Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
01. briefing paper	Political Pros and Cons of Supporting Premium Support (1 page)	nd	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23749 Box 3

FOLDER TITLE:
Balanced Budget Act/Givebacks [11]

Gary Foulk

gf3

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 advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Took off words / forgot to Dan, Greg, Mark (only one w/ Fargo #s.)

POLITICAL PROS AND CONS OF SUPPORTING PREMIUM SUPPORT

PROS

- **Elite validation would enhance credibility and increase likelihood of bipartisan agreement on Medicare -- and Social Security.** Most economist and elite media consider premium support "real" reform. An openness to it would end Republican criticism that we only want an election issue or more revenues and benefits for Medicare. It also would undermine the media's criticism that we are not willing to make tough choices -- the same criticism that we are experiencing in the Social Security debate.

- **Would significantly increase the likelihood of a drug benefit for all beneficiaries and new purchasing tools for the traditional program.** Republicans will clearly not consider either a drug benefit or the modernization proposals for Medicare fee-for-service without premium support. Thus, an openness to premium support could open the door to these desired changes.

- **Drugs and the dedication of the surplus in return for premium support may be a good trade.** The complexity and controversy surrounding premium support will necessitate it being phased in and otherwise altered. Therefore, it is likely the surplus tranfer would begin in 2000, the drug benefit in 2001, but premium support on a more phased-in basis. Thus, we could get credit for being supportive without having to address its immediate effects.

- **Defining acceptable premium support at the beginning of the debate will give us more credibility in opposing at the end of Congress passes a flawed version.** An early openness to premium support may prevent criticism that we only signed onto this idea because we want to get prescription drugs. It could also offer us the opportunity to define what a good premium support plan would be -- laying the groundwork for a veto if necessary.

CONS

- **Will alienate Democrats base, particularly in the House.** Democrats in the House do not want a Medicare deal. They think that the risk of something bad coming out of any negotiation far exceeds any potential for a positive outcome -- even if that means a prescription drug benefit. Moreover, they believe that a Medicare compromise will help the Republican party far more than the Democratic party in 2000.

- **Risk of higher premiums and elderly dissatisfaction is too high relative to any potential positives.** High costs and less certainty will always be much more threatening and politically volatile to the elderly than the promise of a new benefit. This is particularly the case given the low odds that a good drug benefit and premium support proposal could emerge from a Republican Congress.

- **More difficult to oppose premium support at the end of the process -- particularly if included in a broader reconciliation.** The only message that the public will hear will be our support for premium support. Once that message is solidified, it will be extremely difficult to justify any opposition to premium support, no matter how flawed the particular proposal. Any such change will be considered as a political rather than a substantive move.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. draft	Draft- Health Coverage Ideas for Budget (7 pages)	12/10/99	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23756

FOLDER TITLE:
FY 2001 Budget [2]

Gary Foulk

gf19

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]
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DRAFT: **HEALTH COVERAGE IDEAS FOR BUDGET**
December 10, 1999

TAX

1. Tax credit for individual insurance
2. Expanding small business purchasing coalitions
3. Long-term care tax credit
4. Tax credit for workers with disabilities
5. Creating low-income tax credit by capping employer

FEDERAL GOVERNMENT / OPM

1. Contract only with firms offering health insurance
2. Offer health insurance to temporary or term employees

MEDICARE

1. Addressing arbitrary limit on Medicare coverage for people with disabilities

MEDICAID/CHIP

1. Low-income premium / cost sharing protections for seniors
2. Restoring state options to cover legal immigrants
3. Extending transitional Medicaid
4. Broadening presumptive eligibility for children for Medicaid
5. Medicaid coverage for certain women with breast cancer
6. Option for using school lunch information for children's health insurance outreach
7. Family coverage initiative
8. Medicaid option to cover any low-income person
9. Enrollment bonus for children in Medicaid
10. Allow CHIP to cover children up to age 21
11. Option for Medicaid-only CHIP states to convert to one matching rate
12. Aligning Medicaid and CHIP and eliminating barriers to enrollment
13. Outreach to homeless children

DRAFT: HEALTH COVERAGE IDEAS FOR BUDGET
LONG VERSION

TAX

1. Tax credit for individual insurance. The Vice President has proposed to provide a 25 percent refundable credit for people who lack access to employer-sponsored insurance who purchase individual insurance. This credit could only be used for policies that meet certain criteria (e.g., minimum actuarial value equal to FEHBP Blue Cross Blue Shield standard option). This evaluation could be done through a state insurance commissioner certification process. This credit could be also be used for Medicaid or Medicare buy-ins, CHIP, or other state-run health insurance programs.

2. Expanding small business purchasing coalitions: The President's FY2000 budget proposed to (1) give small firms (fewer than 25 employees) that do not offer health insurance a temporary (2 year) tax credit of 10 percent of their contribution towards health insurance, up to $200 per individual, $500 per family for purchasing health insurance through purchasing coalitions; and (2) allowing donations from foundations to coalitions from foundations for start-up to be considered charitable. The option would sunset in 2003. The Vice President has proposed to expand this by:

- Making all small businesses participating in coalitions (not just those that do not current offer health insurance) eligible for the tax credit; or
- Increasing the credit to 25 percent of the employer contribution (no cap).

3. Long-term care tax credit. The President's FY2000 budget proposed a $1,000 tax credit for people with long-term care needs or their caregivers. It phases out for higher income tax payers (taxpayer with modified adjusted gross income exceeding $110,000 for couples, $75,000 for unmarried taxpayers, and $55,000 if the taxpayer is married but filing a separate return; same phase-out as the child tax credit). It may be refundable for taxpayers with 3 or more dependents. Three types of people could receive this tax credit: (1) taxpayers with long-term care needs; (2) taxpayers whose spouses have long-term care needs; and (3) taxpayers with dependents with long-term care needs. "Long-term care needs" is defined as 3 or more limitations in activities of daily living (ADL) or severe cognitive impairment (different definition for children). This policy could be expanded by:

- Making the credit refundable; or
- Increasing the size of the credit (e.g., up to $2,000).

4. Tax credit for workers with disabilities. The President's FY2000 budget proposed a $1,000 tax credit for people with disabilities who work of $1,000. It would phase out for higher income tax payers (taxpayer with modified adjusted gross income exceeding $110,000 for couples, $75,000 for unmarried taxpayers, and $55,000 if the taxpayer is married but filing a separate return; same phase-out as the child tax credit). This credit may be refundable for taxpayers with 3 or more dependents. A taxpayer (or his or her spouse) would qualify for the proposed tax credit if he or she had earnings and was disabled. "Disabled" for this credit would be defined as being certified within the previous 12 months as being unable, for at least 12 months, to perform at least one activity of daily living without personal assistance from another individual, due to loss of functional capacity. [no proposed changes]

5. Creating low-income tax credit by capping employer deduction for people over $100,000. [OMB idea; need to ask about details]

FEDERAL GOVERNMENT / OPM

1. Contract only with firms offering health insurance. While the Federal government is a model employer in offering coverage to its employees, employers with whom it does business do not always offer health insurance to their employees. This proposal would require that the Federal government only [prefer to] contract with firms that offer health insurance to their employees. [very rough / preliminary]

2. Offer health insurance to temporary or term employees. Currently, the Federal government does not offer health insurance to temporary or short-term employees. This proposal would treat these employees like other Federal employees and allow them into FEHBP. [very rough / preliminary]

MEDICARE

1. Addressing arbitrary limit on Medicare coverage for people with disabilities. In the compromise on the Work Incentives Improvement Act, its Medicare benefit was limited to an additional 4 and a half years. This policy would remove this limit (same policy as in the President's budget last year).

MEDICAID/CHIP

1. Low-income premium / cost sharing protections for seniors. Although nearly all people eligible for Medicare participate in this program, only about 40 percent of Medicare beneficiaries eligible for Medicaid premium and cost sharing assistance participate. To address this problem, this proposal would give states the option of allowing SSA eligibility workers – who help beneficiaries enroll in Medicare – to grant presumptive eligibility for these programs.

2. Restoring state options to cover legal immigrants. Welfare reform prohibited states from providing health insurance for certain legal immigrants. This proposal would restore this option for pregnant women, SSI recipients and children in Medicaid and CHIP. This proposal was in the last two budgets.

3. Extending transitional Medicaid. This provision would eliminate the 10/01 sunset on the transitional Medicaid assistance program and would simplify reporting requirements.

4, Broadening presumptive eligibility for children for Medicaid. This proposal builds on the 1997 option to allow workers in programs that provide services to children, like school lunch programs, TANF and CHIP programs, and child care subsidy programs, to provide families with immediate, temporary Medicaid coverage while their full application is being provided. It would also allow states to presumptively enroll all children in the school lunch program or subsidized child care programs, a variant on the President's FY 1999 budget proposal.

5. Medicaid coverage for certain women with breast cancer. This proposal is the Breast and Cervical Cancer Prevention Act (HR 1070) that has 272 House cosponsors and passed unanimously by the House Commerce Committee (there is a Senate bill, but it has not yet been marked up). It would give states the option to provide temporary Medicaid coverage to uninsured women who have learned that they have breast or cervical cancer through a CDC screening program. States would get the CHIP match rate for this group.

6. Option for using school lunch information for children's health insurance outreach. Currently, school lunch programs are allowed to share enrollment information with other social programs, but not health insurance programs. The proposal would allow schools to elect to share school meal applications with Medicaid and CHIP staff unless parents opt not to have such information disclosed. When shared, application information may be used only for the purpose of child health insurance outreach and enrollment. [Lugar amendment, without the WIC grants]

7. Family coverage initiative. This option, which was included in the Gore health proposal, would allow states to use their enhanced Federal match rate from their CHIP allotments to cover parents of eligible children. This has the benefit not only of efficiently enrolling uninsured adults (since most parents of uninsured children are also uninsured) but could increase enrollment of children since there is a greater incentive for the family to enroll them.

Currently, states have the option of extending Medicaid to low-income families through section 1931. However, most states have extended access to state health insurance to children at higher income levels than their parents. This is an indirect effect of the Children's Health Insurance Program that provides higher matching rate and greater flexibility to states that extend coverage for children above their Medicaid eligibility levels. However, over 85 percent of the parents of uninsured children in families with income below 200 percent of poverty are themselves uninsured.

This plan would encourage states to expand coverage for the entire family, not just children, by:

- **Providing enhanced Federal matching payments for targeted low-income parents.** This option would allow states to access the CHIP enhanced matching rate from an increased CHIP allotment for covering parents of Medicaid or CHIP-eligible children whose income exceeds the current Medicaid eligibility level and is no higher than the current CHIP upper eligibility limit in the state. This option would only be available to states that have expanded CHIP to at least 200 percent of poverty and no waiting list.

- **Increasing CHIP allotments.** To ensure adequate funding for this option, the state CHIP allotments would be increased, beginning in 2002, so that the 2002 total is 50 percent higher than the 2001 allotment, and the total allotment increases at 5 percent annually. States would only get this allotment if they file a state plan for parents.

	01	02	03	04	05	2001-05
CHIP:	4.275	3.150	3.150	3.150	4.050	17.775
Addition:	0	3.263	3.583	3.920	3.373	14.139
New total:	4.275	6.413	6.733	7.070	7.423	27.639

  This total allotment would be allocated to states using a similar formula as that (modified by the Balanced Budget Refinement Act). In addition, the current provision that reallocates unused allotment amounts after 3 years would be changed to 5 years, to help in the transition to the new system. The rules for what happens when the allotments are used up would remain the same, with one exception: states would have to reduce eligibility levels for parents before reducing eligibility levels for children (they could only reduce eligibility levels for children if they no longer drew the enhanced matching rate from the allotment for any parents).

- **Benefits and entitlement.** Parents would be covered in the same program that their children; states could not cover a parent in a state-designed program when their children are currently eligible for Medicaid and vice-versa. States must cover lower-income parents before covering upper-income parents, as in CHIP.

8. Medicaid option to cover any low-income person. This proposal would give states the option to fully convert their Medicaid eligibility to an income-only standard, irrespective of age, work or family status. This approach has been take by several states through Medicaid 1115 waivers. To access this option, states would have to file a state plan, as in CHIP, that includes a description of current state-only spending on health care, proposed income definitions, etc. States with current state-only spending would have maintenance of effort (modeled on CHIP). This option would be limited to 150 percent of poverty.

9. Enrollment bonus for children in Medicaid. A new option would be created that allows states to draw from their CHIP allotments the same, enhanced match rate for any newly enrolled Medicaid child over a base-year number. This has the advantage of eliminating the financial bias to enroll children in CHIP.

- **Conditions for accessing CHIP allotments for Medicaid children.** Given that the original use of these funds is to help children not previously eligible for Medicaid, only states that have done the following can access this new option:

  - Expanded through CHIP to 200 percent of poverty, with no waiting lists;

  - Conducted aggressive outreach, including:
    - adopting a shortened and simplified application procedure;
    - allowing families to mail/phone-in applications;
    - eliminating the assets test;
    - outstationing Medicaid eligibility workers.

- **Enrollment bonus.** States meeting the above conditions could draw from their CHIP allotment an amount the number of newly enrolled Medicaid children (full-year equivalents) multiplied by the average Medicaid per capita costs and the difference between the CHIP and Medicaid Federal matching rates. The number of newly enrolled Medicaid children is the difference between the previous year's actual full-year enrollment and the FY 2000 [or 1999?] full-year enrollment in Medicaid (adjusted for any eligibility changes). This bonus would be calculated once annually.

10. Allow CHIP to cover children up to age 21. [HHS idea] Currently, CHIP is limited to children up to age 18; this policy would make CHIP consistent with Medicaid.

11. Option for Medicaid-only CHIP states to convert to one matching rate. Currently, 23 [check] states have chosen to use Medicaid as their CHIP option. For these states, the only difference between traditional Medicaid and CHIP is the matching rate. This proposal would allow these states to simplify their system and get the same Federal matching rate for enrolling a child in traditional Medicaid or CHIP. It would do so by allowing states to convert, in a budget-neutral way, to a single combined matching rate for all children. This rate would be calculated using the weighted average total costs in the latest year for which data are available. The formula would be:

$$\frac{[(\text{Total Medicaid costs})*(\text{FMAP-Medicaid}) + (\text{Total CHIP costs})*(\text{FMAP-CHIP})]}{(\text{Total Medicaid} + \text{Total CHIP costs})}$$

The enhance match (the difference between the Medicaid FMAP and the new FMAP) would be drawn from the allotment as under current Medicaid CHIP expansions.

12. Aligning Medicaid and CHIP and eliminating barriers to enrollment. States would be required to use the same application and income verification process for children eligible for Medicaid and CHIP and could not use an assets test for children in Medicaid or CHIP. States also must use the same redetermination process for Medicaid and CHIP.

13. Outreach to homeless children. This initiative would give $5 million in mandatory, administrative grants to states to ensure that so-called "mainstream" programs – Medicaid, CHIP, TANF, and the Mental Health and Substance Abuse Block Grant -- are accountable to the homeless. States would use the grants to examine: (1) how outreach is being done to the homeless; (2) how intake questioning asks about homeless status and other indicia of homelessness; (3) how the program is accountable to treating the homeless; (4) what are the future goals of addressing the needs of the homeless; and (5) what outcome measures are in place to see whether the homeless needs are being addressed.

Mrs Gore was supposed to announce reports (women said there has a big problem & then announced it himself. People very angry - his up prospects are down.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. entire folder	Dr. Jane Henney - Outline for Confirmation Strategy (56 pages)	nd	P2

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23757 [3]

FOLDER TITLE:
Henney Confirmation [3]

Gary Foulk

gf24

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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Henney, FDA Confirmation File

DR. JANE HENNEY
OUTLINE FOR CONFIRMATION STRATEGY

Chris
Jeanne

CORE MESSAGE

A physician and cancer specialist with two decades of experience managing change in public and private health care institutions, Dr. Jane Henney is the ideal candidate to lead the Food and Drug Administration into the next century. She supports the FDA Modernization Act of 1997 and will make full and timely implementation of the Act her top priority. As part of this effort, she plans to improve the agency's scientific base and to continue to build constructive relationships between the FDA and its major stakeholders - Congress, industry, consumers and physicians.

KEY ELEMENTS OF STRATEGY

- Ensure that Pro FDA reform Democrats (Dodd, Mikulski, Harkin, Wellstone, and Bingaman) take the lead among Democrats in confirmation drive.

- Continue courting influential moderate Republicans to encourage their support (Frist, Hatch, Mack, Collins, Snowe, and Lugar).

- Continue working with Senator Domenici to help secure Republican support, encourage July confirmation hearing, and validate candidate with leadership for later floor consideration.

- Work closely with Jeffords, Coats and other key committee members to help build case for July hearing and confirmation this year - meetings with nominee, respond expeditiously to written questions, targeted media and advocacy contact from home states.

- Implement regional press and advocacy campaign in target states (attached).

- Generate support/neutrality within regulated industries. Identify one major company or association within each industry to support nominee.

- Work with women members of Congress and women's health groups to generate support for nominee.

- Continue building support among national advocacy groups.

CONGRESSIONAL CONTACT LIST FOR THE FDA COMMISSIONER ROLL-OUT*

A LIST:

Senate

Republicans	Democrats
Jeffords (R-VT)	Daschle (D-SD)
Domenici (R-NM)	Kennedy (D-MA)
Hatch (R-UT)	Mikulski (D-MD)
Frist (R-TN)	Dodd (D-CT)
Collins (R-ME)	Harkin (D-IA)
Snowe (R-ME)	Bingaman (D-NM)
Mack (R-FL)	Murray (D-WA)
Lugar (R-IN)	Bumpers (D-AR)
Coats (R-IN)	Lieberman (D-CT)
Cochran (R-MS)	

House

Republicans	Democrats
Skeen (R-NM)	Dingell (D-MI)
	S. Brown (D-OH)
	Waxman (D-CA)
	Obey (D-WI)
	Kaptur (D-OH)
	Eshoo (D-CA)

B LIST

A List Plus . . .

Senate Leadership

Trent Lott (R-MS)
Don Nickles (R-OK)
Wendel Ford (D-MI)

Senate Labor Committee

Gregg (R-NH)
DeWine (R-OH)
Enzi (R-WY)
Hutchinson (R-AR)
Warner (R-VA)
McConnell (R-KY)
Wellstone (D-MN)
Reed (D-RI)

Senate Appropriations Subcommittee on Agriculture

Specter (R-PA)
Bond (R-MO)
Gorton (R-WA)
Burns (R-MT)
Stevens (R-AK)
Kohl (D-WI)
Byrd (D-WV)
Leahy (D-VT)

Women Senators

Hutchison (R-TX)
Boxer (D-CA)
Feinstein (D-CA)
Landrieu (D-LA)
Moseley-Braun (D-IL)

Moderate Senators

Chafee (R-RI)

House Leadership

Gingrich (R-GA)
Gephardt (D-MO)

House Commerce Subcommittee on Health and the Environment

Michael Bilirakis, (R-FL)
Joe Barton, (R-TX)
James C. Greenwood, (R-PA)
Greg Ganske, (R-IA)
Ron Klink (D-PA), *Full Committee*

House Women's Caucus

Johnson, Nancy (R-CT)
Norton, Eleanor Holmes (D-DC)

New Mexico Delegation

Bill Redmond (R)

Indiana Delegation

David M. McIntosh (R)
Mark Souder (R)
Steve Buyer (R)
Dan Burton (R)
Ed Pease (R)
John Hostettler (R)
Peter J. Visclosky (D)
Tim Roemer (D)
Lee H. Hamilton (D)
Julia Carson (D)

*Members listed previously are not duplicated

COURTESY VISIT SCHEDULE FOR DR. JANE E. HENNEY

July 1, 1998 (9:22am)

Time	Date	Contact	Contact	Location
	WEDNESDAY, JUNE 24			
11:15	Senator Bill Frist (R-TN)	P 224-3344 F228-1264	SCH Ramona Lesson STF Sue Ramthun	567 Dirksen
12:45	Senator Patty Murray (D-WA)	P 224-2621 F 202-224-0238	SCH Kristen Hochswinder STF Ann Grady	111 Russell Building
1:30	Representative Henry Waxman (D-CA)	P 225-3976 F 225-4099	SCH Norah Mail STF Karen Nelson/Paul	2204 Rayburn
4:00	Representative Anna Eshoo (D-CA)	P 225-8104 F 225-8890	SCH Micha Liberty STF Bill Bates	308 Cannon
	THURSDAY, JUNE 25			
8:45	Senator Orrin Hatch (R-UT)	P 224-6621 F 224-7371	SCH Ruth Monyoya STF Patricia Knight	Meet 8:30 at Senator Domenici's office, 328 Hart
9:30	Senator Connie Mack (R-FL) (5 minutes)	P 224-5274 F 224-8022	SCH Suzanne Schaffrath STF Mark Smith	517 Russell
11:30	Senator Dan Coats (R-IN)	P 224-5623 F 228-4745	SCH Karen Parker STF Sharon Soderstrom	Meet 11:25 at Senator Coat's office, 404 Russell
12:00 - 12:30	New Mexico delegation - Senators Domenici & Bingaman; Representatives Skeen & Redmond	Contact: Senator Domenici's ofc P 224-6621	SCH Jenny	Senator Domenici's office, 328 Hart

	MONDAY, JULY 6			
	TUESDAY, JULY 7			
3:00 - 3:15	Senator Olympia Snowe (R-ME)	P 224-5344 F 228-1071 (Pat)	SCH Pat Doak	250 Russell
	WEDNESDAY, JULY 8			
	THURSDAY, JULY 9			
3:00 - 3:30	Senator Tim Hutchinson (R-AR)	P 224-2353 F 228-3973	SCH Heather Larrison (Little Rock 501-324-6336)	245 Dirksen
	FRIDAY, JULY 10			
	(Possible Lugar - late morning or afternoon)			

TARGET STATES

Mississippi
Florida
New Mexico
Vermont
Indiana
Connecticut
Maryland
Iowa
Tennessee
Maine
Ohio
Washington
Pennsylvania

INFORMATION ON DR. JANE HENNEY,
FDA COMMISSIONER - NOMINEE

- BIOGRAPHY OF DR. JANE HENNEY
- WHY DR. JANE HENNEY IS THE IDEAL CANDIDATE
- LIST OF ACCOMPLISHMENTS
- WHITE HOUSE PRESS RELEASE
- STATMENT BY SECRETARY SHALALA
- STATEMENTS OF SUPPORT
- ARTICLES ON DR. HENNEY

Jane E. Henney, M.D.
Vice President for Health Sciences
University of New Mexico

Dr. Jane E. Henney, Vice President for Health Sciences at the University of New Mexico (UNM), is a physician, a cancer specialist and a nationally recognized academic leader and public health administrator.

As UNM's first Vice President for Health Sciences, Dr. Henney, 51, spearheaded the successful consolidation of the university's hospitals, schools of medicine, nursing and pharmacy, and specialized facilities for mental health, cancer and pediatrics into the Health Sciences Center. She has also led this organization during a time of dramatic change in the health care environment.

Having grown up in Woodburn, Indiana, a town with a population of 512, she brings a unique understanding of the medical and health care needs of small, relatively isolated populations. Under her leadership, the Health Sciences Center has expanded its efforts to stabilize local health care delivery systems by bringing primary care directly to rural communities and has given renewed emphasis and commitment to community based interdisciplinary education, service and research programs.

Before coming to the University of New Mexico, Dr. Henney was Deputy Commissioner for Operations at the Food and Drug Administration (FDA) from 1992 to 1994, where she played a key role in reform efforts. As Deputy Commissioner, Dr. Henney revitalized FDA's centers for biologics, drugs, medical devices, foods, veterinary medicine and toxological research to make them more effective and efficient and to more closely align their research and review functions. In addition, she developed a strategic planning process and recruited new leadership for five of the agency's six centers.

At Kansas University from 1985 to 1992, Dr. Henney provided strong leadership as Interim Dean of the University of Kansas School of Medicine, Kansas City; Vice Chancellor for Health Programs and Policy; and Acting Director for the University of Kansas Mid America Cancer Center.

From 1976 to 1985, Dr. Henney rapidly assumed a leadership role at the National Cancer Institute (NCI). She rose from a Senior Investigator in the Cancer Therapy Evaluation Program in the Division of Cancer Treatment to the position of NCI

Deputy Director. She worked with Dr. Vincent T. DeVita, an oncologist who pioneered chemotherapy for patients with Hodgkin's Disease. She served successfully during an explosion in new knowledge through dramatic advances in molecular biology.

Dr. Henney graduated from the Indiana University School of Medicine in 1973, a time when relatively few women were admitted to medical school, and took an internship in Indianapolis and a medical residency in Atlanta. Dr. Henney's fellowship training was at the M.D. Anderson Hospital and Tumor Institute in Houston, Texas. She received a B.S. in biology from Manchester College, North Manchester, Indiana, in 1969.

Dr. Henney has served in the Carter, Reagan, Bush and Clinton Administrations. She is currently President of the United States Pharmacopeia, a private, non-profit, standards-setting organization for pharmaceuticals that publishes the annual compendium of medicines used in the U.S. She serves on numerous committees of governmental and professional organizations, including the Advisory Committee to the Director of the National Institutes of Health. She is a member of the American Medical Association, the American Society of Clinical Oncology, and the Council for Excellence in Government. She has served as a consultant for the Commonwealth Fund and the W.K. Kellogg Foundation, among others.

Dr. Henney has authored or co-authored more than 40 scientific papers and book chapters. Much of her research has focused on advancing therapies for cancers of the breast and new drug development. She currently holds the academic rank of Professor of Medicine. She has also received numerous awards, including the Public Health Service Commendation Medal, and her work has been generously supported by institutions ranging from the National Institutes of Health to the American Cancer Society, as well as private foundations such as the Wesley Foundation, the Kellogg Foundation, and the Robert Wood Johnson Foundation.

She is married to Robert Graham, M.D., executive vice president of the American Academy of Family Physicians in Kansas City, Missouri.

DR. JANE E. HENNEY IS THE IDEAL CANDIDATE FOR THE COMMISSIONER OF FOOD AND DRUGS

A Nationally Recognized Public Health Leader. Dr. Jane E. Henney is a physician, a cancer specialist and a nationally recognized academic leader and public health administrator who has served in the Carter, Reagan, Bush and Clinton Administrations.

A Dedicated Reformer. Dr. Henney is already thoroughly familiar with FDA's responsibilities and challenges. From 1992 to 1994, Dr. Henney was FDA's Deputy Commissioner for Operations. During her tenure, she was integral in numerous reform efforts. As FDA Commissioner, she would continue to shape the agency to respond to the changing nature of the industry and the health care marketplace.

As Deputy Commissioner for Operations, Dr. Henney managed the agency's daily activities, overseeing FDA's six operating centers which regulate drugs, biologics, devices, foods, veterinary medicine, and toxological research, as well as the Office of Regulatory Affairs. Under her direction, the agency underwent significant management changes and new leaders were recruited to senior leadership positions. In addition, new initiatives were launched, such as the way FDA reviews new pharmaceuticals under the Prescription Drug User Fee Act of 1992 and the creation of the program that raised the safety and quality of mammographies throughout the country.

An Innovative Health Care Professional. Dr. Henney's lifelong commitment to providing innovative health care through individual patient care, scientific research and modern management of small, as well as large, complex medical organizations makes her an ideal candidate to lead the Food and Drug Administration into the next century.

A Leader in Food and Drug Safety Issues. Dr. Henney has remained professionally active in issues related to pharmaceuticals. Dr. Henney is currently President of the United States Pharmacopeia, a private, non-profit, standards-setting organization for pharmaceuticals that publishes the nation's annual compendium of medicines. She serves on numerous committees of professional organizations and has received many awards such as the Public Health Service Commendation Medal.

A Skilled Manager. Dr. Henney has also demonstrated her ability to manage large health care organizations. For the last four years, she has been Vice President of the University of New Mexico's Health Sciences Center and has

presided over a major consolidation of the university's hospitals, schools of medicine, nursing and pharmacy, and specialized facilities for mental health, cancer and pediatrics. As one of the nation's leading female VPs, she is responsible for the day-to-day operations of the state's largest integrated healthcare treatment, research and education institution, which has an annual budget of $466 million.

An Innovative Cancer Physician and Scientist. As a physician and scientist, Dr. Henney became a specialist in cancer care after a hometown friend died of breast cancer. She spent nine years at the National Cancer Institute, rising from Senior Investigator in the Cancer Therapy Evaluation Program in the Division of Cancer Treatment to the position of NCI Deputy Director. She was instrumental in the development of two innovative programs: The first was designed to engage community based oncologists in research and the second provided physicians and patients with up-to-date information on state-of-the-art therapy and investigative research protocols. She has authored or co-authored more than 40 articles and book chapters.

Accomplishments of Jane E. Henney, M.D.

Dr. Jane E. Henney is a physician, a cancer specialist and a nationally recognized academic leader and public health administrator. As a top official at two federal public health agencies in four different Administrations, she has championed modern management strategies while maintaining the highest clinical and research standards. As a top official at two major university medical centers, she has fashioned innovative health care strategies with a focus on individual patient care.

Food and Drug Administration

Championed Reform Efforts. Dr. Henney's track record at the Food and Drug Administration, where she was Deputy Commissioner for Operations from 1992 to 1994, is impressive. She supports recent reforms enacted by the Congress and being implemented by FDA, and as FDA Commissioner would continue to shape the agency to respond to the changing nature of the industry and the health care marketplace.

Reorganized FDA Centers. As Deputy Commissioner for Operations, Dr. Henney revitalized FDA's six centers which regulate biologics, drugs, medical devices, foods, veterinary medicine, and toxological research, as well as the Office of Regulatory Affairs. Dr. Henney recruited new directors for five of the six centers. The centers were reorganized in order to more closely align their research and review functions and to make them more effective and efficient.

Revitalized the Agency's Drug Review Systems. Dr. Henney was principally involved in the effort to enact the Prescription Drug User Fee Act (PDUFA) of 1992, which revitalized the agency's drug and biologics review system by infusing it with additional resources. Dr. Henney supervised the creation of the PDUFA program that dramatically reduced FDA's review times for new pharmaceuticals and biologics for widespread use. In 1997, new drugs were reviewed and approved in an average of just 12.2 months, compared to a decade ago when it took more than 30 months for a drug to reach the market. Dr. Henney was also instrumental in helping to create the program that raised the safety and quality of mammographies throughout the country.

National Cancer Institute

Innovative Cancer Research. Dr. Henney became the Deputy Director of the National Cancer Institute at the age of 32. She served directly with NCI Director Vincent T.

DeVita, M.D., a leading cancer researcher who led the cancer institute from 1980 to 1988. She was instrumental in the development of two innovative programs: the first was designed to engage community-based oncologists in research and the second provided physicians and patients with up-to-date information on state-of-the-art therapy and investigative research protocols. During her time at NCI, she rose to the rank of Captain in the commissioned corps of the U.S. Public Health Service.

University of New Mexico

Demonstrated Managerial Excellence. Dr. Henney became the first Vice President for Health Sciences at the University of New Mexico in 1994. She is responsible for the day-to-day operations of the state's largest integrated healthcare treatment, research and education institution, which has an annual budget of $466 million.

Implemented Strategic Initiatives. Dr. Henney quickly developed and implemented strategic initiatives for the University of New Mexico Health Science Center that have guided the organization through a time of extensive change in health care delivery. Under her leadership, the university's health care system was re-engineered to provide a continuum of care from the primary care centers off campus where patients could be seen in their own communities to the highly specialized care at the university hospital.

Strengthened Local Health Care Systems. Having grown up in Woodburn, Indiana, a town with a population of 512, Dr. Henney brought a unique understanding of the medical and health care needs of small, relatively isolated populations to the University of New Mexico Health Science Center. Under her leadership, the Health Sciences Center has expanded its efforts to stabilize local health care delivery systems and has given renewed emphasis and commitment to community based interdisciplinary education, service and research programs.

Increased Research Grant Money. By increasing the Health Science Center's focus on programmatic, interdisciplinary research which emphasized New Mexican health care needs, Dr. Henney helped raise the amount of research grant money flowing into the university by more than 30 percent in the four years of her tenure. Research space also was increased dramatically.

University of Kansas Medical Center

Developed Multidisciplinary Centers. When Dr. Henney served as the interim dean of the University of Kansas Medical Center, she was one of very few women to hold such a position in the 1980s. While at Kansas, she developed multidisciplinary centers that focused on specific health problems, such as the Center on Aging and the Center on Environmental Health, and the Mid-America Cancer Center where she also served as director.

Secured Funding for Cancer Research. Taking a regional view of research and training, Dr. Henney was instrumental in developing and securing funding for a large multi-institutional cancer research and training center that included investigators from Kansas University, Kansas State University and the University of Kansas Medical Center. These multi-institutional centers enabled researchers from the separate universities to establish closer collaborations to advance their work.

Other Accomplishments

President of United States Pharmacopeia. Dr. Henney is currently President of the U.S. Pharmacopeia, a private, non-profit, standards-setting organization for pharmaceuticals that publishes the annual compendium of medicines used in the U.S. Dr. Henney's term ends in 2000.

Numerous Awards. Dr. Henney serves on numerous committees of professional organizations and has received many awards such as the Public Health Service Commendation Medal. She has authored or co-authored more than 40 articles and book chapters.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Tuesday, June 23, 1998

Contact: HHS Press Office
(202) 690-6343

STATEMENT BY DONNA E. SHALALA
SECRETARY OF HEALTH AND HUMAN SERVICES
REGARDING THE NOMINATION OF JANE E. HENNEY, M.D.
AS COMMISSIONER OF FOOD AND DRUGS

"The position of FDA Commissioner is vital to the nation's health and safety, and Dr. Jane E. Henney is the person to lead the FDA into the next millenium. From the safety of our foods to the effectiveness of our pharmaceutical and other medical products, Americans rely heavily on the processes, resources and judgement of the Food and Drug Administration.

"Dr. Henney has a proven track record at FDA, and if confirmed by the Senate, she will continue to shape the agency to respond to the changing nature of the industry and the health care marketplace. Dr. Henney will encourage and nurture collaborative relationships with consumers and industry alike – this is crucial to FDA's success in the years ahead. Dr. Henney will work vigorously to carry out the Food and Drug Administration Modernization Act, and as Commissioner she will work closely with Congress to ensure its implementation.

"A talented manager, Dr. Henney has the solid medical and academic credentials that are needed to understand the burgeoning field of biomedical research and development. As FDA Commissioner, Dr. Henney will provide the leadership that is needed to make the 21st century FDA the model agency of consumer protection that it must be.

"In addition to voicing my support for Dr. Henney, I would like to commend Dr. Michael Friedman for the outstanding service and dedicated professionalism that he has demonstrated while serving as Acting FDA Commissioner."

# # #

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 23,1998

PRESIDENT CLINTON NAMES JANE E. HENNEY AS COMMISSIONER OF THE FOOD AND DRUG ADMINISTRATION AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The President today announced his intent to nominate Dr. Jane E. Henney to serve as Commissioner of the Food and Drug Administration at the Department of Health and Human Services.

Dr. Jane E. Henney is a physician, a cancer specialist and a nationally recognized academic leader and public health administrator who has served in the Carter, Reagan, Bush and Clinton administrations. If confirmed by the Senate, Dr. Henney would become the first woman to serve as Commissioner of the Food and Drug Administration. During her distinguished career, she has championed modern management strategies and maintained the highest clinical and research standards at two federal public health agencies, and has fashioned innovative health care strategies with a focus on individual patient care at two major university medical centers.

Since 1994, Dr. Henney has been the Vice President for Health Sciences at the University of New Mexico where she presided over a major consolidation of the university's hospitals, schools of medicine, nursing and pharmacy, and specialized facilities for mental health, cancer and pediatrics. From January 1992 to March 1994, Dr. Henney served as Deputy Commissioner for Operations at the Food and Drug Administration where she managed the agency's daily activities, revitalized FDA's six science centers and implemented key legislation, including the Prescription Drug User Fee Act of 1992. From 1985 until joining FDA, Dr. Henney served as Interim Dean of the University of Kansas School of Medicine, as Vice Chancellor for Health Programs and Policy, and as Acting Director of the Mid America Cancer Center at the University of Kansas. Between 1976 and 1985, Dr. Henney served at the National Cancer Institute, rising to the position of Deputy Director, where she was instrumental in the development of two innovative programs which engaged community-based oncologists in research and provided physicians and patients with up-to-date information on state-of-the-art therapy and investigational research protocols.

Born in Woodburn, Indiana, she received a B.S. in biology from Manchester College, North Manchester, Indiana, in 1969. At a time when relatively few women were admitted to medical school, Dr. Henney graduated from the Indiana University School of Medicine in 1973, and took an internship at St. Vincent's Hospital in Indianapolis, a medical residency in Atlanta, and a fellowship in oncology at M.D. Anderson Hospital and Tumor Institute in Houston. She is the author or co-author of some 40 academic articles and book chapters and has received numerous awards, including the Public Health Service Commendation Medal.

The Commissioner is the head of the Food and Drug Administration, a critical consumer protection agency that assures the safety and efficacy of pharmaceutical and biological therapeutics, medical devices, blood products, generic drugs, food safety, food additives and cosmetics.

30-30-30

ENDORSEMENTS FOR DR. JANE E. HENNEY
as of June 30, 1998

American Academy of Pediatrics
American Cancer Society
American College of Obstetricians and Gynecologists
American College of Physicians
American Heart Association
American Medical Association
American Medical Women's Association, Inc.
American Nurses Association
American Society for Reproductive Medicine
American Society of Clinical Oncology
Association of Academic Health Centers
Association of American Medical Colleges
Association of Schools of Public Health
National Association of Chain Drug Stores
National Breast Cancer Coalition
National Coalition of Hispanic Health And Human Services Organization
National Community Pharmacists Association
National Partnership for Women & Families
Nonprescription Drug Manufacturers Association
Older Women's League
Partnership for Prevention
Pfizer Inc.
Research!America
Society for the Advancement of Women's Health
Former Secretary Otis R. Bowen, M.D.

Pediatrics

Department of Government Liaison
American Academy of Pediatrics
The Homer Building
601 Thirteenth Street, NW
Suite 400 North
Washington, DC 20005
202/347-8600
800/336-5475
Fax: 202/393-6137
E-mail: kids1st@aap.org
Web Site: http://www.aap.org

June 22, 1998

The Honorable James M. Jeffords
728 Hart Senate Office Building
Washington, DC 20510-4503

Dear Senator Jeffords:

The American Academy of Pediatrics is very pleased to support the nomination of Jane E. Hanney, MD as FDA Commissioner. The challenges before the FDA are daunting and the Administration should be commended for selecting a candidate who is well-suited for such a challenge on both the scientific and political fronts.

Through what we hope will be a speedy confirmation hearing, you will have a Commissioner in place that will hit the ground running by virtue of her past experience as FDA Deputy Commissioner for Operations. Her management skills, exhibited as Vice President of the University of New Mexico's Health Sciences Center, reflect her broad-based fund of knowledge, combined with practical know-how and determination, render her well-qualified for this key position.

We have found Dr. Hanney to be a team player who will reach out to the medical specialties, as appropriate. She has excellent standing in the pediatric community and has earned our respect and trust.

We urge your favorable consideration of Jane Hanney, MD, for this important post.

Sincerely yours,

/S/

Joseph R. Zanga, MD, FAAP
President

JRZ:jn

AMERICAN CANCER SOCIETY® NATIONAL GOVERNMENT RELATIONS OFFICE

June 23, 1998

The Honorable William Jefferson Clinton
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Clinton:

The American Cancer Society has set some tough goals for significantly reducing the number of people diagnosed with or dying of cancer by the year 2015. For the first time in history we have seen a slight decline in cancer incidence and mortality rates overall. Our analysis of why these trends have taken that critical downward spiral gives us real hope that we can achieve our stated 2015 goals. Accelerating these downward trends requires a strong investment in cancer research and expanding access to cancer prevention, early detection and treatment for all Americans. Accomplishing this will require a renewed partnership among the public, private and nonprofit sectors.

The Food and Drug Administration (FDA) is an important component of this partnership. The FDA plays a critical role in getting new and innovative cancer therapies to the cancer patient. Confirming the appointment of Jane Henney, MD as Commissioner of the U.S. Food and Drug Administration will ensure that we have a knowledgeable health professional and dedicated public health servant at the helm of one of our key cancer-fighting agencies.

Dr. Henney has a proven track record as a researcher, health care provider, public servant and health administrator. As Deputy Commissioner at FDA in the early 1990s she was responsible for reorganizing the agency's drug development program, streamlining the review process and successfully involving pharmaceutical partners in a new fee and review structure for drug approvals. Her knowledge of cutting edge medicine and science is critical as the agency faces new opportunities and pressures to expedite approvals and ensure safety of breakthrough drugs, biologics and medical devices for the prevention and treatment of cancer and other illnesses and diseases. Dr. Henney's diverse experience in both the public and private sectors has given her a keen understanding of the role of government in the changing health care environment and the relationships between consumers, health care providers and payors. Like most Americans, Dr. Henney understands the personal side of dealing with illness and brings to the agency the

compassion and understanding that the mission of FDA is not just about science, technology or safety, but assuring quality patient care and the health and well-being of all Americans.

The American Cancer Society is very familiar with Dr. Henney's work, dedication and accomplishments in the field of oncology. She was an American Cancer Society research grantee and served as a volunteer at local and national levels for many years before entering the public health service. As we look ahead to the critical role of the FDA in continuing to approve new cancer drug applications, oversee the regulation of tobacco products to protect our children, and ensure food safety standards and regulations, we need a strong, knowledgeable leader who understands the different roles of government, the private sector and health charities. Dr. Henney is such a candidate and we strongly support her nomination and urge swift approval.

Thank you for your consideration.

Sincerely,

David S. Rosenthal, MD
President

June 23, 1998

President William J. Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500-0003

Dear President Clinton:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 38,000 physicians dedicated to improving women's health, I am writing to express our support of your nomination of Jane E. Henney, MD for Commissioner of the U.S. Food and Drug Administration (FDA).

Dr. Henney's leadership in medicine, academia, and public health will bring much to the critically important position of FDA Commissioner. Her previous roles as Deputy Commissioner for Operations at the FDA in spearheading and implementing reform efforts make her an excellent candidate to lead the FDA as it faces numerous challenges. Dr. Henney was instrumental in the reorganization of the FDA's six centers, which regulate drugs, medical devices, biologics, foods, toxicological research, veterinary medicine, and the Office of Regulatory Affairs. Dr. Henney also was involved in the enactment of the Prescription Drug User Fee Act (PDUFA) of 1992, which revitalized the FDA's drug and biologics review system. As a result of this new system, the FDA was able to reduce review and approval times for new pharmaceuticals.

In addition to Dr. Henney's leadership at the FDA, she has also served as Deputy Director of the National Cancer Institute. In this position she lead innovative programs that sought to ensure access to safe and effective therapies, including one which sought to engage community-based oncologists in cancer research and one which assisted patients and physicians in receiving the latest information on therapy and research.

ACOG recognizes Dr. Henney's leadership in food and drug safety issues and as a innovative health care professional and supports her nomination as FDA Commissioner.

Sincerely,

Ralph W. Hale, M.D

Ralph W. Hale, MD
Executive Vice President

American College of Physicians

Independence Mall West Sixth Street at Race. Philadelphia. PA 19106-1572
Telephone: 215 351 2400 or 800 523 1546 Fax: 215 351 2829
http://www.acponline.org

Harold C. Sox. MD. FACP
President

June 23, 1998

The Honorable James Jeffords
Chairman
Committee on Labor and Human Resources
United States Senate
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the American College of Physicians (ACP), the nation's largest medical specialty society with more than 100,000 internal medicine physicians and medical students, I urge you to support the nomination of Dr. Jane Henney for Commissioner of the Food and Drug Administration (FDA).

The ACP supports the nomination of Dr. Henney because of her accomplishments as a physician, cancer specialist, academic leader, and public health administrator. Her career has been marked by many successes in management as well as improvements in clinical care.

For the last four years, Dr. Henney has been Vice President of the University of New Mexico's Health Sciences Center where she is responsible for the daily operations of the state's largest integrated healthcare treatment, research, and education institution. In that role, she also presided over a consolidation of the university's hospitals, schools of medicine, nursing and pharmacy, and specialized facilities for mental health, cancer, and pediatrics.

Dr. Henney has also devoted many years to public service. As Deputy Commissioner for Operations at the FDA from 1992-1994, she played a key role in several reform efforts. Dr. Henney led the reorganization of the FDA's centers that regulate biologics, drugs, medical devices, foods, and toxicological research. She also helped revitalize the agency's drug and biologics review system to reduce the review times for new pharmaceuticals and biologics.

Prior to her position at the FDA, Dr. Henney was the Deputy Director of the National Cancer Institute. While there, she was instrumental in the development of programs to engage community-based oncologists in research as well as to provide physicians and patients with updated information on state-of-the-art therapy and investigative research protocols.

Throughout her career, Dr. Henney has demonstrated strong commitments to research, clinical care, and the long-term improvement of public health. The College is confident that she will be an excellent Commissioner.

Sincerely,

Harold C Sox

Harold C. Sox, MD, FACP

American Heart Association.
Fighting Heart Disease and Stroke

Office of Communications and Advocacy
1150 Connecticut Avenue Northwest, Suite 810
Washington, D.C. 20036
Tel 202 785 7900
Fax 202 785 7950

June 23, 1998

The Honorable Jim M. Jeffords
Chair, Committee on Labor & Human Resources
United States Senate
Washington, DC 20510

Dear Senator Jeffords:

On behalf of the American Heart Association, and its 4.2 million volunteers nationwide, I am pleased to offer our support for the nomination of Dr. Jane E. Henney for the position of Commissioner of the Food and Drug Administration (FDA).

Dr. Henney has a broad range of experience both in and out of government, including distinguished service at the FDA as Deputy Commissioner for Operations. At FDA, Dr. Henney helped spearhead reorganization efforts which resulted in greatly improved times for drug approvals.

It is clear that Dr. Henney has the necessary mix of management, science, patient and research skills to move the FDA into the 21st Century.

Again, I offer our strong support for Dr. Henney's nomination as Commissioner of the FDA.

Sincerely,

Diane M. Canova, Esq.
Vice President, Advocacy

American Medical Association
Physicians dedicated to the health of America

June 23, 1998

Senator James M. Jeffords
Chairman of the Senate Labor & Human Resources Committee
728 Senate Hart Office Building
Washington, DC 20510-4503

Dear Chairman Jeffords:

On behalf of the American Medical Association (AMA), I would like to enthusiastically support the nomination of Jane E. Henney, MD, for the position of Commissioner of the Food and Drug Administration (FDA).

Dr. Henney has excellent credentials to serve in the challenging role of FDA Commissioner. Throughout her career, Dr. Henney has had significant experience running large bureaucracies. In her present position as Vice President of The University of New Mexico Health Sciences Center (UNM), Dr. Henney is responsible for the operation of the UNM's School of Medicine, the Colleges of Nursing and Pharmacy, University Hospital, Mental Health Center, Cancer Research and Treatment Center, Children's Psychiatric Hospital, and Carrie Tingley Hospital.

Dr. Henney has had extensive experience within various facets of the federal government including the FDA. For almost ten years, Dr. Henney worked in senior positions in the National Cancer Institutes (NCI) at the National Institutes of Health (NIH). During five of those years at NCI, Dr. Henney served as the Deputy Director of the Institute. Dr. Henney's membership on the Advisory Committee to the Director of NIH provides a different dimension to her executive branch experience. The prestigious, advisory committee allows Dr. Henney to bring her private sector expertise to the challenges confronting the NIH. In her role as Deputy FDA Commissioner, Dr. Henney deepened her overall knowledge of the Department of Health and Human Services (DHHS), as well as becoming intimately familiar with the FDA and the challenging issues it confronts. Such a wealth of experience at DHHS at such a senior level has uniquely prepared Dr. Henney to handle the tough policy issues that she will face as FDA Commissioner.

Thank you for this opportunity to comment on a position of such importance to the health of our nation. Dr. Henney's impressive private and public sector expertise provides strong assurance that Dr. Henney will serve the nation well as FDA Commissioner. The AMA urges the Senate Labor and Human Resource Committee to move quickly to approve the nomination of Dr. Henney as the next FDA Commissioner.

Sincerely,

E. Ratcliffe Anderson, Jr., MD
Executive Vice President

American Medical Women's Association, Inc.

"Career Development and the Female Physician"
AMWA's 83rd Annual Meeting
New Orleans, LA
November 18-22, 1998

The Honorable Jim M. Jeffords
Chair
Senate Labor and Human Resources Committee
Dirksen Senate Office Building, Room 428
Washington, DC 20510

June 24, 1998

Dear Chairman Jeffords:

The American Medical Women's Association most enthusiastically supports the appointment of Jane E. Henney, MD, for Commissioner of the Food and Drug Administration (FDA). A leader in public health, Dr. Henney is a physician and cancer specialist, a skilled administrator, and a team builder. She has demonstrated her skills in working with all administrations, having served in the Carter, Bush, Reagan, and Clinton Administrations.

Dr. Henney proved her leadership in the FDA as the Deputy Commissioner for Operations from 1992 to 1994. During her tenure at the FDA, Dr. Henney reorganized the FDA's six centers to make them more efficient and effective and made critical appointments in these centers. She also was a leader in the enactment of the Prescription Drug User Fee Act (PDUFA) of 1992, which dramatically reduced the FDA's review times for new biologics and pharmaceuticals. This legislation has resulted in an average approval time for new medications of 12.2 months in 1997 verses an average of 30 months for approval just one decade earlier. She served as interim Dean of the University of Kansas Medical Center in the 1980's. In her current position at the University of New Mexico, she serves as Vice President for Health Sciences and has demonstrated her expertise at team building and systems' design to meet future health needs.

AMWA has been familiar with the excellence of Dr. Henney's work since her role in the creation of the program that raised the safety and quality of mammograms and their standards throughout America. Millions of women and their families have Dr. Henney to thank for this effort. As health advocates for women, AMWA's vision is to empower women to take the lead in improving health for all within a model that uniquely reflects the perspective of women. Along those lines, one of our main goals is to support the advancement of women in medicine. We believe that Dr. Henney is a true champion and would be an asset to the FDA.

If you have any questions regarding AMWA or Dr. Henney, please feel free to contact either of us.

Sincerely,

Anita Johnson

Anita Johnson, MD
President-Elect

Debra R Judelson MD

Debra R. Judelson, MD, FACC, FACP
1996-1997 AMWA President

801 NORTH FAIRFAX STREET • SUITE 400 • ALEXANDRIA, VIRGINIA 22314
TELEPHONE (703) 838-0500 • FAX (703) 549-3864 • EMAIL: info@amwa-doc.org • http://www.amwa-doc.org

AMERICAN NURSES ASSOCIATION

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Suite 100 West
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202 651-7000 • Fax 202 651-7001
http://www.nursingworld.org

Beverly L. Malone, PhD, RN, FAAN
President

Argene Carswell, JD, RN
Executive Director (Interim)

June 23, 1998

The Honorable James Jeffords
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

On behalf of the American Nurses Association (ANA), I am writing to express ANA's support for the nomination of Dr. Jane E. Henney to be Commissioner of the Food and Drug Administration.

Dr. Henney's experience as a public health administrator, as well as her clinical expertise, will serve the nation well in a post that requires an extraordinary capacity to work effectively with public health professionals and to exhibit great personal integrity and intellectual strength. She will bring to the FDA substantial experience at senior levels of the agency, a strong academic background, and important contributions in health care research.

Since the nursing profession leads the way in bringing health care to rural and other underserved areas, it is particularly heartening that Dr. Henney has personal and professional experience in those communities and will be able to work effectively with other public health offices to assure appropriate attention to their needs.

ANA believes that Dr. Henney's nomination to head the Food and Drug Administration also advances the cause of women assuming positions that have previously been held only by men. This achievement is especially important in the health care arena, which disproportionately impacts women in our nation.

ANA appreciates your consideration of our views on this matter, and we strongly urge favorable consideration of Dr. Henney's nomination.

Sincerely,

Argene Carswell

Argene Carswell, JD, RN
Executive Director (Interim)

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Formerly The American Fertility Society

1209 MONTGOMERY HIGHWAY • BIRMINGHAM, ALABAMA 35216-2809
TEL 205/978-5000 • FAX 205/978-5005
EMAIL: asrm@asrm.com • URL: http://www.asrm.com

June 23, 1998

The Honorable James M. Jeffords, Chair
Senate Labor and Human Resources Committee
Dirksen Senate Office Building, Room 428
Washington, DC 20510

Dear Senator Jeffords:

On behalf of the American Society for Reproductive Medicine, an organization representing 9000 health professionals committed to promoting the reproductive health of the nation, I would like to voice our support for the nomination of Jane E. Henney, M.D to serve as Commissioner of the Food and Drug Administration at the Department of Health and Human Services.

Dr. Jane Henney, a cancer specialist is a renowned academic leader and public health administrator. She has served as a top official at federal public health agencies in the Carter, Reagan, Bush, and Clinton Administrations. As Deputy Commissioner for Operations at the Food and Drug Administration, Dr. Henney reorganized six centers, increasing their effectiveness and efficiency. Dr. Henney also helped significantly reduce the time for drug review and approval through her involvement in the Prescription Drug User Fee Act of 1992.

Dr. Henney's academic accomplishments are also impressive. She has authored or co-authored more than 40 articles and book chapters. She has received numerous awards, including the Public Health Services Commendation Medal.

Dr. Henney's administrative skills are highlighted by her accomplishments at the National Cancer Institute, the University of New Mexico, and the University of Kansas Medical Center. She became Deputy Director of the National Cancer Institute at the age of 32 and served an important role in implementing two programs: one involved community oncologists in research and the second provided physicians and patients with up-to-date information on the newest therapies. Dr. Henney became the University of New Mexico's first Vice President for Health Sciences in 1994. She is responsible for the daily operations of the state's largest integrated healthcare institution with an annual budget of $466 million. In the last four years, Dr. Henney has helped raise the amount of research grant money for the university by more than 30 percent. Finally, as interim dean at the University of Kansas Medical Center, Dr. Henney, established the Center for Aging, the Center for Environmental Health, and the Mid-American Cancer Center. In addition, she helped develop and secure funding for a large multi-institutional cancer research center.

If confirmed by the Senate, Dr. Henney would become the first woman to serve as Commissioner of the Food and Drug Administration. She has demonstrated leadership in developing innovative management strategies and maintaining high clinical and research standards at two major university medical centers and two federal public health agencies. Dr. Jane E. Henney makes an ideal candidate for the post of Comissioner for the Food And Drug Administration at the Department of Health and Human Services.

Sincerely,

J Benj MD

J. Benjamin Younger, M.D.
Executive Director

American Society of Clinical Oncolo

225 Reinekers Lane, Suite 650, Alexandria, VA 22314 USA
E-Mail: asco@asco.org • Web-Site: http://www.asco.org
Phone: 703-299-0150 Fax 703-299-1044

June 23, 1998

The Honorable Jim M. Jeffords
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The American Society of Clinical Oncology strongly supports the nomination of Dr. Jane Henney for the new Commissioner of Food and Drugs. ASCO, which has over 11,000 members, is the national organization representing physicians who specialize in the treatment of cancer. An active member and leader in ASCO, Dr. Henney has been a powerful advocate for physicians who treat cancer and the patients who fall victim to this deadly disease.

As you may have noted in the past several weeks, cancer research is pointing to many promising new therapies. We look forward to Dr. Henney's leadership and support as providers and patients continue their efforts in cancer research, treatment, and prevention.

Sincerely,

Allen S. Lichter, MD
President

John R. Durant
Executive Vice President

ROGER J. BULGER, M.D.
President

MARIAN OSTERWEIS, PH.D.
Executive Vice President

PAUL G. ROGERS, J.D.
Counsel

June 23, 1998

The Honorable Jim M. Jeffords
United States Senate
Washington, DC 20510

Dear Senator Jeffords:

I am pleased to enthusiastically support the nomination of Dr. Jane E. Henney as Commissioner of the Food and Drug Administration. I have known her for several years, have followed her professional accomplishments closely, and have worked with her in a variety of settings.

Dr. Henney is an accomplished professional noted for her integrity, candor, sense of perspective, and her common sense. Her experience within the government and most recently within the FDA assures her capacity to get a running start in the job. Her achievements as an innovative and effective institutional leader most recently at the University of Mexico provide clear evidence of her ability to move a complex entity successfully through a challenging social and political environment to a higher level of performance and achievement.

She is an individual who will continually improve her working relationship through her collaborative, team playing abilities, her hard work and competence, and her communication skills. She is as tough as any administrator I know, partly because she focuses on the institutional, corporate, and public goals rather than any personal agenda. I believe she is the sort of person who will be appreciated on both sides of the political aisle.

In sum, I cannot think of anyone better qualified to head the FDA by dint of background, experience, professional accomplishment, and character than Dr. Jane Henney. I hope and trust she will win confirmation.

Sincerely,

Roger J. Bulger, M.D.
President

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1129
HTTP://WWW.AAMC.ORG
Jordan J. Cohen, M.D., President

June 22, 1998

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

As President of the Association of American Medical Colleges, I write to convey our strong support for the nomination of Jane Henney, M.D., to be Commissioner of the Food and Drug Administration (FDA).

Dr. Henney brings a wealth of experience as a physician, scientist, educator, and administrator to this position. She has had an outstanding career in academic medicine. At the University of Kansas, Dr. Henney served as Interim Dean of the University of Kansas School of Medicine, Kansas City; Vice Chancellor for Health Programs and Policy; and Acting Director for the University of Kansas Mid American Cancer Center. As the first Vice President for Health Sciences at the University of New Mexico, Dr. Henney led the successful consolidation of the university's hospitals, schools of medicine, nursing and pharmacy, and specialized facilities for mental health, cancer and pediatrics into the Health Sciences Center. She has also authored or co-authored more than 40 scientific papers and book chapters.

Dr. Henney also has distinguished herself while serving in the Carter, Reagan, Bush, and Clinton Administrations, as demonstrated by her numerous awards, including the Public Health Service Commnedation Medal. At the National Cancer Institute, where she spent nine years and rose from the level of Senior Investigator to become Deputy Director, Dr. Henney sought to encourage community based oncologists to participate in research and to provide physicians and patients with timely information on state-of-the-art therapy and investigative research protocols.

From 1992 to 1994, Dr. Henney was Deputy Commissioner for Operations at the FDA, where she successfully reorganized FDA's six centers and the Office of Regulatory Affairs. Dr. Henney also helped lead the efforts in support of the Prescription Drug User Fee Act of 1992, which revitalized the agency's drug and biologics review system.

Her experience with the FDA, her proven ability to manage large and complex enterprises, her commitment to excellence in patient care and research, and her dedication to the health of the American people qualify Jane Henney beyond question to lead the FDA into the next century. The Association of American Medical Colleges respectfully urges the Senate to confirm her nomination as soon as possible.

Sincerely,

Jordan J. Cohen, M.D.

June 24, 1998

The Honorable Jim M. Jeffords
U.S. Senate
728 Hart Senate Office Building
Washington, DC 20510

RE: FDA Commissioner

Dear Senator Jeffords:

The purpose of this letter is to support President Clinton's nomination of Dr. Jane Henney as FDA commissioner. On behalf of the deans of this nation's 28 graduate schools of public health,* I urge a quick, yet thorough, confirmation hearing for Dr. Henney.

Dr. Henney is well qualified for the FDA commissioner's post. Not only does she possess extensive managerial skills and operational experience in both governmental and academic arenas; she is a first-rate scientist and recognized public health leader. She has served with distinction in the past four administrations in a variety of important posts, primarily director of operations for FDA from 1992 to 1994.

Not only is Dr. Henney an energetic force in the public health field, her ability to collaborate and to build consensus amongst diverse interests and organizations is well known. Her innovative and reform-minded approach to the conduct of her duties and responsibilities over the course of her career have resulted in significant contributions to public health science, health professions education and delivery of health care in this country. These attributes, no doubt, will pay dividends as FDA commissioner.

In addition, Dr. Henney will lead the FDA in constructive ways and will manage and confront difficult, if not controversial, problems that face FDA now and in the future. Dr. Henney's abilities and expertise will ensure that the FDA will be lead by a consummate professional and scientist.

Once again, on behalf of all the deans of the accredited schools of public health throughout the United States and Puerto Rico, I extend our strong endorsement of Dr. Jane Henney for the position of FDA commissioner. Thank you.

Sincerely,

Allan Rosenfield, MD
President
Association of Schools of Public Health

cc: Senator Kennedy

* list attached

ASP
ASSOCIATIC
SCHOOLS
PUBLIC HE

President
Allan Rosenfield, MD
Dean, School of Public Hea
Columbia University

President-Elect
Alfred Sommer, MD, MHS
Dean, School of Public Hea
Johns Hopkins University

Secretary-Treasurer
Patricia A. Buffler, MPH, P
Dean, School of Public Heal
University of California at B

Immediate Past-Presid
Harvey V. Fineberg, MD, PH
Dean, School of Public Healt
Harvard University

Accreditation Commit
Chair
A. A. Adi, PhD
Dean, School of Public Healt
University of California at L

Education Committee
R. Palmer Beasley, MD
Dean, School of Public Health
UT-Houston Health Science C

International Health
Committee Chair
Michael H. Merson, MD
Dean of Public Health
Yale University

Legislative Committee C
Susan C. Scrimshaw, PhD
Dean, School of Public Health
University of Illinois at Chicag

New Schools Committee
David O. Carpenter, MD
Dean, School of Public Health
University at Albany (SUNY)

Publications Committee
Richard S. Kurz, PhD
Dean, School of Public Health
Saint Louis University

Executive Director
Michael K. Gemmell, CAE

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NACDS

National Association of Chain Drug Stores

June 23, 1998

The Honorable James M. Jeffords
Chairman
Committee on Labor and Human Resources
728 Senate Hart Office Building
Washington, DC 20510

Dear Mr. Chairman:

On behalf of the National Association of Chain Drug Stores, I am writing to express support for President Clinton's nomination of Dr. Jane E. Henney, M.D., to become Commissioner of the Food and Drug Administration.

NACDS represents the chain community pharmacy industry which operates over 30,000 community pharmacies, and provides practice settings for over 91,000 pharmacists. These pharmacies have annual sales totaling over $135 billion including prescription drugs, over-the-counter (OTC) medications and health and beauty aids (HBA). Chain operated community retail pharmacies fill over 60% of the more than 2.7 billion prescriptions dispensed annually in the United States.

Dr. Henney has a long and distinguished record of leadership and public service. Of particular note is her innovation and commitment to modern management strategies in the administration of health services.

In helping to shape our nation's health care system for the next century, community retail pharmacy continues to develop new health care services designed to improve patient outcomes. As Commissioner, we believe Dr. Henney would bring the right management skills, dedication to food and drug safety, and commitment to appropriate agency reform to lead the FDA into the future.

Sincerely,

Ronald L. Ziegler
President and Chief Executive Officer

413 North Lee Street, P.O. Box 1417-D49, Alexandria, Virginia 22313-1480 Phone: 703-549-3001 Fax: 703-836-4869 Web: www.nacds.o

COSSMHO

25 Years of Connecting Communities & Creating Change

National Coalition of Hispanic Health and Human Services Organizations

1501 Sixteenth Street, NW • Washington, DC 20036-1401 • (202) 387-5000

June 24, 1998

William J. Clinton
600 Pennsylvania Ave., NW
Washington, D.C. 20500

Dear President Clinton:

I am writing to you today on behalf of the members of the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) to express our full support for your nomination of Dr. Jane Henney as Administrator of the Food and Drug Administration (FDA). Dr. Henney's career has been marked by a commitment to meeting the needs of diverse communities, innovation in management, and practical applications of new knowledge.

The FDA will benefit from the strong and innovative leadership that Dr. Henney will bring to the job of Administrator. We look forward to swift action on this nomination and the appointment of Dr. Henney as the new FDA Administrator.

Sincerely,

Jane L. Delgado, Ph.D.
President and CEO
National Coalition of Hispanic Health and
Human Services Organizations (COSSMHO)

cc: Maria Echaveste

National
COMMUNITY
PHARMACISTS
Association

Formerly NARD, the National Association of Retail Druggists

June 22, 1998

Senator James M. Jeffords
Chairman of the Senate Labor & Human Resources Committee
728 Senate Hart Office Building
Washington, DC 20510-4503

Dear Chairman Jeffords:

The National Community Pharmacists Association (NCPA), enthusiastically supports the nomination of Jane E. Henney, MD, for the position of Commissioner of the Food and Drug Administration (FDA).

She has excellent credentials to serve as FDA Commissioner including extensive experience at both the FDA and the National Institutes of Health.

Thank you for the opportunity to comment on the nomination to fill a position of such national significance. Dr. Henney's credentials strongly indicate that she is thoroughly prepared to serve as FDA Commissioner.

We urge favorable consideration of this nomination.

Sincerely,

John M. Rector
Sr. Vice President & General Counsel

NCPA
205 Daingerfield Road
Alexandria, Virginia
22314-2885
phone
703.683.8200
fax
703.683.3619
www.ncpanet.org

DRAFT LETTER TO SEN. KENNEDY AND SEN. JEFFORDS
from the National Partnership for Women & Families

DRAFT

I am writing in support of President Clinton's nomination of Jane E. Henney, M.D., for Commissioner of the Food and Drug Administration (FDA). Dr. Henney is eminently qualified to lead the FDA, an agency that plays a powerful role in the health of America's women.

A physician who graduated from medical school when few women were in the field, Dr. Henney brings to the FDA a personal and professional perspective about women's health that is vitally important for America's women and families. She has served with great distinction as a practitioner, researcher, administrator and leader in her field, while always keeping patients' needs front and center.

During her tenure as the FDA's Deputy Commissioner for Operations from 1992 to 1994, Dr. Henney championed the reform efforts recently enacted by Congress and cut bureaucratic red tape by significantly reducing the review time for new treatments and technologies. She has advanced the science of cancer treatment, successfully built patient-focused programs at major academic medical centers, created innovative programs at two federal public health agencies and been recognized for her achievements with the highest honor of her field, the Public Health Service Commendation Medal. [mps to check this]

Because of women's unique roles as the primary consumers and purchasers of health services and as the primary health care decision-makers for their families, the National Partnership is especially pleased that President Clinton selected a talented and dedicated woman for this critical post. We commend President Clinton and encourage you to support Dr. Jane Henney's nomination as Commissioner of the Food & Drug Administration.

Sincerely,

Judith L. Lichtman
President

Founded 1881

NDMA

NONPRESCRIPTION DRUG MANUFACTURERS ASSOCIATION

Better Health Through Responsible Self-Medication

June 23, 1998

The President
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

The Nonprescription Drug Manufacturers Association, the 117-year-old trade organization representing manufacturers and distributors of nonprescription medicines -- those medicines used in self-care -- supports your nomination of Jane E. Henney, M.D., as Commissioner of Food and Drugs. While her career speaks for itself, we will state the obvious: it is distinguished.

NDMA was privileged to work with Dr. Henney during her service as FDA Deputy Commissioner for Operations in the early 1990s. Dr. Henney displayed a positive outlook on the important role of nonprescription medicines and their contribution to increased consumer empowerment and the nation's health care system, including their cost-saving potential. She has been supportive of the appropriate and expanded role of self-medication with nonprescription medicines. We were pleased with the attention she gave to nonprescription medicines within the Center for Drug Evaluation and Research.

The strong regulatory foundation established for nonprescription medicines during Dr. Henney's tenure continues to be the basis on which the nonprescription medicines industry operates today. We welcome the opportunity to improve on that foundation under her leadership as Commissioner of Food and Drugs.

Sincerely,

James D. Cope
President

JC/dcs

1150 Connecticut Avenue, N.W., Washington, D.C. 20036 • Tel: (202) 429-9260 • Fax: (202) 223-6835

PARTNERSHIP FOR PREVENTION
Today's Investment in America's Health

William L. Roper, MD, MPH, *Chair*
Jonathan E. Fielding, MD, MPH, MBA, *Vice Chair*
Donald M. Vickery, MD, *Secretary*
John R. Seffrin, PhD, *Treasurer*

The Honorable Richard Schweiker, *Chairman Emeritus*

Jordan H. Richland, MPA, *President*

June 23, 1998

The Honorable James M. Jeffords
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, DC 20510

Dear Senator Jeffords:

On behalf of *Partnership for Prevention*, I am pleased to offer enthusiastic support for the nomination of Dr. Jane E. Henney as Commissioner of Food and Drugs. As one of the nation's most important prevention agencies, the FDA requires strong, committed, and effective leadership. Dr. Henney will ably provide that leadership.

Dr. Henney is an experienced administrator who understands how population-based approaches to public health issues combined with clinical expertise can lead to a healthier and safer nation. Her commitment to basing public policy on the best science available will serve the FDA and the nation well.

I have had the privilege of knowing Dr. Henney for 15 years, and I can think of no individual more capable of helping the FDA successfully confront the many controversial and complex issues it confronts. Her intellectual strength, personal integrity, and determination to serve the American people make her an outstanding choice to become our next FDA Commissioner, and *Partnership for Prevention* urges the United States Senates to consider and approve her nomination as quickly as possible.

Sincerely,

William L. Roper

William L. Roper, MD, MPH
Chairman

Partnership for Prevention is a national non-profit organization committed to increasing visibility and priority for prevention in national health policy and practice.

1233 20th Street, NW
Suite 200
Washington, DC 20036
(202) 833-0009
(202) 833-0113 Fax

235 East 42nd Street
New York, NY 10017-5755
Tel 212 573 3116

William C. Steere, Jr.
Chairman of the Board and
Chief Executive Officer

June 23, 1998

The Honorable James M. Jeffords
Senate Committee on Labor and Human Resources
728 Senate Hart Office Building
Washington, D.C. 20510-4503

Dear Chairman Jeffords:

We are writing to express our support for the nomination of Dr. Jane E. Henney for the position of Commissioner of the Food and Drug Administration (FDA). We are pleased that the Senate will be considering such a qualified candidate to fill this important position.

Dr. Henney's leadership qualifications, management skills and science background combine to make the right mix to ensure that the FDA operates efficiently, protects the public health, and patients have timely access to health care treatments. The challenging health care issues we will face in the coming years will be shaped, in part, by the next FDA Commissioner. We have confidence that Dr. Henney is an individual who can successfully meet these challenges.

We appreciate the opportunity to share Pfizer's views about a person as qualified as Dr. Henney, and we hope you will act swiftly to approve her appointment as FDA Commissioner.

Sincerely,

William C. Steere, Jr.

Research | America
AN ALLIANCE FOR DISCOVERIES IN HEALTH

June 23, 1998

President William J. Clinton
The White House
Washington, DC 20500

Dear President Clinton:

Research!America, the nation's largest alliance of groups and individuals committed to public education and advocacy for discoveries in health, is pleased to commend Dr. Jane E. Henney as an outstanding candidate for Commissioner of Food and Drugs.

Dr. Jane Henney has a long and distinguished record of leadership and public service. Her previous tenure and record of achievement at the FDA is an especially relevant indication of her understanding of and commitment to the mission of the agency. In addition, her qualifications and accomplishments as an academic leader, physician and researcher demonstrate her hands-on familiarity with the issues that the FDA must continue to address effectively on behalf of the health of the American public.

Dr. Henney will bring to the challenge of assuring that food and pharmaceutical products are both safe and effective a thorough grounding in evidence-based decision-making, as well as long experience in leading people and institutions in a fast-paced, rapidly changing environment. Her familiarity with and commitment to research as the key to understanding and conquest of disease and disability are especially noteworthy credentials.

Dr. Henney has consistently earned the confidence and respect of her peers and of those who have selected her for a succession of positions of significant responsibility. Hers is a record that is certain to be extended with additional accomplishments and leadership in the years ahead.

Research!America is pleased to have the opportunity to support Dr. Jane Henney's candidacy for Commissioner of Food and Drugs.

Sincerely,

Mary Woolley

Mary Woolley

908 King Street, Suite 400 East, Alexandria, VA 22314-3067 (703) 739-2577 Fax: (703) 739-2372 email: researcham@aol.com

TOTAL P.02

STATEMENTS BY MEMBERS OF CONGRESS
ON THE NOMINATION OF
DR. JANE HENNEY TO BE THE
FDA COMMISSIONER

Senator Christopher Dodd (D-CT)

Representative Henry Waxman (D-CA)

Representative Anna Eshoo (D-CA)

CHRISTOPHER J. DODD
CONNECTICUT

COMMITTEES
BANKING, HOUSING, AND URBAN AFFAIRS
BUDGET
FOREIGN RELATIONS
LABOR AND HUMAN RESOURCES

United States Senate
WASHINGTON, DC 20510-0702

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THE NOMINATION OF DR. JANE HENNEY FOR THE COMMISSIONER OF FOOD AND DRUGS

Statement of Senator Christopher J. Dodd
June 23, 1998

Mr. President, I rise today in strong support of the nomination of Dr. Jane Henney for the Commissioner of Food and Drugs.

In November, 1997, President Clinton signed legislation charging the Food and Drug Administration with the responsibility for bringing lifesaving drugs and medical devices to the American people more quickly and efficiently, without compromising safety or effectiveness. This legislation requires the FDA to rethink many of its old models and to work collaboratively with the public and with drug and device manufacturers to improve the certainty of the product review process, to provide patients with better access to investigational therapies, and to encourage manufacturers to test the safety and efficacy of their products for children. Such responsibilities require strong, innovative leadership--leadership that Dr. Henney can clearly provide.

Dr. Henney is a distinguished physician, a cancer specialist, and a nationally recognized academic leader and public health administrator who has served in the Carter, Reagan, Bush, and Clinton Administrations. She served as Deputy Commissioner for Operations at the FDA from 1992 to 1994 and is thoroughly familiar with FDA's responsibilities, having managed the agency's daily activities and six operating centers.

Dr. Henney has also proven her ability to manage in a challenging environment. At the University of New Mexico, she led the Health Sciences Center to increase its efforts to stabilize local health care delivery systems and to engage in extensive reorganization initiatives. Earlier, as a Deputy Commissioner at the FDA, Dr. Henney reorganized and improved the efficiency of the FDA's centers, recruiting new directors for five of the six centers. She also played a principal role in the enactment of the Prescription Drug User Fee Act of 1992, which revitalized the agency's drug and biologics review system.

The position of Commissioner of Food and Drugs has been vacant for more than 14 months, leaving without leadership a federal agency that arguably has a more direct and significant impact on the lives of the American people than any other. The foods we serve our family, the medicines we take when we're sick, and even the drugs we give our pets, are all approved and monitored by the FDA. One quarter of every dollar spent by consumers goes to products regulated by the FDA. Jane Henney's innovative managing skills as well as her medical reputation make her ideal candidate to shoulder the responsibility for leading the Food and Drug Administration into the next century. I encourage the Senate to act expeditiously and support Dr. Henney's well-deserved nomination.

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Ranking Member
Committee on Government
Reform and Oversight

Member
Committee on Commerce
Democratic Steering Committee

Congress of the United States
House of Representatives
Washington, DC 20515-0529

HENRY A. WAXMAN
29th District, California

STATEMENT BY CONG. HENRY A. WAXMAN
ON THE NOMINATION OF DR. JANE E. HENNEY
AS COMMISSIONER OF THE FOOD AND DRUG ADMINISTRATION
June 23, 1998

Congressman Henry A. Waxman greeted the nomination of Dr. Jane E. Henney to serve as the Commissioner of the Food and Drug Administration with high praise. "Dr. Henney has a distinguished career in the health care field. She is a well-known cancer specialist, she has experience in the academic world, she has served at the National Cancer Institute at the NIH, and she has previous administrative experience at the FDA. She is an ideal choice for a difficult and demanding job."

Waxman noted that the Food and Drug Administration is responsible for the safety of our food supply, for the safety and effectiveness of drugs and devices, and for anti-tobacco control programs to stop our children from smoking. "Every American has a stake in the FDA doing its job and doing it well. I am certain that Jane Henney will prove to be a highly effective Commissioner and that she will direct an efficient and well-run agency."

Waxman noted that the FDA has been without a Commissioner since the resignation of Dr. Kessler. He had strong words of praise for the job done by Acting Commissioner Dr. Michael Friedman, and by Deputy Commissioner for Policy William Schultz, during this interim period, but noted that an agency with the breadth and importance of FDA's should have a Commissioner in place. He noted, "I have nothing but praise for the exceptional job Bill Schultz did during this interim period, particularly in representing the agency in the formulation of the FDA Reform bill, and for Mike Friedman who kept the agency running and performing its many tasks so effectively. But it is time to have a Commissioner in place, and I hope that the Senate acts expeditiously to confirm Dr. Henney."

"She is a physician with a proven record in science, in management, and in public health. Dr. Henney will do an excellent job in serving the needs of Americans as the next Commissioner of the FDA. I welcome her back to public service."

Anna Eshoo

U.S. House of Representatives
14th Congressional District of California

NEWS

For Immediate Release
June 23, 1998

Contact: Tracy Warren
(202) 225-8104

Eshoo: Henney First-Rate Choice to Lead Food and Drug Administration

Washington, D.C. – Rep. Anna Eshoo (D-CA), one of the principle authors of the 1997 Food and Drug Administration (FDA) Modernization Act, today made the following statement on the nomination of Dr. Jane Henney as Commissioner of Food and Drugs.

> The President has made an excellent choice in nominating Dr. Jane Henney as Commissioner of Food and Drugs. This is a critical time for the Agency, which is now implementing new rules for medical devices, food products and drug approval. The FDA needs a leader committed to making the new rules work for everyone. With solid academic and agency experience, Dr. Henney fits the bill.

A New FDA Nominee

THE NOMINATION of University of New Mexico Vice President Jane Henney to succeed David Kessler as commissioner of the Food and Drug Administration could be the occasion for yet another round in the endless dispute between Congress and the administration over how powerful the regulatory agency should be and how fast it clears new drugs for market. But the Senate, in considering the nomination, would do well to glean some benefit from the ground covered in previous years—notably last year, when an FDA reform bill finally passed after negotiations made it something both sides could live with—and not start the whole thing over again.

Dr. Henney, a seasoned public health official and medical doctor who has worked closely with Dr. Kessler in streamlining the agency, is a solid nominee whose views are mostly known already to the players. A good discussion of her nomination, rather than opening old issues, would take stock of the progress already made and the emergence of significant common ground between the FDA and the drug industry it regulates.

Dr. Henney is in fact closely associated with the program that most exemplifies that common ground, the Prescription Drug User Fee Act, which authorizes the FDA to collect fees from pharmaceutical companies and use them to speed up the drug-approval process. Drug companies have benefited so markedly from this program that, when it came up for reauthorization in 1997, they dropped what had been a fairly continual drumbeat of demands for FDA reform and fairly sang the agency's praises, distributing charts of the progress that had been made under the act in its first four years and enthusiastically outlining the great things the FDA could do for them if the program were allowed to continue.

With the user-fee program safely reauthorized and, shortly afterward, the vastly complex FDA reform bill passed as well, there's a tremendous amount of purely managerial work to be done at the agency to make sure the changes do not endanger the FDA's other central role—keeping consumers safe. (The recall of five drugs in the past year, in fact, has raised questions as to whether all this streamlining is pushing the safety barrier already.)

Dr. Henney's supporters say that task makes it all the more important to appoint someone who, like her, is deeply familiar with the agency and has proven managerial skills elsewhere in health care (she also has presided over major management streamlining at the University of New Mexico, where she is vice president for health sciences). Though her predecessor, Dr. Kessler, was as often attacked on symbol as on substance, the job of running the FDA is primarily a hands-on task, on whose effectiveness and attention to detail the health and safety of the food supply and the medical system depend. The Senate should take that seriously.

L.A. Times; 6-25-98

Building on Kessler's Legacy

That she was one of David Kessler's closest deputies should be an asset to Dr. Jane Henney when her nomination to succeed him as Food and Drug Administration commissioner goes to the Senate. That Henney's association with Kessler may instead hurt her speaks to the super-partisan atmosphere in the Capitol and some confusion about the FDA's real mission.

Kessler, the agency's high-profile leader from 1990 to 1997, vigorously pushed initiatives to speed up drug approvals, revamp food labels and inspections and regulate tobacco—infuriating some GOP leaders along the way.

Henney, 51, is an oncologist who spent nearly a decade at the National Cancer Institute before joining Kessler for two years at the FDA. Currently vice president of the University of New Mexico Health Sciences Administration, Henney was nominated by President Clinton Tuesday to head the 9,000-person agency that regulates foods, drugs, cosmetics and medical devices. She has earned high marks for her administrative skills and independence. Moreover, Clinton first floated Henney's name in January and in the months since no unpleasant surprises about her credentials or views have surfaced. But the game in the Senate of late has been to stall Clinton's nominees—for federal judge, for ambassador, for agency head. So even though the FDA has been without a permanent commissioner for 16 months, a quick vote is unlikely.

Delay would have consequences reaching well beyond the agency's staff and into the medicine chest and refrigerator of every American. The FDA has an almost impossible task: monitoring the safety and effectiveness of products totaling $1 trillion in spending each year, 25 cents of every consumer dollar.

For years the agency has been understaffed and underfunded. Complaints about long waits for FDA approval of promising new drugs prompted Congress, after much delay, to pass legislation last year to further speed the review of new medicines. A major task for the next commissioner will be to implement this law, balancing the potential to improve health and save lives against the risks almost every drug carries. Securing adequate staff and budget must be part of that task.

Adverse reactions from drugs already on the market account for 100,000 deaths and 1.5 million hospitalizations yearly. Better monitoring of approved drugs should be high on the next commissioner's agenda. The recent withdrawals of a blood-pressure drug and a pain reliever underscore how tough the balancing act will be.

Just as difficult is the mission of protecting the food supply, especially cutting the growing risk of food-borne diseases. The next commissioner should also push hard for authority to monitor the exploding use of dietary supplements—vitamins and herbs whose safety and effectiveness are largely unregulated.

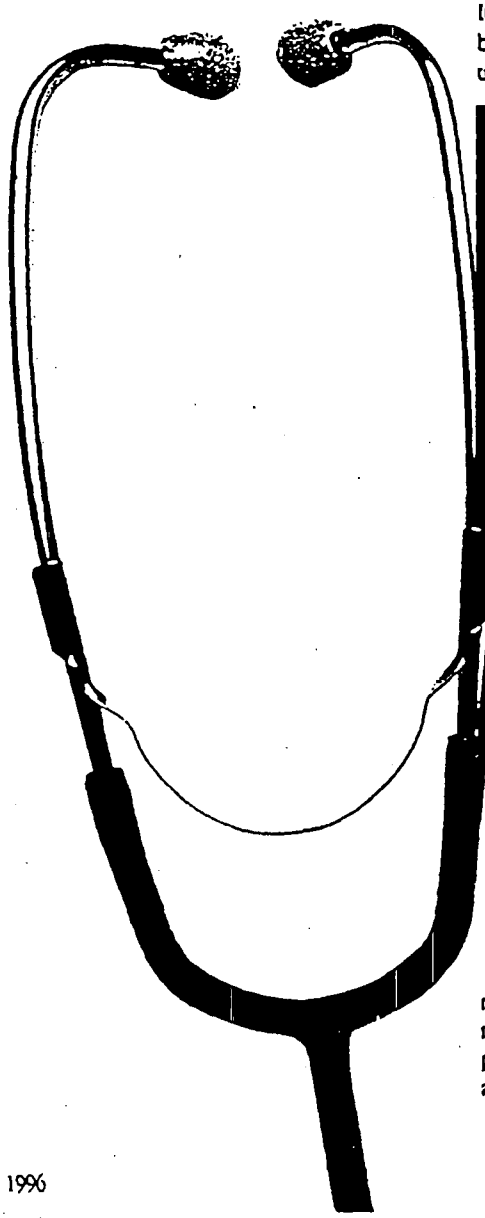
David Kessler's successor should continue the fight he began to regulate nicotine in cigarettes. With at least one-third of all teenagers who try cigarettes becoming hooked, Kessler correctly labeled teen smoking as a national public health problem.

Above all, the FDA exists to protect the public, not to placate pharmaceutical manufacturers, food processors or cigarette makers. Jane Henney appears to understand that mandate and should be allowed a chance soon to demonstrate that to the Senate.

Small Town Charm Major Operation Savvy

She grew up in a town of 512. Now she's in charge of a $314 million operation that includes all the academic and patient-care facilities of the University—the UNM Health Sciences Center. But Jane Henney can still identify with rural New Mexico.

by Susan Moczygemba-McKinsey

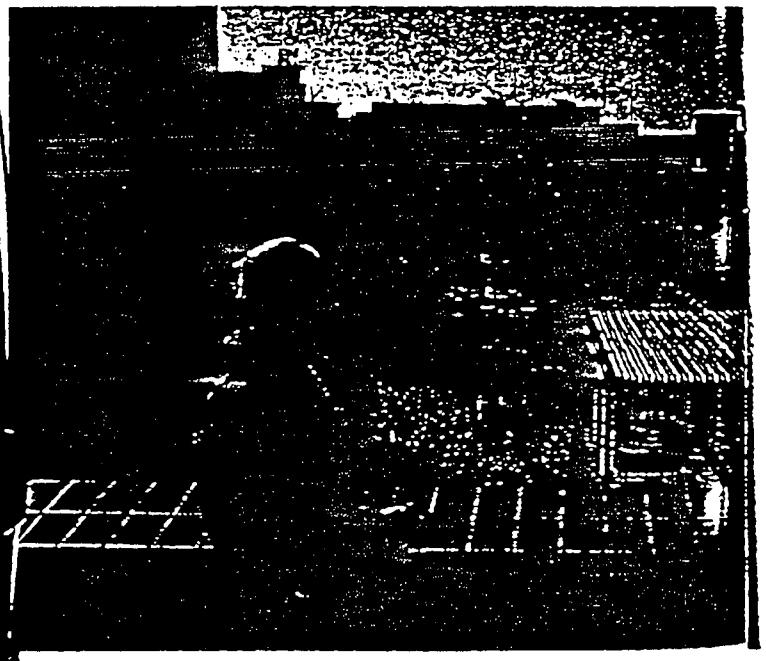


Dr. Jane Henney started her job as head of the UNM Health Sciences Center on July 1, 1994 - the day the Center officially came into existence.

Susan Moczygemba-McKinsey caught up with Dr. Henney during a recent workday that had begun at 4 a.m. and would last till 10 p.m. Their conversation follows.

Jane Henney grew up in Woodburn, Indiana – population 500 or something.

512 ... when I was home. It's recently doubled in size because they annexed a trailer court that popped up long after I moved away from the city. Woodburn is the smallest city in Indiana!



When did you start thinking in terms of medicine?

Probably my first memory of thinking about medicine was writing a term paper in the fifth grade about the AMA, about which I knew nothing. We were also lucky enough to have a family doctor in my hometown. Everybody knew Dr. Moser and loved him. He fit the stereotype small town doctor. We went to his house where he had his office and all of his medicines.

I really didn't start thinking seriously about medical school until I was in college. I was a biology major at a liberal arts college that had a very strong pre-med program. I found myself drawn toward exploring whether or not I could go to medical school. I was getting reasonable grades. In fact, I was tutoring most of the pre-meds in order to earn my way through college. I was also very fortunate to know many of my professors. One of them told me that women should absolutely not go into medicine, but another said, "Why not?" So I listened to him. I suppose I've always

had a tendency to be very selective about the information I'm willing to receive. I also had a mother who was very supportive of me at least trying it. There was no one in my family who had pursued a health profession. Most of the members of my family in professional roles at that point were school teachers.

In the early 70s, you were still pretty much of a pioneer. Women weren't going into medicine quite as frequently as they are now. Women weren't going into cancer research at all.

Both of those are true. In my class at medical school, less than 10 percent were women. Indiana had one of the largest medical school classes in the country. My class exceeded 250. There were 10 or 12 women. When I was applying for my residency and fellowship, most women physicians were still being counseled to go into pediatrics. Some selected OB, though that was not necessarily an accepted profession for a woman because you would have to do surgery. I really was drawn to cancer patients even as a junior medical student. I knew that was the patient population I really wanted to care for.

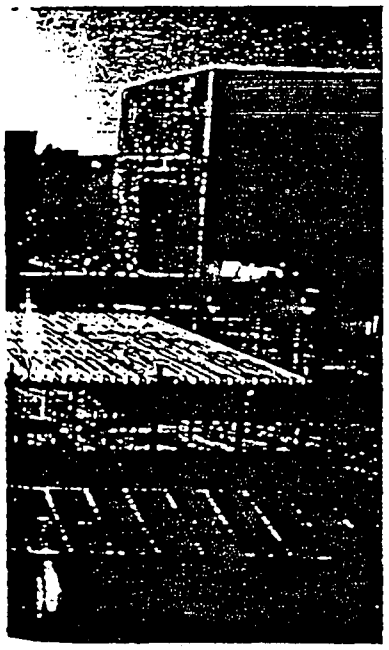
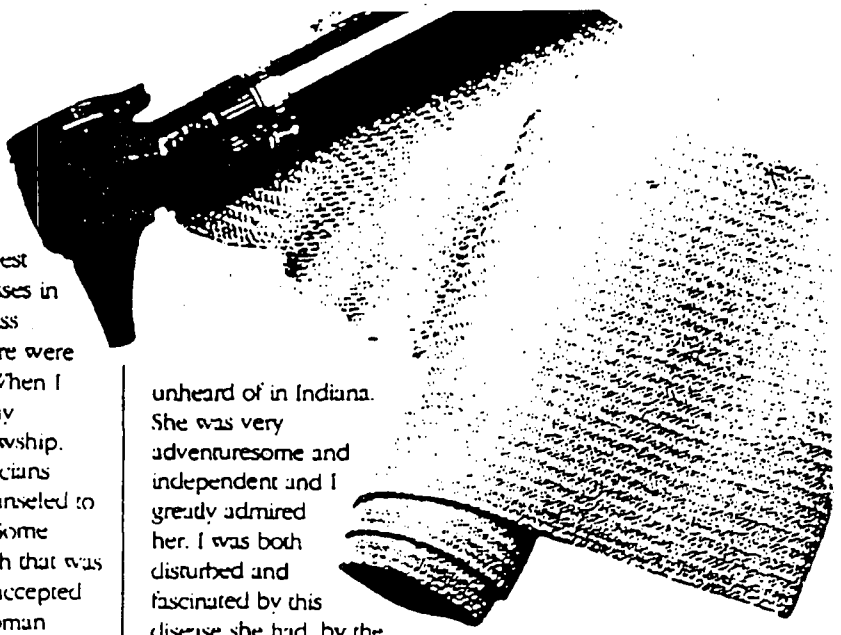


PHOTO BY STEVE CRAWFORD

Didn't you have a family friend with cancer?

When I was in high school, I had a family friend who had breast cancer. She was the first woman in Woodburn to be put on an investigational drug. Now investigational agents are used quite commonly in the treatment of cancer patients. And all of that fascinated me. Kay was such a dear friend. She was the mother of a classmate of mine. She was a woman who always accomplished what she set out to do. I can remember her taking her family on a trip to Alaska. That was unheard of in Indiana. She was very adventuresome and independent and I greatly admired her. I was both disturbed and fascinated by this disease she had, by the treatments she was getting. I admired and cared a great deal for her, so I'm sure she and her experience with cancer influenced me greatly.



Cancer patients by and large are very serious about their disease and about what is happening to them. As an oncologist, you often feel that you can make a real difference in someone's life, even though you may not be able to save that life in terms of curing. You feel that you can be a help and a source of support that you might not be able to be in other fields of medicine.

At this point, after 15 months on the job [at UNM], what do you feel is your major accomplishment?

One of the major achievements in the past 15 months is bringing the whole of the Health Sciences together. When you're changing or reorganizing an institution, you count on at least two to three years to watch change evolve. I think we've really quickened that pace. We've had to come together both because of people's desire to do so—an internal force—and because of many external forces in the environment in which all of health care is conducted that really present challenges to us now.

The other really major accomplishment over this past year is to have set some fairly high goals for ourselves. What did we want to try to accomplish? What did we want to be known for as a Health Sciences Center? We've set seven strategic directions and we are being faithful to them. I believe this has really added momentum to our change, giving us something concrete to work on and work for. We want to increase and strengthen what we do in terms of rural health; to expand what we do in terms of academic primary care; to emphasize programmatic research that's very specific and targeted to the health care needs of New Mexico.

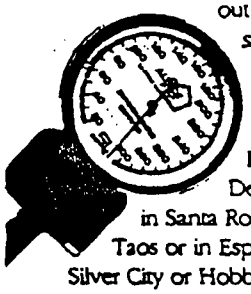
Looking out over the UNM medical complex, Vice President of Health Sciences Jane Henney finds the prognosis good.

We're exploring the development of a core curriculum for health professionals and developing a model academic healthcare delivery system. We're not the only health sciences center in a rural state, and we think we can start setting an example for [other rural states in] the nation.

We are also getting out into the community, particularly into some of the smaller communities of New Mexico, trying to learn more about their expectations about us as a Health Sciences Center and to explore ways in which we can serve them better.

One might ask "what does the Health Sciences Center mean for Joe Public out in Somewhere, New Mexico?"

Our best conveyors of what we are about are our people. And our people are out in the state nearly every day of the week. People in Deming or in Santa Rosa or in Taos or in Española, Silver City or Hobbs probably know us best by a relationship they have with one of our people. It's easier to understand an organization when you can identify a face or faces with it. We're trying, by going out into the state, to communicate better what we are and how we serve the state in all our missions—research, education, or patient care.



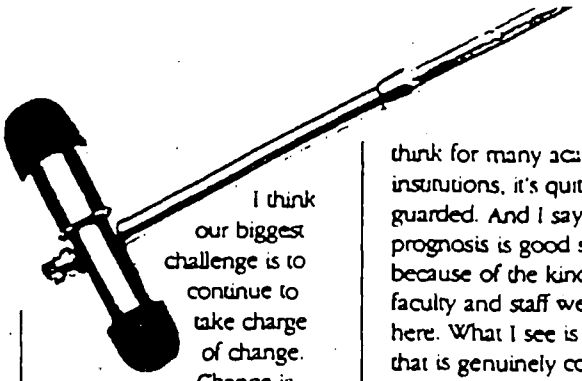
Does the fact that you grew up in a small town help you identify with the needs of rural New Mexico? Because folks will wonder if you can.

It's a tremendous help. I don't have any problem understanding the challenges or the tremendous opportunity and desirability of a small town. I don't romanticize the experience in any way. There are some real advantages. The interdependency people have with one another is certainly one. Sometimes you can feel closed in...where everyone knows everything you're doing...and yet that same closeness can be quite comforting as well.

I know the challenges of the small town keeping its young people...keeping them both occupied and feeling that there are opportunities and reasons for them to stay. When we go out to smaller communities in rural New Mexico, I don't have trouble at all understanding what people are saying to me.

We are finding more and more students who go into medicine are seeking careers in family medicine or general practice. If we can expose those students early to experiences in a rural community, we've found from our own data here at the University that they have three times as great a chance of locating in a smaller community... and this is where they have been needed for many years.

In these uncertain times, can you deliver on the goal of a model academic health care delivery system? Is this your biggest challenge?



I think our biggest challenge is to continue to take charge of change. Change is coming for all of us and in the health care arena it is coming at a very rapid clip. We've got to be prepared for it. If we just stand back and see what happens and hope that it's all right, I don't think we will serve ourselves or serve anybody very well. While some of the things we need to take on seem like momentous tasks, we must take them on. There is not an option to give the responsibility to somebody else.

It's our job to try to evolve as rapidly as we can so that we're still serving as a strong educational resource for the state, as well as a strong service site for the people in the state who need us and as an institution that continues to generate new knowledge. The latter is exceedingly important or we will fail to advance the field.

What's your prognosis, Doctor, for academic health institutions and health care?

I think the prognosis for this institution is good. I think for many academic institutions, it's quite guarded. And I say our prognosis is good simply because of the kind of faculty and staff we have here. What I see is a faculty that is genuinely committed to the people it serves. We are trying our best to evolve in the kinds of ways we need to in order to meet the challenges of tomorrow's system. I don't have that same kind of feeling as I've gone to other academic institutions around the country.

What about Jane Henney's future?

What about Jane Henney? Jane Henney is exceedingly happy in doing what she's doing right now. I love my work. Will that last forever? Who knows? But this is the kind of place that has a commitment and caring to people far beyond the walls of its buildings. We're not bound by our buildings. We're bound by the boundaries of our state. When you hear faculty talking about "what are we doing for the people of New Mexico... how are we making a difference in their lives," that can keep me excited about this kind of work for a long time.

"I think our biggest challenge is to continue to take charge of change. Change is coming for all of us and in the health care arena it is coming at a very rapid clip."

Isabella Cherest

Dr. Jane Henney, UNM's vice president for health sciences, confers with pediatrics Professor Herb Koffler (left) and Fred Mettler, chair of the Radiology Department.

Small town roots led to big time medicine

by Mike Maiello
Staff Reporter

UNM Vice President for Health Sciences Jane Henney once had to watch a close friend die from breast cancer. Since then, she's been keeping a promise made to her friend to do everything in her power to fight the disease.

Henney grew up in Woodburn, Indiana, a town of 512 people, where she says everybody knew each other. The friend was the mother of one of Henney's high school friends.

"She was involved in the 4-H club and all of those things traditional for a woman," Henney said. "She taught me how to bake sugar cookies, and she played the traditional roles of wife and mother. But she was independent. Her husband was killed in an auto accident, and I remember that when her son and I were in high school together, she had the kind of courage that was really impressive. She got her life and her family to work on her terms."

Henney attended Manchester College while her friend was undergoing treatments for cancer. Henney said she became interested in the medical uses of experimental drugs.

"I tried to find out all I could about the drugs from my chemistry professor," Henney said.

This sparked her interest in medicine. Like her family, which she says have been schoolteachers for "eons and eons," Henney originally intended to teach. She was working for a Bachelor's of Science in biology with a minor in chemistry while trying to get her teaching certificate.

Henney was also surrounded by pre-med students throughout her undergraduate career, especially while she was working as a lab instructor, part of her teacher-training.

"I had already, by overlap phenomenon, taken the pre-med requirements," Henney said. "And when everybody in my classes was pre-med and I was the lab instructor, it suddenly occurred to me I could do that too."

But when Henney decided to pursue a career in medicine, she did not get the unanimous support of her peers.

"I got encouragement from some professors, and discouragement from others," Henney said.

She remembers one professor who particularly discouraged women from going to medical school.

"His words to me were basically, 'I knew two who went into medicine. One's never enjoyed her career and the other one's divorced, so why would you want to do that?'" Henney said. "I thought, God, what does that have to do with anything?"

She persisted, and found herself one of 12 women in a 250-member class at the University of Indiana

see medicine page 12

medicine

continued from page 1

Medical School.

"I was really on the cusp of these classes before they started to be a lot more open to women and minority groups," she said.

Henney graduated from medical school in 1973 without forming close bonds with the other 11 women in her class.

"We were very different, and in terms of our housing and accommodations we were quite spread out," Henney said. "We all knew each other because there were so few of us, but I wouldn't say we were necessarily close. Medical school is different than the undergraduate experience. You still have friends and colleagues, but not the same bonding occurs as it did with my friends when I was an undergrad."

She has since, among other jobs, been deputy director of the National Cancer Institute, director of operations at the U.S. Food and Drug Administration and director of the University of Kansas Cancer Center before coming to UNM a year ago.

She says she holds no grudge against the professor who discouraged her.

"He died while I was in med school," Henney said. "I admired him greatly and if he were alive today, I think he would be proud of my accomplishments. What he said to me was not atypical advice for the time. I didn't resent it; I just didn't use it. In one's life and times you get all kinds of advice and it's all free, and sometimes it's worth every penny you pay for it."

Times have changed for women in medicine, Henney said. The 1995 first-year class of medical students is 56.2 percent male and 43.8 percent female. In the second-year class, 68.5 percent of students are women.

"When I made this decision there was a mindset which said there were a certain number of professions open to women and the others were pretty much closed," Henney said. "Teaching, nursing or being a secretary were all acceptable things for a woman to make a career out of. But now, girls or women in high school, junior high and college have a whole availability of options open to them that there never were before."

Henney spent most of her career working with patients, but at UNM she's taken a high-level managerial position overseeing the medical school, hospital, mental health center and the medical outreach programs that serve New Mexico. This has kept her away from patients.

"I think there are different challenges and rewards of being a clinician — seeing patients every day — and being in an administrative position," Henney said. "The feedback system for a clinician is immediate — you get the sheer joy of seeing patients every day and seeing how you're a part of their getting better. It's very satisfying. Hardly anything, I think, can replace that particular feeling and that particular relationship.

"Management means that seeing your work come to fruition takes much longer. I've had to learn to expect results in terms of months or years, even though I have to deal with these problems on a daily and hourly basis," Henney added.

Henney is making some personal sacrifices for her job as well. Her husband is director of the American Academy of Family Physicians in Kansas City. They maintain separate households, and visit each other on weekends.

"We're keeping Southwestern, Delta and everybody else that flies in business," Henney said.

Henney said they also lived apart while she was working with the FDA in Washington, D.C. Since leaving Woodburn, Henney has been all over the country, and seen apartment buildings with more people living inside than lived in her entire hometown.

"The transition from living in such a small place has been gradual for me," Henney said. "I think it was an advantage to grow up in such a small town, because I think even though there may be more people in the organizations I run than lived in my town, people usually organize themselves into what are, in essence, small communities.

"Coming from a small town taught me both self-reliance and a real sense of the interdependence of people. It's helped me to know people better as whole people, and not just the little bit you see of them during the day."

"Jane E. Henney, M.D. - Meeting the Challenge"

by Teresa Renger

The view from Dr. Jane Henney's office on the third floor of the Health Sciences Building at the University of New Mexico is nothing short of spectacular. The ceiling-high bank of windows provides a long, glorious view toward the Sandia Mountains, but Henney's polished mahogany desk is positioned to face in exactly the opposite direction.

I comment on this paradox as she strides toward me, hand extended, her petite frame fashionably clad in a knee-length silk skirt and a red wool jacket. "With such a magnificent distraction facing me, I'd never get any work done," she says with a laugh. The remark is a small indicator of the extent of self-discipline she routinely imposes upon herself and is a partial explanation as to why she has been such a successful professional.

Henney arrived in Albuquerque in July 1994 to become the vice president of Health Sciences at the UNM Health Sciences Center. It was a significant organizational change when President ~~Peck~~ began restructuring UNM's ~~health~~-related teaching, research, and patient-care facilities under one administrative umbrella, and Henney was chosen as the key individual responsible for making this a smooth transition. The choice of a "small-town girl from Indiana" seems to have been a wise one.

As we settle into comfortable chairs in the "visiting area" of her office (I am treated to the chair facing the Sandias), Henney provides some background information on the career path that has led her to her current position.

"I guess I have very good roots," says the 49-year-old physician. "I had a very close-knit family and I come from Midwestern stock where the expectations of hard work and a solid education were automatic. My grandparents were farmers, and my father, an uncle, and an aunt are schoolteachers. My mother was not able to go to college for financial reasons, but she was valedictorian of her [high school] class, and, after she finished business school, she went to work in the school system. She simply expected her four children to succeed in their studies."

With such role models in her life, Henney initially gravitated toward becoming an educator herself and entered Manchester College in Indiana where she majored in biology with a minor in chemistry. "I always had loved math and the sciences, and I had a keen interest in health issues as well. As a kid I actually looked forward to going to the doctor because he would show me how his equipment worked and give me detailed answers to my questions."

As she approached the end of her undergraduate studies, Henney listened to her male colleagues discuss their plans for medical school and beyond. Because she was already tutoring many of them in their upper level science classes, the idea crystallized in her own mind that medical school was a possibility for her as well.

Noting that the field of medicine had opened up dramatically for women over the past two decades, Henney described her own entry into professional study as somewhat more constrained.

"Dr. Weimar, my chemistry professor, was a real curmudgeon, very gruff, and discouraged me from the outset. He told me he had known only two women who had followed through with their medical studies: one of them had never married and the other had gone through a divorce. I listened to what he was saying and I knew he was trying to be helpful, but I didn't think his logic had any relevance for me. My biology professor, on the other hand, simply said, 'Sure, why not?' My mother was very supportive, too, so I merely chose to listen to them."

The untimely loss of a lifelong friend to breast cancer during her young adulthood spurred an interest in oncology, which became her specialty by the completion of her medical training. In her heart of heart, she says, she carries some regrets over not having been able to maintain direct links with patient care.

"But I've always been very good at building programs connected to patient care," she says, "so in that sense I feel as though I'm still delivering on that commitment."

Building programs is what Henney does exceptionally well. In the past she has served as the deputy director of the National Cancer Institute and director of the University of Kansas Cancer Center. Immediately prior to coming to UNM, she was deputy commissioner at the US Food and Drug Administration, where she oversaw a budget of $800 million. In her current position at UNM, the budget dollars are not as high, but the list of her responsibilities is formidable. Essentially she oversees the medical school, the health of the student body, the hospital, the mental health center, and the medical outreach programs that serve New Mexico.

Such prodigious responsibilities exact a toll on lifestyle choices, and in Henney's

case this has meant a commuter marriage. Her husband of twenty-one years, currently executive vice president of the American Academy of Family Physicians, bases his residence in Kansas City but has a demanding travel schedule to meet throughout the year. So for the past five years they have had to maintain, and more importantly coordinate, separate households. It has been, Henney acknowledges, a logistical challenge.

"You just learn how to deal with it. We sit down with our planners and project from three to six months ahead to schedule our time together. We manage to be with each other almost every weekend; perhaps only once every six to eight weeks we can't arrange it."

When together, they most appreciate spending time in a unstructured manner, away from the many obligations that dictate the way they must spend time during their busy work weeks. Indeed, time is the precious resource Henney covets most.

"I would love to have more time to spend on gardening and reading, and I wish I weren't so geographically distant from my family in the Midwest. I don't get as many chances to visit with them in person as I would like ... there just isn't time."

But, despite her demanding and hectic schedule, Henney is enjoying herself. "This is a wonderful job and I feel privileged to come to work each day with the people I'm associated with. Organizational change does not take place rapidly, but everyone here is committed to the goal of making this the leading publicly funded academic health care center in the country. Our school of medicine is already ranked in the top four in the country in rural and family medicine, and we are doing cutting-edge work in interdisciplinary curriculum development at all levels. The future of medical care in the United States lies in teamwork among health professionals, and we are working to educate new physicians to that concept."

Asked to describe the managerial style which enables her to engender cooperation rather than conflict among the many divisions she oversees, Henney hooks a low-heeled shoe on the edge of a nearby coffee table and reflectively tips back her chair, much the way she might have done years ago in an Indiana kitchen while working through a calculus problem.

"I would say I am a very strong listener," she muses. "I'm very inclusive in my decision-making process, but I'm also unafraid to make decisions independently. And of course the best technique I use is to hire strongly competent professionals and then step back and let them do their jobs."

It is a matter of no small significance to Henney that many of these professionals are women, for she well remembers the dearth of them in the field when she, along with 11 other women colleagues, graduated from the Indiana University of Medicine in 1973. Today, women make up fully 60 percent of the current crop of medical students at UNM. Women have also become a strong presence in the teaching and administrative branches of medical education.

"I don't think it is widely known, but the newest data (which is collected on an annual basis) shows that UNM's medical school ranks number one in the nation for the number of women in senior leadership positions, such as at the department chair or assistant or associate dean level. Women have a very strong role in our institution and are looked to as leaders with much responsibility."

It is clear then that the linking of gender to success and achievement has never been an issue for Henney. Rather, the key to it all for her seems to lie with an inner sense of one's own abilities and how best to present them to the world.

"From time to time in my life I have had challenges where I feared I might fail. But I've learned that people give you those responsibilities and challenges because they believe in you and are counting on you. It is exactly their faith in you, their belief that you can do a task, that buoys you up and gives you the ability to succeed when you otherwise might not have. So that's where the focus should lie."

I:W

Teresa Renger is a freelance writer living in Albuquerque.

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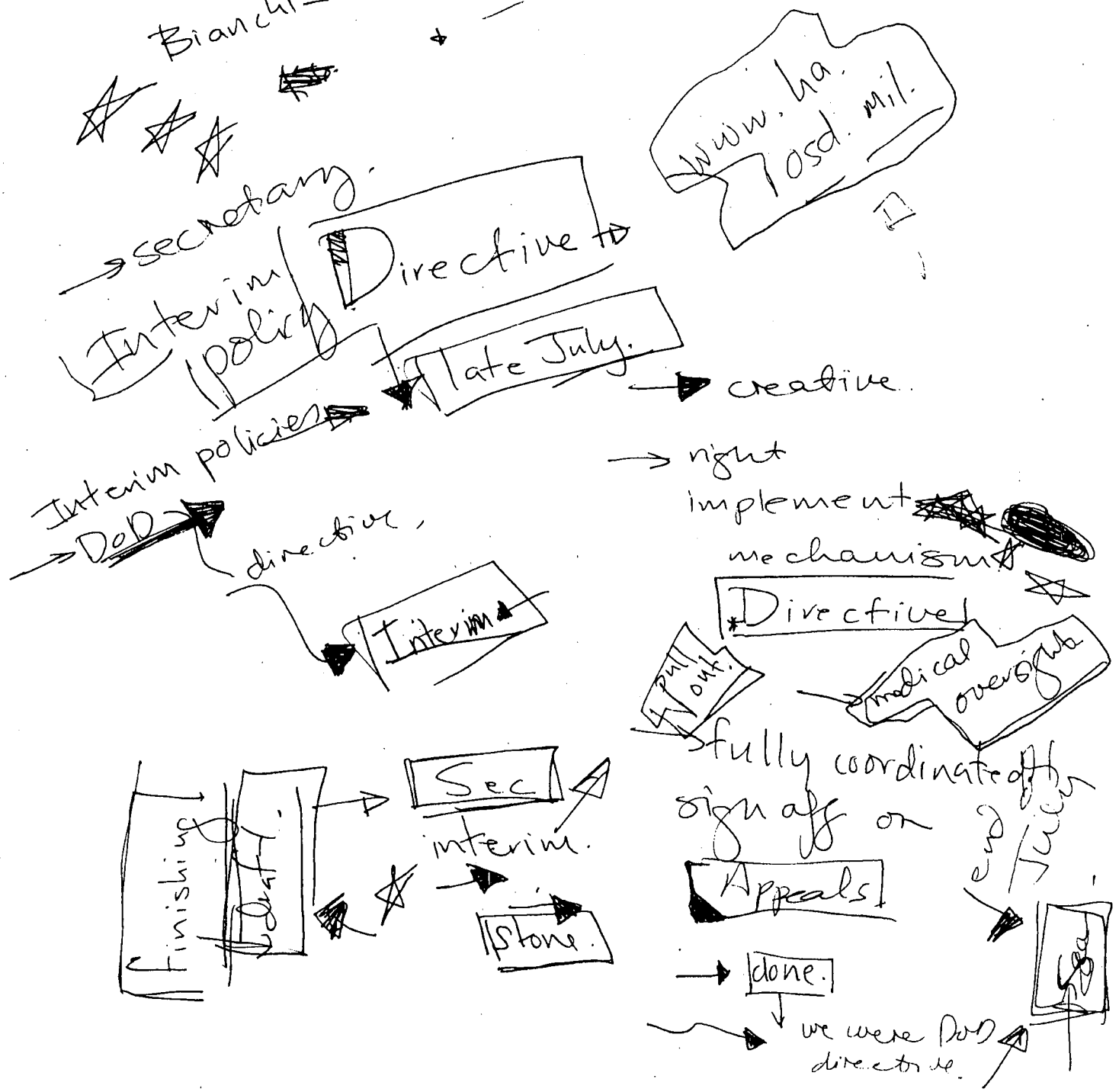

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Options for Responding to Last Week's Decision by Many HMO's to Pull Out of Medicare (2 pages)	nd	P5

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Chris Jennings (Subject File)
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FOLDER TITLE:
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Gary Foulk

gf26

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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 advise 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]

Options for responding to last week's decision by many HMOs to pull out of Medicare:

1. **Explicitly announce a "no action is merited" position.** In short, draw a line in the sand quite publicly and reject any proposal to allow HMOs to shift costs back onto beneficiaries. Blame any subsequent mess on HMOs who signed a contract in May and who now want to renege on their commitment. Highlight all the "selfish" reasons why some HMOs are dropping out and underscore our commitment to never be "black-mailed" into changing the contracts we signed on behalf of the beneficiaries.

   Pros: Strong and decisive action; Puts industry on the defensive and initiates a much more public war with one of the nation's most unpopular industries -- HMOs.

   Cons: Republicans, some Democrats, and AARP may feel we are acting too politically and too abruptly; Charges of callousness to harmed beneficiaries may ensue; If we don't stay tough throughout inevitable "horror" stories, we will look much weaker.

2. **Tacit "do nothing" position, but leave door (quietly) open option.** Under this scenario, we would continue to say we are looking into impact to determine severity, but would say we continue to be skeptical that there is a valid argument to do anything. We would background the press on the weaknesses of the HMOs' arguments, but would hint that we might not reject out of hand any future intervention if our review turns up major problems for beneficiaries.

   Pros: Appears that we are standing up to the industry, but also gives us time and flexibility in case we want to alter our current course; would likely be supported by the Republicans and AARP for now, might be safest -- but certainly not boldest --option for the moment.

   Cons: Could appear weak and indecisive; In the alternative, could appear we are insensitive to beneficiaries' woes; Opens door to HMOs to come in to cut a deal that may viewed by the validators as setting very bad precedent for the Medicare program.

3. **Expedite approval of new plans coming into counties now not served.** This option would highlight our commitment to work with and give expedited approval to HMOs that were not in a service area when another HMO dropped its coverage. These so-called "good-guy" plans could give a less comprehensive benefit or cost-sharing protection package than the one that it would replace.

   Pros: Rewards good players and punishes "bad apple" HMOs; Supports our contention that we are taking reasonable actions to help beneficiaries keep access to an HMO option; In combination with base administrative and legislative package (outlined above), would illustrate that our "first and foremost" commitment is to beneficiaries -- not HMOs.

Cons: Very few new plans can be expected to come into these marginal markets; Will not significantly reduce the number of "victim" stories that will be reported; Makes us potentially more vulnerable to criticism that we did not do everything we could to help beneficiaries; If we pursue this option but eventually cave to HMOs' desires for other plans to get a similar offering, we would be perceived as very weak.

4. **Expedite approval of new plans, but allow selected old plans to apply to come back in if no other option is available.** This approach would allow a plan that withdrew from a service area, which now has no HMO option, to downgrade its benefits package to a level the HMO believes is financially viable.

   Pros: Would help more beneficiaries at least retain some of their current HMO coverage; Would be more responsive to the inevitable pressure from the Congress to do more to give hope that plans will come back; and if -- as is likely -- the old HMOs do not come back, it is easier to lay the blame on them. (In other words, we did everything the HMOs asked for and they still did not come back.)

   Cons: Rewards bad actors; Makes us look somewhat weak -- as though we backed down from pressure of the HMOs, Sets bad precedence for Medicare for future similar disputes with the industry (unless our administrative/legislative package makes it appear certain that we cannot or would not be able to do this again.)

5. **"Third way" option: try to split the difference between option 3 and 4 to attempt to get the best and avoid the worst of both options.** It might be possible (although we are still trying to develop a way to rationally apply this option) to allow only new plans in, but to give the HHS Secretary emergency authority to approve -- in selected cases -- applications from HMOs from the old service area to come back into the county. Under this approach, no such plan could even be considered unless it was clear that no new plan was a contender. There would have to be additional criteria as well to ensure that there is a substantive difference between option 4 and 5.

   Pros: Could argue that we showed how we could respond to beneficiaries' concerns without backing down to the "bad apple" HMOs; See #4 above for similar pros.

   Cons: Could be vulnerable to charges that it is "too cute by half;" Might not be able to develop criteria that provided enough direction/cover to the Secretary to differentiate.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings and Jeanne Lambrew to FLOTUS re: Issues About the Use of Health Insurance Premium Tax for Research Funding (3 pages)	10/27/97	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23753 Box 12

FOLDER TITLE:
Increase in NIH Funding for Biomedical Research [1]

Gary Foulk

gf28

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 advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitote a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Biomedical Research

THE WHITE HOUSE

WASHINGTON

October 27, 1997

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Chris Jennings and Jeanne Lambrew

RE: Issues about the Use of a Health Insurance Premium Tax for Research Funding

cc: Melanne, Jen

This memo responds to your request for information about Donna's proposal to use a health insurance premium tax to substantially increase the NIH budget. Without a new source of revenue that supplements the capped discretionary budget, desired increased investments in biomedical research will be extremely difficult to achieve since such increases must compete with other Presidential priorities -- such as education.

Having said this, using a new Federal premium tax as a funding source should be considered in the context of our other health care reform initiatives (such as our quality/"consumer bill of rights" agenda) that have the potential to indirectly increase premiums. Since private insurance premiums are projected to rise next year without any reforms, we may have limited political capital to push for initiatives that opponents will argue will further increase premiums. Thus, we may be forced to seriously consider tapping into and relying on a different funding source for increased investments in research, such as tobacco revenue from the enactment of national tobacco legislation.

BACKGROUND

HHS Proposal. Almost all states now use premium taxes for a variety of purposes, (although none now do for biomedical research purposes). With this and the budgetary constraints the Department faces in mind, the HHS 1999 budget includes a 1.35 percent premium tax. Its revenue is dedicated to supporting a new research trust fund, which HHS suggests would increase the NIH budget by about 50 percent over 5 years and double it in 10 years. Although the 1.35 percent tax would finance an unprecedented funding increase, it appears it may not be sufficient to finance HHS' promised increase in research. HHS did not take into account the typical offset to receipts that Treasury assumes (25 percent) nor the fact that it would be difficult to tax self-funded plans. Thus, Treasury and OMB will definitely state that a much higher tax is needed to support the trust fund as proposed.

Benefits of a Premium Tax. Keeping in mind the constraints in the discretionary budget and the real need for enhanced investment in biomedical research, there are clear merits to a premium tax. It essentially acts as a user fee, so that insured people that benefit from research pay for it through the tax. It has precedence, since virtually all states use a premium tax of some sort. Moreover, as competitive managed care plans end the historical cross-subsidies for research in academic health centers, it makes sense to make research support explicit rather than implicit in higher rates. And finally, in the absence of some type of outside revenue that funds research on top of the discretionary caps, our research investment from the Congress either will be insufficient or, just as likely, will drown out other Presidential priorities. (Donna's fear of the continued success of NIH in eating up the rest of her HHS budget is as much a reason for the premium tax proposal as anything else.)

Impact of a Premium Tax. CBO has not recently assessed the potential revenue from a premium tax, but estimates from last year's private insurance bills give a sense of the magnitude of HHS proposal. CBO estimated that the Kassebaum-Kennedy bill would raise private health insurance costs by 0.1 percent. The 48-hour maternity stay law was estimated to increase premiums by 0.02 percent, and the mental health parity provision was projected to increase premiums by 0.4 percent.

HHS's premium tax of 1.35 percent is more than twice as large as any of the effects of the provisions enacted last year and, even according to HHS' estimates, would have to be raised in later years to fully double the NIH budget. Treasury will likely say that the tax needs to be even higher. This leads to the question that was raised in the context of last year's provisions: Will such a premium increase reduce health insurance coverage?

We strongly countered this criticism of the insurance reforms by arguing that they were small enough to not significantly alter people's ability to purchase insurance. While we could make the same argument about the premium tax, it will be more difficult to sustain because (1) as noted above, the tax is larger, (2) it would be in conjunction with our consumer protections reform agenda, and (3) it will take place concurrently with projected hikes in private premiums (that would have taken place anyway.)

Combined Effect of Multiple Provisions. As we are considering the feasibility and advisability of a premium tax, we are also expecting to support Federal quality assurance legislation. We plan to strongly advocate for genetic anti-discrimination, privacy, and a host of consumer protection bills next year. Although these provisions could increase premiums somewhat, no one within the Administration seriously believes that they will have a profound impact on private insurance premiums. However, independent analysts may validate at least some of the claims that will inevitably be made by the insurance and business communities. For example, CBO has already warned of its concern about multiple insurance reforms happening simultaneously. In testimony earlier this month, one official wrote: "By themselves, those mandates [last year's reforms] should not add significantly to the growth in health insurance premiums between 1997 and 1998. Nonetheless as more state and federal mandates are imposed, their cumulative effects on premiums could become considerable."

Interaction with Higher Premiums. Equally concerning are early reports that premiums may be rising faster than in the past few years. FEHBP premiums are estimated to grow by 8.5 percent in 1998, considerably higher than their recent growth rates of below 2 percent. Most private sector analysts are forecasting industry-wide growth rates between 5 and 10 percent.

This premium growth has two implications for the premium tax. First, its revenue could be higher since it will be based on larger premiums. For example, if a family premium were $6,000 instead of $5,500, then the tax would be $81 versus $77. Although this effect may not show up in the official scoring — neither CBO nor OMB have plans in the next several months to update their private sector baselines — it could in the long run make the research trust fund more viable.

However, a second implication of the premium growth is that any past, present and future health insurance reforms will be blamed. Already, the newspaper articles that portend the higher premium growth list the recent health insurance reforms as a possible cause. The final numbers for 1997 and projected premiums are usually released in February — the same time that the budget including the premium tax would be introduced. This could make it difficult to generate political support, especially when considered together with our other insurance reforms.

Conclusion. We clearly need to weigh our support for a premium tax on political as well as policy grounds. If we pursue this concept, we must be prepared for a major battle with the usual suspects. We must understand that, if we succeed in enacting what would be an extremely useful revenue source, opponents will attempt to link virtually any subsequent premium increase and any increase in the number of the uninsured to this initiative. In addition, we need to weigh this policy option against any consumer protection reforms we are concurrently considering, since such reforms will be targeted by critics as regulatory interventions that will also increase premiums.

The difficulties associated with a premium tax suggest that we may want to seriously consider other sources of funding for the health research investment. In light of the magnitude of the desired investment, there are not many choices. However, most of the President's policy advisors assumed that a significant portion of any revenue produced from the national tobacco legislation would be dedicated to research. There is strong rationale for using tobacco settlement funds for research, given tobacco's contribution to major diseases like cancer. The downside is that we would have to assume that the Congress will pass out an acceptable bill in order to assert that suitable levels of revenues will be available. Moreover, we have have as yet had no internal discussions as to how or whether we should present such an assumption in the President's budget (or as an addendum to it). And finally, relying soley on the tobacco revenue now envisioned in the settlement might well be inadequate to underwrite the type of commitment the President is contemplating.

We offer no final recommendations at this time. As you suggested last week, it might be useful to arrange a meeting to discuss this and the other health policy issues (mental health parity, quality, etc.) you raised. You may also be interested to know that we are reviewing a number of new ideas on children's health outreach that are logical extensions of the child care conference. We are discussing these with Melanne and Jen; we will keep you apprised of developments.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings, Jennifer Klein to FLOTUS re: Response to Questions About Coverage Expansions (4 pages)	11/24/98	P5
002. briefing paper	Background on Arkansas Children's Health Plan (2 pages)	9/24/97	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23746 Box 14

FOLDER TITLE:
Insurance Coverage Expansion [1]

Gary Foulk

gf32

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]
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Health Insurance Coverage FIG

November 24, 1998

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings, Jennifer Klein, Jeanne Lambrew

SUBJECT: Response to Questions about Coverage Expansions

cc: Melanne Verveer, Neera Tanden, Nicole Rabner

In a recent discussion of the uninsured, you asked about several coverage expansion proposals, including a 55 to 65 coverage option, a Medicaid buy-in, a Federal Employees Health Benefit Plan (FEHBP) buy-in, and a new health insurance option for young adults. This memo summarizes these proposals, discusses their rationale, and provides you with a budget and Congressional status update. As was discussed in the memo to the President on the uninsured, the absence of substantial subsidies and the omission of an individual or employer mandate significantly limits the number of Americans who will be newly insured as a result of these policies. Having said this, each of these options (or modifications to them) can improve access to needed health insurance and are being considered for the FY2000 budget.

Medicare Buy-In / Health Insurance Options for People Ages 55 to 65

Policy. In our FY 1999 budget, we proposed three policies: (1) a Medicare buy-in for people ages 62 to 65 that is fully self-financed through an unsubsidized, two-part premium (an up-front premium plus a smaller, post-65 premium to compensate for any risk selection); (2) a similar Medicare buy-in for displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) guaranteed access to former employers' insurance for retirees age 55 and over whose retiree health benefits have been ended. According to CBO, this entire initiative costs about $1.5 billion over 5 years (mostly a temporary cost until the participants begin contributing their post-65 premium) and would assist about 300,000 people.

Rationale. This initiative, according to the latest data, is needed more than ever. Although still low, the number of uninsured people ages 55 to 65 grew the fastest in 1997 -- and will grow exponentially in the future since the number of people in this age cohort is projected to rise by over 60 percent by 2010. Moreover, we have increasing evidence that the individual insurance market -- relied on by this age group more than any other -- is raising its rates dramatically. Kaiser Permanente, for example, will double its individual insurance premiums for its older enrollees on January 1. This initiative gives people in this age group options to purchase insurance that they might not otherwise have. It also would be the bare minimum policy needed if the age eligibility for Medicare were raised -- an idea seriously being contemplated by the Medicare Commission.

Issues. Despite the need, this initiative was victimized by conflicting "too much - too little" criticisms. Republicans (and some conservative Democrats) claimed that the buy-in creates a huge loophole in Medicare that will ultimately lead to large costs. In part, this reflects a disbelief in our technical ability to set premiums that are self-financing in the long run. But mostly, it results from a strong belief that, even if the premium estimates are accurate, we will eventually succumb to the pressure to subsidize these premiums to make them more affordable for the lower income uninsured. In contrast, a number of traditionally liberal advocates and academics criticized the policy for helping too few people to justify the political capital that would be necessary to expend to get the proposal any serious attention by the Republican Congress.

Regardless of its political viability in this Congress, this proposal addresses a population in need, remains generally popular outside the beltway, and will continue to be seriously considered for inclusion in the FY 2000 budget. It is unclear whether it will make the final cut, however. The short-term savings needed to finance this initiative are controversial and/or likely to be used for other priorities (such as for underwriting the costs of the Jeffords/Kennedy disability coverage expansion bill). Also, there is concern about putting this proposal out so close to the final report released by the Medicare Commission this March. No matter how we resolve the budget question, however, we expect Senators Moynihan and Daschle as well as Congressman Gephardt to introduce this bill at the beginning of the next Congress.

Medicaid Buy-In

Policy. A Medicaid buy-in would allow states to charge income-related premiums for people in optional eligibility groups with income above 150 percent of poverty (the level at which states may charge cost sharing under the Children's Health Insurance Program (CHIP)). This proposal could be broadened to allow all people below a fixed income level -- not just those in current optional eligibility groups -- to buy into Medicaid.

Currently, states cannot charge premiums to Medicaid beneficiaries. A lesser known fact is that Medicaid law limits who can be covered as well. Historically, adults were eligible for Medicaid only if they were: (a) single parents, or married but unemployed parents, who receive welfare; (b) low-income elderly or people with disabilities who receive SSI; or (c) nursing home residents. During this Administration, however, new Medicaid eligibility options have been created. Welfare reform gave states the option to cover higher income single parents and unemployed married parents. The exclusion of married employed parents -- which is anti-work and anti-family -- was changed last summer with "100-hour rule" regulation. This lets states define "unemployed" as working more than 100 hours a month -- meaning that they may cover parents working 40-hour weeks if they so choose. And, in the Balanced Budget Act, we created a Medicaid buy-in for people with disabilities with incomes below 250 percent of poverty.

Rationale. A Medicaid buy-in could be an incentive for states to expand coverage to working adults, since even small family contributions improve the acceptance of such expansions. It also gives all states the flexibility that we have permitted through Medicaid waivers and supported in CHIP, as well as in the Medicaid buy-in for workers with disabilities.

Issues. Despite its sound policy basis, the likelihood that a Medicaid buy-in will significantly reduce the uninsured is low. Since large subsidies are required to encourage low-income, uninsured people to purchase health insurance, states would have to charge the families low premiums and pay for most of the costs themselves in order to get meaningful participation. Moreover, only states that have already expanded coverage to 150 percent of poverty could charge premiums to all new participants. Unfortunately, states typically cover few adults with incomes above 50 percent of poverty. Thus, premiums collected through a Medicaid buy-in would not come close to offsetting the large Federal and state costs. Additionally, while allowing premium payments from beneficiaries may be attractive to states, Republicans, and moderate Democrats, it would be vehemently opposed by advocates and liberal Democrats who believe that this opens the door to high premiums for lower-income Medicaid beneficiaries.

One idea that could possibly address the financial limitations of this proposal is to link the Medicaid buy-in proposal to a tobacco recoupment bill. The recent state tobacco settlement will likely lead to legislation about whether and under what terms states may keep the Federal share of that settlement. In such legislation, we could make expansion through a Medicaid buy-in one of the uses (or the sole use) of the Federal share. Congressional Democrats and advocates have long argued that tobacco settlements should be directly linked to health care, health insurance expansions, and Medicaid. It is possible they would accept a buy-in in a recoupment bill that assures Medicaid expansions. States, obviously, do not want any strings on the uses of the Federal share of the settlement, but may have the hardest time arguing against Medicaid investments since the settlement itself is premised on Medicaid costs resulting from tobacco use. The clear downside to this option is that money spent on expansions would limit the money used for other priorities like child care. This issue will be debated in our budget process.

FEHBP Buy-In

Policy. Another proposal for expanding coverage is opening up the Federal Employees Health Benefits Plan (FEHBP) to various groups of people (e.g., workers in small businesses, people ages 55 to 65 years old). In order to participate in FEHBP, health plans would have to offer health insurance to the designated group of eligibles. There are two options for how premiums would be set: first, new participants could be charged the same premiums as Federal employees; second, new participants could be charged premiums separately, depending on their own costs.

Rationale. The FEHBP buy-in would give certain groups of uninsured people the benefit of accessing the health plan options, information and possibly premiums that Federal government negotiates for its employees. It also reinforces our support for group health insurance purchasing, plan choices, and adequate information with which to make such choices.

Issues. Depending on how premiums are set, the FEHBP buy-in would either be costly to new participants or affect the premiums and choices of all Federal employees. Because newly eligible people who wish to purchase insurance who are healthy can likely find individual insurance that is cheaper, the population that decides to go into FEHBP is likely to be sicker. This will increase premiums of all current Federal employees if they are charged the same premium. It could also reduce plans participating in FEHBP if their enrollees include more costly, new participants than

Federal employees (which could happen in rural areas). As a consequence, most FEBHP buy-in proposals assume a risk pool separate from that of Federal employees for setting premiums. But because this pool would be a smaller and include less healthy people, premiums would be more expensive than FEHBP. As a consequence, most analysts project a relatively small effect on coverage. The only way to address this would be subsidies which carry significant cost implications. These complexities explain why there have been few FEHBP buy-in bills.

Given concerns about its use as a source of coverage, FEHBP may be better used as a model for other coverage expansion proposals. What makes FEHBP successful -- purchasing power for a large group of people; consumer information; plan choices -- could be incorporated into small businesses purchasing coalitions. These coalitions, promoted in previous budgets, provide any small business in the area with a set of plan choices and more affordable premiums. This year, we are examining options to aggressively encourage their development. For example, FEHBP managers could provide technical assistance in establishing these coalitions. They could also be granted non-profit status to facilitate private foundation support.

Catastrophic Coverage for Young Adults

Proposal. You mentioned an interest in policy options that would provide catastrophic coverage for young adults. Medicare, Medicaid, and FEHBP all provide comprehensive coverage, although we could conceivably develop a special program for catastrophic coverage. It is also possible through regulation to require individual insurers to offer such coverage to young adults.

Rationale. Young adults are more likely than any other age group to be uninsured -- nearly one in three 18 to 24 year olds lacks insurance. In part, this problem results because young adults are usually healthy and do not think that their need justifies the cost of comprehensive coverage. Thus, catastrophic coverage may be the best option for young adults since it is cheaper and protects them from the real risk of illness or injury that can be financially devastating.

Issues. Catastrophic coverage options probably would not insure many young adults. Few young adults would purchase even the lowest-cost catastrophic coverage without significant subsidies. In fact, some analysts believe that only an individual mandate will make young adults pay any level of premium for health insurance. This is because they rarely recognize their financial risk (e.g., one in four young adults sustains major injuries in a year and one in 20 is hospitalized). Second, while catastrophic coverage makes economic sense, people interested in insurance do not appear to like it. The lack of interest in the medical savings account (MSA) demonstration has shown that people prefer lower cost sharing and coverage of primary care.

Recognizing these challenges, we continue to examine policies to allow young adults to buy into Medicaid. Some of the most needing of insurance in this age group are foster care children who have aged past their 18th birthday (and thus last year of Medicaid eligibility.) We are working with OMB to provide a new state option for those Governors interested in expanding Medicaid coverage to this population. We believe it will be affordable (about $50 million over 5), sound policy that a number of states will pick up. As of this writing, the chances of this proposal being included in the budget appear to be quite good.

Everyone (Sally, Gary) are at a meeting til 2pm — but I don't think there's been much contact

BACKGROUND ON ARKANSAS CHILDREN'S HEALTH PLAN

What do you think?

A major health care issue that may be raised in Arkansas is: Does the State's new Medicaid expansion qualify for funding under the new Children's Health Initiative?

What do we do w/ it when we've done?

Timing?

- There is currently a question about whether the recently-approved "ARKids First" Medicaid expansion will qualify for the higher matching rate and allotment under the new State Children's Health Insurance Program (CHIP).
- ARKids First will expand coverage similar to state employees' benefits to children in families with incomes below 200 percent of poverty (see attached description).
- The Medicaid waiver authorizing this program was approved on August 19, two weeks after the budget and children's initiative were signed into law.
- There was some discussion at the time of approval of whether the waiver would qualify under CHIP, but the issue was not resolved. The state was told that it would have to submit an application for CHIP funding, as specified by law.
- There are three potential issues:
  - **Cost sharing**: ARKids First allows for cost sharing (e.g., 20% for inpatient days) that exceeds the limits in CHIP. Chris Jennings spoke with Ray Hanley, who implied that he could probably adjust the cost sharing to fit the limits. There may be some less important benefits questions as well.
  - **State employees' children**: The state would like to extend coverage to low-wage state workers' children. However, the new law prohibits this coverage under any new, non-Medicaid program. Staff are exploring whether the Medicaid option in CHIP would allow state to cover these types of children.
  - **Precedent**: There may also be a strong, negative reaction by the Congressional Democrats if we allow states to bend Medicaid rules in CHIP. Liberals argue that states that want to alter benefits may do so through a new, non-Medicaid program. Allowing flexibility in Medicaid can only lead down the slippery slope of cost sharing and benefits reductions for all Medicaid beneficiaries.
- **Our strategy is to work with Arkansas quietly to find a way to allow them into the new program without risking exposing the children's program to exceptions for all states. Until the details are worked out and a state plan application is approved, however, we cannot promise anything.**

Also — should we make sure that there's a NH/PROVIDER TAX ROLL-OUT meeting next week?
I also am going to trade down Jen K.

ARKids First Program

HISTORY

- In February 1997, the Arkansas State Legislature passed, almost unanimously, Governor Huckabee's proposal called "ARKids First". At the same time, the State, led by Ray Hanley, started working with HCFA on a Medicaid 1115 waiver to implement the program.

- An official Medicaid 1115 application was submitted on May 13. The waiver was approved on August 19, 1997.

SUMMARY

Eligibility

- Children not eligible under the State's existing Medicaid program with family income at or below 200 percent of poverty (using gross income, no assets tests)

- Children with no comprehensive health coverage in the last 12 months (except for Medicaid)

Enrollment

- Mail-in or in-person application process

- Applicants receive educational information on benefits and cost sharing, how the primary care provider system works, how to identify local availability of providers, grievance process

- Outreach through television and radio ads

- Start date: September 1

Benefits

- Comparable to state employees

Services:

Medicaid excluding certain services including:

- Hearing aids
- Inpatient psychiatric hospital care
- Physical therapy
- Non-emergency transportation
- Rehabilitation and ventilator services

Limits on services including:

- Vision: 1 visit per year
- Dental: 2 visits per year, for cleaning, x-ray, restorative
- Outpatient mental health: Cap of $2,500 per year

Cost sharing:

None for immunizations, preventive health screening, family planning and prenatal care

From $5 / prescription; $10 / most visits; 20% coinsurance of 1st day's hospital per diem

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Briefing Paper - Various Topics (1 page)	7/21/97	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23753 Box 16

FOLDER TITLE:
Medicaid- Disproportionate Share Hospital Policies (Budget 1997) [2]

Gary Foulk

gf35

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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- We invited Governc [illegible] (D-NC) and Paul Patton (D-KY) to join a meeting held by Secretaries [illegible] with Bruce Reed and the leaders of the state farm bureaus to disc[illegible]. Governor Hunt participated and was grateful for the opportunity.

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Jennings - pg. 3
B. Nash - pg. 3

- While at the White [illegible]g, Governor Hunt pressed for help with the Department of Defe[illegible] to the proposed fuel pipeline designed to replace the current [illegible]viation fuel from the port at Morehead City to the Cherry Point, S[illegible] Pope Air Force Bases. We have arranged for Secretary Cohen to [illegible] discuss it with the Governor.

- Governor Tony Knowles (D-AK) called for assistance on two issues: the candidacy of former Governor Steve Cowper for Assistant Secretary of State for Oceans and International Environmental and Scientific Affairs and the Medicaid match rate for Alaska. We have coordinated with White House Presidential Personnel to assist former Governor Cowper. On the Medicaid issue, the Alaskan Senators have added language to change the match rate from 50/50 to 59.2/40.8. We relayed to the Governor that as outlined in a letter transmitted to Congressional leaders by OMB Director Frank Raines, the Administration does not favor individual state remedies of this kind. We agreed, however, to publicly indicate (if asked) that we are aware that Alaska's cost-of-living makes their case unique. We facilitated conversations between Governor Knowles, Sylvia Mathews, and Jack Lew to explain our position on this issue.

- Governor Ben Cayetano (D-HI) has also recently written us to present a similar request attempting to change his match rate to near 60 percent based on the cost-of-living in Hawaii.

- Governor Tom Carper (D-DE) has followed up on the funding of the Amtrak Trust Fund, stemming from a conversation you had with him at the Baltimore Orioles game. We have briefed OMB Director Raines, and the Governor will be calling Director Raines to pursue the matter.

- We are working with Governors Pete Wilson (R-CA), and Bob Miller (D-NV), and other elected officials on the upcoming Lake Tahoe Summit. There will be significant state and local elected official participation at the summit. IGA staff will be on site to support this event.

- Governor Paul Patton (D-KY) has asked for our help on a sensitive matter involving the potential deportation of two Canadian doctors in western Kentucky. These doctors are the only two in the western region of the state and the local communities are alarmed at the prospect of losing them. The potential deportation may result from a simple misunderstanding, but we are working with the Department of Justice to review the situation.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Democratic Leadership Meeting and Statement on Medicare and Prescription Drug Coverage (6 pages)	5/24/00	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23749 Box 17

FOLDER TITLE:
Medicare Drug Benefit [3]

Gary Foulk

gf39

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

THE WHITE HOUSE

WASHINGTON

May 24, 2000

DEMOCRATIC LEADERSHIP MEETING AND STATEMENT ON MEDICARE AND PRESCRIPTION DRUG COVERAGE

DATE:	May 25, 2000
LOCATION:	Cabinet Room/Rose Garden
BRIEFING TIME:	9:15am – 9:40am
EVENT TIME:	9:45am – 10:30am
STATEMENT TIME:	10:30am – 11:00am
FROM:	Charles Brain, Bruce Reed, Chris Jennings

I. PURPOSE

To discuss the Medicare prescription drug benefit issue as one of the key unfinished agenda items, send an implicit message that the Democrats remain united after the China PNTR vote, and send an explicit message that a unified Democratic party can produce a voluntary prescription drug benefit that is available and affordable to all Medicare beneficiaries.

II. BACKGROUND

The issue of a Medicare prescription drug benefit is becoming one of the hottest domestic policy issues confronting the Congress. The Republicans are afraid of being seen as working to prevent seniors from receiving a new benefit, and, therefore, are tempering their criticism of your proposal. They want their proposal to be viewed as a credible alternative that only differs from your proposal in that it is not a "one-size-fits-all, government" program.

Reports from the House indicate that Speaker Hastert is desperate to have the House pass a prescription drug benefit – even if it means that he has to do it without bipartisan support. House Republicans are burdened by advocating for a private insurance policy that is structurally unworkable, would not be offered to all beneficiaries, and would not meet the needs of seniors and Americans with disabilities. They are having an extremely difficult time getting an acceptable score from the Congressional Budget Office; moreover, they fear that their current policy could not stand up to significant public scrutiny.

In the Senate, all eyes are on the Finance Committee to see if a bipartisan compromise can and will emerge from the committee late next month. Senator Roth is sending signals to the Democrats that he wants a bipartisan bill, and that he is not particularly concerned how Senator Lott and Senator Nickles view the final agreement. He is apparently coming to the conclusion that the Republican leadership has written off his reelection prospects. This development is good news, but is offset by the fact that Senators Moynihan, Breaux, and Kerrey may be willing to lower the standard of what constitutes an acceptable compromise to the point that their final agreement will alienate the rest of the Democratic caucus.

Senator Breaux is aggressively marketing his drug-only, private insurance model to Finance Committee members, without much success to date. Senator Kerrey is reportedly attempting to reach a compromise between the Graham-Conrad-Bryan-Robb approach and the Breaux proposal. As of this writing, it appears that he has yet to have much success because the four Democrats are insisting that the policy be workable and attractive to more Senate Democrats than just Senator Breaux.

Just today, we also learned that Senator Wyden has agreed to work with Congressman Thomas on a new bipartisan drug benefit. This move appears even to have alienated Senator Breaux, and it is unclear what, if any, substantive agreement can be produced from this unlikely marriage. Notwithstanding these developments, Senator Daschle is working diligently to keep the Democrats unified and strengthen our hand in any response that might take place.

Tomorrow's meeting will be successful if we can portray the Democratic party as unified behind a strong bill that is similar to your policy. There is a risk that Senator Breaux and Senator Kerrey, as part of Senator Daschle's leadership team, could undermine this meeting if they publicly state that the Democrats are more interested in an issue than passing a policy. We are trying to coordinate with Senator Daschle and Congressman Gephardt to keep the Democrats focused on the message that we want a strong bill this year and we believe the best way to achieve that end is to unite behind a policy or policies that achieve this goal.

III. PARTICIPANTS

Briefing Participants:
YOU
Secretary Lawrence Summers
Secretary Donna Shalala
John Podesta
Charles Burson or designee
Joel Johnson
Charles Brain
Bruce Reed
Gene Sperling

Joe Lockhart
Loretta Ucelli
Terry Edmonds
Chris Jennings

Meeting Participants:
YOU
See attachment list of Members

Administration Members
Secretary Lawrence Summers
Secretary Donna Shalala
John Podesta
Charles Burson or designee
Joel Johnson
Charles Brain
Bruce Reed
Gene Sperling
Chris Jennings
Jeanne Lambrew
David Wilcox, Assistant Secretary for Domestic Policy, Department of Treasury
Rich Tarplin, Assistant Secretary for Legislation, Department of Health and Human Services

Program Participants:
YOU
Senator Thomas Daschle (D-ND)
Rep Richard Gephardt (D-MO)

IV. PRESS PLAN

Cabinet Room Meeting – White House Photo Only
Statement – Open Press

V. SEQUENCE OF EVENTS

- **YOU** will participate in a meeting with the House and Senate Democratic Leadership.
- **YOU** will be announced into the Rose Garden, accompanied by Sen. Thomas Daschle, Rep. Richard Gephardt, and the House and Senate Democratic Leadership.
- **YOU** will make remarks and introduce Rep. Richard Gephardt.
- Rep. Richard Gephardt will make remarks and introduce Senator Thomas Daschle.
- Senator Thomas Daschle will make remarks.
- **YOU** will thank the leadership and depart.

VI. REMARKS

- Meeting Talking Points are attached.
- Statement Remarks to be provided by speechwriting.

VI. ATTACHMENT

Meeting Talking Points

Members of Congress attending meeting

TALKING POINTS

- The reason why the prescription drug issue has touched such a nerve in the public is because it is truly a problem that affects real people on a daily basis.

- As I've said repeatedly, no one could design the Medicare program today and leave out a prescription drug benefit. This nation now has more than enough resources necessary to adequately finance a prescription drug benefit, and we should get to work on it. The Democrats have been very successful in framing this issue, and you have designed policies that will respond in a meaningful manner to the void in coverage burdening millions of older Americans and disabled individuals.

- We need to stay united in order to ensure that we can produce a strong bill that has the chance of passing the Congress this year. That should be our goal. I want to be clear – that is my goal.

- But I believe it's important to stress that even if a bill can't be enacted this year, it is imperative that we define what we consider to be good policy. And I believe good policy would ensure that we have a Medicare drug benefit that is voluntary, affordable, and available to all beneficiaries.

- As long as we stay united, I am confident that we will either have another great Democratic achievement – the passage and announcement of a voluntary prescription drug benefit – or ensure that next year, under a Gore Administration, such a bill is certain to be enacted into law.

MEMBERS OF CONGRESS ATTENDING MEETING (13):

Senator Tom Daschle (D-SD)
Senator Dick Durbin (D-IL)
Senator Byron Dorgan (D-ND)
Senator Harry Reid (D-NV)
Senator John Breaux (D-LA)
Senator Barbara Mikulski (D-MD)
Senator Patty Murray (D-WA)
Rep Richard Gephardt (D-MO)
Rep David Bonior (D-MI)
Rep Martin Frost (D-TX)
Rep Patrick Kennedy (D-RI)
Rep John Lewis (D-GA)
Rep Bob Menendez (D-NJ)

MEMBERS PENDING (2):

Rep Chet Edwards (D-TX)
Rep Maxine Waters (D-CA)

MEMBER REGRETS (7):

Senator Bob Kerrey (D-NE)
Senator John Kerry (D-MA)
Senator Jay Rockefeller (D-WV)
Senator Robert Torricelli (D-NJ)
Rep Rosa DeLauro (D-CT)
Rep Steny Hoyer (D-MD)
Rep Ed Pastor (D-AZ)

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Meeting With Senate Finance Democrats (6 pages)	7/16/99	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23748 Box 20

FOLDER TITLE:
Medicare Reform- Extend Solvency [8]

Gary Foulk

gf42

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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July 16, 1999

MEETING WITH SENATE FINANCE DEMOCRATS

DATE:	Monday, July 19, 1999
LOCATION:	Cabinet Room
TIME:	5:45 pm – 6:45 pm
FROM:	Larry Stein

I. PURPOSE

To assure Senate Finance Committee Democrats that you will not sign a tax cut that is so large it crowds out the more important Medicare, Social Security and domestic discretionary investments, and to encourage Democrats to be united in support of your Medicare plan when Secretary Shalala testifies before the Finance Committee next Thursday.

II. BACKGROUND

Among Senate Democrats, suspicion that you are poised to agree with Republicans on a tax cut of about $500 billion over 10 years—half way between your $250 billion and the Republican $800 billion—is now rampant. Stoked primarily by Senators Breaux, Kerrey, and Torricelli, the charge is that Democrats shouldn't allow themselves to vote against a large tax cut because ultimately one will be signed and they will have cast a vulnerable vote.

The Finance Committee is particularly conducive to these suspicions because of its composition and because its members traditionally want to be actively involved in any tax bill even when they are opposed, in principle, to cutting taxes. The Finance Senators almost always feel that simple opposition deprives them of the opportunity to express their tax cut preference and, more important, that it reduces their role to that of bystanders in a process that's leading, in their view, to a backroom deal.

As a consequence of these considerations, Finance Democrats have put together their own tax cut alternative for next week's mark-up. The package is presently approximately $300 billion over 10 years. (It is described below under the "Tax Plans" section.) Though larger than your allocation, the Democratic proposal is similar enough in its magnitude to what you have proposed that it permits Democrats to make two claims: first, that they allow room for Medicare and domestic investment, and, second, that they have tax cut priorities of their own. (Social

Security, as you know, is dealt with in this context because the money being portioned out is the "on-budget" surplus with the Social Security surplus left untouched off-budget). Even with a Democratic package, however, Kerrey and Breaux are still maintaining that they want a $500 billion cut and may offer one in committee. Privately, Breaux is telling Daschle that he thinks this is the size of the cut that will be incorporated into a final deal. Moynihan is inclined to believe Breaux on this score, and Senator Daschle feels strongly that the single most crucial step we can take toward holding Democrats together against the Republicans is your assurance to the Finance Democrats that you won't sign an exorbitant cut.

Such an assurance has to be delivered categorically in the Monday night meeting. Toward that end, we recommend that you make three basic arguments underscoring the "first things first" theme you have consistently stated: 1) that huge tax cuts crowd out other more necessary priorities like Medicare, Social Security solvency, military preparedness and investments in education and children; 2) that our modernization of Medicare with its attractive prescription drug benefit and its extension of solvency is a politically powerful trump to the tax cut; and 3) that the skewed distributional impact of the Republican tax cut and its explosion in the outyears make it a dangerous and irresponsible tax scheme.

The Crowd Out

This argument is the most important one for you to make to Democrats. They need to understand that the crowded out priorities are **your** priorities and that an unconstrained tax cut is, in fact, an assault on the economic advance you and the Democratic Party have established over the last 6 years.

Roth's tax cut is $792 billion over 10. With the associated interest component of $179 billion included, it would absorb all but $25 billion of the CBO estimated $966 billion in on-budget surpluses. Your own distribution of those surpluses employs the OMB estimates of $1.1 trillion for the ten year period. You provide $374 billion for Medicare solvency, $328 billion for discretionary investment including military readiness and the "Children and Education Trust Fund"; $250 billion for the U.S.A Accounts savings-oriented tax cut; and $132 billion in financing costs.

Clearly, Medicare and adequate discretionary investment are completely impossible with either Republican bill described below. Moreover, Medicare and discretionary are equally impossible given a $500 billion tax cut plus the associated interest. In addition, the outyear explosion of the Republican tax cuts directly threatens a return to the deficit ridden era of economic stagnation that your policies, backed replaced with an unprecedented period of durable growth without

inflation.

Tax Plan Options

Roth mark. The mark that Chairman Roth plans to put before the Senate Finance Committee next week is anticipated to reduce Federal tax receipts by approximately $792 billion over 10 years (five-year estimates are unavailable). As in the Ways and Means bill, the effects of many of the provisions in the mark are delayed or phased-in over the 10-year budget period and the benefits of the major components of the mark are skewed toward higher income individuals. The major components (with ten-year revenue costs in billions) are: **1)** broad-based relief, including reduction of the 15% marginal individual income tax rate to 14% in 2005 and expansion of the 14% bracket (**Revenue cost:** $300); **2)** family tax relief, including elimination of the marriage penalty AMT relief and tax credits for child care (**Revenue cost:** $220); **3)** retirement savings tax relief, 47 items including phased-in expansion of contribution limitations of IRAs, Roth IRAs and 401(k) plans (**Revenue cost:** $90); **4)** estate and gift tax rate reduction and increased estate and gift tax exemptions (**Revenue cost:** $63); **5)** health care relief, including provisions similar to those of the Ways and Means bill (**Revenue cost:** $52); and **6)** five-year extension of expiring provisions (the Ways and Means bill generally provided shorter extensions) (**Revenue cost:** $23).

Senate Finance Committee Democrats – Summary of Major Provisions The package assembled by Senator Moynihan and the Senate Finance Committee Democrats would reduce tax by a net $295 billion over 10 years. It does not include exploding out-year costs at the levels featured in the Archer and Roth packages, is far more progressive, and provides significant simplification. The package includes: **1) Broad-based individual tax reduction.** a phased-in increase in the standard deduction, providing a tax reduction for joint filers using the standard deduction of $653 when fully phased in. Reducing taxes for individuals in this manner has the virtues of both being highly progressive – very few higher-income taxpayers use the standard deduction, itemizing instead – and providing significant simplification – many taxpayers who currently itemize would be better off using the standard deduction under this proposal, making their tax calculations simpler and easier (**Revenue cost:** Approximately $169 billion over 10 years.); **2) Marriage penalty.** Two-earner deduction for couples who itemize – lesser of $4,350 or 20% deduction of lower earning spouse's earned income. (**Revenue cost:** Approximately $26 billion over 10 years.); **3) Health.** Tax credits for individuals without employer-provided health insurance; health insurance for self-employed fully deductible; tax breaks for long-term care costs. (**Revenue cost:** Approximately $27 billion over 10 years.) **4) Estate tax.** Accelerate the phase-in of the increase in the unified credit enacted in 1997. (**Revenue cost:** Approximately $10 billion over 10 years.) **5)**

Education. School construction, extension and expansion of employer-provided educational assistance, prepaid tuition plans, expansion of student loan interest deduction, technology-related incentives. (**Revenue cost:** Approximately $12 billion over 10 years.) **6) Extensions of expiring provisions.** Two-year extension of most expiring provisions; permanent extension for R&E credit and employer-provided educational assistance exclusion. (Revenue cost: Approximately $16 billion over 10 years.) **7) Miscellaneous.** Increase in low-income housing credit per-capita cap to $1.50 (Budget and Archer at $1.75); New Markets tax credit; **8) Revenue offsets.** Approximately $26 billion over 10 years.

Archer bill. The Ways and Means-passed bill would reduce Federal tax receipts by approximately $200 billion over 5 years and $864 billion over 10 years. Because many of the provisions in the Ways and Means bill are phased-in over the 10-year budget period, the full impact of the bill is not felt until after 2009. Treasury□s preliminary estimate is that the 20-year (1999-2019) cost of the bill is approximately $3 trillion, meaning that the second ten years is 2.5 times as costly as first ten years. The benefits of the major components of the bill are skewed toward higher income individuals. The major components (with estimated five and ten-year revenue costs in billions) are: **1)** phased-in 10% across-the-board cuts in individual regular tax and AMT rates (**Revenue cost:** $74/$405); **2)** phased-in repeal of the individual AMT (**Revenue cost:** $10/$82); **3)** phased-in repeal of the estate and gift tax (**Revenue cost:** $18/$75); **4)** reduction in individual capital gain rates from 20% and 10% to 15% and 7.5% (**Revenue cost:** $22/$52); **5)** phased-in deductions for certain health and long-term care insurance expenses (**Revenue cost:** $9/$42); and **6)** phased-in reductions in corporate capital gains rates and repeal of the corporate AMT (**Revenue cost:** $6/30).

Medicare

Medicare is the most politically potent priority that would be squeezed out by an excessive tax cut. We recommend that you underscore the fact that, without allocating $374 billion over 10 years to Medicare, it is not possible to modernize Medicare with a prescription drug benefit or extend the life of the Trust Fund to 2027. The Medicare program is now projected to become insolvent almost two decades before Social Security – and even with your Medicare commitment, we would not even reach the current 2034 insolvency date for Social Security. Moreover, a lower Medicare commitment reduces not only the solvency impact but also the ability to assist providers in the wake of BBA 1997.

Moreover, because Secretary Shalala will be testifying before the Committee on Thursday, we recommend that you encourage the Senators to use the hearing as an opportunity to play up the Medicare vs. tax cut issue. There is no more effective

block against a large and irresponsible tax cut. As such, it is important that you request that the Senators avoid statements that could be detrimental to the Democrats larger budget strategy. Indeed, we need the Democrats on this committee to be supportive of not only the Medicare surplus dedication, but – to the extent possible -- your Medicare reform plan as a whole.

Issue Concerning Medicare Prescription Drug Benefit
Some Members of the Finance Committee will raise concerns about the size and scope of the drug benefit. They will argue that it covers too many high-income beneficiaries. As such, they will argue that it should be better targeted to the low-income or, at a minimum, be more expensive for higher income beneficiaries. Some may also ask whether the cost of the drug benefit explodes in the out-years (similar to what would happen with the Republicans' tax cuts). We would suggest that you respond with several points. First, modernizing the Medicare program without updating its benefits is analogous to not paying for physicians in 1965. We simply cannot expect Medicare to deliver high-quality, modern medicine without offering this coverage. Second, the problem of lacking drug coverage cuts across all income, age and geographic groups. It is simply impossible to target a policy only to those who do not have coverage because nearly 40 percent of the uninsured have incomes above $11,000 for singles, $22,000 for coverage. Finally, on the issue of out-year costs, your benefit is designed to limit Federal cost growth so that the spending growth roughly parallels that of the savings proposals in the plan.

III. PARTICIPANTS

Pre-Brief
President
John Podesta
Steve Ricchetti
Secretary Larry Summers
Larry Stein
Jack Lew
Gene Sperling
Ron Klain

Members of Congress
Senator Tom Daschle (D-SD)
Senator Daniel Moynihan (D-NY)
Senator Max Baucus (D-MT)
Senator John Rockefeller (D-WV)

Senator John Breaux (D-LA)
Senator Kent Conrad (D-ND)
Senator Bob Graham (D-FL)
Senator Richard Bryan (D-NV)
Senator Robert Kerrey (D-NE)
Senator Charles Robb (D-VA)

IV. PRESS PLAN

Closed Press.

V. SEQUENCE OF EVENTS

As usual.

VI. REMARKS

None.

VII. ATTACHMENTS

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Harold Ickes re: Equal Access - Ways and Means Issue (1 page)	6/3/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [3]

Gary Foulk

gf62

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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MEMORANDUM

To: Harold Ickes

From: Chris Jennings

Date: June 3, 1994

Re: ~~Following up on Conversation of June 2~~

I have spoken with both Rob Waspe of the National Association of Chain Drug Stores (NACDS) and Charlie West of the National Association of Retail Druggists (NARD) to discuss the equal access issue and its relationship to the Ways and Means mark-up. Apparently, Ron Zeigler continues to be adamant about us sending some signal of support for the committee to include the Energy and Commerce equal access provision into the Ways and Means Chairman's mark. Charlie West is not in such a panic, but thinks that it would be constructive for us to do something that would address Zeigler's concerns. (By the way, Charlie West is from Arkansas, knows the Clintons, and is very close to Carol Rasco).

I think it would be consistent with our discussion yesterday that Jack or I ~~can~~ relay a message to Janis Mays and David Abernathy that indicates how supportive these two groups would be and indicating our desire for an additional high level meeting with Janis Mays on the equal access issue. (We had already ~~previously~~ successfully arranged a meeting with the two groups and Abernathy). In the context of our conversation, we could also state that the ~~Administration has no objection~~ to the Energy and Commerce language that NACDS/NARD seeks. Prior to doing this, we do believe it important that you contact Ron Zeigler and Charlie West today to be responsive to their concerns and to outline our proposed discussion with Ways and Means. During the course of your conversation, we believe it is also imperative that you stress the sensitivity ~~of such a discussion~~ and the determination of the Administration to separate ourselves from them should anything become public ~~surrounding~~ ~~them~~ and, in fact, our determination to oppose such provisions should ~~not occur~~. (Pat Griffin thinks this message is important to deliver).

Ron is traveling in Spain today. We believe he can be reached at the following number at -:-- today. Charlie will be at 703-455-4374 until 10:00 this morning. If you cannot reach him by then, you can reach him in Denver between 4:30 and 6:00 Eastern time this afternoon at 303-297-1300.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. notes	Notes from Bentsen "Economic Team" Lunch (5 pages)	7/28/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [14]

Gary Foulk

gf64

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Feinstein:
Responding to comments by Laura Tyson about evidence of negligible job loss from reform which includes a mandate, Feinstein started by giving the example of the Tree Lovers Floor Finishers. They have 18 employees. It costs them $100,000 before they even open the door. Workers comp cost are very high. What's driving me is the streets, not think tanks. If the plan is going to drive up unemployment or drive up the deficit is unacceptable to me. Employers have said that they will have let employees go. Especially restaurants, retailers -- important employers in California. California is different more low wage workers more part-timers. Next to Texas, it has 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. What will it do in a state with 4.4 million uninsured. We have 2.2 million undocumented. None of the plans cover them.

A year ago, we started something in California. It is a voluntary plan for small businesses. To qualify they must cover 70% of their employees and pay at least 50% of the cost. Premiums have gone down; it covers 50,000. There is a choice of 15 plan in San Francisco; 17 in Los Angeles.

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Baucus:
We agree in abstract. The issue is how to get from here to there. In Montana, people just don't care about health care. And the people who do are livid. Businessmen are adamantly opposed. Middle income folks are concerned we'll take away their plans. I cosponsored the Clinton plan because I though in the abstract it was good. I've had the First Lady, Ira Magaziner, Donna Shalala out to Montana and for a time Montanans suspended judgement. But if it is good for small business why are they not convinced.

I'm concerned about mandates in the absence of cost controls. I'm for premium caps. The tax on high cost plans in the Finance committee bill will move to consumers in the form of higher premiums, not to providers as lower reimbursement. If the mandate is triggered, what about the cost. The Senate plan has no cost containment; the House fee schedule is politically unrealistic.

I believe that managed competition will cause an initial dip in health inflation but as we get into it will start to go up again. The only way is premium caps, but I don't see them passing.

I am not a member of the Finance Committee. This debate is being driven from outside. You need to work this like the assault ban. Must get the middle from both sides together. We need a free market approach. People don't want a big brother program. Get the uninsured covered, control costs (perhaps include a cost commission). What's really bothering me is that there is not fine print ((no details). Not on the Finance Mark; not on the Mitchell bill. We are getting conflicting information on costs. I'm mad at being threatened with the loss of the recess being spanked like a naughty children. We have not time to evaluate the proposals. We're just supposed to salute and say yes. We may have the new plan by tomorrow and debate starting next week. We need more discussion. These bus trips and marches, the pressure form the leadership make me dig in my heels even more. It must be right for the people.

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Conrad:
Told of walking into a diner in a small town in North Dakota. As he approached one table he could tell that the couple mad. After exchanging pleasantries, Conrad asked what the problem was? The man said the Clinton Health Plan. It going to bankrupt me. He owned a grocery and paid $500 month to cover 2 employees no way he could cover all ten. Conrad explained about the cap for small businesses and how he'd actually pay less covering everyone. The man was still mad because he was being required to do something. We are killing businesses with requirements.

I was an original cosponsor of the HSA. I believe it has merit. But out where we're running, people don't believe the numbers. They don't believe you will maintain quality while lowering rates. It just hasn't been sold.

I joined the rump group to pass something. It falls short of the President's plan but I believe it is close to what can pass the Senate floor given current circumstances. The dynamic could change but it would take a significant effort by the President (he suggested two hours on Larry King taking questions).

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Exon:
As I listen to this discussion and I listen to the people in Nebraska my experience has been similar to Senator Conrad's. We are planning to go possible to the mat for the Mitchell bill. He is concerned given what we have heard today. He supports the concepts of the Finance Committee bill. But that bill is not paid for. Even its authors don't claim it is paid for. The Administration has not done a good job selling the President's plan. The high ground for the President's plan is that it is paid for.

I believe that with the circumstances that confront us, politically we are in for a blood bath. He has not turned his back on a mandate. The success of the current system is based on employer provided coverage. There is possibly a chance of working this out. He is still open and has not said no.

Thinks we are headed for disaster if we don't have more consensus among the Democrats. He thinks we are headed for a train wreck. He knows there are pressures to pass this year. But as he looks at the politics in Nebraska, a republican state where he has won a few elections, he wants to assure that we don't lose the majority and keep it to just a few seats.

Abortion would not be a deciding issue for him even though his views are different from others. One solution is leaving it to the states.

He agreed the Administration had not sold the President's plan. He felt we were trying to force something through.
He suggested having the President bringing the Democrats and Republican leadership together at Camp David, if the Republicans don't agree to anything then put it off. At least if would not be the fault of the Democratic President and Congress.

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Robb:
He was troubled by the politics as it has evolved. He doesn't disagree with what has been said. He has been using the same numbers and examples. But this brew has not come together yet. Not seeing critical mass. He has dabbled in this issue previously working with Henry Simmons National Leadership Coalition on Health Care Reform but he pulled back because he's never been comfortable.

He is willing to remain in a position to support the plan but what you are hearing here today is an accurate portrayal of what is out there. He would vote for anything that will work, but he doesn't think we're there yet. He doesn't know how to resolve it. He has declined invitations to go the White House because he has no advice and doesn't want to add to their problems.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Lorraine Lewis to Frank W. Hunger Re: FEHB and Suits Against the Tobacco Industry (3 pages)	10/16/98	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23758

FOLDER TITLE:
Qualified Medicare Beneficiary

Gary Foulk

gf150

RESTRICTION CODES

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

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

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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	To POTUS Re: Meeting with Senator Robb (2 pages)	8/1/94	P5
002. memo	Chris Jennings, Steve Edelstein to Secretary Bentsen, Erskine Bowles, Alice Rivlin, Robert Rubin, Laura D'Andrea Tyson RE: Profiles of Senators attending Economic Team Lunch Today (3 pages)	7/28/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [11]

Gary Foulk

gf63

RESTRICTION CODES

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

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

WASHINGTON

August 1, 1994

MEETING WITH SENATOR ROBB

Date: August 1, 1994
Location: Oval Office
Time: 6:30 - 7:00 PM
From: Patrick J. Griffin

I. PURPOSE

- To underscore the importance of health care reform to your Presidency and to the Democratic Party and to seek his support for a bill that achieves universal coverage.

- To illustrate your flexibility and willingness to compromise for a universal coverage bill.

II. BACKGROUND

Senator Robb has not cosponsored any health care bill. In late May, Robb said, "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." [*Richmond Times Dispatch*] He also supports insurance market reforms which would allow employees to change jobs without losing their insurance and prohibit exclusions for pre-existing conditions.

Senator Robb's overriding concern is his widely publicized reelection effort. He is currently locked in a tight four-way race with Republican Oliver North and independents Douglas Wilder and Marshall Coleman. Senator Robb has expressed some concern about the impact of reform on small business. Small business has been an important political ally to Robb over the years, so he will be looking for cover on the employer mandate. In the final analysis, his decision will be based on a political calculus of the impact of a vote for health reform on his race. With the race expected to be decided by a very narrow margin, hearing from loyal Democratic constituency groups may well be key to his support.

At a lunch hosted by Secretary Bentsen for five swing Senators with the Administration's Economic Team, Senator Robb was troubled with how the politics of this issue have evolved. He did not disagree with the numbers and examples cited by the economic team in support of universal coverage and the fiscal need for health care reform and noted that he had been using some of them himself. But he did not feel that critical mass had yet developed for any reform approach. Senator Robb declared himself open to any plan that would work, but did not think we were there yet and he did not know how to resolve it. Robb also said that he had declined invitations to meet with the President up until then because he had no advice on solutions and did not want to add to the Administration's burdens.

III. PARTICIPANTS

The President
Senator Robb
Patrick Griffin
Steve Ricchetti

IV. SEQUENCE OF EVENTS

Closed Meeting with Senator Robb in the Oval Office

V. PRESS PLAN

Closed Press. (White House photographer will be present.)

THE WHITE HOUSE

WASHINGTON

July 28, 1994

Memorandum for

Secretary Bentsen
Erskine Bowles
Alice Rivlin
Robert Rubin
Laura D'Andrea Tyson

From: Chris Jennings and Steve Edelstein

Re: Profiles of Senators attending Economic Team Lunch Today

The following are brief profiles and summaries of the health care views of the senators scheduled to attend the lunch with the Administration's Economic Team hosted by Secretary Bentsen at the Treasury Building at 1:00 p.m. today. Senators Baucus, Conrad, Exon, Feinstein, and Robb have accepted the invitation. An invitation to Senator Bradley is outstanding, however based on conversations with his scheduler his attendance is unlikely.

SENATOR MAX BAUCUS (D-MT):

Senator Baucus is a Health Security Act cosponsor whose primary concerns are small business and rural access. In the past, he has advocated a single payer approach and has had difficulties with the employer mandate, but he appeared comfortable with the provisions in the HSA. He was part of the "rump group" effort at the Finance Committee to draft an alternative bill but dropped out because he did not feel their plan adequately tackled the issue of cost containment. Baucus has a package of rural health care proposals that he wants included in the reform bill. He supports: increased funding for the National Health Service Corps; helping rural hospitals through higher federal Medicare payments; increased grants for telecommunications in medicine; tax incentives and other enticements for health care providers to work in rural areas; and instituting health insurance changes to benefit rural residents.

In addition, Baucus wants to implement cost controls but has not reached a decision on what form they should take. He cosigned the letter to the President relating health care concerns to the domestic oil and gas industry.

SENATOR KENT CONRAD (D-ND):

As one of the "rump group of 7" and a key vote who will influence Sen. Dorgan among others, Senator Conrad is an important health care player. Although a Health Security Act cosponsor, he has always been uncomfortable with the legislation. His particular concerns are rural health care and small business. Conrad has characterized the effort to draft health reform bills for the House and Senate as taking "the wisdom of Solomon to put it all together." In recent statements he has indicated he could support a hard trigger to an employer mandate.

Conrad, who is up for re-election this fall, was not happy with the DNC ads emphasizing how the middle class will be hurt unless there is universal coverage. He complained that the main theme should have been the need for cost control.

SENATOR JAMES EXON (D-NE):

Senator Exon sees himself as a key centrist vote on health care, one who can be of assistance in getting other moderates to vote for passage of health care reform. To this end, he reacted favorably to the reports from the NGA. He was quoted as saying "Good for him! Until the president said something like that, I think we were dead in the water," (Los Angeles Times) and "This may get us to a place where we can negotiate" (Washington Post).

Senator Exon has raised three issues which are of primary interest to him: First, he is concerned about the size of the benefit package. He believes it should be an "Escort not a Cadillac." Second, he believes that states, not the federal government, should choose whether or not to fund abortion. Finally, he has sought relief for small business from the employer mandate. He has said he might be able to support a 50-50 split. He has also said that universal coverage should be a priority but should be phased-in.

SENATOR DIANNE FEINSTEIN (D-CA):

Senator Feinstein's overriding concern is her reelection which many now consider to be a toss-up. Once a cosponsor of the Health Security Act, she is the only Senator to remove his or her name from the bill. Now she is sending mixed signals and very vague about whether or not she will be there for the White House when needed. However, the issues about which she is concerned - small business, bureaucracy, cost containment, and premium caps - are all addressed in the Mitchell bill. She has said she would be open to a compromise if it helps small businesses and is it provided a greater degree of state control.

In recent conversations, Senator Feinstein made clear that she prefers CALPERS, California's voluntary pool, to an employer mandate and she doesn't understand why a mandate is necessary. She stated that the Finance Committee mark was closest to her current thinking. She also said that while not completely closed to the mandate concept, she was getting more so every day but could not support an 80-20 split.

SENATOR CHUCK ROBB (D-VA):

Senator Robb believes that cost-containment is the key to health care reform but has not cosponsored any of the major bills. With his reelection questionable at best, he has been relatively silent on health care. Answering questions on health care in the Richmond Times-Dispatch in May, Robb said he had not endorsed any specific plan but a set of principles, "including universal coverage, tough cost containment, strict quality controls and equitable financing ... I have not endorsed any financing option to date." He also listed portability and prohibiting exclusions for pre-existing conditions. At a July candidate's debate, his opponents stated their opposition to employer mandates but Robb did not rule them out.

[May also attend. Awaiting confirmation:

SENATOR BILL BRADLEY (NJ):

With the Finance Committee mark-up, Senator Bradley appears to have finally engaged in the issue of health care reform. He participated in the work of the "rump group" focusing particularly on market-oriented alternatives to the premium caps which he opposes. This reflects the concerns of his state's sizable insurance and pharmaceutical industries.His proposal to impose a 25% tax on high cost insurance plans was adopted by the Committee. This provision engendered strong union opposition, something he had not anticipated. While he voted for the Finance Committee mark, he is concerned it may be seriously underfunded.

In a phone conversation with Secretary Reich this month, Bradley expressed his support for shared responsibility but noted that he did not think the Senate leadership would be able to get sufficient votes for the mandate even though polls show that the American people support it. He believes we need to craft a bill that can get 60 votes and that a 51 vote majority won't do.]

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Harold Ickes re: Equal Access - Ways and Means Issue (1 page)	6/3/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [3]

Gary Foulk

gf62

RESTRICTION CODES

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

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

To: Harold Ickes

From: Chris Jennings

Date: June 3, 1994

Re: ~~Following up on Conversation of June 2~~

I have spoken with both Rob Waspe of the National Association of Chain Drug Stores (NACDS) and Charlie West of the National Association of Retail Druggists (NARD) to discuss the equal access issue and its relationship to the Ways and Means mark-up. Apparently, Ron Zeigler continues to be adamant about us sending some signal of support for the committee to include the Energy and Commerce equal access provision into the Ways and Means Chairman's mark. Charlie West is not in such a panic, but thinks that it would be constructive for us to do something that would address Zeigler's concerns. (By the way, Charlie West is from Arkansas, knows the Clintons, and is very close to Carol Rasco).

I think it would be consistent with our discussion yesterday that Jack or I ~~can~~ relay a message to Janis Mays and David Abernathy that indicates how supportive these two groups would be and indicating our desire for an additional high level meeting with Janis Mays on the equal access issue. (We had already ~~previously~~ successfully arranged a meeting with the two groups and Abernathy). In the context of our conversation, we could also state that the ~~Administration has no objection~~ to the Energy and Commerce language that NACDS/NARD seeks. Prior to doing this, we do believe it important that you contact Ron Zeigler and Charlie West today to be responsive to their concerns and to outline our proposed discussion with Ways and Means. During the course of your conversation, we believe it is also imperative that you stress the sensitivity ~~of such a discussion~~ and the determination of the Administration to separate ourselves from them should anything become public ~~surrounding~~ them and, in fact, our determination to oppose such provisions should ~~that occur~~. (Pat Griffin thinks this message is important to deliver).

Ron is traveling in Spain today. We believe he can be reached at the following number at -:-- today. Charlie will be at 703-455-4374 until 10:00 this morning. If you cannot reach him by then, you can reach him in Denver between 4:30 and 6:00 Eastern time this afternoon at 303-297-1300.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. notes	Notes from Bentsen "Economic Team" Lunch (5 pages)	7/28/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Analysis [14]

Gary Foulk

gf64

RESTRICTION CODES

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I'm concerned about mandates in the absence of cost controls. I'm for premium caps. The tax on high cost plans in the Finance committee bill will move to consumers in the form of higher premiums, not to providers as lower reimbursement. If the mandate is triggered, what about the cost. The Senate plan has no cost containment; the House fee schedule is politically unrealistic.

I believe that managed competition will cause an initial dip in health inflation but as we get into it will start to go up again. The only way is premium caps, but I don't see them passing.

I am not a member of the Finance Committee. This debate is being driven from outside. You need to work this like the assault ban. Must get the middle from both sides together. We need a free market approach. People don't want a big brother program. Get the uninsured covered, control costs (perhaps include a cost commission). What's really bothering me is that there is not fine print ((no details). Not on the Finance Mark; not on the Mitchell bill. We are getting conflicting information on costs. I'm mad at being threatened with the loss of the recess being spanked like a naughty children. We have not time to evaluate the proposals. We're just supposed to salute and say yes. We may have the new plan by tomorrow and debate starting next week. We need more discussion. These bus trips and marches, the pressure form the leadership make me dig in my heels even more. It must be right for the people.

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Conrad:
Told of walking into a diner in a small town in North Dakota. As he approached one table he could tell that the couple mad. After exchanging pleasantries, Conrad asked what the problem was? The man said the Clinton Health Plan. It going to bankrupt me. He owned a grocery and paid $500 month to cover 2 employees no way he could cover all ten. Conrad explained about the cap for small businesses and how he'd actually pay less covering everyone. The man was still mad because he was being required to do something. We are killing businesses with requirements.

I was an original cosponsor of the HSA. I believe it has merit. But out where we're running, people don't believe the numbers. They don't believe you will maintain quality while lowering rates. It just hasn't been sold.

I joined the rump group to pass something. It falls short of the President's plan but I believe it is close to what can pass the Senate floor given current circumstances. The dynamic could change but it would take a significant effort by the President (he suggested two hours on Larry King taking questions).

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Exon:
As I listen to this discussion and I listen to the people in Nebraska my experience has been similar to Senator Conrad's. We are planning to go possible to the mat for the Mitchell bill. He is concerned given what we have heard today. He supports the concepts of the Finance Committee bill. But that bill is not paid for. Even its authors don't claim it is paid for. The Administration has not done a good job selling the President's plan. The high ground for the President's plan is that it is paid for.

I believe that with the circumstances that confront us, politically we are in for a blood bath. He has not turned his back on a mandate. The success of the current system is based on employer provided coverage. There is possibly a chance of working this out. He is still open and has not said no.

Thinks we are headed for disaster if we don't have more consensus among the Democrats. He thinks we are headed for a train wreck. He knows there are pressures to pass this year. But as he looks at the politics in Nebraska, a republican state where he has won a few elections, he wants to assure that we don't lose the majority and keep it to just a few seats.

Abortion would not be a deciding issue for him even though his views are different from others. One solution is leaving it to the states.

He agreed the Administration had not sold the President's plan. He felt we were trying to force something through.
He suggested having the President bringing the Democrats and Republican leadership together at Camp David, if the Republicans don't agree to anything then put it off. At least if would not be the fault of the Democratic President and Congress.

Notes from Bentsen "Economic Team" Lunch 7/28/94

Senator Robb:
He was troubled by the politics as it has evolved. He doesn't disagree with what has been said. He has been using the same numbers and examples. But this brew has not come together yet. Not seeing critical mass. He has dabbled in this issue previously working with Henry Simmons National Leadership Coalition on Health Care Reform but he pulled back because he's never been comfortable.

He is willing to remain in a position to support the plan but what you are hearing here today is an accurate portrayal of what is out there. He would vote for anything that will work, but he doesn't think we're there yet. He doesn't know how to resolve it. He has declined invitations to go the White House because he has no advice and doesn't want to add to their problems.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Dole, Chafee Visit Following Senate Democrats Meeting (1 page)	2/4/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Staff
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
January 1993 HSA

Gary Foulk

gf73

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 advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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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]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

M E M O R A N D U M

TO: First Lady Hillary Rodham Clinton February 4, 1993
FR: Chris Jennings
RE: Dole, Chafee Visit Following Senate Democrats Meeting
cc: Melanne, Steve R.

Following your Senate Democrats Meeting, you and your staff are scheduled to meeting with Senator Dole and Senator Chafee (R-RI), Chairman of the Republican Health Task Force. Steve Richetti has indicated that there may be others, in particular Senator Durenberger (R-MN).

ISSUES TO RAISE

* Consistent with the President's appointment of Senator Dole as one of the four lead Congressional health care representatives, will look forward to building on what you feel will be a close and productive working relationship.

* If there are problems, I want to know about it. I will be as responsive as possible. Based on our previous conversation, I know that this will be a two-way commitment.

* Will consult Senator Dole as frequently as possible. Interested in having a good relationship with not only Senator Dole, but with all Republicans committed to effective cost containment and universal coverage.

* Outline the structure and roles of Task Force and Working Groups. Omit ANY discussion of incorporation of staff into the work groups, however. (They should not know anything about the Democratic staff role at this time and we believe it is unwise to address unless raised by them).

ISSUES THEY MAY RAISE AND TO DANCE AROUND (as you have)

* They will suggest that the Administration needs Republicans to pass a bill and it would be best not to draw significant lines of destinction between the way Democrats and Republicans are treated.

* Raise questions about financing and how cost containment savings are allocated.

* Raise questions about legislative strategy, i.e. what will be timing and the likely legislative vehicle.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Howard Paster, Steve and Lorraine Re: Ways and Means Subcommittee on Health Interaction Meetings (2 pages)	4/4/93	P5
002. draft memo	Linda Bergthold, Robert Valdez to Hillary Clinton Re: President Clinton's Meeting with Congressional Caucus for Women's Issues on Thursday, March 11, 1993 (9 pages)	3/11/93	P5
003. memo	Mike Lux to Vince Foster Re: Health Political/Policy Working Team (2 pages)	4/12/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Staff
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
April 1993 HSA [1]

Gary Foulk

gf75

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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M E M O R A N D U M

TO: Howard Paster, Steve and Lorraine April 4, 1993

FR: Chris J.

RE: Ways and Means Subc. on Health/ Interactive Meetings

cc: Melanne, Susan

BACKROUND

As you know, last Wednesday, Ira was the recipient of a classic Pete Stark personal attack. In the meeting, Congressman Stark -- among many extraordinarily negative comments -- stated he had no desire in meeting with Ira until after decisions and paper were available to review.

Following the meeting, most of the Members -- embarassed by the treatment Ira received -- expressly stated that they disagreed with Congressman Stark and requested that we set up meetings separately with them, even if the Subcommittee Chairman would not attend. Hours later, Chairman Rostenkowski called to apologize on behalf of the entire Committee for Congressman Stark's behavior.

After this conversation, and following a discussion between Majority Leader Gephardt, Mrs. Clinton, and Ira, it was decided that Ira should try to set up a meeting with Pete Stark to attempt one more time to establish a more constructive relationship. Ira did so, and arranged and held a meeting on Thursday morning.

Although Congressman Stark did not apologize during the meeting, Ira characterized the discussion as generally constructive and substantive. In fact, they agreed that they would hold another one-on-one conversation again either this week or next.

Before and again following the Thursday morning meeting, David Abernathy (the Subcommittee Staff Director who directly reports to Rostenkowski) made it clear that Pete Stark would not want to have any Subcommittee Members' meeting without being present. He also stated, however, that meetings would be advisable and requested that they take place during the week of April 12th. Prior to these Members' meetings, he urged (and I agreed to schedule) one or two Committee staff meetings.

CURRENT ISSUE

Karen Pollitz (from Jerry Klepner's shop) reports that Congressman Levin, although he knows that Pete Stark and his staff wants to wait until next week to hold Members' meetings, feels extremely strongly that a meeting between the Members and Ira should not wait a week. He believes (and I believe he is right) that most of the Subcommittee Members want a meeting before then.

We could arrange for such a meeting, but -- out of a concern that I should not risk further alienating Stark -- I have chosen to defer to the Subcommittee Chairman for the moment and have yet to schedule anything. I mention this to you for two reasons:

(1) Because I want to make certain you agree with my current call on a non-Pete Stark Subcommittee Members meeting; and

(2) Because I believe that Congressman Levin may feel so strongly about proceeding with meetings that he may actively lobby you or me for a Members' meeting.

Should Congressman Levin follow-up and call, I believe we should be honest with him about our concerns about further straining our relationship with Stark. If he still persists, I recommend that we respond by holding a one-on-one meeting between Congressman Levin and Ira and/or Judy.

REVISED 4/5/93
(Revisions in bold and underlined)

March 10, 1993

DRAFT ~~CONFIDENTIAL~~ MEMORANDUM

TO: HILLARY RODHAM CLINTON

FROM: LINDA BERGTHOLD
ROBERT VALDEZ

cc: Chris Jennings
Ira Magaziner
Judy Feder
Atul Gawande

RE: PRESIDENT CLINTON'S MEETING WITH CONGRESSIONAL CAUCUS FOR WOMEN'S ISSUES ON THURSDAY, MARCH 11, 1993

Chris Jennings has asked us to prepare a background memo for you in preparation for President Clinton's meeting with the Congressional Caucus for Women's Issues tomorrow.

Members of the benefits coverage working group representing the Congressional Caucus for Women's Issues and Senator Mikulski have indicated serious concerns about the coverage of abortion services in the benefit package and the process for developing options. In President Clinton's meeting with the Caucus on Thursday, we understand that he will be asked specifically about these issues.

BACKGROUND

Our working group was asked to explore all options related to benefit coverage as we proceed through the Tollgates. When the issue of coverage for abortion first came up, several women in our group objected to the fact that we were even considering a "no coverage" option. They said that President Clinton had clearly stated during the campaign that abortion would be covered in the benefit package, and he had not backed away from supporting abortion when this issue confronted Secretary Shalala during preparation for the confirmation hearings.

The women's advocates in our group emphasized that anything less than clear support for abortion coverage now would be a "signal" to women that the President was abandoning his original commitment. Following discussion with you, Atul and Judy asked us to continue developing all options for consideration (see our options in Attachment A).

ISSUES

Should abortion be covered in the core benefit package?

The problems with including abortion services in the core benefit package are clear. There are probably not enough votes in the Senate to pass a health care reform package that explicitly includes abortion. Support in the House may also be weakened.

Excluding abortion from the core benefit package has obvious political implications. Women's groups perceive that abortion service guarantees can or will be addressed as part of overall system reform. Most women perceive that abortion has been promised as part of the core benefit package.

Our working group has included abortion services as part of our recommendation in Tollgate 5, covered as part of "pregnancy related care." We have also told our working group and the women's groups with whom we have been meeting that the inclusion of abortion services in the final package will be a Presidential level decision.

If part of the core, should abortion be implicitly covered as part of pregnancy related care or as a surgical procedure or explicitly identified?

Making abortion an implicitly covered service may postpone direct confrontation for a short time, but the first time someone asks "Is abortion covered?" a direct answer will be required. Subjecting abortion services to medical necessity provisions is strongly opposed by the Congresswomen as well, because it allows for too much ambiguity and returns power over the decision to medical providers. **We are proposing including abortion services as part of pregnancy related care. This care will be subject to**

the same test of "medical necessity or medical appropriateness" as all other services in the guaranteed package. By defining it as "or", we gain the support of the women's groups.

The advocates in our working group have presented **three options** for abortion coverage. The options they have outlined are: 1) Establish a comprehensive reproductive health benefit including family planning, abortion as part of maternity related care, and post-reproductive care; 2) Integrate abortion services into prevention and maternity care; and 3) Cover abortion as part of maternity-related care only. Their options do **not** exclude abortion, make it a state issue, or subject it to medical necessity control.

We have developed several options for covering abortion short of making it a core benefit in Attachment A. We have also attached provisions for covering abortion in selected western countries in Attachment B.

SUGGESTED TALKING POINTS

Given the complexity of this issue and the importance of gaining as much time as possible to resolve differences among supporters, we would suggest the following talking points for the President in tomorrow's meeting:

Reaffirm support for a woman's right to choose and indicate that he and you understand this issue very well.

Explain the importance of maintaining the integrity of the Tollgate process, which requires that all issues and options be explored until the narrowing process begins.

Indicate that treating abortion differently from other issues at this time will create a credibility problem both within the Task Force work groups and outside.

Explain that you want to develop mechanisms that allow all women to have access to the entire range of reproductive services. This

may mean creating provisions or programs outside the benefit package.

Ask for their patience and support during this planning phase. Ask them to work with him to develop options and strategies that will support the passage of the overall health care reform bill and guarantee the woman's right to choose.

ATTACHMENT A
OPTIONS FOR COVERAGE OF REPRODUCTIVE HEALTH SERVICES

Our working group has considered several options related to the coverage of reproductive health services, including abortion. As we prepared our Tollgate papers, we collected information on current coverage of abortion in the U.S. and abroad:

Many European countries cover abortion subject to some conditions **(see Attachment B);**

Data on the coverage of abortion services in U.S. private insurance plans is difficult to obtain. Many private plans implicitly cover these services;

Some HMOs and private insurers cover abortion subject to definitions of "medical necessity" only;

Ten states have laws that require the exclusion of abortion services from at least some private coverage. Only twelve states fund Medicaid abortions for low income women using state funds;

The Hyde Amendment restricts federal funding except in cases where the life of the mother is endangered if the fetus is carried to term.

This patchwork of coverage demonstrates the highly sensitive nature of the coverage and the lack of consensus on financing arrangements in either the public or private sector.

We think that there are four main options for coverage of abortion:

OPTION 1: Exclude abortion services from the core benefit package.

PRO: Mollifies opponents of abortion.

Keeps the focus of health care reform on system change.

CON: Provokes strong attacks by most women's groups and weakens support among critical allies. Would be viewed as a serious breach of commitment by the President.

SUBOPTION A: Make abortion coverage available in a supplemental package, with subsidies for low income women.

PRO: The subsidizing of abortion services for low income women may be acceptable to some women supporters and has good chance of gaining support from moderate groups.

Making abortion coverage a supplemental coverage issue may soften some of the opposition by abortion opponents.

CON: Including abortion in a supplemental package may be seen as backing down from broader support.

OPTION 2: Include abortion services implicitly in the core benefit package as part of maternity related care or outpatient surgery.

PRO: May avoid immediate direct confrontation with opponents of abortion and buy time for building broader support among women's groups.

CON: Strategy becomes apparent as soon as anyone asks, "Is abortion covered or not?"

Raises "medical necessity" issues.

OPTION 3: Mandate states to cover abortion services for low income women.

SUBOPTION A: States could be given the option of covering abortion services.

PRO: Removes issue from central point of attack: federal support for abortion.

Supports states' rights.

CON: Bumping this down to the states will be politically contentious and potentially inequitable.

OPTION 4: Cover abortion services subject to a "medically necessary" provision.

PRO: Treat abortion coverage the same as other services subject to determinations of medical necessity.

CON: Women's groups will strongly object to the language of medical necessity, because of the potentially narrow legal definition of necessity, the violation of privacy concerns, and possibility of abuse by providers.

Within the context of managed competition, providers might withhold these services selectively because of personal convictions. Furthermore, some providers may refuse to provide them altogether by invoking the "conscience clause."

QUESTION: **SHOULD ABORTION SERVICES BE COVERED IN THE CORE BENEFIT PACKAGE?**

ISSUE: During the campaign, President Clinton stated that abortion services would be part of the core benefit package under national health care reform. In the last few months, the President has given clear signals that he supports a woman's right to choose by overturning five abortion restrictions, including the "gag rule," refusing to seek reauthorization of the Hyde Amendment, and proposing coverage for abortions in the federal employee health insurance plans. Should the President now support the coverage of abortions in the core benefit package he sends to Congress next month?

BACKGROUND: There is no clear pattern of coverage of abortion services, either in the U. S. or abroad. Many European countries cover abortion subject to some conditions. Most of this coverage was established before the issue became so polarized. Information about the coverage of abortion services in private insurance plans in the U.S. is difficult to obtain. Many private plans implicitly cover these services by including them under "pregnancy related care." Hawaii covers abortion as "childbirth or other termination of pregnancy." Some HMOs cover abortion subject to "medical necessity" only. Ten states have laws that require the exclusion of abortion services from at least some private coverage. Only twelve states allow Medicaid funds to be used to fund abortions for low income women. This patchwork of coverage and the lack of consensus among Americans about whether to allow abortion and how to fund it, demonstrates the highly sensitive nature of this issue.

There are three main options for coverage of abortion:

OPTION 1: Include abortion services implicitly in the core benefit package as part of maternity related care or outpatient surgery.

Although implicit coverage might avoid immediate direct confrontation with opponents of abortion, the strategy would

become apparent as soon as anyone asks, "Is abortion covered or not?" Including abortion, however, would be consistent with the President's previous record of support and would add Presidential level leadership to the issue. There would certainly be intense debate in Congress over the inclusion of abortion, and limitations would undoubtedly be placed if coverage survived the debate. This option would remove the President from direct blame for its defeat or modification, focussing attention on Congress instead.

OPTION 2: Exclude abortion services from the national core package and leave coverage decisions to the states. A sub-option might be to mandate for coverage at the state level for low income women only through a supplemental package.

By placing the decision at the state level, the President and Congress would be removed from direct attack. Leaving the abortion issue to the states would be consistent with the general principle of state flexibility being followed throughout the reform. The combination of state flexibility with mandates to cover low income women would gain some support among women's groups and soften the opposition of those opposed to all coverage.

Bumping this issue down to the states would be politically contentious and potentially inequitable. Some would accuse the President and Congress of backing down. In a completely flexible arrangement, some states would choose not to cover abortion services at all, perpetuating the current unfairness. Even with a mandate on coverage for low income women, middle class women might face unequal distribution of services.

OPTION 3: Exclude coverage of abortion services in the core benefit package.

This option would mollify opponents of abortion and keep the focus of health care reform on system change, but women's groups and liberal Congress members would view it as a serious breach of commitment by the President. It is even possible that the President could lose key liberal votes for the overall health care reform package by excluding abortion coverage without any alternative strategy.

THE WHITE HOUSE

WASHINGTON

April 12, 1993

MEMORANDUM FOR VINCE FOSTER

SUBJECT: Health Political/Policy Working Team

FROM: Mike Lux

One of the most worrisome policy/political decisions we have to make on the health care reform package is what to do in the medical malpractice tort reform area. The political/ communications team that has been working on health care decided that we should set up three working teams to think about resolution of our most problematic issues, and one of the groups will be on medical malpractice tort reform. We would like you to lead this team. I plan to be involved in coordinating the work of all three teams, and will be a part of all of them.

I would recommend that someone from the tort reform issue working group be on our team, as well as Celia Fisher or someone else from the DNC, and anyone else you think appropriate.

Major Issues

The political dynamic we find ourselves in is obviously a tough one. We need to give some concrete things to doctors and hospitals to compensate for what we're taking away from them, and tort reform is a very big symbol to them. It's an important symbol as well to the business community, and we must draw significant business support to pass the package.

On the other hand, if we are to keep our Democratic base together, we will have a very tough time if we are warring with the trial lawyers. Single payer advocates are already feeling nervous about our plan, and all of them are also close to ATLA. Key Senators like Hollings, Biden, Metzenbaum, and others are also unlikely to cross ATLA. And leaving this issue aside, you know better than anyone what kind of position the DNC would find itself in with trial lawyers at war with us.

The good news is that the trial lawyers have already dropped their long standing position of total opposition to any federal involvement in the area of tort reform. There are things we are thinking of they are begrudgingly willing to swallow, including:

- making all law suits against health plans, instead of individual providers.

- setting up practice guidelines/standards of care, so that if a provider follows those standards, a lawsuit could be thrown out.

- requiring a doctor's affidavit explaining how a procedure was done wrong before a lawsuit can be filed.

- requiring that contestants try to resolve things through mediation before going to court.

The two things that we are considering that they violently oppose are any kind of limitation on contingency fees, and caps of non-economic damages. The latter is the one that engenders the most violent opposition.

Summary

We would like you, if you are willing, to convene your team ASAP to come up with a recommended course of action for the President. If other commitments make you unable to work on this project, let me know as quickly as possible.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Distribution Re: Upcoming CBO Reports (2 pages)	4/15/93	P5
002. list	Senate Finance Committee (14 pages)	4/19/93	P5
003. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Legislative/Congressional Distribution List (2 pages)	4/20/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

FOLDER TITLE:
April 1993 HSA [2]

gf77

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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SPECIFIC POINTS TO HIT IN DISCUSSIONS WITH THE FINANCE MEMBERS

* State Importance of Finance Committee. The Finance Committee feels that it is the most important Committee in the Senate, particularly as it relates to health care reform. It is, therefore, advisable to acknowledge the Committee's role and history, as well as the many Members who have been active in health reform. (See attached summaries).

* Discuss Importance of Bipartisan Effort. It is important to stress how determined the President and you are to making the work on this legislation a bipartisan effort. Acknowledge the longstanding tradition of bipartisanship on the Finance Committee. (If the Republicans complain about how they have been treated inequitably, you may want to acknowledge that they have been treated on a somewhat separate basis, but also on an equal basis. You could cite the numerous meetings -- see attached list of meetings -- that we have held with Members and/or staff).

* Provide Update on Timing of President's Decisions. Acknowledge the two week delay in forwarding the final working document to the President, but ONLY two weeks. Stress that you anticipate that the bill will be unveiled and introduced soon thereafter.

* Illustrate Commitment to Pass Health Care This Year. Because of the doubts surrounding health care, it is advisable to emphasize that the President is strongly committed to passing health reform this year.

* Illustrate Understanding of Timing and Process Constraints. Acknowledge that the Finance Committee will kept very busy if it is to mark-up both the Reconciliation bill and then the health reform initiative. Reiterate that it is the President's desire to do just that, though, and how confident the President and you are that this will be achieved with the bipartisan cooperation and guidance of this Committee. (If any question is raised about the Committee jurisdiction issue, you should probably state that the President and you will be working closely with the Congressional Leadership on the matter, but that you could not imagine that the Finance Committee would not have significant [redacted] jurisdiction over the bill).

* Give Commitment to Consultation. Indicate how determined the President and you are to building on the consultation that has already taken place. Discuss how committed the President and you are to consulting with Senator Mitchell, Senator Dole, Chairman Moynihan, Senator Packwood (the Ranking Republican of the Finance Committee) and the rest of the Committee over the next few weeks.

* Acknowledge Perception Problem that Decisions are Made. Acknowledge how anyone reading the papers might conclude that decisions about cost control and financing have been made. Explain how this is not the case, and that the President does not desire to make final decisions in this regard until after he has had direct conversations with the Senate and House Leadership (including committees) from both sides of the aisle.

* Provide General Outline of Direction the President May Be Headed. Although some Members have heard Ira give a general outline of the likely direction health reform is going, many (and all Republicans) have not. This should not be a long or detailed discussion, but it would be good to illustrate your command of the complexities of health reform. Although they (will then) know no decisions have been made on cost containment and financing, they will want to hear you at least acknowledge the issues. Since virtually every one of these Members are from predominantly rural states, some likely to be well received issues you or Ira may want to touch on are rural and state flexibility issues.

* Request Suggestions, Guidance, and Questions. As is the case with all Members, they will want to give their own views. So you do not have to do a monologue, and go into all the difficult issues on your own. Throw back some of the questions to them. They will be appreciative of the opportunity to speak and be heard.

* Consider Concluding with a Suggestion for Another Finance Committee Meeting. Because this Committee is so critical, just as you are doing with the Ways and Means Subcommittee, you or Ira and Judy should seriously consider suggesting holding substantive meetings with this Committee during the next few weeks.

SENATE FINANCE COMMITTEE

DEMOCRATS

DANIEL PATRICK MOYNIHAN (D-New York) (Finance Committee Chairman)

As you know, the new Chairman has yet to take a position on national health reform. His interests lie primarily in the areas of Social Security and welfare reform. He is not a detail person when it comes to the health care debate. Although a number of people have discussed health care with him, it is notable that the one who seemed to catch his fancy the most was Alan Enthoven.

The only health care-specific issues that the Senator is particularly known for are: (1) his advocacy and support of New York hospitals, (2) his concern about the mentally ill and the homeless, (3) his support for chemical and substance abuse in a benefit package, and, most recently, (4) his support of innovation at the state level. On the latter point, he introduced a liberalized Medicaid managed care measure that the NGA strongly supported. (This legislation was opposed by the Children's Defense Fund because they felt that savings through this cost containment approach would be at the expense of the Medicaid population).

Most recently, the Chairman and his staff have been rather pessimistic about the chances for health reform this year. The compexity, controversy, and potential expense of it frighten them. The Chairman, in comments that have been somewhat retracted by staff, has indicated his concern about any large new taxes to fund the program and any use of price controls to contain costs. Although he has stated to you his willingness to raise whatever tax is necessary for the elimination and integration of Medicaid into the new system, as well as a one card for all system, his nervous statements should not be totally written off.

Senator Moynihan's most recent communication was in a letter to the President, in which he reiterated his strong support for a health security card and in which he proposes the idea of merging the health card and Social Security card into one. In the letter, he also expressed his strong concerns that the Social Security Commissioner has not yet been appointed.

MAX BAUCUS (D-Montana)

In health circles, Senator Baucus is best known for his early 1980s work to reform the private Medicare supplemental "Medigap" insurance market. The provisions came to be known as the "Baucus" Amendments, for which he is very proud. In addition, Senator Baucus was a member of the Pepper Commission. Most notably, however, he voted against the final access recommendations (they won by just an 8-7 vote), primarily because of his concern about the proposal's impact on small business. Baucus is concerned about any proposal that utilizes any employer requirement to help finance health care. As a result of this concern, and because the Canadian system is quite popular in Montana, he is a single-payer advocate.

He is a member of a 5-Member working group (Daschle, Kerrey, Bingaman, and Wofford) that is looking at alternatives to employer-based models. This group wrote to you on February 3rd on principles which should be incorporated into a managed competition framework including universal participation (no opt-outs), state or regional administration, and phase-in of coverage for long-term care. More recently, on March 30th, he sent a letter with 8 Democratic Senators from rural states expressing their belief that the allocation of health budgets among states should not be based on historical costs but on the true cost of providing appropriate level of care to a state's residents.

Senator Baucus believes health reform must include real cost containment, sensitivity to legitimate small business concerns, and the advisability of a special consideration for rural concerns. We have been advised by staff that he is very committed to the concept of every citizen being in the health allisance (or HPIC). In addition, he apparently would be supportive of a VAT tax for health care.

DAVID BOREN (D-Oklahoma)

Although not generally associated as a health care reform leader, Senator David Boren is the lead sponsor of the Senate companion (S. 3299) to the House Conservative Democratic Forum's managed competition bill. In recent months, however, he has become more sensitive to the inability of the Conservative Democratic Forum's approach to adequately address the access or cost containment challenge. Like virtually every member of the Committee, he considers himself to be a strong supporter of rural health and small business issues. Like Senator Bradley, though, he has been traditionally more focused on tax policy than health care.

There have been some exceptions to the rule of Senator Boren's non-interest/association with heath care. In addition to the CDF bill, he is now supporting the concept of significant state flexibility within the context of any health reform proposal (OK Governor Walters is pushing a major initiative now and wants some significant assistance/relief from the Federal Government). In addition, he sponsored legislation last year to provide for an extension on higher payments to rural hospitals that disproportionately serve Medicare patients. (This legislation passed the Congress, but was vetoed when then President Bush vetoed the tax bill).

BILL BRADLEY (D-New Jersey)

Senator Bradley is known more for his work on tax policy than for his work on health care financing. He has indicated an interest in introducing health care reform legislation similar to managed competition model that he believes the President has been advocating. The one exception to his general support of the Clinton health care approach may well be with regard to prescription drugs. As a Senator representing the state which is the capital of the pharmaceutical industry, Bradley is a fierce advocate for the industry and their concerns. With Senator Hatch, he led the fight against Senator Pryor's effort to influence the industry to contain price increases to inflation by linking their pricing behavior to eligibility for tax credits. (The Pryor proposal was endorsed by President Clinton in the campaign).

As a member of the Infant Mortality Commission, Senator Bradley is proud of his work to ensure that the Medicaid program was expanded to eventually cover pregnant women and kids. He also is a strong advocate for preventative care services. He has sponsored several bills on tobacco, including revised warning labels and tobacco as a drug to be included in the Drug Free Schools program. Lastly, although he incurred the wrath of some aging groups with his opposition to prescription drug price constraint, he has been a long-time supporter of home and community-based long term care services, particularly with regard to respite care services.

GEORGE MITCHELL (D-Maine) (Senate Majority Leader)

Few Majority Leaders in the Senate's history have been as interested and as committed to passing comprehensive health care reforms. Mitchell is the sponsor of two Senate Democratic leadership comprehensive reform bills dealing, respectively, with access (S. 1227, Health America) and long-term care (S. 2571, the Long Term Care Family Security Act).

Senator Mitchell is leading an effort by the Democratic Policy Committee (within the Senate) to attempt to develop consensus on the health care issue within the Democratic party. For weeks now, Ira and Judy have been holding very successfuly briefings with, on average, 30 plus Senate Democrats a meeting.

Senator Mitchell believes that the single payer approach is not politically feasible. However, at this point, his primary concern and commitment is to push through anything, which can be defined as truly comprehensive, that will pass the Congress. He has repeatedly indicated his intention to work closely with the President to help assure that a bill can make it to the White House before the end of the 103rd Congress.

As you know, however, he was a strong advocate of incorporating the health care legislation into the budget reconcilation bill. Having failed that, he and his lead staff are now relatively pessimistic about attracting enough Republicans to support a health reform initiative without having to make major, and perhaps unacceptable, concessions. Just yesterday, (Sunday, April 18th), he indicated his opposition to price controls, his uneasiness with but possible openess to a VAT tax for health, and his desire to wean out all the fraud, abuse and waste BEFORE contemplating large tax hikes.

DAVID PRYOR (D-Arkansas) (Aging Committee Chairman and Secretary of the Senate)

Senator David Pryor is part of the Senate leadership (Secretary of the Democratic Conference). As the Chairman of the Senate Special Committee on Aging, he is well liked and respected by the powerful aging advocacy community. In addition, he is one of the few Democrats that the small business community genuinely trusts. Further, his status as a former Governor and his advocacy of state-based approaches to comprehensive reforms has gained him a great deal of good will with the Governors. Although an unassuming Member and one who does not get overly involved in detailed policy discussions, he has also emerged as one of the most influential and best liked Members of the Senate. All of these roles ensure that he will be a particularly key player on the health care front.

In terms of health care priorities, drug cost containment is the first, second, and third highest priority for Senator Pryor. The concept of linking drug cost containment to tax credits (embodied in Pryor's Prescription Drug Cost Containment Act -- S. 2000) was endorsed by President Clinton.

In addition to his drug cost containment interests, he also has a notable legislative achievement record in rural health (relief for hospitals and incentives for primary care doctors in medically underserved areas), state-based reform (his NGA and Clinton candidate-endorsed Leahy/Pryor bill), and long-term care (his proposal for Federal standards for private long-term care insurance policies).

DONALD REIGLE (D-Michigan) (Finance Medicaid Subc. Chairman)

Senator Riegle considers himself to be a major player in the health care debate. He is Chairman of the Finance Subcommittee on Medicaid and was a lead sponsor of the Mitchell, Rockefeller, Kennedy "play or pay" health care reform proposal. He has always felt he did not get adequate credit for his work on the bill. Although he sponsored this bill, he appears to be extremely willing to sign on to virtually any approach that achieves universal coverage and cost containment.

Senator Riegle is very interested in many health issues, including: child immunization programs, rural health care, Medicare prescription drug coverage, retiree health liability concerns, long-term care, and a host of others. Senator Riegle strongly believes that cost containment savings should be used to help reform the health care system -- NOT for deficit reduction.

Most recently, Senator Riegle has pushed his outreach efforts with the Medicare Qualified Medicare Beneficiary (QMB) program. The QMB program pays for the deductibles, premiums and copays of low-income Medicare beneficiaries. Unfortunately, only about 50 percent of the eligible population receive the benefit. This program, because it is partially underwritten by the states, is one of the most unpopular benefits that the states support. (Most of the states believe there are higher priorities). At any rate, Senator Riegle has introduced legislation to expand outreach efforts at SSA offices and other areas. (The Administration has not yet taken a formal position yet).

JAY ROCKEFELLER (D-West Virginia) (Finance Medicare Subcommittee Chairman)

Senator Rockefeller views himself as being (and is) Bill Clinton's number one health care advocate. He was a tireless campaigner and defender of the Clinton health care plan and was a National Co-Chair of the Clinton campaign. Rockefeller is the current Chairman of the Finance Subcommittee on Medicare and Long Term Care. He also has chaired the Pepper Commission and the National Commission on Children.

In addition, Senator Rockefeller is the founder and Chairman of the Alliance for Health Reform, a nonpartisan organization dedicated to advance health care reform through education of public opinion leaders. Lastly, as you well know, his is now serving as the new Chairman of the Senate Veterans Committee.

Senator Rockefeller's health care priority is very simple: He desperately wants to see a comprehensive reform package enacted during the Clinton Presidency. Although he thinks the long-term outcome of such an achievement is politically attractive, he is primarily pushing this reform because he is sincerely committed to the need for reform. In this vein, he is not overly committed to any one particular approach although he has advocated an employer-based approach. He, therefore, can be counted on to support virtually anything the President ends up proposing, as long as it achieves universal access and cost containment.

Senator Rockefeller was very pleased with the Veterans' meeting last Thursday. He was concerned about the the AP story the day after, but from the beginning did not believe it was true.

As you know, he has requested a meeting with you to discuss substance and strategy. He very much wants this to occur this week. He feels he needs a substantive background briefing to be at his best in his role as cheerleader in the Congress and with the press. At that meeting, it is my understanding through Steve Ricchetti and his staff that he may extend an invitation to you and the President to go out to his house for dinner. If you wish to come, he will suggest you using his house and the event for whatever purpose you want: to have a quiet dinner out or to use it for a backdrop for a social occasion for appropriate guests interested in health reform.

TOM DASCHLE (D-South Dakota)

Senator Daschle is the Co-Chair of the Democratic Policy Committee (with Majority Leader Mitchell) and he is one of the more well informed Democratic Members on health care issues. In his brief tenure, he has already become very well known in this arena, particularly through his work on rural health and Medigap insurance reform issues.

Senator Daschle and his staff are participating in (and helping run) Senator Mitchell's DPC working group, but he has also been a leader of a separate working group (Kerrey, Bingaman, Wofford, and Baucus) that was developing alternative approaches to health reform. This group has been relatively quiet lately, seeming to be comfortable with working with and through the DPC health policy group.

Personally, Daschle is much more comfortable with a single-payer type approach to health care, primarily because he believes it is a much easier political sell to his small business folks and the rest of his constituents. He joined Senator Harris Wofford in introducing legislation (S.2513) to achieve this end. Daschle is a team player, however. As part of the Senate leadership, he can be counted on to push his agenda as far as it can go, but he will also do everything he can to assure that we pass comprehensive reform and the President's plan.

In addition, Senator Daschle is one of the signatories of a March 30th letter opposing the allocation of the global budget among states based on historic costs. He is very concerned that rural states would be discriminated against using such a formula.

Senator Daschle also worries that people don't understand the real costs of the current health system and how they are paying too much in direct and indirect spending. He feels that education regarding these costs are critical so that people don't feel the new system will cost them too much money. Lastly, Senator Daschle also supports restructuring graduate medical education to emphasize primary care.

Most recently, Senator Daschle has requested that you join him in South Dakota at some health care event at some point in the future. We are trying to be responsive to a request by him to get someone from with working groups to go to an early May event that he is holding. (We may also ask you to do a satelite feed for this event).

JOHN BREAUX (D-Louisiana)

Senator Breaux is the second most junior Member of the Finance Committee. He is one of those "up and coming" New Democrats for whom many see a bright future. His politics are moderate to conservative but he is known more as a pragmatist than a idealogue. In the area of health care, Breaux is yet another of the Committee members who care deeply about small businesses and rural health care.

Previous to this year, Senator Breaux was not overly active in health care issues. That changed when he introduced the Conservative Democratic Forum's managed competition bill with Senator Boren in 1992. He is very concerned, however, about the bill's limitations with regard to assuring adequate access to health care in rural areas. He is also concerned about whether this approach will actually achieve broad-based costs savings. Despite this, he remains uncomfortable with alternative approaches and he will want to make sure that the Conservative Democratic Forum's model is used as much as possible during the upcoming debate. He opposes price caps and freezes to control costs.

KENT CONRAD (D-North Dakota)

Kent Conrad is the newest member of the Senate Finance Committee. Senator Conrad is known as a "budget hawk." Strong cost controls will be critical for his support. He will look closely at the financing package and how the reform plan impacts the federal deficit. He opposes large new taxes to support reform.

Senator Conrad's foremost health concern is rural health care. He is concerned both with how rural health care will be addressed in the context of managed competition as well as current access and delivery issues. He is aware of successful models from his state -- one a network of clinics, the other an HMO -- which have been able to increase access to primary and preventive care. He signed the March 30th letter opposing the allocation of the global budget among states based on histoci costs. He is also an advocate for the need to improve and increase funding for the Indian Health Services. Insufficient funding has led to rationing of services. He also feels the IHS has not been sufficiently responsive to Congress or tribal leadership.

Most recently, I (Chris J.) and Christine gave him a general health care background briefing. (He had missed one given by Ira and wanted a private meeting). He was very appreciative and appeared to feel much better about the direction the President andyou are heading by the conclusion of the discussion.

REPUBLICANS

BOB PACKWOOD (R-Oregon) (Finance Ranking Republican Member)

Senator Packwood is an advocate of an employer-based universal coverage plan. He is the only Republican on the Finance Committee that has publicly supported an employer mandate and as a result, putting him in a somewhat uncomfortable position with many in the Senate leadership--who vehemently oppose an employer mandate.

Packwood attacked his opponent's (AuCoin) single-payer approach last year as a multi-billion dollar tax increase that would result in a government run system. The primary criticism of Packwood's plan was that it didn't go far enough on the cost containment side. Some of the aging advocacy groups also criticized it for its lack of comprehensive long-term care coverage. In Oregon, at least, Packwood won the debate.

Beyond the above-mentioned work, Senator Packwood has had a notable health care career. He has sponsored quite a bit of legislation dealing with rural health and long-term care (LTC). Specifically, he introduced a relatively extensive public/private LTC bill in the 101st Congress. However, because it costed-out as a rather expensive initiative and because the aging advocates were not enthralled with it, he decided to stick to Federal standards and tax clarifications for private LTC insurance policies. In addition, working with Pryor, he introduced legislation that could provide tax credits for primary care personnel to serve medically underserved rural areas.

ROBERT DOLE (R-Kansas) (Senate Minority Leader)

The Minority Leader is, without question, the most influential Senator among Republicans. As an ally, he can be absolutely invaluable. As an enemy, he can be vicious and effective. Currently, it appears he is trying to decide whether health care reform should be a partisan or a bipartisan issue. Dole and his staff will probably opt to appear to be willing to work with the Democrats, but will eventually choose to turn on the new Administration on the reform issue.

Senator Dole has a strong interest in rural health and is currently Co-Chair of the Senate Rural Health Caucus. Legislatively he has supported initiatives to protect the viability of small rural hospitals as well as to expand civil rights protections and services for the handicapped.

Yesterday (Sunday, April 18th, on Meet the Press), he indicated his opposition to price controls, his concern about large taxes without delivering on cost containment first, and his hesitancy about a VAT tax unless it is used to replace or offset other taxes. Although it may well be an impossible task, we must continue to work to at least try to get him on board with us. If we do not succeed, we might have some success in attracting other moderate Republicans for making the effort to obtain Dole's support.

WILLIAM (BILL) ROTH (R-Delaware)

Until the last couple of Congresses, Senator Roth was not known for his involvement in health care. As Ranking Member of the Government Affairs Committee, he has had extensive involvement and interest in the Committee's Permanent Subcommittee on Investigation's inquiry into the multi-billion dollar issue of health care fraud and abuse.

More recently, Roth has actively advocated that the Federal Employee Health Benefit Program, which the Government Affairs Committee oversees, be extended to the working uninsured and small businesses. (This is similar to, and builds on, a proposal that has been championed by the Heritage Foundation.) Under this proposal, the self-employed and working uninsured would have access to the FEHB plans that were utilizing managed competition as a cost containment/quality assurance mechanism. In so doing, these individuals would have access to the same rates that the insurers charge the federal government and their employees for the benefits.

JOHN DANFORTH (R-Missouri)

Senator Danforth is to cost containment what Bob Packwood is to mandates. He is the most likely to state that strong federal/state caps on spending must be imposed to effectively contain health care costs. He states his strong views on this issue repeatedly, despite admonitions from his staff and other Republicans that such statements are not consistent with the Republican Party line.

Although willing to support the need for strong government cost regulation, he also believes that to do so would require explicit rationing. (He is a big fan of the Oregon waiver). What is more, unlike most Democrats, he desires to publicly proclaim that rationing is necessary and something we must own up to.

JOHN CHAFEE (R-Rhode Island) (Finance Medicaid Subc. Ranking Republican)

Senator Chafee is the Chair of the Republican Task Force on Health Care. He likes to point out that the bill they introduced in the last Congress had the most cosponsors of any major comprehensive health reform bill. He was not pleased with last year's health care debate with the Democrats. He believes that, if not for Presidential and partisan politics, there was enough consensus between his and many Democrats' bills to move forward on many high priority health reform proposals such as: self-employed tax deduction increase to 100 percent, insurance market reform, expansion of community health centers and other health care delivery systems, and state experimentation.

On the Committee, Senator Chafee is primarily known for his long-standing interest in providing alternative care settings -- through the Medicaid program -- to persons who are disabled. He and his staff are literally heroes with many in this field, particularly those who advocate non-institutional care approaches. He is also well known for his strong advocacy of, and relationship with, community health care centers. In addition, he -- like a number of the Finance Committee membership -- are growing weary of funding programs for the elderly when there are so many needs in the non-elderly population.

As you know, we have been trying for weeks to invite Senator Chafee to talk with Ira. We sense that he and his staff want desperately to come in, but are afraid to alienate Dole. On Friday (April 16th), though, I (Chris J.) received a call indicating that he might come for a meeting. We will have to wait until Monday or Tuesday to get a confirmation. We will keep you informed.

DAVE DURENBERGER (R-Minnesota) (Finance Medicare Subc. Ranking Republican)

Senator Durenberger is one of the Committee's most well versed Members on health care reform. He also is one of the few Members who has served concurrently on the Labor and Human Resources Committee (the other major health care committee) and the Finance Committee. He is a moderate who is viewed by the Republican leadership as somewhat of a loose cannon. Because of this and his long-standing interest in health care reform, Durenberger, too, is a candidate to be a possible and important ally.

In the last Congress, he joined Senator Bentsen as the lead Republican on the Texas' Senator's incremental (insurance market reform, etc.) health reform initiative. He has been a key health care player for years, however. He now is the Ranking Republican on Jay Rockefeller's Subcommittee on Medicare and Long Term Care, and he has served as either a Chairman or Ranking Member of this Committee for years. In addition, he served (as a Vice-Chair) on the Pepper Commission. While he joined all the other Republicans in voting against the access recommendations of this Commission, (he did vote for the long-term care recommendations) it is important to note that it was unclear that Durenberger was going to vote against the Pepper Commission recommendations until very late in the process. An important offshoot of this experience, though, was that he and Jay Rockefeller forged a close working relationship.

Most recently, Durenberger has focused on state-based comprehensive care initiatives. This is because he does not believe that a consensus yet exists for national reform and because his own state is tired of waiting. Minnesota has a long tradition of moving ahead on health care reforms and is THE nation's capital of managed care/HMO delivery systems. It is one of the 5 or 6 states that has gone ahead and passed legislation to implement its own reform proposal. Since Minnesota has historically been more efficient in terms of the delivery of health care, Senator Durenberger will be very concerned about the allocation of the global budget, particularly that it does not reward the inefficient at the expense of the efficient.

Last week, Senator Durenberger called me (Chris) to talk a little strategy and health policy substance. He indicated his nervousness with any price controls. He said he thought we could get some savings for speeding up implementation of the new physician payment system. He also urged us to find a way to fold in Medicare into whatever we do. Lastly, he again asked for a meeting with Ira. It has been arranged for Wednesday, April 21st, at 11:00.

CHARLES GRASSLEY (R-Iowa)

Senator Grassley is one of those Senators who can give the impression (because he is far from a detail-oriented person) that he is less than sharp and is not a significant player. This is not the case. Although he may not be extremely quick, he has a very sensitive and accurate gut for politics and policy and, with a very capable staff, he has managed to become quite an effective Member of the Committee.

Grassley's primary health care interest has been related to rural health care. He, again like most other Members of the Committee, has been greatly concerned about perceived inequities in reimbursement to rural providers.

ORRIN HATCH (R-Utah)

Senator Hatch is relatively new to the Committee having joined during the last Congress. He is one of the brightest individuals in the Senate, but has yet to really get a comfortable grasp of the Finance Committee. Although he is well known for his very conservative philosophy, he has in recent years appeared to become more open to more traditionally moderate approaches. For example, although he is close with the drug industry, he has been willing to push them to be more responsive on pricing issues.

Up until 1993, he served as either the Chairman or the Ranking Republican of the much more conflict-oriented Labor and Human Resources Committee. In this capacity, he became extremely well informed about PHS, NIH, and FDA issues. On health reform issues, he can be expected to be very supportive of market-oriented reforms to the health care system. In that vein, he will be extremely uncomfortable with employer mandates and discussions of global budgeting and enforcement. He has introduced legislation to reform the medical malpractice system and sees this as an important means for reducing health care costs.

MALCOLM WALLOP (R-Wyoming)

Senator Wallop was just renamed to the Finance Committee this term. In his previous tenure (1979-1988) he demonstrated an interest in rural health concerns but focused primarily on tax matters. He is known for his very strong conservative views. In the last Congress, he cosponsored the Republican reform bill and Senator Hatch's bill to improve the medical liability system. If there is one Member of the Committee we can almost certainly write off as a possible supporter, it is Senator Wallop.

DATE	MEMBER(S)	MET WITH	SUBJECT
2/4	DOLE/CHAFEE	HRC/ICM/JF	process, general discussion
* 2/23	DURENBERGER	HRC/ICM	
3/10	Senate Republican Members Bond Burns **Chafee** Cohen Craig Danforth **Dole** Durenberger Gregg Kassebaum Mack Murkowski Nichols Packwood Roth Simpson Stevens Thurmond (others were present as well)	HRC	general discussions about process and about directions for/components of reform
* 3/10	JEFFORDS	ICM	
3/12	Senate Republican Staff	ICM	
3/23	Senate Republican Staff	Walter Zellman Rick Kronick Lois Quam	New System Development Governance
4/1	Senate Republican Staff Sheila Burke Christy Ferguson Ed Mihulski	ICM	short-term controls
4/19	Senate Republican staff	Gary Claxton	Insurance Reform

* Individual Meetings.

MEMORANDUM

Privileged and Confidential

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: House Targeting Strategy
cc: Legislative/Congressional Distribution List

April 20, 1993

As was done with the Senate, a targeting session was held to determine the key congressional districts needed to pass health care reform. To pass this bill a simple majority of 218 votes will be required. While the overall strategy is similar to the Senate, successfully achieving this goal will require a somewhat different approach.

House members, since they face reelection every two years and represent, on the whole, more homogeneous constituencies, tend to be more responsive to public pressure and to particular concerns of their district. As a result, more so than the Senate, the substance of our health care reform package, especially the financing mechanisms, the employer role and the overall cost of the package, will play a much more significant role in how members will vote.

Particular elements of the package have the potential to shift large blocs of votes. For example, decreasing the burden on small employers may increase the package' attractiveness to both Democrats and Republicans. In addition, if the package includes a long-term care benefit that seniors groups are excited about it may increase are ability to attract more conservative members from states with large elderly populations whom we would otherwise have little expectation of attracting.

Consultation with the House Leadership yielded 79 members who they are confident will support the reform bill. To reach our goal of 218 from there, will require the targeting of roughly 250 members. The states targeted for our Senate strategy match well with those targeted for the House, particularly the Republicans. In addition, in nontargeted states existing DNC resources can be coordinated with resources of friendly interest groups and of supportive Congressional, State and Local officials to mobilize on the local level as needs arise.

Here in Washington, we must work with leading House members, through the various caucuses and with the help of influential interest groups to build a coalition of 218 members. From the base of 74 the leadership identified, we added members of the three committees of jurisdiction (Ways and Means, Energy and Commerce and Education and Labor) and members of various caucuses which should contain substantial support if we are to be successful (Congressional Black Caucus, Congressional Hispanic Caucus, Congressional Women's Caucus, Mainstream Forum, and the Rural Health Task Force).

Selected members of the rank and file and the large freshman class were also targeted. Many of these have endorsed Rep. McDermott's single payer bill, the majority of whom we will need with us in the end.

In addition to the Democratic members, a group of moderate Republicans, were also identified. In selecting this group, votes on the Family and Medical Leave Bill and the Minimum Wage increase (for those members who have served more than 2 terms) were analyzed. This group may well provide the margin of victory.

Attached is the House Leadership's list of reliable votes for health care reform as well as a lists of the targeted Democratic and Republican members by state. Pertinent information such as relevant committee assignments, caucus membership, bill sponsorship have been noted. Since support will depend very heavily on the specifics of the package, this list may be modified as decisions are made regarding the proposal itself. Finally, by combining the information from these House lists with the Senate list, including committee assignments and voting records, an overall state target list by rank was created.