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001. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senator Ford (11 pages)	5/27/93	P5
002. memo w/attach	Chris Jennings , Steve Edelstein Re: Meeting with Senator Kerrey (19 pages)	5/27/93	P5

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May 1993 HSA [6]

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gf86

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~~PRIVILEGED AND CONFIDENTIAL~~
M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senator Ford
cc: Melanne, Steve, Distribution

May 27, 1993

Tomorrow you are scheduled to meet with Senator Ford. The purpose of this meeting is to establish a dialogue and a relationship in preparation for future negotiations regarding possible tobacco tax provisions as part of financing package for the health reform initiative.

In attendance will be Miles Goggans, special assistant to the President on Agriculture. Attached for your review is (1) a memo discussing the impact of a possible cigarette tax on tobacco production and the potential cost of ameliorating that impact (2) a memo prepared by USDA which provides a background on tobacco (3) a memo from USDA to Miles Goggans outlining the various ways tobacco receives support from the Federal government, and (4) a summary of Senator Ford's health background.

BACKGROUND:

Senator Ford wants very much to be the dealmaker regarding any tobacco tax that included in the financing provisions of the Administration's health reform plan. As you know, tobacco is a significant part of Kentucky's farm economy and as such any tax on tobacco will have a major impact on key constituents of his state.

Senator Ford has a well earned reputation in the Senate for aggressively protecting his home state interests. However, in previous discussions with the Senator he has indicated some willingness to discuss a tobacco tax as long as there was some effort to help the Kentucky's tobacco growers.

Senator Ford does not view this meeting as a deal cutting meeting, but rather a general discussion of the issues and an opportunity to establish a relationship to facilitate such a meeting at a future date. You may wish, however to use this meeting as an opportunity to demonstrate your understanding of the issues surrounding the tobacco tax and farm subsidies.

You may also wish to seek Senator Ford's opinion about the advisability of including Congressman Rose at future discussions between you and the Senator on this issue. Congressman Rose of North Carolina envisions a similar deal making role on a tobacco tax for himself in the House.

ATTACHMENT 1

Cigarette Tax Increase and Tobacco Quota Buyout

The Administration, some members of Congress, and others have proposed raising cigarette excise taxes to help pay for health care reform. Different amounts of increase have been proposed but they range from a few cents to \$2.00 per pack. To evaluate the full potential effects of the increase we will assume the tax is jumped \$2.00 per pack.

An increase of \$2.00 per pack of 20 in the Federal excise tax would reduce U.S. cigarette consumption by 25 to 40 percent from 500 billion to 300 to 375 billion cigarettes. As a result, U.S. tobacco production could fall as much as 30 percent.

To soften the impact of the decline in U.S. tobacco production, a proposal has been made to pay quota owners to retire unneeded quotas. Quotas are pounds of tobacco for which government price support is available. Since quotas cannot be sold between counties, the capitalized value of quota varies widely from as little 25 cents in some marginal producing counties to as much as \$3.50 per pound in some of the most extensive producing counties. A wider variation probably exists for burley quota values than for flue-cured but both vary considerably. Burley and flue-cured are the major cigarette kinds of tobacco grown in the United States. Burley is grown mainly in Kentucky and Tennessee and flue-cured is produced mostly in North Carolina, South Carolina, Georgia, and Virginia.

The average capitalized value of flue-cured and burley quotas probably averages \$2.00 to \$2.50 per pound. For illustrative purposes, we will use \$2.25 per pound. In 1993, the flue-cured effective quota totals 890 million pounds and the burley effective quota totals 730 million pounds. If an additional \$2.00 per pack excise tax was imposed, flue-cured and burley quotas would fall about 500 million pounds. The flue-cured quota would fall about 230 million pounds and burley about 270 million pounds because of the decline in cigarette consumption and cost-saving measures for producing cigarettes. The relative decline in burley would be greater because a larger share of burley is used domestically to produce cigarettes. At an average rate of \$2.25 per pound, it would require about \$1.1 billion to buy out the unneeded burley and flue-cured quotas. In addition, if other tobacco product taxes were increased at the same rate as cigarettes, another \$100 million would be required to purchase fire-cured, dark air-cured and cigar acreage allotments (Production is controlled by acres rather than pounds for these kinds).

There are about 450,000 individual tobacco quota owners in 15 states in the United States. Around 300,000 or two-thirds are burley quotas. There are about 55,000 flue-cured quotas and 95,000 fire-cured, dark air-cured, and cigar acreage allotments. About 200,000 of the burley quotas are 2,000 pounds (1 acre) or less. These quota owners would likely have the greatest interest in selling quota. Flue-cured quotas are much larger averaging

over 16,000 pounds per quota. A likely scenario might see 125,000 burley quotas, 15,000 flue-cured, and 30,000 other allotments retired.

An increase in the Federal cigarette excise tax would clearly increase Federal revenues. A \$2.00 a pack increase in the excise tax could increase Federal tax revenues \$30 to \$35 billion. However, consumption would likely decline more than could be attributed to the Federal tax increase because States would likely increase their excise taxes and manufacturers would likely increase prices more than the amount of the tax increase to recover losses from lower cigarette consumption. The additional decline in consumption attributable to factors other than the Federal tax increase would represent a reduction in potential tax receipts. Consequently, Federal excise tax collections after a \$2.00 hike might be closer to \$25 billion than \$35 billion.

Gains from the increase in Federal tax revenues with a higher cigarette tax would be offset by several losses. State taxes would decline by \$2 to \$3 billion (unless rates were increased), both agricultural and nonagricultural jobs would be lost-- estimates indicate 1 to 1.5 million jobs could be lost. Some community infrastructures could be decimated by reductions in tobacco production, particularly marginal producing areas. Tenants, farmworkers, tobacco warehouse operators, chemical, fuel and fertilizer dealers, bankers, equipment dealers and others

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together with former tobacco growers might well leave some tobacco growing areas.

Although a buyout of quotas would soften the impact of reduced tobacco production in local economies, there is a concern that much of the money would not be reinvested locally. Consequently, other economic assistance in addition to a quota buyout might be needed. Clearly, tenants who own little or no quota would be hurt by a big drop in tobacco production and farmworkers employment opportunities would be reduced.

Because tobacco farms are small, traditional crops such as corn and soybeans do not come close to replacing tobacco as a source of income. Other high value crops such as vegetables offer only limited opportunities because these crops can be produced more economically in other areas. Consequently, other economic assistance in addition to a quota buyout might be needed to retrain tenants and farm operators for off-farm jobs, explore alternative agricultural enterprises and provide training for a limited number of people, provide investment capital for new farm and nonfarm business ventures to generate economic activity and help replace the tax base lost because of reduced tobacco production. Although tobacco farming areas would experience the greatest impact of a \$2.00 Federal tax increase, reduced cigarette consumption would cause unemployment of cigarette manufacturing plant workers, wholesalers, distributors, and retailers.

ATTACHMENT 2

MAY 27, 1993

MEMORANDUM TO: HEALTH CARE TASK FORCE
FROM: U.S.D.A.
SUBJECT: BACKGROUND ON TOBACCO

Tobacco is produced in 20 states. In 15 states, tobacco production is under the Federal price support-production control program. Growers vote whether or not they wish to be covered by the Federal program. If covered, they are guaranteed minimum prices for their tobacco. Most costs of operating the tobacco program are borne by growers and manufacturers.

Tobacco is produced on relatively small farms. There are two major cigarette kinds: flue-cured and burley. Burley is grown mainly in Kentucky and Tennessee. Flue-cured is produced mainly in North Carolina, South Carolina, Virginia, and Georgia. Burley farms are small averaging only about 3 acres of tobacco per farm. Flue-cured farms are somewhat larger and average around 25 acres per farm. About 2,200 pounds of tobacco is produced per acre. Gross income from an acre of tobacco totals nearly \$4,000 per acre. Net income totals \$1,000 to \$2,000 per acre. After falling sharply in the mid-1980's, grower incomes have increased from 1986 to 1992. However, big jumps in cheaper imported leaf is causing production to decline in 1993. Unless imports are curtailed, further declines in production are expected in subsequent years.

Traditionally, tobacco growers, warehouse operators, export dealers, and cigarette manufacturers have been united on issues facing the tobacco industry. However, large increases in imports have caused some grower groups to question their commitment to support for limiting increases in Federal excise taxes. For their support, growers are seeking a commitment from tobacco companies that they will limit imported leaf use in their cigarette blends. Some grower groups prefer that the commitments be incorporated into law because they feel cigarette companies reneged on promises of the mid-1980's to limit use of imported leaf.

The proposed Federal cigarette tax increase of \$1.00 to \$2.00 per pack of 20 cigarettes would reduce U.S. consumption 25 to 40 percent. Tobacco production would decline 25 to 30 percent. The relative decline in burley would be greater because a larger share of burley is used domestically to produce cigarettes. Because tobacco farms are small, traditional crops such as corn and soybeans do not come close to replacing tobacco as a source of income. Other high value crops such as vegetables offer only limited opportunities because

these crops can be produced more economically in other areas.

To soften the impact of the decline in U.S. tobacco production, a proposal has been made to pay quota owners to retire unneeded quotas. Quotas are pounds of tobacco for which government price support is available. The capitalized value of quotas averages about \$2.25 per pound. With a \$2.00 per pack increase in the Federal excise tax, about 500 million pounds of current quota would be unneeded. Consequently, at the current capitalized rate, about \$1.1 billion would be needed to buy out quotas. Around 170,000 of the 450,000 quotas might be sold under such a program.

In addition to quota owners, a drop in tobacco production would hurt tenants who own little or no quota and farm workers. Consequently, in addition to a quota buy out, assistance for retraining for off-farm jobs, investment capital for new farm and non-farm businesses, and exploration of alternative agricultural enterprises for a limited number of people would be needed.

Tobaccos' political base is far-reaching. It is a major source of income in 6 states and is grown in 14 others.

1991 BURLEY TOBACCO
LIST RANKING FOR EFFECTIVE QUOTAS

RANK	REPRESENTATIVE	PARTY	STATE	CONG. DIST.	POUNDS
1	Scotty Beasler	D	KY	06	162,244,766
2	William H. Natcher	D	KY	02	137,183,403
3	Jim Bunning	R	KY	04	125,365,214
4	James H. Ouilien	R	TN	01	73,014,959
5	Tom Barlow	D	KY	01	64,024,880
6	Harold Rogers	R	KY	05	52,151,602
7	Bart Gordon	D	TN	06	50,781,804
8	Jim Cooper	D	TN	04	33,992,064
9	Rick Boucher	D	VA	09	33,949,265
10	Lee H. Hamilton	D	IN	09	22,870,524
11	Charles H. Taylor	R	NC	11	20,767,283
12	~~James~~ <i>Reed</i> PORTMAN	R	OH	02	17,763,911
13	Don Sundquist	R	TN	07	15,388,842
14	John J. "Jimmy" Duncan, Jr.	R	TN	02	14,367,044
15	Cass Ballenger	R	NC	10	13,149,774
16	Stephen L. Neel	D	NC	05	9,210,333
17	Ted Strickland	D	OH	06	8,473,616
18	Pat Danner	D	MO	06	7,271,025
19	Nick Joe Rahall II	D	WV	03	4,253,729
20	Marilyn Lloyd	D	TN	03	4,191,937
21	Robert E. Wise, Jr.	D	WV	02	3,534,626
22	Bob Clement	D	TN	05	3,436,634
23	John S. Tanner	D	TN	08	1,190,785
24	Romano L. Mazzoli	D	KY	03	960,995
25	Lewie F. Payne, Jr.	D	VA	05	613,951
26	Frank McCloskey	D	IN	08	571,664
27	Philip R. Sharp	D	IN	02	447,746
28	Nathan Deal	D	GA	09	239,891
29	David L. Hobson	R	OH	07	179,462
30	Herold L. Volkmer	D	MO	09	153,938
31	Douglas Applegate	D	OH	18	140,523
32	David Mann	D	OH	01	139,006
33	Jim Slatery	D	KS	02	114,150

1991 BURLEY TOBACCO
LIST RANKING FOR EFFECTIVE QUOTAS

RANK	REPRESENTATIVE	PARTY	STATE	CONG. DIST.	POUNDS
34	Ike Skelton	D	MO	04	110,226
35	Robert W. Goodlatte	R	VA	06	97,299
36	John T. Myers	R	IN	07	72,214
37	Alan B. Mollohan	D	WV	01	63,975
38	Mel Hancock	R	MO	07	48,553
39	Bud Crumer	D	AL	05	35,994
40	Norman Sisisky	D	VA	04	25,229
41	Tim Hutchinson	R	AR	03	22,238
42	Dan Burton	R	IN	06	21,436
43	Bill Emerson	R	MO	08	11,351
44	J. Alex McMillan	R	NC	09	10,323
45	Tony P. Hall	D	OH	03	5,423
45	John A. Boehner	R	OH	08	5,423
46	Thomas J. Bliley, Jr.	R	VA	07	2,942
47	Howard Coble	R	NC	06	1,902
47	Melvin Watt	D	NC	12	1,902

1991 FLUE-CURED TOBACCO
LIST RANKING FOR EFFECTIVE QUOTAS

RANK	REPRESENTATIVE	PARTY	STATE	CONG. DIST.	POUNDS
1	Eva Clayton	D	NC	01	287,115,689
2	Tim Valentine	D	NC	02	192,090,160
3	H. Martin Lancaster	D	NC	03	162,400,167
4	Stephen L. Neal	D	NC	05	97,495,162
5	Charles Rose	D	NC	07	83,900,188
6	Lewis F. Payne, Jr.	D	VA	05	66,922,012
7	James E. Clyburn	D	SC	06	65,992,461
8	W. G. "Bill" Hefner	D	NC	08	49,931,619
9	J. Roy Rowland	D	GA	08	47,634,084
10	Arthur Ravenel, Jr.	R	SC	01	35,277,070
11	Jack Kingston	R	GA	01	34,009,365
12	Melvin Watt	D	NC	12	33,534,182
13	David E. Price	D	NC	04	29,591,644
14	John M. Spratt, Jr.	D	SC	05	25,883,888
15	Howard Coble	R	NC	06	24,029,790
16	Sanford Bishop	D	GA	02	21,334,182
17	Cass Ballenger	R	NC	10	20,949,728
18	Douglas (Petel) Peterson	D	FL	02	14,102,214
19	Norman Sisisky	D	VA	04	13,745,158
20	Corrine Brown	D	FL	03	4,693,185
21	Karen L. Thurman	D	FL	05	3,183,337
22	Floyd Spence	R	SC	02	1,190,978
23	Cliff Stearns	R	FL	06	1,022,344
24	Terry Everett	R	AL	02	734,413
25	Cynthia McKinney	D	GA	11	501,192
26	Thomas J. Bliley, Jr.	R	VA	07	434,229
27	Robert C. Scott	D	VA	03	265,047
28	Robert W. Goodlatte	R	VA	06	242,232
29	Tillie Fowler	R	FL	04	67,431
30	Earl Hutto	D	FL	01	57,970
31	Rick Boucher	D	VA	09	42,495
32	J. Alex McMillan	R	NC	09	7,841
33	Glen Browder	D	AL	03	2,320

ATTACHMENT 3

APR 68



United States
Department of
Agriculture

Agricultural
Stabilization and
Conservation Service

P.O. Box 2415
Washington, D.C.
20013

TO: Miles Goggans, Special Assistant to the President

FROM: Dallas R. Smith, Director
Tobacco and Peanuts Division

Dallas R. Smith

SUBJECT: Various Ways Tobacco Receives Support from the Federal Government and
Names of Principle Interested Parties on Capitol Hill.

BACKGROUND

Beginning with the 1982 crop, the No Net Cost Tobacco Program Act of 1982 (the Act) mandated that the tobacco price support loan program be administered in such a manner as to result in no net cost to the taxpayers other than such administrative expenses as are incidental to the implementation of any commodity. The Act provides authority for USDA to impose producer and purchaser assessments to be used to reimbursement the federal government should the price support program incur losses.

However, because the law exempted price support administrative expenses and non price support activities are not included in the No Net Cost law, USDA does incur expenditures of approximately \$31 million annually. These funds are expended through nine (9) different USDA agencies. The following is a list of the agencies and amounts expended for FY 1992:

AGENCY

EXPENDITURE

(million\$)

Agricultural Stabilization and Conservation Service (Price Support)	\$16.3
Agricultural Marketing Service (Market News & Standards)	1.1
Federal Crop Insurance Corporation (Indemnities and Premium Subsidy)	3.3
Agricultural Research Service (Market and Health Research)	5.5
Cooperative State Research Service (Plant Research-insects, weeds, etc.)	2.6
Extension Service (Education and Pest Management Programs)	.8
Economic Research Service (Forecasting and Projections)	.2
National Agricultural Statistic Service (Tobacco Statistic Reports)	.6
Foreign Agricultural Service (World Market Development)	.5
Total	30.9

CONGRESSIONAL INTEREST

Senate

Jessie Helms
Wendell Ford
Mitch McConnell

Howell Heflin

Sam Brown

House of Representatives

Charlie Rose
Eva Clayton
Scott Baesler
Steve Gunderson
Martin Lancaster
James Clyburn
James Quillen



ATTACHMENT 4

SENATOR WENDELL FORD (D-KY) (The Senate Majority Whip)

Senator Ford, the Chairman of the Rules Committee and the Majority Whip, wants to be helpful to the President. During his reelection campaign this year he talked about wanting to work with a President who would sign health care legislation passed by Congress. However, he is a fierce protector of the interests of his state. As he says, "if it is not good for Kentucky, I'm not for it." As a result, Ford can be expected to fight any tobacco tax. He is also nervous about mandated benefits and wants freedom of choice for consumers. He also has a personal interest in health care since his daughter is undergoing chemotherapy following a mastectomy and his brother-in-law is a pediatrician in Kentucky.

Senator Ford opposes giving states too much flexibility, because some may not be prepared for the responsibility. But more likely, it comes down to local politics, and a long-standing feud with Kentucky's Governor Brereton Jones. As a result it places Ford in the unusual position of opposing State-based reform at the same time Kentucky's Democratic Governor is pursuing such an initiative.

At the retreat in Jamestown, Senator Ford noted that his state produces coal, liquor, and tobacco, and that the Administration has been hitting all of these industries and will continue to do so. He expressed a willingness to take the hit on sin taxes, but needs a quid pro quo (something for his 95,000 farmers).

PRIVILEGED AND CONFIDENTIAL
M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senator Kerrey
cc: Melanne, Steve, Distribution

May 27, 1993

Tomorrow you are scheduled to meet with Senator Kerrey. This meeting is a continuation of your ongoing dialogue with the Senator, both in person and by telephone, regarding health care issues. Despite his recent stance on reconciliation, Senator Kerrey is expected to be an ally for health reform but will need attention all the way through the process. He should be fine as long as he is "stroked."

Attached for your review is material from Senator Kerrey's office regarding his proposal for a health care trust fund including (1) talking points which differentiate between the health care trust fund and the deficit-reduction trust fund, (2) response to policy concerns raised by Senator Kennedy, (3) a Dear Colleague letter outlining the Health trust fund proposal, (4) a letter Senator Kerrey sent to you earlier this month, (5) a letter from Henry Aaron of the Brookings Institution to Senator Kerrey discussing the health trust fund concept, (6) an article on health reform and the trust fund by Senator Kerrey which appeared in Roll Call. Also attached is a summary of Senator Kerrey's health background.

BACKGROUND

As you know, Senator Kerrey will be interested in discussing his proposal to establish a national trust fund for all federal health care expenditures including Medicare, Medicaid, VA, DOD, NIH, Centers for Disease Control, and other Public Health programs. Funding would be pay-as-you-go, so that failure to adequately control federal health care costs or decisions to increase benefits would require additional taxes or cuts in other health programs. Senator Kerrey believes this will force greater discipline on health spending by the Federal government.

Senator Kennedy has raised concerns about this idea, namely that health programs should compete against other budgeting priorities not just against each other and that in competing against each other mandatory programs will swallow up the funding for discretionary programs. He also expressed political concerns that seniors may have reservations about merging their Medicare monies into a larger pool. It also will not assist in prioritizing overall health spending since private health insurance expenditures are not included in the trust fund.

Because of Senator Kennedy's concerns as well as Senator Mitchell's strong opposition to the deficit reduction trust fund proposal, we recommend that you give this proposal every consideration but that you not make any specific commitment until we have further opportunity to review it and analyze its political ramifications.

ATTACHMENT 1

**Health Care Trust Fund Proposal
versus
the Deficit Reduction Trust Fund**

- o The health care trust fund targets the most quickly growing element of the federal budget, health expenditures. Approximately seventy percent of the year-to-year increase in the federal budget is driven by health spending. A deficit reduction trust fund would be general in nature.
- o The trust fund would place these program costs on a pay as you go basis, thus creating pressure for cost control. As projected costs outpace earmarked revenues, Congress would need to cut expenditures, raise taxes, or both to balance the fund. Under the revenue mix identified in the proposal, this effect would be felt in FY 1994 with a \$10 billion shortfall. A deficit reduction trust fund would not force these types of budget decisions.
- o The trust fund creates a permanent appropriation from general revenues which will be triggered if the fund does not balance. This permanent appropriation will impact other discretionary spending, thereby forcing Congress to choose, through budget reconciliation, whether to cut other spending, raise other taxes, or balance the fund. Congress will not be able to avoid making a difficult policy decision on budget priorities. Because the deficit reduction fund proposal does not include this type of budget trigger, it would not force Congress to make these choices.
- o The trust fund provides an avenue for reconsidering how the United States funds its health care spending. Congress can alter the mix of revenues flowing into the fund to relieve employers from the burden of the current payroll tax and remove employment disincentives, increase the share of health care funded by "sin" taxes, or improve the progressivity of revenues dedicated to health.
- o The trust fund should be an integral component of comprehensive health reform. It will bring much needed fiscal clarity and fiscal discipline to federal health spending. However, it is not the sole solution to America's health care crisis.

ATTACHMENT 2

Concerns About the Trust Fund (expressed by Senator Kennedy)

- o The trust fund might allow Congress to avoid hard decisions about cost-containment and expanded access to health care.
- o Pooling discretionary and mandatory programs in the same fund will allow mandatory programs to "swallow up" other programs.
- o Health programs should compete against all other budget priorities, not just against each other.
- o Seniors may be concerned about merging the HI and SMI trust funds into a larger pool.

Response

The trust fund proposal neither shields Congress from difficult budget decisions nor sacrifices health programs -- either discretionary or mandatory -- through the guise of a global budget. Rather, it creates a mechanism which forces Congress to make deliberate choices about its budget priorities, inside and outside the trust fund, and commit to fully funding the most quickly growing portion of the federal budget.

The proposal groups all federal health expenditures into a single fund and mandates that these expenses be covered on a pay as you go basis from earmarked revenues. Congress can choose to expand federal health programs, but then it must also raise taxes to cover increased expenditures. The trust fund would include a permanent appropriation from general revenues which will be triggered if the fund does not balance. This permanent appropriation will impact other discretionary spending, thereby forcing Congress to choose between balancing spending and revenues within the trust fund and cutting spending or raising taxes in the overall budget. The competition between health programs and other programs will be explicit.

The trust fund would ensure that health care expenditures are debated, as they should be, in the context of the full federal budget. The year-to-year increase in the federal budget is largely driven by health care spending; by making a commitment to fully funding these expenditures, we will be

attacking the budget deficit and making fully-informed policy choices.

Health care entitlement programs are expanding more rapidly than other health care spending, or any other federal spending programs.

Discretionary health spending on important public health priorities, such as the National Institutes of Health, are vulnerable today to continued escalation in entitlement spending. The trust fund will also pressure Congress to find effective cost-containment mechanisms to rein in the health entitlement programs, such as expanded use of managed care and tighter limits on provider payments while also continuing to fund important programs like the NIH. The discretionary health programs should be budget priorities, but Congress also needs to pay for them.

While senior citizens may be concerned about merging Medicare funds into a unitary health care trust fund, they will be primary beneficiaries of the unified fund. The trust fund does not diminish the federal government's commitment to the integrity of the Medicare program. In fact, I believe that the elderly will be better served by being part of the overall health care budget -- their care will be financed as an integrated piece of health spending.

Finally, the health care trust fund proposal is not a complete solution to America's health care crisis. It would be an important first step to bring needed fiscal discipline to health spending, and it would pave the way for full financing of comprehensive health reform.

J. ROBERT KERREY
NEBRASKA

ATTACHMENT 3

United States Senate

WASHINGTON, DC 20510-2704

May 5, 1993

Dear Colleague:

I am writing to call your attention to legislation I will soon introduce to establish a National Unitary Health Care Trust Fund, which would group all federal health expenditures into one trust fund and would mandate these expenditures to be disbursed on a pay as you go basis.

This trust fund should precede enactment of comprehensive health care reform legislation. The federal trust fund will become the foundation for the financing debate which will accompany health reform. A health care trust fund, analogous to the Social Security trust fund, will allow us to account for and monitor federal health expenditures. It would also help the American public become a larger and more informed participant in the health care debate.

A health care trust fund will serve three important purposes:

1. It will force needed fiscal discipline on the health care system by fully financing federal health care spending. Currently, health care expenditures are the fastest growing area of the federal budget. Federal spending is projected to jump by \$34 billion from FY93 to FY94 alone.

2. It will allow us to present an invoice to the American public of the government's share of health expenditures. This year the federal government will spend \$284 billion directly on health care services and another \$80 billion indirectly through the tax code.

3. It will force us to decide which taxes we want to use to pay the bills. Americans need to see that nearly three hundred billion of their federal taxes are already being collected and spent for health care.

The health care trust fund would include all federal spending for health services, including Medicare, Medicaid, VA, the Department of Defense health programs, and the Federal Employees Health Benefits Program. In addition, the trust fund would also cover the research and infrastructure investments funded through the National Institutes of Health, the Centers for Disease Control, and other Public Health Service programs. At this point I have not proposed including the indirect expenditures made through the current tax system because uncollected taxes are not part of the budget process.

In Year 1, the current fiscal year, federal expenditures for these programs will total \$284.3 billion. I propose designating five current sources of revenue to meet these expenditures:

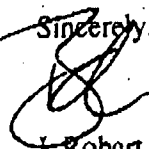
1. The 2.9% payroll tax equally divided between employers and employees (currently designated for Medicare Part A);
2. Health insurance premiums (collected for Medicare Part B);
3. All excise taxes for cigarettes and alcohol;
4. Individual income taxes, the first 27% of taxes collected or approximately the first 6% of individual taxable income; and
5. Corporate income taxes, the first 27% of taxes collected.

During Year 2, FY 1994, direct federal expenditures are projected to grow by \$34.2 billion to \$318.5 billion. However, designating the same revenue sources in FY94 as FY93 will produce only \$308 billion. Thus, in Year 2, there will already be a shortfall of approximately \$10 billion. In order to keep the fund in balance, at that time, either spending must be cut or additional taxes must be raised to cover the shortfall.

There are many possible alternatives that will cover these additional federal health expenditures. The trust fund gives us an opportunity to debate different methods of paying for federal health programs, including "sin" taxes, consumption taxes or income taxes; or spending reductions.

I would be happy to discuss this proposal with you in greater detail. If you have any questions, please contact Karen Davenport of my staff at 4-6551. Thank you for your interest.

Sincerely,



J. Robert Kerrey

J. ROBERT KERREY
NEBRASKACOPY

ATTACHMENT 21

United States Senate

WASHINGTON, DC 20510-2704

May 5, 1993

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Hillary:

Enclosed please find materials on a proposal for a National Unitary Health Care Trust Fund which we have previously discussed. The use of a trust fund to account for federal health care expenditures has many advantages, including providing a foundation for an honest argument about the need for fully-funded comprehensive health care reform.

I see three benefits of this unitary trust fund:

1. Assuming the trust fund is set up on a "pay as you go" basis, it will force needed fiscal discipline on the health care system by fully accounting for federal health care expenditures. Currently federal health care expenditures are the fastest growing area of the federal budget. From FY93 to FY94 alone, federal health expenditures will increase by \$34 billion.
2. It allows us to present an invoice to the American public on the share of health expenditures currently funded by the government. This will refute the weak arguments of opponents of health care reform that we do not want a health care system that includes large federal government involvement. We already have such a system. This year the federal government will expend \$284 billion on direct health care services as well as another \$80 billion indirectly through the tax system. The government pays nearly 40% of all health expenditures in the United States.
3. It sets the stage for debate on which taxes to use to pay for health care. Opponents of health care reform are already accusing President Clinton of supporting a tax increase for health care. Americans need to see that taxes are already being collected and

spent on health care.

In discussing the idea of a federal health care trust fund with advocates for health care reform, I spoke with Henry Aaron of the Brookings Institute. By a fortunate coincidence, it turns out that Mr. Aaron has advocated for several years the establishment of such a trust fund. He discusses the trust fund idea in his book, *Serious and Unstable Condition: Financing America's Health Care*, Brookings 1991. He states that, "Because health care expenditures are large and certain to keep growing, it would be sound budgetary procedure to...finance federal expenditures on health care through a trust fund, like those now used for social security pensions and medicare hospital benefits" (pp. 146-47). I have attached a letter Mr. Aaron sent me subsequent to our meeting.

The attached charts illustrate how the trust fund would work. First, all federal health care expenditures must be part of the fund, including money spent on, *inter alia*, FEHB and NIH. At this point I have not proposed including the indirect expenditures made through the current tax system, which total approximately \$80 billion for FY93 in the trust fund because uncollected taxes are not part of the budget process.

In Year 1, the current fiscal year, federal health expenditures will total \$284.3 billion. I have designated five sources of revenue to pay for these expenditures:

1. The 2.90% payroll tax equally divided between employers and employees (currently designated for Medicare Part A);
2. Health insurance premiums (collected for Medicare Part B);
3. All excise taxes for cigarettes and alcohol;
4. Individual income taxes, the first 27% of taxes collected or approximately the first 6% of individual taxable income; and
5. Corporate income taxes, the first 27% of taxes collected.

Table 2 illustrates how Year 2, FY94, of the trust fund would work. Direct federal expenditures are projected to grow by \$34.2 billion to \$318.5 billion. However, designating the same revenue sources in FY94 as

FY93 will produce only \$308 billion. Therefore, in Year 2, there will already be a shortfall of approximately \$10 billion. In order to keep the fund in balance, at that time, either spending must be cut or additional taxes must be designated or raised to cover the shortfall.

Let me demonstrate how the trust fund would encourage a vigorous and honest debate about appropriate taxes to use for health care expenditures. For example, another alternative scenario for designating taxes for the trust fund which I find attractive, would be to use the following taxes in FY94:

1. Health insurance premiums	\$ 14.6 billion
2. Progressive consumption tax	\$120.0 billion
3. Tobacco Excise Taxes (includes \$0.70 increase per pack)	\$ 15.9 billion
4. Alcohol Excise Taxes	\$ 7.7 billion
5. Corporate Income Taxes	\$ 32.4 billion
6. Individual Income Taxes	<u>\$127.9 billion</u>
TOTAL	\$318.5 billion

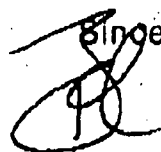
This scheme could be criticized because I am supporting new taxes for health care. However, my argument is that I am eliminating a 3% payroll tax which relieves the burden on employers as well as reducing allocated individual income tax.

There are many possible alternatives for designating the taxes needed to cover federal health expenditures besides the ones I have discussed here. Under all these scenarios, however, the trust fund gives us an opportunity to debate different ways to pay the federal share of health expenditures. It is worth noting that Henry Aaron proposes that the federal trust fund capture amounts currently expended by the states for Medicaid. *Serious and Unstable Condition*, p.p. 146-47. Others have advocated state and federal swaps of program responsibilities, i.e. Medicaid for AFDC. These proposals open the door for welfare reform.

A proposal on the appropriate taxes to designate for health care expenditures should be presented to the American public before the introduction of a comprehensive reform proposal. The federal trust fund concept will lay the groundwork for the financing debate we will need with a new reform proposal. The trust fund alone cannot prevent cost

shifting as a way of lowering federal health expenditures. However, public awareness of increases in federal health care cost will impose some discipline on the entire health care system. If, like the social security trust fund, we account for and monitor federal health expenditures, the American public will be a larger and more vocal participant in the health care system. In conjunction with the forthcoming comprehensive reform, the trust fund will begin to solve our nation's health care crisis.

Legislative Counsel is redrafting the bill; it should be done soon. I look forward to discussing this proposal with you and appreciate your interest.

Sincerely,


J. Robert Kerrey

Table 1, *Proposed Health Care Fund, FY93*

DRAFT

Fiscal Year 1993**Expenditures (in billions)**

Medicare	\$149.2
Medicaid	80.3
Veterans	14.9
Dept. of Defense	15.0
Other **	<u>24.9</u>

Total	\$284.3
-------	---------

Revenues (in billions)*Current Earmarked Revenues*

Medicare:	
Payroll Tax	91.8
Premiums	14.6

Additional Revenues

Excise:	
Tobacco	5.7
Alcohol	7.8

Income:	
Corporate	29.7
Individual	<u>135.3</u>

Total	\$284.9
-------	---------

* 27% of Corporate and Individual Income Taxes Collected (or approximately the first 6% of individual taxable income)

** Other includes Public Health Service, Other HHS and FEHB

Source: CBO Projections, February 1993

DRAFT

Table 2, *Proposed Health Care Trust Fund, FY94***Fiscal Year 1994****Expenditures (in billions)**

Medicare	\$169.7
Medicaid	91.9
Veterans	15.7
Dept. of Defense	15.0
Other**	<u>26.2</u>

Total	\$318.5
-------	---------

Revenues (in billions)*Current Earmarked Revenues*

Medicare:	
Payroll Tax	102.3
Premiums	16.8

Additional Revenues

Excise:	
Tobacco	5.9
Alcohol	7.7

*Income:****

Corporate	32.4
Individual	<u>143.4</u>

Total	\$308.5
-------	---------

* Dept. of Defense projection unavailable, 1993 estimate used

** Other includes Public Health Service, Other HHS and FEHB

*** 27% of Corporate and Individual Income Taxes Collected (or approximately 6% of individual taxable income.)

Source: CBO Projections, February 1993

ATTACHMENT 5



THE BROOKINGS INSTITUTION

1775 MASSACHUSETTS AVENUE, N.W. WASHINGTON, D.C. 20036-2188
TELEPHONE: 202/797-6000 FAX: 202/797-6181

Economic Studies Program

30 March 1993

Senator Bob Kerrey
United States Senate
Washington, DC 20510

Dear Senator Kerrey:

Thank you for the opportunity to discuss federal spending on social security and medical programs last week.

I was particularly intrigued with your proposal to establish a trust fund that would be used to pay for essentially all federal health care programs and which would receive earmarked taxes designated to pay for those programs. If spending grew faster than taxes, Congress would be required under your proposal to allocate additional revenues to the trust fund.

This proposal is quite similar to one that I advanced in a book on health care financing, *Serious and Unstable Condition: Financing America's Health Care*, Brookings, 1991, on pages 137 to 151 and suggested again by Charles Schultze in our co-edited book *Setting Domestic Priorities: What Can Government Do?*, Brookings, 1992, pp. 310 to 314. Our framework is identical to the one you sketch, with one exception that may be significant.

We propose earmarking a specially dedicated tax to the trust fund (together with the payroll tax for medicare, SMI premiums, and revenues from the "sin" taxes). Should spending grow faster than revenues, tax rates on the earmarked taxes would have to be increased. Charles Schultze and I are persuaded that the need to raise taxes if spending on health care grows rapidly will put the question of how much the nation is prepared to spend on health care squarely before the American people and its elected representatives. The need to raise taxes will limit any possible Congressional tendency to want to sweeten benefits.

Earmarking a part of the personal income tax would serve this function quite well provided that Congress treated any increase in the proportion of the tax allocated to the trust fund as forcing an increase in personal income tax rates. However, we know of no procedural device that could bind future Congresses to link changes in the share of income taxes designated to the trust fund to changes in income tax rates. For this reason, I think that use of a special tax, all of the revenue from which was allocated to the health care trust fund, is preferable. A value-added tax is the only revenue

Senator Bob Kerrey
March 29, 1993
Page 2

instrument capable of generating sufficient revenues to pay for the bulk of federal health care programs.

Both Democrats and Republicans should be able to find in your proposal a way to help pay for current health care obligations and for financing reform. It can help discipline government spending. It can help reduce the overall deficit. I wish you the best of fortune in persuading your colleague in the Senate and members of the House of Representatives to support your initiative.

Sincerely yours


Henry J. Aaron
Director

ATTACHMENT 6

Health Care Reform: It's a Necessity For Both Ethical and Economic Reasons

By Sen. Bob Kerrey

Enacting comprehensive health care reform is not an option; it is a necessity. Rising federal costs and a lengthening list of avoidable tragedies motivate that we act. We may as well act now, for economics and ethics are pressing us to act now, rather than delaying for long.

Without comprehensive health reform, deficit reduction will remain a dream. President Clinton's first budget is 3.2 percent larger than President Bush's last one. All federal health care spending will increase from \$285 billion in fiscal year 1993 to \$318 billion in fiscal 1994 — and these totals do not include approximately \$80 billion of tax expenditure for tax-deductible employee benefit payments.

Thus, health care spending increases about approximately 71 percent of all the year-to-year increases.

Without comprehensive health reform, spending for federal health programs will more than double in six years. According to the Congressional Budget Office, Medicare and Medicaid alone will grow from a combined total of \$260 billion in 1992 to \$405 billion in 1998.

Without comprehensive health reform, our economy will continue to add jobs slowly. Non-health care jobs in both the private and public sectors must shrink as health care consumes a larger and larger

A University of North Carolina study concluded that we lost two million jobs nationally in the last four years because of rising health care costs.

percentage of our Gross Domestic Product. Last year, a University of North Carolina study concluded that we lost two million jobs nationally in the last four years because of rising health care costs.

Without comprehensive health care reform, we will continue to provide a perverse incentive to quit work and go on welfare. The growth of Medicaid rolls is actually surprisingly slow given the financial risk of non-insured or underinsured workers.

In addition to economic problems, our current health care system has created a number of ethical problems. Our health care system reduces us to computer numbers that determine our financial risk and decide our fate. If our number reveals a high ability to pay, we are given the finest health care in the world. If our number results in doubt, we may get care, but we may also wonder if it was worth the effort.

Increasingly, Americans are making career decisions based upon health care coverage. Millions of Americans are forced to obtain the security of health insurance from welfare and are told they will lose their benefits if they find work. Others are afraid to change jobs even at a higher salary, because they fear losing their health coverage. Or the system creates situations where government employment is more attractive than private sector jobs.

Americans who have paid all their working lives for health coverage discover their insurer will not cover the care they need. Even worse, after 20 years on the job, Americans receive pink slips and must face a new health care phenomenon during their job hunt: pre-existing medical conditions.

Small businesses — our greatest hope for new jobs — are particularly vulnerable in today's health care marketplace. They approach a shrinking number of insurers who offer coverage at rapidly rising rates. Today, the imbedded cost of health care is a larger barrier to economic expansion than taxes. Unlike taxes, health care costs continue to rise independent of income.

Outrages don't end with obtaining health insurance. Waste is endemic. We spend tens of billions of dollars on paperwork in an effort to find third-party payers and collect payments. Government-financed programs encourage unnecessary procedures. Bills for services rendered are shockingly out of proportion to the value of care received.

strained doctor-patient relationships. Physicians practice in fear of costly malpractice suits, while patients lose confidence in their doctors' judgment. Both parties lose, while costs are driven up by unnecessary procedures.

Health care reform should be more than an effort to solve these problems. It should be part of an effort to construct a new American safety net that meets the changed needs of workers in the information age.

In the industrial age, a job very often lasted a lifetime. The most urgent social concern was the quality of life after retirement. Thus, the safety net provided protection for the two largest fears of the elderly: non-working population; income maintenance and health care.

In the information age, job security is a fading memory. Employers, struggling to maintain a competitive edge in an international marketplace, are either doing more work with the same number of employees or are employing temporary, contract help. Employees who do create new jobs often can no longer afford to offer benefits. Only 38 percent of all new jobs in America come with health care benefits; 15 percent provide pension benefits.

In the information age, workers must acquire health care eligibility as a consequence of being American, not as a consequence of

employment status. However, while I have broken the link between eligibility and employment, I still believe employers should play a role in health care. Health care can continue to be employment-based, and, in addition to making a financial contribution, employers can still make important decisions about health care.

I favor reform that declares every American — now free of the fear and doubt of not being covered — must have a stake in making payments and controlling costs. The good old days (for the fortunate few) of not having to worry about paying the bills because "someone else" is picking up the tab must end. I favor having Americans pay premiums into a state-based plan or purchasing cooperative. If economic incentives are not distorted by the tax code, well-intended politicians, or corporate executives, the market can help control costs.

I favor reform which emphasizes health rather than health care. By establishing

research priorities, developing payment formulas, promulgating practice guidelines, assisting professional training, disseminating information on health care quality, and developing incentives throughout the tax system, government can ensure that public health becomes the primary focus of our health care system.

I favor creating a Health Care Prevention Account to be used for community-based efforts to improve the health of the American people.

I favor the creation of a national board to determine a standard set of benefits. The benefit package will be uniform across the country and will cover all Americans, including Members of Congress. Subsidies will be paid directly to the state purchasing cooperatives. Fee schedules and payment to providers will be determined by self-regulating negotiation between state-based payment corporations and providers, payers, and entrepreneurs who deliver

and manage high-quality, low-cost care.

I favor national standards, benefits, and simplified reporting forms, but I do not favor federalizing the system. Medicaid would disappear. Medicare must be included in the system, and eligible veterans could choose between Veterans Administration hospitals or private hospitals for their care.

I favor a financing system which is direct and disciplined. As a first step and a foundation for any legislation, I propose that we establish a Federal Unitary Health Care Trust Fund, similar to the Social Security Trust Fund.

This Health Care Trust Fund would cover all federal spending for health services, including Medicare, Medicaid, VA, the Department of Defense health programs, and the Federal Employees Health Benefits Program. In addition, the trust fund would also cover the research and infrastructure investments funded through the National Institutes of Health, the Centers for Disease

Control, and other public health service programs. Congress would be required to dedicate sufficient taxes to pay for all authorized or appropriated expenditures.

The Trust Fund provides three major benefits to the government. First, fiscal clarity is established. What the government is paying for and where the funds are coming from are made clear. Second, it forces a vigorous, open, and honest debate on appropriate financing sources. Third, it guarantees fiscal discipline because deficit financing would not be allowed for our most rapidly growing federal expenditure.

To illustrate how the system would work, I propose that the following current sources of existing revenue be dedicated to pay for the \$285 billion of health care spending in the current fiscal year:

	In Billions of Dollars
Payroll Tax**	\$91.8
(Medicare Part A)	
Insurance Premiums	14.6
(Medicare Part B)	
Existing Excise Tax: Tobacco	5.7
Existing Excise Tax: Alcohol	7.8
Individual Income Tax**	135.3
Corporate Income Tax**	29.7
Total	\$284.9
* 2.9%	
** 27% of total revenues collected	

P011/012

TO 94566241

FROM SENATOR KERREY

05-26-93 01:21PM

Next year, federal health care spending is estimated to reach \$118 billion while the so-called dedicated sources of revenue would grow to \$308 billion. Thus, Congress would either have to cut \$10 billion in spending or raise \$10 billion through new taxes.

To show how the Health Trust Fund would encourage a vigorous and honest debate, I will illustrate an alternative financing scenario that I find attractive. I would enact a progressive consumption tax and increase taxes on tobacco by 70 cents per cigarette pack. These taxes would generate \$120 billion and \$10 billion, respectively.

I would allocate the entire amount to the Health Trust Fund, which would enable me to lower the existing health care payroll taxes (Medicare Part A) to zero, thereby relieving employers of a signifi-

I favor national standards, benefits, and simplified reporting forms, but I do not favor federalizing the system.

cant tax burden. I would also reduce allocated individual income taxes by \$20 billion and cut the deficit by approximately \$20 billion.

Economic and ethical concerns are driving the engine of health care reform. We have an opportunity to design a new financing system that controls costs while we continue to have the highest quality health care in the world. We have an opportunity to redesign this financing system so that Americans become healthier.

To do it right, we must insist that all accept their fair share of responsibility. Subsidies will sometimes be unavoidable. They should be the exception and not the rule.

To do it right, we should not try to fashion a coalition of interest groups who want to satisfy their important but narrow needs. To do it right, we must think about all Americans, now and in the future. To do it right will require vision and thoughtful, careful consideration of what we are doing. Most of all it will require the courage to enact legislation which is good, tough economic medicine and more compatible with our moral principles.

Sen. Bob Kerrey (D-Neb), a member of the Appropriations Committee, made health care reform a key plank in his platform during his run for the presidential nomination last year.

SENATOR BOB KERREY (D-NE)

Senator Kerrey has displayed a keen interest in the area of health care reform since first coming to the Senate and made health reform one of the centerpieces of his presidential bid.

In the last Congress, he introduced a comprehensive health reform bill which is actually quite similar to the framework being developed by the Task Force. In the Kerrey bill, however, all businesses would be required to join state-run purchasing groups rather than privately-run groups. At his March 18th meeting with the First Lady, he was very complimentary about Ira's March 4 briefing for the Democratic Senators. In a note to Senator Rockefeller, Kerrey wrote that he "likes what he is hearing out of the White House."

He has made financing a primary focus and advocates creating a health care trust fund run on a pay as you go basis. Sources of financing for his bill include: a payroll tax on employers and employees; current federal health spending except for Veterans (for whom he believes a separate system must be maintained); new taxes on cigarettes and liquor; taxes on Social Security benefits; and increasing income subject to tax as well as increasing the top rate. At his last meeting with the First Lady he expressed interest in providing language to help sell the plan.

Recent Developments: -- Senator Kerrey has recently circulated a proposal in the Senate to create a trust fund which would account for all health expenditures including the Federal Employee Health Benefit Package and NIH. He suggests proposing appropriate taxes designated for health care reform before the introduction of a comprehensive plan.

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings , Steve Ricchetti to Hillary Clinton Re: Proposed Schedule for Congressional Consultative Meetings and Pre-Introduction Briefings for a Scheduled June 23rd Release Date (11 pages)	6/1/93	P5
002. memo	Chris Jennings to Distribution Re: Proposed Congressional Meeting Schedule (1 page)	6/1/93	P5
003. memo	Sara Rosenbaum to Hillary Clinton, Carol Rasco, Ira Magaziner, Judy Freder, Shirley Sagwa Re: Legislative Specifications for the President's National Health Reform Plan (7 pages)	6/3/93	P5
004. memo	Chris Jennings to Hillary Clinton Re: Monday Meeting with Congressman Dickey (2 pages)	6/5/93	P5
005. memo	Chris Jennings to Hillary Rodham Clinton Re: General Comments re Reconciliation Cuts (2 pages)	6/7/93	P5
006. memo w/attach	Donna Shalala to President and Mrs. Clinton Re: Public Portrayal of the Medicare Program (6 pages)	6/7/93	P5
007. memo	Chris Jennings to Hillary Clinton Re: Meeting with Senator Exon (2 pages)	6/9/93	P5
008. memo w/attach	Chris Jennings to Hillary Clinton Re: Meeting with Senator Dodd (3 pages)	6/10/93	P5

COLLECTION:

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

FOLDER TITLE:

June 1993 HSA [1]

gf87

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed
of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C.
2201(3).

RR. Document will be reviewed upon request.

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

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

***** PRIVILEGED AND CONFIDENTIAL *****
M E M O R A N D U M

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

June 1, 1993

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

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

Four Points About Timing, Consultation, Communications and Hearings:

- (1) **Timetable Needs to be Finalized.** As the attached list clearly illustrates, the necessary amount of consultation can only take place if we squeeze it into a very brief period of time. **If the policy is delayed beyond this week, however, it will be literally impossible to have a sufficient amount of time to conduct adequate consultations prior to June 23rd.** Should the policy be unavailable, we need to immediately revisit and restructure what is already a very ambitious timetable.
- (2) **Substantive Consultation Must Occur.** We understand the concerns about leaks and the general frustration with working with many Members of Congress. However, it would be extremely counter-productive to attempt to release a package in which the Members have little or no investment.

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

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

- (3) **Senator Daschle's Outreach Proposals Should Be Implemented.** We believe that Senator Daschle's suggestions for a message/whip group and a focus group are very constructive. We believe that we should get started on these meetings as soon as the Members return from recess regardless of the final decision on the timing of the unveiling. These meetings can be interspersed with the attached schedule of consultative meetings OR conducted on a separate track.
- (4) **Appropriate Witnesses Should Be Prepared for Inevitable Hearings.** Immediately after the unveiling, numerous Committees will request that the Administration supply witnesses for their inevitable series of hearings. We need to carefully consider where we should testify first, who we believe are the most appropriate people to send, and begin to develop the message(s) we want delivered.

SCHEDULE FOR CONGRESSIONAL CONSULTATIVE MEETINGS AND BRIEFINGS

CONSULTATIVE MEETINGS:

Sunday, June 6th:

House Leadership and Committees of Jurisdiction Staff

IM, JF

(To help staff prepare members for meeting with First Lady)

Senate Leadership and Committees of Jurisdiction Staff

IM, JF

(To help staff prepare members for meeting with First Lady)

June 8th:

House Leadership and Chairmen of Committee of Jurisdiction

HRC, IM, JF

Location: White House

(To brief Members and set up consultative process)

Foley
Gephardt
Bonior
Rostenkowski
Stark
Dingell
Waxman
Ford
Williams

Senate Leadership and Chairmen of Committees of Jurisdiction

HRC, IM, JF

Location: White House

(To brief Members and set up consultative process)

Mitchell
Ford
Pryor
Daschle
Moynihan
Kennedy
Rockefeller
Riegle
Mikulski
Breau

Wednesday, June 9th:

Congressional Republican Leadership - HRC, IM, JF

Location: White House

Dole and designees

Michel and designees

Daschle Message/Whip Group:

Rockefeller, Pryor, Daschle, Kerrey, Wofford, Bonior,
Gephardt (if available and willing), and other House Member
"friends." (WEEKLY MEETING)

Staff: Jeff Eller, Bob Boorstin, Steve Ricchetti, Chris
Jennings, Melanne Verveer, Jerry Klepner, Karen Pollitz

Thursday, June 10th:

Single Payer Leaders - HRC, IM, JF

Location: Capitol Hill (Gephardt to Host)

McDermott

Conyers

Wellstone

Conservative Democratic Forum - HRC, IM, JF

Location: Capitol Hill (Gephardt to Host)

Cooper

Andrews

Stenholm

Breaux

Boren

Daschle Focus Group:

Daschle/Pryor and moderate/conservative Democrats: Bryan,
Breaux, Reid, Exon, and Conrad

Staff: Ricchetti, Jennings, Klepner, Pollitz

Friday, June 11th (Possibly Saturday, June 12th, as well):

House Leadership and Committees of Jurisdiction Staff

IM, JF

(Ongoing detailed staff-level discussions)

Senate Leadership and Committees of Jurisdiction Staff

IM, JF

(Ongoing detailed staff-level discussions)

Monday, June 14:

House Ways and Means Committee - HRC, IM, JF

Location: Capitol Hill

(Chairman determines attendees and whether bipartisan)

Senate Finance Committee - HRC, IM, JF

Location: Capitol Hill

(Bipartisan)

House Energy and Commerce Committee - HRC, IM, JF

Location: Capitol Hill

(Chairman determines attendees and whether bipartisan)

Daschle Message/Whip Group:

Rockefeller, Pryor, Daschle, Kerrey, Wofford, Bonior,
Gephardt (if available and willing), and other House Member
"friends." (WEEKLY MEETING)

Staff: Jeff Eller, Bob Boorstin, Steve Ricchetti, Chris
Jennings, Melanne Verveer, Jerry Klepner, Karen Pollitz

Tuesday, June 15th:

Senate Labor and Human Resources Committee - HRC, IM, JF

Location: Capitol Hill

(Bipartisan)

House Education and Labor Committee - HRC, IM, JF

Location: Capitol Hill

(Chairman determines attendees and whether bipartisan)

House Caucuses - IM, JF

Congressional Black Caucus

Congressional Caucus on Women's Issues

Wednesday, June 16th:

House Democratic Whip Organization - HRC, IM, JF

Location: Capitol Hill

House Republican Health Care Task Force - HRC, IM, JF

Location: Capitol Hill

U.S. Senate (Bipartisan) - HRC, IM, JF

Location: Capitol Hill

House Caucuses - IM, JF

Congressional Hispanic Caucus

To Be Scheduled:

Other Meetings with Committees as Needed - IM, JF, Other Staff

Location: Capitol Hill

Biden, Judiciary

Rockefeller, Veterans

Nunn, Armed Services

Bumpers, Small Business

Glenn, Governmental Affairs

Inouye, Indian Affairs

Brooks, Judiciary

Montgomery, Veterans

Dellums, Armed Services

LaFalce, Small Business

Clay, Post Office

Miller, Natural Resources

PRE-UNVEILING BRIEFINGS:

Saturday, June 19th:

House Leadership and Committees of Jurisdiction Staff

IM, JF

(Ongoing detailed discussions and to help staff prepare members for meeting with President and First Lady)

Senate Leadership and Committees of Jurisdiction Staff

IM, JF

(Ongoing detailed discussions and to help staff prepare members for meeting with President and First Lady)

Sunday, June 20th:

House Leadership and Chairmen of Committee of Jurisdiction

HRC, BC(?)

Location: White House

Foley
Gephardt
Bonior
Rostenkowski
Stark
Dingell
Waxman
Ford
Williams

Senate Leadership and Chairmen of Committees of Jurisdiction

HRC, BC(?)

Location: White House

Mitchell
Ford
Pryor
Daschle
Moynihan
Kennedy
Rockefeller
Riegle
Mikulski
Breau

Congressional Republican Leadership - HRC, BC (?)

Location: White House

Dole and designees
Michel and designees

Monday, June 21st:

Senate Democratic Policy Committee - BC?, HRC, IM, JF

Location: Capitol Hill

House Democratic Caucus - HRC, IM, JF

Location: Capitol Hill

Tuesday, June 22nd:

House Republican Caucus - HRC, IM, JF

Location: Capitol Hill

Senate Republican Policy Committee - HRC, IM, JF

Location: Capitol Hill

House Democratic Staff Briefing - IM, JF or appropriate surrogate

Location: Capitol Hill

House Republican Staff Briefing - IM, JF or appropriate surrogate

Location: Capitol Hill

Senate Staff Briefing - IM, JF or appropriate surrogate

Location: Capitol Hill

Other Meetings with Committees and Members as Needed

SCHEDULE FOR CONGRESSIONAL CONSULTATIVE MEETINGS AND BRIEFINGS

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
6/6	6/7	6/8	6/9	6/10	6/11	6/12
House Leadership and Cmte of Jdx Staff IM/JF		House Leadership and Chmn of Cmtes of Jdx HRC/IM/JF	Cong. Republican Leadership HRC/IM/JF	Single Payer Leaders HRC/IM/JF	House Leadership and Cmtes of Jdx Staff IM/JF	
Senate Leadership and Cmte of Jdx Staff IM/JF		Senate Leadership and Chmn of Cmtes of Jdx HRC/IM/JF	Daschle Message/ Whip Group Eller/SR/CJ et. al.	CDF HRC/IM/JF	Senate Leadership and Cmtes of Jdx Staff IM/JF	
				Daschle Focus Group SR/CJ et. al.		

* Other Meetings with Administration Staff to be Scheduled.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
6/13	6/14	6/15	6/16	6/17	6/18	6/19
	Senate Finance Committee HRC/IM/JF	Senate Labor and Human Resources Committee HRC/IM/JF	House Democratic Whip Org. HRC/IM/JF			House Leadership and Cmtes of Jdx Staff IM/JF
	House Energy and Commerce Committee HRC/IM/JF	House Education and Labor Committee HRC/IM/JF	House Republican Health Care Task Force HRC/IM/JF			Senate Leadership and Cmtes of Jdx Staff IM/JF
	Ways and Means Committee HRC/IM/JF	Cong. Caucus on Women's Issues IM/JF	U.S. Senate Bipartisan HRC/IM/JF			
	Daschle Message/ Whip Group Eller/SR/CJ	Cong. Black Caucus IM/JF	Cong. Hispanic Caucus IM/JF			

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
6/20	6/21	6/22	6/23	6/24	6/25	6/26
House Leadership and Chmn of Cmtes of Jdx HRC/BC(?)	Senate DPC BC(?)/HRC/ IM/JF	House Republican Caucus HRC/IM/JF				
Senate Leadership and Chmn of Cmtes of Jdx HRC/BC(?)	House Democratic Caucus HRC/IM/JF	Senate Republican Policy Committee HRC/IM/JF				
Cong. Republican Leadership HRC/BC(?)		House Democratic Staff Briefing Staff				
		House Republican Staff Briefing Staff				
		Senate Staff Briefing Staff				

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Distribution
FR: Chris Jennings
RE: Proposed Congressional Meeting Schedule

June 1, 1993

To create an environment best suited for a positive Congressional reception to the President's health proposal, it will be necessary to hold a series of intense, substantive consultations with key Members of Congress. Attached for your review and for planning purposes is a proposed schedule of meetings that was prepared for the First Lady. The Legislative Affairs offices of both the White House and the Department of Health and Human Services have reviewed and approved this document.

The proposed schedule assumes an admittedly ambitious June 23rd target date for the plan's unveiling. In so doing, we are also assuming that final first cut decisions will be made by late this week in order to assure that substantive meetings can take place beginning early next week. We are, however, waiting until this assumption becomes more of a reality before formally scheduling these meetings. Please don't hesitate to call me at X-2645 with any questions.

DISTRIBUTION:

Bob Boorstin
Susan Brophy
Steve Edelstein
Jeff Eller
Judy Feder
Skila Harris
John Hart
Shirley Sagawa

Charlotte Hayes
Jerry Klepner
Mike Lux
Ira Magaziner
Lorraine Miller
Howard Paster
Karen Pollitz
Kim Tilley

Carol Rasco
Steve Ricchetti
Patti Solis
Marge Tarmey
Melanne Verveer
Maggie Williams
Christine Heenan

June 3, 1993

~~Confidential~~

MEMORANDUM

To: Hillary Rodham Clinton, Carol Rasco, Ira Magaziner, Judy Feder, and Shirley Sagawa

Fr: Sara Rosenbaum, Diane Rowland, Peter Budetti, Greg Lawler and Jennifer Klein

Re: Legislative specifications for the President's national health reform plan

Everyone should feel good about this specifications notebook. As you will see, the work of the Task Force is a long way down the road to actual legislation. While an enormous amount of actual drafting work and revision may lie ahead, we think that a comprehensive piece of legislation is coming into focus.

This memorandum sets out our schedule over the next six weeks and highlights issues in the notebook that need your particular attention.

Timing

The weeks between now and completion of the reconciliation measure provide us with an opportunity to pretty much complete an initial draft of the bill. We will resume actual drafting at the beginning of next week. Our drafting will produce both legislation and a relatively short section-by-section analysis that explains each provision of the bill and the laws it creates, amends, or modifies. It is the section-by-section analysis that is most commonly used to brief press, organizations, and others who do not choose to immerse themselves in the actual legislative language.

We suggest that we meet on the afternoon of Tuesday, June 8th to review each section of the book and begin working through outstanding policy questions. We also must mesh the two processes (i.e., drafting and Congressional negotiations) into one continuous operation with regularly scheduled joint meetings, so that we are apprised as quickly as possible of changes that are needed.

Basis for Specifications

The specifications are based on our notes from the Task Force meetings with the President, our review of the Tollgate 5

papers, and extensive discussions held over the past 6 weeks with work group staff and Administration officials.

In a number of instances we found that no clear policies had yet been developed to deal with certain important issues. In these cases, we have developed specification "placeholders". Many are based on existing bills introduced in the House and Senate. These placeholders have been inserted in order to both offer options and assure that we do not miss important matters.

We recognize that several sections will be significantly modified (e.g., the benefit, coverage and financing sections) as cost estimates and policy decisions continue to evolve. We also assume that the Medicare and long term care provisions may change as cost estimates develop.

Scope and structure of the specifications

The specifications essentially follow the original drafting outline that we prepared during the winter. They deal with 25 separate legislative areas that the bill will have to address, given its size and scope. Much of the length of the bill will be consumed not by the creation of the new coverage and benefit plan, but by the thousands of modifications, revisions and conforming amendments needed to conform existing federal health laws to the new law.

For example, if the final bill includes federal employees in state alliance arrangements, FEHBA will have to be revised accordingly to deal with its dissolution, transition matters, financial reserve disbursements, and so forth. Similarly, if Medicaid remains in a modified fashion, then much of the existing statute will have to be revised to reflect its new elements.

Whenever possible, we will try for brevity through delegation clauses, cross references to existing laws and definitions, and other drafting techniques. However, the final bill will be lengthy for several reasons:

- Drafting any employment-based health insurance bill involving mandates on both employers and individuals inevitably requires lengthy specifications covering the huge number of current and changing relationships that give rise to legal duties. These are employment relationships, individual and family arrangements, and transition rules from one employment or family living arrangement or status to another.
- Moreover, bringing existing statutes into conformity with the new law will require a great deal of drafting.
- Because of the complex and potentially controversial

nature of certain elements of the new law, it will be important for the President to demonstrate that he has considered all of the ramifications of each of the structural, policy, and legal proposals he makes. A comprehensive bill reflects thorough and careful thinking about these issues.

- The monumental nature of this undertaking and the enormity of the interests at stake necessitate detailed legislation. If the President submits a "bare-bones" bill with minimal detail and broad delegation to the federal agencies and states, Congress, reflecting its own oversight role and the pressure of various legislative interests, will "fill in the picture" for him. This means that instead of one bill drafted by the President, there could be as many bills as there are Committees with jurisdiction -- at least several dozen.

We believe that being able to keep substantial control in the drafting room is integrally related to controlling the political and policy process. To do this means offering a thorough draft. This will help guard against losing control of critical issues.

Jurisdiction

How the bill is constructed determines which Committees it goes to and its ultimate chance of passage in a form that to the greatest degree possible approximates the President's original legislation. No issue will be more central to Congress than jurisdiction, since jurisdiction means legislative ownership of critical elements of the measure.

In the notebook you will find a separate summary of jurisdiction decisions. Throughout our drafting process we have consulted at length with our drafting counsel and with Congressional Committee and leadership staff. Our first drafting meetings next week will be devoted again to reviewing jurisdictional matters.

There may be points at which sizable jurisdictional realignment will be needed, simply because there is no other way to tackle a particularly difficult policy problem. However, we are trying to avoid these instances at all costs, since so much new law already will need to be created, with jurisdiction assigned to Committees. To minimize and stay on top of jurisdictional issues will require very intensive collaboration among drafters, White House policy, political and Congressional staff, and Members of Congress and their staff.

Specific issue areas

We want to bring several critical issue areas to your attention.

1. Coverage

Jurisdiction: Our preliminary recommendation is that the basic guarantee of health care for all Americans be crafted as a new law rather than as an amendment to the Social Security Act, the Public Health Service Act, the Fair Labor Standards Act, or some other existing law.¹ If this decision is retained after negotiations with Congress, then the House and Senate leadership may have to devise new Committee "pathways" for these elements of the measure. Depending on the severability of other areas of the bill that deal with conforming changes, new pathways conceivably could realign jurisdiction over current laws. Minimizing these seismic shifts is crucial, since Committees that perceive themselves shortchanged jurisdictionally may be unwilling to act on the measure.

Coverage subsidies for lower and moderate income persons: One of the most important political and policy issues in the bill is the individual coverage mandate. If the bill is not affordable, then enforcement of the mandate is virtually impossible. Until financing decisions ultimately are made, we are unclear how -- and how much -- assistance will be furnished to lower and moderate income persons.

Examples of the types of people whom we are not sure about are: early retirees not yet eligible for Medicare, too "well off" for Medicaid, and unable to afford premium payments; self-employed low wage earners (e.g., handymen, day laborers and housekeepers, and so forth), with no one to pay the employer share of the premiums; and unemployed families with modest incomes.

To the extent that low income assistance has been taken into account, we need to know the assumptions in detail so that we can draft accordingly. In the absence of guidance, we have made a series of "placeholder" drafting assumptions for lower income Americans. For low income persons generally we have created a

¹ An alternative would be to use one of the jurisdictional models negotiated by Members of Congress as part of past bills and bill drafts prepared by the House and Senate Committees. Next week we will begin comparing these previously developed models with the specifications for the President's bill in order to determine whether one, or a combination of, these models provides a good "fit."

new Medicaid subsidy program. For lower income non-workers, we have developed premium caps. For low wage earners we have increased the employer responsibility. And for unemployed persons we have created a funded COBRA benefit.

Undocumented persons: Another major coverage issue concerns uninsured undocumented persons. We know that the funds allotted to public health programs are meant in part to help states and communities meet undocumented residents' primary health care needs. However, we do not know what assumptions have been used to allow for the cost of uncompensated inpatient care. Therefore, we have not specified the removal of the Medicare and Medicaid disproportionate share payment provisions until we know what will take their place.²

2. The future of the Medicaid program

We have questions about Medicaid. The Task Force appears to assume that the program remains as a separate payer, subject to certain spending limitations. On the other hand, many Members of Congress -- both liberal and conservative -- view national health reform as a major opportunity to both mainstream the poor and eliminate Medicaid.

In essence, the only Medicaid changes the Task Force has asked us to draft are the liberalization of the program's nursing home eligibility standards and managed care enrollment and budgeting changes. All of the weaknesses of Medicaid would remain: its separateness, the burdens it places on state budgets, the uncontrolled nature of spending on long term care (by far the biggest piece of the program), and its inability to pay for critically needed care for lower income people regardless of their categorical status. The unresolved Medicaid dilemma compounds the lack of financial assistance for lower income individuals and families subject to the new mandate.

3. Benefits

Task Force v the Actuary: Our draft benefit package is based on the original task force recommendations, with at least some of the modifications as presented to the President recently in Plans A and B. However, we do not know exactly the Actuary's exact actuarial assumptions, which benefits have been removed, and which have been added back into the model. Obviously we will

² If we expand Medicaid to provide at least some assistance to all low income persons, then the current Medicaid rule extending emergency benefits to otherwise qualified undocumented persons would apply. At a minimum, emergency inpatient and outpatient care would be financed.

need complete details on what is meant by a "standard" plan. Changes will be needed in both the benefit package (including applicable amount, duration and scope limitations) and in cost sharing rules.

Persons with supplemental health needs related to physical, mental and developmental disabilities and illnesses: A major benefit issue is what to do for persons with chronic disabilities or illnesses or with treatment needs that extend beyond the "post-acute" phase. The draft long term benefit plan is limited to persons with the most severely disabling conditions, leaving most disabled persons unassisted.

To compensate for the gaps in the benefit plan, we have drafted an expanded Medicaid wrap-around for near-poor disabled adults and to all children under age 19.³ The children's wrap-around is of particular concern to the Department of Education because of the Individuals with Disabilities Education Act, which requires states to pay for extensive remedial services for disabled children. Medicaid already is the principal payer here. Some sort of supplemental program for disabled adults will be of major concern to the disability community.⁴

4. Legal rights and duties

The new law will contain a panoply of both new and altered legal relationships, rights and duties. While legal issues arising from malpractice reforms were extensively addressed by the Task Force, others were not. These are:

- legal rights between individuals and states, alliances, plans and providers;
- legal rights between plans on the one hand and alliances and states on the other; and
- legal rights between providers and plans, and between providers and alliances and states .

³ The reasons that coverage for children is specified more broadly is that the current Medicaid statute gives states the option to cover all children under age 19 regardless of family income.

⁴ Under current Medicaid law, certain disabled adults (those who are current or former SSI recipients) who need extra coverage in order to work are provided with Medicaid. The income eligibility standard is quite liberal for this program and offers a solid precedent on which to build. Interestingly the program was originally sponsored by Senator Dole.

Working with Task Force lawyers, the legal audit group, and others, we have fashioned a series of legal rights and duties. Some are new, while others are amendments to existing rights of action. These rights and duties reflect the sweeping changes in federal law created by national health reform. This section will need particularly close review.

5. The National Health Board

We had to make certain assumptions about the delegation of Congressional authority to the Executive Branch. Changing current patterns of Congressional delegation of legislative authority from existing executive branch agencies to a new Board has enormous jurisdictional implications. For this reason, the Board will be controversial with many Congressional Committees. Thus, whenever the Task Force papers did not appear to expressly delegate powers to the new Board, we left existing federal agencies alone. For example, we assume that HHS will continue to carry out much of the day-to-day federal administrative duties, DOL will oversee ERISA, Treasury will enforce tax laws and penalties, and so forth.

cover.mem

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Monday meeting with Congressman Dickey
cc: Melanne, Lorraine, Steve, Distribution

June 5, 1993

On Monday you are scheduled to meet with Congressman Jay Dickey and 11 physicians from his home district. A list of the physicians, their professional affiliations, and their home towns are attached. Also in attendance will be the Congressman's Executive Assistant, Bob Brooks, Jr. Bob is a lawyer from Fort Smith, Arkansas and used to practice in Little Rock. (He mentioned he has met you before.)

BACKGROUND

Last month, I met with the Congressman and Bob. At that time he expressed some concern about the difficulty he had experienced in setting up an appointment with you. I assured him that there was nothing to it other than the extraordinary demands on your schedule. He also expressed concern about the lack of physician involvement; I cleared him up on that issue and he seemed relieved. We then went on to have a productive meeting that he seemed to genuinely appreciate. The primary issues he raised during the meeting were:

- (1) **Desire to be a visible (Republican) Cosponsor.** He said he really wanted to be a, if not the lead, Republican cosponsor of the Clinton health reform proposal.
- (2) **Meeting Desire for His Physician Working Group.** He wanted to show how he could get access for his physician working group to the First Lady. (By the way, no other Member of the Arkansas Congressional delegation has made a similar request.)
- (3) **Desire for Strong Malpractice Reform Provisions.** He said he could not sell the legislation without strong tort reform provisions. (I assured him that you wanted to address this issue in a very serious way.)
- (4) **Concern About Small Business Impact.** While he was concerned about the impact, he felt he could sell it IF it was perceived to be fair and affordable.

- (5) **Concern About Abortion Coverage.** He said such a provision would make it impossible for him to support the legislation.

According to the Congressman's staff, Monday's meeting will be one that primarily, if not solely, focuses on those issues of particular concern to physicians. Other than the malpractice issue, the other two most likely issues raised will be cost containment (and its impact on physicians) and sensitivity to the special needs of rural communities.

I believe that your usual comments about the need for administrative simplification, malpractice reform, special provisions for health care providers in rural areas, state and local flexibility, and modifications to CLIA will make this group of physicians very happy. You might also wish to discuss the role and participation of physicians on the work groups. The abortion issue and the small business concerns of the Congressman are not expected to come up.

PHYSICIANS IN ATTENDANCE

<u>Name</u>	<u>Specialty</u>	<u>Practice Location</u>
Jack Burge	General Surgeon	Lake Village
Charles Davis	Dermatologist	Pine Bluff
John Giller	Orthopedic Surgeon	El Dorado
Lloyd Langston	Ears, Nose, Throat	Pine Bluff
James Lindsey	Family Practice	Pine Bluff
Ralph Maxwell	Family Practice	Monticello
Kerry Pennington	General Practice	Warren
Richard Pillsbury	Ears, Nose, Throat	El Dorado
Carl Shipp	Ears, Nost, Throat	Texarkana
John Trieschmann	Pediatrician	Hot Springs
Lynn Zeno	ARK. MEDICAL SOCIETY	Little Rock

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton, Ira Magaziner
FR: Chris Jennings
RE: General Comments re Reconciliation cuts

June 7, 1993

The Office of Management and Budget (OMB) has requested that the Department (HHS) supply them with some additional budget proposals that amount to approximately \$35 billion over 5 years. Attached is the list that the Department forwarded today.

The numbers do not yet add up to \$35 billion because HHS does not yet have a final number on the proposal to set the part B premium at 27 percent of program costs. (It is currently set at 25 percent.) These numbers cause great concern (both inside and outside the Administration) because of the perceived negative impact they would have on the prospects of health reform.

Congressional Response

It remains unclear where the Members will come down on these cuts. Many want to support the President on the reconciliation bill. Having said this, the health reform advocates have great concerns about adding much more before health reform is introduced. This list includes Members such as Rockefeller and Mikulski, and many of the liberal House Members. Senator Pryor is also concerned about the aging groups' response to these proposals and counsels caution with regard to deep cuts.

Aging Groups' Response

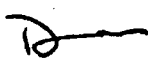
Today, AARP held a press conference decrying the Boren proposal. They repeated their claims that the proposal was trading protection for the rich and the oil companies at the expense of the vulnerable elderly. AARP also made the point that this proposal -- or any other proposal that made significantly greater cuts -- represented a clear and present danger to health reform. All three networks, plus C-SPAN and CNN were in attendance. (AARP's current position is that \$10 billion more in the already unprecedented amount of Medicare cuts is the absolute maximum number that they believe they can tolerate; although they will oppose anything more, it remains unclear what actions they will take to voice their opposition.)

The National Committee to Preserve Social Security and Medicare (the Roosevelt Group) has been even stronger in its opposition to the proposed cuts. They already oppose the level of cuts included in the House-passed package and believe that one dime more is totally unacceptable. They have already started up a phone-in effort to Members of Congress and they are going to go as public as possible on this one. Dana Priest of the Post has already arranged an interview with them tomorrow. Others are sure to follow.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 7 1993

TO: The President and Mrs. Clinton
FROM: Secretary Shalala 
SUBJECT: Public Portrayal of the Medicare Program

As we move from the stage of formulating our plan for Health Care Reform to the process of explaining it to the public and shepherding it through the Congress, my staff and I are increasingly concerned about the way in which the Administration publicly portrays the Medicare program. In particular, we are dismayed by the credence which seems to be attached to any complaint about the program, no matter how ill-founded. While there are many problems with Medicare - which we are trying to address in a number of ways - the program continues to enjoy extremely broad support not only from its beneficiaries and other key constituency groups, but from the general public as well. Key Congressmen are especially sensitive to its political importance.

As representatives of the Administration have met with provider groups, especially physicians, they have heard a continuing litany of complaints about Medicare. Many of these complaints are well-founded. It should be understood, however, that for the last twelve years Medicare has been run by administrations fundamentally hostile, on ideological grounds, to its very existence, unwilling to spend money to improve its operations, and eager to discredit it in a number of ways. Partially as a result, beginning in the mid-'80s, the Congress began micromanaging the program by writing extremely detailed legislation, which has made responsive and constituent-sensitive administration even more difficult.

It's also important to understand that, at the root of many provider complaints about Medicare is the feeling that they are not getting paid enough. If we really agreed with that perception, it would be difficult to justify adding another \$20 to \$30 billion in provider payment reductions to a Reconciliation package which already contained almost \$50 billion in reductions.

In fact, by any objective measure, Medicare is the most efficiently-administered health insurance program in the world. As we showed you in charts last month (attached), since 1983 it has also significantly outperformed the private sector in terms of cost containment, despite insuring an increasingly sick and disabled population. And while there are serious problems in the Medicare HMO program - which we are in the process of fixing - Medicare is still the largest buyer of HMO services in the world.

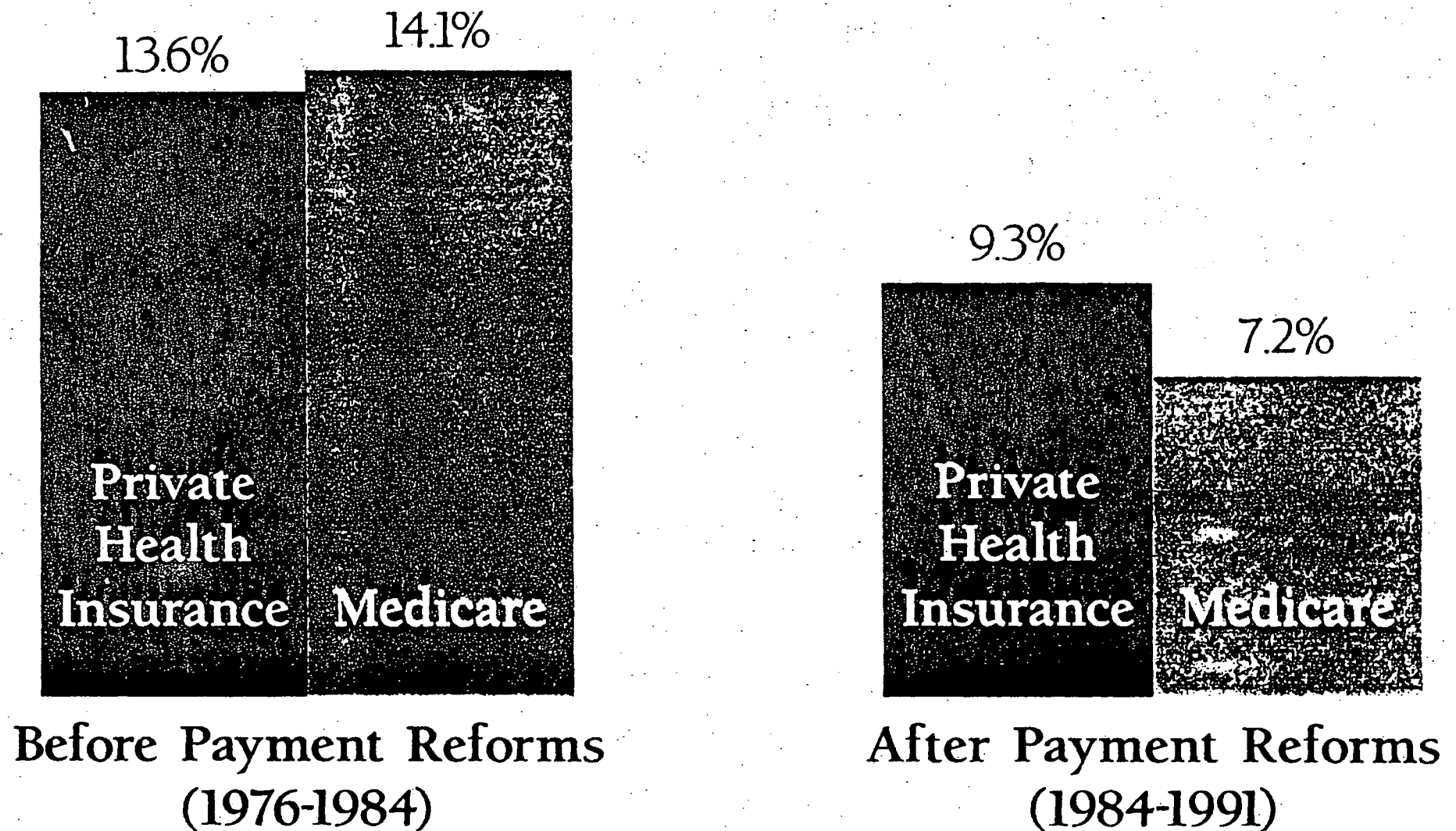
As the extent of the flap over last month's leak that we were even considering integration of Medicare into Health Care Reform reveals, Medicare beneficiaries are not only extremely protective of the program, but highly mobilized. Moreover, to the extent that we reinforce the notion that the government can not even run this most popular of all its programs, we give ammunition to those who would argue that we are incapable of the far more complex task of administering Health Care Reform. We thus run the risk of alienating our friends while giving comfort to our enemies.

For thirty years, Democrats of all persuasions have considered Medicare one of our proudest accomplishments. As New Democrats, we should improve upon and modernize those accomplishments rather than appearing to agree too readily with those who never believed in the principle of social insurance for the aged and disabled in the first place. Otherwise, we run the risk of sending out some very confused and confusing signals about our views on health care and Health Care Reform.

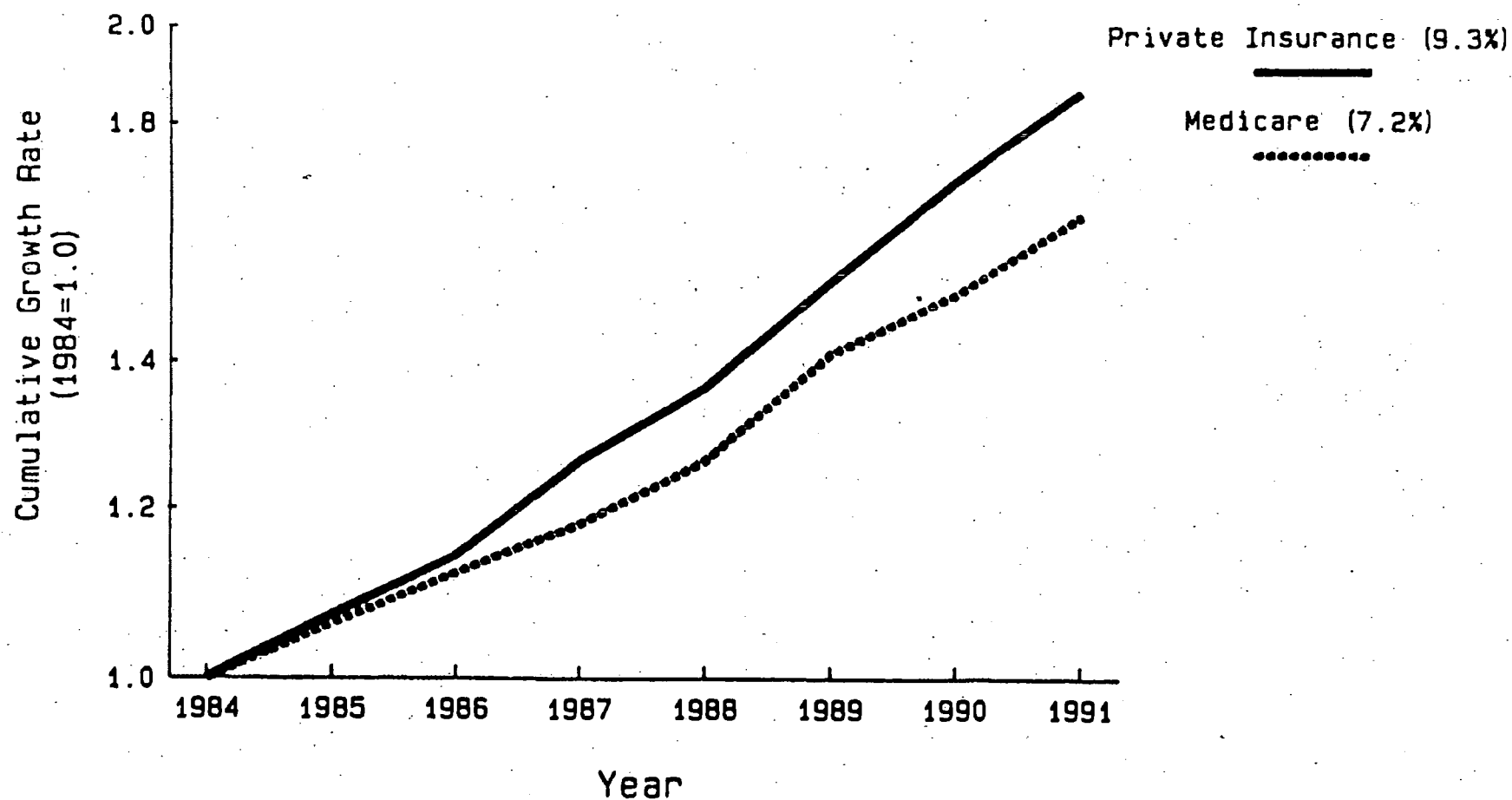
Attachment

cc: Carol Rasco
bcc: Ira Magaziner
Bruce Vladeck
Phil Lee
David Ellwood
Ken Apfel
Jerry Klepner
Judy Feder
Ken Thorpe
Barbara Cooper

Comparison of Growth Rates in Expenditures Per Enrollee: Private Health Insurance and Medicare

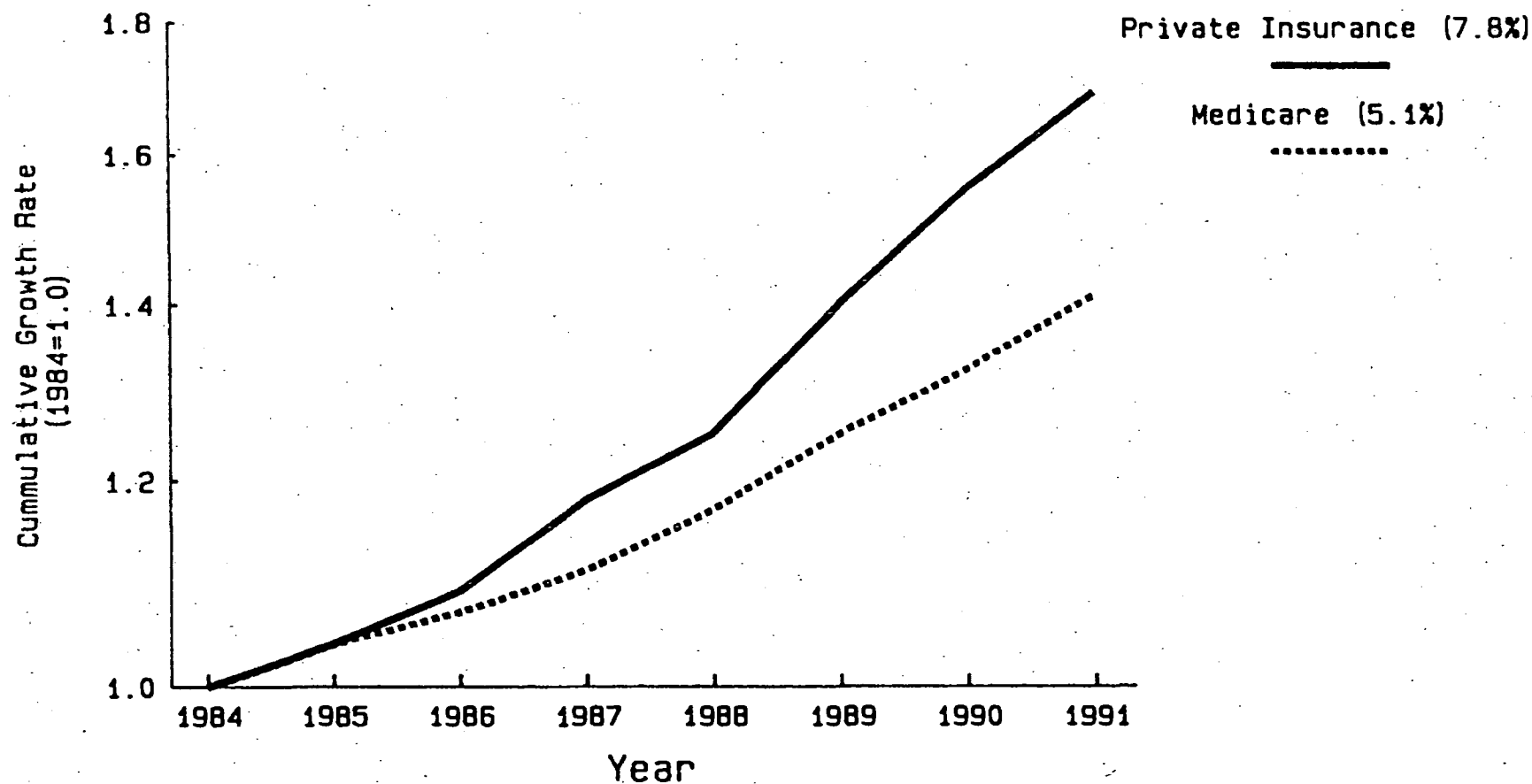


Comparison of Growth Rates in Expenditures Per Enrollee: Private Health Insurance and Medicare 1984-1991



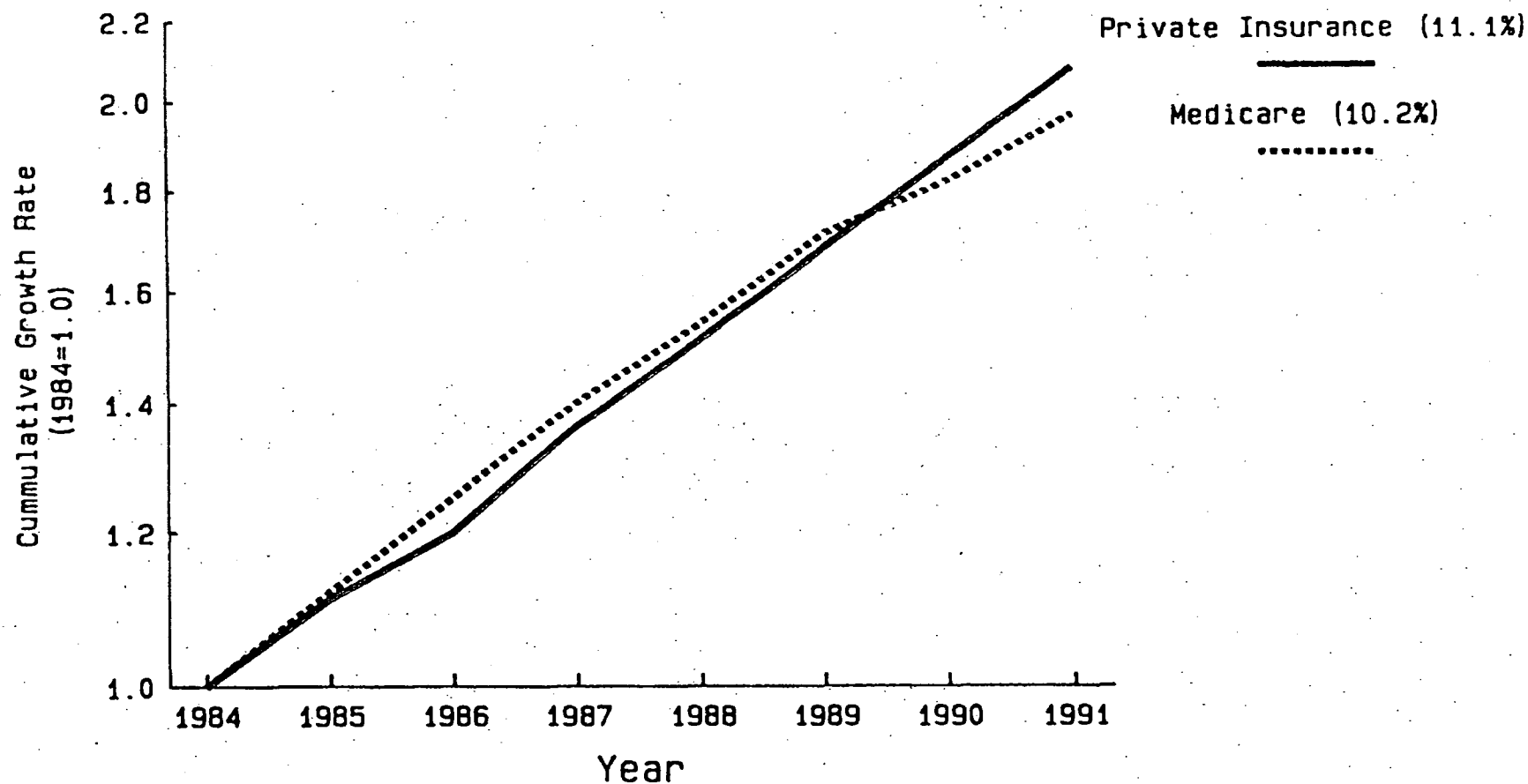
Note: Numbers in parentheses are the 1984-1991 compound average annual rates of growth.

Comparison of Growth Rates in Hospital Expenditures Per Enrollee: Private Health Insurance and Medicare 1984-1991



Note: Numbers in parentheses are the 1984-1991 compound average annual rates of growth.

Comparison of Growth Rates in Physician Expenditures Per Enrollee: Private Health Insurance and Medicare 1984-1991



Note: Numbers in parentheses are the 1984-1991 compound average annual rates of growth.

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Meeting with Senator Exon
cc: Melanne, Steve, Distribution

June 9, 1993

Tomorrow you are scheduled to meet with Senator Exon to give him his long sought after briefing on the status and substance of the health reform plan. In attendance with him will be his health legislative assistant, Mary Peterson.

BACKGROUND

Senator Exon is one of those generally conservative Democrats who serves as a bellweather for the Senate. His votes are usually not the result of a substantive argument as much as they are based on his gut feeling about an issue. As a result, in order for him to vote for a complex, controversial issue, he needs to "feel" as though his supporters/constituents feel generally comfortable about it and he can explain it in relatively easy terms.

The above helps explain why Senator Exon is so focused on the message of health reform. He has been extraordinarily impressed with the way you "sell" this issue and believes your presence and your message has made it easier for him to contemplate supporting the plan.

What has also become clear is that he does not want Senator Kerrey to be the only Senator from Nebraska who is linked with the need to reform health care. He will therefore likely follow up his meeting with you with a press release. I believe that this is a good signal because it illustrates how he still -- despite some concerns -- wants to be associated with the Administration's health reform plan.

While the health reform sales pitch is extremely important to him, Senator Exon does have some specific concerns/interests related to health care that he may raise:

1. **Small Business Impact.** Nebraska, like most states away from the coasts, has numerous small businesses that they have been relying on for most, if not all, of their job creation source. As a result, Senator Exon is extremely sensitive to the concerns about negative impacts on these businesses and the potential for job loss. Of all issues, he is most concerned about selling health reform to this very influential group of employers.

2. **Financing.** Like all Members, he is very concerned that health reform will require a tax increase that exceeds the voters desire for health reform. He may be particularly sensitive about this following the debate surrounding the reconciliation bill and the Texas Senate election. He has indicated general support for a tobacco tax, however.
3. **Insurer Impact.** Nebraska is home to many large insurers, including Mutual of Omaha and Physicians Mutual. Senator Exon is much more sensitive and concerned about any negative impact on these entities than is Senator Kerrey. At the Jamestown retreat, he asked about the role of supplemental insurance policies. Although he may not raise this issue again, he may bring with him the message that overly critical rhetoric against the insurers is counterproductive and puts him in a difficult bind.
4. **Rural Concerns.** As you know from your visit, both Senators are very concerned about assuring that health reform works in rural areas. The comments you have made in the past about how rural communities will become disproportionate winners because they are currently disproportionate losers would be welcomed by Senator Exon.
5. **Concern about how VA and Indian Health Facilities Will Fare.** Senator Exon expressed his concern about this issue during the Senate retreat. He could raise it again, although he seemed satisfied with your response in Jamestown.
6. **Nervousness About Overly Generous Benefit Package.** Senator Exon's staff reports that he is nervous that the benefit package may be too expensive. As a result, he may counsel being cautious in this area.
7. **Abortion.** Senator Exon believes that including abortion in the benefits package will be difficult, if not impossible, to sell to the moderate to conservative Democrats. He feels very uncomfortable with any notion that there would be any subsidization of abortion.
8. **State Flexibility.** The message that health reform should be structured in a way that provides significant state and local flexibility appeals to Senator Exon. Recently, he has been consulting with Frank Barrett, the Chair of the Nebraska Governor's Blue Ribbon Panel on Health Care.

The most important outcome from this meeting is that he continues to feel comfortable about the plan and how we are going to sell it. (He already has great confidence in you.) If you have anything that you would like to test out as a message concept, I would not hesitate to check it out with him. Whatever you decide to do, I am confident that this will be a very good meeting.

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Meeting with Senator Dodd
cc: Melanne, Steve, Distribution

June 10, 1993

Tomorrow you are scheduled to meet with Senator Dodd. Escorting him will be his health legislative assistant, Mary Peterson.

BACKGROUND

Senator Dodd is the Chairman of the Labor and Human Resources Subcommittee on Children, Families, Alcohol and Drugs. As such, he has a particular interest in how and how soon children will be covered, particularly those with special needs.

Senator Dodd has publicly and privately stated that he wants desperately to support the President's health reform proposal (see attached article). He has also indicated that he plans to do so even if he cannot agree with all elements of the plan. This is a very constructive position and one that he seems to like to contrast with Senator Lieberman.

In recent months, however, Senator Dodd has communicated his concern about the Administration's health reform "message." He has been especially troubled by the negative characterizations of the insurance and drug manufacturing industries -- two of the mainstay employers of Connecticut. (Specifically, major health care players in the state include: Travelers, Aetna, and Cigna, as well as Pfizer and some biotech firms). Other specific concerns he and his staff have raised in the past include:

1. **Job Impact.** Currently, Connecticut continues to face recessionary times. Its unemployment rate is stuck at around 7%, largely due to an increasing number of jobs lost to cuts in the Defense Industry. Since the pharmaceutical and insurance industries now serve as two of Connecticut's few remaining "reliable" and large employers, he has great concerns regarding possible job losses that could result from reform.
2. **Cost Containment.** Global budgets and drug price review boards scare the insurers and the pharmaceutical manufacturers. Both industries are managed competition converts and believe that the market is now beginning to show how it can contain costs. They both are deathly afraid of government regulation and price controls -- approaches that they argue would kill managed competition.

3. **Insurance Reform.** The Connecticut insurers are very concerned that HIPC's or Alliances are just fancy name covers for single payer, anti-competitive systems. They argue if they are so competitive, let other insurers compete with them -- under the same rules -- outside of the alliance. Senator Dodd may not take the insurers' position, but he may raise it to hear your response. (Our latest policy read on this issue is that we cannot have companies outside of the alliance because, whatever we do, we cannot totally prevent cherry picking.)
4. **Workers Compensation.** The insurers based in Connecticut underwrite a great deal of workers compensation claims. They are very concerned about the news that we are considering moving the financial responsibilities of workers comp benefits from the workers comp system to the health care system. While the task force considered this option, the great complexity in doing this over the short run encouraged us to develop a two part strategy that has met with general approval from employers and insurers. Initially, under this proposal, people would go to their health plan for treatment of work related injuries. Workers comp insurers would remain responsible for payment and would reimburse the health plan for the services provided. Alliances would apply fee schedules and other cost containment devices to reduce workers comp costs. Finally, a national committee would be established to study the feasibility of more complete integration.

Although Senator Dodd does have the concerns raised above, his staff has continually reiterated his strong intention to support the plan. The best outcome for this meeting is to hear this sentiment and commitment expressed directly from him to you.

Middletown

Dodd vows to support health plan

Continued from Page B1

Medicare, by contrast, amounted to mere "figuring out how to send checks to people," Dodd said.

Dodd, who met with about 20 leaders of community health centers throughout the state at the Community Health Center in Middletown, said a consensus seems to be developing in Congress to reform the system in some way.

"There's a strong desire to move forward — to get something cooking," he said.

Even without new laws, progress on reform already has been made, Dodd said, because "No one's defending the mess anymore."

Asked whether the Clinton plan would include dental care as a basic benefit, Dodd said he hoped so. But he said even if it severely limits benefits for dental care, he will support the bill.

"If they come back with [a proposal that offers coverage for] prevention only, I'll tell you right now, I'm going to support it," he said.

Dodd said he has a similar position on mental health care.

"The good news is, [dental and mental health care] are going to be a part of it," he said. "The bad news is, it's not as much as you would like." The community health center leaders advocate universal access to health care.

Janet Skane Stern, president of the Southwest Community Health Center in Bridgeport, said she was satisfied with Dodd's answers.

"Sen. Dodd has been a strong supporter of community health centers for a long, long time," said Stern.

"He's always supported us in the past, and we will work with him to see that the uninsured get the [medical] service they deserve."

By MATTHEW DALY
Circuit Staff Writer

MIDDLETOWN — Describing national health care reform as the most significant social policy issue of his lifetime, U.S. Sen. Christopher J. Dodd vowed Wednesday to support President Clinton's forthcoming proposal even if Dodd objects to parts of it.

"For the first time in my lifetime — and maybe the last, if we screw it up — we have a chance to do something" on health care reform, Dodd, 49, told a group of community health care providers.

"I don't want to say 36 months down the road, 'Damn, we missed a hell of an opportunity,'" he said.

Dodd, who also met Wednesday with about 10 people he described as victims of the current

system, said health care reform will be "a long, painful journey."

But he said he was confident that Congress would pass some kind of reform bill by the end of the year.

"I'm very optimistic about it and very excited to be a part of it," he said, calling the debate over health care reform "one of those rare moments" in the Senate when he and other lawmakers have an opportunity "to do something with a profound, positive impact on people's lives."

Dodd said he does not know exactly what a plan being put together by first lady Hillary Rodham Clinton would entail, but he said he has been impressed by Clinton and her task force.

The first lady expects to release a proposal for health care reform in September.

"I have attended a lot of briefings" in 13

years in the Senate, Dodd said, "and I have never attended better, more thorough or more knowledgeable briefings than with Mrs. Clinton."

Dodd, whose strong support for the president's health care plan contrasts with more neutral comments by fellow Democratic Sen. Joseph I. Lieberman, also praised the Clintons for attempting health care reform.

Dodd's father, former U.S. Sen. Thomas J. Dodd, introduced a bill for health care reform four decades ago, Dodd said, and Congress has never completely tackled the issue since then.

"This is the single most comprehensive social policy question ever debated in the U.S. Congress," Dodd said.

Efforts to institute Social Security and

Please see Dodd, Page B1

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Dinner Hosted by Congressman Kasich (7 pages)	6/12/93	P5
002. memo w/attach	Chris Jennings to Hillary Clinton Re: Meeting with Congressman Cooper (3 pages)	6/14/93	P5
003. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senators Leahy and Pryor (8 pages)	6/14/93	P5
004. memo	Chris Jennings/Melanie to Hillary Clinton/Patti Re: Congressional Meetings (2 pages)	6/16/93	P5
005. memo w/attach	Steve Edelstein Hillary Clinton Re: Cosponsors of McDermott Bill (8 pages)	6/17/93	P5

COLLECTION:

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Gary Foulk

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RESTRICTION CODES

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

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential 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]
- 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]
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Dinner hosted by Congressman Kasich
cc: Melanne, Steve, Lorraine, Distribution

June 12, 1993

On Monday evening you are scheduled to attend a dinner at Congressman John Kasich's home. In attendance will be a number of other Republicans interested in health reform, including: Wayne Allard (CO), Dennis Hastert (IL), David Hobson (OH), Nancy Johnson (CT), Jim Kolbe (AZ), Alex McMillan (NC), Dan Miller (FL), Deborah Pryce (OH), Christopher Shays (CT), and Olympia Snowe (ME).

Attached are brief summary backgrounds on each of the attendees. It is difficult to characterize this group of Members because they are so different. Their ideologies range from moderate to very conservative, their influence on other Members ranges from modest to significant, and their backgrounds and understanding about health care vary greatly as well. Regardless, however, they are all now very interested in the health care issue and are very much looking forward to Monday evening.

BACKGROUND

I believe that Melanne received this invitation directly from Congressman Kasich. As one of the up-and-coming Members, and because of his growing influence and national prominence (as a result of his recent work on a Republican budget alternative -- see attached), Melanne felt it would be a good idea to take him up on his desire to have an informal discussion on health reform.

In late May, Congressman Kasich and his House Republican Budget Members released the attached "White Paper on Health Reform." The report does not purport to have all the answers, but it does strongly advocate a stereotypical conservative approach to health reform, such as the use of MediSave Accounts, means-testing Medicare, increasing Medicare beneficiary copayments, and categorical spending targets for health entitlements (but not for the private sector).

The "White Paper" also includes a number of suggestions that are consistent with what you and Ira have working on including: Developing incentives for greater use of competition in the Medicare and Medicaid programs, providing flexibility/waiver authority to the states, reducing health care fraud, assuring insurance portability, establishing purchasing groups, and addressing the medical liability problem.

The report concludes with this statement:

With all the above in mind, two fundamental points emerge from this analysis: policymakers should not put government first in seeking solutions to the nation's health care problems; and true reform must include restoring personal responsibility and the vitality of the doctor-patient relationship. Any reform attempts that circumvent these fundamental budgetary and economic factors will fail.

I am not exactly certain how the "doctor-patient relationship" and the degree to which reform relies on the government can be described as "fundamental budgetary and economic factors." However, the quotation may give you an idea of the philosophical priorities of at least Congressman Kasich. More importantly, since we intend to rely on the Federal Government as little as possible and retain (and enhance) the option of choice of doctor in the President's plan, I thought you might find the reference to be helpful.

HOUSE REPUBLICAN HEALTH CARE DINNER MEETING
JUNE 14, 1993

CONGRESSMAN JOHN KASICH (R-OH): Congressman Kasich was first elected to the House in 1982. He was reelected with 70% of the vote and has not fallen below that mark since. The Congressman is acknowledged by most to be one of the most intellectually gifted Members in the House. Yet, until recently, he has appeared to take on a role similar to Justice Scalia; that is, a very smart Member who had not been very successful in influencing his colleagues.

In recent years, he has made a name for himself by advocating tough measures to control federal spending. In 1989, he proposed a federal budget freeze that would have held all discretionary spending to fiscal 1989 levels. The bill was defeated by a large margin on the House floor 30-393. His 1990 proposal went further, freezing all domestic and defense spending levels. It received very little support as well. This year he took on the lead in crafting the House Republican's alternative to the President's budget. His proposal was praised by some in the media for backing up the usual Republican rhetoric, with specific cuts, how it would be possible to significantly reduce the deficit without raising taxes. However, although the proposal did receive more Republican support than usual, it still obviously failed to gain sufficient support for passage by the House Budget Committee.

Until this year, other than advocating large cuts in Federal health programs and his opposition to public funding for abortions, he did not appear to have any detailed position on health care. In late May, however, he released a "White Paper on Health Reform." In the report, he took -- not too surprisingly -- a rather stereotypical conservative position on health reform. (The specifics have been outlined in the cover memo.)

CONGRESSMAN WAYNE ALLARD (R-CO): Successor to current Senator Hank Brown, Allard is considered likely to follow Brown's fairly conservative voting pattern. He served eight years as a Colorado State Senator prior to his election to the House in 1990. He opposes abortion except in cases of rape, incest, or where the mother's life is in danger. Due to the rural makeup of his district, he sits on the Agriculture committee and will be interested in rural health care. He also sits on the Small Business Committee and may be sensitive to small business concerns.

CONGRESSMAN DENNIS HASTERT (R-IL): Congressman Hastert was selected by House Minority Leader Michel to be his point person on health care reform. A fellow Illinoisan, his appointment was a surprise, considering that he is only in his fourth term in the House and his second term on the Energy and Commerce Committee. Congressman Hastert does not have a long track record in the House or in health care reform. A staunch conservative, Hastert seems to be a "Michel style" House Republican willing to offer proposals and be a part of the process rather than the more confrontational Gingrich-Armey approach.

Before entering politics, Congressman Hastert was a teacher and coach for 16 years. He served in the Illinois Assembly for five years prior to running for Congress. Hastert's district is on the line between suburban Chicago and the "down state" area resulting in a mix of suburbs, small industrial towns and agricultural areas. Congressman Hastert is conservative, and, according to the Almanac of American Politics, "...is one of the party's most fervent opponents of taxes."

Congressman Hastert co-sponsored many Republican health bills in the 102nd Congress including the bill introduced by the Republican Leader Bob Michel. This year, Hastert has sponsored his own "Health Care Choice and Access Improvement Act" (HR 150), which would reform the small group insurance market, increase the tax deductibility for the self-employed, and allow employers to establish tax-free Medi-Save accounts.

Congressman Hastert has been pleased and appreciative of the weekly briefings by Ira and other members of the working groups to Republican members.

CONGRESSMAN DAVID HOBSON (R-OH): Hobson was elected in 1990 after a successful 8 year stint in the Ohio State Senate, which he culminated as president pro tem. In the State legislature, he was appointed to the Health Committee at an early stage of his career. Despite his lack of background on health issues he became engrossed in the subject and sponsored many health care bills in Ohio including measures dealing with AIDS, aging and mental health. His comprehensive AIDS bills was criticized heavily by conservatives, but he pushed it through the Republican controlled Senate. He has attended (and seemingly appreciated) a number of the Republican Task Force briefings by Ira.

CONGRESSWOMAN NANCY JOHNSON (R-CT) Congresswoman Nancy Johnson is a moderate Republican with a rather inconsistent voting record. Her tendency to vote independently, both in committee and on the floor, made it difficult for her to get the committee posts she sought. Congresswoman Johnson can also be angrily partisan. She supported Newt Gingrich, an advocate of confrontation rather than cooperation with the majority, in his contest for Minority Whip. Perhaps as a result, in the 101st Congress, she became the first Republican woman ever to serve on Ways and Means. On the Committee she has earned praise for her efforts to craft a comprehensive package of child care initiatives. With her seat on its Health Subcommittee, she has focused on Medicare, health, and child care.

She has been an active member of the '92 Group, a coalition of moderate Republicans, working on ways to set budget priorities and reduce the deficit and served as the co-chair in the 100th Congress. In 1988, she joined Lowell Weicker in an effort to moderate the GOP's opposition to abortion rights and restore support for the Equal Rights Amendment in the party's platform, but their efforts were rejected.

Johnson is a strong supporter of outcomes research. She does not see insurance reform as the key to cost control. She seems to be leaning toward requiring the individual to obtain health care coverage. Her husband is an oncologist, and she has said repeatedly that doctors are not the cause of the country's health care ills.

In recent comments, Congresswoman Johnson expressed her support for folding some of the less controversial aspects of health care reform such as insurance reform and establishment of the HPCs into the reconciliation bill so that it can move more quickly. This is consistent with many of the moderate Republicans who would just assumed get passed "what we can agree on" -- insurance reform, malpractice reform, delivery system reform, etc. -- and agree to disagree on all the rest for the moment. (She has major problems, she says, with price controls, global budgets, and employer mandates.)

Obviously, being from Connecticut, she is sensitive to the concerns of the insurance industry and, to some extent, the pharmaceutical manufacturers. She does not like to dwell on their shortcomings and is uncomfortable with negative rhetoric aimed at these industries.

Finally, it is very clear that she genuinely likes and trusts the First Lady. She has stated, however, that she is afraid that Mrs. Clinton may be overly influenced by overly liberal thinkers who have an overly optimistic trust in the government to solve the health reform challenge.

CONGRESSMAN JIM KOLBE (R-AZ): Kolbe has been in the house since 1984 representing the east side of Tucson, Arizona. His district includes many high-tech businesses and defense contractors. Previously he served in the Arizona legislature where he earned a reputation as a moderate spurring Arizona to finally enter the Medicaid program. In the House, he votes consistently with the GOP and his record on economic issues is among the most conservative. At the same time, Kolbe is a long time supporter of abortion rights. He sits on Appropriations and Budget Committees. There is speculation that he may challenge embattled Democratic Senator Dennis DeConcini in 1994.

CONGRESSMAN ALEX McMILLAN (R-NC): Conservative but pragmatic, Congressman McMillan has become a key ally of the House Republican leadership. For example, McMillan supported the 1990 bipartisan budget summit agreement backed by congressional leaders and the President, even though it included gasoline and cigarette taxes. A former businessman, he consistently opposes Federal mandates on business. He voted against an increase in the minimum wage and against the family medical leave bill.

McMillan has been a leader on the House Republican Task Force on Health studying health care reform. He co-sponsored the House Republican health care reform bill, which has been reintroduced in the 103rd. He led the subgroup examining administrative reforms in health care and cosponsored a separate health care administrative reform bill. He also has introduced malpractice reform legislation. There are a substantial number of insurance companies headquartered in his district.

CONGRESSMAN DAN MILLER (R-FL): Congressman Miller is a freshman member. He is a political novice with a business background. He is on the Education and Labor and Budget Committees and the Republican Task Force on Health. He was, and may still be, on the Board of the Manatee Memorial Hospital. Miller supports a cap for medical malpractice lawsuits, arguing that it is one of the only ways to get health care costs under control.

Before entering politics, Congressman Hastert was a teacher and coach for 16 years. He served in the Illinois Assembly for five years prior to running for Congress. Hastert's district is on the line between suburban Chicago and the "down state" area resulting in a mix of suburbs, small industrial towns and agricultural areas. Congressman Hastert is conservative, and, according to the Almanac of American Politics, "...is one of the party's most fervent opponents of taxes."

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CONGRESSWOMAN DEBORAH PRYCE (R-OH): Pryce comes to the Hill after an eight year stint as a Municipal Court Judge in Ohio. She won her election with a narrow 44% of the vote due in part to some controversy over her abortion views. Even though she is personally opposed to abortion, she has said that she will support the Freedom of Choice Act, allowing states to impose "reasonable restrictions." Her views on health care and not known. She sits on the Budget Committee.

CONGRESSMAN CHRISTOPHER SHAYS (R-CT): After years at odds with other members of his party in the Connecticut House for being too liberal, Shays won his seat in the House in a special election in 1987. His district contains some of the wealthiest communities in the national as well as the corporate headquarters for such companies as Xerox, Pitney-Bowes and GTE.

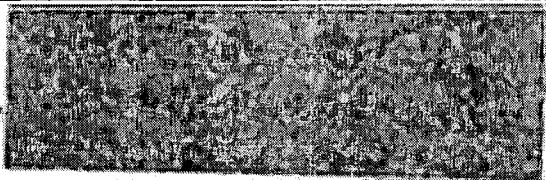
Congressman Shays sometimes moves in directions that make the Republican leadership uncomfortable. He parted with the Bush White House on such issues as abortion rights and parental leave. Despite some of his social views which he argues reflects his urban constituency, Shays considers himself more conservative than many in his party on federal spending. He fought for a seat and won a seat on the Budget Committee arguing that his economics positions were more in line with the mainstream of his party.

His health care views are not known but given his voting record on social issues he is considered a primary Republican target by both the White House and Congressman Bonior.

CONGRESSWOMAN OLYMPIA SNOWE (R-ME): Congresswoman Olympia Snowe is in her eighth term and represents that northern half of Maine. She was elected when then-Congressman Bill Cohen decided to run for the Senate. Snowe has served as an effective member of the House, working with both sides of the aisle to find common ground.

At times, she can be a liberal Republican working with members like Pat Schroeder and Barbara Boxer on abortion issues and fetal tissue research. At other times, she can be strictly partisan, aligning herself with Congressman Kasich on the budget committee and one of Newt Gingrich's biggest supporter in his run for Majority Whip.

Congresswoman Snowe is the co-chair of the Congressional Caucus on Women's Issues. She is also energized by local issues. A knowledgeable moderate Republican tells us that the best way to get her vote is to have local groups bring pressure on her. While it is assumed that Snowe will want abortion coverage in the final package, she did not co-sign the May 13 letter on that issue. She is married to the Governor of Maine, John R. McKernan.



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ADMINISTRATIVE MARKING
INITIALS: 29 DATE: 8-15-05

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Meeting with Congressman Cooper
cc: Melanne, Steve, Lorraine, Ira, Distribution

June 14, 1993

Tomorrow you are scheduled to meet with Congressman Jim Cooper. Caroline Chambers, his health legislative assistant, will be coming in with the Congressman. Ira will also be sitting in on this meeting.

BACKGROUND

Congressman Cooper has become increasingly bitter about his perception of the likely direction of the President's health reform proposal. He assumes that it will reject the precepts of managed competition -- as he defines it -- and fears it will be much more similar to a government administered and regulated, single-payer plan.

In addition, as you know, the Congressman is also extremely concerned about the plan's possible use of global budgets, short-term price control, and employer mandates. He also believes our somewhat public rejection of pure managed competition has been overly gratuitous.

Finally, in recent weeks, we have heard reports that he has been unhappy with the limited amount of consultation he believes he and moderate to conservative Democrats have received on this issue. (See attached a recent letter to his constituents on this matter). He believes that his efforts to comply with the Administration's wishes to not introduce reform legislation have been unappreciated, or at least underappreciated. He apparently feels that his decision to not introduce his CDF proposal has made him look impotent with his constituents and less of a "player" with his colleagues and the press.

There appears to be no specific agenda for this meeting. I would simply advise opening it up for a substantive discussion between you, Ira and the Congressman. I believe an honest, open exchange will be helpful. Although it is clear you won't find agreement on anything, at least we can say we had a direct, constructive conversation with the leader of the managed competition movement.

JIM COOPER
4TH DISTRICT, TENNESSEE

COMMITTEES:
BUDGET
ENERGY AND COMMERCE

WASHINGTON OFFICE
118 CANNON BUILDING
WASHINGTON, DC 20515
TELEPHONE: 202-226-4931

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

DISTRICT OFFICE:
210 EAST DECAT STREET
P.O. BOX 728
SHELBYVILLE, TN 37160
TELEPHONE 615-667-1114

CITY HALL
7 SOUTH HIGH STREET
WINCHESTER, TN 37388
TELEPHONE 615-667-4160

SLATE ONE
308 EAST FIRST NORTH STREET
P.O. BOX 2028
MORRISTOWN, TN 37816
TELEPHONE 615-667-9000

315 LANTANA ROAD
P.O. BOX 848
CROSSVILLE, TN 38608
TELEPHONE 615-667-1664

To: Tennesseans Following Health Care Reform

From: Congressman Jim Cooper

Date: Wednesday, June 2, 1993

Further indications this week from the White House that the big public announcement of the President's health care reform plan will be delayed, possibly for several months. The Administration's current priority is to see its budget plan pass the Senate. With the narrow victory in the House last week and as many as 10 Senate Democrats leaning against the plan, the President needs to focus all of his efforts there. Also, David Gergen, the new White House communications director, has publicly advised that the President hold off until fall.

I am hopeful that Gergen will play a key role in the final shaping of the President's health care proposal. I worked recently with Gergen on a private commission which proposed possible solutions to the federal budget deficit. I believe he shares my bias for market-based reform over more government regulation. He should also be able to give the President good political advice.

The battle in Congress over his budget plan will pale in comparison to what is to come on health care reform. Currently, President Clinton's proposal -- to the extent we know what's in it -- offers little to the conservative and moderate Democrats he will need to get it passed. The elements of managed competition have been so watered-down that the foundation of his plan has become the global budget and the employer mandate, or payroll tax. These are precisely the features which caused moderates to oppose "play-or-pay" and the Canadian-style single-payer plans.

Once released, the President will need significant help in promoting his proposal. The Administration has actively courted labor unions and moderate consumer groups such as Families USA. They can be expected to help sell the reform plan to the public and to Congress. In addition, the Democratic National Committee is staging a nationwide campaign (reportedly targeting key congressional districts) to promote the President's proposal.

The American Association of Retired Persons is likely to endorse the Clinton plan because it will include a new prescription drug benefit under Medicare and will make a token "down-payment"

on long-term care coverage. Many other key groups, however, seem to be lining up against the Administration.

Small business, through the National Federation of Independent Business, will fight with everything it has to kill an employer mandate or payroll tax, one of which the plan will almost certainly contain. The Administration's attempt to win their support by integrating workers' compensation into their proposal hasn't had much success.

The same is true of their efforts to woo doctors. The goodwill they had gained by pursuing malpractice reforms and repeal of many of the clinical lab requirements in the CLIA law has not translated into much support. Between their focus on global budgets and the gratuitous attacks on the profession (made most recently by the First Lady), the Administration seems doomed to having a majority of doctors opposing its plan.

Large, multi-state businesses, represented by the Chamber of Commerce and the National Association of Manufacturers, are nervous about the tremendous flexibility Clinton wants to give states to design their own systems. And hospitals may be faced with a double whammy: global budgets and a hospital tax. Even without opposition from any of these groups, the President's plan could still fail if he insists on pushing the lightning rod issue of abortion.

For the most part the lobbies in Washington have been quietly trying to make their respective cases to the Administration. But the longer they are starved on a diet of press leaks, with no real detail on the plan, the anticipation and the tension will grow. When the plan is finally disclosed, all hell could break loose.

Everyone will have to sacrifice something if we really are to reform our health care system. But the reform plan needs to be fair, and more importantly, it needs to work. I still believe that if the President starts consulting with the moderates in his party now, he can develop a plan which can work and which can pass with broad support.

Close Call Dept: Late into the evening last Wednesday, liberal Democrats in the Congress attempted to preempt the debate over health care reform and include a global budget in the President's economic package. In one of the later versions of a compromise on capping entitlement spending, Energy and Commerce Committee Chairman John Dingell included a requirement that any cuts in Medicare or Medicaid spending must be matched with corresponding cuts in private sector health care spending. Many of my colleagues did not understand the implications of this language (of course there was no explanation of how it could possibly be enforced). Fortunately, working with Rep. Charlie Stenholm (D-TX), we were able to get it removed from the final compromise near midnight the night before the budget vote.

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senators Leahy and Pryor
cc: Melanne, Steve, Distribution

June 14, 1993

Tomorrow you are scheduled to meet with Senators Leahy and Pryor. Escorting them will be Theresa Alberghini, Senator Leahy's health legislative assistant; Theresa Forster, the new Staff Director of Senator Pryor's Aging Committee; and Bonnie Hogue, another Aging Committee staffer.

BACKGROUND

This is a meeting that Senator Leahy has wanted for some time. He has been growing increasingly frustrated over the fact that Senator Jeffords has been receiving disproportionate, as well as favorable, coverage in the Vermont press on health care. Much of this stems from statements by Jeffords that his bill is identical to the bill that he perceives the Administration is crafting. It is also because Jefford's office has publicized any meeting he has held with you or the staff of the White House.

The stated purpose of this meeting is to conduct a discussion with you about the need and desire for state flexibility within the context of national health reform. The desired outcome of this meeting, however, has more to do with illustrating how Senator Leahy has access to you and the White House. It will also give you an opportunity to recognize his (and Senator Pryor's) longstanding work on state-based health reform and the important contribution his past legislation has made to the debate. (As cynical as the above sounds, Senator Leahy's continued strong support of the President's positions on the economic package and health care do merit appreciation.)

Senator Leahy does not have a long-standing history on health issues. To the extent he has been involved, it has mostly been in the area of rural health. His last year's introduction (with Senator Pryor) of S. 3180, the State Care Act, represented his first venture into the national health reform scene. This bill provided for Medicare, Medicaid, and ERISA waivers to states that enact legislation providing universal coverage and cost containment. Then-Governor and Presidential candidate Bill Clinton endorsed this legislation in a letter to Senator Pryor. Attached for your review is a copy of this letter as well as a summary and other background materials on this legislation.

Senator Leahy invited Senator Pryor to participate, in part, because he felt it would increase the likelihood of a meeting but also because Senator Pryor was interested in attending. The meeting will likely revolve around the following issues:

1. **State Flexibility.** Senator Leahy will want to thank you for your continuing assurances that the Administration's proposal will have adequate flexibility for the states to design their own plans which best meet their needs and preferences.
2. **Reintroduction of Bill.** Senator Leahy has held off on reintroducing his state reform initiative, so as not to send the wrong signal on the prospects for reform. However, should reform efforts stall, he will be under increasing pressure from his state to reintroduce this bill. He may wish to discuss this matter with you.
3. **Politics and Communications.** The meeting is unlikely to involve detailed discussions of state-based initiatives. Instead, the Senators will be more interested in discussing the politics of health reform, their views on timing, and communications strategy. I expect that Senator Pryor will be especially interested in addressing these issues. You may want to talk to Senator Pryor about his recent idea to host meetings with Republicans interested in health reform and Administration representatives to discuss health care in a less "pre-arranged" setting.

Lastly, a reminder: Senator Leahy will precede you in addressing the Democratic Governors Association meeting in Vermont on Saturday. (He will be preceded by Governor Dean.) Senator Leahy (and possibly his wife and his staffer) is planning on flying with you to Vermont. We are working on last second details as the memo is being written.



STATE OF ARKANSAS
OFFICE OF THE GOVERNOR
State Capitol
Little Rock 72201

Bill Clinton
Governor

September 4, 1992

The Honorable David H. Pryor
United States Senate
267 Senate Russell Office Building
Washington, DC 20510-0402

Dear David:

I appreciate the time and effort you and others have spent in developing the legislation introduced by you and Senator Leahy which outlines a process for assisting states to plan and implement state-based comprehensive health care reform efforts.

The "one-stop-shop" concept for waiver approval outlined in your bill will help states to truly perform the laboratory function in this area of health care reform as we seek to design an overall system of health care for all our nation's citizens. I appreciate the recognition the bill gives as well as your personal statements in recent weeks that the first choice for national health care reform is for the federal government to act, but in the interim this bill gives states the needed process for moving ahead.

I support your efforts in this bill toward moving us to a national solution and look forward to working with you further on this critical area of health care reform.

Sincerely,

A handwritten signature in dark ink, appearing to read "Bill", written over the printed name.

Bill Clinton

Business and Health | Milt Freudenheim

States Seek Aid For the Uninsured

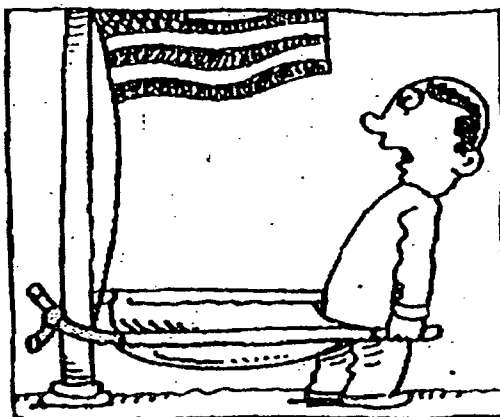
A DELEGATION of 14 governors went to the White House last week seeking help for efforts by states to bring health care to millions of uninsured Americans. Despairing of obtaining national solutions on health care in the election year political gridlock, the governors — 9 Republicans and 5 Democrats — are trying to push ahead on their own.

The states need Bush Administration support to get Congress to waive provisions of the Federal law that exempts two-thirds of all businesses from state taxes linked to health insurance. Self-insured companies invoke the Employee Retirement Income Security Act, called Erisa, to escape taxes on insurance premiums. They can also refuse to contribute to state pools to insure people viewed as poor risks.

But the Administration, heeding the concerns of business, reacted coolly to the governors. Although most company executives are upset about rapidly rising health costs, many self-insured companies fear that their expenses could grow even more if they lost the Erisa shield and had to comply with health insurance laws that vary across the country. And the business lobbyists contend that if Congress waived even one provision, the floodgates would open to demolishing the entire Erisa statute, which protects pensions.

The states' concerns were heightened when a Federal judge in Newark, citing the Erisa law, recently invalidated the New Jersey surcharge on hospital bills. The surcharge subsidized hospital costs of uninsured patients.

Senator Dave Durenberger, Republican of Minnesota, said the Newark ruling, which New Jersey is appealing, threatened to sabotage Minnesota's



Stuart Goldenberg

plans for new taxes on hospitals and doctors to help provide health coverage for the uninsured. The recent New York increases in hospital charges to commercial health insurers could also be challenged, as could financing for expanded Medicaid programs in many states.

Florida, Hawaii, Oregon and Vermont, like Minnesota, have passed sweeping health-care laws that could be hobbled by the Erisa provisions. Alicia Pelrine, a policy analyst with the National Governors Association, said. She said the governors of Colorado, Connecticut and Kentucky were also concerned because they planned wide-ranging health-care legislation this year.

The 14 governors met with Samuel K. Skinner, the White House chief of staff, Roger D. Porter and Clayton K. Yeutter, domestic policy advisers, and Gail R. Wilensky, the senior health-care adviser.

A number of states are also seeking exemptions from Medicaid and Medicare rules. Oregon, for example, has been waiting for years for a Medicaid waiver to let the state set priorities in covering certain types of patients and illnesses. The Administration is expected to announce a decision on the Oregon request this summer.

The governors association is working with Mr. Durenberger and with two Democrats, Senators David H. Pryor of Arkansas and Patrick J. Leahy of Vermont, on bills that would allow states to apply for waivers from certain Erisa restrictions for programs to increase access to health care.

The Administration does support measures to speed decisions on requests for Medicaid and Medicare waivers, which sometimes languish in the pipeline for three or four years. And it also supports a proposal, sponsored by Senator Daniel Patrick Moynihan, Democrat of New York, and Senator Durenberger, to let states place Medicaid patients in H.M.O.'s or physician networks without special Federal permission.

But Administration officials said they opposed granting Erisa waivers, unless states agreed to reduce taxes on insurance premiums; eliminate laws that mandate coverage for hundreds of specific health-care services; and put people into large purchasing groups, which could force hospitals and doctors to reduce their charges.

The Pryor-Leahy bill would deal with some of these concerns by exempting "multistate" businesses in states where they have dozens of employees — if they offered a package of health benefits equivalent to \$2,500 a year for each family covered and \$1,250 for single employees. Christopher Jennings, a Pryor legislative aide, said: "The states could develop a minimum package of benefits. But all the 'good guy' multistate employers would not have to deal with it."

The Durenberger waiver proposal would permit the Secretary of Labor to grant "limited exemptions under Erisa." Under this approach, self-insured employers would pay state insurance taxes and other fees, but they would still be exempted from mandated state benefits.

Dr. Wilensky said the Administration was serious about trying to deal with at least some of the governors' concerns. "We really like the state innovations and flexibility," she said. But White House officials made it clear that the Administration was not ready for Erisa law waivers.

S. 3180, THE STATE CARE ACT OF 1992
SUMMARY OF MAJOR PROVISIONS

Establishment of State Care Demonstration Projects

- * The bill establishes a federal Commission to consider State applications for 5-year waivers of specified provisions of Medicare, Medicaid and ERISA law to allow States to implement state-wide, comprehensive health care reform initiatives meeting certain criteria.
- * The Commission provides for timely approval of demonstration projects, oversees implementation, and has the authority to revoke waivers and terminate demonstrations for good cause.
- * Demonstrations are limited to 10 states.
- * The Commission is authorized to provide implementation grants of up to \$2 million to each approved State.
- * The Commission consists of the Secretary of Health and Human Services, the Secretary of Labor, and 11 members appointed by the President and confirmed by the Senate.

Requirements of State Plans

In order to obtain Medicare, Medicaid and ERISA waivers, a state must:

- * demonstrate that by the end of the five-year period, the percentage of the insured has increased to at least 95% of the population OR the insured population has increased by 10 percentage points. (The 10 percentage point increase clause is designed to be fairer to states with higher numbers of uninsured.) With either goal, coverage for children must increase at an equal rate.
- * demonstrate that health care inflation within the State does not exceed the average annual percentage increase in the gross domestic product plus 3.7% for 1994, 2.7% for 1995, 1.7% for 1996, .7% for 1997, and for each year thereafter, 0 percentage points.
- * develop a common benefit package which is at least equal to one of two benefit packages contained in Senator Bentsen's small group insurance reform bill.
- * demonstrate that the project will be federal cost-neutral over the five-year period.

Waiver Authority

States that meet the above criteria would be eligible for the following waivers:

Medicaid. Waiver authority allows states to include Medicaid beneficiaries and Medicaid payment systems in plans to restructure health care finance and service delivery systems.

Protections for Medicaid Beneficiaries. States must provide mandatory Medicaid services to all groups current law requires States to serve. States must maintain safeguards currently specified in the Medicaid program (including procedures sufficient to ensure the high quality and availability of care) to protect the health and welfare of Medicaid recipients.

Medicare. Waiver authority is very limited with respect to Medicare. The bill gives states the ability to include Medicare in all-payor negotiated rate systems for hospitals. Benefits to Medicare beneficiaries cannot be diminished.

ERISA. Waiver authority has been crafted narrowly to recognize the concerns of business and labor.

- * Allows states to collect assessments from ERISA plans. States are prohibited from singling-out ERISA plans for assessment. The provision enables states to broaden their current funding base to support health-related initiatives, such as risk pools for the uninsured.

- * Allows states to establish a standard health benefit package for employers in the state. However, employers with self-funded health benefit plans could deviate from the standard benefit package if the employer offers a health benefit plan with benefits equal to an adjusted \$1,250 per individual and \$2,500 per family. The provision enables states to establish a minimum set of health benefits for its residents.

- * Allows states to develop common administrative procedures. The provision enables states to require both health insurers and ERISA plans to use the same procedures and processes in the areas of claims processing and quality assurance.

- * Allows states to establish a negotiated system of hospital or other provider reimbursement rates to be used by both health insurers and ERISA plans.



United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 102^d CONGRESS, SECOND SESSION

Vol. 138

WASHINGTON, WEDNESDAY, AUGUST 12, 1992

No. 119

Senate

Mr. PRYOR. Mr. President, today I am pleased to join my friend and esteemed colleague from Vermont, Senator LEAHY, in introducing legislation to provide needed flexibility to States which are committed to comprehensively reforming their health care systems. We are honored to be joined in this effort by the majority leader, Senator ROCKEFELLER, Senator RIEGLE, Senator CHAFFE, Senator DANFORTH, Senator KERREY, Senator WELLSTONE, Senator ADAMS, Senator AKAKA, Senator BINGAMAN, Senator GRAHAM, Senator INOUE, and Senator JEFFORDS.

Mr. President, everyone of us in this body is struggling to find a workable solution to the overwhelming health care challenges that confront our Nation. No one is satisfied with, or accepting of, the status quo.

There is no question that we must find a way to achieve nation-wide, comprehensive reform of our health care system. Following Senator MITCHELL's lead, I remain committed to developing and passing a workable and comprehensive national health care reform initiative at the earliest possible moment.

Unfortunately, to date, we have not been able to achieve consensus on a comprehensive health care reform package that the President will sign into law. It is fascinating to note, however, that there is a common thread that runs throughout virtually every significant health care reform proposal before us. Despite the differing and numerous alternative approaches, every proposal provides for a significant amount of State flexibility and responsibility. This is the case with the Mitchell/Kennedy/Rockefeller/Riegle bill; it is the case with Senator KERREY's bill; it is the case with Senator WELLSTONE's bill; and it is the case with the Republican Health Care Task Force bill, whose primary author is the chairman of the task force, Senator CHAFFE. I am pleased to say that every one of the primary sponsors of these bills is joining with Senator LEAHY and me in introducing our legislation today.

Why is it that the major health care

initiatives emerging from both sides of the aisle all assure a significant State role? I believe the answer is twofold. First, all of us want to ensure that our health care system is more accountable and responsive to local desires and needs. Second, and probably at least as important, it is because the States and their Governors have been the ones who have succeeded in progressing from talking about the problem to actually acting to solve it. In fact, more than 15 States are working on massive system-wide restructuring. At least four States have actually passed legislation that begins to implement massive overhauls of their health care systems.

Unlike the Federal Government, these States have sought and, to the extent possible, achieved consensus within their own borders. These achievements were not accomplished without controversy. They were also not achieved without political risk, leadership, and courage. Most importantly, though, they were achieved.

Unfortunately, according to a June 1992 General Accounting Office report, many if not all of the State health care reform initiatives cannot be successfully implemented without the removal of certain Federal statutory barriers. In effect, therefore, our Federal inaction is not the only barrier to providing affordable health care to our citizens; current Federal law actually provides a significant roadblock as well.

The purpose of the legislation we are introducing today is to remove those roadblocks for States that are committed to overhauling their health care delivery systems. Through a new Federal commission, our bill sets up a streamlined, "one-stop-shop" waiver approval process that provides narrowly crafted, but important, waivers from Medicare, Medicaid, and the Employee Retirement Income Security Act [ERISA]. These waivers are absolutely necessary to the success of state-based comprehensive health care reform efforts.

To be eligible to receive the waivers, States must submit a plan to the Commission that is comprehensive, and meets strong access, cost-containment,

and quality assurance criteria. States also must continue to provide Medicare services to the Medicare population and federally-mandated Medicaid services to Medicaid recipients.

Mr. President, we have worked for months with representatives of consumers, States, small and large businesses, and many others in developing this legislation. While our bill is not flawless, we believe it moves a long way toward striking a fair and reasonable balance between interested parties. Having said this, as we have been in the months prior to today's introduction, we remain open to constructive suggestions. In fact, we sincerely hope that our introduction of this bill will be taken as an open invitation for comments and suggested improvements.

To further the debate on this issue, I am particularly pleased that the chairman of the Finance Committee, Senator BENTSEN, is planning on holding a hearing on State-based health care reform initiatives in September. I would like to take this opportunity to thank Senator BENTSEN and his staff for the encouragement and technical support they have given me and my staff throughout the development of this bill.

Mr. President, there is no question that there will be those who will oppose this effort. They will cite a number of reasons, but I fear the real reason is that their second choice for health care reform is to do nothing. I do not believe we can accept or condone this position.

The first choice for restructuring our health care system, including the first choice of almost every Governor, is that the Federal Government meet the need for national comprehensive reform. However, if a divided Government ensures that we cannot gain consensus on the national reforms we so desperately need, we simply cannot continue to hold the States hostage to our gridlock.

Mr. President, it is essential to remember, though, that this bill can, in some respects, work out as being the first choice of practically everyone. First, it can work to fill in some of the details of the previously introduced nationally comprehensive initiatives. Second, waivers are not granted in any case unless the State-based effort is comprehensive in nature. Finally, while holding the States accountable

for comprehensive, affordable, quality, accessible health care, it does not direct the States as to how they must achieve these criteria. In other words, advocates of single-payer approaches, advocates of employer-based approaches, and advocates of everything

around and between might well see their approach embodied in one of the States' comprehensive efforts.

Mr. President, regardless of the approach, I cannot and I will not continue to look into the eyes of the Governors committed to comprehensive health care reforms and say, "Sorry, because we don't have a national solution, there can be no solution." If an individual State can come up with a program that assures access to quality, affordable health care to its citizens, who are we to stand in the way?

I have long felt that we, as representatives of the Federal Government, are all-too-frequently negative and overly paternalistic to State-born reform initiatives on almost any issue. Sometimes it seems that if the idea isn't ours, we always find a way to show that it somehow isn't good enough. Well, when it comes to health care reform, at least to date, we have not come up with anything better than what many of the States are offering. To the contrary, we have as yet to produce anything approximating comprehensive reform.

There is broad-based and bipartisan support for this important initiative. I am particularly pleased to report that, despite the fact that the Governor--like everyone else--were forced to compromise on many issues of importance to them, the National Governors' Association [NGA] has indicated its support of this bill. I would like to thank the NGA, as well as the Democratic Governors' Association, for their thoughtful and constructive suggestions.

Many other organizations, in particular, Families USA, have also been extremely helpful. I look forward to working with all interested parties to assure we have the strongest package possible.

I am also extremely pleased to note that Congressman WYDEN has already indicated his desire for introducing the companion legislation on the House side. Although not cosponsoring this legislation today, I would also like to thank Senator DURENBERGER for his interest and support of many of the concepts outlined in this legislation. Senator LEAHY and I are very encouraged by these developments. I urge all of our colleagues to join Senator LEAHY, Congressman WYDEN, and me in our efforts to help the State help their, and our, constituents.

Finally, Mr. President, I would like to take one moment to say what an honor and a privilege it has been to work with Senator LEAHY and his fine staff on this bill. Today's introduction of our bill represents a vindication for his efforts and his commitment to change and restructure our health care system.

M E M O R A N D U M

TO: Hillary Rodham Clinton/Patti
FR: Chris J./Melanne
RE: Congressional Meetings
cc: Steve, Distribution

June 16, 1993

<u>Meeting</u>	<u>Purpose</u>	<u>Timeframe/Contact</u>
Political Veting with Steve R., Chris J., Jerry K., Karen P., Stan G., Mandy G., Melanne, Stan G., Jeff E., and perhaps others.	To reassess current political environment, timing advisability, legislative strategy, consultation schedule, and political implications of policy.	Sunday June 20th or Monday, 6/21 CHRIS J./ext 2645
Senate/House <u>Policy</u> discussion with Mitchell, Gephardt, Bonier, Daschle, Pryor	To get a policy/political reads from our closest Congressional friends from the leadership. (We need to invite Rockefeller for his own briefing b/c he is not leadership -- and his presence may alienate Chairmen and others -- if it ever gets out, and because HRC promised an individual, substantive briefing/meeting). We should schedule this later in the week.	Monday, June 21 or Tuesday. Contact: Chris J
Senate/House <u>Message</u> Meeting with Mitchell, Gephardt, and 10 other Members	To respond to Daschle's request for HRC to meet with these Members to discuss "selling" health care.	Tuesday afternoon or Wednesday lunch. Contact: Deborah Silemeo 224-3232
Senate Small Business Committee Meeting.	To respond to Sen. Bumpers request for a bipartisan meeting to discuss small business issues and health reform	Late in week of June 21st or sometime the week of June 28th. Contact: Rosi Smith/224-4843
Bill Clay MEETING	To discuss impact of health reform on Fed. Empl. health benefits	Anytime within next 2-3 weeks. Contact: Gail Weiss/225-4054

MEMORANDUM FOR THE RECORD

On June 17, 1993, I spoke with Chris Jennings of the White House Health Care Reform Office. Chris asked that VA General Counsel provide a legal opinion on draft legislation on the "non-discrimination drug price proposal". He also asked for an assessment of the cost impact of the proposal on VA (and DoD and PHS) if the proposal negated P.L. 102-585. He asked that the opinion be done by Monday (6/21/93) for the First Lady's briefing book. He also asked for a political analysis of the policy.

I told Mr. Jennings that I would be meeting this afternoon with the Deputy General Counsel and would be back in touch with him.

Louise R. Rodriguez

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton
FR: Steve Edelstein
RE: Cosponsors of McDermott Bill

June 17, 1993

There are currently 83 Cosponsors of Congressman McDermott's single payer bill. This is a significant bloc of votes, representing over one-third of the total number needed for passage in the House. **There are 25 cosponsors who sit on the three primary House committees of jurisdiction: 4 on Ways and Means; 7 on Energy and Commerce; and 14 on Education and Labor.**

Half the cosponsors (41 in all) are members of House caucuses -- 29 members of the Congressional Black Caucus, 8 members of the Congressional Hispanic Caucus and 13 members of the Congressional Caucus on Women's Issues (some are members of more than one caucus). In addition, 20 are Members serving the first term in Congress.

Attached is a list of the cosponsors, their party affiliation, home state, committee assignments and caucus memberships. Freshman Members are also indicated. The list is broken into three categories based on our targeting lists -- Reliable, More Inclined, Need Work.

- (1) Reliable - **19 cosponsors** who the House leadership believes we can count on as "reliable" votes for the Administration's plan.
- (2) More Inclined - **52 members** are categorized as "more inclined," those who are likely to vote with us in the end but cannot be taken for granted.
- (3) Need Work - **11 cosponsors** are listed as "need work." These Members will be the most difficult to get on board and will need significant attention to get their support.

RELIABLE:

Abercrombie	(D-HI)	-Armed Services; Natural Resources
Ackerman	(D-NY)	-Foreign Affairs; Merchant Marine and Fisheries; Post Office & Civil Service
Clyburn	(D-SC)	-Public Works and Transportation; Veterans Affairs; <i>Congressional Black Caucus</i> ; Freshman
C. Collins	(D-IL)	- Energy and Commerce ; Government Operations; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>
Engel	(D-NY)	- Education and Labor ; Foreign Affairs
Evans	(D-IL)	-Armed Services; Natural Resources; Veterans' Affairs
Frank	(D-MA)	-Budget; Public Works and Transportation
Gejdenson	(D-CT)	-Foreign Affairs; House Administration; Natural Resources
Kennedy	(D-MA)	-Banking, Finance and Urban Affairs; Veterans' Affairs
Lewis	(D-GA)	-District of Columbia; Ways & Means; <i>Congressional Black Caucus</i>
Manton	(D-NY)	- Energy & Commerce ; House Administration; Merchant Marine & Fisheries
Markey	(D-MA)	- Energy & Commerce ; Natural Resources
Moakley	(D-MA)	-Rules (chairman)
Pelosi	(D-CA)	-Appropriations; Select Intelligence; Standards of Official Conduct; <i>Congressional Caucus for Women's Issues</i>
Sabo	(D-MN)	-Appropriations; Budget (chairman)
Schumer	(D-NY)	-Banking; Finance & Urban Affairs; Foreign Affairs; Judiciary
Scott	(D-VA)	- Education & Labor ; Judiciary; Science, Space & Technology; <i>Congressional Black Caucus</i> ; Freshman

Studds (D-MA) -Energy & Commerce; Merchant Marine & Fisheries
(chairman)

Swift (D-WA) -Energy and Commerce; House Administration

MORE INCLINED:

Andrews	(D-ME)	-Armed Services; Merchant Marine and Fisheries; Small Business
Becerra	(D-CA)	- Education and Labor ; Judiciary; Science Space and Technology; <i>Congressional Hispanic Caucus</i> ; Freshman
Beilenson	(D-CA)	-Budget; Rules
Berman	(D-CA)	-Budget; Foreign Affairs; Judiciary; Natural Resources
Blackwell	(D-PA)	-Budget; Public Works and Transportation; <i>Congressional Black Caucus</i>
Borski	(D-PA)	-Foreign Affairs; Public Works and Transportation; Standards of Official Conduct
Brown	(D-CA)	-Agriculture; Science, Space & Technology (chair)
Clayton	(D-NC)	-Agriculture; Small Business; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
B.R. Collins	(D-MI)	-Government Operations; Post Office and Civil Service; Public Works and Transportation; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>
Coyne	(D-PA)	-Budget; Ways and Means
Dellums	(D-CA)	-Armed Services (Chair); <i>Congressional Black Caucus</i>
de Lugo	(D-VI)	- Education and Labor ; Natural Resources; Public Works and Transportation
Dixon	(D-CA)	-Appropriations; Select Intelligence; <i>Congressional Black Caucus</i>
Edwards	(D-CA)	-Foreign Affairs; Judiciary; Veterans' Affairs
Faleomavaega	(D-AS)	- Education and Labor ; Foreign Affairs; Natural Resources
Flake	(D-NY)	-Banking, Finance, and Urban Affairs; Government Operations; Small Business; <i>Congressional Black Caucus</i>

Furse	(D-OR)	-Armed Services; Banking, Finance & Urban Affairs; Merchant Marine & Fisheries; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Gutierrez	(D-IL)	-Banking, Finance and Urban Affairs; Veterans' Affairs; Freshman
Hamburg	(D-CA)	-Merchant Marine and Fisheries; Public Works and Transportation; Freshman
Hilliard	(D-AL)	-Agriculture; Small Business; <i>Congressional Black Caucus</i> ; Freshman
Hochbrueckner	(D-NY)	-Armed Services; Merchant Marine & Fisheries
Lantos	(D-CA)	-Foreign Affairs; Government Operations
Martinez	(D-CA)	- Education & Labor ; Foreign Affairs; <i>Congressional Hispanic Caucus</i>
McCloskey	(D-IN)	-Armed Services; Foreign Affairs; Post Office & Civil Service
McDermott	(D-WA)	- Ways & Means ; District of Columbia; Standards of Official Conduct (chairman)
McKinney	(D-GA)	-Agriculture; Foreign Affairs; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Meek	(D-FL)	-Appropriations; <i>Congressional Caucus for Women's Issues</i> ; <i>Congressional Black Caucus</i> ; Freshman
Miller	(D-CA)	- Education & Labor ; Natural Resources (chairman)
Mink	(D-HI)	- Education & Labor ; Budget; Natural Resources
Murphy	(D-PA)	- Education & Labor ; Natural Resources
Norton	(D-DC)	-District of Columbia; Post Office & Civil Service; Public Works & Transportation; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>
Oberstar	(D-MN)	-Foreign Affairs; Public Works & Transportation
Olver	(D-MA)	-Appropriations

Owens	(D-NY)	- Education & Labor ; Government Operations; <i>Congressional Black Caucus</i>
Rangel	(D-NY)	- Ways & Means ; <i>Congressional Black Caucus</i>
Romero-Barcelo	(D-PR)	- Education and Labor ; Natural Resources; <i>Congressional Hispanic Caucus</i> ; Freshman
Roybal-Allard	(D-CA)	-Banking, Finance & Urban Affairs; Small Business; <i>Congressional Hispanic Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Reynolds	(D-IL)	- Ways & Means ; <i>Congressional Black Caucus</i> ; Freshman
Rush	(D-IL)	-Banking, Finance and Urban Affairs; Government Operations; <i>Congressional Black Caucus</i> ; Freshman
Stark	(D-CA)	- Ways & Means ; District of Columbia (chairman); Joint Economic
Stokes	(D-OH)	-Appropriations; <i>Congressional Black Caucus</i>
Thompson	(D-MS)	- <i>Congressional Black Caucus</i> ; Freshman
Torres	(D-CA)	-Appropriations; <i>Congressional Hispanic Caucus</i>
Towns	(D-NY)	- Energy & Commerce ; Government Operations; <i>Congressional Black Caucus</i>
Tucker	(D-CA)	-Public Works & Transportation; Small Business; <i>Congressional Black Caucus</i> ; Freshman
Underwood	(D-GU)	-Armed Services; Natural Resources; <i>Congressional Hispanic Caucus</i> ; Freshman
Velazquez	(D-NY)	-Banking, Finance & Urban Affairs; Small Business; <i>Congressional Hispanic Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Vento	(D-MN)	-Banking, Finance & Urban Affairs; Natural Resources
Washington	(D-TX)	- Energy & Commerce ; Government Operations; Judiciary
Watt	(D-NC)	-Banking, Finance and Urban Affairs; Judiciary; Post Office and

Civil Service; *Congressional Black Caucus*; Freshman

Woolsey (D-CA) -**Education & Labor**; Budget; Government Operations;
Congressional Caucus for Women's Issues

Yates (D-IL) -Appropriations

NEED WORK:

Clay	(D-MO)	- Education and Labor ; House Administration; Post Office and Civil Service (Chair); <i>Congressional Black Caucus</i>
Conyers	(D-MI)	-Government Operations (Chair); Judiciary; Small Business; <i>Congressional Black Caucus</i>
Gibbons	(D-FL)	- Ways & Means ; Joint Taxation
Hinchey	(D-NY)	-Banking; Finance & Urban Affairs; Natural Resources; Freshman
LaFalce	(D-NY)	-Banking; Finance & Urban Affairs; Small Business (chairman)
Maloney	(D-NY)	-Banking; Finance & Urban Affairs; Government Operations; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Mfume	(D-MD)	-Banking; Finance & Urban Affairs; Joint Economic; Small Business; Standards of Official Conduct; <i>Congressional Black Caucus (Chair)</i>
Nadler	(D-NY)	-Judiciary; Public Works & Transportation; Freshman
Payne	(D-NJ)	- Education & Labor ; Foreign Affairs; Government Operations; <i>Congressional Black Caucus</i>
Serrano	(D-NY)	-Appropriations; <i>Congressional Hispanic Caucus (Chair)</i>
Waters	(D-CA)	-Banking, Finance & Urban Affairs; Small Business; Veterans' Affairs; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Health Care/Reconciliation Senate Member Meeting (2 pages)	6/21/93	P5
002. memo	Chris Jennings to Hillary Clinton Re: Meeting with Representative Andrews (5 pages)	6/21/93	P5
003. list	Agenda for Meeting with First Lady Hillary Clinton Social Security numbers redacted (3 pages)	6/22/93	P6/b(6)
004. memo	Chris Jennings to Hillary Clinton Re: Health Care/Reconciliation Senate Member Meeting (2 pages)	6/21/93	P5
005. memo w/attach	Chris Jennings to Hillary Clinton Re: House and Senate "Message" Meeting (3 pages)	6/21/93	P5
006. memo	Chris Jennings to Hillary Clinton Re: House Single-Payor Meeting (2 pages)	06/23/1993	P5
007. draft	Medicaid Goals (5 pages)	6/23/93	P5
008. list	Congressional List (7 pages)	nd	P5

COLLECTION:

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

FOLDER TITLE:

June 1993 HSA [3]

gf89

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

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

PERSONAL AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Health Care/Reconciliation Senate Member Meeting
cc: Melanne, Steve, Jerry, Karen, Distribution

June 21, 1993

Tomorrow afternoon you are scheduled to participate in a meeting with Senators Kennedy, Rockefeller, Wofford, Dodd, Harkin, Metzenbaum, and Wellstone. As you know, you are attending this meeting in response to a request from Majority Leader Mitchell.

BACKGROUND

Last week, the Senate Finance Committee marked up its version of the reconciliation bill. Within the package was an additional \$19 billion in Medicare cuts. These cuts have not been well received by the more liberal element of the Democratic party and a number of Members have openly suggested that they will try to reduce the cuts, through amendment, on the Senate floor.

Senator Mitchell feels very strongly that the bill passed by the Finance Committee is the only compromise legislation that can attract a sufficient number of Democratic votes for passage. He is extremely concerned about amendments to reduce the Medicare cuts because he thinks their inclusion severely threatens his ability to pass the reconciliation legislation out of the Senate.

The liberals in the Senate, however, believe they are all too often counted on as sure votes because they "have no where else to go." They feel they are being taken for granted and seem to be flexing their muscles to get more serious attention focused on them.

Senator Metzenbaum, in particular, has drafted an amendment to eliminate the additional \$19 billion in cuts and substitute an increase in the corporate tax from 35 to 36. (An increase in the corporate tax by one percent produces an additional \$16 billion.) Joining him in at least talking about offering such an amendment are Senators Harkin, Wellstone, Simon, and probably others.

Senator Mitchell views any such Medicare cut reduction amendment as a "killer" amendment because its inclusion would likely chase away too many moderate to conservative Democrats. He is hoping you and Senators Kennedy, Rockefeller, and Wofford can make progress to convincing Senator Metzenbaum and the others that, blemishes and all, the Finance-passed bill is probably the best we can get until we get to the joint House-Senate conference.

Although the meeting will take place in Senator Metzenbaum's office, he views Senator Kennedy as the host. (Senator Kennedy called his office up and suggested the meeting, with the blessings of Senator Mitchell's staff.) As you know, Senator Rockefeller's office was thinking about hosting this meeting, but Senator Kennedy suggested that it might be better to hold the meeting in a non-Finance Committee Member's office.

In this meeting, Senator Mitchell (who will not be in attendance) expects that Senators Kennedy, Rockefeller, and Wofford will take positions that argue against any amendments to reduce the additional \$19 billion in Medicare cuts. Of all the Members present, Senator Rockefeller will no doubt be the strongest in advocating for no amendments to the reconciliation bill. (Please see attached comments he made before the Democratic Caucus.) All three, however, believe that you should stick primarily to the general issue of health reform and talk about reconciliation bill to the extent it inter-relates with health reform.

POSSIBLE POINTS TO HIT:

- * We will never get health care unless we pass reconciliation.
- * The Medicare cuts are difficult and they make this a very tough vote, but they are necessary to allow us to move on to health reform this year.
- * Although the Medicare cuts are not insignificant, I believe we can reduce them in the joint Senate/House conference.

**PRIVILEGED AND CONFIDENTIAL
MEMORANDUM**

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: 177 DATE: 8-15-05

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Meeting With Representative Andrews
cc: Distribution

June 21, 1993

Tomorrow you are scheduled to meet with Representative Mike Andrews and a group of physicians he asked you to speak with.

Background

Andrews is, as you know, an important member of the House Ways and Means Committee for a number of reasons: 1) he is a co-sponsor of the Cooper managed competition bill; 2) he helps us with the conservative Democrats; 3) he is an influential voice in the Texas Delegation; and 4) he is more pragmatic regarding health care reform than is Cooper.

As a reminder, he supports a tax cap on benefits and the use of sin taxes -- particularly cigarette taxes -- to fund reform. He is nervous about cost controls, particularly with how they would stall delivery system changes and competitive positioning so important to the managed competition approach.

Agenda

Andrews will open the meeting and introduce you. You will then say a few words about the status of health reform and the importance of input from the health care provider community. Following this brief statement, you will introduce Ira and Phil Lee, and explain that while you will have to leave during the meeting, Phil will stay to continue the discussion. The group will then make brief presentations. After roughly 30 minutes, you and Ira will leave and Phil Lee will continue the discussion. The list of attendees and the focus of their remarks is attached.

While the doctors will address a number of areas concerning physicians, this group of Texans is primarily concerned with how health reform will affect academic health centers. It is important to stress that the Administration recognizes the unique and important role that these institutions fill in our society, and that we plan to preserve their role in our reform. They have also submitted a list of questions. Attached are draft responses.

DETERMINED TO BE AN ADMINISTRATIVE
MARKING Per E.O. 12958 as amended, Sec. 3.2 (c)
Initials: _____ Date: _____

Topic: Research and Innovation

Question: What are the necessary components in a health care system to ensure that medical research and innovation continue to make improvements in the health of individuals?

Answer: Health care reform will increase funding for medical research, placing special emphasis on prevention research and health services research. Preventive research will target areas medical areas or conditions where there is pressing demand and where breakthroughs promise the greatest return, including:

Chronic and recurrent illnesses - Including research on Alzheimer's disease, cancer, cardiovascular diseases, bone and joint diseases, and other chronic diseases and conditions.

Pediatric health - Including perinatal health, birth defects and diseases of childhood, unintentional injuries, learning and cognitive development, and adolescent health.

Mental Health and Substance Abuse - Including research on mental disorders in children and adolescents, child abuse and neglect, women's mental health, mental disorders in racial and ethnic minorities, mental disorders in the elderly and their caregivers, severe mental disorders, and violence.

Substance abuse research will target vulnerable populations, including high-risk youth, and will study medications development, substance abuse, and the relationship between substance abuse and women's health.

Infectious diseases - Focusing on new and emerging infectious diseases, vaccine development, and fundamental vaccine research, as well as on infectious diseases currently taking societal tolls.

Prevention Research and Resource Development - Basic science providing foundations for prevention efforts across a range of diseases and disorder, including behavioral and social approaches, genetics, and drugs.

Resource development will include support for research training, enhancement of statistical and epidemiologic techniques, and informatics and database management.

Topic: Centers of Excellence and Provider Networks

Question: How can the new health care system make sure that centers of excellence have responsibility for the most complex cases and are available as a resource to primary care settings?

Answer: The new health care system will recognize the unique role centers of excellence play in providing the most innovative and advanced treatments to patients with rare and complicated illnesses. Health care plans that contract with alliances will be structured in such a way that does not allow competition to close them out or force them to compete solely on cost. Alliances will help establish the special payment provisions and encourage the referrals that will take place from other plans to these centers.

Topic: Primary Care

Question: What will academic health centers need to do to meet a rise in demand for primary care health providers?

Answer: We will need a shift the emphasis in training so that academic health centers offer training toward primary care. We might have to consider restricting availability of positions for specialist and subspecialist training to make primary care practice a more attractive option. Finally, we'll need to expand training beyond the walls of the hospital and take training to the community settings where good, responsive primary care will be practiced.

Topic: Graduate Medical Education and Indirect Medical Education Costs

Question: How should the costs and income from training new health care providers be set under the new system?

Question: How should the health care system distribute the additional health care delivery costs associated with training new physician?

Answer: We are looking to recognize the unique costs of Medical centers related to training and research, and to create a pool of funds dedicated specifically to these purposes. We recognize that academic health centers cannot compete if these costs have to be built into their regular rates. The pools will be derived from current Medicare payments and from assessments on premiums paid by regional or corporate health alliances.

Topic: Clinical Research

Question: How will clinical research be paid for under the new system when today no systematic funding mechanism today exists?

Answer: We will continue to invest in clinical research and will include patient-care costs for clinical trials and standard premiums that are sponsored or approved by the NIH.

Topic: Health Care Report Cards

Question: How will reports on outcomes be adjusted to account for the greater complexity of cases seen at academic health centers?

Answer: Outcomes aren't accurate gauges of quality if they don't take into account the health status of the patient before seeking treatment. This is called "risk adjusting".

Because of their excellent reputations for treating the "difficult" cases - patients who have rare diseases, or who suffer from multiple complications - doctors in academic health centers may treat more patients who, simply because of their condition when they entered the hospital, aren't as likely to fully recover.

That's why we won't use outcomes unless we have scientific research that adjusts for those things that will affect a patient's recovery. We want to compare apples to apples so that we don't unfairly judge an institution or a doctor, simply for taking on the most difficult cases.

We know it's going to take some time to get there - - look at New York State and Pennsylvania and their experience with cardiac bypass outcomes. They had to struggle with this for many years until they got it right. But, now, after working with doctors, hospital administrators, and patients, they now believe they're measuring something that works.

Topic: Quality of Care

Question: How can the quality of health care delivery be assured for the treatment of conditions like cancer where the medical outcome does not necessarily reflect the quality of treatment?

Answer: Quality isn't just the measure of how well a patient feels after surgery or whether chemotherapy works. It's much more than that. High-quality care is when a doctor's patients feel at ease in her office; when the patient doesn't have to wait in lines just to be seen; when necessary treatment is affordable and close by.

Topic: Outcomes Research and Practice Guidelines

Question: How should academic health centers participate in the development of practice guidelines in outcomes research?

Answer: Academic Health Centers have long been the locomotive pulling us along the tracks of medical progress. They'll continue to lead the way for us under reform, developing the practice guidelines and researching outcomes that will provide the foundations of our quality system.

We're providing more money to support these efforts.

PERSONAL AND CONFIDENTIAL MEMORANDUM

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FR: Chris Jennings
RE: Health Care/Reconciliation Senate Member Meeting
cc: Melanne, Steve, Jerry, Karen, Distribution

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PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: House and Senate "Message" meeting
cc: Melanne, Steve, Lorraine, Jeff, Ira, Distribution

June 21, 1993

Tomorrow evening you are scheduled to meet with House and Senate members to discuss plans for "selling" the health care reform plan. Congressmen Gephardt and Bonior will be attending from the House. Senate attendees will include Senators Mitchell, Daschle, Pryor, Kennedy, Rockefeller, Riegle, Kerrey, Wofford. Senator Reid will probably attend. Also invited were Senators Moynihan and Boxer but their attendance was not confirmed.

BACKGROUND

Both Senator Daschle and Congressman Gephardt feel very strongly about the importance of the message piece for the success of our legislative strategy. This meeting is primarily an opportunity for these Members to lay out their priorities on what needs to be done before the launch of the bill. And an opportunity for us to share with them where we are in developing our communications plan.

The Senate Democratic Policy Committee in consultation with the House Leadership has prepared a "to do" list. That list (attached for your review) will serve as a the basis for discussion at tomorrow's meeting. While this list was not available in time to attach to this memo, we will make sure you receive a copy for your review first thing tomorrow.

Jeff Eller has recommended that you highlight the planned war room and the fact that it will serve as a resource for both the Administration and for Congress. You may also wish to mention that we plan on learning from our mistakes with the economic plan and will invest a great deal of resources into close coordination with the Hill on the health care communication strategy. Lastly, you could also discuss how much we appreciate all the hard work that all of them have put into the development of a message strategy, and how much we look forward to working closely with them during the upcoming weeks and months. Since Jeff will be attending the meeting, you may wish to recognize him and call on him to answer specific questions and suggestions that are made by the Members.

DRAFT

To: Health Care Group

Fr: DPC Staff

The following list includes some of the tasks that need to be completed for a successful launch of the health care reform proposal. The tasks listed below are meant to be shared by a variety of organizations not limited to, but including the WH, House, Senate, NHCC and other grassroots organizations.

1. Launch Date Criteria/ Launch Date Public Message

- need agreement on criteria we need to meet before we're ready to launch
- need coordinated public message on launch date

2. Message

- central theme (WH)
- what it is
- how to stay on it
- how to infuse it into all parts of effort
- ongoing survey research to refine, etc.

3. Strengths list - key strengths, talking points on our plan (WH) :

- hc security (even if you switch jobs, lose your job or have a pre-existing condition)
- greater choice of health benefits plans
- improved quality of care
- controlled costs
- comprehensive coverage
- simplicity, will reduce admin. paperwork

4. Vulnerability - identification and response:

- families already face rising costs - this will increase their costs
- taxes will increase
- government can't get anything done and this is just another government program
- employer mandates
- rationing
- loss of choice
- govt. workers, others who now have excellent coverage
- abortion
- quality
- untested plan, no one has tried to reform this system on this scale before
- reform may increase spending not decrease it
- unfair to young people
- the system would be so complex that it would collapse

DRAFT

5. Opposition research - determination of vulnerabilities of other plans

- competing proposals
- need to address the special interest groups who are mounting their own campaigns and be prepared for their attacks (NHCC)
- use DPC health contact as a "clearinghouse" for opposition information from other offices

6. Visibility

- establish weekly visibility plan
- recess use
- publications
- media agenda before launch/after launch

7. Effective ways to reach and involve Members

- Health University
- consultation groups

8. Health Groups

- need to identify the allies (consumer, labor and business organizations) (NHCC & DPC)
- need to identify the opposition

9. Media lists-- comprehensive hc press lists including specialty and regional press

- work with press secs to draft list and compile with existing lists (NHCC, DPC & WH) (includes press, academics, interest groups)

10. Rapid Response

- who (WH)
- how (NHCC & DPC)

11. Coordination with House

- message
- organization (work with their message board)
- education
- legislative scheduling

12. Coordination with State/Other Elected Officials

- message
- education
- legislative scheduling

13. Coordination with White House

14. Calendar(s) - calendar for task accomplishment of overall effort and of major sub-efforts

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: House Single-Payer Meeting

June 22, 1993

Tomorrow you are scheduled to host a meeting of the House cosponsors of the McDermott/Conyers single-payer bill (H.R. 1200). Congressman McDermott requested this meeting to give his 83 cosponsors the opportunity to hear your explanation as to why the President's bill is very similar to H.R. 1200, (as well as to, no doubt, illustrate to you what a big block of supporters he has for his legislation).

Many of the hard core supporters of a single payer plan appreciate the similarities between the President's approach and their bill. However, they perceive that the President's plan does not go far enough in their direction -- that it is overly complex and does not take advantage of the administrative simplicities that would be realized by a single-payer approach. They also believe that the President should start with as comprehensive and expansive a proposal as possible so as to energize the rank and file single-payer advocates. They believe that such an approach would protect the final package as much as possible from the inevitable watering down that goes along with the Congressional process.

From all reports, your meeting with Senator Wellstone's group of single-payer supporters went very well. A repeat performance, perhaps with a more political spin, should be very well received.

FORMAT

According to Congressman McDermott's office, he wants this meeting to be as much a "working" discussion as possible. McDermott would like to lead off with a few introductory comments of appreciation for the meeting. Then he will introduce you. At that point, you may wish to recognize the work that he and Congressman Conyers have done in pushing their legislation. (If Pete Stark is in the room, you may wish to acknowledge him as well.)

As with most Members, they will want to know about the status of the policy development and the likely timing for the unveiling. Then, it might be advisable to very briefly illustrate how our proposal meets the health reform principles (attached again for your review/use) advocated by Congressman McDermott and his cosponsors. The Members would then like to throw it open to questions/comments and have a healthy give and take. As of this morning, it was very unclear how many of the 83 Members will be in attendance. McDermott's office expects a much smaller crowd and hopes there will be few enough to arrange the seating in a less formal manner. (It remains very unclear if this can happen if more than 35 Members show up.)

All in all, the single-payer Members will be a generally receptive audience. Some recent articles/news stories about how the delay in introduction has given some special interests the opportunity to water down the provisions of our proposal (a ridiculous perception, of course) are making some Members anxious. Similarly frustrating to many of these Members is the perception that the White House is turning more towards the right wing of the Party and potentially setting up an environment in which the Administration believes it is in its political interest to either reject or take for granted the left wing of the Party. As a result, some of the meeting participants may be "feeling their oats" and making a stronger push than they otherwise would. I believe, however, that some reassuring comments from you will be more than adequate for all or most of these Members. The bottom line is that most of them truly want some form of comprehensive health reform, and most of them will be with you when it is really needed. (They just don't want to be ignored; they want to be viewed as a formidable and substantive group that should be taken seriously.)

The cosponsors of the McDermott/Conyers bill are notable for both their numbers and their Committee assignments. The following gives you a quick break down of just who these Members are and how we currently view them as potential supporters.

The 83 cosponsors represent over one-third of the total number of votes needed for passage in the House. **There are 25 cosponsors who sit on the three primary House committees of jurisdiction: 4 on Ways and Means, 7 on Energy and Commerce, and 14 on Education and Labor.**

Half the cosponsors (41 in all) are members of House caucuses -- 29 members of the Congressional Black Caucus, 8 members of the Congressional Hispanic Caucus and 13 members of the Congressional Caucus on Women's Issues (some are members of more than one caucus). In addition, 20 are Members serving their first term in Congress.

Attached is a list of the cosponsors, their party affiliation, home state, committee assignments and caucus memberships. Freshman Members are also indicated. The list is broken into three categories based on our targeting lists -- Reliable, More Inclined, Need Work.

- (1) Reliable - **19 cosponsors** who the House leadership believes we can count on as "reliable" votes for the Administration's plan.
- (2) More Inclined - **52 members** are categorized as "more inclined," those who are likely to vote with us in the end but cannot be taken for granted.
- (3) Need Work - **11 cosponsors** are listed as "need work." These Members will be the most difficult to get on board and will need significant attention to get their support.

9:07am June 23, 1993

draft draft draft draft

Goals

- **Improve health care quality, access and choice for Medicaid beneficiaries.**
- **Avoid separate treatment in enrollment and care in a health plan of Medicaid beneficiaries and other people.**
- **Contain Federal and State Medicaid costs and introduce greater predictability to Medicaid financing.**
- **Promote welfare reform objectives by removing current work disincentives.**

Summary of Medicaid policy

- **Medicaid blend-in with employment.** Medicaid recipients would be blended into Alliance coverage as they become employed. When a recipient or a family member is employed, they will receive employer coverage. Once in Alliance coverage, they will have the same financial requirements as others. They will also remain covered regardless of work situation, even if they return to welfare or unemployment, and carry Medicaid coverage for supplemental benefits only. Given the turnover in Medicaid, the Medicaid acute care population would shrink rapidly.
- **Long term, nonworking Medicaid phased in over three years.** For nonworkers on Medicaid, including the disabled, who remain continuously unemployed, States would have the option to continue to pay providers directly under Medicaid rates or contract with Alliance health plans. After three years, these remaining nonworkers are integrated into Alliance coverage.
- **SSI-related disabled Medicaid recipients.**
 - ▶ Like other Medicaid recipients, the SSI-related disabled not covered by Medicare could be covered by Alliance coverage when they or a family member become employed or at the end of three years. For SSI-related disabled persons, however, families would be given the option to remain with Medicaid for acute coverage (paying providers directly or through managed care contracting). Regardless, Medicaid would continue to provide supplemental coverage for Medicaid services excluded or limited in the benefit package. When disabled persons qualify for Medicare, like individuals turning 65, they will then switch to Medicare coverage as primary payor.

- ▶ To avoid a large impact on premiums for Medicaid disabled persons in Alliance plans, the risk adjustment formula would include a factor which would increase payments to plans for enrollees who are SSI-related disabled Medicaid recipients. The factor would be equal to current per capita Medicaid spending for acute care services for disabled recipients.
- **State and Federal Medicaid maintenance of effort.** State and Federal governments will maintain their level of Medicaid acute care spending on prior to reform, trended forward by the health budget growth. Funds not spent on non-working Medicaid recipients would be transferred to alliances and thereby reduce the wage-based premium/premium-subsidy costs.
- **Medicaid provides supplemental coverage for recipients.**
 - ▶ Alliance health plans cover the comprehensive benefits of the new benefit package for all enrollees.
 - ▶ Medicaid will be the secondary payor, providing supplemental coverage for current Medicaid benefits not provided (e.g., hearing aids, adult dental), or of limited duration or scope (e.g., rehabilitation), in the new benefit package. This will assure Medicaid beneficiaries do not experience a loss of benefits. States may pay providers directly for these services or contract with the Alliance plans to provide them.

Specific policies

- **Medicaid acute care coverage is phased out gradually by making employer-sponsored coverage the primary payor for Medicaid recipients in working families:**
 - ▶ Upon implementation of the employer mandate in a State, Medicaid recipients (non-SSI-related under age 65) who are employed, become employed, or have a family member who is employed¹ will be covered by the mandated employer sponsored coverage for the comprehensive services in the new benefit package.

For this group of people, the employer sponsored coverage will be the primary payor for their acute care. Medicaid will cease to be their primary payor.

¹Definition: The recipient is covered by an employed family member's policy if there is a person who qualifies for employer premium contributions and if a family policy for this person would cover the Medicaid recipient as a member of their family.

- ▶ Furthermore, once covered by an alliance or employer-sponsored plan, individuals will not be returned to Medicaid for acute care coverage. As of the implementation date, Medicaid will no longer cover new (non-SSI-related under age 65) recipients for the acute care services included in the alliance plans (see below for provisions for disabled). Medicaid will only provide supplemental coverage (see secondary payor provisions below).
- ▶ For those who remain on Medicaid continuously, (the long term nonworking), Medicaid remains the primary payor for their acute care services for three years after implementation. After three years, these individuals also enter the alliance coverage.
 - For those who receive Medicaid acute care coverage (not alliance coverage), States have the option to continue to pay providers directly under Medicaid rates or contract with alliance health plans. Any such contracts are approved under current rules except that health plans meeting access, quality and other requirements for offer in a regional alliance are deemed Medicaid-qualified.

• **Financing:**

- ▶ Maintenance of effort. State and Federal governments must maintain acute care spending at a level equal to its share of:
 - the State's baseline level of total Medicaid spending for recipients under age 65
 - for the services in the benefit package
 - in the year prior to implementation of reform
 - trended forward by the budgeted growth in the State's weighted average premium.

Medicaid will spend a portion of this amount on direct payments for those still covered by Medicaid for acute care services. The remainder will go as a lump sum to alliances to reduce the payroll percentage/subsidy costs for those in the alliance. The Secretary may make adjustments as necessary in the amounts required of individual states so long as the total Medicaid maintenance of effort remains constant.²

²This provision allows the Board to increase or decrease a State's payment requirements under a maintenance of effort in a budget neutral manner to correct as necessary for any payment

- ▶ The State/Federal share of the Medicaid "block grant" and continuing Medicaid costs remain as in current law.
- **Medicaid remains as secondary payor for any person with alliance or employer-sponsored coverage.**
 - ▶ Medicaid provides supplemental coverage for currently mandatory services (and any optional services chosen by the State) not in the comprehensive benefit package (e.g., adult dental) or of limited duration or scope (e.g., rehabilitation) for all eligible recipients covered by alliance or employer-sponsored coverage.
 - ▶ Note: In the transition, for non-cash assistance, non-working Medicaid recipients (e.g., pregnant women and kids in nonworking families who qualify because of poverty), it will be difficult to continue to enroll these people in Medicaid for acute care unless they come forward for the wrap-around coverage provided for Medicaid. The focus will inevitably be on continuing enrollment of Medicaid recipients on cash assistance (AFDC, SSI, foster kids, adoption assistance, etc.) and those requiring Medicaid's wrap-around coverage and continued cost-sharing protection.
- **Coverage for Medicaid eligible SSI-related disabled persons under age 65 not eligible for Medicare.**
 - ▶ Like other Medicaid recipients, the SSI-related disabled could be covered by Alliance coverage when they or a family member become employed or at the end of three years. However, SSI-related disabled persons (or the person legally responsible for them) may choose to remain with Medicaid for acute coverage. In addition, Medicaid would continue to provide supplemental coverage for Medicaid services excluded or limited in the benefit package. As noted earlier, for those receiving Medicaid acute coverage, States may pay providers directly or contract with Alliance health plans directly for covered acute services, supplemental services or both.
 - ▶ To avoid a large impact on premiums for Medicaid disabled persons in Alliance plans, the risk adjustment formula would include a factor which would increase payments to plans for enrollees who are SSI-related disabled Medicaid recipients.

distortions or inequities among States.

- The average payment to a plan for a SSI-related Medicaid disabled enrollee (i.e., the average base payment plus SSI-disability "factor" payment) is capped at:
 - the State's baseline level of per capita Medicaid spending
 - for the services in the benefit package
 - in the year prior to implementation of reform
 - trended forward by the budgeted growth in the State's weighted average premium for their alliances' non-Medicaid population.
- **Changes in Medicaid eligibility rules:**
 - ▶ Recipients finding employment will be retain Medicaid supplemental coverage for 6 months after finding employment.
 - ▶ Eligibility determination and administration remains the same as current law.
 - ▶ See long-term care section for additional provisions.

RELIABLE:

Abercrombie	(D-HI)	-Armed Services; Natural Resources
Ackerman	(D-NY)	-Foreign Affairs; Merchant Marine and Fisheries; Post Office & Civil Service
Clyburn	(D-SC)	-Public Works and Transportation; Veterans Affairs; <i>Congressional Black Caucus</i> ; Freshman
C. Collins	(D-IL)	- Energy and Commerce ; Government Operations; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>
Engel	(D-NY)	- Education and Labor ; Foreign Affairs
Evans	(D-IL)	-Armed Services; Natural Resources; Veterans' Affairs
Frank	(D-MA)	-Budget; Public Works and Transportation
Gejdenson	(D-CT)	-Foreign Affairs; House Administration; Natural Resources
Kennedy	(D-MA)	-Banking, Finance and Urban Affairs; Veterans' Affairs
Lewis	(D-GA)	-District of Columbia; Ways & Means; <i>Congressional Black Caucus</i>
Manton	(D-NY)	- Energy & Commerce ; House Administration; Merchant Marine & Fisheries
Markey	(D-MA)	- Energy & Commerce ; Natural Resources
Moakley	(D-MA)	-Rules (chairman)
Pelosi	(D-CA)	-Appropriations; Select Intelligence; Standards of Official Conduct; <i>Congressional Caucus for Women's Issues</i>
Sabo	(D-MN)	-Appropriations; Budget (chairman)
Schumer	(D-NY)	-Banking; Finance & Urban Affairs; Foreign Affairs; Judiciary
Scott	(D-VA)	- Education & Labor ; Judiciary; Science, Space & Technology; <i>Congressional Black Caucus</i> ; Freshman

Studds (D-MA) -Energy & Commerce; Merchant Marine & Fisheries
(chairman)

Swift (D-WA) -Energy and Commerce; House Administration

MORE INCLINED:

Andrews	(D-ME)	-Armed Services; Merchant Marine and Fisheries; Small Business
Becerra	(D-CA)	- Education and Labor ; Judiciary; Science Space and Technology; <i>Congressional Hispanic Caucus</i> ; Freshman
Beilenson	(D-CA)	-Budget; Rules
Berman	(D-CA)	-Budget; Foreign Affairs; Judiciary; Natural Resources
Blackwell	(D-PA)	-Budget; Public Works and Transportation; <i>Congressional Black Caucus</i>
Borski	(D-PA)	-Foreign Affairs; Public Works and Transportation; Standards of Official Conduct
Brown	(D-CA)	-Agriculture; Science, Space & Technology (chair)
Clayton	(D-NC)	-Agriculture; Small Business; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
B.R. Collins	(D-MI)	-Government Operations; Post Office and Civil Service; Public Works and Transportation; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>
Coyne	(D-PA)	-Budget; Ways and Means
Dellums	(D-CA)	-Armed Services (Chair); <i>Congressional Black Caucus</i>
de Lugo	(D-VI)	- Education and Labor ; Natural Resources; Public Works and Transportation
Dixon	(D-CA)	-Appropriations; Select Intelligence; <i>Congressional Black Caucus</i>
Edwards	(D-CA)	-Foreign Affairs; Judiciary; Veterans' Affairs
Faleomavaega	(D-AS)	- Education and Labor ; Foreign Affairs; Natural Resources
Flake	(D-NY)	-Banking, Finance, and Urban Affairs; Government Operations; Small Business; <i>Congressional Black Caucus</i>

Furse	(D-OR)	-Armed Services; Banking, Finance & Urban Affairs; Merchant Marine & Fisheries; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Gutierrez	(D-IL)	-Banking, Finance and Urban Affairs; Veterans' Affairs; Freshman
Hamburg	(D-CA)	-Merchant Marine and Fisheries; Public Works and Transportation; Freshman
Hilliard	(D-AL)	-Agriculture; Small Business; <i>Congressional Black Caucus</i> ; Freshman
Hochbrueckner	(D-NY)	-Armed Services; Merchant Marine & Fisheries
Lantos	(D-CA)	-Foreign Affairs; Government Operations
Martinez	(D-CA)	- Education & Labor ; Foreign Affairs; <i>Congressional Hispanic Caucus</i>
McCloskey	(D-IN)	-Armed Services; Foreign Affairs; Post Office & Civil Service
McDermott	(D-WA)	- Ways & Means ; District of Columbia; Standards of Official Conduct (chairman)
McKinney	(D-GA)	-Agriculture; Foreign Affairs; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Meek	(D-FL)	-Appropriations; <i>Congressional Caucus for Women's Issues</i> ; <i>Congressional Black Caucus</i> ; Freshman
Miller	(D-CA)	- Education & Labor ; Natural Resources (chairman)
Mink	(D-HI)	- Education & Labor ; Budget; Natural Resources
Murphy	(D-PA)	- Education & Labor ; Natural Resources
Norton	(D-DC)	-District of Columbia; Post Office & Civil Service; Public Works & Transportation; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>
Oberstar	(D-MN)	-Foreign Affairs; Public Works & Transportation
Olver	(D-MA)	-Appropriations

Owens	(D-NY)	- Education & Labor ; Government Operations; <i>Congressional Black Caucus</i>
Rangel	(D-NY)	-Ways & Means; <i>Congressional Black Caucus</i>
Romero-Barcelo	(D-PR)	- Education and Labor ; Natural Resources; <i>Congressional Hispanic Caucus</i> ; Freshman
Roybal-Allard	(D-CA)	-Banking, Finance & Urban Affairs; Small Business; <i>Congressional Hispanic Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Reynolds	(D-IL)	- Ways & Means ; <i>Congressional Black Caucus</i> ; Freshman
Rush	(D-IL)	-Banking, Finance and Urban Affairs; Government Operations; <i>Congressional Black Caucus</i> ; Freshman
Stark	(D-CA)	- Ways & Means ; District of Columbia (chairman); Joint Economic
Stokes	(D-OH)	-Appropriations; <i>Congressional Black Caucus</i>
Thompson	(D-MS)	- <i>Congressional Black Caucus</i> ; Freshman
Torres	(D-CA)	-Appropriations; <i>Congressional Hispanic Caucus</i>
Towns	(D-NY)	- Energy & Commerce ; Government Operations; <i>Congressional Black Caucus</i>
Tucker	(D-CA)	-Public Works & Transportation; Small Business; <i>Congressional Black Caucus</i> ; Freshman
Underwood	(D-GU)	-Armed Services; Natural Resources; <i>Congressional Hispanic Caucus</i> ; Freshman
Velazquez	(D-NY)	-Banking, Finance & Urban Affairs; Small Business; <i>Congressional Hispanic Caucus</i> ; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Vento	(D-MN)	-Banking, Finance & Urban Affairs; Natural Resources
Washington	(D-TX)	- Energy & Commerce ; Government Operations; Judiciary
Watt	(D-NC)	-Banking, Finance and Urban Affairs; Judiciary; Post Office and

Civil Service; *Congressional Black Caucus*; Freshman

Woolsey (D-CA) -**Education & Labor**; Budget; Government Operations;
Congressional Caucus for Women's Issues

Yates (D-IL) -Appropriations

NEED WORK:

Clay	(D-MO)	- Education and Labor ; House Administration; Post Office and Civil Service (Chair); <i>Congressional Black Caucus</i>
Conyers	(D-MI)	-Government Operations (Chair); Judiciary; Small Business; <i>Congressional Black Caucus</i>
Gibbons	(D-FL)	- Ways & Means ; Joint Taxation
Hinchey	(D-NY)	-Banking; Finance & Urban Affairs; Natural Resources; Freshman
LaFalce	(D-NY)	-Banking; Finance & Urban Affairs; Small Business (chairman)
Maloney	(D-NY)	-Banking; Finance & Urban Affairs; Government Operations; <i>Congressional Caucus for Women's Issues</i> ; Freshman
Mfume	(D-MD)	-Banking; Finance & Urban Affairs; Joint Economic; Small Business; Standards of Official Conduct; <i>Congressional Black Caucus (Chair)</i>
Nadler	(D-NY)	-Judiciary; Public Works & Transportation; Freshman
Payne	(D-NJ)	- Education & Labor ; Foreign Affairs; Government Operations; <i>Congressional Black Caucus</i>
Serrano	(D-NY)	-Appropriations; <i>Congressional Hispanic Caucus (Chair)</i>
Waters	(D-CA)	-Banking, Finance & Urban Affairs; Small Business; Veterans' Affairs; <i>Congressional Black Caucus</i> ; <i>Congressional Caucus for Women's Issues</i>

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Charles J. Lynn to Hillary Clinton/Jeff Eller Re: Health Care University (8 pages)	6/28/93	P5

COLLECTION:

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

FOLDER TITLE:

June 1993 HSA [4]

Gary Foulk

g90

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

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

PERSONAL AND CONFIDENTIAL MEMORANDUM

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

June 28, 1993

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

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

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

- (1) Reinvigorate the "need for action" mentality that, until very recently, had been effectively fanning the flames of desire for comprehensive health reform in the Congress;
- (2) Ease Congressional concerns about, and raise Member comfort levels with, the President's proposal to address the problems;
- (3) Better enable perspective Congressional supporters to explain, defend, and sell the President's proposal; and
- (4) Be utilized to help educate surrogates in home Congressional districts.

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

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

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

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

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

TARGET THE ISSUES

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

- (1) **An Overview of the Plan, its Design and its Philosophy;**
- (2) **Consumers in the New System;**
- (3) **Cost Containment and Budgets;**
- (4) **Savings, Costs and Financing;**
- (5) **Small and Large Businesses in the New System;**
- (6) **Health Care Providers in the New System;**
- (7) **Federal/State Roles;**
- (8) **The Elderly in the New System;**
- (9) **Rural Communities and the New System; and**
- (10) **Urban Communities, Underserved, and the New System.**

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

TARGET THE BEST PERSONNEL TO MAKE PRESENTATIONS

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

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

Policy Expert Resources

Within the White House health care working groups and the Departments (in particular, HHS), the Administration has an impressive array of health care policy experts who could serve in briefing roles extremely well. (In most cases, Ira and Judy -- in particular -- have been, and likely will continue to be, very well received.) Having said this, the other briefers that we will need must be evaluated carefully -- keeping in mind not only how competent they are, but how well they will be received by different collections of Members. (We have prepared a tentative staff resource list linked to the ten topics previously mentioned, but it is undergoing final review by Ira and HHS; in any event, it will be a continually updated list based on their performance and Congressional reception.)

Legislative/Policy Resources

We strongly advise that those most familiar with the Congress and their predilections -- the Administration's Legislative Affairs staff -- play a major role in briefing the Members and the staff on this issue. The White House and Departmental Legislative Affairs staff (particularly at HHS) have strong and long-standing relationships with the Members and staff that should be utilized to the benefit of the Administration's health reform effort.

At every briefing, there should be one Legislative Affairs Administration representative who has equal status to the policy presenter. This is absolutely necessary to best assure that no situation gets out of hand, that there is a politically sensitive individual always present, that there are careful notes of the meeting, and that responsive follow-up occurs.

ESTABLISH A STAFF/INTAKE AND SCHEDULING PROCESS

The scheduling of the university and other requested briefings should be coordinated out of the War Room. This work should be closely coordinated with the Department of Health and Human Services' Office of the Assistant Secretary for Legislation (ASL and other Departments as necessary). In addition, if desirable and appropriate, we should work closely with the House Democratic Caucus and the Senate Democratic Policy Committee to help coordinate topics, schedules, and rooms. The schedule of all briefings should be updated daily, provided to Steve Ricchetti/Chris J./Jerry K./Karen P., and announced at the morning Communications meeting.

To ensure that the briefing operation is a success requires an experienced and politically sensitive staff person who can work closely with the Congressional Leadership and Administration personnel in meeting the scheduling and substantive needs of the Members. We propose that Steve Edelstein take on this role (in addition to his other responsibilities) and work with Lori Davis and other staff at HHS to assist him. Depending on the volume of and desire for briefings, additional staff (perhaps a full-time intern who is mature and responsible) may be required.

PREPARE THE BRIEFING MATERIALS AND PRESENTATIONS

In order to ensure the delivery of a consistent, simple, understandable message, we need to prepare educational materials and the presenters in advance of the briefings that all staff can and should use. Educational materials should include charts, graphs, detailed outlines to guide presentation, questions and answers as appropriate. These materials and presentations should be user friendly and targeted to specific audiences.

Working with the initial approval of Ira and Judy, as well as the Legislative Affairs staff, Steve E. will assign one policy expert to each of the issues chosen for briefings to take the lead in preparing the substance of the briefing materials and their presentation. He will make certain that each presentation is finalized on time and in the best format possible. The Communications staff will review and edit the briefing materials for clarity, directness, and consistency of message.

The presentations will also be screened by Legislative Affairs staff to ensure that they meet the needs of the audiences. (They will know who is attending because we propose to limit the size of each briefing to between 25-35 Members and have them signed up in advance of the briefing; we believe that such a small structure will best assure a less lecture-like atmosphere and better encourage a give and take constructive discussion.)

Each "class" will be structured to briefly outline the problem(s) with the current system, how the President's proposal addresses the problem(s) (if relatively non-controversial), and the rationale behind the Administration's proposal. The briefings will be designed to last no longer than 60 minutes: 20-30 minutes (at most) of presentation and 30-40 minutes for questions and answers. On an as needed basis, these classes will be repeated to enable interested Administration representatives and Members of Congress the opportunity to learn about (and be comforted by) the substance and rationale behind our proposals.

Substantive and detailed presentations about the most controversial policy recommendations -- if they are even available -- of the President's proposal should be avoided. There is great concern among the Congressional Leadership that controversial recommendations -- such as financing, exact cost containment mechanisms, etc -- could lead to public and potentially problematic disclosure. Instead, the two Majority Leaders have suggested that we detail the **options** we are considering to address the most challenging issues.

BRIEF AND TRAIN THE BRIEFERS

Communications staff will be needed to provide guidance to all briefers on how to orally deliver their presentations in an easily understandable manner. In addition, before each presentation, the Legislative Affairs staff from either the White House or the appropriate Department (usually Jerry Klepner's shop) will brief the presenters on who will be in the audience, what issues are particularly sensitive, what issues to highlight/avoid, and how best to present complex, potentially controversial materials to them. As mentioned previously, Legislative Affairs staff will accompany and participate in all briefings with the Congress to assure that Member response is closely monitored and documented, and to assure that appropriate follow-up occurs.

DEVELOP A WORKABLE TIMETABLE

We need to make a final decision as to when it would be most appropriate and useful to commence the health care seminars. Senator Daschle originally envisioned the "classes" beginning only after the legislation had been introduced. Majority Leader Gephardt believes it is advisable to hold a series of briefings into one or two days of presentations in an attempt to hold a dry run -- presenting options not final decisions -- in an effort to begin to work out the kinks and determine what briefing format will work the best in September.

There are arguments on both sides of the appropriate start-up timeframe issue, but we assume that Senator Daschle will defer to Congressman on this issue. Should this be the case, the "dry-run" briefings could commence as soon as late July or early August. Both strongly believe, however, that this not occur until we are comfortable with the materials and presenters before we go to the Hill.

Lastly, Congressman Gephardt has initiated an invitation for the First Lady to speak before the House Democratic Caucus soon after she returns from her July trip (roughly the 21st). The concept behind this presentation is for Mrs. Clinton to reinvigorate the Members into, once again, feeling that health care reform is a political and economic imperative.

One last point: If we proceed with the establishment of the health care briefing formats, we must make certain that the Committee Leadership is well aware that these presentations are not substitutes for the normal detailed consultations that will take place with them. To assure them that this is not the case, we must schedule and conduct regular briefings with the Chairmen and their staff. If we do not do this, they are likely to view these briefing forums as an insulting gesture. THIS WOULD NOT SIT WELL AND WOULD BE UNWISE.

WORKPLAN TIMELINE

Activity	6/27	7/5	7/12	7/19	7/26	8/2- 8/30	9/6	9/13	9/20	9/27
Target Issues	-----									
Target Personnel	-----									
Finalize Staffing	-----									
Prepare Briefing Materials		-----								
Brief the Briefers			-----			(on how best to communicate/ legislative prep)			----- (communication and leg. prep continues)	
Hone the Message						-----				
HRC CAUCUS PRESENTATION					-----					
CONGRESSIONAL BRIEFINGS						----- Dry run 1st briefing before recess			----- RETURN TO briefings and continue them even after introduction on a bipartisan basis.	

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings, Steve Edelstein Re: Meeting with Senator Jeffords (6 pages)	6/28/93	P5
002. memo w/attach	Chris Jennings, Sean Burton to Hillary Clinton Re: Meeting with Congressman LaFalce (34 pages)	6/28/93	P5
003. memo w/attach	Chris Jennings to Hillary Clinton Re: House and Senate "Message" Meetings (11 pages)	6/29/93	P5

COLLECTION:

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

FOLDER TITLE:

June 1993 [5]

g191

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

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- 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]
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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]

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chirs Jennings, Steve Edelstein
RE: Meeting with Senator Jeffords
cc: Melanne, Steve, Distribution

June 28, 1993

Tomorrow you are scheduled to meet with Senator Jeffords. This meeting was requested by the Senator when he accompanied you on the flight to Vermont. In attendance will be Mark Powden, his Legislative Director and Vicki Caldiera, his Legislative Assistant for health issues.

BACKGROUND:

As you know, Senator Jeffords is a maverick Republican with a fair amount of interest in health-related matters. Because of his progressive views and because we are still working hard to attract Republicans to the President's health reform proposal, he is one of our top Republican targets.

Earlier this year, Senator Jeffords introduced his own health care reform bill entitled "Medicare." For financing, this legislation relies on a modified single-payer oriented payment approach that relies on:

- (1) 70 percent federal financing (from a six percent payroll -- 4 percent from the employer and 2 percent from the employee that goes directly to the Treasury);
- (2) 30 percent state financing (it could be virtually anything, including raising copayments and deductibles); and
- (3) The elimination of all health care deductions for the employer and the elimination of any health care deductions for any employee cost over 2 percent of payroll.

In addition, his legislation assumes: a fairly comprehensive benefit package, with significant mental health and dental coverage for kids; a heavy focus on preventive and primary care; subsidies for low income beneficiaries; and a state-based flexibility grounding. His cost containment enforcement mechanism is the denial of any additional Federal dollars (above the 70 percent contribution) unless there is a health care disaster.

Senator Jeffords has been making much lately of his view that his plan is the plan most like the proposal he perceives the administration to be formulating. He has also been taking credit for the fact that the Administration's plan includes state flexibility. Although the accuracy of his characterizations could be questioned, his continued satisfaction with our plan (and eventually, hopefully, our joint plan) is to be encouraged.

Tomorrow's meeting will likely revolve around a general discussion of his bill and its similarities to the Administration plan. In addition, he is likely to stress two issues of particular importance to him: 1) **broad-based financing** and 2) **concrete budget goals**. He will be seeking to reinforce his strong support for these principles as elements of the final plan. While his bill's approaches differ somewhat from our current plan, Jeffords feels that the two approaches are consistent. Nonetheless, he will want reassurances that his understanding of where we are heading on financing and a global budget is correct and in general accordance with his views.

This should be a relatively easy, but important meeting. We are confident that it will go well.



THE MEDICORE NATIONAL HEALTH ACT

U.S. Senator Jim Jeffords

The MediCORE National Health Act addresses several grave problems with the current American health care system. Rapidly rising health care costs and expenditures burden all Americans and are one of the leading contributors to the mounting federal budget deficit. These rising costs also exacerbate the unfairness of a health care system where many Americans lack adequate, if any, health care insurance. The MediCORE program reforms the American health care system by guaranteeing universal access to a set of basic CORE services, stemming escalating health care costs to individuals, employers and governments, and preserving quality and flexibility in health care delivery. The Act is also designed to ensure equitable financing for the provision of CORE services.

STATES DESIGN AND ADMINISTER PLANS TO PROVIDE A SET OF CORE BENEFITS TO ALL STATE RESIDENTS

The basic structure of the MediCORE program divides responsibilities for the design, administration and funding of health care delivery between federal and state governments. The Act charges states with the primary responsibility for designing and running health care programs for all U.S. citizens and legal residents within their territory. CORE services provided under state plans must cover medically necessary services, including prescription drugs, mental health treatment, and substance abuse and rehabilitative services; preventative care and long-term care must also be covered. Those presently receiving benefits under Medicare or Medicaid will receive expanded services under the CORE on an equal basis with other citizens.

FEDERAL MEDICORE BOARD OVERSEES STATE PROGRAMS AND ENSURES THAT STATES MEET MINIMUM FEDERAL STANDARDS

A federal MediCORE Board is established under the Act to oversee the design and administration of state health care plans. Though states will be given wide latitude to meet the special circumstances of their population in the design of delivery systems, the Board will ensure that states meet minimum federal standards for universal access, portability, administration, affordability and quality. For instance, state benefit packages must be substantially equivalent to a model set of CORE services to be outlined by the Board. Furthermore, in order to ensure quality and flexibility in health care services, states are encouraged to involve competition between two or more health care providers, and at least one delivery plan must permit significant freedom of choice by consumers among health care providers. If a state chooses to contract with the Board for the administration of its health care program, the Board will use networks of managed competition in all areas of the state with sufficient health care providers. Networks of managed competition will also be used if a state plan fails to meet minimum federal standards and is placed in receivership by the Board.

**FEDERAL PREMIUM ON PAYROLL AND UNEARNED INCOME PROVIDES
APPROXIMATELY 70% OF FUNDING FOR STATE PLANS, WITH STATES
CONTRIBUTING THE REMAINDER**

Most of the funding for state health care plans will derive from a MediCORE Trust Fund to be administered by the Board. A federal payroll premium--4 percent from the employer and 2 percent from the employee--will provide the principle source of monies for the Trust. Individuals who have income in addition to their earnings will be assessed up to a 6 percent health care premium on this additional income. These federal premiums will supply approximately 70% of the cost of running state health care plans. States will receive from the Trust at least those monies which have been generated from the MediCORE premiums upon their residents. They will also receive an amount equal to their portion of Medicare spending under Title XVIII of the Social Security Act for the year in which MediCORE is adopted. The Board will distribute additional funds from the Trust to states that need these monies in order to provide CORE services to their residents. The remaining funds for running state health care programs will be supplied by the states. States may use the 15 percent cost sharing permitted under MediCORE to offset their financial responsibility. If states use cost sharing, their contributions to state health care plans will be roughly equal to the amount they currently spend for health care.

**SPENDING UNDER THE MEDICORE ACT WILL BE LIMITED TO CURRENT LEVELS
OF NATIONAL HEALTH CARE EXPENDITURES**

The financing provisions of the MediCORE plan are designed to arrest the growth of health care costs by limiting the costs of running state programs to present levels of national expenditures on health care, adjusted for growth in Gross Domestic Product (GDP). The MediCORE health plan essentially redistributes monies currently being spent on health care by government, insurance companies and individuals. Resources available to the states through the MediCORE Trust Fund will only be increased if Congress makes an express, public decision to increase health care expenditures. Nevertheless, in order to maintain flexibility in the system and to preserve incentives for technological advances in medical care, individuals are free to use private insurance to purchase services beyond CORE benefits, and states themselves may supplement CORE services at their own expense.

ADDITIONAL FEATURES FOR CONTROLLING HEALTH CARE COSTS

In addition to keeping national health care expenditures at their current levels, the MediCORE program provides for additional mechanisms to control health care costs and spending. States are encouraged to develop fee schedules for health care providers, and the Board is directed to develop model fee schedules for the benefit of states. Limited cost sharing by health care recipients is also permitted under the MediCORE Act. Furthermore, managed competition in state programs will serve to keep costs down. In addition, the MediCORE Board has an important responsibility to study and recommend ways to reform medical malpractice laws.

The various provisions of the MediCORE Act ensure a system of health care delivery which is both fair and economically sound. MediCORE guarantees universal access to CORE health care benefits and finances these benefits equitably. At the same time, it effectively controls health care costs and preserves quality and flexibility within the American health care system.

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tough votes. That is what I heard during my reelection contest last year. Ohioans said, "We're willing to do our fair share. Just be honest with us. Be honest about our Nation's problems." That is why the people of Ohio sent me back to the Senate and that is what I intend to do.

And the honest truth is that our national debt is a cancer on our economy. In effect, interest payments on this monstrous debt constitute a tax on our economy that is gobbling up America's prosperity. And it has a stranglehold on the American dream—the dream of opportunity that I want to pass on to my grandchildren. That is what we face. And its time we confronted it head on. Not with charts and graphs. Not with cartoons and one-liners. But with real action.

Mr. President, it is the unfortunate, sad truth that Americans have grown skeptical about our actions here in the Congress. They have grown weary of the bickering. Weary of the shenanigans. They expect honesty. And that's what they deserve. No more bells and whistles. No more gimmicks, no smoke and no mirrors. Just the facts. And politicians who will face up to the facts, and make the hard choices.

And supporting this bill is a hard choice. I do not like every page, every provision, every punctuation point. I do not think this bill is Nirvana. It is not. In fact, there is a great deal here I don't like. There are things that I hope will get worked out in conference—and you can bet that the conference will be hearing from me.

But there is one thing that is far worse than even the most distasteful provision in this bill. And that is inaction. It is time to act. And it is high time for honesty here in this town. It is time to come clean about what needs to be done. It is no fun voting for taxes. It is much easier to oppose them.

And it is not easy to vote for spending cuts that will hit the elderly, that will hit retirees, that will hit farmers, that will hit Federal workers. It is much easier to oppose these cuts. But I am not here to take the easy way out.

I am here to make the hard choices. To do what is right for my State—and for the Nation. And, Mr. President, that is why I am going to vote for this bill.

BUDGET RECONCILIATION

Mr. JEFFORDS. Mr. President, I rise today to oppose the entire bill. During the past few months, the Senate has been carefully reviewing the President's economic proposal and we are presently considering the newest installment in this process, the omnibus budget reconciliation bill, S. 1134, which contains many aspects of that proposal. This proposal does not meet my goal, or the President's, of matching every dollar in increased taxes with a dollar in reduced Government spending.

First, I would like to make it clear that there are many provisions within this proposal that I could support. But,

as I learned from the 1990 budget agreement, where there was supposed to be some \$500 billion in budget reductions over a 5-year period, the tax increases were immediately implemented, but the spending cuts never seemed to materialize. The 1990 tax package, sought to enforce strict budgetary limits and targeted spending reductions. I can only hope that the bill we are currently considering will place enforceable budgetary caps and spending reductions.

Furthermore, I would have supported the administration's original goal of about \$1 in spending cuts for every \$1 in tax increases. It is understandable that this goal slipped, and indeed I would have been satisfied with a proposal that had an equal amount of tax increases and spending cuts. It strikes me as fair to ask the American people to pay more in taxes if the Government will reduce its spending by the same amount, in effect meeting the public half way.

Unfortunately, this measure fails to even come close to this goal. It contains close to \$70 billion in tax increases and user fees over the next 5 years, and just over \$30 billion in spending cuts over the same period. I think a 3-to-1 ratio of tax increases to spending cuts is just too steep.

The bulk of budget savings, approximately \$76 billion in the proposal, come from Medicare and Medicaid. I can not, and will not support any measure that unfairly singles out one group or groups for deficit reduction, particularly those individuals who can least afford it, such as the elderly and the poor. The fact is that much of this reduction in Federal spending, if enacted into law, will be simply cost-shifting to people covered by private health insurance.

In 1994, at the end of the President's program, the deficit is expected to be around \$240 billion, just about what it was in 1990. From that point on, it is expected to rise steadily. For these reasons, this proposal does not make the fundamental structural changes in Federal domestic spending necessary to create viable and sustained deficit reduction.

Further, this proposal in fiscal year 1994 has \$9 in tax increases for every \$1 in spending cuts. It does not meet the goal of \$1 in tax increases for every \$1 in spending cuts, the President's pledge, until fiscal year 1998. To borrow a phrase from the President: We can do better and we must do better in our efforts to change America's economic future. We must ensure that real spending cuts at least equal the tax increases in this proposal.

I had hoped that Congress would improve upon the original proposal offered by the President. Instead, we have a Senate bill that proposes tax increases on Social Security benefits, as well as a 4.9-cent tax increase on transportation fuel. I feel an increase in the tax on Social Security benefits is not the place to start. Furthermore, I be-

lieve that the proceeds from any tax on energy, such as the proposed gas tax increase, must be dedicated to two purposes: improving our infrastructure and developing a viable alternative fuels industry to reduce our dependency on imported oil.

In order to truly address the Federal deficit, all Americans, senior citizens included, should share in the necessary sacrifice. However, eliminating Social Security benefits disproportionately affects individuals on a fixed income. While Social Security should not be excluded from the debate on deficit reduction, we must assure that our efforts to reduce the deficit not lead to a disproportionate sacrifice by the needy.

For all these reasons, I must vote no on this measure. We have got to start making the hard choices instead.

Moreover, as many of my colleagues have stated throughout this debate, to significantly lower the Federal deficit, budget reform must go hand in hand with health care reform. We can no longer afford to deceive ourselves into thinking that tinkering with Medicare and Medicaid is the answer to our country's deficit problem. Health care plays such an important role in our economy, that without overall health care reform, not only will the deficit continue to grow, but the economy will continue to suffer. Health reform can only be achieved if it is complete, including all segments of society, working people in addition to the Medicare and Medicaid population.

I believe both my Republican and Democratic colleagues understand that we need a seamless system for good health policy. Yet, the budget proposals offered today contradict what we know is necessary for good health policy.

We have heard a great deal about the 37 million uninsured and the inequities in our current health care policy. What we don't focus enough on is the fact that Federal entitlements and the deficit are growing largely due to the impact of health care inflation. By the end of this year, we will spend more than \$913 billion on health care. That's a lot of health care, more than any other industrialized nation in the world. The public sector currently spends \$422 billion on health care, \$296 billion in Federal spending. The private sector spends \$490 billion. The bill cut Medicare and Medicaid by \$76 billion in public health care spending. But without any more reform, this will simply shift health care spending, adding to the already numerous health care cost problems in the private sector. We should not forget that private sector spending results in substantial foregone Government revenues, too. This is due to the fact that health care is tax deductible by businesses. In fact, CBO predicts that if we continue with our current health care system and spending habits, by the year 2000, the public sector will spend \$932 billion on health care, \$563 billion of which will

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be in Federal spending. Private sector will grow to \$600 billion.

That means that by the year 2000, we will spend \$1.6 trillion on health care. In percentage terms, this will represent 27 percent of the overall Federal budget. State and local governments will be spending an additional 18 percent on top of this amount. How much spending on health care is enough?

Well, we already spend \$3,100 per person on health care. By comparison, we spend \$1,700 per person on education and \$1,200 per person on national defense. In fact, per capita health care spending has and will continue to increase twice as fast as per capita GDP growth unless health care reform is enacted. This is bad news for both the budget and the economy. Moreover, we are spending more on health care than any other country in the world. On a per capita basis, we spend 1.5 times more than Canada, 1.7 times more than West Germany, and \$2.6 billion more than Great Britain.

We are spending a great deal on health care, but we are financing and delivering health care in a very inequitable and irrational way. We need to rationalize the system, give health care to everyone, and pay for health care for everyone, in a straight forward, across the board fashion. When we do this, we will find that health care can be provided so that all but the poor will pay 6 percent of a person's adjusted gross income. For most people, this could be collected in the form of a payroll premium, 4 percent paid by the employer, 2 percent paid by the employee.

This is much less than the 22 percent of payroll many auto companies and small employers currently pay for health care. Costs are high for many companies because everyone is not paying their fair share and the costs of uncompensated care and very sick individuals are not evenly borne by all.

With an all inclusive health care financing scheme, businesses will be able to reduce product prices and become more competitive. Additional workers could be hired. Fair financing for health care will also free up money to be used to provide pensions, education benefits and higher wages to employees. This translates into a higher standard of living and better quality of life for all American families.

But we can't stop there. We also need a health care budget. We have too many inefficiencies in our current health care system. Americans currently pay for administrative waste, fraud and abuse in claims processing and defensive medicine, that should not be in the system. This is the kind of health care spending nobody needs. Many people believe managed competition will squeeze much of the waste out of our health care system. However, a health care budget will ensure that waste is eliminated. Over the next decade, if growth in health care spending were limited to growth in GDP, we could cut the federal deficit in half.

Finally, health care delivery systems must be created and evaluated at the State level. States are more accountable and able to respond more quickly to the needs of the people than the Federal Government. States must have the flexibility to design the delivery system that works best given each State's demographic and geographic needs. We are a diverse country with diverse needs. State flexibility will account for this and ensure that everyone's health care needs are met in the best possible way.

I have incorporated all these elements of good health care policy that translates into good budget policy in S. 1067, the MEDICARE Health Act of 1993. The bill ensures that every citizen has access to a CORE set of health services. It provides a broad based financing scheme to pay for these benefits. Moreover, it sets strict budget goals to be administered by the States, to make sure health care is affordable. Finally, it gives States the flexibility to design the health care delivery system that is most ideally suited to the needs of its people.

Mr. President, once Congress tackles health care costs, our Federal budget problems should largely be under control. Therefore, the next choice Congress must address is reprioritizing expenditures in the Federal budget. The area needing the most attention is American education.

Dealing with the budget process, the reconciliation instructions to the Senate Committee on Labor and Human Resources was to reduce \$4.6 billion from covered expenditures. The administration planned to achieve these savings by completely replacing the current Federal Family Loan Program with a Federal Direct Student Loan Program by 1997-98. After long negotiations and with the assistance of my colleagues Senators PELL, KASSABAUER, DONN, MIKULSKI, and Chairman Kennedy the committee has crafted a compromise to the President's initial bill.

The committee compromise now includes the replacement of only half of the current guaranteed lending program with direct lending in the next 5 years. It also establishes a Commission to study the advisability of moving fully into direct lending before the end of the fifth year.

For those of us who support a more cautious approach to direct lending this compromise represents a step in the right direction. The committee's compromise allows the concept of direct lending to be tested before moving full speed ahead into uncharted waters. I believe that direct lending may be the best way to deliver loans to students. However, I believe just as firmly that we need to test that assumption and move slowly so that the beneficiaries of this program—the students—are not left without access to needed loan money. The committee's compromise does just that.

However, the committee compromise does more than just move cautiously to

a new delivery system for student financial aid. It also saves \$4.6 billion. It does that by a combination of moving 50 percent of new loan volume to direct lending, decreasing subsidies paid to lenders and guaranty agencies, and by assessing fees on lenders and Sallie Mae.

While I am pleased that the committee was able to meet the budget instructions and reduce many of the excessive costs paid to participants in the current program, I am very concerned that this money is not being funneled back into education programs but is instead going to pay off our debts.

For years we have been told that the threat from foreign enemies demanded massive defense buildup. Without question, this country threw itself behind that call and spent hundreds of billions of dollars on warplanes, submarines, and battleships. But now that threat has receded and has been replaced by a new threat—just as serious and just as frightening.

The new threat is not somewhere across the Atlantic—it is here, in our own country. It is the threat that our children are not getting a fair shot at what they deserve. Just today, the National Research Council released its 3-year study suggesting that the serious problems of the Nation's adolescents—drug use, school failure, delinquency, and violence—have grown to tragic proportions. The reasons are clear—the programs designed to assist children have come under siege over the past two decades. But teenagers are not the only losers in our country—young children and babies are also being ignored. When 1 in 5 children—14.3 million—lived in poverty in 1991 there is little wonder why children fail in school and become disillusioned with the future.

We have a clear and present danger in this country—just as we did decades ago with our foreign enemies—but we have yet to take that threat seriously. We have not—as we did with our defense buildup—understood that now is the time to build up education, health, and social services programs in the same way that we committed ourselves to the cold war buildup.

The problems of this country have moved from being a distant threat to a frightening reality. We must begin to reevaluate our priorities and devote our funding to solving the crisis at home.

AND RESPONSE

Mr. LIEBERMAN, Mr. President, yesterday, I filed an amendment to this bill which would restore one of the President's investment proposals to his economic package—the President's alternative minimum tax reform provision. I did so because I believed—and I continue to believe—that the Congress must deliver three things to the American people—deficit reduction, spending cuts, and job creating investment incentives.

We are two-thirds of the way there. The bill sent to this floor by the Senate Finance Committee

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Sean Burton
RE: Meeting with Congressman LaFalce
cc: Melanne, Steve, Lorraine, Distribution

June 28, 1993

Tomorrow you are scheduled to meet with Congressman John LaFalce from New York. As you know, the Congressman serves as the Chairman of the House Small Business Committee and would provide valuable cover to us should he be an early and public supporter of the Clinton health reform proposal. This meeting was scheduled to begin to cultivate a strong working and personal relationship.

BACKGROUND:

Interestingly, besides being the House Small Business Chairman, Congressman LaFalce is a cosponsor of Congressman McDermott's single payer bill. This meeting will be a general briefing on health care reform. The Congressman will be particularly interested in the elements our plan share with a single payer system and the steps taken to minimize the impact on small businesses.

The Congressman is concerned that health care reform, especially employer mandate approaches, could have a devastating affect on small businesses. It is primarily this concern that has lead LaFalce to support the single payer plan. The fact that his upstate New York district lies on the Canadian border and that many of his constituents have a familiarity with the Canadian system (often through relatives who live there), makes this decision all the more comfortable for him. (It is interesting to note, however, that the McDermott bill contains a 6 percent payroll tax to help finance the cost of the measure.)

While not a major player on health care reform, with sufficient attention, the Congressman will likely be with us in the end and can serve as useful connection to the small business community. And although his committee is unlikely to receive jurisdiction over parts of the plan, it can serve as a forum for airing our message on health care reform and small business. In meetings with his committee staff, they have suggested the possibility of holding hearings at an appropriate time on the current problems facing small businesses in providing insurance and how the Administration's plan would help.

Over the last couple of months, we developed an on-going and generally productive relationship with the Congressman and his staff. We have held a small meeting with his staff and then had Ken Thorpe brief the entire staff of those who serve on the Committee.

In addition, Ira met with the Congressman last month. Although the meeting was not overly substantive, the Congressman appeared to sincerely appreciate the outreach effort. Since he has a past working relationship with Ira, Congressman LeFalce seems to place great trust in Ira.

Lastly, however, it should be noted that LeFalce feels relatively close to John Motley, of the National Federation of Independent Business. They worked together to kill Section 89 of the tax code, which required health care expense reporting requirements that the small business community hated. With this in mind, you may wish to ask him to give you guidance on how best to work with NFIB and other small business representatives.

As you requested, attached to this memo is the latest version of a small business presentation that the Department of Health and Human Services is writing. Although it is far from a state that we are totally comfortable with, we thought you might find this information to be useful for meetings with small business advocates. We will provide updated versions of this and other small business documents as they become available.

Health Reform and Small Business

A Look at Problems in Today's System and
Solutions Under the President's Health Reform

Small Business and Health Care Reform: Overview

It takes courage and ingenuity to start and succeed as a small business. It means taking a risk with your future and betting that you succeed. As many as 1 out of 12 small businesses fail within the first year. It is not right that many small business owners also face the risk that their families and employees won't have health care when they need it. It is not right that those who provide coverage risk that within a year that coverage may be taken away or priced out of reach.

Small businesses fuel job creation and strengthen our economy. Responsible for 90% of job growth in 1990, small businesses has become the nation's engine of economic growth. Yet this growth is endangered by a health care system which threatens every American business, especially small businesses. Small business owners can face financial devastation if a family member or just one employee falls ill. And employers who try to provide health care to their employees find a health care system stacked against small businesses.

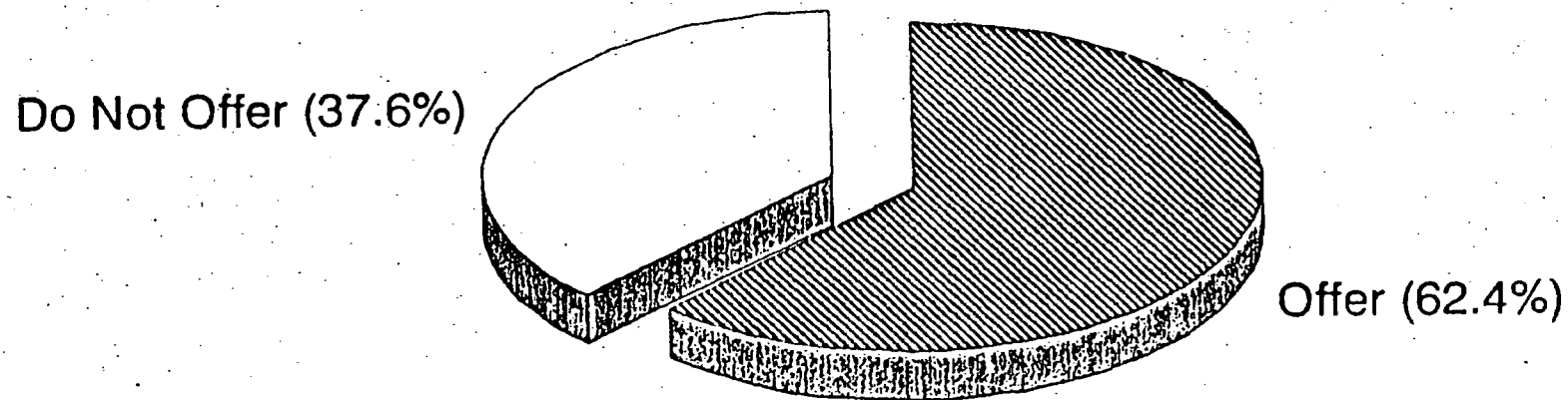
Nonetheless, a majority of American small businesses manage to provide coverage. Today 62% of American businesses with less than 100 employees provide health care coverage to their employees. And 51% of those with fewer than 25 employees provide health care. But providing these benefits isn't easy.

The Clinton Administration believes that most small business want to cover their employees -- and most do. Our health care plan will work for small business, taking away the hassle and ensuring security of affordable, predictable health care coverage. And for those businesses who don't provide health insurance coverage, our reform will protect them while they make the transition. The plan provides financial assistance and a phase-in period so they may provide health security to their employees and families.

In today's Mom and Pop stores, the Mom or the Pop serves as the de facto benefits department. They fill out the paperwork. They make the phone calls. They negotiate rates and enroll their employees. They dutifully pay their premiums every month. But all too often, within a year, their insurer will raise rates and price them out of the market -- many times for no reason. Or the insurer will refuse to renew coverage. Then the small business owner is back to the drawing board -- spending more time and more money to find another insurer -- and the cycle starts again.

The following document examines the major problems faced by small businesses in today's health market and shows how health reform and the formation of health alliances will address most, if not all, of the major problems facing small businesses.

The Majority of Small Businesses Offer Health Insurance to Their Employees



For Firms with Less than 100 Employees

Source: Dept. of Labor, Based on SBA Calculation of May 1988 CPS Survey Data

The Small Business Obstacle Course

- Time and Money
- Price Discrimination
- Insurance Abuses
 - Redlining
 - Underwriting
- High Administrative Costs
- A Volatile Insurance Market
 - Price Gouging
 - Difficulty Securing Renewal

THE SMALL BUSINESS OBSTACLE COURSE

Problem: *Small business owners must go through an obstacle course of insurance abuses and higher costs to provide health care coverage for their employees.*

Small business owners who spend the time and money to cover employees frequently must deal with an insurance market which changes its rules at every stage of the game, a volatile market, unpredictable cost increases, higher administrative costs, and premiums rising at a faster rate than health care costs for larger employers.

Lacking a benefits department like larger firms most small business owners must perform all the functions of such a department by themselves. Negotiating health coverage in today's health care system is a process often fraught with frustration and obstacles.

Many small business owners, after setting aside the time to negotiate coverage for their employees, encounter obstacles like "occupational redlining" a practice where insurers will simply refuse to cover entire industries perceived to be high risk; or medical underwriting, basing premiums on perceived risk and medical history; or experience rating, where insurers jack up costs if just one employee falls ill or gets injured. Many insurers engage in "price baiting and gouging" offering "discount" rates for the first year of coverage only to charge much higher prices in the next year when pre-existing condition exclusions expire. And many small firms with sick workers find that an insurance company will refuse to renew their policy in the second year.

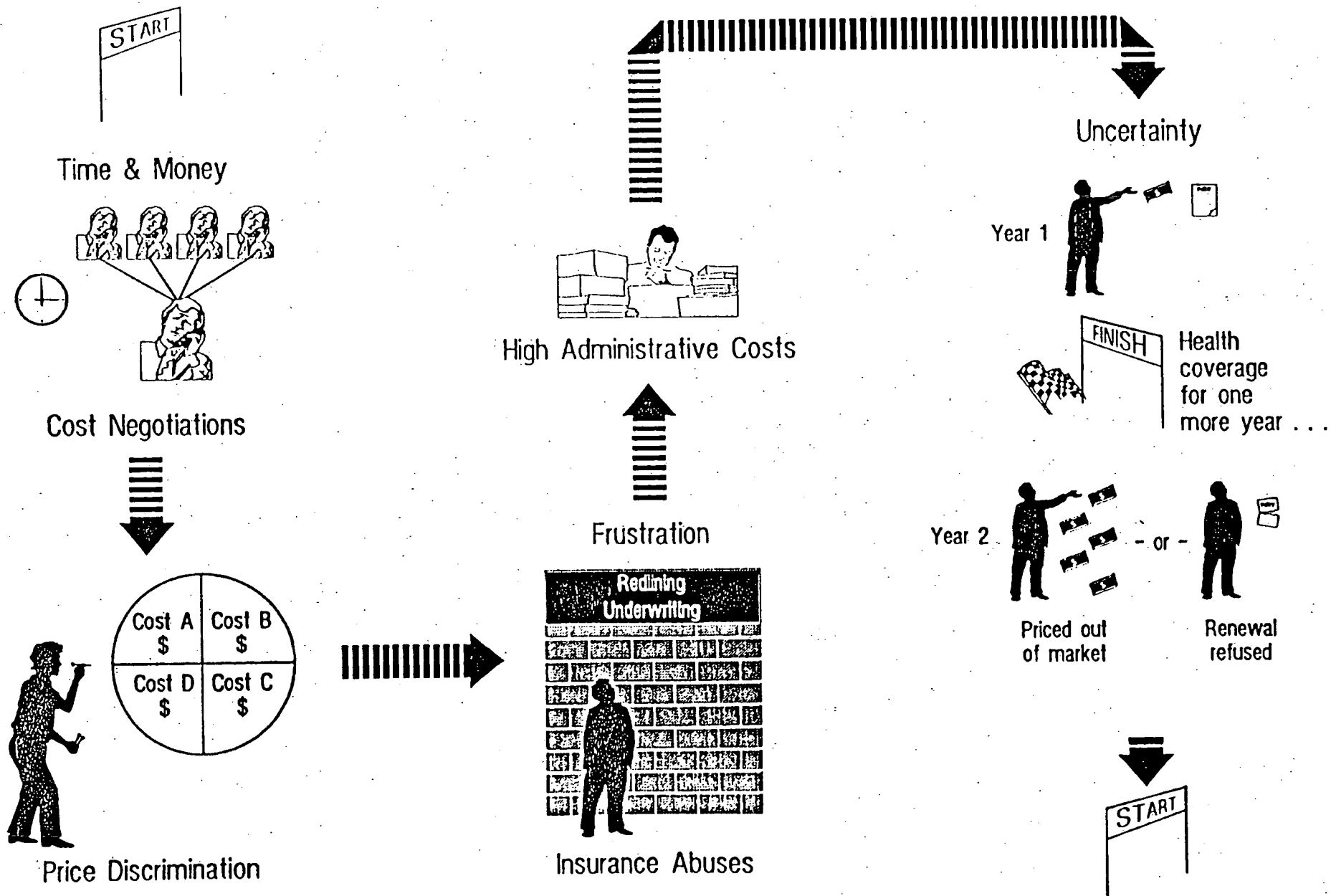
Not surprisingly the hassle and discrimination in today's system make many small owners worry about being able to continue to provide this coverage. The reform plan addresses nearly all of the problems which cause the small business owner so much hassle and time in obtaining insurance.

The Plan: *Health reform outlaws insurance practices like underwriting and redlining. The health alliance helps small businesses cut through the hassle.*

We will take the burden off the small business with health alliances which will deal with the insurance companies and bargain for competitive prices. The alliance will take over the paperwork and the negotiations; provide information on plans and increase ease of enrollment. Higher administrative costs will be reduced and the hassle of the current system is eliminated.

The Clinton reform plan outlaws insurance abuses such as redlining, underwriting and experience ratings. Costs of premiums are controlled and the insurance market is stabilized. Under our reform, everyone living in the same area pays a similar price for a similar plan. And they have the security knowing those costs will be predictable and increase at a lower rate.

Small Business Owners Face an Obstacle Course in Obtaining Health Insurance



The New System



Insurance Industry Abuses

- Medical Underwriting
- Experience Rating
- Price Baiting and Price Gouging
- Refusal to Renew Policy
- Occupational Redlining

OCCUPATIONAL REDLINING

TYPES OF INDUSTRIES OFTEN EXCLUDED FROM HEALTH INSURANCE PLANS

Amusement Parks	Insurance Agencies
Asbestos-Related Industries	Interior Decorators
Auto Dealers	Janitorial Services
Aviation	Junk and Scrap Metal
Barbers and Beauty Shops	Law Firms
Bars and Taverns	Limousine Services
Car Washes	Liquor Stores
Commercial Fishing	Logging and Lumber Mills
Construction	Meat/Fish Packers
Convenience Stores	Mining Operations
Domestic Help	Moving Operations
Entertainment/Athletic Groups	Oil Field Operations
Exterminators	Parking Lots
Federally Funded Organizations	Physicians Practices
Florists	Restaurants
Foundries	Roofing Companies
Grocery Stores	Security Guard Firms
Health Clubs and Spas	State Funded Organizations
Hospitals and Nursing Homes	Taxicabs
Hotels and Motels	Trucking Firms (Long-Haul)

Sources:

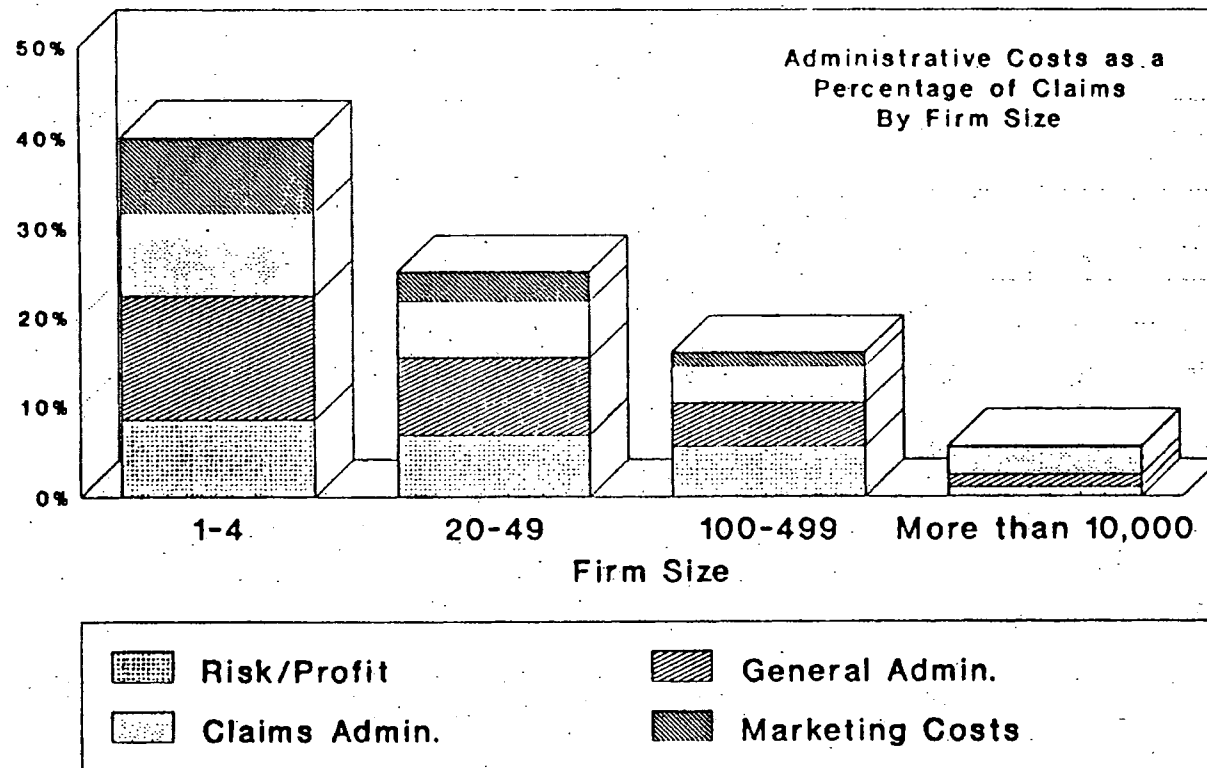
List of "ineligible industries" and industries requiring "special consideration" from selected insurance plans analyzed by the Alpha Center.

American Hospital Association, Promoting Health Insurance in the Workplace and Local Initiatives to Increase Private Coverage (Chicago: 1988), as cited in: United States General Accounting Office, Health Insurance: Cost Increases Lead to Coverage Limitations and Cost-Shifting. (GAO/HRD 90-68)

Higher Administrative Costs

- Higher Overhead
- No Benefits Department
- Faster Increases in Costs

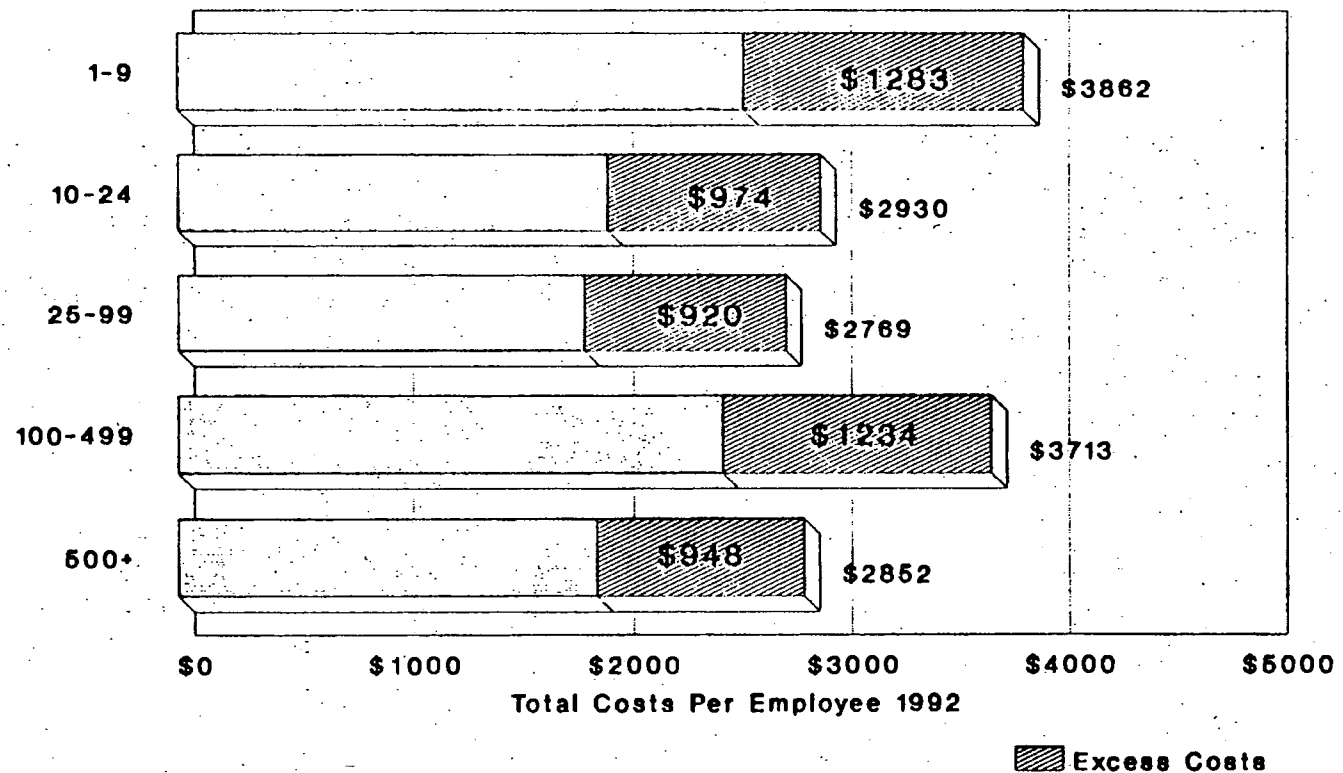
Small Businesses Face Higher Administrative Costs



Source: Hay/Huggins, Inc.

Employers Would Save \$1,015 Per Employee Per Year If Costs Were Controlled -- Small Businesses Save Most

Employees in Firm

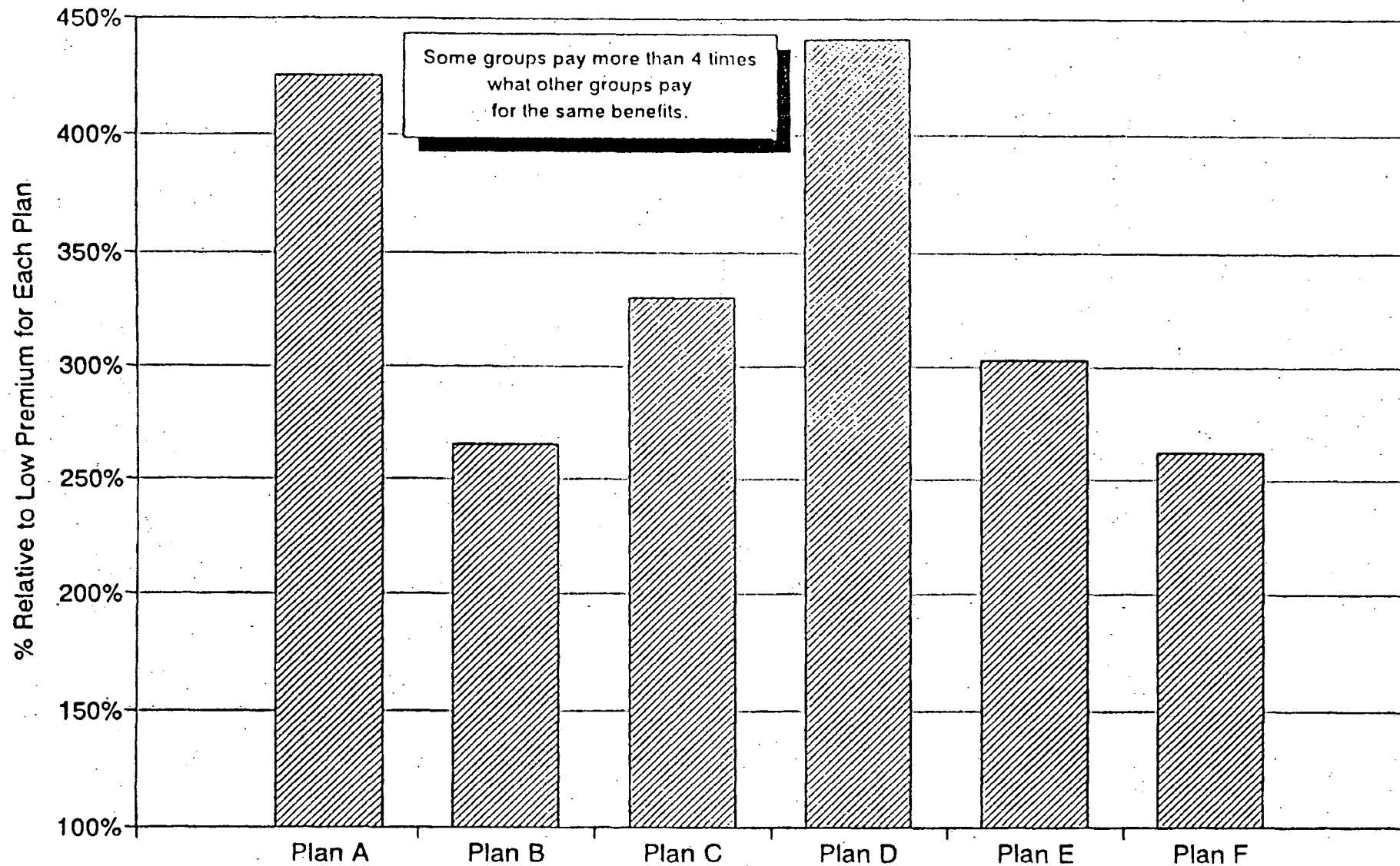


Source: Lewin-ICF

A Volatile Market

- Cost Variations
- Unpredictable Cost Increases
- Durational Rating
- Churning

Small Groups (2-25) Face Large Variations in Health Insurance Premiums



Source: Blue Cross/Blue Shield Association, Survey of Six Sample BC/BS Plans, January 1992.

SMBUS.WQI

SUMMARY

TODAY	REFORM
High Administrative Costs: Higher administrative costs account for as much as 40% of the policy costs compared to about 5% for large companies. [CBO, 5/92]	Cuts Administrative Costs: The health alliance assumes the administrative functions and costs which kill small business owners.
The Obstacle Course: Small business owners who cover their employees must spend a lot of time and effort dealing with an insurance market which changes its rules at each stage of the game.	Eliminates Hassle: The health alliance negotiates rates, provides information on plans, increases ease of enrollment and absorbs the manpower drain.
Dramatically Increasing Costs: Premiums for small employers rise at a faster rate than for other employers -- as much as 50% in any given year. [NAM]	Aggressively Controls Costs: Health reform will aggressively control cost increases which hit small businesses disproportionately hard.
Difficulty Obtaining Renewal: After a first year of reasonable rates, small businesses often face higher costs and difficulty obtaining renewal.	Guarantees Renewal: Guarantees renewal and stabilizes premiums.
Small Risk Pool: Fewer employees mean a smaller pool to share the risk. Insurance companies frequently charge more for these policies and one illness can cause plan cost to increase dramatically.	Spreads Risk Evenly: Consolidates small businesses in large purchasing pools to give them the same bargaining power as large companies.
Insurance Industry Abuses: Insurance companies redline large sectors of the small business market. Underwriting and experience rating leads to discriminatory prices for small business policies.	Outlaws Unfair Insurance Practices: Prohibits redlining, experience rating and underwriting. Requires that plans charge all firms in a given area a similar price for the same health plan.

Insurance Problems Facing the Small Group Employee Market

- **Large Volatile Variation in Premiums**
 - Underwriting
 - High Risk
- **Workers in Small Firms Finance a Higher Proportion of Total Premiums**
- **Insurance is More Expensive Relative to Large Firms**
 - High Administrative Costs
 - Premiums Include Costs of Uninsured
 - Provider Payments Substantially Above Costs
- **Growth in Insurance Premiums is Higher in the Small Group Market**
 - Less Likely to Have Established Cost Containment Programs

Average insured worker's health spending without health reform

	Health Bill as % of 1994 Compensation		Health Bill as % of 2000 Compensation	
Average compensation per worker:	\$36,299		\$50,334	
Average insured worker's health bill	\$7,423	20.45%	\$12,386	24.61%
Health insurance	\$4,132	11.38%	\$6,895	13.70%
Employer's share of premium	\$3,163	8.71%	\$5,278	10.49%
Individual's share of premium	\$969	2.67%	\$1,617	3.21%
Medicare payroll tax	\$926	2.55%	\$1,546	3.07%
Workers' comp/disability/Industrial Inplant	\$246	0.68%	\$411	0.82%
Out-of-pocket	\$782	2.15%	\$1,305	2.59%
Other spending at health facilities	\$113	0.31%	\$188	0.37%
Federal taxes, fees, & other payments	\$654	1.80%	\$1,092	2.17%
Federal employees' health premiums	\$53	0.15%	\$88	0.18%
Federal contributions to Medicare HI	\$11	0.03%	\$19	0.04%
Medicare (general revenue)	\$169	0.47%	\$283	0.56%
Medicaid	\$246	0.68%	\$411	0.82%
Other federal health programs	\$174	0.48%	\$290	0.58%
State & local taxes, fees, & other payments	\$569	1.57%	\$950	1.89%
State/local employees' health premiums	\$149	0.41%	\$248	0.49%
State/local contributions to Medicare HI	\$24	0.06%	\$39	0.08%
Medicaid	\$188	0.51%	\$310	0.62%
Hospital subsidies	\$81	0.22%	\$135	0.27%
Other programs	\$130	0.36%	\$218	0.43%

Source: Office of Health Policy, ASPH, HHS analysis using Health Care Financing Administration; Urban Institute; and
and Department of Commerce, Bureau of Economic Analysis data.

Current Spending on Private Health Insurance Premiums by State;
As a Percent of Taxable Earnings

	Taxable Earnings	Premiums	Percent
ALABAMA	38,998,615,328	3,751,897,975	9.62%
ALASKA	7,471,145,760	542,968,282	7.27%
ARIZONA	40,891,512,828	3,674,537,304	8.99%
ARKANSAS	22,072,511,494	2,369,779,864	10.74%
CALIFORNIA	376,824,975,470	31,877,334,190	8.46%
COLORADO	42,952,222,017	4,135,548,261	9.63%
CONNECTICUT	47,909,041,475	4,355,805,242	9.09%
DELAWARE	8,849,078,807	773,909,213	8.75%
DC	7,552,877,819	445,947,314	5.90%
FLORIDA	138,666,533,016	10,936,916,977	7.89%
GEORGIA	69,107,458,029	6,723,213,419	9.73%
HAWAII	14,976,797,447	1,346,035,317	8.99%
IDAHO	9,025,688,646	1,028,354,152	10.47%
ILLINOIS	143,985,945,827	13,640,116,472	9.47%
INDIANA	61,043,580,896	6,713,556,189	11.00%
IOWA	30,016,622,605	3,056,074,535	10.18%
KANSAS	28,715,089,385	2,789,136,209	9.71%
KENTUCKY	34,784,608,184	3,266,394,864	9.39%
LOUISIANA	39,529,575,525	3,484,793,997	8.82%
MAINE	12,889,977,383	1,321,989,294	10.26%
MARYLAND	68,211,468,897	5,210,965,088	7.64%
MASSACHUSETTS	77,961,860,617	6,503,215,432	8.34%
MICHIGAN	109,409,081,232	11,912,093,402	10.89%
MINNESOTA	51,705,415,820	5,314,122,517	10.28%
MISSISSIPPI	20,557,808,856	2,125,883,724	10.34%
MISSOURI	60,244,888,374	6,222,536,523	10.33%
MONTANA	7,830,490,164	890,991,169	11.38%
NEBRASKA	17,478,845,803	1,796,956,659	10.28%
NEVADA	15,537,209,212	1,714,663,640	11.04%
NEW HAMPSHIRE	16,013,650,661	1,667,820,843	10.41%
NEW JERSEY	110,015,651,967	9,024,393,868	8.93%
NEW MEXICO	14,950,233,670	1,464,499,881	9.80%
NEW YORK	217,920,564,116	19,235,998,662	8.83%
NORTH CAROLINA	72,154,332,101	6,571,365,130	9.11%
NORTH DAKOTA	6,052,341,293	618,523,636	10.22%
OHIO	124,378,294,987	13,280,058,130	10.68%
OKLAHOMA	32,097,793,109	2,870,309,363	9.00%
OREGON	32,773,518,112	3,490,744,060	10.65%
PENNSYLVANIA	132,224,234,494	15,138,836,639	11.45%
RHODE ISLAND	12,056,487,582	1,263,223,740	10.48%
SOUTH CAROLINA	37,791,500,551	3,703,870,746	9.80%
SOUTH DAKOTA	6,456,992,930	705,755,456	10.93%
TENNESSEE	47,647,609,848	4,872,056,097	10.23%
TEXAS	186,606,311,095	15,700,711,823	8.41%
UTAH	16,607,270,729	1,809,372,751	10.90%
VERMONT	6,477,098,200	645,079,504	9.96%
VIRGINIA	83,193,483,170	6,488,962,015	7.80%
WASHINGTON	63,863,931,291	6,009,963,683	9.41%
WEST VIRGINIA	15,348,775,523	1,602,410,413	10.44%
WISCONSIN	58,699,280,587	6,469,131,821	11.02%
WYOMING	5,005,270,744	493,327,885	9.86%
TOTAL	2,004,335,574,606	271,872,153,970	9.36%

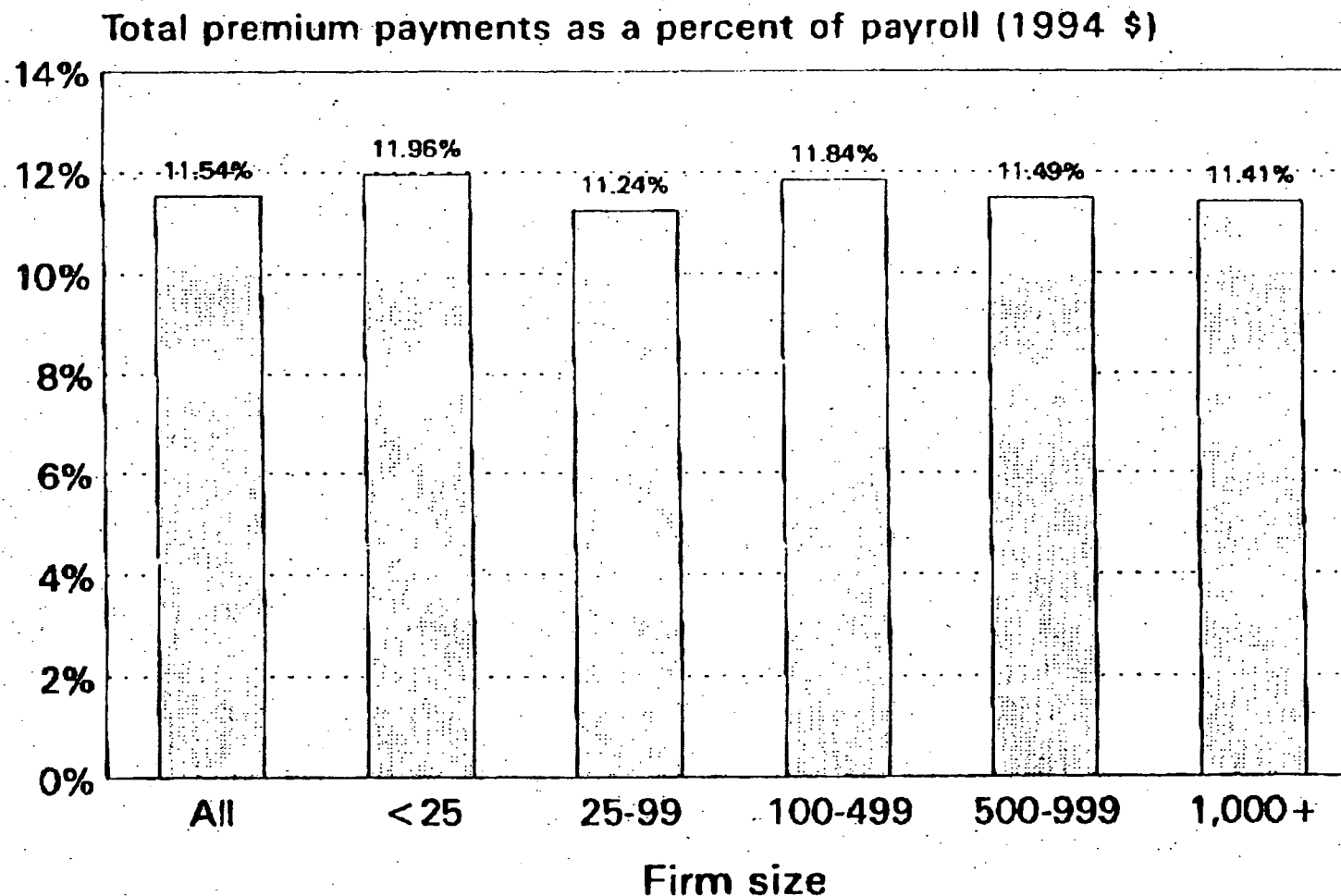
Source: Social Security Wage Base

**Total Premium Payments as Percent of Payroll
Without Health Reform**

Firm Size	1994	1995	1996	1997	1998	1999	2000
All	11.54%	12.06%	12.53%	12.96%	13.42%	13.88%	14.36%
<25	11.96%	12.50%	12.98%	13.43%	13.90%	14.39%	14.89%
25-99	11.24%	11.75%	12.20%	12.62%	13.07%	13.52%	13.99%
100-499	11.84%	12.38%	12.85%	13.29%	13.77%	14.24%	14.74%
500-999	11.49%	12.01%	12.47%	12.90%	13.36%	13.82%	14.30%
1000+	11.41%	11.93%	12.39%	12.81%	13.27%	13.72%	14.20%

Source: HHS analysis using Urban Institute analyses of March 1992 Current Population Survey.

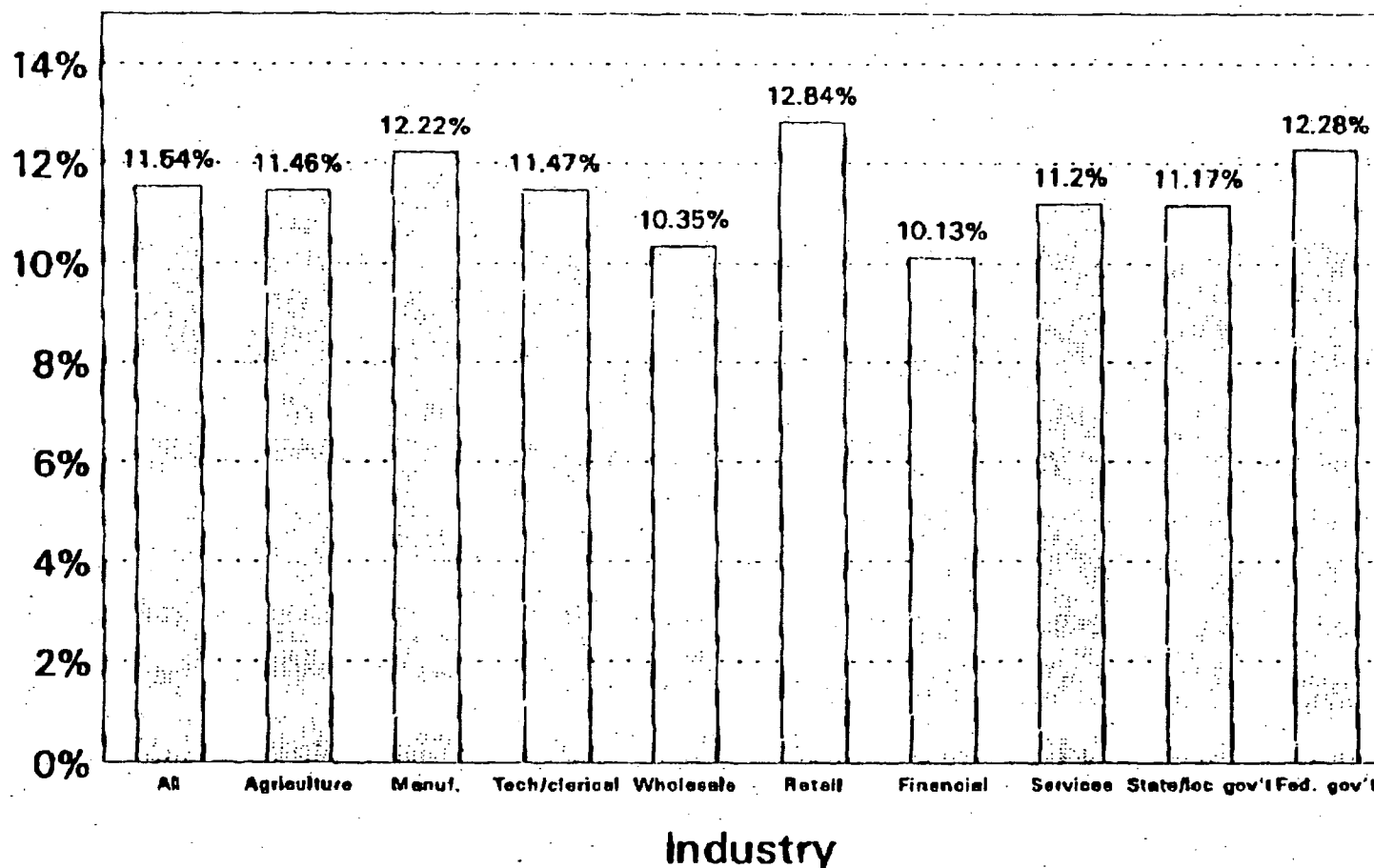
Total premium payments as a percent of payroll vary by firm size and are highest for firms with less than 25 employees.



Source: Urban Institute analyses of the March 1992 Current Population Survey.

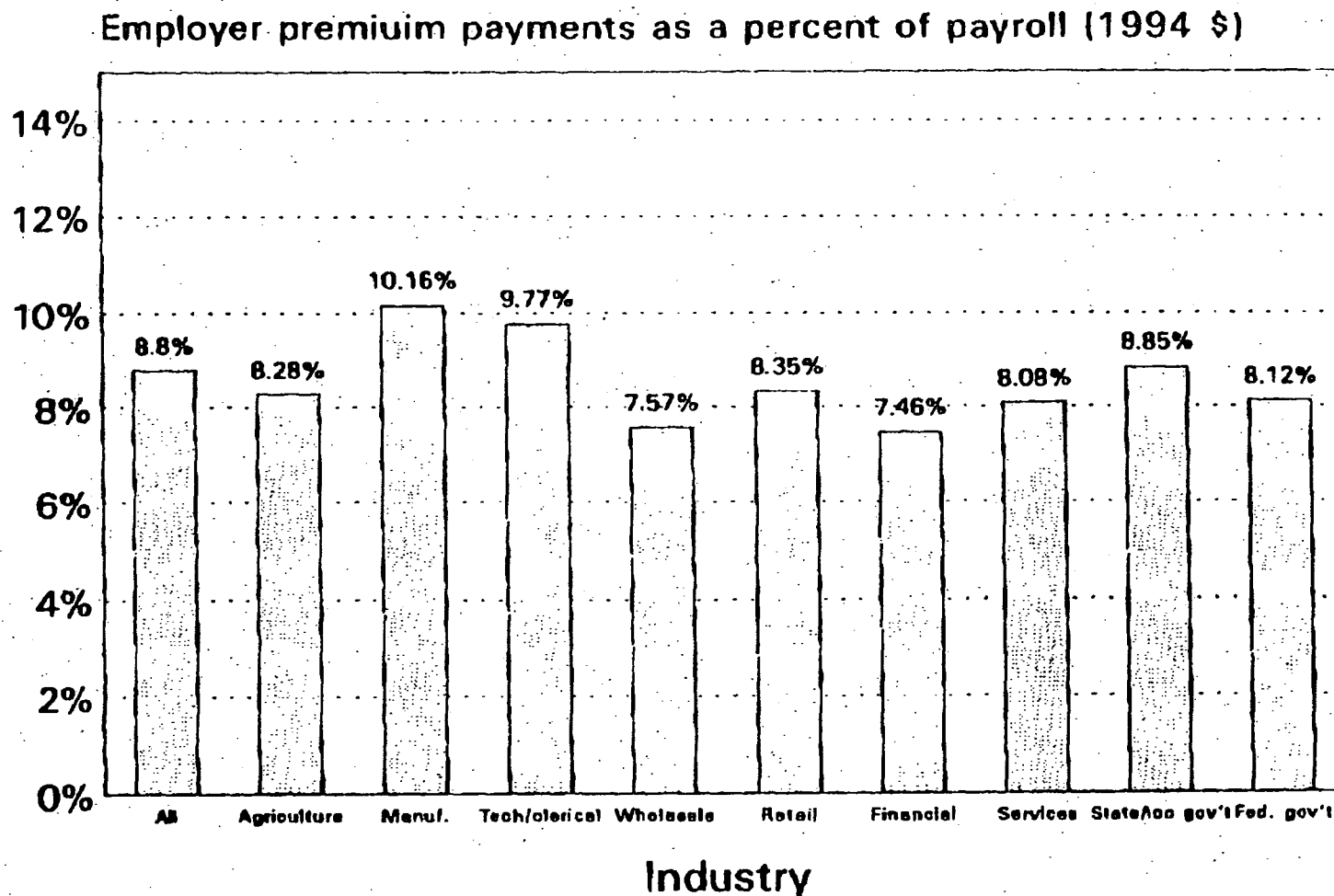
Total premium payments as a percent of payroll vary by industry and are highest for retail.

Total premium payments as a percent of payroll



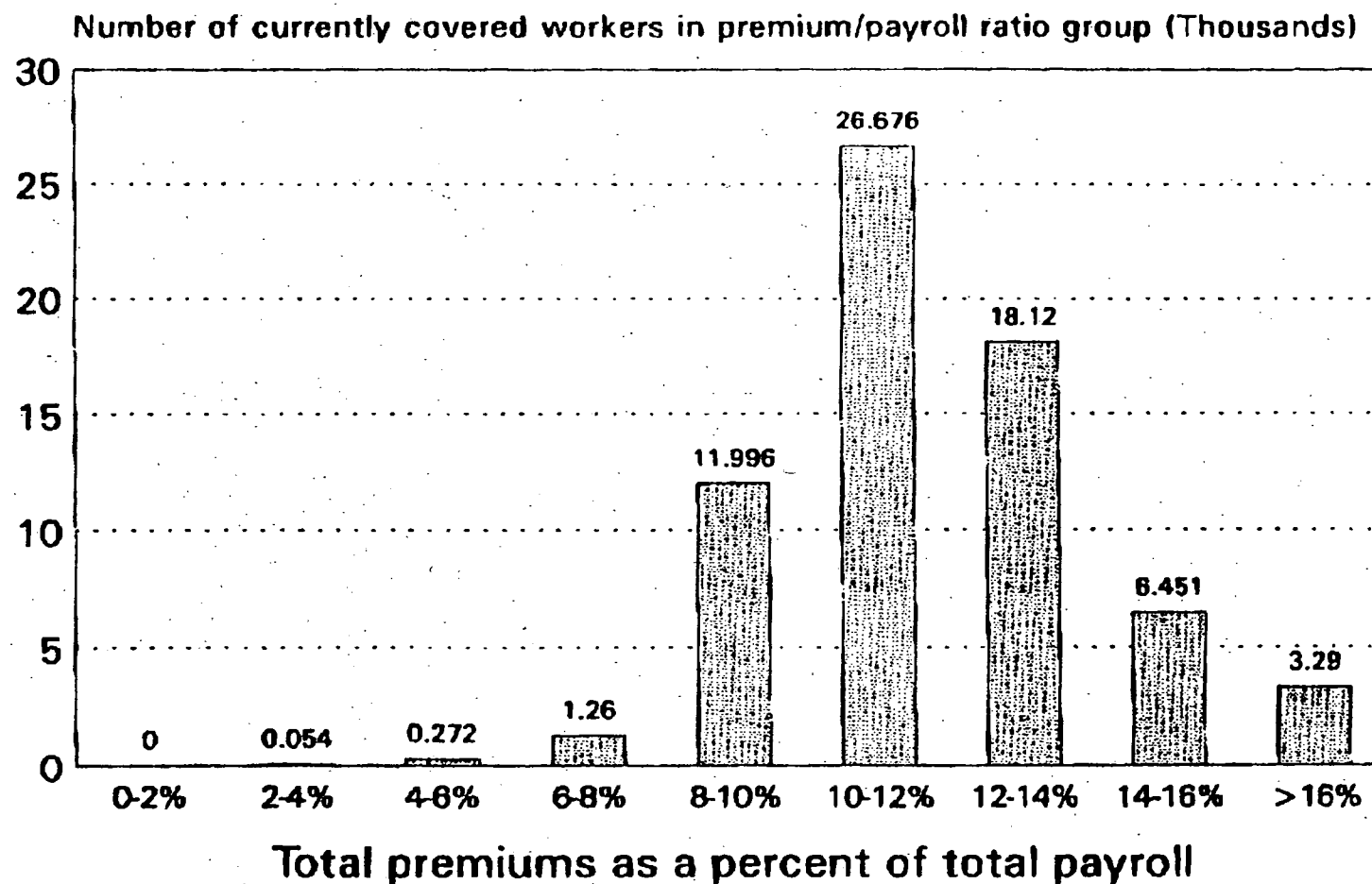
Source: Urban Institute analyses of March 1992 Current Population Survey.

Employer premium payments as a percent of payroll vary by industry and are highest for manufacturing.



Source: Urban Institute analyses of March 1992 Current Population Survey.

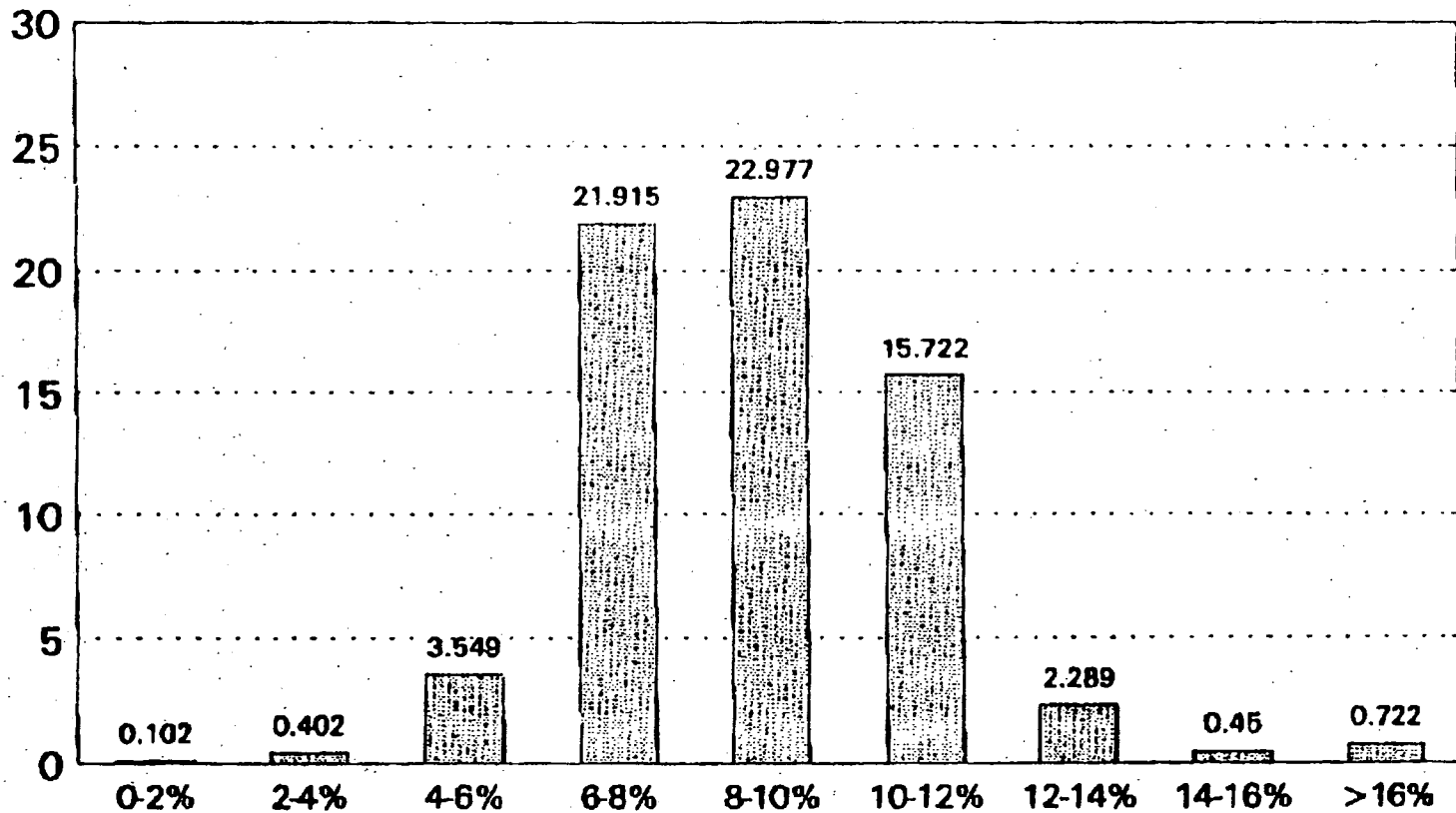
Health Insurance Premiums Relative to Payrolls: The Distribution Under the Current System



Source: Urban Institute's TRIM2 model, based on the March 1991 Current Population Survey.

Health Insurance Premiums Relative to Payrolls: The Distribution Under the Current System

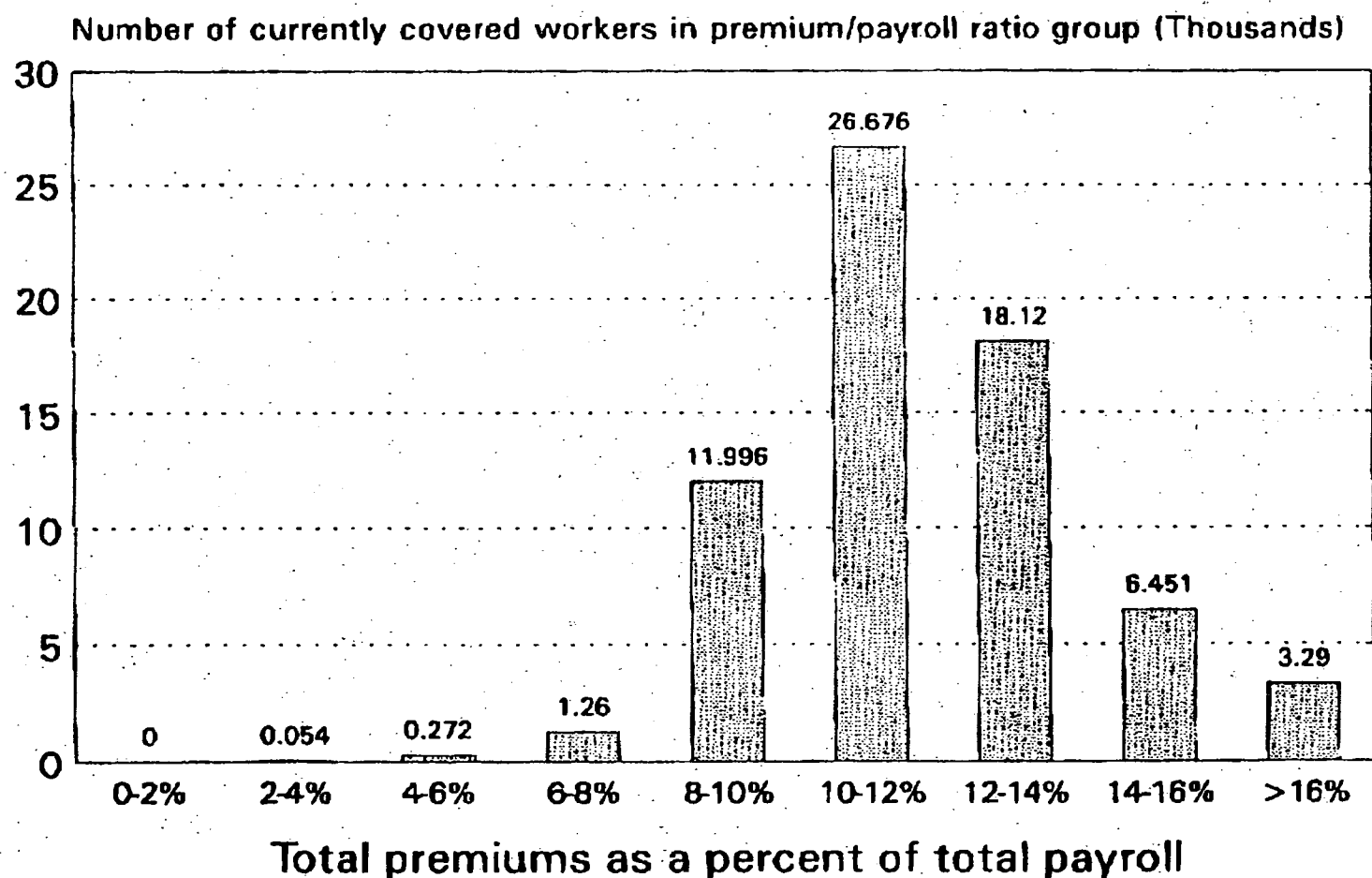
Number of currently covered workers in premium/payroll ratio group (Thousands)



Employer premiums as a percent of total payroll

Source: Urban Institute's TRIM2 model, based on the March 1991 Current Population Survey.

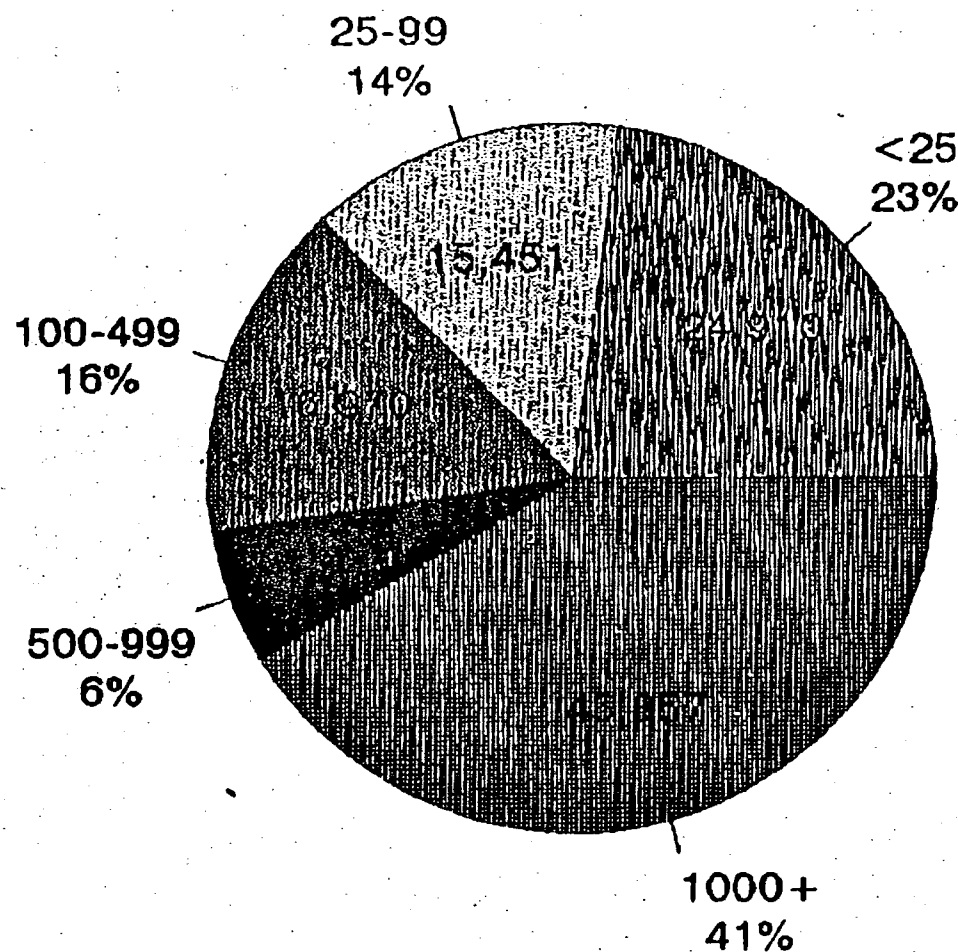
Health Insurance Premiums Relative to Payrolls: The Distribution Under the Current System



Source: Urban Institute's TRIM2 model, based on the March 1991 Current Population Survey.

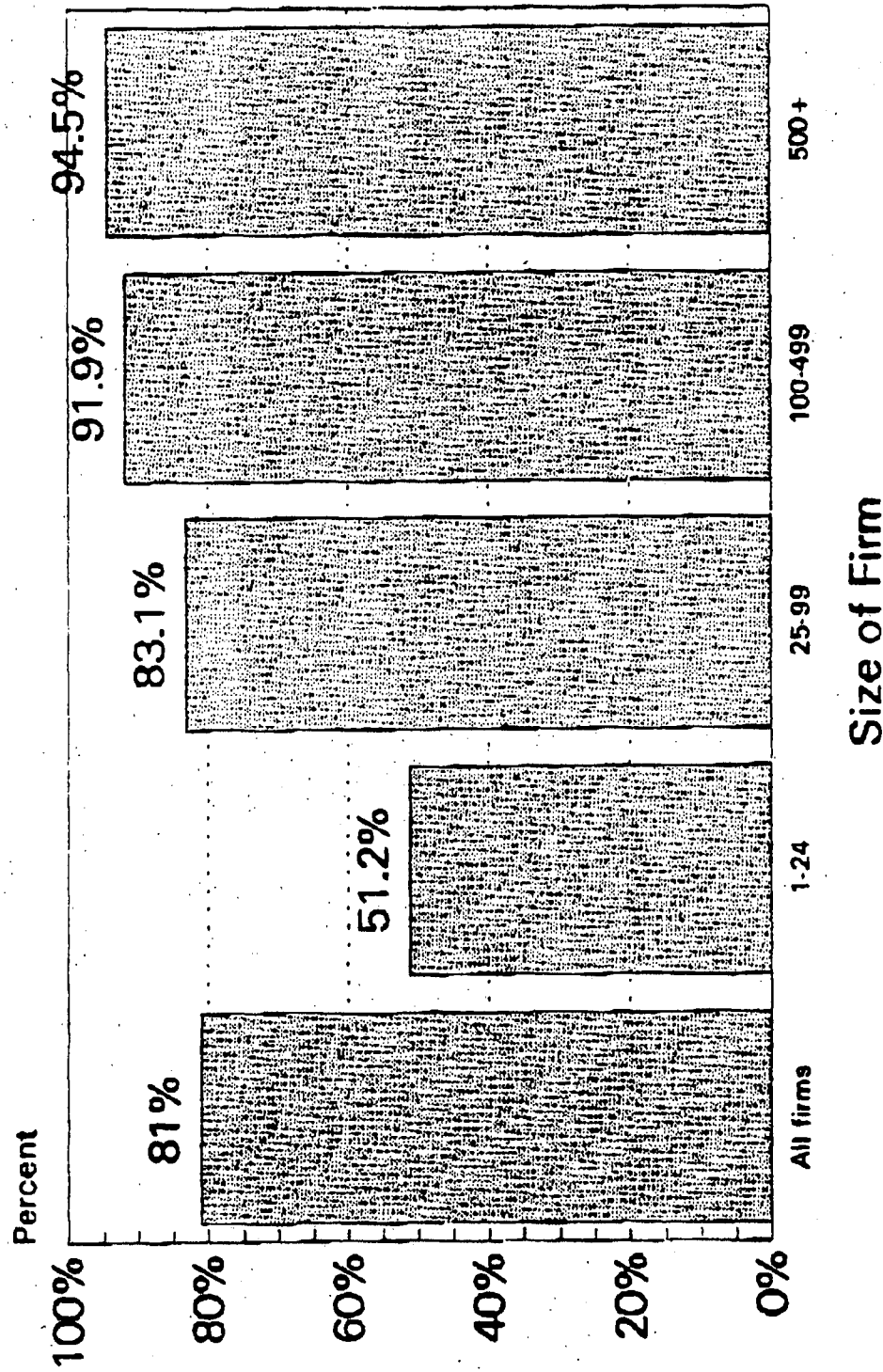
Workers: How many work for small firms?

Distribution of workers by firm size



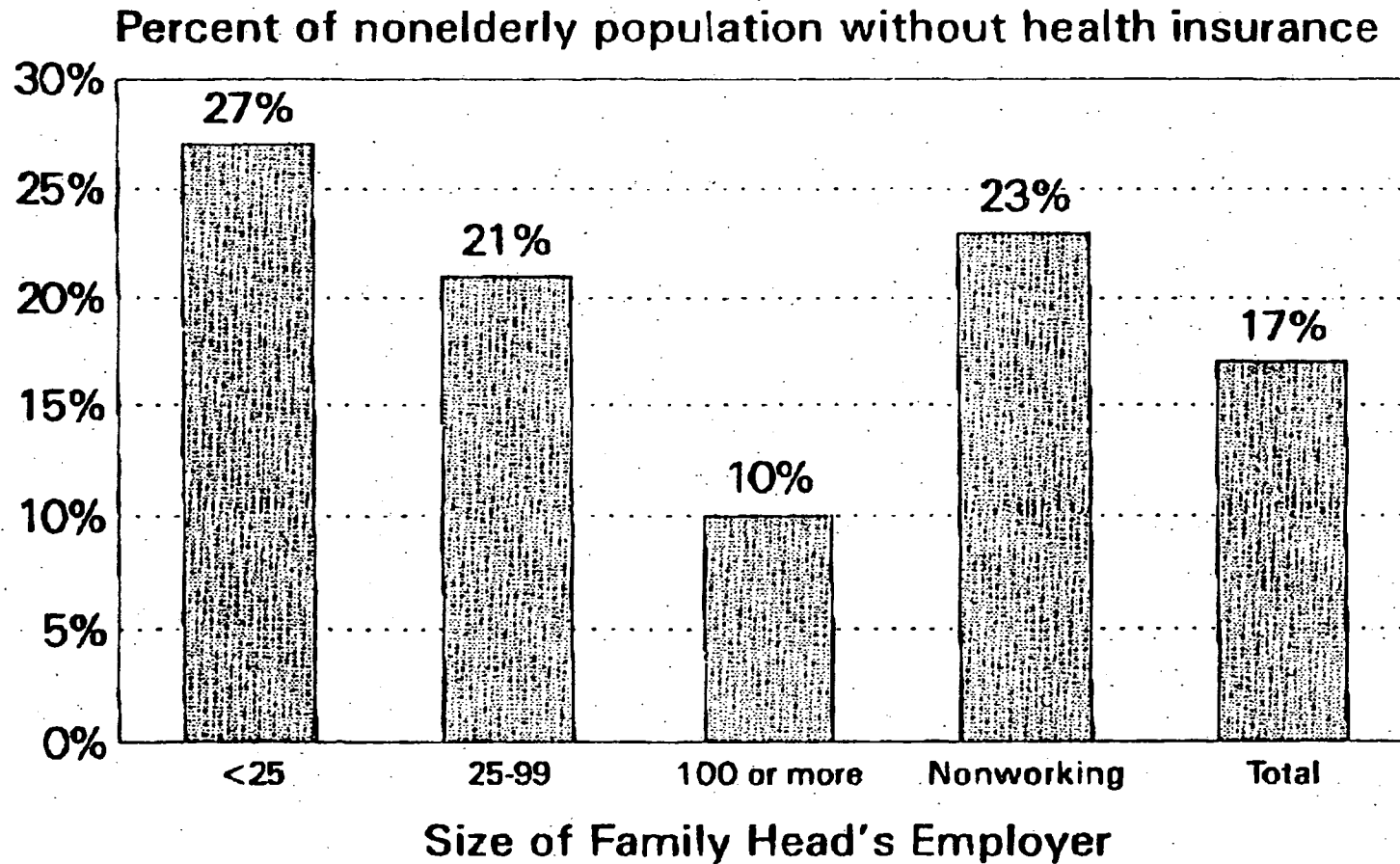
Source: The Urban Institute (1993), based on the March 1992 CPS and TRIM2.
Numbers are in thousands.

Percentage of Firms Offering Health Insurance By Firm Size



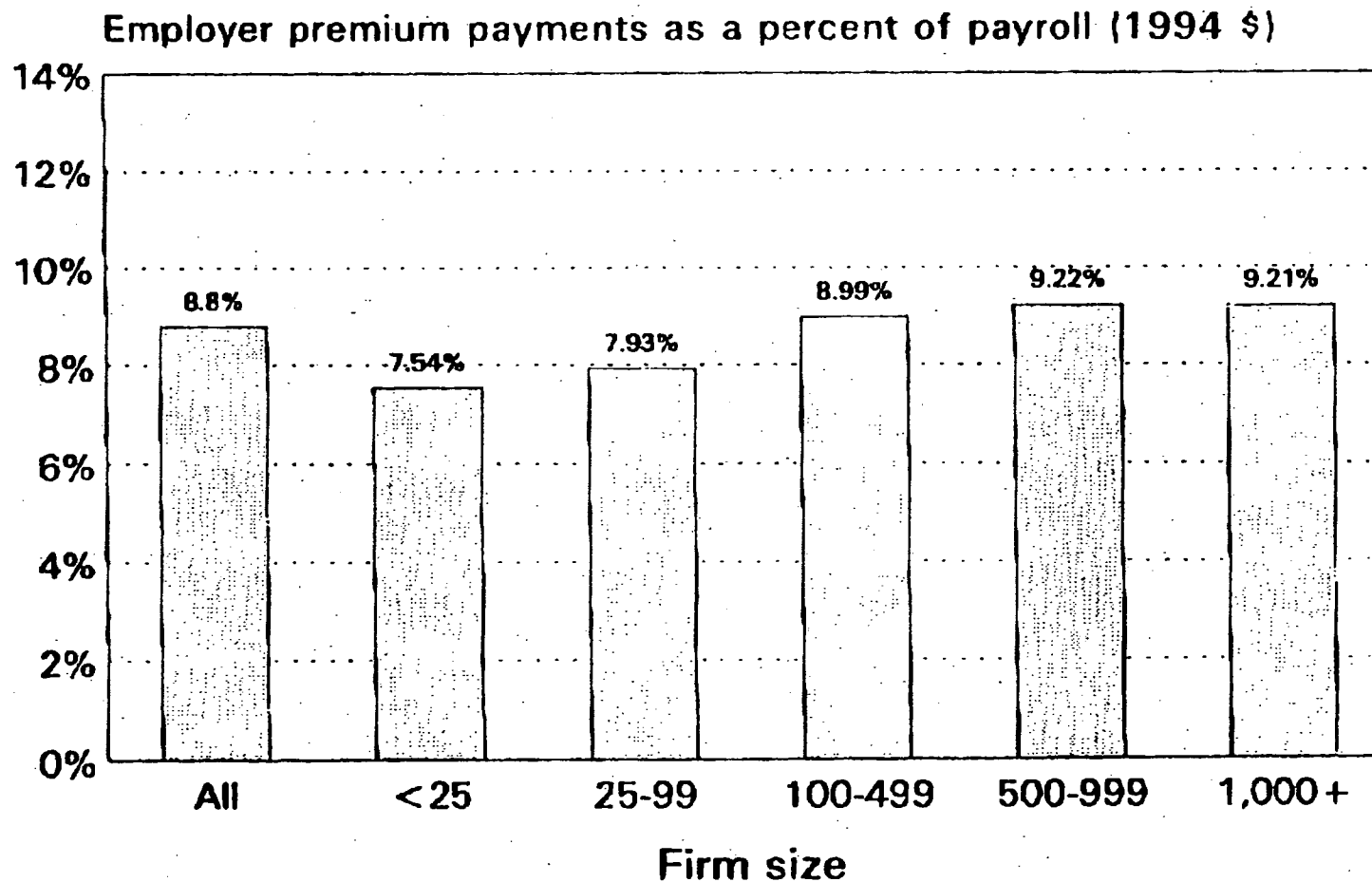
Source: Dept. of Labor, based on Small Business Admin calculations of May 1988 CPS Survey Data

People who work for small businesses are more likely to be without health insurance.



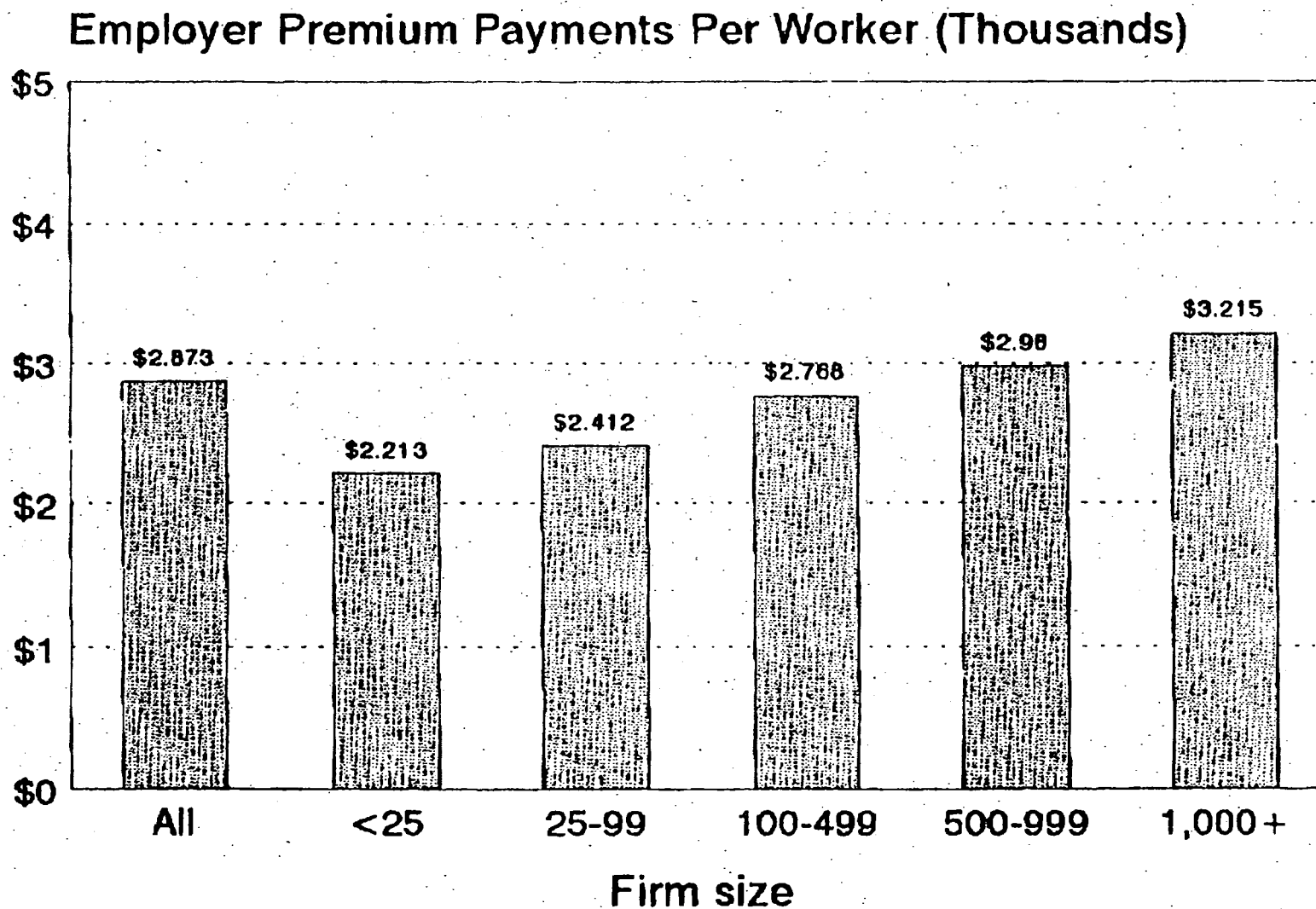
Source: Employee Benefits Research Institute Analysis of the March 1992 CPS.

Employer premium payments as a percent of payroll are lowest for small firms.

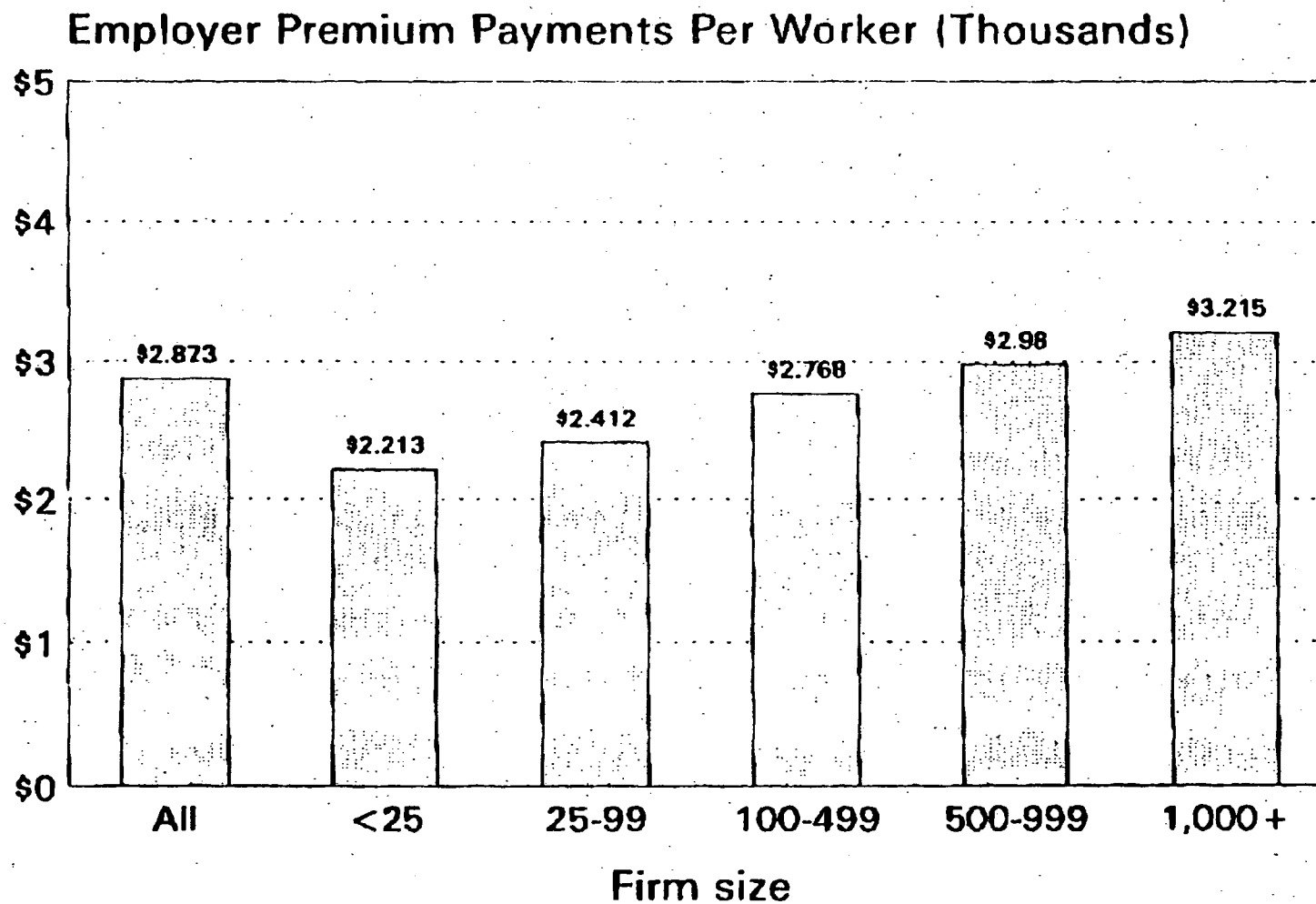


Source: Urban Institute analyses of the March 1992 Current Population Survey.

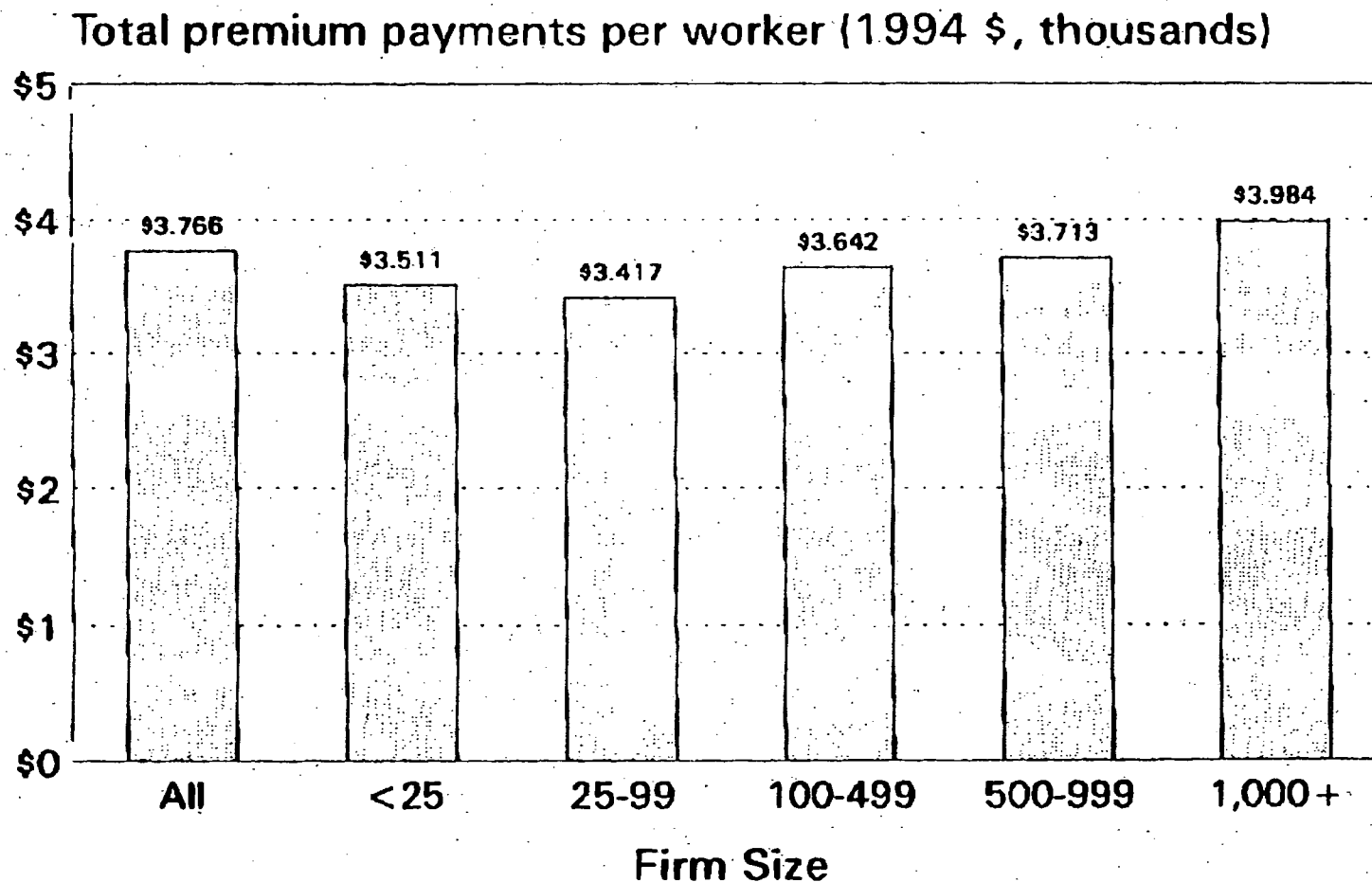
Employer premium payments per worker vary by firm size and are the largest for large firms.



**Employer premium payments per worker vary by firm size
and are the largest for large firms.**



**Total premium payments per worker vary with firm size
and are highest for large firms.**



Source: Urban Institute analyses of March 1992 Current Population Survey.

PRIVILEGED AND CONFIDENTIAL MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings, Steve Edelstein
RE: House and Senate "Message" Meeting
cc: Melanne, Steve, Lorraine, Jeff, Ira, Distribution

June 29, 1993

Tomorrow you are scheduled to attend the second meeting of the joint House-Senate "Message" group on health reform. Congressmen Gephardt and Bonior will represent the House. Senate attendees will include Senators Mitchell, Daschle, Pryor, Kennedy, Rockefeller, Reid, Boxer, Wofford and Kerrey. Senators Moynihan and Riegle have been invited but their attendance was not confirmed.

This meeting is a follow-up to last week's meeting in which the Message group laid out their "to do" list of tasks to be completed before the launch of the plan. At tomorrow's meeting Jeff Eller plans to respond to the first three items on their list. More specifically, a draft has been prepared on the strengths of our plan which Jeff will review, as well as our efforts to develop a strong central message and our plan to educate Members, Administration officials and supporters.

The message group's "to do" list and the strengths memo are attached for your review.

To: Health Care Group
Fr: Senate and House Health Care Leadership

The following list includes some of the tasks that need to be completed for a successful launch of the health care reform proposal. The tasks listed below are meant to be shared by a variety of organizations not limited to, but including the White House, House, Senate, NHCC and other grassroots organizations.

1. Launch Date Criteria/ Launch Date Public Message

· need agreement on criteria we need to meet before we're ready to launch
For example, the President should announce his plan publicly only when:

- the policy is complete and sufficiently detailed
- back-up numbers are adequate and available (costs, savings numbers should be vetted with CBO to avoid post-announcement controversy)
- message points and name of bill are vetted and available
- informative material on strengths and vulnerabilities is available
- back-up information sheets are adequate and available
- endorsing groups are identified, committed and ready to endorse publicly
- opinion-leader supporters are identified, committed and ready to support publicly
- grass roots operation is in place
- Member information level is adequate
- Member endorsers are identified, sufficient, and ready to endorse publicly
- legal questions have been answered to the extent that no major structural changes will be required and no obviously valid constitutional problems will arise
- legislative strategy is developed, agreed upon with Committee chairs
- proposed date fits reasonably with Presidential and Congressional schedules

· need coordinated public message on launch date

2. Message

- need to develop and agree upon strong central theme
- educate Members, Administration officials, supporters re: message and how to stay on it
- how to infuse it into all parts of effort

3. Strengths list - key strengths, talking points on our plan :

- security (even if you switch jobs, lose your job or have a pre-existing condition)
- eliminates loopholes and fine print - no more battle with insurers
- greater consumer choice of health benefits plans
- improved quality of care
- putting the brakes on escalating health care costs
- comprehensive coverage for all Americans
- simplicity, will reduce paperwork for you and your doctor
- help for small businesses who will have increased bargaining power and lower costs for premiums
- help for big businesses who are being consumed by health care costs, improving competitiveness and job growth
- positive impact on state and local budgets
- helps families deal with financial burden of long term care
- increases role of doctors and patients in medical decisions
- more consumer information and protection

4. Vulnerability - identification and response:

- families already face rising costs - this will increase their costs
- taxes will increase
- government can't get anything done and this is just another government program
- employer mandates
- rationing
- loss of choice
- govt. workers, others who now have excellent coverage
- abortion
- quality
- untested plan, no one has tried to reform this system on this scale before
- reform may increase spending not decrease it
- unfair to young people
- the system would be so complex that it would collapse

5. Opposition research - determination of vulnerabilities of other plans

- competing proposals (on and off Hill)
- special interest groups who are mounting their own attack campaigns (NHCC)
- identify health and other groups that oppose reform, who are they? why are they opposed? What is the effect of their opposition?
- use DPC health contact for information from other Senate offices

6. Visibility

- establish weekly visibility plan
- recess plan
- media agenda before launch/after launch
- coordinate public events, publications, statements for maximum impact

7. Effective ways to reach and involve Members

- Health University
- consultation groups
- effective use of existing House/Senate forums (caucus, DPC)

8. Health Groups/Grassroots

- need to identify and involve the allies (consumer, labor and business organizations) (NHCC & DPC) in grassroots effort

9. Party Grassroots

- activate party troops to educate others and build support

10. Mailing lists

- Media: need comprehensive press lists including specialty and regional press; coordinate existing lists (NHCC, DPC & WH)
- Academics, Health Care Leaders
- Other outreach: groups, elected officials

10. Rapid Response

- who will lead effort
- mechanism for response

11. Coordination with White House, Senate & House

- identify point persons who will stay in daily contact with each other in White House, Senate and House (staff) to coordinate, address issues as they develop
- establish health care working group with representatives from each
- House/Senate mirror organizations (message board groups)
- education (Health University)
- legislative scheduling (Leadership)

12. Coordination with State/Other Elected Officials

- . ways to involve Governors active in reform
- . ways to involve state legislators, mayors, etc.

13. Coordination Systemwide

- . National Steering Committee might be appropriate framework for coordination among all engaged in reform effort

- Administration
- Congressional leadership
- DNC/NHCC
- DCCC and DSCC
- DGA
- Labor (AFL)
- Others

13. Calendar

- . calendar for task accomplishment

STRENGTHS OF THE PLAN

- 1) **Security (even if you switch jobs, lose your job or have a pre-existing condition)**

"Under the current system, one in four Americans will lose their insurance at some point over the next two years. Today, if you or your child gets sick, if you switch jobs, if you want to start a small business, you can lose your insurance. Under the President's plan, you'll get health security.

Lose your job -- and you'll still be covered. Get sick -- you'll still be covered. Start a small business -- you won't have to worry. That's what insurance is supposed to be all about. The President's plan asks all Americans to take responsibility for their health -- and offers health security in return."

- 2) **Putting the brakes on escalating health care costs**

"Right now, what you're charged for health care is draining your savings, threatening your salary, bankrupting businesses and exploding our deficit. We've got a health care system that's overloaded with excess paperwork, outrageous fraud and waste, and con artists looking for a fast buck. And if we do nothing, things will only get worse.

The Clinton plan will change the way things work. It will crack down on those insurance companies and drug companies that are making excessive profits -- but not investing in better care. We'll aggressively go after the people that exploit loopholes to make a profit. And we'll stop the overcharging and put the brakes on rising costs."

- 3) **Improved quality of care**

"First, the Clinton plan will guarantee every American a comprehensive benefits package that emphasizes preventive care to keep you healthy instead of waiting until you get sick. We'll give you more primary care doctors and nurses.

And for the first time, we're going to require doctors and hospitals to give you information about the results of the work they do. You'll know how each health plan is doing -- and what the people who use that plan think of the care they get. "

4) **Greater consumer choice of health plans**

"Today, you're at the mercy of the insurance company that your boss decides to contract with. You're told what health plan you've got to use -- and even forced to give up your doctor if your doctor's not part of that plan.

Under the President's plan, you're in the driver's seat. You'll get to choose among health plans -- giving you the widest and best choice of how you get your care."

5) **Preserves doctor choice**

"The doctor-patient relationship is in danger. More and more employers are forcing their workers to switch to health plans that may not allow them to see the doctor they're used to.

The Clinton plan will preserve your right to see the doctor of your choice. Reform will put consumers in the driver's seat. You -- not your employer or some insurance company -- get to choose your health plan and your doctor."

6) **Eliminates loopholes and fine print -- no more battles with insurers**

"We're all sick of it: the endless, confusing forms; the insurance policies that you need a translator to understand, the fine print that strips you of your coverage when you need it most.

That's why the President's plan will put you in the driver's seat. Simple forms. Plain language. A comprehensive package of benefits -- and no loopholes or fine print to take it away. You shouldn't have to battle insurance companies to get the benefits you pay for -- and with the President's plan, you won't."

7) **Comprehensive coverage for all Americans**

"Right now, millions of Americans have insurance that isn't there when they need it. Some things get covered, but often the insurance company points to hidden limits in the fine print to rob you of benefits you thought you had.

The Clinton plan will guarantee every American a comprehensive benefits package that can never be taken away. And it includes more than a couple of trips to the doctor. Hospital care -- covered. Lab work -- you're safe. Preventive care -- so you and your children stay healthy. Prescription drugs. More options for long-term care. Together, it adds up to health security for all Americans -- the knowledge that you will always be able to get the care you need when you need it."

8) **Simplicity, will reduce paperwork for you and your doctor**

"Under the Clinton plan, you'll be able to wave goodbye to the endless, complex forms and all the hassles. Because we're going to scrap the system that produces so much paper that even if you've got the patience to wade through it, you probably don't understand it. We'll take the forms from the 1500 different insurance companies and make them into one.

And we're going to let medical professionals practice medicine again. Today, nurses and doctors are forced to spend time filling out form after form -- time that could have been spent caring for patients. Some nurses have to fill out 19 forms for each patient -- and then those forms are checked and checked again. That won't happen after reform."

9) **Eliminates fraud and abuse**

"Right now, fraud and abuse run rampant throughout the system. While some people file false claims about procedures that never happened, others figure out how to exploit the loopholes in the maze of forms. Either way, they're making a profit -- and you're getting ripped off.

The Clinton plan cracks down on fraud and abuse. We'll toughen penalties for people that try to game the system. We'll eliminate the loopholes that let people make a fast buck. And we'll hold all health plans accountable by requiring them to provide easy-to-understand information about their results and success rates -- so abusers have no place to hide."

- 10) **Help for small businesses who will have increased bargaining power and lower costs for premiums**

"Right now, the cost of insurance for small businesses is spiraling out of control -- bankrupting small businesses across the country. The smaller your company, the more you pay for insurance and the faster your premiums are rising. And small businesses are going broke trying to keep pace with rapidly rising premiums.

If you're a small business owner who covers your employees now, this plan will bring your costs under control. We'll stop the insurance schemes that discriminate against you and drive your premiums through the roof. We'll fold in workers' comp and the medical part of auto insurance -- so you don't have to pay for three insurance policies for each worker. And we'll enable you to team up with other small businesses and negotiate for the same rates that insurance companies give the big guys.

Under the Clinton plan, everyone benefits because everyone takes responsibility. Small businesses that provide insurance shouldn't have to pick up the tab for firms that can't afford it.

If you're not able now to cover your employees, reform will help make insurance affordable for you, your family, and your employees. The plan will ask everybody -- workers and employers alike -- to chip in for health care. And coverage would be phased in and government assistance provided to make it easier to provide insurance."

- 11) **Improving competitiveness and companies' ability to create jobs**

"Right now, many businesses are falling behind because of the enormous burden of rising health costs. Take the auto industry, for example. Health care costs add \$1,100 to the price of every car made in America -- double the cost added to Japanese imports. So companies can't hire new workers -- and they're at a disadvantage in the global marketplace.

The Clinton plan will reduce health costs for many companies. Health reform will free up money to create new jobs and increase incomes. And the plan asks all employers to take responsibility for covering their employees -- so some businesses aren't stuck with the bill for people who work for companies that don't provide insurance."

12) Positive impact on state and local budgets

"Right now, health care costs are spiraling out of control -- bankrupting state and local governments. And our federal deficit means we have had to cut programs like Medicare and Medicaid -- leading to an even greater burden on state and local budgets.

Comprehensive reform will ease this burden. The federal government will lead the way, and work in partnership with state and local governments to control the costs that are bleeding our communities dry. State and local governments will no longer be asked to go it alone in facing exploding costs."

13) Helps families deal with financial burden of long-term care

"Too often, American families are bankrupted by the long-term care costs of family members. Often, the elderly and disabled are forced into nursing homes because they have no other options. We need a system that offers real choices to the elderly and the disabled.

People want to remain in their homes and communities, and the Clinton plan will provide services to make this possible for more Americans. There will be more services available -- so that seniors and disabled citizens who can't manage on their own can remain in their own homes or communities for as long as possible."

14) Increases roles of doctors and patients in medical decisions

"Right now, doctors have too many people looking over their shoulders, second-guessing their professional judgment. They're buried under an avalanche of paperwork that does nothing to help deliver high-quality care.

The Clinton plan takes away the hassle, the second-guessing by insurance company representatives at the end of a telephone line, and the time spent doing paperwork. It restores the treasured doctor-patient relationship and allows physicians and patients to work together to make medical decisions."

15) **More consumer information and protection**

"No longer will consumers be at the mercy of their employer or insurance company when it comes to choosing a health plan or seeing a doctor. The Clinton plan empowers consumers to make educated decisions about how and where they get their care.

After reform, you'll get a "performance report" that gives you easy-to-understand information on each health plan -- what doctors and hospitals are included, an evaluation of the quality of care, a consumer satisfaction survey, and the price. And you choose your plan. If you want to switch plans later, you can do it. It's simple."

16) **Emphasizes preventive care**

"We have the most sophisticated health care available anywhere in the world. But there's something wrong with a system where you're guaranteed a triple bypass, but you can't be sure that your child gets the shots she needs.

This plan offers a new bargain: you take responsibility for your health and your children's health -- and we'll cover preventive services: regular physicals, immunization, and tests like mammograms. And you won't have to pay for them anymore.

Emphasizing preventive care is a new approach based on what's always worked -- keeping you healthy instead of waiting until you get sick. It will improve health and save us all a lot of money at the same time."