strategy recommended.

SENATOR JOHN BREAUX

State: Louisiana

Election in 1994: No

Priority Health Issues:

Facilitating Health Care Deal
Small Business and Employer Mandates - Concerned impact. Might support triggered mandate with carve out for smallest businesses
Opposes Premium Caps - Prefers Market-Oriented Approach
Supports Improvements in Rural Health

Priority Non-Health Issues:

Supports Relief for Oil and Gas Industries
Concerned about Increases in Taxes

Recent Comments:

7/3/94 - Opened door again to triggered employer mandate. *This Week with David Brinkley*

Strategy: Inside

Principal Contact: POCUS

Cabinet/White House Contact: McLarty/Bentsen [Cabinet Affairs Recommends Shalala]

Influential State/Local Officials:

Jim Brown, Insurance Commissioner
Melinda Schwegmann, Lieutenant Governor
Mary Landriiu, State Treasurer
Sammy Nunez, President of the Senate

Influential Groups and Organizations:

Labor
Small Business (DLC Small Business Groups)

Media/Grassroots Efforts Advisable: Uncertain

Notes on Strategy: Breaux wants most of all to facilitate the final deal on health care. Regular cabinet contact to make him feel a part of the action and a meeting with the President to solidify his role are suggested.

SENATOR RICHARD BRYAN

State: Nevada

Election in 1994: Yes

Priority Health Issues:

Fiscal Responsibility
Concerned about Employer Mandate and Impact on Small Business and Jobs
Concerned about Overly Bureaucratic Nature of Alliance Structure
Supports Prescription Drug Coverage for Seniors
Prefers Slower Phase-in

Priority Non-Health Issues:

Gambling Tax
Nuclear Waste (Yucca Mountain)
Indian Gaming

Recent Comments:

Strategy: Outside

Principal Contact:

Cabinet/White House Contact: Babbitt?/Griffin [Cabinet Affairs Recommends Pena)

Influential State/Local Officials:

Frankie Sue Del Papa, Attorney General

Influential Groups and Organizations:

Unions - (Hotel and Restaurant Workers - Lukewarm)
AARP
NEA Affiliate

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform
Middle Class
Needs to Hear from Seniors

Notes on Strategy: Running for reelection and needs political and financial support. (Has close relationship with DSCC Donors). Call on financial donors who are advocates of health reform to weigh in. We believe a media strategy stressing fiscal responsibility and effect of universal coverage on middle class would be beneficial. Labor may also have an effect.

SENATOR BEN NIGHTHORSE CAMPBELL

State: Colorado

Election in 1994: No

Priority Health Issues:

HSA Cosponsor
Concerned about imapct of Reform on Small Business
Supports Improvements to the Indian Health Service

Priority Non-Health Issues:

Recent Comments:

Strategy: Inside

Principal Contact: POCUS/VPOTUS

Cabinet/White House Contact: [Cabinet Affairs Recommends Pena]

Influential State/Local Officials:

Governor Roy Romer
Gail Schoettler, Treasurer
Gary Laura, Jefferson County Commissioner
Alegra "Happy" Haynes, Denver City Council

Influential Groups and Organizations:

Media/Grassroots Efforts Advisable: No

Notes on Strategy: Contact by the Vice President, who has a close relationship with Senator Campbell, followed by a Presidential appeal for his vote.

SENATOR KENT CONRAD

State: North Dakota

Election in 1994: Yes

Priority Health Issues:

Potential Impact of Employer Mandate on Small Businesses and Family Farms
Fiscal Responsibility of Plan
Supports Improvements in Rural and Indian health
Feels Medicare Cuts are too High (Medicare Represents 70% of Hospital Billing)
Supports Higher Co-Pays and Deductibles (Key to Cost Consciousness)
Supports State Flexibility so Plan will Meet Needs of his Rural Frontier State

Priority Non-Health Issues:

Deficit Reduction
Canadian Trade (Wheat and Barley)
Agriculture

Recent Comments:

7/6/94 - On Employer Mandates: In his state, 90% of businesses have fewer than 20 employees and many can't afford to pay for workers' insurance. *New York Times*

Strategy: Inside/Outside

Principal Contact: POCUS/HOC

Cabinet/White House Contact: [Cabinet Affairs recommends Shalala]

Influential State/Local Officials:

Heidi Heitkamp, Attorney General
Glen Pomeroy, Department of Insurance

Influential Groups and Organizations:

Farmers Union
NEA Affiliate

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform
Needs to Hear from Seniors
Political Cover

Notes on Strategy: Needs cover with small businesses and farmers. Possible trip by President or First Lady to secure vote. Invest in inexpensive paid media to give cover for Conrad (as well as Dorgan and Pomeroy). Stress fiscal responsibility.

SENATOR DENNIS DECONCINI

State: Arizona

Election in 1994: No - Retiring at end of term

Priority Health Issues:

Fiscal Responsibility (Concerned about Accuracy of Revenue Projections)
Concerned about impact of Employer Mandates on Small Business
Feels Level of Medicare Cuts may be too High
Opposes including Abortion in Benefits Package
Supports Taxing Alcohol

Priority Non-Health Issues:

Recent Comments:

Strategy: Inside

Principal Contact:

Cabinet/White House Contact: McLarty/Griffin [Cabinet Affairs recommends Riley]

Influential State/Local Officials:

Senator Cindy Resnick
Representative Art Hamilton, Minority Leader

Influential Groups and Organizations:

Media/Grassroots Efforts Advisable: No

Notes on Strategy: Alleviate fears on the deficit and small business. Direct appeal from White House.

SENATOR BYRON DORGAN

State: North Dakota

Election in 1994: No

Priority Health Issues:

Insufficient Cost Containment -
(Not Enough to Arrest Spending as Percent of GDP)
Imapct of Employer Mandates on Small Business
Improving Rural Health Care
Concern over Overly Bureaucratic Nature of Alliances
Improving Health Care Services Native Americans

Priority Non-Health Issues:

Fiscal (Slowing Growth of Entitlement Expenditure)

Recent Comments:

Strategy: Outside

Principal Contact:

Cabinet/White House Contact: [Cabinet Affairs Recommends O'Leary]

Influential State/Local Officials:

Heidi Heitkamp, Attorney General
Glen Pomeroy, Department of Insurance

Influential Groups and Organizations:

Farmers Union
Teachers (NEA Affiliate)

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform
Middle Class and Small Business

Notes on Strategy: Needs to be touched by Administration. Link to media campaign for Conrad and Pomeroy. Get local supporters who are small business people and rural health advocates to stress support for Mitchell plan.

SENATOR J. JAMES EXON

State: Nebraska

Election in 1994: No

Priority Health Issues:

Impact of Mandate on Small Business (But strongly Opposes Individual Mandate)
Improving Rural Health
Benefits Package Too Generous
Concerned about Impact on Cost Containment Insurance Industry
Wants Abortion Out of Benefits Package

Priority Non-Health Issues:

Defense/Armed Services
Balanced Budget

Recent Comments:

5/8/94 - Doesn't agree with President's proposal to require businesses to pay 80% of worker's benefits, but feels it might be fair to require 50% employer coverage. *Omaha World-Herald*

Strategy: Outside

Principal Contact: HOC

Cabinet/White House Contact: Perry/Bentsen/Ricchetti [Cabinet Affairs Recommends Pena]

Influential State/Local Officials:

Influential Groups and Organizations:

Small Business
Insurance Co.
Farmers Union
NEA Affiliate
Nebraska Commission on Status of Women
Catholic Health Association

Media/Grassroots Efforts Advisable: Yes

Message: Middle Class
Fiscal Irresponsibility of Incremental Reform

Notes on Strategy: Needs cover for support, particularly from business community. Note presence of Mutual Omaha. Believe that **positive** media will influence.

SENATOR DIANE FEINSTEIN

State: California

Election in 1994: Yes

Priority Health Issues:

Impact of Mandate on Large Low-wage Businesses (i.e. retailers)
Supports Emphasizing Primary and Preventive Care
Supports Women's Health Coverage (Breast Cancer Research, Abortion Rights)
Concerned about Economic Cost of Health Care Illegal Aliens
Preserve Choice of Providers
Supports Malpractice Reform Along California Model.
Increased Funding and Services for AIDS

Priority Non-Health Issues:

Crime
Education
Child Care

Recent Comments:

Strategy: Outside

Principal Contact: HOC

Cabinet/White House Contact: [Cabinet Affairs Recommends Shalala]

Influential State/Local Officials:

Insurance Commissioner John Garamendi
State Treasurer Kathleen Brown
Senator Diane Watson, Chair, Health and Human Services Cmte
Assemblyman Burt Margolin, Chair, Health Cmte
Speaker Willie Brown
Mayor Frank Jordan, San Francisco

Influential Groups and Organizations:

Unions (SEIU, Machinists, AFSCME)
NEA Affiliate
Women's Groups

Media/Grassroots Efforts Advisable: Yes

Message: Middle Class
Political cover

Notes on Strategy: Needs to hear from as many supportive groups as possible. Labor, in particular, needs to weigh in. Senator Feinstein is in a potentially tight race for reelection. Grassroots efforts are most important here. This should be combined with a meeting with the First Lady to make the substantive case.

SENATOR WENDELL FORD

State: Kentucky

Election in 1994: No

Priority Health Issues:
Reduce Tobacco Tax
Preserve Choice of Provider
Impact of Employer Mandate on Small Businesses and Jobs

Priority Non-Health Issues:

Recent Comments:

Strategy: Primarily Inside

Principal Contact: POCUS

Cabinet/White House Contact: Griffin [Cabinet Affairs Recommends Reich]

Influential State/Local Officials:
Governor Brereton Jones
Chris Gorman, Attorney General

Influential Groups and Organizations:
NEA Affiliate
Small Business
Farmers
Distillers (Spirits)

Media/Grassroots Efforts Advisable: Yes

Notes on Strategy: Primarily an inside strategy, although with three representatives from Kentucky also on the fence it would be helpful to change the very negative perception of the plan in the state. Tobacco must be addressed. Direct appeals from the President and the Majority Leader should be the key to his vote

SENATOR HOWELL HEFLIN

State: Alabama

Election in 1994: No

Priority Health Issues:

Impact of Employer Mandate on Small Business
Supports Folding in Workers Compensation
Preserve Choice of Provider
Malpractice Reform - Does not support Caps
Supports Insurance Reforms to Eliminate Preexisting Conditions

Priority Non-Health Issues:

Recent Comments:

Strategy: Inside

Principal Contact: HOC

Cabinet/White House Contact: Griffin/Bowles? [Cabinet Affairs Recommends Espy?]

Influential State/Local Officials:

Terry Ellis, State Auditor
Lillian Jackson, Montgomery County Commissioner
Representative Tom Butler

Influential Groups and Organizations:

African American Organizations
labor - (Steel Workers, Machinists)
NEA Affiliate

Media/Grassroots Efforts Advisable: No

Notes on Strategy: Meeting with Mrs. Clinton to have her walk through the substance of the bill. Grassroots strategy to provide cover for Heflin, particularly from groups who are close to and influential with Shelby would be helpful.

SENATOR ERNEST HOLLINGS

State: South Carolina

Election in 1994: No

Priority Health Issues:

Deficit Reduction/Fiscal Responsibility
Impact of Employer Mandates on Small Businesses
Increase Support for Community Health Centers and NIH
Improvements in Rural Health Care
Concerned about Overpromising about what Health Reform will Accomplish

Priority Non-Health Issues:

Telecommunications
Trade
Deficit Reduction
Product Liability

Recent Comments:

Strategy: Outside

Principal Contact: POCUS

Cabinet/White House Contact: Griffin [Cabinet Affairs Recommends Reno/R. Brown]

Influential State/Local Officials:

Mayor Joe Riley/Candidate for Governor
Harriet Gardin Fields, Chair, Richland County Council

Influential Groups and Organizations:

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform
Middle Class and Small Business

Notes on Strategy: A targeted grassroots strategy to highlight small business support would be desirable. This should be combined with an inside strategy centered on a meeting with the President.

SENATOR J. BENNETT JOHNSTON

State: Louisiana

Election in 1994: No

Priority Health Issues:

Validity Long-Term Budget Assumptions
Concerned about Financial Impact of Reform on State Charity Hospitals
Advocate of Emphasis on Preventive Care

Priority Non-Health Issues:

Energy (Oil and Gas)

Recent Comments:

6/12/94 - "I'm not an enthusiastic supporter of employer mandates. But I have not taken a position because there's a whole lot of difference between a minimal employer mandate and a big employer mandate." He also stated that he wants action this year. *New Orleans Times*

Strategy: Inside

Principal Contact:

Cabinet/White House Contact: Bentsen [Cabinet Affairs Recommends O'Leary/Deutsch]

Influential State/Local Officials:

Jim Brown, Insurance Commissioner
Melinda Schwegmann, Lieutenant Governor
Mary Landriiu, State Treasurer
Sammy Nunez, President of the Senate

Influential Groups and Organizations:

Media/Grassroots Efforts Advisable: No

Notes on Strategy: We believe a direct appeal from the administration would be most effective. If possible, Johnston should be solicited to assist in overall inside strategy.

SENATOR BOB KERREY

State: Nebraska

Election in 1994: Yes

Priority Health Issues:

Fiscal Responsibility
Benefits Package is Too Generous
Impact of Employer Mandates on Small Business
Opposes Mandate but Supports Required Employer Contribution
Concerned about Cost Control Provisions

Priority Non-Health Issues:

Entitlements

Recent Comments:

Strategy: Inside/Outside

Principal Contact:

Cabinet/White House Contact: Ricchetti [Cabinet Affairs Recommends Riley/Espy]

Influential State/Local Officials:

Influential Groups and Organizations:

Media/Grassroots Efforts Advisable: Yes

Message: Political Cover

Notes on Strategy: While primarily an inside game requiring attention from a number of administration officials, he is running for reelection and should be targeted by advocates of small business, labor, farmers and seniors. The media strategy should focus on the fiscal irresponsibility of incremental reform and the consequences to the middle class.

SENATOR HERB KOHL

State: Wisconsin

Election in 1994: Yes

Priority Health Issues:

More Concerned about Business Perception of Plan than Impact of Mandate
Opposes Premium Caps (Insurance Cos. are Second Leading Employer in State)
Concerned about Overly Bureaucratic Nature of Alliances

Priority Non-Health Issues:

$15 Million Grant for Milwaukee Safe Drinking Water
Lost Job Corps Site
Empowerment Zone in Milwaukee
Elementary and Secondary Education Formula

Recent Comments:

Strategy: Outside

Principal Contact:

Cabinet/White House Contact: Ricchetti [Cabinet Affairs Recommends Riley/Shalala]

Influential State/Local Officials:

Rick Phelps, Dane County Executive
Senator Ross Decker, Senate Health Committee
State Senators: David Helbach, Charles Chvala, Rodney Moen
Assembly Speaker Walter Kunicki
Assembly Speaker Pro Tem Tim Carpenter
Judith Robson, Chair, Assembly Health Committee
Alvin Baldus, Chair, Assembly Insurance Committee

Influential Groups and Organizations:

UAW
Machinists
NEA
Wisconsin Citizen Action

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform
Middle Class

Notes on Strategy: Running for reelection. Target business support and cover for employer requirement. Stress changes in Mitchell Bill that address Kohl's concerns on premium caps and bureaucratic nature alliances. David Pryor has good relationship and should be asked to work with him directly.

SENATOR FRANK LAUTENBERG

State: New Jersey

Election in 1994: Yes

Priority Health Issues:

Impact of Employer Mandate on Small Business
Impact of Price Controls and Advisory Board on Pharmaceutical Industry
Impact of Premium Caps on Insurance Industry
Believes Health Care Reform must be sold as Deficit Reduction

Priority Non-Health Issues:

SuperFund

Recent Comments:

Strategy: Outside

Principal Contact:

Cabinet/White House Contact: [Cabinet Affairs Recommends Cisneros/Pena]

Influential State/Local Officials:

Robert Janiszewski, Hudson County Executive
Carol Clark, City Council, E. Orange

Influential Groups and Organizations:

Unions (CWA; AFSCME; SEIU; 1199)
National Council of Senior Citizens
Jewish Groups
Women's Groups
African-American Organizations

Media/Grassroots Efforts Advisable: Yes

Message: Middle Class
Fiscal Irresponsibility of Incremental Reform

Notes on Strategy: Running for reelection and potentially close race. Needs to hear directly from supportive groups and Democratic constituencies. Is concerned about pharmaceutical issues and needs to hear from our supporters in the industry. We believe media would be effective in providing political cover, stressing fiscal irresponsibility of incremental and middle class consequences.

SENATOR JOSEPH LIEBERMAN

State: Connecticut

Election in 1994: Yes

Priority Health Issues:

Supports Incremental Reform
Believes in Building on Current Market Efforts
Concerned about Impact of Employer Mandate on Small Business and Jobs

Priority Non-Health Issues:

Recent Comments:

6/12/94 - "For the first time, I have felt there is a chance we will not pass health care reform this year." *New York Times*

6/30/94 - "It is all so up in the air. I'm willing to take a fresh look at what Senator Dole proposes." *Washington Post*

Strategy: Inside

Principal Contact: POCUS

Cabinet/White House Contact: Ricchetti [Cabinet Affairs recommends Deutsch]

Influential State/Local Officials:

Dick Blumenthal, Attorney General
Senator John Larson
Senator Ken Pryzbysz
Representative Joe Courtney

Influential Groups and Organizations:

Media/Grassroots Efforts Advisable: No

Notes on Strategy: Senator Leiberman wants to be a player. We need to find a way to raise his visibility in the health care debate to help accomplish this. He is in the moderate camp and could help facilitate a deal. Considered a friend of the President, he can intervene directly. Note insurance industry is very important in Connecticut.

SENATOR SAM NUNN

State: Georgia

Election in 1994: No

Priority Health Issues:

Fiscal Responsibility and Budget Effects
Impact of Employer Mandates on Small Business and Jobs
Believes Savings form Cost Containment Should be Realized before Increasing Spending
Supports Improvements to Rural Health

Priority Non-Health Issues:

Defense
Foreign Policy
Deficit Reduction

Recent Comments:

Strategy: Outside

Principal Contact:

Cabinet/White House Contact: [Cabinet Affairs Recommends Lee Brown]

Influential State/Local Officials:

Influential Groups and Organizations:

Women's Groups
African-American Organizations (Atlanta)
NEA
SEIU

Media/Grassroots Efforts Advisable: Yes

Message: Fiscal Irresponsibility of Incremental Reform

Notes on Strategy: Our ability to influence directly is limited and would likely be unconstructive. Needs to hear from supportive constituents and needs to know business community is behind plan to gain support.

SENATOR CHUCK ROBB (D-VA)

Senator Robb serves on the Armed Service and Commerce Committees. This fall, he faces three challengers in a hotly contested race: Republican Oliver North, former Governor Doug Wilder, and former Attorney General Marshall Coleman, the latter two running as Independents.

Robb has not cosponsored any of the major health care bills. He supports universal coverage, a state single payer option, and taxation of benefits above average cost. In late May, he told the Richmond Times Dispatch that he endorses "a set of broad principles" including strict quality controls, portability, equitable financing, and the elimination of preexisting condition exclusions. He believes that cost-containment is the key to health care reform.

Robb has expressed concerns about the effects of reform on small business.

Votes:	*FOR:*	*AGAINST:*
	Family & Medical Leave	
	Budget	
	NAFTA	
	National Service	

General Virginia Information:
The Washington Post reported that Governor George Allen said the President's plan "would be disastrous for Virginia, costing more than 40,000 jobs and more than one billion dollars per year in additional expenses.

SENATOR CHARLES ROBB

State: Virginia

Election in 1994: Yes

Priority Health Issues:

Deficit Reduction
Impact of Employer Mandate on Small Business
Believes Cost Containment is Key to Reform but Has not Specified Mechanism

Priority Non-Health Issues:

Defense
Budget

Recent Comments:

5/20/94 - "While I have not endorsed any specific health care plan, I have endorsed a set of broad principles which include universal coverage, tough cost containment, strict quality controls and equitable financing [but has not endorsed any financing option to date]. I support insurance market reform that allows employees to change jobs without losing their insurance and prohibits exclusions for pre-existing conditions." *Richmond Times Dispatch*

Strategy: Outside

Principal Contact:

Cabinet/White House Contact: Ricchetti [Cabinet Affairs Recommends Riley]

Influential State/Local Officials:

Don Beyer, Lieutenant Governor
Ronald Tillett, Treasurer

Influential Groups and Organizations:

Coal Miners Union
Women's Groups
AFSCME
NEA Affiliate

Media/Grassroots Efforts Advisable: Yes

Message: Political Cover

Notes on Strategy: Running for reelection in a four-way race. He needs to have message reinforced from Democratic constituencies in the state. Business community has been an important political ally of Robb's. He need to hear from business community in support for bill. Media strategy stressing fiscal responsibility and middle class for political cover for Robb could be very helpful.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Maureen Shea to Anne Bartley et al re: Discussion with Judy Lichtman, WLDF, and others (2 pages)	07/12/1993	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting [8]

Racheal Carter
2011-0747-S
rc859

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TO: ANNE BARTLEY, STEVE EDELSTEIN, CHRIS JENNINGS, AND MELANNE VERVERR

FROM: MAUREEN SHEA DATE: 7/12/93

RE: Discussion with Judy Lichtman, WLDF, and others

Today I had lunch with Judy and two of her staff plus Joanne Howes of Bass & Howes. I had asked to meet with Judy specifically to discuss F&ML and the political insights on members gathered in that seven year battle. I was clear that I do neither substance nor strategy on health care.

As you have guessed, their agenda and mine were not the same. I write this bloodied but unbowed! The addition of Joanne was the first clue that they wanted to send a message - using me as one of what I suspect are many messengers - to the Whtie House. The rest was less subtle. Their message was, is, and I fear will be:

I. While they believe there are women who could for the first time be mobilized around the issues of women's health as contained in the health care package, that will only happen if comprehensive reproductive rights are included, because: one, those previously unmobilized women care about choice; and/or two, the leaders will abandon the mobilization effort if they are not happy with the handling of choice in HCR no matter what the newly mobilized women might want or think.

II. The groups will use reproductive rights in HCR as an organizing/membership tool - with the White House as the good guy or the bad as they see fit.

III. The only mesage they are getting from the Whtie House is that there will be a compromise on choice. They either get their package in toto or they don't support health care reform. Health care reform without comprehensive reproductive rights is not reform.

IV. As the recent Hyde vote and debate and defection of Sen. Mosely-Braun demostrate, the schism between the middle class and the poor on abortion, particularly minorities, is a painful one and getting worse. Compromise will mean the poor don't have a choice while the middle class do. Thus, compromise is unacceptable because it will leave the poor out.

V. The White House backed down on the Hyde vote and the groups fear that even if they like the reproductive parts of HCR, the White House won't sustain that fight in Congress. The groups will judge the White House actions there and act accordingly.

Needless to say, I've had more fun lunches. I did not feel it my

place to argue. However, having bitten my tongue throughout, I did ask the following - could they count a majority of the House who would vote for health care reform with the comprehensive reproductive rights package they support. That question did induce the only moment of silence. Judy finally said yes, with a closed rule and no Hyde/Natcher shenangians.

I also told them that on a personal level, I felt I was not alone in believing that health care reform, even with a compromise on reproductive rights, was of singular importance to women, and needed to be passed. Needless to say, that launched another tirade on it's not reform without full reproductive rights.

Frankly, I was angry at beintg set up - this not being the "intelligence gathering" I had asked for - and saddened by their arguments. I fear the Lani Guinier episode still festers and is adding to the negative tone. That may be helped a bit by a strong stand in support of Dr. Elders.

While Joanne was a bit softer than the others, I was discouraged about any chance at all for a broad-based mobilization of women on health care without comprehensive reproductive rights as a key item. Or at least such a mobilization being undertaken by any of the leaders to whom we would normally turn.

I think Donna Lenhoff of WLDF has helpful information on F&ML and Joanne on fetal tissue/NIH but I will not followup without your okay.

We are off the 14th and I will call my leader, Steve, when we return next week.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Maureen to Chris et al re: Notes from meeting with Michael Edwards (4 pages)	06/01/1993	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting [9]

Racheal Carter
2011-0747-S
rc860

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TO: CHRIS, MELANNE, AND STEVE

FROM: MAUREEN DATE: 6/1/93

Notes from meeting with Michael Edwards of NEA lobbying staff:

TARGETS:

Key House members to have who aren't leadership:

Murtha
Natcher
Brooks

La Falce - pivotal on F &ML and Civil Rights Act
Smith, Neal - along with LaFalce, key with small business

Slattery
Hughes, Wm. - both moderate and responsible

would not spend a lot of time on Stenholm and Penny who, as budget vote indicates, don't necessarily bring anyone with them but take a lot of care

Republicans to target:

Boehlert	Gilchrist	Gilman
Gunderson	Houghton	Johnson
Klug	Leach	Machtley
McDade	Meyers	Molinari
Morella	Petri	Porter
Roukema	Shays	Snowe
Weldon - very important at end on F&ML		Zimmer

Freshman class - all

DATA BASE:

- when package is ready, divide it into categories and keep track of members views on each of those categories - would be more sophisticated profile than simply lean yes, lean no etc. - given the complexity of the issue, few will be rated easily - information would also be helpful as prepare for committee and floor amendments - may want to develop a questionnaire for groups to use to gather data and report back to WH

- votes to look at: 1) combine F&ML and budget vote - anyone who voted no on both certainly not rock solid on President's agenda and someone able to resist intense WH

pressure - people who will need grassroots effort; 2) Civil Rights Act in last Congress and Danforth compromise - particularly helpful on small business where it was an issued of mandated benefits and small business exemptions; 3) catastrophic - particularly those who switched sides.

- health care situation in state - will effect Members of Congress and national organizations which may have interenal political problems in states where their members may not be better off under health care reform

STRATEGY:

- consider a bipartisan health care summit - with Members of Congress, Govenors, Mayors etc. to keep message on what's in it for the country

- look at what went wrong in catastropic vote - learn particularly from their sending out too many messages and most groups inability to change message quickly

- keep members, particularly Republicans, from committing early against the plan - get them to subscribe to principles in the beginning and keep open mind as long as possible

- sophisticated, pinpointed strategy for those with real interest in particular issues - broadbased for those who are always on the target list

- with coalitions, keep people engaged, don't just keep asking them to do things - they have to feel a part of the process - need to have them buy-in early so will stay with health care as other priorities arise for them - Joel Packer at Labor handled F&ML for NEA and is very knowledgeable about groups who may be in coalition

TO: CHRIS, MELANNE, STEVE

FROM: MAUREEN DATE: 5/20/93

Yesterday I met with David Cohen to ask him to suggest members of the House he would consider key to influencing the health care debate. Not surprisingly, he also offered some advice on strategy. I was clear that I am far removed from that part of things, so any or all of these ideas may be in place. With that caveat, here are the list and the ideas.

IMPLEMENTATION PLAN - Before the package is introduced there needs to be a bipartisan implementation plan laid out which:

- includes the leadership of both parties appointing task forces to work with the White House as the package progresses

- makes the Republicans full players - Clinton will get more political credit if the Republicans are seen as included - look for those who are not idealogues but will want to be helpful

- positions the White House to take the lead on compromises which may need to be made

- uses outside people, particularly those with institutional memories - he mentioned Linda Kamm, Dick Warden, and Ken Young as examples - to help make contacts, get intelligence, give advice

- builds relationships with the outside groups so that they aren't simply cheerleaders but part of the process as well - involve them in the substantive base and again, use their institutional memories

- ditto with Hill staffers

- look to the Johnson Administration legislative model of pulling all departments into meetings and giving them all a role to play

The Senate - David advocated being very inclusive of Republicans in the Senate, more so than in the House, and offered this list:

Chafee
D'Amato
Cohen
Danforth

Domenici Hatfield
Jeffords (don't take for granted and a very good workers with other Senators if he is on board)
Kassebaum
Lugar (a longshot but worth the effort)
Packwood
Specter
Stevens (another longshot but good on tobacco)
Roth (worth a try)

The House - Suggested using the Coelho method of being very inclusive of all groups - in addition to the leadership and relevant committee chairs:

Berman	Brooks	Cardin
Cooper	Derrick	Dixon
Durbin	Fazio	Fingerhut
Frank	Gejdenson	
Hamilton (an important weathervane)		Kennelly
Kleczka	Kopetski	Lewis, John

Delauro, Pelozi, and Lowey - all three very good with members of both genders

Miller, George	Rangel	Sabo
Slaughter (needs some work after vaccination compromise)	Richardson	Stokes
Synar	Serrano	Torres
Waters	Williams	Waxman
Wheat	Wyden	Owens
Townes	Vacarres (sp?)	
Goodling	Grandy	Morella
McDade	Snowe	

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: Senators (4 pages)	n.d.	P5
002. fax	Micahel Werner to Chris Jennings re: Senators' Health Views (6 pages)	04/1993	P5
003. list	re: Senators (8 pages)	n.d.	P5
004a. letter	Edward Kennedy to Hillary Rodham Clinton (2 pages)	08/13/1993	P5
004b. memo	David Nexon to Michael Werner re: WHIP Meeting with Senator Biden (1 page)	06/15/1992	P5
004c. memo	David Nexon to Michael Werner re: Senator Dodd (1 page)	06/09/1992	P5
004d. memo	David Nexon to Michael Werner re: WHIP Meeting with Senator Deconcini (1 page)	06/09/1992	P5
004e. memo	David Nexon to Michael Werner re: WHIP Meeting with Senator Hollings (1 page)	06/08/1992	P5
004f. memo	David Nexon to Michael Werner re: WHIP Meeting with Senator Bingman (1 page)	06/08/1992	P5
004g. memo	David Nexon to Michael Werner re: WHIP Meeting with Senator Bnun (2 pages)	06/08/1992	P5
004h. memo	Sherry Hayes to Michael W. re: WHIP report (2 pages)	05/21/1992	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting [10]

Racheal Carter
2011-0747-S
rc861

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

ENERGY AND COMMERCE (27-17)

Democrats	
DINGELL	Y
WAXMAN	Y
SHARP	Y
MARKEY	Y
SWIFT	Y
COLLINS	Y
SYNAR	Y
TAUZIN	Likely N - strong anti-abortion, anti-mandates, extremely protective of his small employers
WYDEN	Y
HALL (TX)	Likely N - might support package in committee if chairman applies pressure, but not on floor or subcommittee. anti-abortion, anti-mandates, anti-taxes, anti-cost controls on providers.
RICHARDSON	Possible Y - so far saying right things, but undependable
SLATTERY	Possible Y - wants to support package; can be valuable whip among moderate and conservative dems. will oppose the bill if it covers abortion.
BRYANT	Y
BOUCHER	Likely N - would like to support package, but will strongly oppose tobacco tax. also rural concerns, strong black lung concerns
COOPER	Likely N - possible to apply pressure on senate race?
ROWLAND	Leaning N - dislikes mandates, cost controls, taxes. However, interested in talking and does respond to pressure from chairman
MANTON	Likely Y
TOWNS	Likely Y - strong inner city concerns

STUDDS	Y
LEHMAN	
PALLONE	Likely Y - single payer
WASHINGTON	Likely Y
SCHENK	Likely Y - women's health concerns
BROWN	Y
KREIDLER	Y
M.MEZVINSKY	Likely Y - women's health concerns
LAMBERT	Likely Y - women's health concerns
<u>Republicans</u> MOORHEAD	Likely N
BLILEY	N
FIELDS	N
OXLEY	N
BILIRAKIS	Likely N
SCHAEFFER	N
BARTON	N
MCMILLAN	Likely N
HASTERT	N
UPTON	Likely N
STEARNS	N
PAXON	N
GILLMOR	N
KLUG	N
FRANKS	N
GREENWOOD	Possible Y
CRAPO	N

EDUCATION AND LABOR (27-15)**

FORD	Y
CLAY	Y
MILLER (CA)	Possible Y - generally supportive; can be a maverick; bad vote last year on consumer health insurance protections
MURPHY	? - maverick, anti-abortion
KILDEE	Possible Y - anti-abortion, but perhaps not so much so to vote against health reform
WILLIAMS	Y
MARTINEZ	
OWENS	
SAWYER	Y
PAYNE (NJ)	? - Strong insurance influence (Prudential) in his district. Former Prudential employee. Cosponsored McDermott bill?
UNSOELD	Y
MINK	Likely Y - will insist on special treatment for Hawaii
ANDREWS (NJ)	Possible Y - Also influenced by Prudential, though not as much as Payne
REED	Likely Y
ROEMER	Likely N - Often votes with Republicans; Bennett Johnston's son-in-law
ENGEL	Likely Y
BECERRA	Likely Y
SCOTT	Likely Y - possible tobacco problem
GREEN	Likely Y
WOOLSEY	
ROMERO-BARCELO **	Likely Y
KLINK	Likely Y

ENGLISH	Likely Y
STRICKLAND	Likely Y
DELUGO **	Likely Y
FALEOMAVAEGA **	Likely Y
BAESLER	Possible N - tobacco problem

Republicans

GOODLING	Likely N - heart in right place, but pressured from conservative Rs on committee to vote no
PETRI	Possible Y
ROUKEMA	Possible Y
GUNDERSON	Possible Y - quit leadership; wants to be a player
ARMEY	N
FAWELL	N
HENRY	N - may miss vote; hospitalized with brain tumor
BALLENGER	N
MOLINARI	Possible Y
BARRETT	N
CUNNINGHAM	N
HOEKSTRA	N
MCKEKON	N
MILLER (FL)	N

To: Chris Jennings

Fr: Michael Werner

224-6182

6 pages including cover.

Please deliver to Chris.

(*) Steve, et al: FYI

SENATORS' HEALTH VIEWS -- April, 1993

These represent the views of Democratic Senators, as of April 1993, as expressed by them during meetings on health care reform this year.

Baucus -- He is concerned about rural areas. Supports single-payer, or in a managed competition framework, no opt outs for large business. Also Supports state flexibility.

Bingaman -- Primary care and reform of graduate medical education are imperative. Thinks it should be part of budget reconciliation so Senators don't have to vote for tax increases twice. Believes that all employers should be required to go through the HIPC.

Breaux -- Supports managed competition, and believes that it must be in place across the country for it to reduce costs effectively. Opposes price caps and freezes. Disagrees with CBO estimates on cost savings from managed competition.

Boxer -- Concerned about women's and children's health. Basic benefits package should be determined by National Board, otherwise we will face big political battles (i.e. abortion.).

Conrad -- He believes that strong cost control is key. Concerned that managed competition won't work in rural areas because of their sparse population. Concerned about Native Americans. Also believes we must educate the public about health reform. Opposes funding health reform through a new, large tax.

Daschle -- He believes we should re-structure Graduate Medical Education to emphasize primary care. He also feels that the National Board should set a global budget based on a consultative process with HIPCs and states. He believes that in a managed competition system, large businesses should not be allowed to opt out. He is very concerned that people don't understand the real costs of the current health system -- that they are already paying too much in direct and indirect spending. He thinks this education is crucial, so people don't think the new system will cost them too much money.

Dodd -- Concerned that pharmaceutical companies will be hit too hard. "The only industry in Connecticut to have an increase in jobs over the past five years". Supports the PMA offer to negotiate price reductions with the Administration.

Exon -- He believes we should move this year. Concerned about the cost to the federal government.

Feingold -- He thinks a long term care benefit must be included. Supports single-payer.

Feinstein -- Strong cost containment must be a critical element of the bill or she will not support it.

Glenn -- Thinks doctors are unfairly characterized as villains. He says their revenue is less than one-fifth of all health spending. He's concerned that a large percentage of lifetime health costs occur in the last four months of life. He's also concerned about retirees, and changes to Medicare and Medicaid.

Graham -- Cost control is key element of health reform. He believes that a long-term care benefit is necessary. But, he's concerned that states will be forced to pick up the entire long term care tab, or that the federal contribution will be capped.

Harkin -- Concerned about rural health, preventive care (no co-pays for preventive services), and access to health care (including long term care) for people with disabilities.

Hollings -- He believes the only way to get enough money for health reform is through a VAT.

Kennedy -- He believes that a new system must be universal with tough cost control and systemic change. Concerned about how long it will take for HIPCs to develop.

Kerrey, R. -- He believes that health costs necessitate reform. Thinks that going slow is not the same as being an obstructionist. "I'll only vote for this bill if I think it will work". Believes that federal health payments should be made through a trust fund like Social Security, and be dispersed "pay as you go."

Kerry, J. -- He warns that expectations are high. Regular meetings with Senators is critical.

Lautenberg -- Concerned that health reform will hit two big industries in New Jersey (pharmaceuticals, and insurance companies). He wonders if there will be transportation needs in rural areas to help provide access to health services. Also concerned with overuse of technology.

Leahy -- Concerned about access to health care in rural areas. Also wants maximum flexibility for states, so they can move ahead now.

Levin -- Concerned about the bill's cost control mechanism. Wants states to have flexibility to design and implement their own cost control measures.

Lieberman -- He says that it is critical to educate the public so people understand the problems with our health system, and what solutions are necessary. Believes that before the plan is announced, White House should have process to hear people's concerns. He's concerned we may lose the middle class because this will require a big new tax.

Metzenbaum -- To truly reform the health care system, he believes, the Administration must be willing to take on and defeat the special interests, and take the program to the people. He's concerned that managed competition is too easy on special interests and in particular, insurance companies. Co-sponsor of single-payer bill.

Mikulski -- Concerned with the influence of Jackson Hole Group. She calls them "a bunch of geriatric Republicans that represent everything that's wrong with health care." Wants a change in the delivery system to increase the focus on public health, and thinks health professionals such as nurse practitioners, midwives, social workers should be more involved in health care delivery.

Moseley-Braun -- Supports system with "single collector" of revenue, but with state differences.

Moynihan -- Interested in Rochester, NY as model. Also concerned about mental illness, and the homeless.

Pell -- "Is the Administration considering rationing?"

Reid -- Concerned about mandated benefit packages, because he believes they have not worked at the state level. Also concerned about the impact of a bill on doctor earnings.

Riegle -- "You'll never get a perfect bill. Don't wait until next year."

Robb -- "Cost containment is the key."

Rockefeller -- Senators must be willing to compromise. "We must all leave our theology at the door." Don't wait -- move now.

Simon -- Long term care is key benefit. It helps the middle class whose support we need.

Wellstone -- Supports single-payer bill. Concerned with rural areas. Wants state flexibility (for his own state and to help single-payer movement) and consumer choice. Also interested in mental health. Willing to compromise. He told HRC: "I'll get off single-payer and work with you." We need to move now.

Wofford -- Do it this year. Key issue is how we recapture the money from cost containment to cover the uninsured. Savings should be used to pay for access. Cost control should be an interim measure. Is uncomfortable with the tax cap.

HEALTH CARE VIEWS OF UNCOMMITTED DEMOCRATIC SENATORS
1992

The following are the views of uncommitted Senators on health care reform as of October, 1992. This information was obtained throughout the year through individual meetings with Senators on the health task force.

Biden -- He said he is still learning the issue, but will give an answer at end of the month. Key is DuPont Corp.-- they are pushing for national health insurance. They also control the Delaware Chamber of Commerce. The National Leadership Coalition will follow-up with Biden and DuPont. Biden is concerned that play-or-pay could lead to rationing.

Bingaman -- At this time, he is only comfortable with his bill, which relies on an Enthoven-type managed competition approach. Although he supported play-or-pay in Committee, he is very reluctant to support it on the floor.

Boren -- Will not support single-payer. Concerned that play-or-pay will lead to more taxes, and shifting people into public plan. Also concerned about small business. Wants a solution that is market oriented as suggested by Enthoven and House Conservative Dems. Also interested in rural health issues and would like the bill to address them.

Bryan -- Concerned about small business as well as unfair insurance practices. His constituents overwhelmingly support single-payer over play-or-pay. He fears that in a play-or-pay model, businesses will unload their high-risk workers into a public plan. Scared that our plan will increase taxes. Doesn't think we need immediate access. Will not support a bill small business opposes. Believes medical malpractice reform is needed. At this time, he would vote against pay-or-play or single-payer.

Bumpers -- Does not support play-or-pay. Very concerned about small business. Wants to learn more about the issue. Would take cue from Pryor.

Conrad -- Concerned about small business, health care in rural areas, and ensuring that Americans will be able to choose their doctors. Also believes medical malpractice reform is essential. Supports global budgeting and concept of negotiations between payers and providers to reduce costs. He believes that the health care system should not be under supervision of federal government. He argues that if we eliminate waste we can provide coverage without increased costs.

DeConcini -- Key concerns are cost containment and state flexibility. Also concerned with small business but is prepared to tell them they should be required to either provide insurance to their employees or pay a tax -- provided the tax is less than the amount required in HealthAmerica as currently drafted. He will oppose a single-payer bill.

Dodd -- Concerned about small business and insurance industry. Kennedy believes he could get Dodd's vote on play-or-pay if we needed it on the floor. He would never support a single-payer plan.

Exon -- Not supportive of play-or-pay or single-payer models. Seems to prefer managed competition plan.

Heflin -- Seemed to be open to reform. Not focused on the issue, needed education. There's been follow-up educational efforts with staff scheduled.

Hollings -- Small business is a major problem. Will not support a bill this year.

Levin -- Doesn't feel comfortable, still learning the issue. Cannot support play-or-pay yet. Wants a focus on preventive care and administrative simplification. Concerned about the impact on business, especially small business. He would like to see long-term care included, and an increased focus on preventive care. He said if these concerns were addressed, he would probably support our package.

Lieberman -- Supports managed competition/Enthoven approach. Concerned about small business and the insurance industry.

Mikulski -- Would support consensus package, but believes it must be a "true" consensus and good public policy -- she would not support it if she felt it was a "paper" coalition, not good policy and just brought to the floor for a political statement.

Moynihan -- Co-sponsored Kerrey health bill, and takes his cues from him. Nonetheless, willing to learn more about issue and consider other plans.

Nunn -- Concerned about small business, cost control, and financing. Expressed an interest in "Medical IRAs". He believes that part of any comprehensive solution should be to reduce administrative costs. He would not support a single-payer plan.

Robb -- Willing to support comprehensive package, especially play-or-pay. Less sure about single-payer models. Will support leadership-sponsored Democratic consensus package.

Sarbanes -- Will support leadership package. Understands political implications of health care issue.

Shelby -- Doesn't want a "top-down" system. Need local control and decision-making.

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Akaka	cosponsor	no	-	-	Will want special waiver to allow Hawaii to continue its present system.
Baucus	-	*		concerned about moving too fast and not doing it right.	* Part of Daschle/Wofford group that advocates all employers in HIPC; voted against Pepper Commission "pay or play" plan; concerned about small business and rural health issues;
Biden	-	no	noncommittal but skeptical- especially concerned about HMO's	hasn't taken a position publicly	
Bingaman	-	N	Y		Introduced a "pure" Jackson Hole plan but with a budget; rural health and prevention major concerns; concerned about employer-based financing
Boren	-	N	Y		Senate sponsor of House CDF bill which does not have an employer mandate
Boxer	-	Co-sponsored Russo bill, but no enthusiast	Y	Not public; very willing to wait	New member, very interested in working with leadership; staff now attending DPC health meetings
Bradley	-	N	Y	will wait for WH	Sees the need for cost control, willing to use global budget, reluctant about rate regulation; believes long-term care needs to be addressed <u>now</u> in some way
Breaux	-	N	Y		Senate sponsor of CDF bill which does <u>not</u> have an employer mandate; opposes global budget, rate regulation.

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Bryan	-	Doesn't think it will work but noncommittal	Unsure it will work in rural areas such as Nevada	Neutral	Has publicly supported Pryor's prescription drug legislation and supports insurance reform (mentioned pre-existing conditions)
Bumpers	-			Not on record, but will wait for WH	Resisted effort to be pushed into Daschle camp
Byrd	-	-	-	wait and see	Mostly financing concerns, especially any specific directions for the Appropriations Committee on funding that might be included in health reform bill. Also concerned about jurisdiction, particularly if health care financing might "take over" some of their discretionary programs. Generally puts energies into "infrastructure." Specifically mentioned possibly redundant financing received by community health centers for various health care services. Has no preference on overall approach, likely to defer to Rockefeller on this. Wants to look at total package.
Campbell	-	-	Y	Not on record; wait and see	Comfortable with the process; special concern for IHS
Conrad	-			Not on record; wait and see	"Evolving" opinions; worried about managed competition working in rural ND; Indian health care a concern; strong support of need to cut entitlements; need to have a strong emphasis on cost containment. Staff is on WH working group.
Daschle	-	modified single payer	-	-	Introduced American Health Security Planm in 102nd Cong.: State administered single payer-like proposal, includes long-term care; major advocate of all employers being required to join HIPC (Paul Starr approach); staff on WH working group

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Deconcini	-	N	Depends on how defined. Willing to work with it but also believes we should preserve some of our current system	Not on record; wait and see	Very concerned with how the new system will be paid for because doesn't want to see more taxes. Also concerned with the effects on small businesses and incentives for Medicaid because many doctors refuse to treat patients.
Dodd	Voted for bill in L&HR Committee; but not at all comfortable with and has since backtracked from the vote.	N	-	Wait and see.	Large and med size insurance companies in state: Aetna, Travellers, CIGNA, Hartford; also have many drug companies; not uncomfortable with employer mandate as long as there are sufficient subsidies, phase-ins, etc.; short term cost controls likely to be major concern, esp. premium caps; childrens health care and prevention key concerns.
Dorgan	-	N	Will support if in combination with an other efforts to help rural areas; very open-minded	Not on record. Will support as long as attention is really given to rural areas	Big concern with cost containment and rural health care
Exon	-	_		Wait and see.	Sen Exon talks to Frank Barrett, insurance man in Omaha; watches Kerrey with interest but not support
Feingold	-	Y	Y	Not on record, wait and see	Sponsor of single-payer legis. in WI; new member, will likely support President; strong LTC and farmers concern
Feinstein	-	N	-	Will wait for WH plan	No positions taken, although very knowledgeable about health, esp. at state and local level; supports strong cost containment

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Ford	-	N	Y	Wants to support President	Will fight tobacco tax; brother-in-law is pediatrician in KY; wants freedom of choice for consumers, nervous about mandated benefits
Glenn	-	N	-	-	Supported pay-or-play (but not cosponsor of HealthAmerica); held hearings on German and French systems; worried about small businesses
Graham	-	N	Y	Wants to support President.	Long term care a BIG interest; feels ltc should be part of package, his staff is on WH ltc working group; OK on employer mandate and wants to be player on global budgets (except would be concerned if Fla. was somehow adversely affected in comparison to other states).
Harkin					Major concern about prevention and rural health care; staff active on Mitchell's and White House working groups
Heflin	-	Noncommittal	Depends on how it is defined.	Not publicly. Wait for plan and concrete numbers of how and where money is spent.	
Hollings			Worried by CBO testimony, by rural cov'ge	wants to support President's plan	Steered clear of leadership bill; worried about employer mandate w/o cost control; expressed interest in Medicaid buy-in.
Inouye	Cosponsor	Cosponsored Wellstone single payer bill		likely to support	will want to continue special exemption to retain Hawaii's current system.

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Johnston		Noncommittal	Not opposed but sees problems with regional pricing	No position yet but wants to be a constructive player	Big concern with preventive care--he'll give in on other issues if it's made a high priority
Kennedy	Introduced	-	will support in context of global budgets and universal coverage	Will be major proponent.	Jurisdictional split with Finance Committee will be a BIG issue. Marked-up and passed HealthAmerica bill out of L&HR Committee, Jan. 1992. Staff on WH working group and keeping close tabs on work.
Kerrey	N	Modified single payer	-	recently said he "likes what he is hearing from the WH"	comprehensive legislation introduced by Kerrey is actually very similar to Clinton framework, except all businesses would be required to join state-run purchasing group (versus privately run HIPC) and link to employment would be severed, although employers and employees would be required to contribute through payroll taxes.
Kerry	-	N	Y	Wants to support Pres.; not on record	Administrative and insurance reform of special interest; wants to protect biomedical and biotech industry (growth sector in MA)
Kohl	-	N	-	Likely to be supportive.	Comfortable with employer mandate with adequate subsidies; insurance companies are the 2nd largest employer in state so that will be a concern. Member of the Mitchell working group and staff is participating on the WH working group
Krueger	-				Focused on re-election; recognizes important issue but worried about huge challenge

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Lautenberg	-				Met w/ Daschle; wants to be part of whole team, up for re-election; was pushed on single-payer but resisted; "in mangd. comp. mode;" skittish on emp. mandate, but feels can be liaison to business community
Leahy	Cosponsor	N	Y	Likely supporter.	Will want some state flexibility. Gov. Dean's aide (as NGA health co-chair) is working on WH working group, as is Leahy's staffer.
Levin	-	N	Y	On record wanting to support	Rural and small business concerns; wants good primary preventive, hospice, and home care
Lieberman	-	N	Supports the concept but has a problem with global budgets and caps. Liked Cooper's plan	Has said he is encouraged but has a "wait and see" attitude	
Mathews	-	Noncommittal	Generally supportive	Not publicly but supportive of reform efforts with some modifications	
Metzenbaum	_	sponsored Wellstone's single payer bill	N		Concerns will be antitrust (chairs subcomm.), malpractice; strong consumer protections; staff is active on WH working groups.
Mikulski	-	?	?	Waiting for the President	former social worker; wants expansive benefit package that emphasizes public health services; supports home and community-based care; nervous about influence of Jackhole group.
Mitchell	Cosponsor	N	Y	Yes	Rural and long-term care concerns

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Moseley Braun	-	Y	-	Will wait for the President	Integrity of basic benefit plan a concern; vulnerable and low income populations
Moynihan	-	-	-	indicated he wants to be helpful to passing in passing the President's health care plan.	New Finance Chairman, mostly interested in income security issues; has said he opposed new health care taxes, but staff said what he meant to say was that he did not support tax caps on benefits but not necessarily other taxes to finance health care reform. Finance staff is participating on the WH working group.
Murray	-	-	?	Will likely support President	Will want to preserve state reforms; long-term care
Nunn	N	N	Hasn't taken a stand yet -- CSIS group that he chairs is studying it and he'll support its recommendations	Likely to be very opposed to employer mandate..	Strongly in favor of tight entitlement caps. Unsure how a global budget will work on private spending; has said that he has been assured by President Clinton that plan won't include an employer mandate. Rural concerns.
Pell	Supported in L&HR committee	-	-	wait and see -- but nervous	is absolutely committed to health care reform; is interested in in-depth look at other countries' experiences; believes prevention, long-term care, insurance reform, use of non-M.D. poviders all must be addressed
Pryor					Voted for Pepper Commis. recommendations; small business concerns, drug costs, senior issues
Reid	-	N	?	Waiting for the President	Concerned about rural areas; has spoken to HRC; wants Pb screening emphasized
Riegle	Introduced	-	-		Wants reform to be enacted this year; retiree health care is a big issue.

	HEALTHAMERICA	SINGLE PAYER	MANAGED COMPETITION	ON RECORD ON CLINTON PLAN	COMMENTS
Robb	-	-	-	Likely to be supportive; comfortable with approach so far.	Active member of the Mitchell working group and was comfortable with its overall approach; wants cost containment to be stringent. Was a member of the National Leadership Commission on Health Care which predated the National Leadership Coalition.
Rockefeller	Introduced	N	with a national health care budget and universal access	Y	
Sarbanes		Supported Kennedy's plan in 1972 but realizes it won't work today	Noncommittal but willing to work with it	Wait and see attitude but wants to help Clinton and will support Rockefeller, Mitchell, etc.	
Sasser	-	N	Y	Wants to work with President	Strongly believes that health care reform should be done in reconciliation
Shelby	-	N	?	Waiting	Anti employer mandates, anti rate setting; small business concerns; some self-insured have used managed care very well in AL
Simon	Cosponsor	Cosponsor of Wellstone bill			Amended HealthAmerica in L&HR Committee to tighten cost containment (AFL-CIO amendments)
Wellstone	N	Introduced single single-payer. 3/93	N		Personal interest in comprehensive mental health benefits; also LTC; more than likely will support President, but very strong single payer bias
Wofford	N			likely to support	Very active on health care reform; supports Starr approach (advisor on health during campaign) that would require all businesses to join a HIPC.

cc: Melanne Smiley

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

August 13, 1993

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Hillary:

Many thanks for our meeting on Wednesday -- I'm looking forward more than ever to working as closely as possible with you and the President to achieve our goals on health reform.

To follow up on our discussion, I am enclosing the reports I mentioned from the one-on-one contacts made with Democratic Senators during the last Congress to explore their concerns on health care reform. Unfortunately, only the reports from my own meetings and Senator Kohl's meetings are still available. The focus of the meetings was on the Democratic Leadership "pay-or-play" bill, but some of the comments are still relevant. Sam Nunn's and Dennis DeConcini's comments seem particularly interesting and useful. I will also be forwarding you, under separate cover, a draft proposal developed by my staff for the inclusion of an occupational health and safety initiative in the Administration's health care reform proposal.

With regard to Senator Hatch, the health accomplishments that might be most appropriate to mention include his work on the Ryan White AIDS Care Bill; his breast and cervical cancer information program, which requires federally funded clinics to provide appropriate information to their patients; his activities on behalf of home health care; and his authorship of the Orphan Drug Act and the Drug Price Competition and Patent Term Restoration Act. The latter bill allows drug manufacturers to extend the term of their patents to compensate for delays in the regulatory approval process; it also makes it possible to approve generic drugs more quickly.

With regard to Senator Chafee's bill, my staff is still tracking down details, and I will send you a fuller report next week. The information gathered so far does not go much beyond what you already know. There will be an individual mandate, but no employer mandate. Insurance for small businesses and individuals will be provided through a HIPC structure, but participation in the HIPCs will be restricted to businesses much smaller than those in the Administration bill. The Republicans will attempt to portray their HIPCs as market-oriented, and our Health Alliances as bureaucratic and regulatory. Subsidies will be provided to low income families and individuals.

According to Senator Chafee's staff, he does not really want to introduce a bill. The Republicans would like to have the Administration and Senator Chafee announce principles and a general program outline, followed by a "summit" to reach a compromise.

I hope this information is useful, and I look forward to seeing you again soon.

As ever,

Ted Kennedy

Edward M. Kennedy

TO: Michael Werner

FROM: David Nexon

DATE: 6/15/92

SUBJECT: WHIP MEETING WITH SENATOR BIDEN

Senator Biden had a number of intelligent questions about the proposal and the issue. He indicated that he knew little about it and would try to educate himself over the next few weeks in order to give us an answer prior to the end of the month.

He made several interesting observations:

--When he was first running for office, he met with the then head of DuPont who was fairly abusive and said that the reason he did not like him (Biden) was that Biden was for national health insurance (which Biden actually did not and does not support). Two years ago, he met with the current head of DuPont, who did a whole chart show on DuPont's health costs which concluded with the statement, "This is why we have to have national health insurance." Biden also said that DuPont controls the Delaware Chamber of Commerce, and if they were on the right side, he would not get any pressure from the Chamber. We have followed up with the National Leadership Coalition, who said that they would see Biden directly and that they would contact DuPont as well.

--The main complaints he has hear about "pay-or-play" from Delaware was not on the small business aspect but on the argument that it would lead to rationing. Biden wondered what our response to that argument was.

--We agreed to supply Biden with additional materials and further briefing. Senator Kennedy's sense was that we had a good chance of getting his vote.

TO: Michael Werner

FROM: David Nexon

DATE: 6/9/92

SUBJECT: Senator Dodd

Senator Kennedy decided that he talks to Dodd enough that he knows where he is and that a separate meeting was unnecessary.

Dodd is concerned about small business and about the large Connecticut insurance industry. Based on his actions in Committee, we will likely have his vote if we need it. He would never support a single-payer plan.

TO: Michael Werner

FROM: David Nexon

DATE: 6/9/92

SUBJECT: WHIP MEETING WITH SENATOR DECONCINI

Senator Deconcini said he was very interested in cost containment. Provisions for state flexibility or a state opt-out sold well in Arizona.

He said that small business, of course, was a major concern, and that small businesses didn't want to pay a dime more. He was prepared to tell them that they are going to have to contribute to the solution and would support a program that required them to. He wanted to find a way of reducing the amount they had to contribute below what was required in the current bill. He would like to see their contribution reduced to 30 per cent or 40 per cent of the total cost of covering their workers, and he would be prepared to vote for broad-based taxes to help cover the difference between the cost in the current bill and the additional cost of subsidies for small business.

Senator Deconcini said he had been approached by the Catholic Conference. The Conference did not want to raise any kind of a ruckus that might derail progress on the bill, but they also felt strongly that no public funds should be used to fund abortions. The issue actually goes beyond public funds to the required benefit package, and it is one that we will ultimately have to deal with.

Deconcini seemed to like the idea of paying for the cost of the program with recaptured health system savings.

Deconcini volunteered that he did not support a single-payer approach.

TO: Michael Werner

FROM: David Nexon

DATE: 6/8/92

SUBJECT: WHIP MEETING WITH SENATOR HOLLINGS

Senator Kennedy and Senator Hollings talked on the floor. Hollings told Kennedy that he had done a great job with HealthAmerica and had legitimately addressed both small business concerns and cost control and that you could put him down as a co-sponsor right after the election. The whole political problem for him is small business.

TO: Michael Werner

FROM: David Nexon

DATE: 6/8/92

SUBJECT: WHIP MEETING WITH SENATOR BINGAMAN

Senator Bingaman began by saying that the only health proposal that he is currently comfortable with is the HIPC incremental plan that he recently introduced. He said that there was nothing original about it. It was drawn from Allan Enthoven's ideas. He is still trying to learn--anxious to see what a more comprehensive plans along these lines would like. He is interested in what the Conservative Democratic Forum in the House is coming up with.

He voted for pay-or-play in Committee, but would have an upheaval in the State if we were to make this law. He'd have problems voting for it on the floor. He is taking the public position in the State that he hasn't signed onto any of the bills yet. In the meantime, he would like to do what we can to make some progress this year on something short of a comprehensive bill--and he thinks that the HIPC approach is the best thing to do.

He said that he didn't know if the HIPC makes sense as part of any comprehensive plan--he knows it would fit into pay or play--but not the others. He believes in a national budget for health care, and he thinks that will help, but he doesn't know that we will make much progress on cost control without bringing more competition into the system.

We described the possible compromise that we have been talking about in the small business committee. Bingaman said he was very interested in that approach and would like to see what the bill would look like redrafted to include this compromise.

TO: Michael Werner

FROM: David Nexon

DATE: 6/8/92

SUBJECT: WHIP MEETING WITH SENATOR NUNN

Senator Nunn said that he had three concerns that needed to be satisfied:

--cost control;

--impact on small business;

--financing (beyond the amount provided by "pay or play" contributions)

Kennedy described what we were doing on cost control and small business, and he indicated that these were the subject of DPC task groups. He offered to supply Nunn with additional material. Nunn asked if his staff person could attend any meetings we had which were not private.

We said that we were trying to finance the cost of the program by recapturing some of the savings from cost control, but we indicated that this was a problem, because the savings were primarily to the private sector but the costs were to the public sector. Nunn seemed to pick up on this concept.

Nunn talked extensively about Breaux's ideas for medical savings accounts, and asked if that could be factored into our program. He said that he knew that this was not a comprehensive solution to the problem and that a comprehensive solution was necessary, but he wondered if it could be part of the solution. Nunn felt the idea was a good one because it reduce administrative costs and give individuals incentives to economize in the use of medical care.

Nunn said that he did not support a single-payer program.

Nunn asked about the timing, and indicated that he was going to

study the issue and would give Senator Kennedy an answer as to where he was prior to the July recess.

Senator Kennedy's conclusion was that Nunn was genuinely undecided and would study the issue carefully to decide what his position ought to be.

M E M O R A N D U M

TO: Michael W., DPC
FROM: Sherry Hayes, Kohl
DATE: May 21, 1992

RE: Whip report

Staff contact has been made with all four offices (Harkin, Levin, Conrad, Bryan). A summary of the staff representation of Member concerns is attached.

Senator Kohl has spoken with Senators Levin, Conrad and Bryan. His notes from those conversations are as follows:

Levin: Will provide short list of concerns with Health America in one week. Right now, he can't support Pay or Play; doesn't feel knowledgeable enough to suggest changes that WOULD elicit his support, but will identify objectionable provisions.

Conrad: Enthusiastic about the prospects of bringing a bill up and hopeful for a consensus. Likes German model. Must have strong negotiations between payors and providers --expenditure caps must be tough and enforceable. Must maintain a role for the private sector. Small business concerns, especially mom and pops in soft economy. Choice of provider. He indicated that he thinks "Pay or Play" is a marketing loser. He says when he explains the 3 options (Canada, West Germany, Bush versus Canada, Pay-or-Play, or Bush) West Germany is most popular. However, under the Pay-or-Play title, it loses to Canada. Somehow, he says, folks respond negatively to the Pay-or-Play title, too cavalier or something. Same program called German model, sells

well.

Bryan: Skeptical of our ability to reach consensus. In his state forums, (which he doesn't equate with polls), there is NO support for Pay or Play. Single payor is far and away the winner. Small business concerns. Also, he is concerned with long form underwriting/redlining practices; concerned that depending on the pool itself, many businesses would unload high risks onto public pool. Eager to meet again and to be educated.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re; Jack Lew Notes from meetings (5 pages)	07/14/1994	P5
002. note	re: Health Care Notes -Targets (1 page)	07/21/1994	P5
003. note	re: Greg Laughlin (1 page)	07/21/1994	P5
004. note	re: Chet Edwards (1 page)	07/15/1994	P5
005. note	Karen to Jerry re: update on calls (2 pages)	07/12	P5
006. note	re: from Secretary Reich (2 pages)	07/14/1994	P5
007. note	re: Lew Notes from 7/20 Dems Meeting with First Lady (4 pages)	07/20	P5
008. note	re: Lew notes from his meting 07/19/94 (4 pages)	07/19/1994	P5
009. list	re: Representatives (1 page)	07/13/1994	P5
010. note	re: Health Care Targets (11 pages)	07/19/1994	P5
011. memo	Lori Davis and Alan Hoffman to Jerry Klepner re: Health care reform calls (7 pages)	07/12/1994	P5
012. form	re: Health Care Congressional Feedback (1 page)	08/15/1994	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting - Meeting Notes

Racheal Carter
2011-0747-S
rc613

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
013. form	re: Health Care Congressional Feedback (1 page)	08/15/1994	P5
014. note	re: POTUS Meeting with House Members (2 pages)	08/08/1994	P5
015. memo	Lori Davis to Steve Edelstein re: HRC meeting (1 page)	08/09/1994	P5
016. note	re: meetings with Senators (2 pages)	n.d.	P5
017. form	re: Health Care Congressional Feedback Senator Kohl (1 page)	08/10/1994	P5
018. form	re: Health Care Congressional Feedback Senator Lieberman (1 page)	08/09/1994	P5
019. form	re: Health Care Congressional Feedback Senator Bradley (1 page)	08/09/1994	P5
020. form	re: Health Care Congressional Feedback Paul Simon (1 page)	08/09/1994	P5
021. form	re: Health Care Congressional Feedback Senator Mikulski (1 page)	08/09/1994	P5
022. form	re: Health Care Congressional Feedback Senator Dodd (1 page)	08/09/1994	P5
023. form	re: Health Care Congressional Feedback (1 page)	08/03/1994	P5
024. form	re: Health Care Congressional Feedback D. Payne (1 page)	08/03/1994	P5
025. form	re: Health Care Congressional Feedback N. Smitz (1 page)	08/03/1994	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting - Meeting Notes

Racheal Carter
2011-0747-S
rc613

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
026. form	re: Health Care Congressional Feedback J. Brooks (1 page)	08/03/1994	P5
027. form	re: Health Care Congressional Feedback Senator Hatfield (1 page)	08/09/1994	P5
028. note	re: VP Calls (2 pages)	08/09	P5
029. memo	Elaine Holland to Dana Hyde re: Congressional Health Care Calls (1 page)	08/07/1994	P5
030. memo	Elaine Holland to Dana Hyde re: Senate Visists (3 pages)	08/12/1994	P5, P6/b(6)
031. memo	Elaine Holland to Dana Hyde re: Congressional Health Care Calls (4 pages)	08/04/1994	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
Targeting - Meeting Notes

Racheal Carter
2011-0747-S
rc613

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Hamilton

JACK LEW NOTES FROM MEETINGS 7/14/94

Lee Hamilton - No support in his district for the President's bill. People are scared of change and losing what they have now. His own advice is this is too big to do without a broad bipartisan consensus. Doesn't know how he'll vote. Waiting to see the leadership bill. Too much, too soon. Seemed like the W& M phase-in might help, but he'll have to wait to see the outcome of the leadership process.

Klink

JACK LEW NOTES FROM MEETINGS 7/14/94

Klink - All abortion. Otherwise OK.

Margolies-Mezvinsk

JACK LEW NOTES FROM MEETINGS 7/14/94

Margolies-Mezvinsky - strictly local politics. The mandate is very unpopular, she has the health care industry, being killed for the budget vote. Won't wait until the last minute this time. She'll look at the leadership package. But don't count on her. Her deal with Dingell was OK because it took care of some problems for her that she had to solve, and she could say that she was moving the process along, but it's not the same on the floor. Being killed with local ads. All the national money seems to be pouring into her district.

SISISKY

JACK LEW NOTES FROM MEETINGS 7/14/94

Sisisky: There are a lot of issues that he could use as an excuse if he wanted to - abortion, mandate, tobacco tax- the real issue for him personally is he doesn't think the numbers add up. It was clear that of the issues, the mandate was the biggest. He's heard the minimum wage arguments from Gephardt but they don't fly with his businesses. And he's waiting to see what the leadership comes up with. The only bill he is on is R-B, thinks there has to be a vote on it or the rule will go down. At the moment he thinks R-B will pass. Nevertheless he sounded like he genuinely wanted to be helpful and certainly wasn't closing the door. He's getting a hard time because of the NAFTA vote, and annoyed with the DNC ads - what they should be running is ads telling that budget vote was one to help people, not hurt them, because they don't understand it. Concerned about the Sen -no BTU rerun.

Stupak

JACK LEW NOTES FROM MEETINGS 7/14/94

Stupak- Generally positive, wants to see health care reform this yr. Wants to see rural issues addressed, wants Ed & L rural provisions, doesn't know what the leadership will do. For him abortion is the real issue, can't vote for an abortion mandate. Thinks W&M phase-in of mandate is OK, seems ok on cost containment. Concerned about the Senate - no BTU.

FELTON — Here's one more.

JANET

[redacted]

Health Care Notes - Targets

SPRATT - Would prefer a trigger of some sort w/ the benefits pkg. scaled back a bit. But cd. probably support sm. form of a mandate; "Maybe start it at a 50/50, employer/employee split." Does not like Ways & Means approach w/ Medicare Part C component. Is still trying to sort out what he thinks he can support.

(7/18)

[redacted]

[redacted]

: LORRAINE MILLER

[redacted]

Mon. July 18, 1994

THE WHITE HOUSE

Greg Frazier

Destruct not supportive of employer mandates, worried that House may vote for a compromise bill including mandates and Senate version to include that provision. Cynical of being BTU'd wants a more managed care approach. Will not make public statement against mandates to keep options open.

[redacted]

[redacted]

Worried

LORRAINE MILLER

[redacted]

Chet Edwards July 15, 1994

Believes some type of employer mandate may be necessary to get a health bill. His district is opposed. Will not make public statement against mandates ~~~~ Willing to vote for mandates, but reluctantly!

[redacted]

Peter DeFazio 7/15

Can not vote for employer mandates!

[redacted]

[redacted]

July 12
Note to Jerry

Here's an update on my calls this morning:

Immunization

Kohl - Richard Turman is the LA. Markup may not begin before next week. Richard has been struck by the volume and perceived import of the arguments raised against the new program and especially the new distribution system. He noted the NYTimes and WSJ pieces in particular and suggested that the general impression on the HIll is that the Administration has been "disrespectful" to Bumpers (not inviting him/MAC to briefings, etc.) is not helping us or our credibility. This is consistent with what Harkin's staff told me on Friday.

I rebutted several of the arguments on the phone (eg, all the vaccine being stored under one roof...) and promised to send up more information. Turman was very cagy. Said he did not have any read on the Senator yet. Said he did not want to talk about scheduling any staff/member briefings at this time -- perhaps after reviewing our materials. Suggested he would be talking to Mary Ann and indicated he might not be in a position to give us a heads up once he knows what Bumpers is doing. He then asked for an early heads up on the Milwaukee healthy start grant. I said I'd want the same courtesy on a Bumpers amendmnet. He said that was fair. Sheez!

Harkin - call not returned as of noon.

Deborah Von Z. - DVZ is going to ask MAC again to be included in the GAO briefing and knows that it may be tomorrow. MAC told DVZ that Bumpers would not try to kill VFC in appropriations. Further, she told her that Bumpers' criteria for deciding on what, if anything, to do in Approps depends on two main findings of the GAO report: 1. Is the proposed distribution system safe (eg, meets FDA standards, not all vaccine under one roof, etc.) 2. Can we be confident the new VFC will not lead to a disruption of the vaccine supply/availability for kids. If the answer to both questions is yes, Bumpers would not offer an approps amendment. If not, he would.

Health Care Reform

Kohl - noncommittal. kohl will hold cards close to vest until last minute. Wants universal coverage. Believes employers have responsibility to provide coverage (as he did for his own employees) but would like to see this achieved without government mandates. Likes market-based cost containment. Doesn't want to

add to the deficit. Staff has been attending Chafee group (see below) but for now is "just listening."

Dorgan - Very much wants universal coverage and strong cost containment through a reform package that is paid for. At this point, he's closer to Kennedy's mark than to the Finance mark. Would vote for a mandate for large employers today (large not yet defined -- maybe 100? maybe 75?) and could probably go for a mandate, or a hard triggered mandate, that includes a carveout for small business (maybe 50?) with some payroll tax on firms not providing coverage. Dorgan is very mindful of Conrad. They made a pact earlier to stick together. Dorgan doesn't want to do anything to undermine Conrad's reelection.

Dorgan's staff attended the group of 23 moderates that Chafee is trying to organize. He was disgusted at what he heard but will continue to attend in order to keep tabs on what is going on. Attached is a confidential draft letter to Mitchell Chafee is trying to get the moderate group to sign. Attending last week were staff from: Shelby, Robb, Reid, Lieberman, Kohl, [redacted] Bob Kerrey, Kassebaum, Jeffords, Hollings, Johnston, Heflin, Bob Graham, Feinstein, Dodd, DeConcini, Danforth, Bond, Bumpers, Bryan, Bradley, Bingaman. Conrad, Breaux and Boren were up front with Chafee. Only strong positions stated at the last meeting were: Lieberman and [redacted] Kerrey (definitely for the Chafee plan; like its protections for the insurance industry; will be Chafee's non-Finance lieutenants); Kassebaum (staff said she no longer wants reform this year); Hollings (only wants reform that doesn't cost anything); Graham (staff realizes Chafee's plan and arguments stink). The moderate group is supposed to meet 3 times/week. Dorgan's staff will keep us informed but would like not to be identified as the mole.

Karen

NOTES FROM SECRETARY REICH (7/14/94)

Joseph Lieberman -

Likes what came out of the finance committee. Doesn't like the carve out but expressed some flexibility regarding a trigger. He is open to a hard trigger but believes we do not have the votes for it. He feels that it needs to be bipartisan because we need Republican cover. Otherwise he feels we will be right back at it in two years. He also believes that Shelby and Boren are lost causes.

Herb Kohl -

He is not committed. He is not in any camp. He has an open mind on the mandate but feels strongly that this should be a bipartisan effort.

Dianne Feinstein -

She likes California's voluntary pool (CALpers) . She notes the progress that program has made and doesn't understand why we need a mandate. She hasn't closed out the possiblity of voting for a mandate but is less inclined every day. She strongly prefers a voluntary approach. She noted the discussion about the ads in the caucus. She doesn't like them. She feels that it makes them all look bad and more particularly hurts her in her reelection. Finally, she noted that she is not hearing a much from her constituents that they want health care reform.

Bill Bradley -

(Confidential to Reich - Bradley is working on his own semi-soft trigger plan. It would include maintenace of effort for employers who provide. Impose a tax on those who don't and use money for subsidies for the uninsured. Nondiscrimination. If managed competition doesn't reach 94% coverage by a date certain, commission reports and Congress votes up or down. He was a little vague on the concepts)

He does not believe the leadership will get the votes for a mandate. He feels that they should go for a bipartisan approach. He was surprised by the union reaction to his cost containment plan.

Wendell Ford -

Tobacco tax is the key. While he does not like the employer mandate, it is not a deal breaker.

Rick Boucher -

Line in sand is tobacco tax. Over the weekend met with tobacco farmers. Very hostile crowd. He was booed. Just an ugly atmosphere. He said that if they could do a separate vote on tax which he could vote against, then he would consider vote on mandate. Needs cover on tobacco tax. NFIB hads done a great job in district but perhaps could support carve out along lines of Dingell.

Lynn Schenk -

Reminded Secretary, she told chairman she would vote for the Dingell package, had worked out her problems - Breakthough Drug Committee; softening impact on small business. She was prepared to go with Dingell but now its a whole new ball game. Her concerns have not changed, price has not gone up. Doesn't like Ways and Means language on breakthrough drugcmte. Concerned about the mandate. She suggested a carve out based on profits or phase-in based on size and profits (large businesses in first. On abortion, she sees how we might have to be flexible allowing for religious exemptions. But she doesn't want every business suddenly have religious objections. She also does not like opt-in as a solution. She also does not like the Ways and Means provisions on "Any willing provider". She feels it undermines managed care.

Karan English -

She supports mandate. Has concerns about abortion. Rural issues. Seems fine.

Ron Klink -

All abortion. With us on mandate. Fine on everything else.

LEW NOTES FROM 7/20 DEMS MEETING WITH FIRST LADY

Abercrombie

Not even the Chamber of Commerce of HI would run against the Hawaii plan.
With 50–50 mandate, most employers went to 100% voluntarily.

LEW NOTES FROM 7/20 DEMS MEETING WITH FIRST LADY

Gephardt

Met with CA HMO this morning– 2nd largest in the state – very postive about Medicare part C as an option. They currently compete against Medicare with a 95% reimubrsemand and they voluntarily throw $1200 in drug benefits, and still making a huge profit – proof that they believe savings go to people if you cut the adminsitrative costs.

Need to make sure there's a delivery system, – urban and rural – community health centers.

LEW NOTES FROM 7/20 DEMS MEETING WITH FIRST LADY

Lambert

When you say what Gerpahrdt just said – cutting adminsitrtive costs – people agree but they think you can ge there through simple insurance reform.

LEW NOTES FROM 7/20 DEMS MEETING WITH FIRST LADY

Jill Long

Need to pass reform before the election so we can move on to welfare reform. If bill is close to W&M rather than Sen. Finance, it would be hard for me to come back and we could lose the majorty in the House. We need moderate reform and welfare reform to keep a majority.

Lew notes from his meeting 7/19/94

Pomeroy

Conrad will define as far as I can possibly go. I'm pretty squishy. I'm a no on the mandate if the Senate doesn't include it, and maybe even if they do include it. I went out on a limb on the budget and assault weapons ban. Gephardt is out of step for the first time. As soon as the mandate is gone, the focus will be on part C. Personally doesn't see the difference between a hard trigger and a soft trigger and not worth losing seats over. Hard trigger is easier for him then a phase-in, because even with a 2050 effective date, he would be tarred as voting for a mandate. Conrad is popular for his independence, "rump" group got great press in ND. He thought seriously about introducing it in the House. But he'll keep his powder dry.

Lew notes:

Clement 7/19/94

with Nancy Ann – she may have more notes
Has concerns about small business as small businessman himself
Could see a hard trigger but not a straight out mandate. Hard or soft trigger, he'd be prepared to help. His staff said the Medicare cuts were a little hard for them. Had an abortion concern, pro-choice but no government money. Had no objections to the DNC ads.

A Cooper and Rondal corporation, he told him he wants to be helpful to the President if he can.

Lew notes from his meeting 7/19/94

Pomeroy

Conrad will define as far as I can possibly go. I'm pretty squishy. I'm a no on the mandate if the Senate doesn't include it, and maybe even if they do include it. I went out on a limb on the budget and assault weapons ban. Gephardt is out of step for the first time. As soon as the mandate is gone, the focus will be on part C. Personally doesn't see the difference between a hard trigger and a soft trigger and not worth losing seats over. Hard trigger is easier for him then a phase-in, because even with a 2050 effective date, he would be tarred as voting for a mandate. Conrad is popular for his independence, "rump" group got great press in ND. He thought seriously about introducing it in the House. But he'll keep his powder dry.

Lew notes:

Clement 7/19/94

with Nancy Ann - she may have more notes

Could see a hard trigger but not a straight out mandate. Hard or soft trigger, he'd be prepared to help. His staff said the Medicare cuts were a little hard for them. Had an abortion concern, pro-choice but no government money.

Member	Phone	Staff	Comments
Pallone, Frank (NJ)	225-4671	Sean Murphy	▸ Supportive of the President's goal of universal coverage -- but would accept SFC's 95% goal. ▸ Originally supported an employer mandate, but is leaning toward a trigger. Likely to support Gephardt's compromise -- waiting to see details. ▸ Concerned about taking a tough vote on the mandate before the Senate acts.
Peterson, Collin (MN)	225-2165	Becky Donovan	☺ supports universal coverage but is not certain how to get there without an employer mandate which he opposes ☺ believes the country will be at a single-payer system in 10-15 years and this is good enough for him with regard to universal coverage ☺ would be difficult to vote for a bill which provides for abortions; would be easier to vote for legislation that either provides an out or a state option ☺ wants patient records protected
Pomeroy, Earl (ND)	225-2611	Pat Davis	Left word. (Staffer is out sick).
Sangmeister, George (IL)	225-3635	Ellen Panepinto	☺ is returning my call - HAS U.C. - PROBLEMS W/ EMP MANDATE BUT NOT HARD POSITION - WILL NOT VOTE FOR R/C approval

JANET MUEGGLIA
X6-6620

HEALTH CARE TARGETS

LaRocco — Very apprehensive about a mandate; but hasn't signed the NFIB Pledge to oppose it. In the right context he may be able to support a soft trigger. Subsidies would have to be right. Has Problems w/ other parts of proposals...like financing. Is trying to keep an open mind but in out & out mandate wld. be very difficult for him to support.
(7/12)
NOTE: He has a rural telecom. piece that he wd. like to see as pxt of a floor bill and might be willing to do some sort of deal to incl. it.

English — Supported House Ed & Labor bill which incl. emp. reqmt/mandates. She stresses that Sm. Business subsidies have to be there for her continued support of mandate. →
(7/13)

But thinks she'll be able to support this thru the floor. Has a very tough re-election campaign.

Roemer – Despite the fact that he supported the Ed & Labor bill which included an employer mandate he has made it very clear that he did so only to move the process along. He has very big problems w/ the mandate in the bill and would have to see it significantly reworked on the floor to support it. Wd. prefer to see a "reasonable" trigger mechanism that wd. also address small business concerns. While he could possibly support some form of a mandate, he wanted to be clear that his comm. vote did not mean he was "okay" with this issue

(713)

S. Brown (Ok) — He will be able to support an employer mandate as part of h.c. reform. Was a strong supporter of Single payer. He was very discouraged that Dingell couldn't get a bill thru Energy & Commerce (Brown serves on this comm.) & feels that cd. be a bad sign for the floor. He is definitely okay on mandate issue despite a fairly conservative district & tough re-election campaign.

(7/12)

Mazzoli — Has definite problems w/ an employer mandate -- could not support "any form" of a mandate. Biggest problem w/ h.c. proposals however is with the abortion issue. "No way" he can support any bill that has abortion services regd. in a benefits pkg.

Gordon - Does not want to be "BTW'd" again -- 2nd does not believe the House should act before the Senate (7/13) or w/out a bipartisan deal. If a mandate survives the Senate he wd. likely support it altho he doesn't like it. Hopes the ~~House~~ Leadership/Administration will act quickly -- believes Dems lose more on substance w/ each passing day w/out a deal. Volunteered that abortion issue was becoming increasingly problematic for him despite the fact that he is clearly Pro-Choice. Polling/Survey results in his district show single-issue voters picking up strength in his district.

[redacted]

(3) Health Care Targets (cont'd)

Mann - Big concern about Administration's proposal (even as modified by committees) - financial solvency. Not many friends of health care reform or of a "massive transformation" of health care system in his district. Lots of opposition in his district to employer mandates. He likes the Moynihan (Senate Finance) bill. Believes a moderate incremental plan would be best. Very disturbed by CBO report/numbers. believes they may be too soft - too speculative. Definitely believes the Senate should go first. Politically, he is worried about

[redacted]

[redacted]

supporting President and being labeled a "Clinton clone." But at same time recognizes danger of accomplishing nothing and demonstrating gridlock is being part of movement to "throw rascals out." [Very squishy]

[redacted]

Surplus -

(7/14) Had just reviewed a recent poll in his district which indicated the Pres's numbers were very weak. In his district the POTUS had a 69% negative rating. In addition, less than 10% of his district put health care in top three issues of concern

Surplus (cont'd)

(4) Believes he will have a very difficult time in his re-election primarily due to his support of the Admin. Budget bill last year. Although a visit by Secty. Bentsen recently was helpful he does not believe that he can convince constituents in his district that the Budget vote was the right thing & effective in bringing deficit down. Despite CBO numbers to the contrary, his poll revealed that 70% of his district believe the deficit has increased in the past yr.

→

[redacted]

Opponents in his campaign are using a slogan capitalizing on the President's low rating: "Retire Slick Willie's Little Billy." Because of all of this he says there is "no way" he can support an employer mandate. Nor can he support any [redacted] benefits as part of health care reform. He believes right now its important to put distance b/t he & the Pres.

[redacted]

[redacted]

(5)

[redacted]

Long — "Probably will be okay with an employer mandate." Bent stressed the importance of a phase-in period & subsidies. Rural health issues are very important to her -- She is co-Chair of the House Rural Caucus. Very important that they Senate go first supporting a mandate. Would like to see White House and Leadership working more closely with moderates and mentioned Rep. Cooper's group.

(7/14)

[redacted]

[redacted]

Grassley — supported Ed + Labor bill as reported out of Committee and believes he will be able to continue to support this approach which included an employer mandate -- very much wants Senate to go first, just thinks that will make it easier for everyone else. Hopes bill on floor looks more like Ed + Labor bill than Ways + Means bill.

(7/13)

[redacted]

[redacted]

(6)

[redacted]

Limbert - Wd. like to see a moderate bipartisan approach. Definitely believes the House shd. not vote before the Senate. Does not believe she could support a mandate. Likes the Senate Finance bill. Doubted a mandate wd. survive the Senate.

(7/14)

[redacted]

[redacted]

STEVE - SORRY THIS LOOKS FUNNY - IT USED TO BE ON LEGAL PAPER. SO I SHRANK IT FOR THE FAX. RUN THE ORIGINAL INTO IS THERE - THAT FORMAT LOOKS FINE.

NOTE TO: Jerry Klepner

FROM: Lori Davis
Alan Hoffman

SUBJECT: Health care reform calls

DATE: Tuesday, July 12, 1994

Member	Phone	Staff	Comments
Barca, Peter (WI)	225-3031	John Altenberg	Left word.
Byrne, Leslie (VA)	225-1492	Andrew Goldberg	Left word.
Clement, Bob (TN)	225-4311	Jay Hansen	▸ Supports universal coverage (95% is O.K.) and likes a trigger -- "but hasn't thought it out fully". Anxious to see what form Gephardt's compromise takes. ▸ Concerned about voting on the employer mandate before the Senate acts.
Darden, George (GA)	225-2931	Catherine Eaton	☺ supports universal coverage ☺ strongly opposes employer mandates and probably would not vote for legislation which included a mandate (opposes because of the undue burden on small business)

Member	Phone	Staff	Comments
Feinstein, Dianne (CA)	224-3841	Alexander Russo	☺ supports universal coverage in theory but would probably vote for a bill that did not guarantee 100% coverage ☺ does not support the employer mandate as she believes it will cost jobs for California
Hall, Tony (OH)	225-6465	Gail Amidzich	▸ Trying to "keep an open mind" - especially on controversial issues - because of Rules Committee membership. ▸ Supports universal coverage but is "nervous" about the employer mandate. As a former business owner, he is concerned about very small businesses. ▸ Cares a great deal about Dayton managed care waivers. Gail would like to talk to someone about how the various health care reform options effect Dayton.

Not a target?

Member	Phone	Staff	Comments
Harman, Jane (CA)	225-8220	Kathryn Pearson	☺ is not a co-sponsor of any legislation as the Congresswoman wants to remain open-minded ☺ has not made a final decision regarding universal coverage and employer mandate ☺ in literature the Congresswoman sent out, she said she supports universal health coverage for all Americans but this does not mean that she would vote against a bill that guarantees 95% coverage ☺ has not made any decisions regarding triggers ☺ most important concern is comprehensive reproductive health coverage, including abortion coverage - this is non-negotiable

Member	Phone	Staff	Comments
Holden, Tim (PA)	225-5546	Vince Huddock	▸ Supportive of the Mainstream Coalition's provisions in the SFC. Thinks they made a "good first step". Stressed he wants a "realistic" approach. Was shocked to read Gephardt thinks an employer mandate can pass in the House. Waiting to see what Gephardt will produce next week. ▸ Concerned about being "BTU'ed" again. ▸ Small businesses in his district have been very vocal in their opposition to the employer mandate. There is little support for Clinton in his district -- Bush won the Presidential vote there in 1992.
Lambert, Blanche (AR)	225-4076	Tom Boyer	☺ major concern is effect on small business and farmers ☺ has not made a decision regarding support for universal coverage and employer mandate and believes these will be subjected to numerous conversations

Member	Phone	Staff	Comments
LaRocco, Larry (ID)	225-6611	Mark Brownell	☺ favors universal coverage in principal and wants to cover as many people as possible but probably would not vote against legislation that did not guarantee coverage for all ☺ is nervous about employer mandates as Idaho is not the most progressive state ☺ probably would vote for a bill that included a mandate but other benefits for Idaho would have to be present in the legislation ☺ telemedicine is of the utmost importance to the Congressman and wants it to be a pilot program in Idaho ☺ rural medicine is also important and sees telemedicine as a way to help rural health care ☺ wants to pass health care reform this year ☺ will be the only Member from Idaho who will support the President's health care reform package

Bridgett's calls:

Member	Comments
Martin Frost	Supportive of universal coverage / undecided on employer mandate (waiting to get through Rules Committee -- what is leadership package -- what substitutes are offered)
Greg Laughlin	Opposes mandate; unsure how to get to universal coverage without it
Chet Edwards	Didn't contact yet

(Not a target?)

Member	Phone	Staff	Comments
Long, Jill (IN)	225-4436	Jennifer Boehm	☺ supports universal coverage but probably would vote for legislation that was less than universal if this was the best that could be obtained ☺ inclined to support the employer mandate but does not agree with the 80-20 split and would prefer a 60-40 split ☺ does not believe we do enough for rural health care and wants greater incentives to lure providers to rural areas
Mazzoli, Romano (KY)	225-5401	Henry Semple	☺ L.A. not extremely knowledgeable about what the congressman thought and it might be a good idea for Jerry to contact the congressman directly ☺ supports universal coverage in theory but wants to know what it will take to achieve this goal ☺ leaning against an employer mandate and is sympathetic to small business ☺ believes the present system will be severely disrupted if health care reform goes through

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Secretary Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Senator Sarbanes

DATE OF CALL: Met with him on August 12

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** He prefers single payer, but will support the Mitchell bill.

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** He will support Mitchell on the mandate.

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:** His line in the sand is preserving the Federal employees system. He will have problems with the Mitchell bill if the Federal employees provisions are weakened as the bill moves through the process.

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Secretary Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Senator Mathews

DATE OF CALL: Met with him on August 12

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** He supports the Mitchell bill.

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** He will support Mitchell on the employer mandate vote.

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:** He feels strongly that he should work with moderate Republicans to get the bill through. He is concerned if we don't we might suffer the same fate as the stimulus package. He also says that his mail is heavily against the Mitchell bill, but most are form letters.

8/8/94 POTUS Meeting with House Members:

Clement:

Wants to do something substantial but prefers the Mitchell approach. He thinks it is attractive to phase in the employer mandate - to let m competition work, the way the Mitchell bill does. The tobacco tax sho be a problem but abortion is a big problem for him. He believes the p are paying so much attention to this issue that they can't be fooled, that Members shouldn't adopt something that won't work. He would come long way by supporting a hard trigger because he wants to let managed competition work.

Roemer:

He wants too vote for something on the House floor. He pleads for cau and protection for doctor choice but opposes the expansion of abortion He thinks that if we allow for votes on the Mitchell Bill in the House members will be able to do a better job of selling the public.

McHale:

He strongly agrees with Roemer and sees little support in his district for the Gephardt bill, but more support for a Mitchell bill. "I can v for the Mitchell Bill, but I would have a great difficutly with the Gephardt Bill."

Cardin:

It's important not to look at this as one bill versus the other. The Mitchell bill has downsides in that it would adversely affect small businesses with 25 and fewer employees by imposing an inndividual mandate. Gephardt does not believe we have the votes to pass the Mitchell Bill in the House and Cardin agrees. We lose too many single payer supporters with the Mitchell Bill. He doesn't think there is mu of a difference between an 80% and 50% employer mandate. Polls show the American people support requiring employers to provide insurance.

Minge:

He wants to bring in the natural allies of the plan to help with publi perception. He wants to start by making sure that the American people understand that if we wait another year things will only get worse fro an economic and political standpoint. Tort reform has to be done. can't raise the minimum wage anytime soon. If we do health care stat by state we balkanize the country. If Gephardt's bill has a fail safe provision with regard to deficit and tort reform and medicare reimburs -then he could support it.

Mann:

The perception among the public is negative and skeptical about Medica Part C, Cost Containment and the assumed savings in Medicare.

Barca:

He wants to do the right thing but he agrees with Roemer and McHale that the people want a more cautious approach. He does not believe th Gephardt bill can be adopted in its current form.

Johnson:

There is a lot of fear and anxiety in his district. His votes on the budget bill, assault weapons, the stimulus package and federally funde abortions were things he supported because he felt they were the right thing. On health care, he's not sure what the right thing is. The mandate issue is important and Medicare Part C is negative too. He can't support Gephardt and he's just not sure about Mitchell.

Chapman:

The Gephardt Bill is in trouble among fairly good Democrats. He is looking for reasons to vote yes, but he doesn't want to see the Demcra lose control of the House. He thinks that 11 or 12 days away from a we shouldn't twist arms - we should have a rule that allows for consideration of the Mitchell bill. Chapman himself could survive politically with a Gephardt bill, but it would be detrimental to a lot of Democrats.

Synar:

The task force bill was pretty good. Marketing is the key. No one ha credibility on the issue. If we can't get a crime bill and a health care bill, we will lose control of the House.

NOTE TO: Steve Edelstein

FROM: Lori Davis

SUBJECT: Jerry Klepner's HCR meeting with Congressman Peter Barca on Tuesday, August 2, 1994

Congressman Barca has not decided how he'll vote on health care reform. He would like to get to universal coverage, but doesn't like the employer mandate in Gephardt's proposal. Is "angry" that the House is likely to vote on a tougher employer mandate than the Senate. Noted that if he isn't given enough time to view Gephardt's bill he will vote against it.

Has been attending Mainstream Forum and Conservative Coalition meetings. Does not believe the American people care about passing health care reform this year. Would rather do it in January of next year, and begin phasing it in before the next election. Doesn't want to take a tough vote on something that won't go into effect until 1999.

Highly concerned about his district -- where he won the last election by only 675 votes. His constituents are "negative, on edge, and scared" about health care reform.

Wants to study how Gephardt's health care reform package will impact the deficit.

Baucus- On July 28th, at a lunch hosted by Secretary Bentsen for a small group of Senators with the Administration's Economic Team, Baucus said that Montanans don't care about health care and those who do are "livid." Businessmen are adamantly opposed and middle-income folks are concerned they'll lose benefits. He said that even though the plan may be good for business, they have not been convinced.

He was most concerned about mandates, with or without a trigger, in the absence of cost controls since there would be no assurances as to the cost businesses would be required to pay. Baucus said he believed that managed competition would cause an initial dip in health inflation, but over time it will start to go up again. While he supports premium caps as in the HSA, he doesn't see them passing. He said the tax on high cost plans in the Finance Committee bill would be passed on to consumers in the form of higher premiums, not to providers as lower reimbursement and would do little to control costs. He also thought the House cost control provisions relying on a fee schedule as in Medicare was politically unrealistic.

Conrad- met with the President on July 15th to discuss health care reform. On July 28th, at a lunch hosted by Secretary Bentsen for a small group of Senators with the Administration's Economic Team, Conrad told of local businesses who are angry about the President's reform plan. He said that even after being told that they would pay less and cover more people than they are now were still mad in general about business requirements. He said that people don't believe the numbers or that you can maintain quality while lowering rates. "It just hasn't been sold."

Conrad said he had joined the "rump group" to pass something, and while it falls short of the President's plan it could pass on the floor. While he supports universal coverage and could support a mandate, he does not see the votes on the Senate floor under current circumstances. He did acknowledge that the dynamic could change, for example if the President appeared on Larry King and took questions from the public on the plan.

Senator Feinstein- met with the President on July 22nd to discuss health care reform.

On July 28th, at a lunch hosted by Secretary Bentsen for a small group of Senators with the Administration's Economic Team, she said that if the plan drives up unemployment or the deficit, it would be unacceptable to her. Employers have told her they would have to let employees go, and restaurants and retailers are important employers in the state. She said that California has a higher percentage of low-wage and part-timer employees, the highest number of uninsured and a high number of uninsured children. "The plan must be street smart. That's why I took myself off the Clinton bill." She also spoke of the plan's not covering the state's 2.2 million undocumented workers. She again mentioned Calpers.

Feinstein told the lunch group she thought the debate was being driven from the outside and it needed to be worked like the assault ban, getting the middle from both sides together. She felt that people don't want a big brother program, and we need a free market approach. She

wanted to get the uninsured covered, control costs - perhaps through a cost commission. What was really bothering her was that there are no details - not on the Finance Committee mark or the Mitchell bill - and feels she's getting conflicting information on costs.

Feinstein was mad at being threatened with the loss of recess but also wanted more time for discussion. She felt too much pressure from the leadership, bus trips, and marches, which she said made her want to dig in her heels even more. She wants the bill to be "right for the people."

exon- On July 28th, at a lunch hosted by Secretary Bentsen for a small group of Senators with the Administration's Economic Team, Exon said the Administration has not done a good job of selling the President's plan. He called its high ground the fact that it is paid for, comparing it to the Finance Committee bill. He fears that we are in for a blood bath. He has not turned his back on an employer mandate because the success of the current system is based employer provided insurance.

He feels there is a chance of working this out, but we are headed for disaster if we don't have more consensus among the Democrats. He is afraid, given the current climate, by forcing this issue we could lose the Democratic majority in the Senate not just a few seats. He reiterated his position that abortion would not be a deciding issue for him, but he thinks a possible solution is to leave it to the states. Exon again mentioned having a meeting of Republicans and Democrats, so that if no bill passes it would not be the fault of the Democratic President and Congress.

Robb- On July 28th, at a lunch hosted by Secretary Bentsen for a small group of Senators with the Administration's Economic Team, Robb said he was willing to remain in a position to support the plan but he shared the political problems of the group - no critical mass, small business concerns, etc. He would vote for anything that will work, but he doesn't think we're there yet and doesn't know how to resolve it. Robb said he had declined invitations to go to the White House and meet with the President because he has no advice and doesn't want to add to the Administration's problems. However, he is scheduled to meet with the President to discuss health care reform on August 2nd. He is a member of the Armed Services and Commerce Committees.

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Senator Kohl

DATE OF CALL: Aug 10, 1994

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** _____

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** ___
Has not made up his mind

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:** He said he was very unhappy with the 51 vote strategy, but he won't be a bomb throwers kind will do everything he can to help.

KOHL
LIEBERMAN
BRADLEY
} DONE

SIMON PAYNE
MIKULSKI SMITH
DODD
BROOKS
} NOT ON WKT

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Senator Lieberman

DATE OF CALL: Aug 9, 1994

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** _____

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** ___
He said he was "not there quite a distance against the mandate". He said it was hard not to vote to strike.

- **OTHER CONCERNS WITH THE MITCHELL BILL:**
His other concerns are minor compared to the mandate. Working on amendments relative to cost-containment & malpractice insurance reform. Seemed to indicate he would support Mitchell w/out a mandate.

- **COMMENTS:** Had a good meeting w/ the RVNP group. Thinks it's important to work with these Republicans because we may need them to shut down a filibuster.

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Robert Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Senator Bradley

DATE OF CALL: 8/9/94

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** Unclear whether he will support Mitchell Bill

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** Will support Mitchell on the mandate vote

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:**

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Robert Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Paul Simon

DATE OF CALL: 8/9/94

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** Supports strongly

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** Supports

- **OTHER CONCERNS WITH THE MITCHELL BILL:** Thinks it's too weak. He will work to strengthen the bill.

- **COMMENTS:**

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Sen. Mikulski

DATE OF CALL: 8/9/94

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** _____

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** ___

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:** She Refused to Take Reich's phone call. She said she knows everything she needs to know about health Care + Doesn't want to be bothered.

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Robert Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Senator Dodd

DATE OF CALL: 8/9/94

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** Very supportive

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** Very supportive

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:** (on Lieberman) Doesn't think we can persuade Lieberman on the merits. Got to give him something in exchange. Doesn't think Lieberman believes there is a political cost in opposing the Democratic bill.

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: REICH

CONGRESSIONAL MEMBER AND/OR STAFF: KILDEE (D-MI)

DATE OF CALL: 8/3/94

Please specify the Member's positions on the following:

- UNIVERSAL COVERAGE: voted for Ed + Labor bill
- SHARED RESPONSIBILITY/ EMPLOYER MANDATE: supports; voted for Ed + Labor bill
- OTHER CONCERNS WITH THE GEPHARDT BILL:
- COMMENTS: Congress cannot go home without passing a bill; members in the House will want to wait and see what the Senate does - he is willing to walk the "BTV" plank

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: REICH

CONGRESSIONAL MEMBER AND/OR STAFF: D. PAYNE (D-NJ)

DATE OF CALL: Aug 3, 1994

Please specify the Member's positions on the following:

- UNIVERSAL COVERAGE: still supports
- SHARED RESPONSIBILITY/ EMPLOYER MANDATE: still supports - does not believe it will hurt small business
- OTHER CONCERNS WITH THE GEPHARDT BILL: believes Gephardt dropped "many good things that were in the Education and Labor bill
- COMMENTS: Hasn't really had a chance to review in detail the Gephardt plan, but will review it and pass his comments on to Gephardt

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Ms. Smith (D-IA)

DATE OF CALL: 8/3/94

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** Supports Mitchell Bill over Gephardt. Wants the House to bring up the Mitchell Bill.

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** Does not want to walk the plank on the mandate if the Senate is going to drop it.

- **OTHER CONCERNS WITH THE MITCHELL BILL:**

- **COMMENTS:** Would like to see Republican support in the Senate. Believes that public support has faded because people are afraid that Congress will produce something worse than what we have now.

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: REICH

CONGRESSIONAL MEMBER AND/OR STAFF: J. BROOKS (D-TX)

DATE OF CALL: 8/3/94

Please specify the Member's positions on the following:

- UNIVERSAL COVERAGE: _____
- SHARED RESPONSIBILITY/ EMPLOYER MANDATE: _____
- OTHER CONCERNS WITH THE GEPHARDT BILL: has not yet reviewed the plan
- COMMENTS: wants to support the Administration

HEALTH CARE CONGRESSIONAL FEEDBACK

CABINET SECRETARY: Robert Reich

CONGRESSIONAL MEMBER AND/OR STAFF: Sen. Hatfield

DATE OF CALL: 8/9/94

Please specify the Member's positions on the following:

- **UNIVERSAL COVERAGE:** _____

- **SHARED RESPONSIBILITY/EMPLOYER MANDATE:** ___
Will vote to strike the employer mandate

- **OTHER CONCERNS WITH THE MITCHELL BILL:**
Thinks the Mitchell bill mandates new programs that costs too much

- **COMMENTS:** Does not like the Dole bill. He is working with the Rump group to come up with alternatives. Hopes to release something soon.

VP CALLS 8/9

BAUCUS – 11:55 AM

STARTING BY NOTING PICK FOR NRC

SENT TO POTUS TODAY

CBO SCORING GOOD

YES ON MANDATES

HAD PROBS W/ BRAD/MITCH TALK ON

GROWTH PLANS. SHOULD MEET LOOK

AT PROBLEM OF STATES W/ LOW GROWTH

ROBB –

ASKED HOW PREPARED TO DEAL W/

FILIBUSTER

INTERESTED IN SCORING CBO

WITH US ON MANDATES

DECONCINI

W/ US ON MANDATE

JUST READING MITCHELL BILL THRU

TODAY. SOME PROBLEMS (NOT

SPECIFIC)

DOESN'T WANT TO USE RECESS AS

LEVERAGE. LEAVE OPTIONS OPEN

SHOULDN'T THREATEN TO STAY TIL

FINISH

PENSION -

THE MANDATE SMACKS OF GOV'T TELLING PEOPLE WHAT TO DO.

COULDN'T WE GET THRU BILL W/OUT MANDATE W/ DEM & REPUB SUPPORT

OPEN MIND ON MANDATE; GETTABLE

BUCUS

BRYAN

DECONCINI

HOLLINGS

JOHNSTON

KOHL

LAUTENBERG

LIEBERMAN

ROBB.

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF INTERGOVERNMENTAL AND INTERAGENCY AFFAIRS

August 7, 1994

TO: Dana Hyde
White House Cabinet Affairs

FROM: Elaine Holland
U.S. Department of Education

SUBJECT: Congressional Health Care Calls

Secretary Richard Riley made the following calls on Friday, August 5, and reported:

SENATOR ERNEST HOLLINGS (D-SC)

Senator Hollings began by commenting he thought the Administration's numbers were wrong when they said funds could cover health care and deficit reform. He said he's waiting for CBO figures on the Mitchell plan. He's not strong on the bill one way or the other.

Senator Hollings said he thinks a small business mandate is dumb. He believes a VAT tax is the way to go -- that would put the plan in shape.

He's not a big fan of Medicare Part C -- he thinks we'll have a "mess".

The overall tone was not positive but it wasn't absolutely negative either.

CONGRESSMAN MARTIN LANCASTER (D-NC)

Congressman Lancaster is opposed to the Gephardt bill. He thinks the leadership's bill has a "zero" chance of passage and said, "we won't be BTU'd again".

His vote on the rule depends on if they come up with a bipartisan package.

He said there's no way he can vote for a tobacco tax. His opponent, Walter Jones, call the tobacco tax in the health care bill the "Clinton/Lancaster tobacco tax".

The overall tone was negative.

UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF INTERGOVERNMENTAL AND INTERAGENCY AFFAIRS

August 4, 1994

TO: Dana Hyde
White House Cabinet Affairs

FROM: Elaine Holland
U.S. Department of Education

SUBJECT: Congressional Health Care Calls

Secretary Richard Riley made the following calls this afternoon and reported:

There was a press conference today with Senators Wellstone, Feingold, Simon, Metzenbaum, Mosley-Braun and Harkin about the Mitchell plan. These Senators are friends of the President and share the same view -- 1) they are not ready to commit to the Mitchell plan and 2) they will fight against any weakening amendments to the Mitchell plan.

SENATOR PAUL WELLSTONE (D-MN)

Senator Wellstone attended the press conference this morning. He reported he wants to help the President. The single payer issue is big and what's in the Mitchell plan is not what he wants but the state single payer option is better than nothing.

Wellstone worked personally with Mrs. Clinton and other staff to develop a health care bill and he wants a bill passed. He won't "trash" the Mitchell bill over an issue that he doesn't see as very significant. The Mitchell plan is a weak bill now. If it's weakened too much he can't go with it. He will fight against any amendments that will weaken the bill.

In the final analysis he'll ask himself, "Is this a step forward or backwards?"

The overall tone of the conversation was positive.

SENATOR RUSSELL FEINGOLD (D-WI)

Senator Feingold also attended the press conference this morning. He favors single payer but has not locked himself in to that issue so far that he's against other options. He thinks the Mitchell plans' state option for single payer is fine.

Senator Feingold (Cont.)

He said he supports key three things:

1) Universal coverage. He worries that the 95 percent coverage in the Mitchell plan isn't real universal coverage. He'll be helpful on key votes and will work to oppose amendments that weaken the plan.

2) Employer mandates. (He didn't go into any detail about that...)

3) Long term care. The President's plan and Senator Kennedy's plans were stronger than the Mitchell bill on this issue. Feingold plans to talk to Mitchell about strengthening this component.

He ended by saying he's sent his children to camp so he's here for the duration and will support the bill where he can and try and strengthen the bill along the way.

The overall tone of the conversation was positive.

SENATOR TOM HARKIN (D-IA)

Senator Harkin also attended the press conference this morning. He said he's a friend and wants a health care bill but doesn't think the Mitchell bill is good. His concern is the Mitchell plan goes too far to the Republican side. Any amendments will weaken it. The plan should have started further left and made it's way to this point. He talked about Senators Boren and Breaux -- if this bill was an attempt to get them, his concern is it hasn't gotten them and they'll end up voting with the republicans anyway.

Harkin said it's not just that group of six Senators (from the press conference) who are concerned -- the group is "alot" larger (no numbers or names were given). This group will offer amendments to strengthen the Mitchell plan. Harkin thinks this will help the President in getting closer to what the President would like to see a bill look like.

Harkin wanted this reported back to the White House:

If he was a republican he would support the Mitchell bill. If the Mitchell bill passes it's a disaster politically for Democrats. People will feel the hurt before they get the benefits -- benefits begin in 1997 but the taxes and cuts begin next year. It's the same thing as they (Republicans) did in the catastrophic bill.

The overall tone of the call was positive.

SENATOR CHUCK ROBB (D-VA)

Senator Robb said he met with the President on Monday (August 1). After that meeting his optimism is increased. Mitchell's bill put something together to keep the debate going toward getting a final bill.

Robb said he will oppose any effort to take out the trigger mechanism of the mandate provision.

Robb met with labor representatives today. Their position was they favored the Gephardt plan and didn't oppose the Mitchell plan.

The overall tone of the conversation was very positive.

SENATOR DANIEL AKAKA (D-HI)

Senator Akaka is supportive of both the Mitchell and Gephardt plans. He likes Gephardt's better but Mitchell's is OK. He will vote for the Mitchell plan and will speak in support of it.

He didn't report any specific problems or issues with the Mitchell plan.

CONGRESSWOMAN NITA LOWEY (D-NY)

Secretary Riley spoke to her Administrative Assistant, Scott Fleming, who reported that the Congresswoman wants a bill and wants to support the President but has not reached any firm conclusions. She wants to see everything before she comments.

CONGRESSMAN ELIOT ENGEL (D-NY)

Congressman Engel supports the President's plan and is a leading proponent for health care reform. He prefers the Gephardt plan 10-1 over the Mitchell plan BUT.....

He reported a major issue of concern:

There is a gigantic political problem for New York in the Gephardt plan. Thirteen democrats from New York would be "destroyed" if the plan goes forward as introduced. The formula in the Gephardt plan will "kill" New York. He referred to the cuts in Medicare and Medicaid which would total about $4.8 billion for New York, the limitations on health professional (New York trains 15 percent of the nation's doctors), ERISA provisions, and that the teaching hospitals would be badly hurt under the Gephardt plan.

Engel has spoken to Gephardt about these issues and was told the Majority Leader would "analyze this."

Engel doesn't know how to deal with this issue without lessening cost containment but it remains a major political issue for New York members.

CONGRESSMAN BILL GOODLING (R-PA)

The Secretary was speaking to Congressman Goodling on education issues but health care came up in the context that Goodling didn't want to see the Congressional recess delayed because young members with families use this time to be with their children before they go back to school. No issues of substance relating to health care were discussed.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	Christopher Jennings to Devorah Adler re; Tobacco - Medicaid Claim (2 pages)	05/02/1999	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco [1]

Racheal Carter
2011-0747-S
rc862

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Christopher C. Jennings
05/02/99 07:40:31 PM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP

cc:
Subject: Re: Tobacco - Medicaid Claim?

---------- Forwarded by Christopher C. Jennings/OPD/EOP on 05/02/99 07:42 PM ----------

Cynthia A. Rice 04/30/99 07:52:07 PM

Record Type: Record

To: Fred DuVal/WHO/EOP, William H. White Jr./WHO/EOP
cc: Mickey Ibarra/WHO/EOP, Christopher C. Jennings/OPD/EOP, J. Eric Gould/OPD/EOP
bcc:
Subject: Re: Tobacco - Medicaid Claim?

I want to sit down with both of you first thing Monday morning to talk about how we proceed on this issue. I think it is extremely counterproductive that you hinted to NCSL that the NGA may be interested in compromise. Of course Bird went ballistic, and so will the Democratic governors when they find out. Bill, despite your characterization of the DGA meeting -- which you didn't even attend -- as being counterproductive, I actually thought we had a frank and open conversation which could help us in crafting a deal. And yes, we have good answers to Bird's arguments which I would have been happy to provide if I had had the opportunity to take part in this conversation. And, not surprisingly, I think the idea of having the President call Carper is a bad one. Let's discuss.

William H. White Jr.

[redacted]

Record Type: Record

To: Christopher C. Jennings/OPD/EOP, Cynthia A. Rice/OPD/EOP, J. Eric Gould/OPD/EOP

cc: Fred DuVal/WHO/EOP, Mickey Ibarra/WHO/EOP
Subject: Tobacco - Medicaid Claim?

I spoke to Michael Bird (NCSL) and was surprised about his confidence on tobacco. He said most of the Wash Post story was inaccurate, and he is utterly convinced that the Medicaid

claim does not hold up outside of FL, TX, MS, and MN claims. He says he has reviewed all of the state claims, and says our position is bogus. Cynthia, how are your talking points on this subject...do you want to join me in calling him back? I also hinted that the NGA may be interested in compromise, and he went ballistic. How about POTUS to Carper call?

FYI, attached is IGA's weekly to POTUS.

TOBACCO RECOUPMENT

- IGA and DPC held a meeting with key Democratic Governors' staff to discuss the possibility of finding an agreement on tobacco recoupment. While we delivered a strong message on our opposition to the Hutchinson legislation, the governors are still reluctant to discuss compromise. Governors Carper (D-DE) and Engler (R-MI) met with Rep. Young (R-FL) to reinforce the NGA position, while Governor Thompson (R-WI) received an assurance from Speaker Hastert (R-IL) that the House would recede to the Senate recoupment language.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: Arguments (8 pages)	n.d.	P5
002a. note	re: Veto (3 pages)	n.d	P5
002b. paper	re: Medicaid Recoupment (1 page)	03/01	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco [2]

Racheal Carter
2011-0747-S
rc863

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PRELIMINARY DRAFT

Arguments

1.) Medicaid law requires states to seek reimbursements for Medicaid costs and provide federal government its share.

➜ Section 1903(d) of the Social Security Act mandates that States allocate from the amount of any Medicaid-related recovery the pro-rata share to which the Federal Government is entitled. Specifically, this law states:

"(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(2)(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25)...."

"(2)(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection."

➜ Furthermore, 42 U.S.C. 1396a(a)(25)(A), which became effective March 31, 1968, establishes that it is the State's responsibility 'to ascertain the legal liability of third parties...to pay for care and services available under the [State's Medicaid] plan.'" Regulations set forth in 42 CFR 433.136 define 'third party' as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan."

➜ 42 CFR 433.140(c) describes the State's obligation clearly: "If the State receives FFP [Federal financial participation] in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP [Federal medical assistance percentage] for the State."

➜ [On average, the federal government pays 57 percent of all Medicaid costs.]

Nationally, we pay 57%.

50 → 77%

relationship btwn State & Leavie not Feds & Leavies
so → State responsibility
Cynthia wants specific example of case law used to see how the statute operates

2.) The states routinely provide the federal government with its share of Medicaid collections.

→ In 1998, states provided the federal government with $XX in Medicaid recoveries -- many from lawsuits filed to recover Medicaid costs.

→ XX of the 50 states provided the federal government with recoveries in 1998 [and 1999]

Harriet says that citing Liggett doesn't help bc we didn't do anything about it

→ The XX states that settled with the Liggett tobacco company reimbursed the federal government with $XX in Medicaid costs.

but persuasive they were Me costs 1994-1998 3rd party liability collections $1.5 billion

by concept, states are supposed to be watchdog — there is no fed right of action to collect.

3.) The federal government has always been clear that tobacco settlements included federal claims.

11/97

→ On [date], HHS sent a letter to every state _____

→ On [date], HHS sent letters to the XX states that had settled with the states saying _____

→ HHS officials testified [cite officials, committees, dates]

→ The President sent a letter to every governor [date] saying _____.

June 13 1996 Liggett states
FL, LA, MA, MI, MS
FL MS TX MN

4.) The states asserted Medicaid claims in their suits.

injury as Me — did they predicate under antitrust or injury → liability one argument another

→ Nearly all states asserted Medicaid claims in their suits.

☛ Get exact number?

→ Because states have an obligation under Medicaid law to pursue funds owed to the Medicaid program all states that sued for tobacco-related health costs should have included tobacco-related Medicaid claims in their suits.

argument:
Me claims over $8b
States only collected $8b
All $8b
However HHS exceptions collections

5.) In the settlement, states gave up Medicaid claims in exchange for settlement funds.

➜ The states gave up all present and future claims in the settlement. Section XII of the November 1998 multi state settlment says "Upon the occurrence of the State-Specific Finality in a Settling State, such Settling State shall absolutely and unconditionally release and forever discharge all Released Parties from all Released Claims that the Releasing Parties directly, indirectly, derivatively, or in any other capacity ever had, now have, or hereafter can, shall or may have" -- this would include Medicaid.

☛ Get language from Mississippi, Florida, Texas, and Minnesota settlement language

6.) Even if states asserted other valid claims, under federal law, Medicaid gets reimbursed first.

☛ Get statutory/reg/case law justification.

7.) Since the tobacco-related Medicaid claims exceed the settlement amount, all the claims must be considered Medicaid.

➜ Tobacco-related Medicaid claims are at least $13 billion a year, far more than the $8 billion a year the states agreed to in the settlements. The most frequently cited study, relied upon by CBO in its April 1998 analysis of the tobacco settlements, estimated that tobacco-related Medicaid costs were $12.9 billion in 1993. The study, published in the March/April Public Health Reports, was by Professor Leonard S. Miller of the University of California.

Counter Arguments

1.) The federal government didn't lift a finger to help the states with these lawsuits -- in fact when the states invited the federal government to join in, the feds refused. Why should the federal government obtain rewards from these suits when they assumed no risk?

- ➜ Under Medicaid law, it is the states' obligation to pursue Medicaid recoveries and to reimburse the federal government for its share. The federal government is not authorized to sue for reimbursements; thus the federal government could not join the suits. (Section 1902(a)(25) of the Social Security Act)

- ➜ Medicaid law requires states to undertake the risk of recovery, so long as "the amount of reimbursement the state can reasonably expect to recover exceeds the cost of such recovery." (Section 1902(a)(25) of the Social Security Act) The federal government pays 50 percent of all state Medicaid administrative costs.

2.) Now that the federal government is launching its own litigation, it doesn't need to take the states' money.

- ➜ The Department of Justice litigation will be for non-Medicaid federal health costs -- tobacco-related costs paid in the Medicare, Defense, Veterans, and federal employees health systems.

3.) The state settlement was designed to reflect only state costs.

- ➜ Under Medicaid law, the state must seek recoveries for both the state and federal costs.

4.) The settlements reflected many other claims besides Medicaid -- consumer fraud and other state health costs for example.

➜ Whatever other, valid legal claims a state might have, federal law requires Medicaid claims to be paid first.

➜ This claim has been routinely recognized in Medicaid cases litigated by HHS and the Department of Justice. [give examples]

5.) But HHS hasn't done an analysis of the Medicaid costs in my state to find out how much is tobacco-related.

➜ all of it until someone says otherwise.

6.) In my state, the federal government pays only 50 percent of Medicaid costs -- how can the federal government claim 57 percent?

➜

7.) The Medicaid statute was not intended to allow the federal government to share a settlement of this type.

Additional Issue

Legislation settling federal Medicaid claims in exchange for a commitment by the states to spend the federal share on certain purposes

Legally, should it provide states the option of administrative recoupment instead?

constitutional conditions
but → we're saying
this is ALL OVR $

Liggett

5 ~~States~~ 1996 291,000 each.

2 States reported

3 States didn't

John Callahan

- Supplemental veto?
  not likely
  strong oppose mode

Bill ~~is~~ if gives recoupment prob re:
budget

ELENA: what to do in the case of STRONGLY
oppose rather than VETO world.

Things to sustain this veto →
they can't let the Ag piece die —
non-foreign policy piece that
has juice in the package →

Showdown on House side b/c they
can't find offsets!

VETO
- offsets
- other orig. elements to
  bill
  negotiate outside elements of bill

STRONGLY O

negotiation on floor amendments

Conrad is weak
beyond
Harkin
Kennedy
Durbin
Lautenberg

pressure from 2 places
① gov spending $ in right way
② states are spending things that are important to them

negotiating in context of GIA

Bob Graham needs to be on vote that is we are going to oppose on the floor

we are in better shape in the house b/c they don't face the same statewide pressure

CBO not scoring this as a cost
1999 vs 2000 cost

out years are being fixed by Dominici

Young was told by Delay that he needed to find offsets don't know where young is on smoking

Chafee alternative on the floor depends on how strong we are. We can't bank on both.

cancellation of hearing is sign of resignation rather than protest

Elena wants conversation w governors → are we in stronger place than we are.

① approach

timing on Senate side Wed-Th for supp. OR wk after next

NEXT STEPS

A1 Clearance from Podesta & Sandy

1 meet w staff Friday to get feedback

Daschle mtg

Senate to talk to

Gephardt

Cooper

Lt

DRAFT 3/1

Medicaid Recoupment

1. Settle the federal claim (57% of the tobacco settlement funds) in exchange for a commitment that states spend the funds on shared national and state priorities to prevent youth smoking, protect tobacco farmers, improve public health, and assist children. This commitment, defined in legislation, would apply to all years of tobacco settlement (not just the five year budget window).

2. Define shared national and state priorities in legislation as:

   a. Tobacco prevention -- prevention, education, enforcement, cessation, evaluation

      → Floor of 15, 20, 25%? (15%=$720 mi/yr; 20%=$960 mi/yr; 25%=$1.2 bi/yr)
      → Require Secretary to certify tobacco plan which must include certain elements?

   b. Tobacco farmers -- a) payments to tobacco farmer trust funds established by recent settlement and/or b) direct payments to quota owners and active producers; career development, financial planning, or educational assistance; economic development grants

   c. Public health: ~~community health centers and other providers of health care for the uninsured~~, CHIP/Medicaid outreach, CHIP match (up to 6% of total), maternal and child health, and mental health

      → Should CHIP presumptive eligibility language be included? (was in McCain)

   d. Anti-drug efforts -- safe and drug free schools, substance abuse treatment

   e. Child care -- child care block grant and early learning fund

3. Maintenance of effort: state spending on specified uses must be in addition to historic spending.

4. States would remit to the federal treasury the $2.9 billion CBO-scored cost.

   → Do states get credit for this $2.9 bi payment, e.g., is the federal share they must spend on specified purposes lowered by the amount of the payment? If so, a given percentage set-aside for tobacco prevention would be smaller through 2004.

   15% = $600 mi/yr through 2004, then rising to $720 mi/yr;
   20% = $800 mi/yr through 2004, then rising to $960 mi/yr;
   25% = $1 bi/yr through 2004, then rising to $1.2 bi/yr.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. paper	re: Questions for Attorney General Reno Regarding the Federal Government's Proposed Lawsuit (12 pages)	04/29/1999	P5
001b. paper	re: Questions for the Record Submitted by Congressman Charles Taylor (4 pages)	04/29/1999	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco [3]

Racheal Carter
2011-0747-S
rc864

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

QUESTIONS FOR ATTORNEY GENERAL RENO REGARDING THE FEDERAL GOVERNMENT'S PROPOSED LAWSUIT AGAINST THE TOBACCO INDUSTRY

QUESTIONS SUBMITTED BY THE SENATE APPROPRIATIONS COMMITTEE

INTRODUCTORY STATEMENT

We will respond to the extent possible to the questions from the Committee, but are constrained by the fact that litigation planning is on-going.

Since December 1998, when the Attorney General decided that there were viable bases to pursue recovery of the Federal government's tobacco-related health care costs through litigation, the Department has been working to establish a tobacco litigation team within the Civil Division. The litigation team, currently comprised solely of Department personnel, is studying all aspects of potential litigation against tobacco companies and working to devise a litigation plan for the United States. Department attorneys are reviewing past litigation against tobacco companies by private litigants and by the state attorneys general. We have heard from members of the public, including law professors and attorneys, who have their own views concerning plausible Federal lawsuits against the tobacco companies. We are considering a large body of factual material concerning the conduct of the tobacco companies, the potential bases for tobacco industry liability to the United States, and the nature and scope of damages that may be recovered. In order to ensure accountability by the tobacco industry, the Department is committed to assembling the strongest team and preparing the most effective litigation effort possible. While we do not intend to hire outside counsel on a contingency-fee basis, we have agreed to retain outside expert legal consultants and may hire experienced attorneys as Justice Department employees, where their prior experience will economically fill litigation requirements. We intend to build a litigation team to present the strongest possible case or cases on behalf of the United States.

The importance of this initiative cannot be overstated. Tobacco-related health care costs exceed $50 billion per year, and the Federal government pays a substantial portion of these costs. The States settled their litigation against the tobacco industry for more than two-hundred billion dollars. It is important to keep in mind that the United States' tobacco-related health care costs substantially exceed those of the States. The Department's efforts to recover money properly owed to the Treasury in litigation brought on behalf of the American people is a matter of singular importance.

We next address the specific questions submitted.

QUESTION SUBMITTED BY SENATOR LAUTENBERG

QUESTION: If the Federal government wants to recover its costs for tobacco-related diseases, the appropriate avenue to do that is a Federal lawsuit, not a raid on the multi-state tobacco settlement. To the extent you are able in a public forum, please provide an update on the Department of Justice's litigation plan against the tobacco industry.

ANSWER: The Department is evaluating the legal and factual predicates that may support liability to the United States for its costs incurred as a result of the use of tobacco products. We previously have identified several statutory bases for such lawsuits, including the Medical Care Recovery Act (MCRA), 42 U.S.C.A., sec. 2651, *et seq.*, and the Medicare Secondary Payer Act (MSPA), 42 U.S.C.§ 1395y(b). These are not the only bases that the Department is considering for a potential lawsuit. Since this process is on-going, however, we cannot provide additional information at this time.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONELL

Please respond to each of the questions and requests below specifically and separately. In addition, please provide any documents, both electronic and written, that address topics covered by the questions below.

1. Farmers' Concerns

QUESTION: On February 2, 1999, seven Members of the Kentucky Congressional delegation, including myself, wrote to President Clinton expressing our concern that the planned litigation by the Justice Department would "further harm tobacco farmers who are already feeling the devastating effects of the proposed settlement between the States and these manufacturers." How does the Administration reconcile its expressed concern for tobacco farmers with the fact that any successful Federal litigation against the tobacco manufacturers would necessarily be an additional devastating blow to the tobacco farmers. When responding to this question, please provide any documents related to this topic, both electronic and written, that the Justice Department has drafted or considered.

ANSWER: The Administration is fully committed to working with all parties, as needed, to ensure the financial well-being of tobacco farmers, their families, and their communities.

First, the Administration supports the $5 billion agreement recently produced by the states, and by farmers and industry representatives, to provide financial assistance to tobacco farmers and their communities.

Second, the Administration would support legislation to settle the Federal claims to the state tobacco settlement funds in exchange for a commitment by the states to use the Federal share on shared national and state priorities, which include protecting tobacco farmers, as well as preventing youth smoking, improving public health, and assisting children.

Third, the Administration believes that in connection with any judgment or settlement of other (non-Medicaid) Federal claims there should be established a fund to protect farmers from the unintended consequences of that lawsuit, as was done in the settlement with the state attorneys general. This Administration is committed, as any Federal litigation proceeds to judgment or settlement, to making sure that adequate funds are set aside by legislation, developed in consultation with Congress and representatives of tobacco farmers, their families, and communities, to ensure the financial security of tobacco farmers and their communities.

2. Legal Action Planned by the Justice Department

QUESTION: You have asked the Congress to appropriate $20 million for fiscal year 2000 to pursue a case that the Wall Street Journal reported -- on the basis of comments by Justice Department officials - as containing "several weaknesses in the federal government's legal position." *Cloud David S., "Congress May Have to Play Key Role in Justice's Department's Tobacco Suit," The Wall Street Journal Jan. 27, 1999; see also, e.g., Adelman, David J. "Tobacco: Review of Federal Reimbursement Claim Conference Call," Morgan Stanley Dean Witter, Feb. 4, 1999.*

In the past, the Justice Department has consistently taken the position that it does not have the authority to sue tobacco manufacturers to recover Medicare and other costs incurred by the Federal Government in connection with tobacco related illness. In evaluating the Department's request for funding, it is important for the Subcommittee to know the Department's assessment of its authority to bring such a suit.

On April 30, 1997, at a hearing before the Senate Judiciary Committee, you testified that the Department did not have authority to bring a direct action against tobacco manufacturers to recover Medicare and other costs incurred by the Federal government in connection with tobacco-related illnesses. What has happened since that time to change your mind concerning the Department's authority to sue the tobacco industry?

ANSWER: The Justice Department has never concluded nor taken the position that the United States has no authority to sue tobacco manufacturers to recover Medicare and other costs, apart from Medicaid. To the contrary, we have concluded that viable grounds for suit do exist. When the Attorney General testified in April 1997 before the Senate Judiciary Committee, she addressed her comments to the issue of the actions filed against the tobacco industry by the States. Accordingly, her comments about the lack of authority for a direct cause of action related solely to Medicaid costs, not to Medicare or other costs. While the Attorney General has acknowledged that her testimony was not as clear as she would have liked, her answer was limited to whether the United States would join in the States' lawsuit relating to Medicaid outlays; and it appears from Senator Kennedy's follow-up question that he understood that the testimony was so limited.

QUESTION: Please provide any memoranda or other documents prepared by or for the Justice Department since January 1, 1994 addressing in any respect whatsoever a potential lawsuit against the tobacco industry, including, but not limited to, the grounds, or lack thereof, for suing the tobacco manufacturers.

ANSWER: We are providing the following documents, which were prepared by persons outside the Justice Department:

a. two 7/28/98 memoranda, "Common Law Claims for Tobacco Related Federal Health Care Costs" and "Public Nuisance as Independent Injury, Basic Principles;"

b. an 8/12/98 memorandum, "The Argument for a Federal Lawsuit to Recover Tobacco-related Health Care Costs;"

c. an 8/13/98 memorandum on antitrust issues from Einer Elhauge;

d. a letter that Professor Laurence Tribe sent to Senator Kennedy on MCRA (dated 7/15/98);

e. a memorandum by G. Robert Blakey, Einer Elhauge, Richard Scruggs, and Laurence Tribe, "The Case for a Federal Tobacco Lawsuit;"

f. a memorandum by the authors of the previous memorandum and by Kim Tucker and Jonathan Massey, "Follow-Up Comments on Federal Tobacco Lawsuit;"

g. an undated draft complaint from the law firm of Scruggs, Millette, Bozeman & Dent, P.A.

h. a document entitled "Methodologies for Calculating Tobacco-Related Health Care Expenditures and Preliminary Estimates," dated 7/24/98, from the law firm of Scruggs, Millette, Bozeman & Dent, P.A.

i. a memorandum entitled "Why the Federal Government Should Sue the Tobacco Industry," prepared by Action on Smoking and Health for Senator Richard Durbin;

j. an analysis written by David Vladeck, Todd Heyman and Allison Zieve, concerning bases for a suit to recover federal health care expenditures caused by tobacco products.

Internal Department analyses prepared in anticipation of litigation are not being provided because to do so could be damaging to the interests of the United States in any litigation that the Department may initiate. Such internal deliberative materials are privileged in litigation and would not be available to the other parties in the litigation.

QUESTION: Why did Department of Justice officials previously think there was no direct cause of action under the Medical Cost Recovery Act? What did Department officials previously see as the flaws in the case and how are you going to overcome such flaws.

ANSWER: At no time has the Department believed that there was no direct cause of action under the Medical Care Recovery Act (MCRA). To the contrary, the Department has brought successful lawsuits to recover the costs of medical care directly under MCRA.

QUESTION: The Administration directly connects its proposed 55-cent increase in the cigarette excise tax to health care expenditures in various Federal programs. See *FY 2000 Budget of the United States Government, Table 3-8 (listing Veterans, Federal Employees Health Benefits Program, Department of Defense, and Indian Health Service).* Doesn't this suggest that the amount of previously collected Federal tobacco excise tax revenues should offset any claims for past Federal health care expenditures?

ANSWER: No. The Department believes that liability for Federal tobacco-related health care costs properly may be assessed against the parties responsible for those costs. The Department does not agree that excise taxes paid by smokers relieve or reduce the accountability of the tobacco companies for these costs.

QUESTION: Similarly, doesn't this indicate that future projected revenues from the current Federal excise tax on tobacco products should offset any claims based on alleged future health care costs?

ANSWER: No. See previous answer.

QUESTION: Please describe and cite the specific statutes and liability theories on which you intend to rely for this lawsuit.

ANSWER: As stated above, the Department is evaluating a number of bases upon which parties may be held liable to the United States for its costs incurred as a result of the use of tobacco products. The legal theories are still under development, and we have not made any final decisions on those that we will rely upon in litigation.

QUESTION: What relief does the Department intend to seek? What types of damages?

ANSWER: See response to previous question.

QUESTION: It has been reported that the Administration will be seeking or supporting new tobacco-liability legislation because of the legal impediments with its case. Will such proposed legislation contain provisions that take away the traditional defenses available to a defendant (i.e., barring defenses, such as assumption of risk, that would apply to

individual smoker claims; allowing proof of causation by statistics; and authorizing apportionment of liability based on market share)? Please provide a copy of any such draft legislation prepared by, or provided to Justice Department employees, and any related memoranda or analyses.

ANSWER: The Administration has not sought new legislation. We believe that we possess authority under current law to pursue tobacco-related health claims. Upon request of Members of Congress or their staff, the Department has provided technical drafting assistance on legislation, regardless of whether we will ultimately support or advocate for the adoption of the underlying bill. On the subject of tobacco, the Department provided such assistance to a number of members of Congress on a variety of issues that arose during the debate on comprehensive tobacco legislation and beyond. The Department, of course, reserves the right to propose or support relevant legislation in the future.

3. Precedent

QUESTION: The Chamber of Commerce sent congressional leaders a letter in response to the President's announcement of this lawsuit. The letter states, in part: "The action contemplated by the President represents an unprecedented intrusion of government into the private sector and a dangerous undermining of the legislative process." What precedent will the Justice Department's actions in this case set for other industries involved in the sale of products which could be associated with adverse health effects, such as high-fat foods, alcohol, firearms, automobiles or motorcycles to name just a few?

ANSWER: While all controversies are analyzed on a case-by-case basis, tobacco is a unique product with a unique history. That unique history, the nature of the risks presented by tobacco products, the unprecedented financial costs such products have imposed on the American taxpayers, our legal analysis of these factors, and the example set by the state attorneys general have led us to conclude that litigation against the tobacco industry is in the National interest. We are not aware of any other industry or product with those characteristics.

4. Outside Counsel Consultants and Experts

QUESTION: Members of Congress have expressed great concern about the level of compensation obtained by private counsel as a result of the State litigation against the tobacco manufacturers. You stated during a press briefing on January 21, 1999 that you "would not foreclose [the] possibility" of hiring outside counsel for this matter. I am concerned by reports that a number of these very attorneys sought to persuade the Justice Department to bring a Federal lawsuit, even though career officials of the Department reportedly had cast strong doubts about the viability of such a lawsuit. For example, the New York Times reported: "Justice Department officials met with several plaintiffs' lawyers and law professors who had been involved in the state lawsuits .... At the meeting the lawyers and professors gave the Justice Department a 100-page document outlining the legal strategies that the government could use to sue the industry . . . ." *Meier, Barry, Many Are Caught Off Guard By Clinton's Tobacco Plan,* " New York *Jan. 21, 1999.*

According to the Wall Street Journal: " [A] group of antitobacco lawyers led by Pascagoula, Miss., lawyer Richard Scruggs have been urging the White House and Justice to file a suit for several months and have offered their services free, said Mississippi Attorney General Mike Moore." *Geyelin, Milo, Justice Department Considers Hiring Outside Trial Lawyer for Tobacco Suit,* Wall Street Journal, Jan. 22, 1999.

Have Justice Department employees met, or otherwise communicated with any persons who are not employees of the Federal government about the possibility of pursuing litigation against the tobacco manufacturers?

ANSWER: Yes. Such meetings are not unusual. Indeed, the Department routinely meets with members of the public and with counsel who request the opportunity to discuss potential litigation in matters of common interest. Over the past several months, in an effort to make the most informed decisions relating to this potential litigation of historical proportions, we have received the views and heard the ideas of private citizens. In addition, the Department has had discussions with legal experts who have agreed to serve as paid consultants or employees of the Department in connection with these matters. See below.

Please provide the following:

(A) the dates of any such meeting or communication,

(B) the participants in any such meeting or communication;

(C) a description of the purpose of any such meeting or communication; and

(D) a brief summary of any such meeting or communication.

ANSWER: Since August 1998, we have had a number of telephone conversations and meetings to discuss existing litigation by the states and by private litigants and have heard the views of citizens on the potential for legal action by the United States. The Department has had discussions with a number of representatives of the state attorneys general and the lawyers who represented the states, as well as discussions, at their request, with attorneys who represented the states and private litigants in tobacco litigation. For instance, in early August 1998, we met with attorney Richard Scruggs and other attorneys from his firm; in late August, we spoke by telephone with Professor Einer Elhauge of Harvard; on October 1, we held a conference call with Professor Laurence Tribe of Harvard; on January 14, 1999, we held a meeting with Professors Tribe and Elhauge, and G. Robert Blakey of Notre Dame, and Jonathan Massey, Richard Scruggs, and Kim Tucker; and in February 1999, we met with those same individuals (with the exception of Professor Tribe), and with attorneys Ronald Motley, Joseph Rice, and Ann Ritter. We also have met with attorneys representing private parties in ongoing cases concerning

the pending litigation. Numerous routine conversations with the state attorneys general and their representatives may also have included discussions concerning a possible legal action by the United States.

In addition to these meetings and conversations, the Department has received countless telephone calls and letters supporting litigation by the United States against the tobacco industry. As mentioned above, among those supporting legal action by the government are law professors, public interest groups, and private litigators, who have represented the state attorneys general and private parties in litigation against tobacco companies, including some attorneys identified in the preface to this question. We have listened to their views. The proposals made to the United States by the citizen participants are generally reflected in the documents they have submitted and which are being made available to the committee.

QUESTION: As of the date of your response to these questions, has the Justice Department hired any outside counsel to assist the Department in this litigation?

If so, please provide

(A) the names of such counsel;

(B) the dates on which they were retained; and

(C) the terms of their retention, including any caps on the compensation that such counsel may receive either in total or on an hourly basis.

If not, do you plan to hire outside counsel to assist in the litigation?

(A) When do you plan to hire outside counsel?

(B) On what terms do you plan to hire such counsel?

ANSWER: On April 5, 1999, the Justice Department entered into an agreement with the Minneapolis law firm, Robins, Kaplan, Miller & Ciresi L.L.P., to retain the firm's services as litigative consultants on tobacco litigation. Under the agreement, Robins, Kaplan, Miller & Ciresi will provide assistance to the Justice Department's tobacco litigation team on a reduced-rate hourly billing basis through June 30, 1999. Under the contract, the Department of Justice will pay the firm $75 per hour and will reimburse the firm for travel costs and expenses. This represents a substantial reduction in the firm's customary billing rate. The total contract, which runs through June 30, 1999, is for a maximum of $81,670, although the contract could be extended with the agreement of both the government and the firm.

QUESTION: Is the Justice Department authorized to retain outside counsel on a contingency fee basis?

ANSWER: We are not contemplating retaining outside counsel on a contingency fee basis. There are statutes providing specific authority to enter into contingency fee arrangements with respect to debt collection (Debt Collection Improvement Act, 31 U.S.C. § 3701) and bank fraud recovery (12 U.S.C. § 4241); but we are not aware of any general grant of such authority.

QUESTION: Is there any Justice Department precedent for such an arrangement?

ANSWER: No, other than under the statutes cited above.

QUESTION: Has the Department hired outside counsel on a contingency-fee basis to work on the federal litigation against the tobacco manufacturers?

ANSWER: No.

QUESTION: If not, is it possible that the Department might do so in the future?

ANSWER: The Department has no intention of hiring any attorneys on a contingency fee basis.

QUESTION: Would the hiring of such outside counsel or consultants be subject to federal procurement law?

ANSWER: Any retention of outside counsel, whether or not under a contingency arrangement, would be subject to federal procurement law. The Federal Acquisition Streamlining Act of 1994, Pub. L. 103-355, codified at 41 U.S.C. § 251 *et seq.*, would be applicable to such a procurement. 41 U.S.C. § 253 exempts such procurements from competitive procedures.

QUESTION: Do you plan to seek competitive bids for such outside services?

ANSWER: We do not plan to seek formal competitive bids for such services.

QUESTION: You have indicated that the Justice Department has formed a task force for this litigation. *Press Availability, Jan. 21, 1999.* Please explain whether this "task force" is an "advisory committee" under the Federal Advisory Committee Act ("FACA")? If members have been appointed, please provide a list of membership and the affiliation of each member.

ANSWER: The FACA applies only to committees that are established or utilized "in the interest of obtaining advice or recommendations." 5 U.S.C. App. § 3(2). Teams assembled to conduct government litigation do not fall within this definition.

QUESTION: What steps has the Justice Department taken to comply with §§ 9-12 of FACA?

ANSWER: Not applicable. See previous response.

QUESTION: Have task force meetings been, or will they be, held in public as required by § 10 of FACA?

ANSWER: Not applicable. See previous responses.

5. Funding Issues

QUESTION: The Justice Department has indicated that its litigation against the tobacco manufacturers is going to be a very expensive endeavor. For example, you have requested $20 million in additional funding in FY 2000 in order to fund this lawsuit. To put this amount in context, the Justice Department's Antitrust Division was funded with $94 million in salaries and expenses in FY 98. In short, I am concerned about the size of your request, and that such an enormous expenditure by the Department would take resources away from other critical programs and Department functions.

If the Antitrust Division can be funded with approximately $100 million per year, why do you need $20 million for a year just to fund one lawsuit?

ANSWER: Tobacco litigation will be a massive and complex undertaking. The evidentiary collection is immense, and the potential damages are unprecedented. The tobacco companies will spend far in excess of this amount defending the matter. In light of the billions of federal dollars spent each year on tobacco-related diseases, we believe the taxpayers will recoup their investment in this litigation many times over.

To put the $20 million in context, we list below a few examples of the tobacco litigation costs being paid by other litigants:

- The California legislature appropriated $11.4 million for FY 1998 and $14 million for FY 1999 to fund 34 attorneys, 40 paralegals, and 47 secretaries to press its case relating to a single state. We expect that the scope of the litigation involving nationwide evidence and damages will be far greater than California's.

- An article in the March 19, 1999, *Washington Times* quotes unnamed tobacco lawyers as saying that the tobacco industry is paying its defense attorneys $600 million annually, thirty times the pending budget request.

- In the Minnesota litigation a single defendant, R.J. Reynolds, stated in a court filing that it had spent more than $90 million to create, maintain, operate, and use its litigation database, alone.

- In the same litigation, a lawyer for defendant Philip Morris declared that it was spending $1.25 million per week on document production. The same attorney later stated that the major defendants spent roughly $125 million on document production alone in that one case involving a single state.

QUESTION: The Justice Department has requested $15 million in FY 2000 to fund 50 employees, including 40 attorneys, to staff the litigation against the tobacco manufacturers. This sum amounts to $300,000 per employee. Please break down your anticipated expenses on a per employee basis, e.g. average salary per employee; average benefits per employee; average expenses per employee etc., and break down, in detail, any remainder of the $15 million according to its designated use(s).

ANSWER: Only $3.8 million of the $15 million is for employee salary, benefits, and overhead expenses for the 50 employees (30 FTE in FY 2000) -- an average of $126,000 per employee ($64,500 - salary, $17,400 - benefits, $44,100 overhead expenses). Of the remainder, an estimated $5.7 million will be needed for litigative consultants, including epidemiologists, expert legal consultants, statisticians, economists, and auditors, to analyze the Government's damages and potential claims, and provide assistance concerning litigative strategies. We project that $5.5 million will be needed for contractor-provided automated litigation support, which will be used to acquire, organize, and automate the massive collection of potential evidentiary documents. Automated litigation support will also be an indispensable tool in enabling the Government to respond timely to the opponents' discovery requests.

QUESTION: Does the request for $15 million include plans to compensate outside counsel or consultants? If so, how have the fees for such outside counsel or consultants been estimated, e.g. were they estimated based on a projected charge per hour?

ANSWER: As stated in the previous answer, $5.7 million is our estimate of the cost for consultants. These cost projections are based upon our experience with such other large-scale litigation as the Winstar litigation, the A-12 stealth fighter case, and the Columbia/HCA health care fraud litigation. We currently anticipate that any money paid to outside counsel would be a small percentage of this figure.

QUESTION: You have stated your intention to pursue this matter whether or not Congress approves your request for an additional $20 million in fiscal year 2000 to fund this lawsuit. Please indicate specifically where you will obtain the funds to proceed if Congress does not provide the additional appropriation, including what specific cuts you would make to other programs or functions in order to finance this litigation.

ANSWER: We are committed to pursuing the recovery of these costs that the taxpayers have borne, regardless of Congressional approval of our request. Congressional denial of the requested resources would have at least two effects. First, the Department will be forced to draw resources away from other matters. As a consequence, numerous cases, such as bankruptcy and fraud cases,

will be declined or placed on hold. Second, we will not be able to pursue the tobacco litigation as effectively, absent the appropriate level of resources. The tobacco industry can be expected to spend enormous resources in defending these actions. Without adequate resources to research, analyze, and prove the nationwide damages inflicted upon the Government, we may be forced to limit the scope of the litigation we bring; and we will likely lose the opportunity to recoup the full extent of the taxpayers' loss.

QUESTION: How did you arrive at the $20 million figure and what specifically will the money be used for?

ANSWER: For the General Legal Activities appropriation, the Departments seeks $15 million for 50 positions, as well as for the costs of gathering, organizing, and computerizing evidentiary materials, and providing contractor paralegal support, and consulting services. For the Fees and Expenses of Witnesses appropriation, the Department seeks an additional $5 million for the costs of expert testimony.

QUESTION: Please provide estimates of your funding need for this litigation for FY 2001, FY 2002, FY 2003 and FY 2004. Please break down these estimates in the manner requested above in paragraph (b).

ANSWER: At this time, we project the funding needs will remain essentially constant through FY 2004. We will need a mandatory increase of about $2.5 million to fund all 50 positions for a full year starting in FY 2001. No other increases are projected at this time.

QUESTION: Have any Justice Department employees assisted in any way, or does the Justice Department plan to assist in any way, foreign governments that have initiated or are considering initiating, litigation against tobacco manufacturers?

ANSWER: We have not provided such assistance and have no current plans to assist foreign governments in connection with their tobacco litigation. We may consult with counsel in any litigation against tobacco manufacturers, when doing so will advance the interests of the United States.

QUESTIONS FOR THE RECORD
SUBMITTED BY

CONGRESSMAN CHARLES H. TAYLOR

FOR THE DEPARTMENT OF JUSTICE FISCAL YEAR 2000 BUDGET HEARING BEFORE THE APPROPRIATIONS SUBCOMMITTEE ON COMMERCE, JUSTICE, STATE AND THE JUDICIARY

[Questions Submitted on March 11, 1999]

INTRODUCTORY STATEMENT

We will respond to the extent possible to the questions from the Subcommittee, but are constrained by the fact that litigation planning is on-going.

Since December 1998, when the Attorney General decided that there were viable bases to pursue recovery of the Federal government's tobacco-related health care costs through litigation, the Department has been working to establish a tobacco litigation team within the Civil Division. The litigation team, currently comprised solely of Department personnel, is studying all aspects of potential litigation against tobacco companies and working to devise a litigation plan for the United States. Department attorneys are reviewing past litigation against tobacco companies by private litigants and by the state attorneys general. We are considering a large body of factual material concerning the conduct of the tobacco companies, the potential bases for tobacco industry liability to the United States, and the nature and scope of damages that may be recovered. In order to ensure accountability by the tobacco industry, the Department is committed to assembling the strongest team and preparing the most effective litigation effort possible. While we do not intend to hire outside counsel on a contingency-fee basis, we have agreed to retain outside expert legal consultants and will hire experienced attorneys as Justice Department employees, where their prior experience will economically fill litigation requirements. We intend to build a litigation team to present the strongest possible case or cases on behalf of the United States.

The importance of this initiative cannot be overstated. Tobacco-related health care costs exceed $50 billion per year, and the Federal government pays a substantial portion of these costs. The States settled their litigation against the tobacco industry for more than two-hundred billion dollars. It is important to keep in mind that the United States' tobacco-related health care costs substantially exceed those of the States. The Department's efforts to recover money properly owed to the Treasury in litigation brought on behalf of the American people is a matter of singular importance.

We next address the specific questions submitted.

QUESTION: As of today, has the Department hired any outside counsel to work on the proposed tobacco litigation? If not, do you plan to hire any outside counsel? How will they be paid -- hourly, or on a contingency basis? Is the Department authorized to retain outside counsel on a contingency basis"

ANSWER: The Justice Department has entered into an agreement with the Minneapolis law firm, Robins, Kaplan, Miller & Ciresi L.L.P., to retain the firm's services as litigative consultants on tobacco litigation. Under the agreement, Robins, Kaplan, Miller & Ciresi will provide assistance to the Justice Department's tobacco litigation team on a reduced-rate hourly billing basis through June 30, 1999. We are not contemplating and have no intention of hiring any attorneys on a contingency fee basis to work on the tobacco litigation. There are statutes providing specific authority to enter into contingency fee arrangements with respect to debt collection (Debt Collection Improvement Act, 31 U.S.C. § 3701) and bank fraud recovery (12 U.S.C. § 4241); but we are not aware of any general grant of such authority.

QUESTION: As of today, has the Department hired any outside experts? If so, who and what is their expertise?

ANSWER: The Department is currently developing a plan to pursue recovery of tobacco-related health care costs. The disclosure of what, if any, experts the Department has hired or intends to hire would be damaging to the interests of the United States in any litigation that the Department may initiate. As noted above, we have entered into an agreement with legal experts who will serve as consultants on an hourly basis.

QUESTION: When do you intend to file the lawsuit (or lawsuits) against the tobacco industry? Where will these lawsuits be filed?

ANSWER: As stated above, the Department is evaluating a number of bases upon which parties may be held liable to the United States for its costs incurred as a result of the use of tobacco products. The legal theories are still under development, and we have not made any final decisions on those that we will rely upon in litigation. Thus, we cannot say when or where we would file lawsuits.

QUESTION: Was this proposed litigation discussed in any way with the President or other White House officials prior to the President's announcement in the State of the Union speech?

ANSWER: The Department did have discussions with White House officials prior to the President's announcement in the State of the Union. In December of 1998, the Attorney General informed the White House of her conclusion that there were viable bases to pursue recovery of the Federal government's tobacco-related health care costs through litigation.

QUESTION: What does the Administration hope to accomplish by announcing that a lawsuit may be filed well in advance of filing it?

ANSWER: The nature of the risks presented by tobacco products, the unique history of the tobacco industry, the unprecedented financial costs such products have imposed on the American taxpayers, our legal analysis of these factors, and the example set by the state attorneys general led us to conclude that litigation against the tobacco industry is in the National interest. Prior to the President's announcement, we recognized that to handle these cases properly, we would need a special appropriation for FY 2000, and that the announcement of the need for that appropriation must include the filing of suit. The public release of that budget request was to occur, and did occur, in early February. As a priority request of the government and Administration, it made sense for the President to announce this in his State of the Union just a few days before. Thus, it was the timing of the budget process that dictated the timing of the announcement that a lawsuit may be filed.

QUESTION: Do you believe that the federal government, through the Department of Justice, has the ability to sue any tobacco company in the absence of express statutory authority?

ANSWER: Yes. We believe that we possess authority under current law to pursue tobacco-related health claims. The Department is evaluating the legal and factual predicates that may support liability to the United States for its costs incurred as a result of the use of tobacco products. We previously have identified several statutory bases for such lawsuits, including the Medical Care Recovery Act (MCRA), 42 U.S.C.A., sec. 2651, *et seq.*, and the Medicare Secondary Payer Act (MSPA), 42 U.S.C.§ 1395y(b). These are not the only bases that the Department is considering for a potential lawsuit. Since this process is on-going, however, we cannot provide additional information at this time.

QUESTION: Do you think that it's relevant that smokers assumed the risks of smoking?

ANSWER: As stated above, the Department is evaluating a number of bases upon which parties may be held liable to the United States for its costs incurred as a result of the use of tobacco products. The legal theories are still under development, and we have not made any final decisions on those that we will rely upon in litigation.

QUESTION: In any litigation, will the Department of Justice have to prove on a person-by-person basis that his or her health expenses were caused by tobacco usage?

ANSWER: See response to previous question.

QUESTION: Isn't it true that a wide variety of sources, including the Congressional Research Service, have concluded that smokers already pay more than their fair share of any health care costs through the current federal excise taxes on tobacco?

ANSWER: The Department believes that liability for Federal tobacco-related health care costs properly may be assessed against the parties responsible for those costs. The Department does not agree that excise taxes paid by smokers relieve or reduce the accountability of the tobacco companies for these costs.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. report	re: Current Tobacco Litigation (14 pages)	07/06/1998	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco [9]

Racheal Carter
2011-0747-S
rc865

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Tobacco F4

I. Current Tobacco Litigation

A. Actions Brought by States. The most significant litigation faced by the tobacco industry are the pending suits brought by 40 state Attorneys General against tobacco manufacturers. Mississippi, Florida, Texas, and Minnesota have obtained settlements for billions of dollars and a variety of injunctive remedies. Although these suits have been proceeding slowly since the announcement of the June 20, 1997 Resolution, they are likely to become more active because the Resolution was dependent on enactment of comprehensive federal legislation. The suit brought by the state of Washington is scheduled to go to trial in September.

The suits brought by the state Attorneys General have alleged a collection of novel theories of recovery. In many cases, these theories have relied on particular features of state common law and special consumer protection statutes that give the state government broad rights to recover for fraud and other misconduct. State theories include:

1. The tobacco manufacturers, the Council for Tobacco Research, and others undertook a special duty to render services for the protection of the public health and to disclose scientific research about smoking and health, but, in fact, conspired to suppress the research to the detriment of the public health.

2. The tobacco manufacturers conspired to restrain trade by suppressing health information about smoking and use of tobacco and the development of a safer cigarette.

3. The tobacco manufacturers maintained a monopoly over the sale of cigarettes by controlling and suppressing research, development, production, and marketing of a safer cigarette.

4. The tobacco manufacturers violated state consumer protection laws by intentionally misrepresenting that there is no causal connection between smoking and adverse health effects, and that use of tobacco is not addictive.

5. The tobacco manufacturers falsely advertised their products to young people and others.

6. The tobacco manufacturers have been unjustly enriched by avoiding paying for the consequences of their illegal activity, i.e., the health care costs to be borne by the states.

None of these theories has been adjudicated or decided, and no judgment has been reached validating the theories. Minnesota's amended complaint is attached as tab 1.

B. Suits Brought by Individuals/Class Actions. As it has for the past thirty years, the tobacco industry is currently defending litigation brought by smokers in various courts throughout the country. Putative class actions seeking smoking cessation programs (the so-called Castano class actions) are pending in at least 6 states. A trial court in Maryland has certified a class of smokers in state court. None of these cases has resulted in a judgment or settlement.

Individual actions have resulted in only two verdicts for plaintiffs, one for $750,000 and another for $950,000 (both are still on appeal). On June 22, 1998, however, the Florida Appeals Court overturned the $750,000 verdict because the lawsuit was barred by the statute of limitations. That court also reversed key rulings on admissibility of documents, and found that the Federal Cigarette Labeling and Advertising Act precluded the plaintiff from arguing that cigarette warning labels were inadequate.

The future course of litigation against the tobacco industry is difficult to predict. Richard Daynard, chairman of the Tobacco Products Liability Project at Northeastern University, believes the release of confidential tobacco documents, the recent settlements with the states, and the collapse of the comprehensive legislation will result in the filing of thousands of individual cases. Nonetheless, there has been no identifiable change in the law that would suggest that suits initiated by smokers will be more successful in the future. Moreover, the Florida appellate court's opinion and the comments of jurors in the Minnesota case suggest that the odds of individual recovery against the tobacco industry have not increased significantly. In particular, although millions of pages of documents have been released by the Minnesota court, it is unclear whether those documents contain information that would overcome the principal defenses of the tobacco companies to smoker initiated suits, *e.g.*, assumption of risk.

C. Litigation Involving the Federal Government. On the federal level, the Fourth Circuit is currently considering the FDA's authority to regulate tobacco products, including the advertising and marketing of such products. In addition, it has been publicly disclosed that there is an ongoing federal criminal investigation involving the tobacco industry.

The consequences of civil litigation brought by the United States to recover health care costs would be enormous -- for the government, the tobacco manufacturers, and the public. We would be committing ourselves to the biggest affirmative lawsuits the United States has ever filed. Moreover, the future viability of tobacco manufacturers would be threatened if the United States recovered the full dollar amount for health care associated with tobacco products. The tobacco companies will have every

incentive to defend these suits vigorously; settlement at anything more than a small fraction of the possible liability would be very unlikely.

II. Possible Theories of Recovery by the United States.

In order to bring any law suit against the tobacco industry, the United States must have a legal basis for going to court. Whether referred to as a cause of action or a claim for relief, the sufficiency of the United States' legal basis for seeking monetary damages from the tobacco industry would likely be challenged at the outset of the litigation on a motion to dismiss. If a court determined that the United States had not stated a valid claim for relief, the case would be dismissed in a matter of months. Various possible theories of recovery are explored below.

A. State Law Causes of Action

Although the lawsuits brought by the state Attorneys General have resulted in some high profile settlements, as well as the June 20, 1997 Resolution, they do not provide good analogs for a lawsuit brought by the federal government. As a general matter, the United States cannot recover health care costs based on state common law theories, absent a federal statute authorizing such recovery. Under *United States v. Standard Oil Co.*, 332 U.S. 301 (1947), the United States was held not entitled to recover, under a common law theory, the health care costs of a serviceman injured by a third-party motorist through alleged negligence. By refusing to allow a common law remedy, the Court left it to Congress to create a cause of action by which the United States could recover its health care costs (which Congress did in the Medical Care Recovery Act, discussed below).

In addition, state statutes specifically differ in important ways from their federal counterparts. Many state legislatures have gone further than Congress in authorizing their attorney general to litigate on behalf of its citizens. Thus, many of the tort, equitable, and consumer protection theories advanced by the State Attorneys General would be of limited, if any, use to the federal government if it attempts to recover health care costs related to tobacco use.

B. Possible Claims Under Existing Federal Law

Because state law theories by themselves are unlikely to be of much use, the United States would have to proceed under a federal statute to recover tobacco-related health care costs. The vast majority of expenditures by the federal government related to health care derive from Medicaid, Medicare, and the direct provision of medical care by federal agencies required to provide such care. Both Medicaid and Medicare have specific statutory provisions defining the federal government's right to recover certain expenditures. The Medical Care Recovery Act ("MCRA") authorizes the government

to recover for medical care provided directly to individuals. Each of these statutes is discussed in turn.

1. Medicaid

Among other things, Medicaid mandates that each state "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [state's Medicaid] plan." 42 U.S.C. § 1396a(a)(25)(A). Where such liability is found to exist after Medicaid payments have been made, each state "will seek reimbursement for such assistance . . . where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery. . . ." 42 U.S.C. § 1396a(a)(25)(B); *see Philip Morris, Inc. v. Harshbarger*, 946 F. Supp. 1067, 1077 (D. Mass. 1996) (federal law requires states "to pursue liable third parties for amounts paid on behalf of Medicaid beneficiaries"). When recoveries are made from third parties, the previous Medicaid expenditures for the services at issue are to be treated as overpayments, 42 U.S.C. § 1396b(d)(2)(B), and overpayments are to be deducted from amounts to which the states are entitled in subsequent quarters. 42 U.S.C. § 1396b(d)(2)(A). *See generally Massachusetts v. Philip Morris, Inc.*, 942 F. Supp. 690, 692-93 (D. Mass. 1996).

The federal government does not have an apparent legal basis to commence litigation on its own against the tobacco companies for Medicaid expenses stemming from tobacco-related illnesses. There is no authorization within the Medicaid statute for the federal government to sue third-party tortfeasors directly. In fact, the argument can be made that, by explicitly providing a mechanism to allow the states to pursue these claims, Congress apparently did not intend that these claims be pursued directly by the federal government. *See National Railroad Passenger Corp. v. Nat'l Assoc. of Railroad Passengers*, 414 U.S. 453, 458 (1974) ("when legislation expressly provides a particular remedy or remedies, courts should not expand the coverage of the statute to subsume other remedies."). The federal government's sole avenue for recovery of Medicaid outlays may be through deductions from future payments to states that have recovered from the tobacco industry. To this point, the federal government has pursued its share from the states that have settled lawsuits with the Liggett Group and has sent letters reminding the states of its claim on settlements reached with the tobacco industry. Indeed, when HHS/HCFA informed the states of Florida, Mississippi, and Texas of its right to share in their tobacco settlements, there was an outcry in Congress.

2. Medicare

a. Pertinent Statutory and Regulatory Provisions.

The Medicare Secondary Payer ("MSP") statute, which was enacted in the 1980s to stem the skyrocketing cost of the Medicare program, permits the United States to recover payments made for medical care when another source of payment is available under "a primary plan." The MSP statute provides the United States with a right to recover "against any entity which is required or responsible . . . to pay . . . under a primary plan. . . ." 42 U.S.C. § 1395y(b)(2)(B)(ii); *accord* 42 C.F.R. § 411.24(e). When a Medicare payment is made, it is "conditioned on reimbursement . . . when notice or other information is received that payment . . . has been or could be made [under a liability insurance policy or plan (including a self-insured plan)]." 42 U.S.C. § 1395y(b)(2)(B)(i). The United States has a separate subrogation right as well. 42 U.S.C. § 1395y(b)(2)(B)(iii); 42 C.F.R. § 411.26(a).

b. Use in Liability Context

Use of the MSP statute in this context would be novel and difficult. Although HCFA pursues claims frequently at an administrative level and on an individual basis, most of the statutory and regulatory provisions have not been interpreted by the courts. Moreover, the theory that we would have to pursue is not based on a natural reading of the statute. Thus, virtually all issues that might arise in this litigation have substantial litigation risk.

To prevail, the United States would first have to establish that the tobacco manufacturers are a "primary plan" within the meaning of the statute. The statutory definition of "primary plan" includes "a liability insurance policy or plan (including a self-insured plan)." 42 U.S.C. § 1395y(b)(2)(A). "Liability insurance" is defined as "insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property" and specifically includes product liability insurance. 42 C.F.R. § 411.50(b). The regulations state that liability insurance payments include any amount paid as a deductible. 42 C.F.R. § 411.50(b). If the manufacturers are not insured (or are less than fully insured), the United States would further have to establish that they are self insured within the meaning of the statute and regulations. The regulations, while untested and perhaps contrary to principles commonly found in the law of insurance, take a broad view and state that any "plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier" is self insured. 42 C.F.R. § 411.50(b). A "plan" under Medicare regulations is "any arrangement, oral or written, by one of more entities, to provide health benefits or medical care or assume legal liability for injury or illness." 42 C.F.R. § 411.21. Our argument would have to be that the tobacco manufacturers are themselves or have a "self-insured plan" and thus are subject to secondary payer liability. Fix

The United States would also have to establish that the tobacco manufacturers are "required or responsible" to pay for the services HCFA has provided to Medicare beneficiaries. 42 U.S.C. § 1395y(b)(2)(B)(ii). In most cases, HCFA relies upon the Medicare beneficiary to establish that a tortfeasor is required or responsible to pay. The vast majority of these cases do not require litigation; usually a settlement is reached in which the United States is paid for its claim. While HCFA frequently makes demands upon alleged tortfeasors (or their insurers) based upon information that is obtained from Medicare beneficiaries and their payment records, we are not aware of any published decision in which the United States has undertaken to prove in the first instance the underlying facts that establish the tortfeasor's liability to the Medicare beneficiary.

In this case, the only way to establish that the tobacco manufacturers are required to pay would be to establish their liability for tobacco-related injuries and diseases suffered by Medicare beneficiaries. As noted above, individual plaintiffs suing tobacco manufacturers have been largely unsuccessful in establishing the liability of tobacco manufacturers for smoking related deaths, disease, and disability. A lawsuit by the United States would have to overcome the same difficulties of establishing liability that so far have defeated almost every individual plaintiff who has brought such an action. Our difficulty would be compounded by the fact that our action would be a derivative action in which we would not have primary access to much of the proof (e.g., the Medicare beneficiary's medical records) needed to establish our claims.

The determination of what law governs the manufacturers' liability for tobacco-related injuries will be complex. Although the rights and obligations of the United States arising from the operation of federal programs are governed by federal law, *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 726 (1979), *Clearfield Trust Co. v. United States*, 318 U.S. 363, 366-67 (1943), state law may be incorporated as the federal rule of decision where application of state law would not frustrate specific objectives of the federal program, *Kimbell Foods*, 440 U.S. at 728. Although we may argue that a uniform federal law is required, courts would likely apply state substantive law to determine whether the tobacco companies are liable in tort for the injuries to Medicare beneficiaries. *Cf. Heusle v. National Mut. Ins. Co.*, 628 F.2d 833 (3d Cir. 1980).

3. Medical Care Recovery Act (MCRA).

Many federal agencies, including the Departments of Veterans Affairs, Defense, Army, Navy, and Air Force, and the Indian Health Service, are required by law to provide health care services directly to certain individuals.

When the United States is the provider of health care (or, under a couple of statutes, just the payer), the Medical Care Recovery Act ("MCRA") provides the United States with a broad range of remedies to recover the cost of its medical care. The United States may intervene or join in any action or proceeding brought by the injured or diseased victim. 42 U.S.C. § 2651(d). The United States may institute its own action against the tortfeasor in the event the victim does not commence his or her own action within six months after the government has furnished care and treatment. *Id.* In addition, the United States may require the victim to assign his or her claim against the tortfeasor to the United States, to the extent of the United States' right of recovery. 42 U.S.C. § 2651(a). The MCRA also provides that the United States is subrogated to any rights or claims of the injured or diseased person against the tortfeasor. *Id.*

The MCRA would authorize the United States to pursue an action in tort against the tobacco companies for the reasonable cost of care provided by various federal programs. State substantive law is typically applied in MCRA cases to determine whether tort liability exists, but not all state law procedural restrictions would apply; nor would state consumer protection or antitrust laws be likely to apply.

4. Antitrust Theories.

The antitrust claims that the State Attorneys General have lodged are unique, and may be inconsistent with the broader context of antitrust enforcement; for example, raising the price of cigarettes to reduce youth consumption does not square well with the antitrust laws' goal of reducing prices to market levels. It may be difficult to establish the antitrust injury needed to proceed under federal law, and the remedies traditionally available in antitrust cases may not advance the public health goals that the President has announced. Moreover, at this time, we are not aware of a factual basis to pursue federal antitrust remedies.

III. Other Legal Obstacles

If the federal government brought suit directly against tobacco manufacturers and were determined to have a federal right of recovery on behalf of Medicare beneficiaries (or to recover funds under MCRA), it would have to establish the liability of the tobacco manufacturers under state tort law. We would then have to establish the liability of the tobacco manufacturers under each state's law where such beneficiaries reside. Because state tort laws are not uniform, to obtain nationwide relief we would have to assert, at the least, fifty-one separate, aggregated claims for relief reflecting the fifty-one different state (and D.C.) tort law systems and beneficiaries in each jurisdiction. Moreover, like the plaintiff in any liability suit, the United States would have the burden of proof as to liability, causation,

and damages. All three elements present substantial hurdles. Regardless of the state where such a suit (possibly a test case) was brought, there would be substantial legal obstacles to the pursuit of damages from the tobacco industry. In many cases, the relevant legal rulings might come several years into the litigation and would effectively end the case.

A. Aggregation

Accordingly, the burden of bringing individual claims for the tens of millions of Medicare recipients would be insurmountable. Unless the United States was permitted to aggregate potential claims on behalf of Medicare beneficiaries, it would be impossible to bring a lawsuit to recover from the tobacco industry.

The trend in federal law, however, is against permitting aggregation of claims in mass tort actions, such as in the tobacco context. *See Castano, et al. v. American Tobacco Co.*, 84 F.3d 734 (5th Cir.1996); *Georgine v. Amchem Products, Inc.*, 83 F.3d 610 (3d Cir. 1996), *aff'd* ___ U.S. ___, 117 S.Ct. 2231 (1997); *Matter of Rhone-Poulenc Rorer, Inc.*, 51 F.3d 1293 (7th Cir.1995). The federal courts have held that such class actions, like the Castano suits, do not present sufficient common issues of fact to proceed as class actions.

Neither the MSP Act nor the MCRA expressly provides for aggregation of claims, separate and apart from the Federal Rules of Civil Procedure. Indeed, it appears that MCRA may require each case to be litigated individually, with the United States standing in the shoes of the recipient of medical care. The MSP Act provides the United States with both a direct right of action against a responsible party and a right of action based on subrogation (in which we assert the injured party's rights). 42 U.S.C. 1395y(b)(2)(B)(ii) and (iii). HCFA's regulations accord with this interpretation. 42 C.F.R. 411.24. However, even when being sued directly, a third party may assert defenses available against the injured party in the context of disputing whether it is a "responsible party." See Health Ins. Ass'n of America v. Shalala, 23 F.3d 411, 420 (D.C. Cir. 1994), cert. denied, 513 U.S. 1147 (1995). As the Fifth Circuit has explained, "the government stands exactly in [the Medicare beneficiary's] shoes when recovering from the available insurance funds." *Waters v. Farmers Texas County Mut. Insur. Co.*, 9 F. 3d 397, 401 (5th Cir. 1993).

Although we would argue that our lawsuits are not class actions under Rule 23 of the Federal Rules of Civil Procedure, because like the states, we are suing to recover our aggregate costs, it is likely that the courts would view our efforts based on the rights of millions of individual injured tobacco users in light of Rule 23. A court could decide this issue early in the litigation, although many class action motions are not decided until several years into a lawsuit.

B. Liability, Causation, and Damages

Although for practical reasons aggregation would be critical to any law suit against the tobacco industry, it would be of little help if the United States were forced to prove liability, causation, and damages for each beneficiary and against each defendant manufacturer. The problems of demonstrating causation in the individual case, with variables such as when the individual began to smoke, what information was available at the time, and what brands the individual smoked over time, would create enormous burdens. Only if the government can use generalized theories of causation, enterprise liability, and statistical models for damages could such a suit proceed. Once again, these ideas are untested in the federal courts -- and in most state courts. Absent statutory authority for such proof, a federal court may be hesitant to permit it. Although some federal district courts have permitted statistical sampling to determine amounts that providers overcharged Medicare, *see Chaves County Home Health Servs. Inc. v. Sullivan*, 732 F. Supp. 188 (D.D.C. 1990), the federal courts have routinely rejected statistical theories of causation and enterprise liability when considering mass torts brought under state law. *See, e.g., Kurczi v. Eli Lilly & Co.*, 113 F. 3d 1426 (6th Cir. 1997) (rejected enterprise liability under Ohio law); *Miller v. Wyeth Laboratories, Inc.*, 43 F. 3d 1483 (10th Cir. 1994) (same under Oklahoma law); *City of Philadelphia v. Lead Indus. Assoc. Inc.*, 994 F. 2d 112 (3d Cir. 1993) (same under Pennsylvania law). State courts have been similarly hesitant to permit introduction of such evidence. Indeed, it was for this reason that certain states, such as Florida, enacted statutes expressly to authorize use of statistical evidence and market share liability.

Even if a court did permit use of such proof, there may be constitutional limits that would require the court to allow tobacco manufacturers to challenge liability, causation, and damages with respect to each individual beneficiary. The Florida Supreme Court determined that, even though the state was permitted to use statistical evidence in its affirmative case, the Constitution requires that the tobacco companies be permitted to discover and admit evidence concerning individual beneficiaries; thus, it is likely that any suit would require review of millions of individual records and an examination of assumption of risk and other defenses in millions of individual cases.

None of these generalized methods of proof necessarily cures the basic problems that individual plaintiffs have had in suing cigarette manufacturers for smoking related death, disease, and disability. A lawsuit by the United States would have to overcome difficulties of establishing liability that so far have defeated almost every individual plaintiff who has brought such an action. Although the Minnesota court rejected the assumption of risk defense, it did so in the context of a suit brought under consumer protection, antitrust, and other theories. Because any federal suit would, under current law, not have the benefit of these theories and because, under the MSP Act or the MCRA, the federal government would stand in the shoes of its beneficiaries, the assumption of risk defense is likely to pose a significant obstacle.

Finally, the federal government may have to face a significant defense to its claim for damages -- namely, that the untimely death of smokers ultimately saves the government money due to death's inevitability and federal costs associated with the aged. This defense was excluded on public policy grounds in the Minnesota case, but could prove more problematic in federal court.

C. Statute of limitations

Because of statutes of limitations, it will be difficult for the United States to recover for Medicare or other costs expended more than six years ago. The six-year statute of limitations in 28 U.S.C. § 2415(a) generally applies to the United States' right to recover under the MSP laws, and should apply to any case filed against tobacco manufacturers. In a suit against the tobacco manufacturers where no underlying suit has been initiated by Medicare beneficiaries, the earliest possible accrual date for a cause of action is the date on which Medicare makes a payment for which the tobacco companies are required or responsible to pay.

The tobacco manufacturers would argue that an action that requires the United States to prove the tort liability of the defendants is not an action "founded upon any contract express or implied in law," 28 U.S.C. § 2415(a), but an action "founded upon a tort," 28 U.S.C. § 2415(b), to which the three-year statute of limitations found in section 2415(b) would apply. If this shorter statute of limitations were to apply, the amount of money available for recovery would be sharply reduced.

The courts may also require the United States to establish that the tobacco manufacturers are legally "responsible to pay" these liability claims. In Health Ins. Ass'n of America v. Shalala, 23 F.3d 411, 418-420 (D.C. Cir. 1994), cert. denied, 513 U.S. 1147(1995), the District of Columbia Circuit held that HCFA exceeded its authority in adopting a regulation that attempted to impose liability even though, the requirements for payment under the plan had not been met, and therefore, payment could not reasonably be expected to be made. It is possible, then, that the United States will have to prove that the claimants or HCFA have met all requirements for filing a claim for payment within the meaning of 42 U.S.C. §1395y(b)(2)B)(i)and that the manufacturers will be able to raise all defenses that, outside of the MSP context, would otherwise be available under state law; this may include state statutes of limitations related to the state tort theories that we would pursue. We would argue that, in the tort context, where there is no issue raised by a contractual agreement entered into by the claimant and an insurance company, that the requirements imposed by the *HIAA* case simply do not apply.

IV. Actions for Injunctive Relief

In order to reform the industry and reduce teen smoking by changing the way tobacco companies do business, any law suit against the tobacco industry would have to seek a large measure of

injunctive relief. In the cases brought by the State Attorneys General, state consumer protection statutes were the key vehicles for such injunctive relief. Federal consumer protection laws are analogous, but they are simply less effective than the laws of some states, such as Minnesota. If we were to pursue such relief, the most likely bases for a cause of action would be 18 U.S.C. § 1345, which provides for civil injunctions based on violations of the federal mail and wire fraud statute, and the Federal Trade Commission Act.

Although greater injunctive relief may be obtained through settlement, it may be difficult to obtain through litigation the broad injunctive relief that would replicate the sorts of regulatory provisions in comprehensive tobacco legislation. Any injunctive relief would have to be related to the alleged violation. For example, misleading advertising or using the mails to make fraudulent statements may lead to injunctions prohibiting or rectifying such conduct, but there is little likelihood that such activities will persuade or permit a court to impose the sorts of broader relief that may be desirable. A court might impose ongoing disclosure obligations or penalties for future misleading advertising, but might well choose not to impose lookback surcharges on the industry.

A. Civil Injunctions under Mail and Wire Fraud Theories.

18 U.S.C. § 1345 states, in relevant part, "if a person is violating or about to violate this chapter or section 287, 371 (insofar as such violation involves a conspiracy to defraud the United States or an agency thereof), or 1001 of this title . . . the Attorney General may commence a civil action in any Federal court to enjoin such violation." The authority for an action under § 1345 will be dependent on what can be demonstrated about the tobacco manufacturers' criminal fraud activity. *See United States v. Fang*, 937 F. Supp. 1186 (D. Md. 1996) (showing of reasonable probability that offense is being committed--or showing of probable cause, which is functionally the same–is required by the government); *United States v. Belden*, 714 F. Supp. 42 (N.D.N.Y. 1987) (solely past conduct will not justify injunction).

While a determination of what predicate offense could serve as grounds for a § 1345 injunction would necessarily have to be made on a case by case basis, one possibility would be to utilize 18 U.S.C. § 1001, the general false statement statute. To the extent that cigarette manufacturers concealed or covered up material facts which affected the government's ability or willingness to regulate tobacco under FCLAA or any other statute, those acts or omissions could possibly violate § 1001. *E.g, United States v. Fern*, 696 F.2d 1269, 1273 (11th Cir. 1983) (Section 1001 prohibits false statement that affects the exercise of government functions).

B. The FTC Act.

Section 45 (a) of Title 15 prohibits unfair or deceptive acts or practices in or affecting commerce. 15 U.S.C. § 45(a). This section provides the simplest basis for asserting jurisdiction over tobacco manufacturers. *See* 15 U.S.C. § 52 (false advertising concerning

food, drugs, devices, services, or cosmetics); *Federal Trade Commission v. Liggett & Myers Tobacco Co.*, 108 F. Supp. 573 (S.D.N.Y) (rejecting FTC argument that cigarettes are a drug), *aff'd*, 203 F.2d 955 (2d Cir. 1953). Various forms of relief are available under the FTC Act, including, but not limited to, temporary restraining orders, preliminary injunctions, and civil penalties.

C. How These Cases Would Be Litigated

An action under section 1345 or the FTC Act would necessarily allege -- whether implicitly or explicitly -- that tobacco companies misled consumers as to the safety and health affects of tobacco use. Any injunctive relief would likely have to withstand commercial speech objections raised by the tobacco manufacturers, advertisers, and retailers regarding any advertising or access restrictions to be imposed by injunction. We have not consulted the FTC, but an action brought under the FTC Act likely would require additional direct evidence related to marketing to children and/or false advertising.

V. Practical Obstacles

A. Documentary Hurdles

In addition to the legal hurdles to prevailing in a suit to recover health care expenses from tobacco companies, the burden of developing the facts necessary to pursue such litigation would be enormous. Under Rule 11 of the Federal Rules of Civil Procedure, any factual assertions made in a complaint must either have "evidentiary support" or be likely to be obtained as the result of discovery. Shortly after filing suit, Rule 26 of the Federal Rules of Civil Procedure could require us to disclose our basis for alleging what the tobacco-related health care costs were, so we must have this information ready.

The development of "evidentiary support" sufficient to file a complaint consistent with the obligations of Rule 11 is a daunting task. The HHS/HCFA, does not maintain payment records in a form that links monetary payments to illnesses caused by tobacco use. Developing such information will not be easy. Whereas it is relatively easy to identify injuries resulting from an automobile accident (through diagnostic and trauma codes), the process is far more complicated where the link between a particular injury or illness and an alleged causative agent is less obvious (such as ailments resulting from cigarette smoking). Moreover, not only must the agency establish a link between the illness and the tobacco, but it also must identify the individual beneficiary as a smoker. To recover for federal medical expenses related to cigarette smoking, the government must be able to link a particular illness (such as emphysema) to cigarette smoking and then identify as a cigarette smoker the specific beneficiary who received federal benefits for treatment of that ailment.

At this time, HHS/HCFA does not have anywhere near the funding, computer resources, or personnel (both in terms of numbers and training) to develop the information that would be needed to litigate this case. At a minimum, HHS/HCFA would be required to dedicate tens of millions of dollars and to divert scarce resources in order to prepare the information necessary to file the complaint.

B. Legal Resources

Assuming HHS/HCFA can begin to provide an evidentiary basis for a case, the Department of Justice would have to assemble a litigation team of many lawyers, paralegals, and expert witnesses to pursue the investigation, evaluate the evidence, and prepare to litigate the cases. This would require a considerable allocation of resources and must be done, as with the HHS/HCFA data development, before suit can be filed.

VI. Graham Bill

Given the difficulties of pursuing claims under current law we believe that proposed legislation, the so-called Graham bill, would provide a more substantial basis for the United States to recover against the tobacco manufacturers in litigation. This legislation would provide jurisdiction for the Attorney General to bring civil actions against tobacco manufacturers for recovery of costs incurred by federal health programs and would reduce the obstacles to litigation described above under current law. In short, although not a panacea, the Graham bill would make litigation a much more realistic option here. The text of the proposed Graham bill is attached as tab 2. It is important to note that the Supreme Court recently handed down a significant decision on Congress' authority to regulate economic rights and impose burdens retroactively that appears relevant to the proposed Graham bill. *See Eastern Enterprises v. Apfel*, No. 97-42, 1998 WL 332966 (June 25, 1998). The Office of Legal Counsel is currently evaluating the effect of that opinion on the Graham bill.

A. Essential Elements of the Graham Bill

1. The elements of proof necessary to establish liability of the tobacco company to the injured person or entity will vary somewhat depending upon the applicable substantive law. In actions where the United States is suing to recover for health care expenses paid or provided directly to injured individuals, the United States will need to establish, as specified by the applicable law, the traditional elements of a tort cause of action: (i) a duty running from the tobacco company to the individual, (ii) breach of that duty, (iii) a proximate causal relationship between breach and injury to the individual, and (iv) injury. The draft bill allows the United States to establish the element of causation with statistical and/or epidemiological evidence (§ 1345a(a)(6)(C)), and affords it the benefit of certain presumptions (§ 1345a(a)(6)(E)). Furthermore, the Draft Bill deprives defendant tobacco companies of the defenses of contributory and comparative negligence

(although it is not clear whether assumption of the risk may still apply) in suits by the United States. (§ 1345a(a)(6)(D)).

2. In actions where the United States sues to recover expenses paid to states and other entities on behalf of individuals treated for tobacco-related conditions, the United States may be able to rely upon various legal theories (including federal and state statutes and common law, *see, e.g.*, theories relied upon by State Attorneys General) to establish liability of the tobacco company to the state or other entity. The proposed bill would give the United States the right to recover the health care expenses for whatever the United States paid for those costs as proved by statistical evidence unless the manufacturers demonstrate by clear and convincing evidence that the health care costs were not caused by tobacco use.

3. This bill is modeled after MCRA and the Florida statute which formed the basis for the state of Florida to recover against tobacco manufacturers. The specific provisions that the Florida Supreme Court struck down have been eliminated.

B. Improvements Over Current Law

The Graham bill would lessen the proof problems that currently face the federal government in bringing these actions. For example, the Graham bill authorizes the use of statistical data, creates a presumption on causation, and requires a jury instruction that nicotine is addictive. These features of Graham will assist in overcoming some of the major litigation hurdles that exist under current law. Even with these improvements, proving damages will be challenging because the precise amount of the costs incurred by the federal government for smoking-related illnesses is difficult to quantify. Therefore, even with Graham, it will be necessary for the federal government to develop statistical estimates of these costs which would be admissible and probative. To date, HHS/HCFA has not done statistical estimates of these costs, and, as indicated above, they believe to estimate these costs would take a massive effort requiring a level of resources that may be well beyond their budget or capability.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Lorraine Lewis to Honorable Frank Hunger (3 pages)	10/16/1998	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco [10]

Racheal Carter
2011-0747-S
rc866

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Tobacco 1800 File

DRAFT

Honorable Frank W. Hunger
Assistant Attorney General
Civil Division
U. S. Department of Justice
Washington, D.C. 20530

Dear Mr. Hunger:

The Federal Employees Health Benefits (FEHB) Program is the largest employer sponsored health benefits system in the country. The Program provides health insurance to active Federal employees and their dependents as well as Federal annuitants and their survivors. The U.S. Office of Personnel Management (OPM) manages the FEHB Program, through contracts with over 350 health benefits plans. OPM also administers the Employees Health Benefits Trust Fund (Fund), under 5 U.S.C. §8909 which is used to make payments to approved health benefits plans and to pay for administrative expenses to administer the FEHB Program.

OPM is mandated to administer the FEHB program in an efficient and economical manner. In times of rapidly increasing medical costs to employers, OPM takes very seriously its obligation to offer the Federal workforce comprehensive medical coverage at the lowest possible costs. As Federal employees and the Government share in the costs of the health insurance provided by the FEHB Program, cost containment is a primary component of OPM's management responsibilities.

In that regard, we have noted with great interest the number of lawsuits recently brought by state governments as well as health plans themselves, against the tobacco industry, in an attempt to recoup the dollars expended for tobacco-related illnesses. As the nation's largest employer and provider of employee health benefits, we seek the advice of the Department of Justice as to whether the FEHB Program might similarly seek to recover the dollars that have been expended in the FEHB Program for tobacco-related illness.

We have been advised by at least one large health plan that it will attempt to seek such recovery for its lines of business involving private sector employers. Although we have been advised that specific plan will not seek recovery on behalf of the FEHB Program, we would be greatly concerned about the FEHB Program becoming involved in such litigation by other plans or other litigants. This is because not all of the many plans that contract with OPM in the FEHB Program are apparently planning such litigation, and we would not want any ultimate recovery to benefit only some of the FEHB plans. Further, we do not believe it is in the best interests of the FEHB Program to have the issue of recovery dependent on litigation brought in various courts,

on behalf of various plans, with potentially inconsistent theories of recovery. Therefore, we bring to your attention the question of whether the Federal Government, through the Department of Justice, should consider its own litigation on behalf of the FEHB Program.

We would appreciate the opportunity to discuss with the Department of Justice such litigation. Our health benefits experts in OPM's Retirement and Insurance Service can fully explain the process of payments of benefits in the Program, and OPM and the Department of Justice could then discuss the various theories that might be applicable to recovering such costs. For example, we understand some health plans have pursued litigation in their private sector business under general theories of tort liability. In those situations, the relief sought included recovery of medical costs paid by the carrier for tobacco-related illness. In the FEHB context, for example, the medical costs paid by the FEHB health plan for the treatment of an enrollee's cancer, where the illness can be shown to be proximately caused by use of tobacco, would be recovered by OPM on behalf of the Program. The FEHB recovery would be in the nature of a typical subrogation recovery, the proceeds of which would be returned to the Fund. While in the usual subrogation context, the enrollee would bring an action to which the health plan would subrogate, we believe that an action on behalf of the entire FEHB program could be more effective and efficient.

A variation of this theory could be for the recovery of the difference in the amount of FEHB premiums that were paid to the health plans and the amount of premiums that would have been owed had the health plans not expended the monies needed to pay for tobacco related medical treatment. Pursuant to statute, the rates charged by FEHB health plans must reflect the cost of benefits provided. 5 U.S.C. § 8902(I). These increased health benefits liabilities have had a direct impact on the Fund, through which premium dollars are used to pay FEHB costs. There is a real cost to the Government as the majority of the premium dollars are contributed by the Government, with the remainder contributed by the individual Federal employee enrollee.

As the managers of the FEHB Program and the Fund, OPM believes that it has a duty to seek out and attempt to recover funds that would reduce the cost of medical insurance for the Federal workforce. We recognize that litigation of this type is a major undertaking, with certainly no guarantee of success. However, we believe it would be productive to further explore the Department of Justice's views on whether such litigation is possible and whether it might comport with similar litigation on behalf of other Federal providers of medical treatment or insurance.

DRAFT

We would appreciate the opportunity to further discuss this matter. I would look forward to meeting with you or members of your staff to more fully review this issue. I can be reached at 202 606-1700.

Very truly yours,

Lorraine Lewis
General Counsel

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris J. to Bruce R. re: Today's Economic Briefing on Tobacco Settlement (1 page)	07/11/1997	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco - Settlement [6]

Racheal Carter
2011-0747-S
rc867

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Tobacco Settlement File

MEMORANDUM

TO: Bruce R.

FROM: Chris J.

RE: **TODAY'S ECONOMIC BRIEFING ON TOBACCO SETTLEMENT**

DATE: July 11, 1997

I just wanted to give you a heads up about your 11am meeting on the economic implications of the tobacco settlement. Jeanne had a conversation with Jon Gruber and Chad Stone, and they are presenting very dramatic numbers to you. They may make the case that about half of the $368 billion in settlement funds will be offset by losses due to the volume offset, the decline in tobacco tax revenue, and a general GDP effect.

Given the enormous implications of these numbers, I am very concerned (1) that they undergo a rigorous review and (2) they not be discussed widely until we are confident of their validity. It is premature to alert people to a major reduction in the amount of public health funds -- especially since our position on the budget side of this settlement hinges on how much we think that we have to invest.

Since I cannot attend the 11am meeting, could you make sure that people understand that both a review of the numbers is required and that, until that happens, they should not be discussed widely?

Thank you.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Miles Goggans to Chris Jennings re: Tobacco (2 pages)	06/23/1993	P5
002a. memo	Miles Goggans to Chris Jennings re: Tobacco/Ford Plan (1 page)	06/17/1993	P5
002b. memo	Miles Goggans to Chris Jennings re: Tobacco/Charlie Rose (1 page)	06/17/1993	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21521

FOLDER TITLE:
Tobacco - Spending [4]

Racheal Carter
2011-0747-S
rc868

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

To: Chris Jennings
From: Miles Goggans
Re: Tobacco

Remember, to these folks, tobacco is not a health issue, it's an economic issue.

Much like Senator Ford, Congressman Rose will emphasize the impact a cigarette tax will have on his growers. I suggest you seize the initiative with some of the following statements:

*recognize that tobacco is not the only sin within a sin tax

*Need to address the issue of increasing import levels of tobacco and to insure that imports share equitably in the health care solutions of this country. We do NOT expect domestic growers to carry this burden alone.

*Pleased that the Administration could help Ford get the current language included in reconciliation, but realize the need to improve upon it.

*Emphasize the **absolute necessity** of teamwork from the Administration, Rose and Ford in addressing the issue. Stress the need to have Rose intimately involved and the desire to reach an agreement with Ford.

Results of Senate measure on tobacco:

- assessment of tobacco imports and limitation on quota reductions, with a CBO projected five year savings of $29 million.

- This requires domestic manufacturers of cigarettes to certify the percentage of imported tobacco used, with penalties and domestic purchase requirements for any imports in excess of 25 percent. Requires assessments on tobacco importers to contribute to the 1990 Omnibus Budget Reconciliation Act tobacco assessments and to maintain a no net cost tobacco program. Requires comparable fees for inspecting imported and domestic tobacco. Extends the Secretary's authority to waive quota reduction floors for the 1995 through 1998 crops. Extends current tobacco producer/purchaser assessments through 1998.

Potential Issues To Be Addressed by Congressman Rose

1. Domestic Content - Rose will claim that the companies are willing to increase the level of domestic content to a higher percentage than Ford has secured (75%).
HRC: It is important to note two items: (a) currently, there is no legal mandate on domestic content, and (b) a mandate, especially a high one, is sure to raise complications with GATT. (NOTE: Brazil is a large tobacco exporter to US and would surely object to this change). Of course, addressing domestic content is the best way to address imports, which is the ultimate goal of Rose.

2. Policing Mechanisms - Rose will want to add to the policing mechanisms of the Ford language, probably by requiring that domestic content be applied by brand instead of by company.
HRC: Companies will fight this approach vigorously. Ask Rose, "Is there another way?"

3. A potential benefit for growers is an increase in grading and inspection fees for imported tobacco. Currently, we only inspect about 10% of imports, none of which is applied to imported stems.

The bottom line for Charlie Rose is to attempt to curtail the increasing imports of tobacco. By focusing on domestic content, he is in effect treating an imported product less favorable than a domestic product, which is GATT illegal. Consider that the US is about to file action against Switzerland, because the Swiss require a percentage of their domestic fruit and vegetables be purchased before those imported from the US. Clearly, the potential for inconsistencies in US policies will arise.

In the end, Congressman Rose should leave with the clear impression that the Administration is very sympathetic and is actively working to help. There will be some trade implications to consider, but we will work with him in addressing them. There must be a cooperative spirit between Rose, Ford and the Administration is handling this somewhat complex issue.

CONFIDENTIAL

To: Chris Jennings
From: Miles Goggans MNG
Re: Tobacco/Ford Plan

GATT implications surrounding the original Ford Plan (as presented at meeting with HRC) are serious and far reaching. Unfortunately, for the US to initiate such a program would prove highly inconsistent with our current efforts challenging **domestic content** laws in other nations (i.e. fruit in Switzerland).

If the Administration adopted and enacted the Ford Plan, containing the current language on domestic conent, which is the primary thrust of the language, adverse reactions will surely ensue from those countries feeling the greatest impact, such as Brazil. The form of reaction usually follows the traits of recent US actions against French wines due to an oilseed dispute, where the "victimized" country will target a commodity that approximately equals the value of the one in question, and carries some degree of visiblity or emotion as well.

The Ford Plan, therefore, causes problems for the US, both in current negotiations, overall direction of our trade policy, and in the risks that are raised from potential reactions.

USDA is now working with Senator Ford in hopes of crafting a proposal that is, if not GATT legal, then at least less vulnerable to charges of unfairness. Details are currently being finalized, which will be immediately sent to you upon their completion. It should accomplish the Administration goal of raising revenue (and perhaps, eventually changing habits) and the Ford goal of addressing the increasing levels of imported tobacco.

To: Chris Jennings
From: Miles Goggans MMG
Re: tobacco/Charlie Rose

For the proposed upcoming meeting with Rose, I believe it is important to stress the following:

*Recognition of the fact that tobacco is not the **only** "sin" within the sin tax.

*Need to address the issue of increasing import levels of tobacco and to insure that imports share equitably in the health care solutions of htis coutry. We do NOT expect domestic growers to carry this burden alone.

*Express understanding of the problems associated with a "domestic content" approach ... consistency with current US Trade Policy, GATT imlications, reactions from effected countries against us.

*Express the **absolute necessity** of teamwork from the Administration, Rose, and Ford in addressing this issue. State the obvious about the health care plan (revenue, votes) and then reemphasize desire to space as much of the impact as possible from the producers.

*Play up the **need** to have Rose intimately involved and the desire to have him and Ford reach agreement on a plan that will not trigger a trade problem.

*More details can be provided if needed.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bob Nash to the President re: Advisory Commission on Consumer Protection and Quality in the Health Care Industry (11 pages)	12/09/1996	P2, b(6)
002. memo	Chris Jennings to Hillary Rodham Clinton re: Background and Talking Points (4 pages)	02/05/1997	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 21536

FOLDER TITLE:
VIP Memos [1]

Racheal Carter
2011-0747-S
rc869

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

HRC

MEMORANDUM

TO: Hillary Rodham Clinton February 5, 1997
FR: Chris Jennings
RE: Background and Talking Points on the President's Children's Health Care Proposals
cc: Melanne, Pauline

First, a sincere thank you for your assistance yesterday. I think all of us around here believe that the President gave one of his best ever speeches.

Following up on our conversation yesterday, I am attaching a two-page description of the President's Children's Health Initiative. Also attached to this document is a set of draft talking points that you could use if you dropped in on the meeting we are planning to hold with the children's advocacy/provider groups tomorrow morning. These talking points summarize the President's children's health proposals; they also directly address the issue that many of these groups dislike most about the President's budget proposal -- the Medicaid per capita cap. (It is not imperative that you address the per capita cap issue, but we want you to be prepared and I think that the absence of your acknowledging it would be noticeable).

We are envisioning this meeting to be a frank and constructive discussion with our traditional base group supporters. Although we will be unable to change their minds about the Medicaid per capita cap, we may be able to get them to better understand our position. Most importantly, we hope to use this meeting to underscore the importance of working together to assure a successful take-off of the President's health coverage expansion investments. We need to, in particular, drive in the following points about the President's children health initiative:

(1) It is a thoughtful policy aimed at providing coverage to the many different categories of children who are uninsured today;

(2) It represents a substantial investment (our total health coverage expansion investment is $17 billion over 5 years); and

(3) It can be modified and enhanced, but only if we present a unified, positive force for change; some in the Congress (who do not want health care coverage investments) will only be too glad to play us off one another and use the money the President is now dedicating for health coverage for some lower priority.

Please don't hesitate to call with any questions about the meeting. We are not advising the groups that you may drop by -- though it would be a welcome and helpful surprise.

Talking Points for Children's Health Coverage Meeting

Medicaid/Per Capita Cap Concerns

- I am well aware that you oppose savings from the Medicaid program. Medicaid's growth has declined substantially. But I can assure you that the President's budget reflects this.

- In fact, the total Medicaid savings in the President's budget is a very modest $9 billion over 5 years. Remember that the program is projected to spend over $600 billion in Federal expenditures over that period.

- I want to be clear: The President, nor anyone in this Administration, views the Medicaid program as a piggy-bank for good or bad investments. That is why our per capita cap will be set at a growth rate that allows for very reasonable growth in the program.

- In fact, if growth rates stay where they are today, the per capita cap will never be breached. And even if costs grow in the out-years, the per capita cap will probably not achieve any savings until 2000 or beyond.

- None of us can kid ourselves into believing that the Medicaid program will not receive major scrutiny in the years to come as the entitlement reform debate heats up. A fiscally responsible constraint, which limits Medicaid spending and preserves the entitlement, may well be the best way to secure the long-term interests of the Medicaid entitlement program.

- I would like you to seriously consider these issues. However, whether we end up agreeing or not, I would like to focus on something I hope we can all agree on -- the need for more affordable, health coverage for the 10 million children who have none.

Children's Health Initiative

- The President's budget proves that it is possible to responsibly balance the budget while still prioritizing investments we all care about -- including expanding coverage for the uninsured.

- His budget includes $17 billion in spending on targeted programs that will cover millions of those 10 million children who lack insurance today.

- Categorizing and targeting uninsured children is not easy. The majority of these children can be found within three groups, each of which require separate initiatives. Specifically, the President's Children's Health Initiative proposes partnerships with you, states, communities and the private sector to target:

  (1) Children at risk because their parents change jobs;

  (2) Children whose parents earn too much for Medicaid but too little for private coverage; and

  (3) Children eligible but not enrolled in Medicaid.

- First, we make sure that children who have private insurance keep it, even when their parents change jobs. As the President said in his State of the Union speech, almost 50 percent (45%) of the children who lose their insurance do so because their parents lose or change jobs.

  Our Workers Between Jobs program helps make affordable the coverage that we made portable through last year's health insurance reform bill.

- Second, we empower States to help cover those children whose parents earn too much to be covered by Medicaid and too little to afford private coverage.

  We will develop a grant program to work with States to effectively target their unique gaps in coverage for working families' children.

- And, finally, we will make absolutely certain that Medicaid's guarantee of coverage for children is fulfilled. We will continue to phase in children's coverage so all poor children have access to Medicaid. But, we can no longer tolerate accepting that 3 million children are eligible but not receiving ANY Medicaid coverage.

  We will remove the barriers that cause children to move in and out of Medicaid by allowing States to guarantee coverage for a full year.

  And, we will work with States, you and the private sector community to help educate and enroll those children whose families do not know or understand Medicaid. I think there is much to do in this area and I hope we can work together on having much greater success in reaching out to eligible children.

- There is little question that our health policies will further evolve in the Congress. While we believe we are proposing sound policy, we are not locked in on any particular approach. We look forward to working with you and both Parties to meet this challenge.

- The greatest potential impediment for children's coverage now is to allow the opponents of coverage investments sit back and let us divide and conquer one another. We can be our own worst enemy when we fight amongst ourselves.

- Let's work together on the policy and how best to improve it. But let's keep the momentum moving forward.

- Let's resolve that all children's advocates, including the White House, strongly support any initiative with substantial investments that can gain bipartisan support and that would make meaningful reductions in the number of uninsured children. This is our window of opportunity; let's take advantage of it.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. report	re: Weekly Senate Report (23 pages)	08/08/1994	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
WHIP Report 8/8/94 [1]

Racheal Carter
2011-0747-S
rc872

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

WEEKLY SENATE REPORT
As of 8/08/94

Name: **BIDEN, JOE (D-DE)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **BRADLEY, BILL (D-NJ)**

Cities:

Status:

Core Issues:

Update: 7/14 Notes from Secretary Reich: (Confidential to Reich - Bradley is working on his own semi-soft trigger plan. It would include maintenance of effort for employers who provide. Impose a tax on those who don't and use money for subsidies for the uninsured. Nondiscrimination. If managed competition doesn't reach 94% coverage by a date certain, commission reports and Congress votes up or down. He was a little vague on the concepts.)

He does not believe the leadership will get the votes for a mandate. He feels that they should go for a bipartisan approach. He was surprised by the union reaction to his cost containment plan.

WEEKLY SENATE REPORT
As of 8/08/94

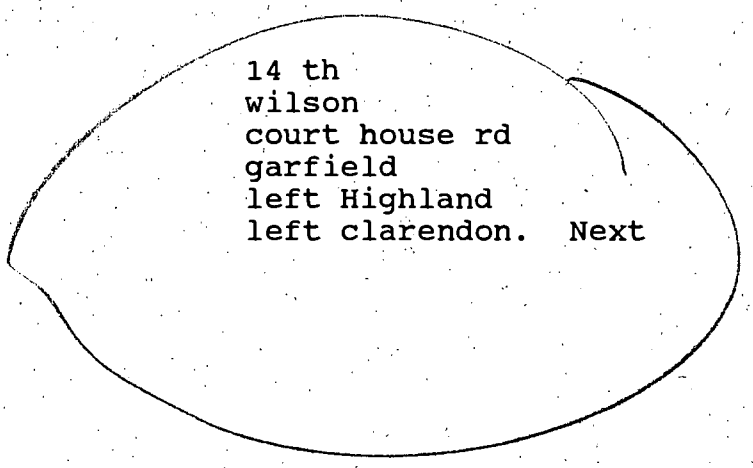
Name: **BREAUX, JOHN (D-LA)**

Cities:

Status:

Core
Issues: Financing - mandate - alliance structure - opposes premium caps

Update: 8/2 AP: Breaux, who opposes requirements on businesses to pay for insurance, said Mitchell had made a "major step." But he said the standby requiremants for business contributions were "an area we need to take another look at."



WEEKLY SENATE REPORT
As of 8/08/94

Name: **BRYAN, RICHARD (D-NV)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **CAMBELL, BEN NIGHTHORSE (D-CO)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **CONRAD, KENT (D-ND)**

Cities:

Status:

Core Issues:

Update: 8/2 AP: Called Mitchell's bill "a superb job" that would dramatically control costs and expand coverage.

WEEKLY SENATE REPORT
As of 8/08/94

Name: **DECONCINI, DENNIS (D-AZ)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **DORGAN, BYRON (D-ND)**

Cities:

Status:

Core Issues:

Update: 7/12 K Pollitz: Very much wants universal coverage and strong cost containment through a reform package that is paid for. At this point, he's closer to Kennedy's mark than Finance Mark. Would vote for a mandate for large employers today (large not yet defined -- maybe 100? maybe 75?) and could probabaly go for a mandate, or hard triggered mandate. That includes a carveout for small business (maybe 50?) with some payroll tax on firms not providing coverage. Dorgan is very mindful of Conrad. They made a pact earlier to stick together. Dorgan dosen't want to do anything to stick together. Dorgan dosen't want to do anything to undermine Conrad's reelection.

Dirgan's staff attended the the group of23 moderates that Chafee is trying to organize. He was disgusted at what he heard but will continue to attend in order to keep tabs on what is going on.

WEEKLY SENATE REPORT
As of 8/08/94

Name: **EXON, JAMES (D-NE)**

Cities:

Status:

Core Issues: Veterans - Native Americans - small business - supports phase-in of plan

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **FEINSTEIN, DIANNE (D-CA)**

Cities:

Status:

Core Issues:

Update: 7/14 Notes from Secretary Reich: She likes Calif's voluntary pool (CALpers). She notes the progress that program has made and doesn't understand why we need a mandate. She hasn't closed out the possibility of voting for a mandate but is less inclined every day. She strongly prefers a voluntary approach. She noted the discussion about the ads in the caucus. She doesn't like them. She feels that it makes them all look bad and more particularly hurts her in her re-election. Finally, she noted that she is not hearing much from her constituents that they want health care reform.

7/12 L. Davis & A. Hoffman: Supports universal coverage in theroy but would probably vote for a bill that did not guarantee 100% coverage.

WEEKLY SENATE REPORT
As of 8/08/94

Name: **FORD, WENDELL H. (D-KY)**

Cities:

Status:

Core Issues:

Update: 7/14 Notes from Secretary Reich: Tobacco tax is the key. While he does not like the employer mandate, it is not a deal breaker.

WEEKLY SENATE REPORT
As of 8/08/94

Name: **HEFLIN, HOWELL (D-AL)**

Cities:

Status:

Core
Issues: Financing - malpractice reform

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **HOLLINGS, ERNEST (D-SC)**

Cities:

Status:

Core
Issues: Employer mandates - rural coverage - community health centers - NIH - cost - paperwork

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **JOHNSTON, J. BENNETT (D-LA)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **KERREY, ROBERT (D-NEB)**

Cities:

Status:

Core
Issues: Up front on real costs - health care both a personal responsibility & a right

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **KOHL, HERBERT (D-WI)**

Cities:

Status:

Core Issues:

Update: 7/14 Notes from Secretary Reich: He is not committed. He is not in any camp. He has an open mind on the mandatebut feels strongly that this needs to be a bipartisan effort.

7/12 J Klepner: noncommittal. Kohl will hold cards close to vest until last minute. wants universal coverage. Believes employers have responsibility to provide coverage (as he did for his own employees) but would like to see this achieved without government mandates. Likes market-based cost containment. Dosen't want to add to the deficit. Staff has been attending Chafee (see Dorgan) but for now is "just listening."

WEEKLY SENATE REPORT
As of 8/08/94

Name: **LAUTENBERG, FRANK (D-NJ)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **LIEBERMAN, JOSEPH (D-CT)**

Cities:

Status:

Core Issues: employer mandates - opposes global budget & caps - wants cost containment

Update: 8/2 AP: Lieberman, a member of a moderate gruop of senators working on a mandate-free approach, said those colleagues "are going to be encouraged but not ready to sign on."

7/14 Notes from Secretary Reich: Likes what came out of Finance Cmte. Doesn't like the carve out, but expressed some flexibility regarding a trigger. He is open to a hard trigger but believes we do not have the votes for it. Process needs to be bipartisan because we need Republican cover. Otherwise, he feels we will be right back at it in two years. He also believes that Shelby and Boren are lost causes.

WEEKLY SENATE REPORT
As of 8/08/94

Name: **NUNN, SAM (D-GA)**

Cities:

Status:

Core Issues:

Update:

WEEKLY SENATE REPORT
As of 8/08/94

Name: **ROBB, CHARLES (D-VA)**

Cities:

Status:

Core Issues:

Update: 8/2 AP: "I think he's (Mitchell) put together the essential elements to achieve the critical mass, which is 51 votes."

WEEKLY SENATE REPORT
As of 8/08/94

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

SENATE ASSIGNMENTS (7/11/94)

Biden	Jennings/McFadden
Bradley	Kelpner/Reich
Breaux	Ricchetti
Bryan	Griffin/R. Brown
Campbell	Ricchetti
Conrad	Jennings
DeConcini	Griffin/Altman
Dorgan	Ricchetti/Klepner
Exon	Ricchetti/Bentsen
Feinstein	Klepner/Panetta/Reich
Ford	Griffin/Reich
Heflin	Griffin/Bentsen
Hollings	Ricchetti/Panetta/Bowles
Johnston	Griffin/McLarty/Bentsen
Kerrey	Ricchetti/Altman
Kohl	Klepner/Shalala/Reich
Lautenberg	Ricchetti
Leiberman	Ricchetti/Riech/Shalala
Nunn	McLarty
Robb	Ricchetti/Klepner/Altman/Bowles

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. entire folder	re: Weekly Congressional Report (74 pages)	08/08/1994	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject Files)
OA/Box Number: 8991

FOLDER TITLE:
WHIP Report 8/8/94 [2]

Racheal Carter
2011-0747-S
rc873

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

HOUSE ASSIGNMENTS

Bevill	Miller
Browder	Miller
Lambert	Murguia/McLarty
English	Murguia/Bentsen/Reich
Harman	Murguia/Klepner/Altman
Lehman	Klepner
Schenk	Ricchetti
Hutto	Miller
Bishop	Miller
Darden	Ricchetti/Klepner
Larocco	Murguia/Klepner
Lipinsky	
Sangmeister	Klepner
Hamilton	Lew
Long	Murguia/Klepner
Roemer	Murguia
Baesler	Murguia/Reich
Barlow	
Mazzoli	Klepner
Meehan	Brophy/
Barcia	Miller
Stupak	Lew
Minge	Murguia/Edelstein
Penny	Altman/Panetta
Peterson	Klepner
Skelton	Murguia
Lancaster	Murguia
Neal (NC)	Altman
Valentine	Murguia
Pomeroy	Lew/Klepner/Brophy/Claxton
Pallone	Lew/Klepner
Brown (OH)	Murguia
Fingerhut	Ricchetti
Mann	Brophy/Murguia
McCurdy	Murguia
Holden	Klepner
Klink	Lew/Reich
Mezvinsky	Lew/Altman
McHale	Miller
Spratt	Murguia
Clement	Klepner/ Min
Andrews	Treasury
Bryant	Murguia
Chapman	Murguia/ Treasury
Edwards	Klepner
Geren	Miller/ Treasury
Green	Altman/ Murguia
Laughlin	Klepner
Pickle	Klepner/ Treasury
Sarpalius	Brophy
Wilson	Lew
Boucher	Murguia/ Reich

Byrne	Klepner
Payne	Altman/ Lew
Pickett	Murguia
Sisisky	Lew
Cantwell	Brophy
Inslee	Brophy/Edelstein
Barca	Klepner
Mollahan	Murguia

Rules

Moakely	Griffin
Derrick	Murguia/Panetta/Bowles
Beilenson	Lew
Frost	Ricchetti/Klepner
Bonior	Griffin
Hall	Murguia
Wheat	Murguia
Gordon	Murguia/Min
Slaughter	Klepner/Altman

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **ANDREWS, MICHAEL (D-TX)**

Cities: Houston

Status: LN

Core
Issues: Cost containment

Update: 7/26 Leadership Staff Meeting: Felt he was about to tip no on employer mandate. Wrote Gephardt with 6 conditions for a support of a health care bill.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BAESLER, SCOTTY (D-KY)**

Cities: Lexington

Status:

Core Issues:

Update: 8/1 Reich has attempted to visit and call but has been unable to connect.

7/26 Leadership Staff Meeting: Considered no on employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BARCA, PETER (D-WI)**

Cities: Racine, Kenosha

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate Feeling vulnerable; would appreciate attention from administration.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BARCIA, JAMES (D-MI)**

Cities: Saginaw

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on Employer mandate. As long as we produce for him, he should be there. Dingell; Bonior to work

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BARLOW, TOM (D-KY)**

Cities: Paducah

Status: U

Core Issues: Small business

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate.
Told Gephardt- "My rule is not to piss off undertakers; insurers or doctors"
In meeting with First Lady- said workers comp should be moved to forefront

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BEVILL, TOM (D-AL)**

Cities: Jasper

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning Yes on employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BISHOP, SANFORD (D-GA)**

Cities: Albany, Americus

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. Cosponsor of every plan.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BOUCHER, RICK (D-VA)**

Cities: Blacksburg, Bristol

Status: LN

Core Issues:

Update: 7/28 J. Murguia: Despite previous indication to Dingell that he could be there, he is now saying that he doesn't think he can support the committee process. He is very concerned about the impact on small businesses and tobacco.

7/26 Leadership Staff Meeting: considered Lean No on employer mandate; tobacco tax; carve out- (Needs work)

7/14 Notes with Secretary Reich: Line in sand is tobacco tax. Over the weekend met with tobacco farmers. Very hostile crowd. He was booed. Just an ugly atmosphere. He said that if they could do a separate vote on tax which he could vote against, then he would consider vote on mandate. Needs cover on tobacco tax. NFIB has done a great job in district, but perhaps could support a carve out along the lines of Dingell proposal.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BROWDER, GLEN (D-AL)**

Cities: Anniston

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Watch Bevill and Craemer. Wants to be helpful. Considered to lean no on Employer mandate.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BROWN, SHERROD (D-OH)**

Cities: Lorain

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate

7/12 J Murguia: He will be able to support an employer mandate as part of health care reform. Was a strong supporter of single payer. He was very discouraged that Dingell couldn't get a bill through Energy & Commerce (Brown serves on this committee) & feels that could be a bad sign for the floor. He is definately OK on mandate issue despite a fairly conservative district and tough reelection campaign

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BRYANT, JOHN (D-TX)**

Cities: Dallas

Status: LY

Core Issues:

Update: 7/28 L. Murguia: He is OK on supporting a mandate. He has a specific concern about the frail elderly program which he has raised with the leadership. Overall, he supports universal coverage and mandates. He also has some concerns about malpractice, and has ties to providers in his district.

7/26 Leadership Staff Meeting: Yes on employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **BYRNE, LESLIE (D-VA)**

Cities: Annandale

Status: LY

Core Issues:

Update: 7/29 Washington Post: Failing to pass a health care plan before the November elections would be a political disaster.

7/26 Leadership Staff Meeting: Leaning yes on employer mandate; watch Moran

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **CANTWELL, MARIA (D-WA)**

Cities: Mt. Lake Terrace

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate; Number for uncompensated care;

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **CHAPMAN, JIM (D-TX)**

Cities: Texarkana, Marshall

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. First Lady Meeting very positive - Conversion change in world view. Understands problems of incremental reform. Usually reasonable.

7/21 J. Murguia: He is undecided. He is receptive to the argument that a mandate is in the best interest of middle class working families. He likes the pitch about this that HRC recently gave. He represents a rural conservative district and is concerned about the Senate vote.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **CLEMENT, BOB (D-TN)**

Cities: Nashville

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Gephardt- fine on trigger. Undecided on employer mandate. Very positive but be wary. Needs attention.

7/19 Meeting with N.A. Min & J Lew: Has concerns about small business as small businessman himself. Could see a hard trigger but not a straight out mandate. Hard or soft trigger, he'd be prepared to help. A Cooper and Rowland cosponsor. he told them that he wants to be helpful to the President if he can. His staff said Medicare cuts were a little hard for them. Had an abortion concern, pro-choice but no government money. Had no objections to the DNC adds.

7/12 L.Davis & A.Hoffman (staff contacts): Supports universal coverage (95% is OK) and likes a trigger - "but hasn't thought it out fully." Anxious to see what form Gephardt's compromise takes. Concerned about voting on the employer mandate before the Senate acts.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **COPPERSMITH, SAM (D-AZ)**

Cities: Tempe

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. Statewide politics will be key; Bill Galston.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **CRAMER, ROBERT (BUD) (D-AL)**

Cities: Huntsville

Status: U?

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. Gephardt assumed "yes." Craig Hanna to follow up.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **DANNER, PAT (D-MO)**

Cities: Kansas City

Status: LN

Core Issues:

Update: 7/28 J. Murguia: She is leaning against the bill because of concerns about the mandate. She wants the Senate to vote first. Her biggest concern is on abortion

7/26 Leadership Staff Meeting: Undecided on employer mandate. Bonior has good relationship; Gephardt does not.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **DARDEN, GEORGE (BUDDY) (D-GA)**

Cities: Rome, Marietta

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. Look at reelectoin race.

7/14 L.Davis & A.Hoffman (staff contact): Supports universal coverage. Strongly opposes employer mandates and probably would not vote for legislation which included a mandate (opposes because of the undue burden on small business)

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **DEFAZIO, PETER (D-OR)**

Cities: Eugene

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: A loose cannon, (anarchist); set up to walk over abortion. Undeceided on employer mandate.

7/15 L.Miller: Can not vote for employer mandates.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **DOOLEY, CALVIN (D-CA)**

Cities: Hamford

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leans no on employer mandate.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **EDWARDS, CHET (D-TX)**

Cities: Waco

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. Watch Senate.

7/15 L. Miller notes: Believes some type of employer mandate may be necessary to get a health bill. His district is opposed. Will not make public statement against mandates. Willing to vote for mandates, but reluctantly.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **ENGLISH, KARAN (D-AZ)**

Cities: Flagstaff

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: OK, Supported out of Ed and Labor; subsidies.

7/14 Reich: She supports mandate. Has concerns about abortion. Rural issues. Seems fine.

7/13 J. Murguia: Supported House Ed and Labor bill which includes comprehensive requirements/ mandates. She stresses that small business subsidies have to be there for her continued support of mandates. But thinks she'll be able to support this through the floor. Has a very tough reelection campaign.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **FINGERHUT, ERIC (D-OH)**

Cities: Willoughby Hills

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate. Refused to commit to Gephardt. Vague possible concerns about budget; unfunded mandates; member of the Administrations Enonomic Team should follow-up.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **GEREN, PETE (D-TX)**

Cities: Fort Worth

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leans no on employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **GLICKMAN, DAN (D-KS)**

Cities: Whchita

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandates. Boxed in by Slattery; wants 50/50; there in the end?

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **GREEN, GENE (D-TX)**

Cities: Houston

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Yes on employer mandate

7/13 J Murguia: Supported Ed & Labor bill as reported out of committee and believes he will be able to continue to support this approach which included an employer mandate-- very much wants Senate to go first, just thinks that will make it easier for everyone else. Hopes bill on floor looks more like Ed & Labor bill than Ways and Means bill.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **HAMILTON, LEE (D-IN)**

Cities: New Albany

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leans no on employer mandate. Needs work. If Jill Long can support, he should be able to be there.

7/14 JL: No support in his district for the President's bill. People are scared of change and losing what they have now. His own advice is this is too big to do without a broad bipartisan consensus. Dosen't kow how he'll vote. Waiting to see the leadership bill. Too much, too soon. Seemed like the Ways and Means phase-in might help, but he'll have to wait to see the outcome of the leadership process.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **HARMAN, JANE (D-CA)**

Cities: Los Angeles

Status: LN

Core Issues:

Update: 7/28 J. Murguia: He is undecided. He is receptive. She believes it is important that the Senate vote for a mandate first. Concerned about subsidies for small businesses. She would not rule out a vote for mandates. She has concernes about cost controls and supports the Senate Finance Bill.

7/26 Leadership Staff Meeting: Leans No on employer mandate. Might not be able to be there? Try to work, deal.

7/12 A. Hoffman & L. Davis (Staff Contact) Is not a cosponsor of any legislation as the Congresswoman wants to remain open minded. Has not mande a final decision regarding universal coverage and employer mandate. In literature the Congresswoman sent out, she said she supports universal coverage but this does not mean that she would vote against a bill that guarantees 95% coverage. Has not made any decisions regarding triggers. Most important concern is comprehensive reproductive health coverage, including abortion coverage - this is non-negotiable.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **HEFNER, W.G. (BILL) (D-NC)**

Cities: Concord

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; OK in end? Bowles should contact.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **HOLDEN, TIM (D-PA)**

Cities: Reading

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; small businesses; worried about supporting President who is unpopular in district.

7/12 A. Hoffman & L. Davis (Staff Contacts) Supportive of the Mainstream coalition's provisions in the SFC. Thinks they made a "good first step." Stressed he wants a "realistic" approach. Was shocked to read Gephardt thinks an employer mandate can pass in the House. Waiting to see what Gephardt will produce next week. Concerned about being BTU'd again.

Small businesses in his district have been very vocal in their opposition to the employer mandate. There is little support for Clinton in his district -- Bush won the Presidential vote there in 1992.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **HUTTO, EARL (D-FL)**

Cities: Pensacola

Status:

Core Issues:

Update: 7/26 Leadership Staff Meeting: No employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **INSLEE, JAY (D-WA)**

Cities: Yakima

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; Washington State already passed a mandate as part of statewide reform; Fiscal concerns primary.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **JOHNSON, DON (D-GA)**

Cities: Athens

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; Not a hard NO.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **KLINK, RON (D-PA)**

Cities: North Huntingdon

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate; abortion

7/14 JL & Reich: All abortion. With us on mandate. Otherwise OK.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LAMBERT, BLANCHE (D-AR)**

Cities: Jonesboro, West Memphis

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; Squishy; would have supported Dingell in committee. Concerns about Rural and small business. Wants cover from Senate.

7/20 JL notes from meeting with First Lady: When you say what Gephardt just said -- cutting administrative costs -- people agree but they think you can get there through simple insurance reform.

7/14 J. Murguia: Would like to see moderate bipartisan approach. Defintely believes the House should NOT vote before the Senate. Does not believe she could support a mandate. Likes the Senate Finance bill. Doubted a mandate would survive the Senate.

7/12 A. Hoffman & L. Davis (Staff Contact): Major concern is effect on small business and farmers.
Has not made a decision regarding support for universal coverage and employer mandate and believes these will be subjected to numerous conversations

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LANCASTER, H. MARTIN (D-NC)**

Cities: Goldsboro

Status: LN

Core Issues:

Update: 7/28 J. Murguia: Feels we've ignored the concerns of tobacco members. He is a lean no to no on mendates and doesn't care what the Senate does.

7/26 Leadership Staff Meeting: Leans No on employer mandate; Dosen't want to support mandate but has interest in health care reform. Tobacco tax big.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LAROCCO, LARRY (D-ID)**

Cities: Bosie

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate; squishy; telemedicine deal?

7/12 J. Murguia: Very apprehensive about a mandate; but hasn't signed the NFIB pledge to oppose it. In the right context he may be able to support a soft trigger. Subsidies would have to be right. Has problems with other parts of proposals... like Financing. Is trying to keep an open mind but an out and out mandate would be very difficult for him to support.
NOTE: He has a rural telecom. piece that he would like to see as part of a floor bill and might be willing to do some sort of deal to include it.

7/12 A. Hoffman & L. Davis (staff contact): Favors universal coverage in principal and wants to cover as many people as possible but probabaly would not vote against legislation that did not gaurantee coverage for all. Is nervous about employer mandates as Idaho is not the most progressive state. Probabaly would vote for a bill that included a mandate but other bebefits for Idaho would have to be present in the legislation. Telemedicine is of the utmost importance to the congressman and wants it to be a pilot program in Idaho. Rural medicine is also important and sees telemedicine as a way to help rural health care. Wants to pass health care reform this year. Will be the only member from Idaho who will support the President's health care reform package.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LAUGHLIN, GREG (D-TX)**

Cities: Victoria

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Considered to lean no on employer mandate

7/12 L. Miller: District not supportive of employer mandate, worried that house may vote for a compromise bill including mandates and Senate refuses to include that provision. Afraid of being BTU'd. Wants more managed care approach. Will not make public statements against mandates to keep options open.

7/12 A Hoffman & L Davis (Staff Contact): Opposes mandate; unsure how to get to universal coverage with out it.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LEHMAN, RICHARD (D-CA)**

Cities: Fresno

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate; watch his race

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LIPINSKI, WILLIAM (D-IL)**

Cities: Chicago

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandates; Fairly decisive usually. Rather health reform hadn't come up

7/26 L Miller: He is emphatically opposed to mandates.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LLOYD, MARILYN (D-TN)**

Cities: Chattanooga

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Considered to lean no on employer mandate; Retiring; appeal outside of health care; women's health

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **LONG, JILL (D-IN)**

Cities: Fort Wayne

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; difficult for her

7/20 Dem's meeting with First Lady: Need to pass reform before the election so we can move on to welfare reform. If bill is close to Ways and Means rather than Sen. Finance, it would be hard for me to come beck and we could lose the majority in the House. We need moderate reform and welfare reform to keep a majority.

7/14 J Murguia: "Probabaly will be OK with an employer mandate." But stressed the importance of a phase-in period and subsidies. Rural health issues are very important to her. She is co-chair of the House Rural Caucus. Very important that the Senate go first supporting a mandate. Would like to see White House and Leadership working more closly with moderates and mentioned Rep. Cooper's group.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MANN, DAVID (D-OH)**

Cities: Cincinnati

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; concerned about numbers; Needs Administration attention.

7/14 J Murguia: Big Concern about Administration's proposal (even as modified by committees.) Finincial solvency. Not many friends of health care reform or of a "massive transformation" of health care system in his district. LOTS of opposition in his district to employer mandates. He likes the Moynihan (Senate Finance) Bill. Believes a moderate incremental plan would be best. Very disturbed by CBO report/numbers. Believes they may be too soft, too speculative. Definitely believes the Senate should go first. Politically he isworried about supporting president and being labeled a "Clinton Clone." But at same time recognizes danger of accomplishing nothing and demostrating gridlock and becoming object of movement to "throw rascals out."

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MARGOLIES-MEZVINSKY, MARJORIE (D-PA)**

Cities: **Philadelphia**

Status: **LN**

Core Issues:

Update: **7/26 Leadership Staff Meeting: Leans No on employer mandates. Very negative. If she knows she is not coming back, it is possible she could support it in the future.**

7/14 JL- strickly local politics. The mandate is very unpopular. She has significant health care industry presence in her district. Being killed for the budget vote. Won't wait until the last minute this time. She'll look at the leadership package. But don't count on her. Her deal with Dingell was OK because it took care of some problems for her that she had to solve, and she could say that she was moving the process along, but it's not the same on the floor. Being killed with local ads. All the national money seems to be pouring into her district.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: MCHALE, PAUL (D-PA)

Cities: Bethlehem

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandates; Insurance companies may be key to vote.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MEEHAN, MARTY (D-MA)**

Cities: Lowell

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning yes on employer mandate; Should be OK, but watch.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MINGE, DAVID (D-MN)**

Cities: Montevideo

Status: LY

Core Issues:

Update: 7/28 J. Murguia: He is undecided to leaning yes on mandates. He needs some assuring and convincing but is definately gettable. He wants the Senate to vote for a mandate first. Minge is "leaving the door open to support a mandate." He has made many statements about the concerns which are important to him: pay-go financing, significant medical malpractice reform, grace period for new businesses, self-insure option for small businesses, mandatory copay for all services, preventive medicine, regionalized charges, continued health care deductability

7/26 Leadership Staff Meeting: Has produced a lot of papers on reform. Senate first; watching Durenberger/Peterson

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MOLLOHAN, ALAN B. (D-WV)**

Cities: Morgantown

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandates

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MONTGOMERY, G.V (D-MS)**

Cities: Meridian

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Considered to lean no on employer mandate; direct appeal vets hospital

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MORAN, JAMES (D-VA)**

Cities: Alexandria

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandates; FEHBP, protecting federal employees and retirees; Has a proposal on PHS. (if take may support on floor)

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **NEAL, STEPHEN (D-NC)**

Cities: Winston-Salem

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; reitiring; gettable if brought in.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **MORAN, JAMES (D-VA)**

Cities: Alexandria

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandates; FEHBP, protecting federal employees and retirees; Has a proposal on PHS. (if take may support on floor)

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **NEAL, STEPHEN (D-NC)**

Cities: Winston-Salem

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; reitiring; gettable if brought in.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **ORTIZ, SOLOMON (D-TX)**

Cities: Corpus Christi

Status: U

Core Issues:

Update: 7/28 J. Murguia: He is leaning against the bill. He has a problem with the mandate and is a supporter of Rowland/Bilirakis. he is also anxious about the Senate.

7/26 Leadership Staff Meeting: Undecided on employer mandate; Usually has a reasonable deal in mind for his support, find out what deal is.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **ORTON, WILLIAM (D-UT)**

Cities: Provo

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: considered to lean no on employer mandate; engage

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **PALLONE, FRANK (D-NJ)**

Cities: Long Branch

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Yes on employer mandate; but will need attention

7/15 A. Hoffman & L. Davis (Staff Contact): supportive of the President's goal of universal coverage-- but would accept SFC's 05% goal.

Originally supported an employer mandate, but is leaning toward a trigger. Likely to support Gephardt's compromise -- waiting to see details

Concerned about taking a tough vote on the mandate before the Senate acts.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **PAYNE, LEWIS F.**

Cities: Danville

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning Yes on employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **PETERSON, COLLIN (D-MN)**

Cities: Detroit Lakes

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: considered to lean no on employer mandate; convinced on First Lady's arguments; but following Durenberger

7/15 A. Hoffman & L. Davis (Staff Contact): Supports universal coverage but is not certian how to get there without an employer mandate which he opposes.

Believes the country will eventually be at a single payer system in 10-15 years and this is good enough for him with regard to universal coverage.

Would be difficult to vote for a bill which provides for abortions; would be easier to vote for legislation that either provides an out or a state option.

Wants patient records protected.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **PICKETT, OWEN (D-VA)**

Cities: Virginia Beach

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning No on employer mandate; Need Sisisky

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **PICKLE, JAKE (D-TX)**

Cities: Austin

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning Yes on employer mandate

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **POMEROY, EARL (D-ND)**

Cities: At-large

Status: U

Core Issues:

Update: 8/3 K. Parker & J Klepner: On employer mandate; Pomeroy stated that recent North Dakota polls do NOT favor an employer mandate, but seem to indicate that the Status Quo is preferred. Pomeroy prefers the Senate Finance Committee bill, and said that he wanted to talk with Gephardt about the options, but his order of preference was (1) soft trigger; (2) hard trigger; and (3) delayed phase-in. Stated

7/26 Leadership Staff Meeting: Undecided on employer mandate; Not optimistic; Conrad is key

7/19 JL: Conrad will define as far as I can possibility go. I'm pretty squishy. I'm a no on the mandate if the Senate dosen't include it, and maybe even if they do include it. I went out on a limb on the budget and assult weapons ban. Gephardt is out of step for the first time. As soon as the mandate is gone the focus will be on Part C. Personally doesn't see the difference between a hard trigger and a soft trigger and not worth losing seats over. Hard trigger is easier for him than a phase-in, because even with a 2050 effective date, he would be tarred as voting for a mandate. Conrad is popular for his independence, "rump" group got great press in ND. He thought seriously about introducing it in the House. But he'll keep his powder dry.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **POSHARD, GLENN (D-IL)**

Cities: Marion

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; abortion; Budget issues

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **ROEMER, TIM (D-IN)**

Cities: South Bend, Elkhart

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; Don't count because of committee vote; Senate Key

7/13 J Murguia: Despite the fact that he supported the Ed & Labor bill which included an employer mandate he has made it very clear that he did so only to move the process along. He has very big problems with the mandate the bill and would have to see it significantly reworked on in floor to support it . Would profer to see a resonable trigger mechanism that would also address small business concerns. While he could possibly support some form of a mandate he wanted to be sure that his comm. vote did not mean he was OK with this issue.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **SANGMEISTER, GEORGE E. (D-IL)**

Cities: Joliet

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; retiring; future

7/15 A. Hoffman & L. Davis (staff contact):
Yes Universal Coverage
Problems with employer mandate but this position is not hard.
Will not vote for package with abortion.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **SARPALIUS, BILL (D-TX)**

Cities: Wichita Falls

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning No on employer mandate; will have problem supporting President because he is unpopular in district

7/14 J Murguia: Had just reviewed 2 recent polls in his district which indicated the President's numbers were very weak. In his district the POTUS had a 69% negative rating. In addition, less than 10% of his district put health care in the top three issues of concern.

Believes he will have a VERY difficult time in his re-election primary due to his support of the Administration's budget last year. Although a visit by Sec. Bentsen recently was helpful he does not believe that he can convince constituents in his district that the Budget vote was the right thing and effective in bringing the deficit down. Despite CBO numbers to the contrary, his poll revealed that 70% of his district believe the deficit has increased in the past year. Opponents in his campaign are using a slogan capitalizing on the President's low rating: "Retire Slick Willie's Little Billy." Because of all of this he says there is "no way" he can support an employer mandate. Nor can he support any abortion benefits as part of health care reform. He believes right now its important to put distance between he and the POTUS.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **SCHENK, LYNN (D-CA)**

Cities: North San Diego, Coronado

Status: U

Core Issues:

Update: 7/26 Leadership Staff Meeting: Undecided on employer mandate; Biotech; Small business; abortion; any willing providor

7/14 Notes from Secretary Reich: Reminded secretary, she told chairman she would vote for the Dingell package, had worked out her problems- Breakthrough Drug Committee; softening impact on small business. She was prepared to go with Dingell but now its a whole new ball game. Her concerns have not changed, price has not gone up. Doesn't like Ways and Means language on breakthrough drug cmte. Concerned about the mandate. She suggested a carve out based on profits or phase-in based on size and profits (large businesses in first) On abortion, she sees how we might have to be flexible allowing for religious exemptions. But she doesn't want every business suddenly having religious objections. She also doesn't like opt-in as a solution. She also does not like the Way & Means' provisions on "any willing provider." She feels it undermines managed competition.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **SISISKY, NORMAN (D-VA)**

Cities: Portsmouth

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Leaning no on employer mandate; Will take something extraordinary. Numbers don't add up. Show fully financed for support. Do something for large low wage employers.

7/14 JL: There are a lot of issues that he could use as an excuse if he wanted to - abortion, mandate, tobacco tax- the real issue for him personally is he dosen't think the numbers add up. It was clear that of the issues, the mandate was the biggest. He's heard the minimum wage arguments from Gephardt but they don't fly with his businesses. And he's waiting to see what the leadership comes up with. The only bill he is on is R-B, thinks there has to be a vote on it or the rule will go down. At the moment he thinks R-B will pass. Nevertheless he sounded like he genuinely wanted to be helpful and certianly wasn't closing the door. He's getting a hard time because of the NAFTA vote, and annoyed with the DNC ads - what they should be running is ads telling that budget vote was one to help people, not hurt them, because they don't understand it. Concerned about the Senate -no BTU rerun.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **SKELTON, IKE (D-MO)**

Cities: Blue Springs

Status: LN

Core Issues:

Update: 7/28 J. Murguia: No way on mandate. Hard on this.

7/26 Leadership Staff Meeting: Leaning toward No on employer mandate. Gephardt not hopeful: something for rural hospitals may help, will be among last to decide.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **SPRATT, JOHN (D-SC)**

Cities: Rock Hill

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: leans yes on employer mandate; Trying to be helpful; three issues: 70/30; longer phase-in; problems with part C

7/18 J Murguia: Would prefer a trigger of some sort with the benefits package scaled back a bit. But could probably support some form of mandate. "maybe start it at a 50/50, employer/employee split." Does NOT like ways & means approach with medicare part C component. Is still trying to sort out what he thinks he can support.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **STUPAK, BART (D-MI)**

Cities: Traverse City

Status: LY

Core Issues:

Update: 7/26 Leadership Staff Meeting: Yes on employer mandate; Fine except abortion

7/14 JL: Generally positive, wants to see health care reform this year. Wants to see rural issues addressed, wants Ed & Labor rural provisions, dosen't know what the leadership will do. For him abortion is the real issue, can't vote for abortion mandate. Thinks W&M phase-in of mandate is OK, seems ok on cost containment. Concerned about the Senate -no BTU.

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **VALENTINE, TIM (D-NC)**

Cities: Durham, Rocky Mount

Status: U

Core Issues:

Update: 8/3 J. Murguia: Despite the concern about tobacco in his district, his overwhelming concerning is about the employer mandate which he believes would be bad for his state. Although, he does not think he can support the Gephardt approach he does like the Mitchell approach. He does think we shoud do someting this year on health care. Although he is retiring, he does not see this as a free vote.

7/26 Leadership Staff Meeting: Undecided on employer mandate; Retiring

WEEKLY CONGRESSIONAL REPORT
As of 8/08/94

Name: **WILSON, CHARLES (D-TX)**

Cities: Lufkin

Status: LN

Core Issues:

Update: 7/26 Leadership Staff Meeting: Retiring; Undecided on employer mandate; Tough but not absolutely no. 50/50 Split. Depends on Senate.