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001. memo w/attach	Chris Jennings to Hillary Clinton Re: Tomorrow's Finance Committee Meeting (19 pages)	4/19/93	P5
002. memo w/attach	Chris Jennings, Steve Edelstein Re: House Targeting Strategy (19 pages)	4/20/93	P5
003. briefing paper	Ten Senate Targets (15 pages)	nd	P5

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HRC Memos-HSA [3]

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MEMORANDUM

~~Privileged~~ and ~~Confidential~~

TO: Hillary Rodham Clinton April 20, 1993
FR: Chris Jennings, Steve Edelstein
RE: House Targeting Strategy
cc: Legislative/Congressional Distribution List

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

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

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

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

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

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

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

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

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

TARGET STATES BY RANK[1]

1. NEW YORK
2. NEW JERSEY
3. CALIFORNIA
4. FLORIDA
5. PENNSYLVANIA
6. MISSOURI
7. KANSAS
8. OREGON
9. LOUSIANA
10. CONNECTICUT
11. MINNESOTA
12. MONTANA
13. TEXAS
14. NEVADA
15. NEBRASKA
16. OKLAHOMA
17. ALABAMA
18. RHODE ISLAND
19. MAINE
20. DELAWARE
21. GEORGIA
22. VIRGINIA
23. ILLINOIS
24. VERMONT
25. UTAH
26. ARIZONA
27. NEW MEXICO
28. KENTUCKY
29. SOUTH CAROLINA
30. NORTH CAROLINA
31. TENNESSEE
32. NORTH DAKOTA
33. INDIANA
34. MICHIGAN
35. WYOMING

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[1] Ranking based on combination of Senate and House targeting priorities

HOUSE LEADERSHIP DEMOCRATIC RELIABLES

Member	Background Information
ARIZONA:	
Coppersmith	
English	Education and Labor, Caucus for Women's Issues, Mainstream Forum, Freshman
Pastor	Hispanic Caucus
ARKANSAS:	
Lambert	Energy and Commerce, Caucus for Women's Issues, Rural Health Care Coalition, Freshman
Thornton	Mainstream Forum
CALIFORNIA:	
Fazio	Rural Health Care Coalition
Matsui	Ways and Means
Mineta	
Pelosi	Caucus for Women's Issues, McDermott Cosponsor
Stark	Ways and Means, Subcommittee on Health, Chair; Rural Health Care Coalition; McDermott Cosponsor
Waxman	Energy and Commerce, Subcommittee on Health, Chair
CONNECTICUT:	
DeLauro	Caucus for Women's Issues
Gedjenson	McDermott Cosponsor
Kennelly	Ways and Means, Health Subcommittee; Caucus for Women's Issues

FLORIDA:	
Bacchus	
Deutsch	
Johnston	
GEORGIA:	
Lewis	Ways and Means, Health Subcommittee; Congressional Black Caucus; McDermott Cosponsor
HAWAII:	
Abercrombie	McDermott Cosponsor
IDAHO:	
LaRocco	Rural Health Care Coalition, Mainstream Forum
ILLINOIS:	
Collins	Energy and Commerce, Caucus for Women's Issues, Congressional Black Caucus, McDermott Cosponsor
Costello	Rural Health Care Coalition, Mainstream Forum
Evans	Rural Health Care Coalition, McDermott Cosponsor
Rostenkowski	Ways and Means
INDIANA:	
Sharp	Energy and Commerce
KENTUCKY:	
Mazzoli	Judiciary
Natcher	
MARYLAND:	
Cardin	Ways and Means, Subcommittee on Health
Hoyer	

MASSACHUSETTS:	
Frank	Judiciary, McDermott Cosponsor
Kennedy	McDermott Cosponsor
Markey	Energy and Commerce
Olver	McDermott Cosponsor
Studds	Energy and Commerce, Health Subcommittee; Rural Health Care Coalition, McDermott Cosponsor
MICHIGAN:	
Bonior	
Carr	Mainstream Forum, McDermott Cosponsor
Dingell	Energy and Commerce
Ford	Education and Labor
Levin	Ways and Means, Subcommittee on Health
Kildee	Education and Labor
MINNESOTA:	
Sabo	McDermott Cosponsor
MISSOURI:	
Danner	Caucus for Women's Issues, Rural Health Care Coalition, Freshman
Gephardt	
Wheat	Rules, Congressional Black Caucus
MONTANA:	
Williams	Education and Labor, Rural Health Care Coalition
NEBRASKA:	
Hoagland	Ways and Means, Health Subcommittee; Rural Health Care Coalition; Mainstream Forum

NEW YORK:	
Ackerman	McDermott Cosponsor
Engel	Education and Labor, McDermott Cosponsor
Lowey	Caucus for Women's Issues, Mainstream Forum
Manton	Energy and Commerce, McDermott Cosponsor
Schumer	Judiciary, McDermott Cosponsor
Slaughter	Rules, Caucus for Women's Issues, Rural Health Care Coalition, Mainstream Forum
NORTH DAKOTA:	
Pomeroy	
OHIO:	
Brown	Energy and Commerce, Health Subcommittee; Freshman
Sawyer	Education and Labor
Strickland	Education and Labor, Rural Health Care Coalition, Freshman
OKLAHOMA:	
Synar	Energy and Commerce, Health Subcommittee; Judiciary, Rural Health Care Coalition
OREGON:	
Kopetski	Ways and Means
Wyden	Energy and Commerce, Health Subcommittee; Rural Health Care Coalition
RHODE ISLAND:	
Reed	Education and Labor, Juciciary
SOUTH CAROLINA:	
Clyburn	Congressional Black Caucus, Single Payer, Freshman
Derrick	Rural Health Care Coalition

TEXAS:	
Bryant	Energy and Commerce, Health Subcommittee; Judiciary
Frost	Rules
Geren	Mainstream Forum
Lauglin	Rural Health Care Coalition
VIRGINIA:	
Byrne	Caucus for Women's Issues, Freshman
Moran	Mainstream Forum
Scott	Education and Labor, Judiciary, Congressional Black Caucus, McDermott Cosponsor, Freshman
WASHINGTON:	
Cantwell	Caucus for Women's Issues, Freshman
Kreidler	Energy and Commerce, Health Subcommittee; Freshman
McDermott	Ways and Means, Health Subcommittee; Rural Health Care Coalition; Sponsor of Single Payer Bill
Swift	Energy and Commerce, Rural Health Care Coalition
Unsoeld	Education and Labor, Caucus for Women's Issues, Rural Health Care Coalition
WEST VIRGINIA:	
Mollohan	Rural Health Care Coalition
Rahall	Rural Health Care Coalition
Wise	Rural Health Care Coalition
WISCONSIN:	
Kleczka	Ways and Means, Subcommittee on Health
Obey	Rural Health Care Coalition

HOUSE DEMOCRATIC TARGETS BY STATE

MEMBER	REASON TARGETED
ALABAMA:	
Hilliard	Congressional Black Caucus, Single, Freshman
CALIFORNIA:	
Becerra	Education and Labor, Judiciary, Hispanic Caucus, McDermott Cosponsor, Freshman
Beilenson	Rules, McDermott Cosponsor
Berman	Judiciary, McDermott Cosponsor
Condit	Rural Health Care Coalition, Mainstream Forum
Dellums	Congressional Black Caucus, McDermott Cosponsor
Dixon	Congressional Black Caucus
Dooley	Rural Health Care Coalition
Edwards	Judiciary, McDermott Cosponsor
Eshoo	Caucus for Women's Issues, Freshman
Hamburg	McDermott Cosponsor, Freshman
Harman	Caucus for Women's Issues, Freshman
Lantos	McDermott Cosponsor
Lehman	Energy and Commerce, Rural Health Care Coalition
Martinez	Education and Labor, McDermott Cosponsor
Miller	Education and Labor, McDermott Cosponsor
Roybal-Allard	Caucus for Women's Issues, Hispanic Caucus, McDermott Cosponsor, Freshman
Schenk	Energy and Commerce, Caucus for Women's Issues, Freshman
Torres	Hispanic Caucus, McDermott Cosponsor

Tucker	Congressional Black Caucus, McDermott Cosponsor
Waters	Congressional Black Caucus, Caucus for Women's Issues, McDermott Cosponsor
Woolsey	Education and Labor, Caucus for Women's Issues, McDermott Cosponsor, Freshman
COLORADO:	
Skaggs	Mainstream Forum
FLORIDA:	
Brown	Caucus for Women's Issues, Congressional Black Caucus, Freshman
Gibbons	Ways and Means
Hastings	Congressional Black Caucus, Freshman
Meek	Caucus for Women's Issues, Congressional Black Caucus, Freshman
Peterson	Rural Health Care Coalition
Thurman	Caucus for Women's Issues, Freshman
GEORGIA:	
Bishop	Congressional Black Caucus, Freshman
Darden	Mainstream Forum
Johnson	Mainstream Forum, Freshman
McKinney	Caucus for Women's Issues, Congressional Black Caucus, McDermott Cosponsor, Freshman
Rowland	Energy and Commerce, Rural Health Care Coalition
HAWAII:	
Mink	Education and Labor, Caucus for Women's Issues, Rural Health Care Coalition, McDermott Cosponsor

ILLINOIS:	
Gutierrez	Hispanic Caucus, Freshman
Lipinski	Mainstream Forum
Poshard	Rural Health Care Coalition, Mainstream Forum
Reynolds	Ways and Means, Congressional Black Caucus, McDermott Cosponsor, Freshman
Rush	Congressional Black Caucus, Freshman
Sangmeister	Judiciary
Yates	McDermott Cosponsor
INDIANA:	
Long	Caucus for Women's Issues, Rural Health Care Coalition
McCloskey	Rural Health Care Coalition, Single Payer
Roemer	Education and Labor, Mainstream Forum
Visclosky	
KANSAS:	
Glickman	Judiciary
Slattery	Energy and Commerce, Rural Health Care Coalition, Mainstream Forum
KENTUCKY:	
Baesler	Education and Labor, Rural Health Care Coalition, Freshman
LOUISIANA:	
Fields	Congressional Black Caucus, Freshman
Hayes	Mainstream Forum
Jefferson	Ways and Means, Congressional Black Caucus, Mainstream Forum

MAINE:	
Andrews	McDermott Cosponsor
MARYLAND:	
Mfume	Congressional Black Caucus, McDermott Cosponsor
Wynn	Congressional Black Caucus, Freshman
MASSACHUSETTS:	
Meehan	Freshman
Moakley	Rules, McDermott Cosponsor
Neal	Ways and Means
MICHIGAN:	
Barcia	Freshman
Carr	Mainstream Forum
Collins	Caucus for Women's Issues, Congressional Black Caucus, McDermott Cosponsor
Conyers	Judiciary, Congressional Black Caucus, McDermott Cosponsor
Stupak	Rural Health Care Coalition, Freshman
MINNESOTA:	
Minge	Rural Health Care Coalition, Freshman
Oberstar	Rural Health Care Coalition, McDermott Cosponsor
Peterson	Rural Health Care Forum
Vento	McDermott Cosponsor
MISSISSIPPI:	
Montgomery	Rural Health Care Coalition

MISSOURI:	
Clay	Education and Labor, Congressional Black Caucus, McDermott Cosponsor
Skelton	Rural Health Care Coalition, Mainstream Forum
Volkmer	
NEW HAMPSHIRE:	
Swett	Rural Health Care Coalition, Mainstream Forum
NEW JERSEY:	
Andrews	Education and Labor
Hughes	Rural Health Care Coalition
Klein	Freshman
Menendez	Hispanic Caucus, Freshman
Pallone	Energy and Commerce, Mainstream Forum
Payne	Education and Labor, Congressional Black Caucus, McDermott Cosponsor
Torricelli	
NEW MEXICO:	
Richardson	Energy and Commerce
NEW YORK:	
Flake	Congressional Black Caucus, McDermott Cosponsor
Hinchey	McDermott Cosponsor, Freshman
Hochbrueckner	McDermott Cosponsor
LaFalce	Rural Health Care Coalition, McDermott Cosponsor
Maloney	Caucus for Women's Issues, McDermott Cosponsor, Freshman
McNulty	Ways and Means

Nadler	Judiciary, McDermott Cosponsor, Freshman
Owens	Education and Labor, Congressional Black Caucus, McDermott Cosponsor
Rangel	Ways and Means, Congressional Black Caucus, McDermott Cosponsor
Serrano	Hispanic Caucus
Towns	Energy and Commerce, Congressional Black Caucus, Rural Health Care Coalition, McDermott Cosponsor
Velazquez	Caucus for Women's Issues, Hispanic Caucus, McDermott Cosponsor, Freshman

NORTH CAROLINA:

Clayton	Congressional Black Caucus, McDermott Cosponsor, Freshman
Hefner	Rural Health care Coalition, Mainstream Forum
Lancaster	Rural Health Care Coalition, Mainstream Forum
Neal	Rural Health Care Coalition, Mainstream Forum
Rose	Rural Health Care Coalition
Price	Mainstream Forum
Watt	Judiciary, Congressional Black Caucus, Freshman

OHIO:

Applegate	Rural Health Care Forum, Mainstream Forum
Fingerhut	Freshman
Kaptur	Caucus for Women's Issues, Rural Health Care Coalition
Stokes	Congressional Balck Caucus, Health Brain Trust, Chair

OKLAHOMA:

Brewster	Ways and Means, Rural Health Care Coalition, Mainstream Forum
English	Rural Health Care Coalition, Mainstream Forum
McCurdy	Rural Health Care Coalition, Mainstream Forum

OREGON:	
De Fazio	Rural Health Care Coalition
Furse	Caucus for Women's Issues, Rural Health Care Coalition, McDermott Cosponsor, Freshman
PENNSYLVANIA:	
Blackwell	Congressional Black Caucus
Borski	McDermott Cosponsor
Coyne	Ways and Means
Foglietta	
Kanjorski	Rural Health Care Coalition
Klink	Education and Labor, Freshman
Margolies-Mezvinsky	Energy and Commerce, Caucus for Women's Issues, Freshman
McHale	Freshman
Murtha	Mainstream Forum
SOUTH CAROLINA:	
Spratt	Rural Health Care Coalition, Mainstream Forum
SOUTH DAKOTA:	
Johnson	Rural Health Care Coalition, Mainstream Forum
TENNESEE:	
Clement	Rural Health Care Coalition, Mainstream Forum
Cooper	Energy and Commerce, Rural Health Care Coalition, Mainstream Forum
Ford	Ways and Means, Congressional Black Caucus
Gordon	Rules, Rural Health Care Coalition, Mainstream Forum
Lloyd	Caucus for Women's Issues, Rural Health Care Coalition
Tanner	Rural Health Care Coalition, Mainstream Forum

TEXAS:	
Andrews	Ways and Means
Brooks	Judiciary
Chapman	Rural Health Care Coalition, Mainstream Forum
Coleman	
de la Garza	Hispanic Caucus
Edwards	Rural Health Care Coalition, Mainstream Forum
Gonzalez	
Green	Education and Labor, Freshman
Johnson	Caucus for Women's Issues, Congressional Black Caucus, Freshman
Ortiz	Hispanic Caucus, Rural Health Care Coalition
Pickle	Ways and Means
Sarpalius	Rural Health Care Coalition, Mainstream Forum
Tejeda	Hispanic Caucus, Freshman
Washington	Energy and Commerce, Judiciary, Congressional Black Caucus
Wilson	Rural Health Care Coalition, Mainstream Forum
UTAH:	
Shepherd	Caucus for Women's Issues, Freshman
VIRGINIA:	
Boucher	Energy and Commerce, Judiciary, Rural Health Care Coalition, Mainstream Forum
Payne	Ways and Means, Rural Health Care Coalition, Mainstream Forum
WASHINGTON:	
Dicks	
Inslee	

HOUSE REPUBLICAN TARGETS BY STATE

CALFORNIA:	
Horn	Freshman
Huffington	Freshman, Banking/Small Business
CONNECTICUT:	
N. Johnson	Caucus for Women's Issues, Task Force on Health
Shays	Budget Committee
DELAWARE:	
Castle	Freshman, Banking, Finance & Urban Affairs, Task Force on Health
FLORIDA:	
Diaz-Belhart	Freshman, Congressional Hispanic Caucus
Goss	Task Force on Health, Rules
Ros-Lehtinen	Congressional Hispanic Caucus
Young	Appropriations
IOWA:	
Grandy*	Ways and Means, Task Force on Health, Rural Health Care Coalition
Leach	Banking, Finance & Urban Affairs, Rural Health Care Coalition
MAINE:	
Snowe	Budget, Caucus for Women's Issues, Rural Health Care Coalition
MARYLAND:	
Morella	Caucus for Women's Issues
MASSACHUSETTS:	
Blute	Freshman
MINNESOTA:	
Ramstad	Judiciary, Small Business

NEW JERSEY:	
Franks	Freshman, Budget
Roukema	Education and Labor, Task Force on Health
Saxton	
C. Smith	Veterans Affairs
Zimmer	
NEW YORK:	
Boehlert	Rural Health Care Coalition
Fish	Judiciary
Gilman	Rural Health Care Coalition
Houghton*	Ways and Means
Lazio	Freshman, Banking/Finance & Urban Affairs, Budget
McHugh	Freshman
Molinari	Eduaction and Labor, Caucus for Women's Issues
Quinn	Freshman, Veterans Affairs
Walsh	Appropriations, Rural Health Care Coalition
OHIO:	
Hoke	Freshman, Task Force on Health, Budget
Regula	Appropriations
PENNSYLVANIA:	
McDade	Appropriations
Weldon	
RHODE ISLAND:	
Matchley	Small Business

WISCONSIN:

Klug	Energy and Commerce
Petri	Education and Labor, Rural Health Care Coalition

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* Only members of Republican Target list to vote against Family and Medical Leave

TEN SENATE TARGETS

Of the 45 members who will be attending the retreat, we have targeted 10 members who we feel it is particularly advisable you try to seek out. Below is a list of these members and a brief explanation of why they have been chosen and what you may want to discuss with them:

Sen. Jeff Bingaman - Garamendi-like plan advocate whose state has many small businesses he is concerned about. Wants to be recognized as a player who has introduced particularly noteworthy legislation.

Sen. Dennis Deconcini - Swing Democrat nervous about taxes and excessive burden on small business. Stress importance to economy, benefits for seniors, and the importance of his support for and advice on the health reform legislation.

Sen. James Exon - A conservative Democrat and a swing vote on this issue. He is concerned that his absence at the Nebraska event -- despite your invitation -- may have been taken as a slight by you. You may want to tell him you completely understood he had a long-standing family obligation and look forward to working with him on this issue.

Sen. Howell Heflin - A conservative Democrat, a swing vote on this issue and influential with Southern Democrats. Stress how important reform is to his constituents and how much we are counting on his leadership among the Southern Democrats. He will be a major roadblock on ANY cap proposal related to medical malpractice reform. You may want to ask his advice on this issue.

Sen. Ernest Hollings - A moderate to conservative Democrat and a swing vote on this issue. Stress importance for economy and competitiveness. Thank him for his strong support on the stimulus package and seek out any advice he may have on health reform.

Sen. Edward Kennedy - Although extremely pleased with everything you and Ira have done, you may want to take this opportunity to acknowledge his recent and repeated requests that we be sensitive to his jurisdictional interests. No commitment should be made, of course, since we will be trying to work this out with the Majority Leader. The primary reason we have placed him on this list, however, is that he is one of the two primary Chairman in the Senate and we

want to make sure he always feels in the loop.

Sen. Patrick Leahy - Upset over rumor that a provision of the bill on state flexibility was to be named for his Republican Senate counterpart from Vermont, Jim Jeffords. No truth to the rumor. You may want to say that, when we think of state flexibility, we think of his leadership on this issue. (Last year he introduced the NGA-endorsed Leahy-Pryor bill). You may also want to share that we are thinking of some type of event in Vermont (perhaps attended by Mrs. Gore) on the issue of state flexibility. You may want to seek his advice on how best to set this up.

Sen. Daniel Patrick Moynihan - All of our reports from the Senate still indicate that he feels insufficiently "stroked" and appreciated. Although he probably would not respond to a "substantive" health care conversation, a personal, informal discussion is probably extremely advisable. You may also want to reiterate your and the President's desire to get reform passed this year.

Sen. Paul Wellstone - Was upset over the Talking Points we sent to the members of Congress, particularly the description of Single-Payer. You may want to stress the commonalities between our approach and his, and your desire to build on the constructive dialogue you started in his office several weeks ago.

Sen. Harris Wofford - In his brief time in the Senate, he has become a leading proponent of health reform. You may want to touch base with him and remind him how much we are counting on his leadership and support. He wants to advise us on how best we can develop and sell a package; it seems advisable to invite him to provide you counsel on this issue.

Democratic Conference Schedule
Saturday, April 24, 1993

7:00 - 9:00 a.m.	**Breakfast**	**Burwell**
9:00 - 11:00 a.m.	**Panel 3: Health Care Policy**	**Tazewell**
	Presentation of Policy Options	
	• Senator George J. Mitchell Moderator	
	• First Lady Hillary Rodham Clinton, Chair Health Care Task Force	
	• Hon. Ira Magaziner Senior Advisor to the President for Policy Development	
	• Hon. Judy Feder Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services	
11:00 - 11:15 a.m.	Break	
11:15 a.m. - 12:00 Noon	**Communication Strategies for Health Care**	**Tazewell**
	• Sen. Tom Daschle Moderator	
	• Arnold Bennett, Media Director Families USA	
12:00 - 2:00 p.m.	**Luncheon/Speaker**	**Plantation**
	• Introduced by Sen. Claiborne Pell	
	• Hon. Strobe Talbott Ambassador at Large and Special Advisor to the Secretary of State on the Newly Independent States	
2:00 - 6:45 p.m.	Free time	
7:00 - 8:00 p.m.	Reception	**Plantation Deck**
8:00 p.m.	**Dinner** President Clinton and Vice President Gore	**Plantation/Burwell**

PROFILES - SENATE DEMOCRATS

SEN. DANIEL AKAKA (D-HI) - State Flexibility is of primary importance to Senator Akaka. He will want a waiver to allow Hawaii to continue its present system. He is a co-sponsor of Health America.

Recent Developments: Hawaii is moving to press the House and Senate Committees to obtain an ERISA waiver as soon as possible even if that means before health reform is passed. It is possible he may raise this issue with you. He has also asked that a staff person who specializes in mental health serve on the working group addressing that issue.

SEN. MAX BAUCUS (D-MT) - Senator Baucus was a member of the Pepper Commission. Most notably, however, he voted against the final access recommendations (they won by just an 8-7 vote), primarily because of his concern about the proposal's impact on small business. Baucus is concerned about any proposal that utilizes any employer requirement to help finance health care. As a result of this concern, and because the Canadian system is quite popular in Montana, he is a single-payer advocate.

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

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

Recent Developments: At a the April 20th meeting with Fiance Committee members, Sen. Baucus stressed the need for the plan to contain costs with some sort of global budget. He shared the view of other committee members that you should take longer if

necessary, but make sure it is done right.

SEN. JEFF BINGAMAN (D-NM) - Senator Jeff Bingaman joined Senate Labor and Human Resources committee in May of 1990. While he does not have a long record on the issue of health care reform, he has been exhibiting increasing interest in the subject. He supports the managed competition model's focus on market adjustment of health care costs but has also supported an eventual cap on health care spending. He has cosponsored legislation with Senator Durenberger to implement the Jackson Hole group recommendations (a managed competition model which rejects global budgets). However, in hearings last December of the Labor Committee, Bingaman expresses strong support for the idea of a global budget to "limit the amount of revenue going into the system, limit the amount of premiums that people can pay into the HPICs." He is a strong advocate of rural health and prevention. He has expressed concern about the effects that employer-based health care reform could have on small businesses.

Recent Developments: Reportedly, Sen. Bingaman was unhappy over our language change from "HIPC" to "Alliance." Bingaman feels that "cooperatives" are rural friendly.

SEN. BARBARA BOXER (D-CA) - As a new member of the Senate, Boxer is very interested in working with the leadership. While in the House, she co-sponsored the Russo single payer bill (predecessor to the current McDermott Bill) but was not an enthusiast. She is particularly interested in issues concerning women and children. Senator Boxer is believes that health care reform should cover reproductive services, including abortion services.

Senator Boxer outlined her basic approach to health care reform in a letter to the First Lady on February 5th. In the letter, the Senator emphasized the following principles: care should be affordable and universal; benefits should not only be employment based; and coverage should include professionals other than doctors. To achieve these goals, the Senator called for a minimum benefits package, increased preventative care, the coverage of reproductive services, increased public health education, services for women in crisis, and services for children. Finally, the Senator called for "full representation" for women on any boards, advisory committees or any other bodies created by health reform legislation.

In meetings with the HCTF, she has also expressed concerns over how the veterans health system will be integrated into the plan.
Recent Developments: She has strongly urged that abortion services be covered up front in the benefit package and protected from any hostile amendment on the Senate Floor. She feels so strongly about this that we are concerned that she may raise this issue in Saturday's Question and Answer Session.

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

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

Recent Developments: At this week's Finance Committee meeting, Sen Bradley asked for an estimate of how much the plan is going to cost, and how much revenue is expected to be needed. He is very concerned about taxes.

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

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

Recent Developments: At the Finance Committee meeting Sen. Breaux stated that he

was very encouraged about what he was hearing. He believes people want health care reform but it will be important to sell the benefits first (and sell people on what they are getting). He wants the plan to be bipartisan and thinks it should contain malpractice reform.

SEN. DALE BUMPERS (D-AR) - Bumpers has waited to see what the White House will do and has resisted efforts to be pushed into Daschle's camp. As Chairman of the Small Business Committee, he may have particular sensitivity to the needs of small business. As you know, he has great concern about children's issues. He therefore can be expected to support coverage of children be phased-in first if such a phase-in is necessary.

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

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

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

Recent Developments: At the Finance Meeting this week Sen. Conrad was very concerned about mandates. He fears that small businesses will be saddled with too much.

SEN. TOM DASCHLE (D-SD) - Senator Daschle is the Co-Chair of the Democratic Policy Committee (with Majority Leader Mitchell) and he is one of the more well informed Democratic Members on health care issues. Senator Daschle and his staff are participating in Senator Mitchell's DPC working group, but he has also been a leader of a separate working group (Kerrey, Bingaman, Wofford, and Baucus) that was developing alternative approaches to health reform. This group has been relatively quiet lately,

seeming to be comfortable with working with and through the DPC health policy group.

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

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

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

Most recently, Senator Daschle has requested that you join him in South Dakota at some health care event at some point in the future. We are trying to be responsive to a request by him to get someone from with working groups to go to an early May event that he is holding.
Recent Developments: At the meeting with the Finance Committee members this week he again expressed his belief that we need to use new language in describing the plan for example using "system-wide" rather than "Federal program". Changing the language will change people's perception.

SEN. DENNIS DECONCINI (D-AZ) - DeConcini, who is up for re-election in 1994 and recently separated from his wife, is opposed to new taxes paying for the health care package. While he is willing to work with the concept of managed competition, he wants to preserve some of the current system. He is particularly concerned about the effects on small business and incentives for doctors to treat Medicaid patients. While he has not raised it so far, he will presumably also be worried about undocumented workers and Native Americans.

SEN. BYRON DORGAN (D-ND)) - He can be expected to back the package as long as careful attention is really given to the problems of rural areas. In addition to rural health care, his major concern is cost containment. He can also be expected watch out for coverage for Native Americans.

SEN. JAMES EXON (D-NE) - While Exon has put forth a wait-and-see attitude, he advocated "doing it this year" to Ira on March 4. He consults closely with Frank Barrett, chair of the Governor of Nebraska's Blue Ribbon Panel on Health Care. His Nebraska colleague, Sen. Kerrey can influence him but Kerrey's support for the plan will not guarantee Exon's support.

SEN. RUSSELL FEINGOLD (D-WI) - A freshman Senator, Feingold has also adopted a wait-and-see attitude but is likely to support the President. In meetings with the HCTF he has discussed the need for long term health care, particularly home and community based care for the elderly and the disabled. He is also concerned abut coverage for farmers. At the state level he was a sponsor of single-payer legislation in Wisconsin.

SEN. WENDELL FORD (D-KY) - The Chairman of the Rules Committee will want to support 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 the Congress, but he is also a fierce protector of the interests of his state. As he says, "if it's not good for Kentucky, I'm not for it." As a result Ford can be expected to fight a 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 brother-in-law is a pediatrician in Kentucky. However, he has also stated that he believes physicians are overpaid.

SEN. JOHN GLENN (D-OH) - Glenn has held hearings into the German and French systems as models for health reform. He supported pay or play but not the Leadership's HealthAmerica bill. His concerns include the impact of reform on small business, retiree health benefits, and potential changes to Medicare and Medicaid.

In a previous meeting with the DPC he questioned where the savings would come from in the new system. He thinks that doctors have been unfairly vilified in debates over health care costs. He says that their income accounts for less than one-fifth of health care spending. He is more intrigued by the large percentage of lifetime health care costs which occur during the last four months of life as an area for health savings.

As chairman of the Government Affairs Committee, he is likely to be interested in and actively involved with any proposal that would fold the FEHBP program into the new system. Since advocates for federal employees are now strongly advocating that they should be treated the same as large employers, they are likely to express serious reservations about the currently envisioned program. It is therefore advisable to meet with Chairman Glenn and other Chairmen of jurisdiction before any decision is made public.

SEN. BOB GRAHAM (D-FL) - Graham wants to support the President and not surprisingly is most concerned abut long term care being included in the final package. With Florida recently enacting health care legislation, he may be sensitive about state flexibility. He is okay on employer mandates and wants to be a player on global budgets. However, he would be concerned if Florida was somehow adversely affected in comparison to other states. His staff is working on the White House long term care working group. In previous meetings with the HCTF, he was worried about the role of the Public Health System.

SEN. TOM HARKIN (D-IA) - Senator Harkin has not sponsored any reform legislation or backed any particular reform approach. He has focused instead on specific issues that will need to be components of an overall plan. He has a strong interest in all rural issues. He was recently named Co-Chair of the Senate Rural Health Care Coalition. He is a leading advocate in the Senate for anything related to people with disabilities. (He has a brother who is deaf.) His sponsorship of the Americans with Disabilities Act is perhaps the major achievement of his political career. Ensuring that the plan provides access to health care including long-term care for people with disabilities is a major concern.

He is especially interested in prevention, sponsored a bill giving money to states for preventive health programs. As a member of the Senate Labor committee and Chairman of the Appropriations Subcommittee on Human Resources he is a key player on public health legislation and funding. Inclusion of preventive services in benefit package will be key. Harkin opposes co-pays for these services.

SEN. HOWELL HEFLIN (D-AL) - Heflin has been noncommittal, preferring to wait for the plan and concrete numbers on how and where the money is spent before taking a position. On the other hand, he appears to be open to the concept of reform but will need education on the issue.

SEN. ERNEST HOLLINGS (D-SC) - While Hollings wants to support the President's plan, he is worried about the following items: employer mandates without cost controls; rural coverage; and by the CBO testimony when cost savings might be realized under a managed competition plan. He steered clear of the leadership bill, expressing interest instead for a Medicaid buy-in. He believes the only way to get enough money for health reform is through a VAT. In meetings with Ira he has stated his hope that the money will be in hand when the bill is ready and his support for a single vote on the package.

SEN. BENNETT JOHNSTON (D-LA) - Sen. Johnston has been noncommittal on health reform but wants to be a constructive player. He may defer to his Louisianan colleague Sen. Breaux who has shown increasing interest in health care reform, since they share concerns on its impact on small business and rural areas. His major concern is

package. Lastly, he will want to be significantly consulted in the upcoming weeks.

SEN. BOB KERREY (D-NE) - Kerrey has displayed a keen interest in the area of health care reform since first coming to the Senate. In his first year, he sat in on deliberations of the Pepper Commission although not a member. He also made health reform one of the centerpieces of his presidential bid.

In the last Congress, Sen. Kerrey introduced a comprehensive health reform bill which is actually quite similar to the framework being developed by the Task Force except that all businesses would be required to join state-run purchasing groups rather than privately run groups. At his meeting with you on March 18th, he was very complimentary of Ira's presentation at the March 4th briefing for the Democratic Senators and in a note to Senator Rockefeller 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 included a payroll tax on employers and employees, current federal health spending except for Veteran's (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 your last meeting prior to your trip to Nebraska, he expressed interest in providing language to help sell the plan.

Recent Developments: Senator Kerrey has recently circulated a proposal to create a trust fund which would account for all health care expenditures. The fund would be "pay as you go" and all health expenditures including FEHBP and NIH. He suggests that a proposal on appropriate taxes to designate for health care reform before the introduction of a comprehensive plan.

SEN. JOHN KERRY (D-MA) - Senator John Kerry has represented Massachusetts since 1984. Senator Kerry is most known for his involvement with the POW/MIA issue. Not known to be a major player on health policy in the Senate, he does have some significant health views. He favors a managed competition approach to reform and wants to support the President. Administrative simplification and insurance reform are of particular interest. Wants to protect biomedical and biotech industry, which is a growth sector in Massachusetts. Senator Kerry is a Vietnam veteran, and may be sensitive to major changes in the VA. Senator Kerry warns that expectations are high and urges regular meetings with Senators.

SEN. FRANK LAUTENBERG (D-NJ) - Senator Lautenberg is very concerned that health reform will hit two big industries in New Jersey: pharmaceuticals and insurance companies. This coupled with the fact that he up for re-election in 1994, which mean skittishness on certain aspects of the plans. Governor Florio re-election effort in 1993,

may also influence Senator Lautenberg's vote. The pushed by Sen. Daschle on Single Payer, he resisted saying he was in the Managed Competition mode. While nervous about employee mandates, Lautenberg wants to be part of the whole team and believes he can serve as a liaison with the business community. Other concerns include transportation services to help provide access to health care in rural areas and about the overuse of technology.

SEN. PATRICK LEAHY (D-VT) - Senator Leahy is chairman of the Senate Agriculture Committee. As such, he notes that one quarter of all Americans live in rural areas and provisions need to be made to ensure that they have access to needed health care services. He was one of the few cosponsors of the Leadership's HealthAmerica Bill and is likely to support the Administration's plan. Leahy will want to see provisions in the legislation for state flexibility so that they can move ahead now. In the last congress he sponsored the Leahy-Pryor bill, legislation endorsed by the NGA, to provide waivers to states willing to undertake comprehensive health care reform.

Recent Developments: Senator Leahy was recently upset about a rumor that the Administration was going to name the provision on state flexibility in the reform legislation for his Republican Senate colleague from Vermont, Jim Jeffords. In conversations with the Senator's office, Chris Jennings reassured his staff that there was no truth to this rumor and that we appreciated and understood the Senator's longstanding interest in and leadership on this issue. He is very interested in holding an event in Vermont, perhaps highlighting the flexibility issue, and would like to work with us on it.

SEN. CARL LEVIN (D-MI) - Senator Carl Levin has served Michigan since 1978. His brother, Sander, serves in the House of Representatives, and is a member of the House Ways and Means Committee. Along with Senator Riegle, they are protective of Michigan's auto industry, unions, and the union's retirees. Senator Levin is concerned about cost control, and is very concerned about the President's plan having sufficient cost control mechanisms (a chief concern of organized labor and large industrial manufacturers of his state). He want states to have flexibility to design and implement their own cost control measures. Senator Levin is also worried that a tax cap will be a benefits reduction (another union concern). He has also wanted to know how many will have greater benefits than minimum benefits. Senator Levin also has rural and small business concerns. The Senator supports inclusion of good primary preventive, hospice and home care services in the reform package. a co-sponsor of HealthAmerica in the 102nd Congress, Senator Levin favors Managed Competition and is on record as wanting to support the Administration's plan.

SEN. JOSEPH LIEBERMAN (D-CT) - Senator Lieberman is in his first term and is up for re-election in 1994. Generally, he is supportive of Managed Competition (he liked

the Cooper Bill), but has a real problem with global budgets and caps. He believes, however, that the plan needs to have significant cost containment.

The Senator believes that before the plan is announced, the White House should have a process to hear people's concerns. He also thinks that it is critical to educate the public so people understand the problems with our health system, and what solutions are necessary. He's very concerned we may lose the middle class because of a big new tax. He is encouraged by what he has heard about the Administration's proposal, but has a wait and see attitude.

SEN. HARLAN MATHEWS (D-TN) - Senator Mathews was appointed to fill the term of Vice President Gore. He is not interested in returning to the Senate, and will serve until Tennesseans elect a new senator to fill the Vice President's term. Senator Mathews is generally supportive of the Managed Competition concept. And while he has not backed the administration's reform efforts publicly, he is supportive with some modifications. He would like to see more action on the state level, especially experimental programs. Vice President Gore will be influential in getting his vote.

SEN. HOWARD METZENBAUM (D-OH) - Senator Metzenbaum strongly believes in the need for health care reform and has cosponsored Senator Wellstone's single payer bill. He is concerned about the managed competition approach because he fears that it is too easy on the special interests, especially the insurance companies. He believes to truly reform the health care system, the Administration must be willing to take on and defeat the special interests and take the program to the American people. He views health care as a social good that should be provided to all people and that the system should be based on providing services to the people at lowest possible costs. Metzenbaum strongly favors rate setting and a national budget.

Senator Metzenbaum also favors eliminating fraud and abuse in the system. He has major criticism of HCFA for not ferreting out fraud and abuse. Other concerns are anti-trust (He chairs the Judiciary subcommittee), malpractice reform and long-term care.

Recent Developments: Senator Metzenbaum's staff has indicated a great concern about the apparent Administration infatuation on caps for medical malpractice. He is strongly opposed to caps and might even oppose the legislation if they are included at the time of introduction. He has also expressed concern that quality standards may be vulnerable to the Administration's decision to cut back on what we view as unnecessary regulation and he would like us to proceed cautiously in this area.

SEN. BARBARA MIKULSKI (D-MD) - Senator Mikulski is known as an outspoken liberal but her working family Baltimore roots make her one of the most pragmatic and

sensitive members. She supports the Clinton health reform plan in principle but is concerned about the influence of the Jackson Hole group who she calls "a bunch of geriatric Republicans that represent everything that wrong with health care. As a former social worker she would like to see greater use of non-physician health professionals to deliver care.

She is a champion of women's health and an avid pro-choice advocate. The plans position on women's reproductive health services will be critical. She is concerned about improving research into women's health and eliminating the gender bias of NIH research. She is also a strong advocate for seniors. She introduced and passed the Spousal Impoverishment provisions in 1988 so that seniors did not have to spend down all of their assets to qualify for benefits. As the new Chairman of the Labor Subcommittee on Aging, she is promoting the expansion of home and community-based long-term care services.

On the Appropriations Committee, she heads the HUD/VA and Independent Agencies Subcommittee. VA--the largest managed health care system--is a big concern for Mikulski. She cites the Canadian experience where under the massive change to a single payer system, vets lost out. She feels strongly that vets need a seat at the reform table.

Recent Developments: Sen. Mikulski asked for and received meeting for Dr. James Block, president of Johns Hopkins University Medical Center. She appreciated Ira Magaziner coming to hill to meet with him. She wants a Maryland event to replace the event cancelled due to snow.

SEN. GEORGE MITCHELL (D-ME) - Few Majority Leaders in the Senate's history have been as interested and as committed to passing comprehensive health care reforms.

Mitchell is the sponsor of two Senate Democratic leadership comprehensive reform bills dealing, respectively, with access (S. 1227, Health America) and long-term care (S. 2571, the Long Term Care Family Security Act). In addition, he is leading an effort by the Democratic Policy Committee (within the Senate) to attempt to develop consensus on the health care issue within the Democratic party.

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

As you know, however, he was a strong advocate of incorporating the health care legislation into the budget reconciliation bill. Having failed that, he and his lead staff

are now relatively pessimistic about attracting enough Republicans to support a health reform initiative without having to make major, and perhaps unacceptable, concessions. Just yesterday, (Sunday, April 18th), he indicated his opposition to price controls, his uneasiness with but possible openness to a VAT tax for health, and his desire to wean out all the fraud, abuse and waste BEFORE contemplating large tax hikes.

SEN. CAROL MOSELEY-BRAUN (D-IL) - Senator Mosely-Braun is one of the freshman members of the Senate. She is a single payer advocate, and is somewhat skeptical of the managed competition model. The Senator believes that there should be one entity collecting revenues for the health care system, and that health care insurance providers unnecessarily duplicate services.

The Senator is particularly interested in financing mechanisms, and would have supported Senator Wellstone's American Health Security Act, introduced March 3, save for her reservations over his approach to funding. She is concerned by public reports of the proposed sin tax, which she feels will not be sufficient to finance health care reform. If a sin tax is not sufficient, and given the tax increases in the President's economic proposal, the Senator is curious about what other mechanisms the Health Policy Task Force is considering for revenue.

Sen. Moseley-Braun is also interested in the composition and mechanism for creating a basic package of services. She is interested in seeing an increase in resources and focus on primary and preventative care. She would also like to make sure that long-term care is part of the reform package, and was a little concerned about signals sent during the meeting with the Congressional Black Caucus on this issue.

The Senator also feels that if managed competition is chosen as the avenue to health care reform, a mechanism be put in place to insure that health insurance provider cooperatives have an incentive to serve consumers in urban and rural poverty areas. Additionally, the Senator is interested in a slow phase-in of veterans into an overall health reform package.

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

The only health care-specific issues that the Senator is particularly known for are: (1) his advocacy and support of New York hospitals, (2) his concern about the mentally ill and the homeless, (3) his support for chemical and substance abuse in a benefit package, and, most recently, (4) his support of innovation at the state level. On the latter point,

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001. memo	Chris Jennings to Hillary Clinton Re: Senate Republicans to Target as Possible Supporters and Senate Democrats to Attract to Keep on Board (3 pages)	3/20/93	P5
002. memo	Mike Lux to Hillary Clinton Re: Health Care Policy and Politics (5 pages)	3/24/93	P5
003. memo w/attach	Chris Jennings to Hillary Clinton Re: Polling Data Analysis by Senator Kennedy's Office (14 pages)	12/12/94	P5
004. memo w/attach	Chris Jennings to Hillary Clinton Re: Health Care Portions of the Budget Document/ Miscellaneous Issues (15 pages)	01/21/1995	P5

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THE WHITE HOUSE

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March 24, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

SUBJECT: Health Care Policy and Politics

FROM: Mike Lux

Per our conversation a few days ago, I wanted to do a broad summary memo on the politics of our health care policy decisions. There are some very clear political/policy trend lines that I'm picking up from the hundreds of meetings and phone conversations I've been engaged in the last few weeks, and I thought it important to share those with you.

cc: Ira Magaziner
Bob Boorstin
Chris Jennings ✓
Alexis Herman
Steve Hilton
Melanne Verveer

A. VAT

I know there has been a serious shift in thinking about whether to go with a VAT in recent days. I, too, assumed it was impossible until recently, but have begun to be convinced as time goes on. Stan Greenberg and the other polling/message gurus are better qualified than I to determine the critical question of whether the public can stomach another major tax increase. But I would argue that is both possible and desirable for the following reasons:

1. There are two major policy choices that drive up the costs of this package significantly that I believe are absolutely vital to its political viability. One of those is a decent long-term care plan, without which we won't get senior citizen support. The other is a relatively rich benefits package, without which we lose the middle class. Even with extreme cost controls, I don't see how we get those two things without a major new revenue source.

2. Doing a VAT would allow us to make the overall transition to the new system faster, lessening the need for short term price controls, medicare extenders, premium caps, or any of the other unpleasant options in front of us. This takes away the biggest excuse that health industry groups would have to oppose our plan, and would genuinely make a serious health industry split possible. The American Hospital Association, the big five insurance companies, and several different physician groups are all possible supporters of our plan without the short term cost controls; with them, their support is unlikely.

3. Doing the VAT would also make easier extending universal coverage more quickly. This is not only a humanitarian and economically sensible goal we all share, but also makes it easier to bring consumer groups and our left flank into the fold.

4. Having worked for Citizen Action, Citizens for Tax Justice, and the AFL-CIO, I've been working most of my adult life against sales taxes because of their regressive nature. But from that work, I know that sales taxes are far easier to win support for than any other kind of broad based tax increase, even from working class people hurt by the regressivity. People like its simplicity, and think it is fair because everyone pays it.

5. The groups mentioned above usually form the basis for organizational pressure against a VAT, but they want universal health care so badly they are willing to give up

their past opposition - especially if we use tax credits or exemptions to structure it more progressively.

6. Overall, both business and labor seem to be moving in the direction of a VAT, and I can think of no serious institutional pressure against it.

B. Long Term Care

As Chris Jennings, our pollsters, and I have argued from the beginning, we can only win this battle with the enthusiastic support of senior citizens and the big groups that represent them. I am convinced that given their fear of losing the choice of their doctor, the one component that assures their support of this plan is a relatively strong long-term care package. Prescription drug prices are important as well, but long-term care is clearly the top priority for most groups.

Depending on how we structure the long-term care program, we'll pick up different organizational support. A strong emphasis on home care and personal assistance services will help us with the disabilities community as well as hospice and home health care interests, and will also be popular with the aging community.

C. Tort Reform

This is one I stay awake nights worrying about, because I think we need a carefully balanced approach here.

On the one hand, for this proposal to be credible, we need to do something real on tort reform. We can't credibly put many insurance companies and insurance agents out of business and ask for real financial sacrifice from physicians and hospitals without asking lawyers for some sacrifice as well: it's too great an excuse to oppose this package and it hurts us badly in the media. Having some tort reform in the package also helps us win business support.

On the other hand, I don't believe there is any legitimate public policy need to do too much in this area: the evidence is not compelling that tough tort reform measures actually bring down medical costs. And trial lawyers have been loyal friends to this Administration and Democrats in general. Certainly their ability to survive twelve years of White House opponents and the business/insurance/medical establishment coalition against them speaks to their great political clout.

Having had indepth conversations with ATLA's leadership, I believe they are willing to compromise on some matters, and that if we don't go too far, they will not only not oppose us but will help us get the whole plan passed.

This is clearly a matter for continued careful negotiation with ATLA.

D. Rural Health Care

Another essential part of passing our health plan, especially in the Senate, is what we do with rural health care. Most rural interests are convinced that managed competition does nothing to improve rural health care. Our legislation must reflect a strong commitment to quality and access for rural America.

There are three observations I have here:

1. Short term cost controls, like price freezes, are probably most damaging to rural hospitals and small town general practitioners because so many of them are living close to the edge financially right now. If we go that route, we need to figure out how to compensate for that impact.

2. Rural states are probably where state flexibility to design their own wrinkles to the basic system is most important.

3. The best argument for paying physicians and hospitals with an all-payer system instead of the Jackson Hole system is that it allows for tighter control over total health expenditures in rural areas where managed care may not be feasible, while still preserving a steady reimbursement system.

E. Workers Compensation

I think the advantages of twenty-four hour coverage in terms of administrative simplicity and cost savings strongly outweigh the disadvantages, but there is one major disadvantage for which we need to compensate. The key advantage of the current system is that the costs of workers compensation are a big financial incentive for companies to make their workplaces more safe. That is one thing there is universal agreement on from labor, insurers, and even business (begrudgingly).

I don't have any easy answers, but I would urge that our working groups take a close look at ways to compensate for that problem.

F. HIPC Structure

The most important thing in structuring HIPCs is to not create a two tier health system that makes health care plans better and cheaper for healthier and wealthier people. Constructing such a system would badly damage our ability to draw support form senior citizens, labor, consumer, and single-payer groups. Even more

importantly in the long run, it threatens the system's ability to deliver high quality health care for the broad middle class.

There are two key issues to decide on here:

1. Opt outs. I would argue strongly that we not allow any businesses to opt out. If firms want to remain self-insured, they should still be forced to pick a HIPC and pay through the HIPC. And if we do decide to allow complete opt outs, there must be significant rate adjustments so that firms with younger, healthier work forces don't drive up everyone else's costs.

It will cost us a modest amount of business support to not allow opt outs, but allowing them hurts us far more among our potential base groups, as well as with businesses. And in terms of the broader public policy goal of not allowing there to be a two tier system, not allowing opt outs is a much simpler option than any of the alternatives.

2. Competing on quality instead of cost. Central to the idea of not allowing a two tier system is that we structure HIPCs so they compete on quality and outcomes instead of cost. This goal is central to getting the support of many key organizations.

I think one policy idea that works in this regard is Rick Brown's formulation of having the HIPC pay each plan a risk adjusted capitation payment for each enrollee. Like Medicare, this would require the HIPC to pay the same set amount to all plans for caring for someone in each defined risk group. Except for limited patient co-pays or deductibles, the HIPC's payment to a health plan should be accepted as payment-in-full, and plans could not charge enrollees more for the comprehensive benefits package than the plan receives from the HIPC.

Again, the idea of this kind of approach is to keep low and middle income consumers from being consigned worse health care. I think this approach would win us considerable support from big business, many of whom understand the importance of paying for long run quality instead of the shortest term, cheapest plan. It is obviously very important to unions and consumer groups as well.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: December 12, 1994

Re: Polling Data Analysis by Senator Kennedy's Office

cc: Melanne Verveer

Since the election, there has been a general acceptance by the so-called "political elite" that health care is a major (if not the number one) reason why Democrats did so poorly in the election. One would think this analysis was based on some of the polling data emerged from the election, but a review of the best surveys does not reveal this -- in fact, these surveys come close to refuting such a claim altogether.

For the past few weeks, Senator Kennedy's staff has been sifting through all the election day polling information. What they found would surprise most anyone who is obtaining their information from the national media.

Although the President's health care proposal was and will continue to be used as a metaphor for "big government" programs (and, as such, has -- fairly or not -- probably contributed to a negative perception about the President), health care reform and the President's definition of it remain impressively popular with the Democratic and Independent voters he will need in 1996.

The information contained in this document can be a helpful educational tool. Perhaps we might suggest that Senator Kennedy's office (if they have not already tried) get this news out. Lastly, as of this writing, Senator Kennedy is scheduled to see the President on Tuesday. I will provide the Kennedy information to Pat Griffin and his shop so they can use it for prep for the meeting with the President.

On an unrelated issue, Ira and I have decided to draft up a revised letter on the medical education issue to be sent to George Will and cced to the Post and other interested parties. It will be signed by Phil Lee and Ira, and we hope to get it out ASAP. (Phil is reviewing it now).

December 8, 1994

TO: Chris Jennings

FR: David Nexon

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

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

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

Summary

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

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

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

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

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

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

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

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

Analysis

1. Health care is a critical issue for the Democrats

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

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

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

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

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

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

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

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

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

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

[3]Kaiser.

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

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

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

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

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[4]Kaiser.

[5]Kaiser.

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

to take control of it again.

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

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

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

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[7]Kaiser.

[8]POS.

[9]Kaiser.

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

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

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

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

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[10]Kaiser.

[11]Kaiser.

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

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

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

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

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

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[13]Kaiser.

[14] POS.

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

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

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

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

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

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

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

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

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

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

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

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

If respondents said they were disappointed with Clinton, they were

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

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

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

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

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

Recommendation:

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

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

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

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

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

o a start on long-term care for seniors.

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

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

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

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

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

MEMORANDUM

To: Hillary Rodham Clinton
From: Chris Jennings
Date: January 21, 1995
Re: Health Care Portions of the Budget Document/Miscellaneous Issues
cc: Melanne

We wanted to make certain you had an opportunity to review and edit the health portions of the budget document before it went to final print. OMB plans on sending it in early this week. (They tell me Monday, but I suspect that they can make changes for you later into the week).

The current draft reflects edits and seemingly endless changes that result from fact checking and substantive review by HHS, Treasury, and the White House policy and political folk. Earlier today, Gene, Nancy Ann, and I sat down to make our final calls before sending it to you. (Our primary concern and priority has been to review this document with an eye towards not giving Republicans ammunition that can be used against the President, as well as establishing a solid foundation from which he can deliver his health care reform message/vision.) A much more professional and clean version of this document will be available on Monday, but we wanted to give you the chance to start reviewing the substance of it as soon as possible.

On an unrelated issue, Don Baer suggested that Gene Sperling and I send the President the suggested key points on the health care portion of the State of the Union. There are two differences from the document you recently received. First, there is a specific section that gives the rationale for why the President should lay out his current vision of health reform. Second, it notes that George and others believe it might be advisable to give serious consideration to having some reference to the "we should take steps to give you what we all have" theme. (I have placed an * by these changes in the enclosed document).

Lastly, the question that I am asking myself and pose to you: Should there be any reference in the State of the Union that directly or indirectly references concerns about capping or cutting the Medicaid program? For example, should the President say something about his commitment to/concerns about poor children and the elderly? It would mean a lot to our base groups, but may raise concerns to those who are uncomfortable with us defending programs for the poor. I think most of our political people would be in the latter camp, but an implicit -- rather than an explicit -- reference might be worth developing.

If you have any concerns or changes to the budget document, please don't hesitate to give me a call. Talk to you soon.

STATE OF THE UNION -- HEALTH CARE INSERT
Structural/Thematic Suggestions -- Outline

1. **Restate commitment to health security.** Important to show that the vision was and still is right, and that whatever political obstacles there are, the President is still committed to this larger goal.

    - Strong restatement of larger goal also provides a way to measure all Republican health care efforts.

2. **Express disappointment and take responsibility, but do not dwell on the past:** The President should briefly acknowledge the past -- that there were differences, mistakes and/or disappointments -- but it should be clear that he is not apologizing for having tried.

3. **Stress that the problem still exists:** There are three goals served by stressing that the problem still exists.

    - **This is not a matter of politics,** it is a real problem that won't go away. Therefore, "we can't give up." We care about middle class families who are losing their health insurance and therefore we have an imperative to keep trying.

    - **Broad problem definition:** We must define the problem broadly enough so that we don't give the impression that minor incremental reform is enough. We are not for things that "sound good, but don't solve the problems".

    - **Health care costs**: Health care costs still threaten the fiscal security of the nation (the major cause of future deficit increases) and the financial security of families. Examples from OMB:

        - Health care costs will rise more than 50% per person by the year 2000 -- from $3,300 in 1993 to over $5,000 in year 2000.

        - Between 1992 and 1993, 1.1 million more Americans lost their health insurance. (**PLEASE NOTE:** no 1994 statistic available).

        - 84% of the uninsured in 1993 lived in working families and more than 55% were in families headed by full-time workers.

        - As many as 30% of employees say that they are afraid to leave their job for fear of losing health coverage.

- **Show bipartisan willingness to reach out on these steps:** By reaching out on these steps, we are telling Americans that we are willing to look for those things that we can all agree on to make progress. This puts the pressure on them to do the same or be held accountable.

5. **Draw the line on Medicare:** The President must make clear that while we are willing to reform health care entitlements in the context of health care reform and expanding coverage, he will not accept Medicare cuts to pay for Republican tax cuts for the wealthy.

6. **Consider the Health Care that Congress Has Approach:** George and others in the group believe that we may want to draft up some language for the President's consideration that says something to the effect that, "we should take steps towards assuring that all Americans have the ability to have and to hold onto affordable health insurance. All of us in this room have that benefit; isn't it time we started to treat our constituents like we treat ourselves?" NOTE: This language is very rough and it needs work; moreover, the pros and cons of using this approach probably merits further discussion.

1/21/95
4:00 PM

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~~10.~~ Continuing the Commitment to Health Security

Gene
Here's
the
latest

19:57 Jan 20, 1995 VerDate 15-FEB-94 Jkt 000000 PO 00000 Frm 00001 Fmt 3620 Sfmt 3620 F:\PRINT\FY96-BUD\BUDGET\BUD08.96

8. CONTINUING THE COMMITMENT TO HEALTH SECURITY

In November 1993, the President sent Congress the Health Security Act, his comprehensive health care reform legislation. It provided one set of solutions to the problems plaguing the health care system: Though the U.S. offers the world's highest quality medical care, many low- and middle-income Americans, ~~including many who work for small businesses,~~ cannot afford it. Health care costs continue to rise rapidly, straining private and public budgets at all levels.

The President's bill spurred an unprecedented debate as Americans began to widely discuss the problems facing the health care system. They recognized that many of their neighbors have no health insurance, and that others could lose it just by changing jobs.

This debate produced a consensus on several key points. Almost all of the health reform proposals introduced last year included insurance market reforms, such as provisions to prevent insurers from denying covering to people who have been sick. Many bills recognized the importance of providing health coverage to low- and middle-income Americans, especially children.

Also, the Nation began to examine and test various solutions to the escalating growth in health care costs.

Congressional committees held nearly 200 hearings on such issues as market reforms, coverage, malpractice, and long-term care. After several months of debate, ~~and compromise~~, and for the first time in history, a congressional committee approved comprehensive health reform legislation—in fact, five Committees did so.[1] And for the first time in history, the Senate brought comprehensive health reform legislation to the floor for debate in August 1994. In the end, however, Congress could not agree on a bill.

The Costs of Doing Nothing

Nevertheless, Americans now share a broad consensus that the U.S. still faces the twin problems of increasing health costs and decreasing coverage. Without action, American families, businesses, and governments will continue to pay the price:

- *Health costs per person will rise* from about $3,300 in 1993 to over $5,000 by the year 2000.
- *More Americans will lose coverage,* including many working Americans. The number of uninsured Americans rose by more than one million from 1992 to 1993. Eighty-four percent of the uninsured in 1993 were in working families, and more than 55 percent lived in families headed by full-time workers.
- *People will continue to stay in current jobs out of fear of losing coverage,* even when faced with opportunities to move to better jobs. Up to 30 percent of employees say they are afraid to leave their jobs for fear of losing health coverage.
- *Health costs will consume an increasing share of Gross Domestic Product (GDP).* rising from 9 percent in 1980 to 14 percent in 1993 to an estimated 18 percent by the middle of the next decade. No other industrialized country in the world spends more than 10 percent of GDP on health care, although many offer good quality care to their entire population.
- *Businesses will continue to face rising health costs.* Total health benefit costs per employee rose 8 percent in 1993, nearly three times the rate of general inflation. Small firms, in particular, suffer under the current system; insurers charge them up to eight times more than large firms (those with at least 10,000 employees) for admin-

[1] Four Committees reported five bills: Senate Labor and Human Resources, S. 2296; Senate Finance, S. 2351; House Ways and Means, H.R. 3600; and House Education and Labor, H.R. 3600 and H.R. 1200.

Insert A

* **Working Americans bear the full burden of the rising costs of health care.** Rising employer contributions for their employees' health insurance will continue to come at the expense of growth in real wages. From 1970-1991, real wages and salaries increased a total of 0.4% while spending for health benefits increased 243%. Unless we do something to control health care costs, American workers' take-home pay will suffer.

istrative costs. Also, in part due to "experience rating" (by which insurers measure the past health records of a company's employees), many small firms pay exorbitant amounts for insurance or cannot get it at all. Small firms often cannot afford to provide any choice of health plans to their employees.

- *Health care will continue to consume a larger share of government budgets,* leaving fewer resources for such other priorities as education and job training, transportation and telecommunications infrastructure, and research and development. Under current projections, Federal health care spending will reach almost one-fourth of all Federal spending by 2000. In fact, over the next five years, almost 40 percent of the growth in total Federal spending will come from health care spending.

- *Growth in health costs will continue to account for a large portion of the growth in mandatory spending.* Medicare and Medicaid will account for about 45 percent of the growth in all mandatory spending between 1996 and 2000. Even with the lower projected growth rates for Federal health care spending outlined in this budget, the growth in these programs remains very high. Medicare will grow at an average annual rate of 9.1 percent from 1996–2000, while Medicaid will grow by 9.3 percent annually, according to projections. These rates are nearly three times the projected inflation rate of 3.2 percent (CPI-U) and, if sustained, will double program spending every eight years.

The Commitment to Health Care Reform

> *We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit."*
>
> President Bill Clinton, in a letter to congresional leaders
> December 27, 1994

Clearly, the problems have not disappeared. That's why the President remains committed to reforms that will guarantee insurance coverage to every American and contain health care costs for families, businesses, and Federal, State, and local governments. The President has asked the new Congress to work with him on a bipartisan basis to take the first steps toward reaching those goals.

Administration Accomplishments to Date

Part of health care reform is to put the Federal Government's own house in order. In the last two years, the Administration took steps to improve Federal and State health care systems by cracking down on fraud and abuse, implementing administrative simplifications, and giving States more flexibility to administer Medicaid and expand coverage. The Administration also made important investments in public health that will significantly improve the health of Americans.

Highlights of the Administration's efforts to date include:

Enhancing State Flexibility to Increase Medicaid Coverage: Under authority of the Social Security Act, the Administration has approved State-wide health reform demonstration programs in ~~Oregon, Tennessee, Hawaii, Kentucky, Rhode Island, and Florida.~~ It granted waivers to these States to reform their Medicaid programs by incorporating managed care concepts, redirecting payments to hospitals for uncompensated care, and consolidating State health programs. States will use the projected savings to expand coverage. Oregon, Tennessee, Hawaii, and Rhode Island have implemented their demonstration projects, extending health coverage to about 530,000 Americans who were not otherwise eligible for Medicaid. The Department of Health and Human Services (HHS) has worked closely with these States to ensure that the waivers not only save the States money, but do not impose additional costs on the Federal Government.

Fighting Fraud and Abuse: ~~The Omnibus Budget Reconciliation Act (OBRA) of 1993~~ OBRA 93 contained several provisions to enhance the integrity of Medicaid financing and operations, such as ensuring that liable third parties make reimbursements that insurers and em-

Florida, Hawaii, Kentucky, Ohio, Oregon, Rhode Island and Tennessee

Insert B

* **Health care will continue to consume a larger share of government budgets**, leaving fewer resources for such other priorities as education and job training, transportation and telecommunications infrastructure, and research and development. In fact, over the next five years, almost 40 percent of the growth in total federal spending will come from health care spending.

Medicare will grow at an average annual rate of 9.1 percent from 1996-2000, while Medicaid will grow by 9.3 percent annually, according to projections. However, it is important to note that almost half of the Medicaid growth rate is due to projected population increases. Even with the lower projected growth rates for Medicare and Medicaid outlined in this budget, the growth in these programs remains very high.

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Lower Medicare and Medicaid Spending

Fortunately, the two largest Federal health programs, Medicare and Medicaid, are now projected to grow at slower rates than expected at the time the Administration's Mid-Session Review was released. Our updated projections have resulted in a nearly $100 billion drop in projected spending in these programs over the next five years.

Several factors have contributed to the actuaries' lower projections. In the Medicare program, Hospital Insurance (HI) expenditures have grown more slowly than expected. Slower HI growth results primarily from slower forecasted hospital cost inflation and the slower growth in the complexity of Medicare inpatient cases. Other factors such as effective program management and the success of the Medicare prospective payment system for inpatient hospitals also may have influenced the lower projections. In the Medicaid program, the lower cost projections continue a trend dating from the President's 1993 budget, and stem from factors such as actual experience (a decline in the rate of State spending); improved economic conditions; slower projected growth of the SSI population; and successful implementation of regulations to limit States' use of provider donations and taxes that had been used to increase Federal payments.

Taken together with the earlier spending reductions that resulted in part from the enactment of the President's budget deficit reduction plan in OBRA '93, these recent changes mean that spending on Medicare and Medicaid has dropped by more than $200 billion, and the average annual rate of growth has slowed by several percentage points, for the 1994-1998 projection period. But despite the progress represented by the lower Medicare and Medicaid baseline projections, spending in these programs remains high.

Insert D

* **Expanding Medicare and Medicaid Managed Care**. The number of Medicare and Medicaid beneficiaries enrolled in managed care plans has grown tremendously. Medicaid has seen a 62% increase from last year with over 7.8 million Medicaid beneficiaries currently enrolled in managed care plans. Medicare has seen over an 18% increase since December of 1993, with 3.3 million Medicare beneficiaries currently enrolled in Medicare managed care.

Increasing the role of managed care in Medicare and Medicaid can provide beneficiaries greater continuity of care, improve access to providers, and provide the framework to assure quality. In addition, by increasing the role of managed care, the Medicare and Medicaid programs will be able to benefit from the revolution currently underway in the private health care market.

ployers comply with medical child support requirements, and that States operate effective Medicaid fraud control units. These measures were designed to save an estimated $65 million in 1996.

In 1994, HHS's Office of the Inspector General (OIG) recovered over $400 million through settlements. For example, a coordinated effort between OIG and several other Federal and State agencies yielded the largest health care fraud settlement ever to the Federal Government. As a result, a major health care firm that owned over 60 psychiatric hospitals agreed to pay the Federal Government a combined civil and criminal settlement of $379 million.

Also in 1994, the OIG successfully prosecuted 1,169 fraud and abuse cases, and imposed 1,334 administrative sanctions (program exclusions or fines) on Medicare and Medicaid health care providers who were caught abusing the system. Finally that year, HHS's Health Care Financing Administration (HCFA) issued stricter standards for durable medical equipment suppliers under Medicare and Medicaid, and HCFA is now working with States to trace repeat offenders.

Simplifying the Medicare Program: Last July, the Medicare program revised the *Explanation of Medicare Benefits* (EOMB), its main tool for communicating with its beneficiaries, making it more accessible and understandable for Medicare's elderly and disabled population. Medicare will further refine the document, starting in ~~the fall of~~ 1995, when it will become a single, easy-to-read ~~monthly~~ statement of all Medicare claims.

In March 1994, Medicare ended a significant paperwork burden on physicians and hospitals. Simply by changing the filing requirement for providers from once a year to one time upon the granting of admitting privileges, Medicare cut red tape while preserving its commitment to quality medical care for all beneficiaries. This regulatory action significantly reduced Medicare's paperwork burden for some 300,000 physicians and 6,000 hospitals.

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Preventing Disease through Immunizations: The Administration has made substantial progress towards the goal of immunizing 90 percent of children up to age 2 by 1996. Immunization rates for some vaccines—such as 3 doses of DTP[2]—almost reached that level by the end of 1993. Total funding for immunization activities will reach $842 million in 1995, as the ~~government implements~~ the Vaccines For Children (VFC) program. VFC improves access to these lifesaving immunizations for uninsured and Medicaid-eligible children by making publicly-financed vaccines available in private physicians' offices.

~~The Administration's New Proposals~~ What We Propose to Do in the 1996 Budget

In 1996, the Administration will continue to put the Federal house in order by further cracking down on fraud and abuse; making research on, and the treatment of, disease a priority; streamlining the Medicare and public health grants programs; and giving States greater flexibility in Medicaid. The initiatives include:

Increased Funding for the Ryan White Act—HIV/AIDS Treatment: The budget proposes $724 million for programs authorized under the Ryan White Act, an increase of $91 million, or 14 percent, over 1995. This level will provide funds for categorical grants to cities disproportionately affected by the HIV epidemic; to States to provide medical and support services to infected individuals; and to community-based organizations to provide early HIV/AIDS treatment services and support demonstration projects on pediatric AIDS issues. The 1996 level will provide assistance to an estimated 7–14 new cities that may become eligible for Title I emergency relief grants in 1996.

Since 1993, funding for Ryan White grant programs has increased by 82 percent. Under the Administration's proposal for 1996, Ryan White funding will increase 108 percent since 1993.

Increased Funding for Biomedical and Behavioral Research: The budget continues the Administration's commitment to biomedical and behavioral research, which will pay off in the long-term health and well-being of Americans. The $11.8 billion proposed for the National Institutes of Health (NIH)—a $466 million, or 4.1 percent, increase over

[2] Diphtheria-tetanus-pertussis vaccine.

Insert E

HCFA, in cooperation with the OIG, stands in the forefront of insurance industry practices in re-engineering current procedures to guard against fraud and abuse. As health care delivery systems become increasingly complex, our activities must expand. We are examining innovative methods to fund and carry out these important program integrity responsibilities to detect fraud and abuse and to prevent erroneous payments from the Medicare Trust funds. This program, an integral part of the next round of reinventing government, makes good sense given the potential for a high return on our investment.

1995—represents a balanced investment in research directed to areas of high need and promise, and in basic biomedical research which sets the foundation for future progress against disease. The budget includes targeted increases for HIV/AIDS-related research, research into breast cancer and other health concerns of women, minority health initiatives, high performance computing, prevention research, brain disorders research, environmental cancer research, and gene therapy. NIH's highest priority will continue to be financing investigator-initiated research project grants.

~~*Streamlining the Grants Process and Enhancing Performance Partnership Grants.*~~ The budget proposes to consolidate over 100 categorical Public Health Service (PHS) programs, worth $3 billion in 1995, into 15 new grant categories and four existing block grants. The budget also would eliminate many restrictions on how States may use existing PHS grant funds. The new and expanded Partnership Grants represent a performance-based model for Federal agencies, States, and communities to jointly address and ameliorate public health problems. They differ in important ways from past block grant efforts: They represent an increase in total funding over 1995, not a cut, and they encourage performance and results-oriented decisionmaking by using bonus grants.

Streamlining the Medicare Program: HCFA processes millions of beneficiary claims and answers inquiries from beneficiaries and providers. The budget includes $20.2 million for the Medicare Transaction System (MTS), which will bring together the automated claims processing functions, letting HCFA streamline contractor operations and letting beneficiaries more easily interact with the Medicare program. Currently, ~~14~~ claims processing systems operate at over 70 contractors. Once MTS is fully implemented, providers will submit all Medicare claims electronically and Medicare will pay them by electronic fund transfers. MTS also will generate a more uniform application of coverage and payment policies.

The budget includes $10 million to fund the HCFA "On-Line" proposal, a customer service project for Medicare beneficiaries. Part of the $10 million would finance a thorough needs assessment, which in turn will help identify beneficiaries' and providers' most frequently-asked questions and seek efficient ways to respond.

Providing Federal Assistance to States for Undocumented ~~Aliens~~. As discussed in Chapter 5, the Administration proposes to establish a formula-based, discretionary grant program to help States finance the Medicaid costs of undocumented ~~aliens~~. The program will help ~~fulfill the Federal Government's shared responsibility with~~ States to mitigate the ~~problem~~ of illegal immigration ~~and its costs~~. The program will provide $150 million a year in discretionary grants. State Medicaid agencies will use the funds to help offset the State and local costs of providing emergency medical services to undocumented aliens. States with a disproportionate share of this population will be eligible for assistance.

Extending Current Medicare Policies: One way to prevent rising health costs from increasing the deficit is to extend expiring Medicare savings provisions. This budget proposes to extend four such provisions: (1) Medicare Secondary Payer protections, (2) the Part B premium of 25 percent of program costs, (3) cost limits for skilled nursing facilities, and (4) cost limits for home health agencies. These are mere continuations of current law. The President does not plan to propose new Medicare savings proposals outside the context of health care reform.

Special Supplemental Feeding Program for Women, Infants, and Children (WIC): The budget proposes $3.8 billion for WIC, which will raise WIC participation levels to 7.4 million individuals, up from 5.9 million in 1993.

Building on Success in Immunizing More Children: The Administration proposes $841 million for immunizations in 1996, which will support the purchases of more vaccine to distribute through public health clinics than in 1995 and continued improvements in systems to immunize children. This level reflects the Administration's proposed cut in the vaccine excise tax, which will cut the cost of vaccine for public and private purchasers and save the Federal Government

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Extending Current Medicare Policies: This budget proposes to extend four current law Medicare provisions: (1) Medicare Secondary Payer protections which allow the Medicare program, like private insurers, to collect payments from primary insurance sources; (2) maintains the Part B premium at 25 percent of program costs; and provisions that assure that the Medicare program does not reimburse excessive costs (3) in skilled nursing facilities and (4) for home health agency services. These provisions, which help reduce Medicare spending, are in effect now but are scheduled to expire unless they are extended. The President does not plan to propose new Medicare savings proposals outside the context of health care reform.

provision that

an estimated $75 million in 1996. ~~The Admin-~~ Federal ~~programs, such as WIC, as opportuni-~~ ~~istration also is exploring ways to use other~~ ties to improve immunization rates.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings to Hillary Clinton Re: Letter to Senator Moynihan (11 pages)	12/8/94	P5
002. memo w/attach	Steve Edelstein, Muareen Shea to Hillary Clinton Re: Trip to California (5 pages)	9/16/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
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FOLDER TITLE:
HRC Memos-HSA [6]

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RESTRICTION CODES

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

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

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

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton
From: Chris Jennings
Date: December 8, 1994
Re: Letter to Senator Moynihan
cc: Ira and Melanne

After our conversation about revising Ira's draft letter to Senator Moynihan regarding the misperceptions surrounding the medical education/training issue, I attempted to draft a letter that could convey, in a subtle way, the truth about our policy with regard to this issue. I must say it was very difficult to produce a document that, knowing him, he would accept in the constructive tone/manner we discussed. Because of my concern, I took the liberty of consulting some of our most trusted friends (ex staff of Moynihan and staff of Rockefeller, Daschle and Pryor) on the Finance Committee on this issue. (Except for Senator Rockefeller, I did not even hint you were interested in this.)

What emerged from my discussions was a universal consensus that any communication on this issue to Senator Moynihan would be, at best, totally unproductive and, at worst, damaging. These Members' staffs say he repeatedly has been presented with the facts and consistently ignores them. Regardless of the facts to the contrary (and he has been given them directly and often), he believes our intent is to micromanage and limit the number of specialists practicing (not just trained) in this country. There is apparently absolutely nothing that will convince him to the contrary. The only strategy they advocate pursuing is a public education approach -- hopefully through the New York Times and hopefully from someone with some political clout.

A strategy of avoiding direct confrontation with Moynihan is also being pursued by our physician advocates. You are aware and have seen the Family Physicians letter; the AAMC has also drafted the attached letter and is shopping it to the NY Times and the Washington Post.

Finally, Senator Rockefeller is planning to invite George Will for an informal hour plus chat to give him the facts on this issue. He is not overly confident that he can turn Will around, but he may attempt to get some press out of the encounter. (Since Laura Quinn is involved, I am confident something will come out of it.)

In light of these activities and the advice I have received, I have come to the conclusion that it would be unwise for you to write Chairman Moynihan and I would advise us to rethink our strategy. I, of course, will finalize a draft if you disagree. Please call me with any questions.

P.S. Also attached is the speech that Rep. Rostenkowski delivered to the Harvard School of Public Health earlier this week.

The 21st Century Facts on Physician Supply

by

Jordan J. Cohen, M.D.
President, Association of American Medical Colleges

One of the many contentious issues that surfaced during the recent debate on health care reform centered around the number and kinds of physicians we are training for the next century. Virtually all policy analysts who have studied the issue agree that the supply of doctors is growing rapidly but that the need for more doctors is not. The debate has been over what, if anything, to do about this growing gap between supply and demand. No one has suggested that the number of practicing physicians should be reduced. What has been proposed by many is reducing the number *doctors in training* so that the gap might eventually stop widening.

George Will's recent piece, "'Medieval' Cap on Doctors" gave voice to one end of the wide spectrum of opinion on this issue. In the view he expressed, nothing should be done, certainly not by the government. But by dismissing opposing points of view as merely wrong-headed attempts to contain health care costs, Mr. Will left out some important facts as well as some of the well-considered judgments of other thoughtful analysts.

The United States now has about 450,000 licensed physicians who practice medicine on a regular basis, or about 180 "patient care" doctors per 100,000 population. Given the average professional life span of a doctor, and given the population growth we can project for the future, we could produce far fewer new doctors without coming close to reducing the supply of physicians in practice. Each year, more than 17,000 new doctors graduate from medical school and begin their residency training. Joining them each year are an additional 7,000 or so graduates of foreign medical schools who, as trainees, provide essential patient care services in our teaching hospitals while they are

- more -

qualifying to enter permanently into our physician workforce. No matter what we do, these numbers mean that the supply of practicing physicians for the foreseeable future is bound to increase.

Add to this fact the incontrovertible evidence that a more organized and managed system of health care delivery needs many fewer doctors per population than our current fragmented system does. Indeed, one close analysis indicates that by the year 2000 we will need only some 140 doctors per 100,000 population, suggesting that in six years we will be facing a surplus of over 150,000 practicing physicians. And virtually all of that excess is slated to occur among highly trained specialists, not among the generalist physicians who provide the bulk of the primary care still in short supply in this country.

The problem that many see in these projections is not, as Mr. Will noted, a concern about "more doctors, more doctor's bills" and the effect each new physician once had on increasing the costs of health care. That dated economic argument went out with the advent of managed care and, in particular, with the rapid advance towards a new mode of paying for health care: capitation--up front, lump sum payment as total compensation for all needed care, no matter how much or how little is actually delivered. Under this emerging payment system, the new adage will be: more doctors, *not* more doctor's bills--just more doctors.

What many are concerned about is the enormous costs of training this projected surplus of unneeded expertise. And they're not talking only about the immense dollar costs. They point to the human costs and ask: Why would we choose to have so many talented young people spend the most creative years of their lives pursuing training for jobs that won't exist? Several

European countries have taken just that approach. They permit anyone who chooses to study medicine to do so and simply tolerate large numbers of medical doctors doing other jobs, like driving taxis.

Solving the problem by putting caps on the number of residents allowed into training, as Mr. Will correctly notes, would constitute a restriction to entry into the medical profession, an approach perceived by many as downright un-American. Others note, also correctly, that no one has ever enjoyed unfettered access to a medical career. Currently, American medical schools have spaces for only about a third of those who seek entry into the profession. The competition continues for entry into several popular specialties, which have far more qualified applicants among American graduates than they have residency training slots available.

An important question that needs answering is: Whose access to the medical profession are we talking about? As noted already, this country's medical schools currently educate an ample number of new physicians each year to satisfy our nation's present and future needs. And we have come to accept the fact that every child in America who aspires to be a doctor can compete freely for the available places but only some of them will succeed. At the same time, we accept thousands of graduates of other country's medical schools each year into our various residency programs, and eventually into our enlarging pool of practicing doctors. We do this because we have grown too dependent on doctors in training to provide essential medical care, especially to some of our most vulnerable patients in our inner-city teaching hospitals.

Consider what might happen if we provided adequate resources to our teaching centers to offset the contribution that the

unneeded residents make to patient care, and were then in a position to size our capacity to train new doctors more in relation to our future need. We could minimize the waste of human resources; we could retain only those residency programs that are doing the best job educating the physicians we do need; and we could be even more selective in picking the most qualified people to be our children's future doctors. Not a bad price to pay.

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For release on delivery
December 5, 1994

Rostenkowski Analyzes Health Reform Failure

Following is the text of a speech prepared for delivery by Rep. Dan Rostenkowski at the Harvard School of Public Health in Cambridge, Mass.:

A bit more than seven months ago, I stood before you in this very room and talked about health reform legislation. I was in an expansive mood and predicted that Congress would enact a law that would guarantee broad health insurance coverage to every American.

As events turned out, my crystal ball was very cloudy and my prediction was very wrong. Perhaps it was just a triumph of hope over experience.

Politicians like to quickly bury their mistakes and hope that no one has noticed what happened. Academics, on the other hand, like to study them in an effort to learn some lessons that will help do things better in the future. Today, I thought I'd do things your way, fess up to my failings as a seer, explain where I think things went wrong and offer some counsel for the future.

I'm not sure that any health legislation could have been passed this year. In retrospect, it is clear that bipartisanship was an impossibility and that the Republicans had a big investment in a Democratic failure.

While we've done things before without Republican votes, It doesn't appear that we could have this time. Our party was split, as usual, and there wasn't a clear compromise.

Nonetheless, I believe we could have done better and should have done better. We could have prevailed if we had done everything perfectly. As things turned out, we did nothing perfectly. Mistakes were made that gradually transmuted a very difficult challenge into an impossible one.

First there was the unique process that the White House used to create its plan. In the past, I've refused to join chorus trashing this mechanism, arguing that it would have been seen as innovative genius if the plan was enacted. But the plan wasn't enacted and it is clear that the process was part of the problem.

I say that for several reasons. First, it wasted months of time that could have better been used debating the options and educating the public. We knew what the issues and options were when President Clinton took office. All we needed were some difficult executive directions about where to go.

In addition to losing time, the White House made itself vulnerable to tangential and damaging discussions about the process as critics from the right argued that illegal procedures had been used.

It took a long time to come up with a plan and the plan that ultimately emerged was too complex to understand and so riddled with centrist compromise that it was a recipe for political roadkill.

In retrospect, one can make a strong argument that the President should have embraced a more radical plan that could have been readily understood by the public and then allowed Congress to amend it in a fashion that would make it more complex and more centrist.

Had the President recommended making medicare universal or adopting a single-payor plan like the one now used in Canada, the debate would have been less theoretical and confusing. Nearly everyone knows how medicare works and while the Canadian plan has been maligned by conservative critics in this country, it is reasonably easy to understand.

At one point early in the process, I expressed a fear that the President would come up with a plan that was the domestic equivalent of Star Wars -- a system that linked several complex theoretical systems that don't yet exist and then assumed that they would interact flawlessly.

The White House didn't take my warning seriously and came up with a strange beast that had many of the features I feared. It was a tough sell, perhaps an impossible one. I still believe that a radical, but comprehensible plan would have fared better than a complex, centrist plan that created broad confusion.

To this day, very few people fully understand how the President's plan worked. And it is difficult to fault people for rejecting a plan that they couldn't understand. We were, after all, talking about major changes, and popular prudence was a proper posture in that situation.

But there was another reason for public wariness about the plan. In addition to not understanding the proposed solution, much of the public never really understood exactly what the problem was either. They didn't see that we were dealing with a dynamic situation that was deteriorating as we debated. During the two years we discussed the problem, the number of uninsured Americans rose by two million to 40 million and millions of Americans lucky enough to be covered found that their choice of providers had been narrowed.

In fact, the President's plan would have given everyone a broader range of choice and it is a shame that it was misconstrued as *limiting* choice. What happened here is a sad replay of the debate about adding catastrophic coverage to medicare. In each case the lies told by opponents overwhelmed the truth.

And in each case we found that we were powerless to educate the public about the reality of the situation. In my ideal world, the media would have told the public that the critics were simply wrong about the facts. They did play this constructive role at times, but were later distracted by other things. During the debate, the press played an interesting and changing role.

At the start, there was a tremendous amount of responsible and helpful journalism that explained what the problems were and what options were available to resolve them. But that was quickly overtaken by the typical political journalism that turned the entire issue into a partisan horserace. Was the President's plan alive or dead? Would the centrist Democrats support managed competition? Or would a more modest Republican alternative be more popular.

Ultimately -- and inevitably -- coverage of the horserace totally overwhelmed a rational a discussion of the policy options.

But I think the biggest problem was a failure by the White House to understand who its biggest and best friends were in this entire debate. The key to enacting comprehensive reform lay in the corporate community. They had the power and influence to lobby strongly for change. And they wanted and needed change.

The businessmen I talk to were frustrated with the status quo. They were worried about escalating costs, amenable to government action and very much in favor of a plan that would compel their competitors to provide the same health insurance that they were already

providing.

The battle should have been between the large employers who are already providing health insurance and the smaller ones who were unwilling to assume a similar responsibility.

I still don't understand why the corporate community and the White House didn't have a closer relationship. There's evidence that business is willing to cooperate and is capable of doing the heavy lifting when lobbying is required. They did in the case of NAFTA. But they thought that they were treated as adversaries rather than allies by the White House from the start -- and responded accordingly.

I don't know where the blame lies. On a number of issues, especially in the budget and trade areas, the Administration has been good to business. But while corporate America is appreciative of the particular policies, it remains unimpressed with the President generally.

Parenthetically, I'd like to raise in passing the question of whether big business is now among the political homeless. While many Republicans of my generation were their friends, the newer Republicans have a tilt toward smaller business and smaller government. I doubt that my corporate friends will find themselves any happier with the new Republican agenda than they were with the old Democratic one.

But that's a question for a different day --and a different speech.

Having spurned their most powerful ally, the White House was betting on a weak hand. It is true there was public interest in improvement of the health system, but that didn't translate into public pressure. The lack of pressure from the public was one constant in this debate. Voters saw themselves as observers rather than participants.

Indeed, to hark back to a theme I raised early and often, the real reason we didn't enact reform was because the voters failed to demand it. Whatever our flaws, Congress is very responsive to public demands.

The President's plan got to Congress and nearly nothing happened. There was a lack of leadership. I think the fact that no plan ever came to a vote in either the Senate or the House is a sad commentary on the Congressional leadership.

In the end, they were more worried about losing in public and were unwilling to take the risks that would have made a victory possible. A contrarian could argue that Democrats in Congress were unwilling to accept the leadership of their President and paid a high price at election time.

I personally am convinced that passage of a plan -- any plan -- would have yielded election results that were better for the Democrats. My colleagues thought it wiser to do nothing than to do something controversial. They were very wrong.

The Democratic leadership was properly worried that it couldn't pass a plan. In retrospect, I would argue that a public debate would have been preferable to a quiet death. It would have separated those members with the courage to vote for change from those who were ducking the issue.

And, frankly, I think the public would have been more lenient with Democrats who tried hard but failed than they were with Democrats who simply let the entire issue die with a whimper rather than a bang.

On the other hand, one could make a case that the public was confused and misled to a point where it ultimately feared change more than it desired reform. The responsibility for creating this environment is shared by many of us, but it begins at the White House.

Stripped of all the complex details, health reform was a fairly simple political transaction where large numbers of people paid something and got something in return that

they believed was worth at least what they paid. For the majority of Americans who already have insurance, the transaction would offer them a guarantee of health insurance for the rest of their life in return for an additional payment.

There was a lot of talk about making the entire system more efficient and I certainly share that goal. But the bottom line was a larger insured population that would inevitably cost more to care for -- unless some restrictions were placed on what care was offered and how it was delivered.

The President was right to talk about making the system more efficient, but he erred when he promised broader coverage for a wider population at no additional cost. People sensed he was acting like a very conventional politician who was promising them a free lunch and they were properly suspicious. Americans are paying a lot of taxes to pay the tab for free lunches they were offered in years past.

Indeed, it was clear that those with comprehensive coverage would be paying more without getting any more while those with less coverage -- or no coverage -- would be getting an additional benefit. It was a classic government ploy of taking a little something from those who had a lot and giving it to those who had nearly nothing.

As a Democrat and an American, I have no problem with that logic. And I suspect the debate would have gotten further had there been a bit more candor on this very basic point.

It may seem that I'm leveling a lot of criticism at the White House because that's where the battle was directed from. But, in fact, I'm more frustrated with my colleagues in Congress for failing to act. The President came up with a solid plan that would get the job done. The Congress didn't come up with anything.

There was an ironic bipartisan belief within the beltway that inaction was the best answer. Republicans believed-- correctly as it turned out -- that a return to gridlock would convince the voters to throw the rascals out. And there was a Democratic fear -- which now appears more than a little misguided -- that the voters would reject politicians who had the courage to vote for change.

So nothing happened.

Which leads us to the next logical question -- what will happen next?

My suspicion is that things will get worse before they get better. One of the excuses for not enacting reform that was that the problem wasn't as serious as the President was painting it. It will take a few months for the public to realize that it was serious -- and has gotten more serious in the intervening months. I hope that the President will make that point -- regularly and forcefully.

I don't think he has an obligation to present a new plan and don't believe that he should given the changing political climate. Rather he should put a spotlight on the problem and challenge the Congress to come up with a solution that it finds more palatable than his proposal.

Congressional enthusiasm for health reform has never been great -- that was a good part of our problem -- and has declined in recent months. Public demand for reform has ranged from the subtle to the totally invisible. Until that changes, Congress, which properly prides itself on responding to public demands, will have little enthusiasm for the issue.

I think it is possible, but not inevitable, that this issue will become important in the 1996 Presidential campaign. But I do think it is inevitable that the issue will reappear on the national agenda before the end of the decade.

One reason our debate this year was so confusing and frustrating is the dynamism of the medical marketplace. We were trying to define managed competition at the very moment it was creating itself. That gave some people the impression that the problem was solving itself and that there was no need for broad government action.

There are a lot of interesting and constructive changes occurring in the health insurance business. Managed care is spreading. Premiums are moderating and, in some instances, actually dropping. And several states are beginning innovative experiments to broaden coverage.

But these positive developments should not be permitted to obscure some broader, continuing trends. The cost of healthcare continues to rise at more than double the pace of consumer prices generally. The number of people who lack insurance is steadily rising -- at a time when the economy is improving. And those fortunate enough to have employment-based coverage are finding that they're being asked to pay more of the cost at the same time that their benefits -- or at least their choices -- are being curtailed.

There is no reason to believe that any of these trends will be reversed soon. Nor is there any reason to believe they can be reversed without action at the Federal level. That logic does not tell us, however, *what* government action will be required. My current counsel would be to avoid another divisive debate about the solution and focus instead on getting everyone to acknowledge that there is a problem.

That's because the American people will ultimately be asked to pay -- in one way or another -- for the solution. Unless and until they agree there's a problem serious enough to warrant their making such a payment, the chance of change won't be great.

Just a moment ago I suggested that changes in the marketplace were partly responsible for derailing our efforts at reform this year. If I understand what's happening out there, there's reason to believe that this dynamic will reverse in the years ahead and participants in the system will begin pressuring the government to change the rules.

That's because the discipline of the marketplace will be seen as too rough-hewn and even brutal. Providers who are rejected by managed care systems and patients whose problems are uncovered by their insurance will increasingly ask the government to make broad rules governed by the moderation of due process.

One of the biggest questions raised by the Republicans who took control of Congress is how broad a responsibility we have for one another and whether there's a need to use the government to share that responsibility. You can't fault them for asking this question and, indeed, it is a very important one.

In their effort to reduce the cost of welfare, some Republicans suggest that mothers who are unable to support their children place them in newly-opened orphanages. But they don't believe these should be government institutions. Rather they suggest they could be financed by our voluntary philanthropic contributions. Personally I believe we've tried a similar strategy with America's homeless and hungry and that it has been an embarrassing failure -- but that's just one man's belief.

My point here, though, is that this broad question has important implications for the healthcare debate. We could care for one another by making voluntary contributions to private agencies. And, if we did that more, we could reduce the cost of government programs like medicaid.

But leaving needy individuals at the mercy of strangers hasn't worked particularly well in the past. In almost every instance, the government has stepped in only after such

private initiatives failed. The insurgents are simply wrong when they say the government is constantly trying to expand its own power. Rather the government is constantly being urged by those who control it -- the citizens and voters of America -- to do more for more. It is only when it is asked to accomplish this expansive goal while spending less that we have a serious problem.

I wish we had a society where every employer voluntarily provided adequate health insurance coverage for every worker and his family and the United Fund could afford to provide similar coverage for those who still needed it. But that hasn't happened in the past and I'm not particularly optimistic about its happening in the future.

And the bottom line is that we'll all be paying for such coverage regardless of how it is provided -- whether our contribution comes from higher taxes or higher prices on the products we buy and growing charitable contributions.

Those of us who spent the past two years fighting to make health insurance coverage universal in America have every reason to be upset and concerned. The plain fact is that we lost -- and lost big.

We made mistakes. Today's challenge is learning the right lessons from our defeat. Whether our defeat moved the debate forward or backward is an open question. But the problem remains and it demands a solution.

We will pay a high price if we delay too long. One of the lessons of this year is that there's a high political price to be paid for inaction. But the economic and social price will rise also if we continue to defer action on this important issue.

It would be foolish and dishonest to attempt to recast what has happened during this Congress as some sort of incremental progress. But I do believe we can salvage something from this experience if we learn from it and avoid making the same mistakes in the future.

# # #

September 16, 1994

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: HILLARY RODHAM CLINTON

FR: STEVE EDELSTEIN AND MAUREEN SHEA

This memorandum is in preparation for your trip to California on Sunday.

SENATOR DIANNE FEINSTEIN (D-CA):

With the most recent poll showing her a mere six percentage points ahead of Rep. Huffington, Senator Feinstein's anxiety level has undoubtedly increased accordingly. The Assault Weapons Ban is her major achievement, and she had hoped that a middle of the road compromise could be worked for health care as well through the "mainstream" proposal. She participated actively with Senator Chafee to develop an alternative approach to health care reform that appealed to Senate moderates.

On health care reform, she is consistent in her concerns about employer mandates and that reform not endanger two voluntary purchasing alliances - the California Public Employee Retirement System (CalPERS) and the Health Insurance plan of California (HIPC) under which small businesses band together to buy health insurance.

Her Republican opponent, who has already spent $10 million of his own money to defeat her, has criticized Feinstein for dropping off the HSA, saying, "it's the only principle of a career politician. Save your own skin." Privately, she has told the Administration that was "the street smart" thing to do. The liberal Sacramento Bee has acknowledged her political problem, saying Huffington will exploit whichever decision Feinstein makes on health reform. Feinstein has expressed her displeasure with the DNC health reform ads, particularly the one featuring Rep. Gingrich, because she felt they made all of Congress look bad and hurt her re-election chances. She also does not think she is getting sufficient support from the DNC for her race. Citizen Action reports that she has received $235,755 from health and insurance industry PACS as well as individual donors associated with those industries in the last 18 months.

On July 28th, at a lunch hosted by Secretary Bentsen for a small group of Senators with the Administration's Economic Team, she added to her list of concerns the state's high number of uninsured children and 2.2 million undocumented workers. She felt too much pressure from the leadership, bus trips, and marches, which she said made her want to dig in her

heels even more.

As you know, she met with both the President and the Vice President on health reform in August.

The daughter of a physician, Feinstein serves on the Judiciary and Appropriations Committees.

Feinstein voted for National Service and Budget Reconciliation, but voted against NAFTA

CONGRESSWOMAN LUCILLE ROYBAL-ALLARD (D-CA 33rd District - Los Angeles):

A freshman, Rep. Roybal-Allard represents the Congressional district with the nation's highest concentration of Hispanics. As her district has 51,000 children and 163,000 people in working families without health insurance, it is no surprise that the uninsured are a primary concern for Roybal-Allard. A McDermott cosponsor, she hoped to bring pressure from the left on the health care debate. Roybal-Allard is a Roman Catholic and pro-choice. Health care is a long-standing issue for her - while serving in the California Assembly, she chaired a subcommittee on health and human services.

In the Congress, she is a member of the Small Business and Banking Committees, as well as the Caucus for Women's Issues.
Roybal-Allard has taken a leadership role in the Congressional Hispanic Caucus.

She voted for the Crime Bill, Family and Medical Leave, Budget Reconciliation, National Service, and NAFTA.

CONGRESSIONAL DELEGATION

SENATOR BARBARA BOXER (D-CA):

Senator Boxer was very helpful during floor debate on the Mitchell bill, both in using stories from her constituents on the need for health reform and in defining the need for universal coverage. She has linked the Preamble to the Constitution's vow of "domestic tranquility" to the peace of mind that comes with adequate health insurance.

Inclusion of full reproductive services has been her priority issue in health reform. In July she was one of the four Senate Democratic women to meet with male moderates of both parties to try to find some common ground on abortion. Other important issues to her are children and treatment of veterans. In July she pledged to fight for a bill that included coverage of preventive services and for the ability of consumers to choose from different types of health plans. She serves on the Banking, Budget, and Environment Committees.

Boxer voted for Budget Reconciliation and National Service, but voted against NAFTA.

CONGRESSMAN XAVIER BECERRA (D-CA 30th District - Los Angeles):

A freshman Congressman representing parts of Los Angeles, Becerra serves on the Education and Labor and Judiciary Committees. His wife is a physician in an inner-city hospital and he

often referred to her experiences there during Committee consideration. He is a McDermott cosponsor. Rep. Becerra is very concerned about immigrant communities and has warned that "if the Administration continues to attack the immigrant population, he will become much less cooperative." This was a particularly sensitive issue for him after the NAFTA vote and when he felt that promised consultation on immigration issues was not forthcoming.

During the Education and Labor Committee mark-up, he worked with Rep. Sawyer on privacy protection issues regarding a health security card, a major area of concern to the Hispanic Caucus.

He has asked Secretary Shalala to intervene on behalf of the LA County Hospital to get FEMA funds to help rebuild the pediatric and psychiatric wings of the facility which were destroyed in the earthquake. The hosital received $11.7 million for their pediatric wing and $4.1 million for their psychiatric wing to establish temporary facilities. They are also likely to qualify for additional funds to rebuild theri facilities.

Becerra voted for the Crime Bill, Family and Medical Leave, budget reconciliation, National Service and NAFTA.

CONGRESSMAN TONY BEILENSON (D-CA 24th District - Woodland Hills):
Congressman Beilenson, a McDermott cosponsor, is an interesting mix of paradoxes - a liberal in a marginal district, an independent-minded politician who is not an insider but sits on the Rules Committee. He is also a member of the Budget Committee and an opponent of wasteful government spending. His winning percentage dropped to 56% in 1992 and Roll Call calls his race a toss-up.

In health care, he is particularly interested in using the health care card as an immigration card also: "You'd save an awful lot of money if the medical card were used for both purposes." His district has 14,000 children and 80,000 people in working families without health coverage.

Beilenson voted against the "motor voter" bill but for the Crime Bill, Family and Medical Leave, the Budget, National Service and NAFTA.

CONGRESSMAN HOWARD BERMAN (D-CA 26th District - Panorama City):

An active and thoughtful legislator, Congressman Berman is safely ensconced in his San Fernando Valley district -- an area which is struggling with the death of the aerospace industry. An HSA and McDermott cosponsor, Berman is a strong supporter of reproductive rights and cosigned the DeFazio-Schroeder letter to the Speaker supporting abortion coverage in any federal benefits package. He is close to Rep. Waxman and their joint political organization dominates West Los Angeles politics. Berman serves on the Judiciary, Budget, Foreign Affairs, and Natural Resources Committees.

Berman voted for the Crime Bill, Family and Medical Leave, NAFTA, National Service, and Budget Reconciliation.

CONGRESSMAN JULIAN DIXON (D-CA 32nd District - Los Angeles):

Congressman Dixon is a HSA and McDermott cosponsor. Dixon sits on the Appropriations Committee where he chairs the Subcommittee on the District of Columbia. His views on how former Marion Barry's probable re-election will affect that Subcommittee would be interesting. Dixon is very popular in his West Los Angeles district and is rumored to be interested in local office.

Dixon has voted with the White House consistently, including supporting the Crime Bill, Family and Medical Leave, the Budget, National Service, and NAFTA.

CONGRESSWOMAN JANE HARMAN (D-CA 36th District - Los Angeles) :

A freshman Member of Congress, Jane Harman returned to Washington with substantial government experience at the national level. Her priority now is to be re-elected in a very difficult race. Harman told the New York Times in September that crime and illegal immigration, not health reform, were her constituents' concerns. She has not cosponsored any of the major health reform plans but is a strong pro-choice supporter. She cosigned the DeFazio-Schroeder letter to Speaker Foley urging inclusion of abortion coverage in any standard federal benefits package.

Considered by pro-reform advocacy groups to be a "no" vote on health reform, she reportedly told them she supported universal coverage but was uncertain as to how it should be achieved. She also told the groups she believes mental benefits needs should be included in reform.

One of the GOP's top state targets, Harman will have to work hard to retain her West Los Angeles seat which she won with 48% of the vote. She serves on the Armed Services Committee - a priority spot for the defense industries in her district.

Harman voted for the Crime Bill, Family and Medical Leave, Budget Reconciliation, National Service, but against NAFTA.

CONGRESSMAN MATTHEW (MARTY) MARTINEZ (D-CA 31st District - Alhambra):

Congressman Martinez chairs the Human Resources Subcommittee of Education and Labor. He was outstanding in his defense of the employer mandate, saying that as a former small businessman who offered employees health care: "It didn't bankrupt me; it won't bankrupt them." A HSA and McDermott cosponsor, he is a relatively quiet member who represents

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings, Steve Edelstein, Muareen Shea to Hillary Clinton Re: Metting with Senator Exon (2 pages)	7/19/94	P5
002. memo	Steve Edelstein, Maureen Shea to Hillary Clinton Re: Trip to Boston (4 pages)	7/29/94	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23758

FOLDER TITLE:
HRC Memos - HSA [7]

Gary Foulk

gf133

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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THE WHITE HOUSE

WASHINGTON

July 19, 1994

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: HILLARY RODHAM CLINTON

FR: CHRIS JENNINGS, STEVE EDELSTEIN AND MAUREEN SHEA

This memo is in preparation for your meeting tomorrow with Senator Exon (NE).

BACKGROUND:

Senator Exon sees himself as a key centrist vote on health care, one who can be of assistance in getting other moderates to vote for passage of health care reform. In May he told the Omaha World-Herald: "I have been working very quietly and behind the scenes with a whole group of senators on both sides of the aisle to fashion a workable and a passable health care plan." The paper said that while Exon does not criticize Kerrey's efforts to reach a bipartisan solution, his own strategy is to reach a Democratic consensus on a plan that can pick up enough Republican support to prevent a filibuster.

The three issues which have been of primary interest to him are:

- concern about the size of the benefit package. (It should be an "Escort not a Cadillac.")

- belief that states, not the federal government, should choose whether or not to fund abortion; and

- relief for small business from the employer mandate. (He has said he might bemable to support a 50-50 split.)

He has also said that universal coverage should be a priority but should be phased-in.

RECENT DEVELOPMENTS:

July 13 Washington Post: Said of his constituents: "people are more and more unsure of what it means to them."

TALKING POINTS:

We should be able to appeal to Senator Exon in at least two ways: one, his desire to be a player and his belief that he can be influential with other Senate moderate; and two, his lack of fondness for his fellow Nebraskan, Senator Kerrey, which we may be able to use to our advantage.

- The importance to the success of this Presidency and the Democratic Party of passing a health care bill that achieves universal coverage .

- We have heard his concerns and are working with Senator Mitchell to develop a consensus bill that moderate members can support.

- We need his support and assistance in reaching out to those members he has been working with and others who look to him for guidance.

- You might ask him for his read on Senator Kerrey. You could state your gratitude for Exon's willingness to work quietly to find a Democratic consensus.

July 29, 1994

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: HILLARY RODHAM CLINTON

FR: STEVE EDELSTEIN AND MAUREEN SHEA

This memorandum is in preparation for your trip to Boston on Sunday. Health issues of particular concern to the delegation include both the biotechnology industry and research and teaching hospitals. Senator Kennedy's unwavering support is essential, but we also need to pay attention to Senator Kerry whose only public comments have been ambivalent. Rules Chairman Moakley is, of course, moving to center stage.

SENATOR EDWARD (TED) KENNEDY (D-MA):

Senator Kennedy is key to insuring that our left liberal base supporters do not bolt when Senator Mitchell unveils his bill. While it might do us some good politically to have some unhappiness on the left, we cannot afford to lose our hard core liberal and union support in the coming floor debate.

Senator Kennedy is frustrated with the Majority Leader's unwillingness to start with a stronger package in the bill he introduces. His issues of particular concern at the moment are:

- Children: He wants all uninsured children to be covered as soon as possible, preferably by 1996;
- Workers: He may offer an amendment, as in Hawaii, to require an earlier 50-50 phase-in of workers, but not their dependents; and the
- Bradley Amendment: Kennedy wants it dropped.

Senator Kennedy's criticism of Pizza Hut and other restaurants which insure their workers abroad but not in the United States received a good deal of press. The Massachusetts Restaurant Association held a news conference stating their disagreement with him and their fear that a mandate would cost 20,000 jobs in the state. However, they did not endorse his opponent, Mitt Romney.

Political observers feel Senator Kennedy's re-election bid is going to be more difficult than originally anticipated both because of the anti-incumbent political mood and his own past negatives.

In a lengthy interview with the Boston Globe earlier this month, Senator Kennedy said that his tough re-election reflects the public's impatience with slow-moving institutional politics and its desire for easy answers to thorny problems, mentioning jobs, health care, and crime. He vowed to fight any health care bill that does not guarantee universal coverage to all Americans, and predicted the President would veto any measures without an employer mandate. He added: "I won't vote for is anything that is going to condition the implementation of that legislation on future congressional action." Kennedy told the Globe that no matter what the details of the final bill, the President will "reap the lion's share of the credit." Kennedy said he would urge the President to veto a partial bill and wage war on the issue in the November elections.

Kennedy reiterated his position that constituent pressure on Republicans will keep them from filibustering. Kennedy said he "relished the opportunity" to debate his Senate colleagues on the issue of universal health coverage. "I can't wait to deal with our colleagues -- when I say we are offering the people of Massachusetts the same thing I have and they are going to say no," Kennedy said. "They are going to say no to that, when 75% of the people say yes?"

SENATOR JOHN KERRY (D-MA):

Senator Kerry has not cosponsored any of the major health reform bills and the Boston Globe has called him "conspicuously absent" from the HSA. While he is being deferential to Senator Kennedy and we expect him to be with us in the end, Senator Kerry's comments of late show a real need for some shoring up. In recent visits with health care providers in Massachusetts, he has been quite critical of both the health care debate and reform proposals. While he said he expected the Senate to pass a phased-in version of universal coverage, he added that all the proposals make unrealistic promises about what can be achieved. He feels "the government is reaching too far," saying "I want to build a framework and then let the marketplace duke it out." These remarks were made after visiting a HMO which lobbied against the "any willing provider" proposals. Kerry asked them to discuss whether the United States could set a budget limit on health care spending the way the HMO develops its budgets.

In a meeting this month with the South Shore Hospital staff he said that legislators have to make choices on health care rather than promises to deliver every suggestion at top quality. "There is a lack of candor in the health care debate. I'm looking for some truth...not this whole bunch of rhetoric." He told them he favored universal care that would be paid for by some mandates to individual and businesses, but that he had not decided whether he favors broad mandates on business. He advocated prevention and keeping health care in the marketplace as a way to keep costs down and quality high. "The Wal-Mart syndrome has its place, but it isn't everywhere."

Administrative simplification and insurance reform are of particular interest to him. Presumably he will be reassured by the compromises made to help the biotech industry which is strong in Massachusetts. He will undoubtedly also support the additional hospital funds contained in the Labor Committee bill. Local groups report that he opposes taxation of health benefits.

Kerry serves on the Small Business as well as Banking and Commerce Committees. He voted for NAFTA, National Service, and the Budget.

CHAIRMAN JOE MOAKLEY (D-MA):

The Chairman of the Rules Committee is a HSA and McDermott cosponsor who prefers the single-payer approach. Congressman Moakley is a party person who, while usually willing to listen to both Republicans and Democrats, dismisses Republican complaints that health care is being decided behind closed doors. "If they're left out, it's because they want to be left out. We'd love to have them play because we're going to need every vote that we can get."

Moakley has predicted that his committee will allow the House to vote on more than one health care plan and "plenty" of amendments. Undoubtedly reflecting the interests from which he had already heard, he mentioned biotechnology companies, foot doctors, nurses and insurance companies as being among the health care "variables" for which there may be amendments. However, despite those comments, he will undoubtedly go along with the leadership decision on amendments. He opposes abortion and said this month he thinks it should have a vote on the floor.

In response to the Massachusetts biotechnology industry, Moakley wrote the President this May opposing the HSA's establishment of a breakthrough drug committee, saying it would "irreparably damage America's preeminence in biotechnology." Massachusetts has 142 biotechnology companies which employ over 17,600 people.
Moakley voted for Family and Medical Leave and the Budget and against NAFTA. He did not vote on National Service.

CONGRESSMAN MARTIN MEEHAN (D-MA):

While he has not cosponsored any of the major health plans, freshman Congressman Meehan has told the Administration that he will support anything that gets to universal coverage. He recently said: "Given that health care represents one-seventh of the economy, reform has to be gradual. I would accept a process over the next four or five years." He is worried about two areas in reform - the insurance industry, which is the largest employer in his district, and small business.

Local groups report that he supports universal coverage unequivocally and will vote for a tax to get it done. They said his greatest fear is that nothing will be passed, and that he wants to see both greater simplicity in insurance and cost cutting. He advocated that nurse

practitioners be granted earlier access into the system. A Roman Catholic, he cosigned the DeFazio-Schroeder letter on abortion benefits.

Meehan represents a liberal constituency and made his reputation as a crime fighter when, as an assistant district attorney, he dealt with white collar and violent crime, as well as hate crimes against gays. He serves on the Small Business and Armed Services Committees.

Meehan has been a good vote for the White House, voting for Family and Medical Leave, Budget Reconciliation, National Service, and NAFTA.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris jennings to Hillary Clinton Re: Meeting with Chairman Rostenkowski (2 pages)	8/9/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] Congressman Rostenkowski

Gary Foulk

gf136

RESTRICTION CODES

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

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PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton August 9, 1993
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Chairman Rostenkowski
cc: Melanne, Steve, Distribution

Tomorrow you are scheduled to briefly meet with Congressman Rostenkowski. This meeting will be a general political discussion of the timing and process and health care reform.

Background:

Chairman Rostenkowski played a key role during the budget reconciliation. He was particularly helpful early on with the immunization provisions by keeping the funding open even though it did not ultimately go through his committee. He played a critical role on the Administration's family preservation and empowerment zone initiatives. Like Chairman Dingell, he is generally unhappy over having his deals bargained away in the Senate. However, he is unlikley to mention any of this.

As you know, the Chairman is the subject of an ongoing investigation for alleged ethics violations. It is important to note that even under a worst case scenario where he is indicted and Congressman Gibbons assumes the chair, Rostenkowski is still likely to wield significant influence behind the scenes. Members will be hesitant to go against him for fear of the consequences if he is successful in fighting the charges and resumes the chair.

TALKING POINTS:

Appreciation for his Efforts on Reconciliation: You may wish to thank the Chairman for all his help during the reconciliation process and for doing the best job possible under difficult circumstances.

Process/Timing: The Chairman will be interested in the timeline for decisionmaking on the policy, consultation with the committees, and the launch of the plan. You may wish to inquire if he and/or his staff will be available for consultation during the August Recess. In addition, you may want to tell him that you have already contacted Pete Stark's office to arrange for a meeting during the week of September 30th.

Testifying before the Committee: Chairman Rostenkowski has already invited you to testify before his committee after the plan is announced. Should he mention this, it probably would be best to thank him for the invitation while avoiding a specific commitment on testifying. If he presses, you could say that you have not had the time to talk this over yet with the President. (FYI, he apparently is planning to hold a series of full Committee hearings; one with you as the primary witness and another hearing the next day with Secretary Shalala. Following these hearings, Pete Stark's Subcommittee is expected to invite other Administration witnesses to testify on the specific provisions and cost/financing assumptions of the President's proposal.)

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senator Jeffords (6 pages)	6/28/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA]- Senator Jeffords

Gary Foulk

gf139

RESTRICTION CODES

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

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

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

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

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PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton June 28, 1993
FR: Chirs Jennings, Steve Edelstein
RE: Meeting with Senator Jeffords
cc: Melanne, Steve, Distribution

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 Repubicans 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 "Medicore." 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 princples as elements fo 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 equitablity. At the same time, it effectively controls health care costs and preserves quality and flexibility within the American health care system.

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 conferees 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 $3 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 $270 billion in tax increases and user fees over the next 5 years, and just over $80 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 1998, 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 increase 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 4.3-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 believe 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 contradicts 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 $912 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, $286 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 revenue, 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 $832 billion on health care, $563 billion of which will

be in Federal spending. Private sector will grow to $800 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 10 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 8 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, 4 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. 1087, the MediCORE 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, KASSEBAUM, DODD, MIKULSKI and Chairman KENNEDY the committee has crafted a compromise to the President's initial bill.

The committee compromise now include 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 2-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.

AMT REFORM

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' 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 cuts spending

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings, Steve Edelstein Re: Meeting with Senator Kerrey (2 pages)	5/27/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA]- Senator Kerrey (NE) [2]

Gary Foulk

gf141

RESTRICTION CODES

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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 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 speicifc commitment until we have further opporunity to review it and analyze its political ramifications.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Taping with Senator Leahy at 7:00 p.m. (2 pages)	9/21/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] - Senator Leahy (VT)

Gary Foulk

gf142

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THE WHITE HOUSE

WASHINGTON

PRIVILEGED AND ~~CONFIDENTIAL~~

September 21, 1993

TO: President Clinton
FR: Chris Jennings
RE: Taping with Senator Leahy at 7:00 p.m.
CC: Howard Paster, Susan Brophy, Steve Ricchetti

Senator Leahy has requested a taping with the President about their mutual commitment towards assuring that there be adequate state flexibility in any national health reform proposal. In short, he wants recognition of his contributions in this regard, in particular with his legislative initiatives that provide for state flexibility. (Please see below).

BACKGROUND

With rare exception, Senator Leahy has been one of our most consistently loyal and supportive Democratic Members in the Senate. He, and particularly his staff, however, frequently feel that the White House pays an inordinate amount of attention to Senator Jeffords. They believe that Senator Jeffords (who is up next year) will have to be with us more often than not just to assure his political survival. More to the point, however, Senator Leahy appears to feel we take him for granted.

With regard to health care, **Senator Leahy has worked for over three years pushing the idea that states should be given the resources and flexibility they need to move ahead with comprehensive reform.** Last year, in the face of inaction at the federal level, **he and Senator Pryor introduced the Leahy-Pryor State Care bill.** The legislation called for federal waivers and start-up funds to give states the resources they need to move ahead with reform. **The bill was endorsed by you (during the campaign) and by the NGA.**

POLITICS

For years, Senator Leahy and Senator Jeffords (and Governor Dean) have been fighting for the public spotlight in Vermont on the health care issue. During the election last year, bad blood was shed between the two Members when Senator Jeffords ran a spot for the opponent of Senator Leahy.

The First Lady has held separate meetings with both Members and held an event (with Senator Leahy and Governor Dean) at a DGA conference. Senator Leahy is somewhat concerned that, if Senator Jeffords endorses your health reform proposal (and he may well do that), the White House will focus so much attention on Jeffords that Leahy will no longer be viewed as a serious health care player.

TALKING POINTS

- Senator Leahy, your message that there must be state flexibility in any health reform bill has been heard.
- I want to personally thank you for allowing us to call on your expertise in this area.
- The concepts and intent embodied in the Leahy State Care Bill have been drawn upon extensively in the Health Security Plan.
- I look forward to working with you and your Governor, Howard Dean, who is also strongly committed to this issue, in the upcoming weeks and months to ensure that we achieve our mutual goals of universal coverage and cost containment and security for all Americans.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Meeting with Senators Leahy and Pryor (2 pages)	6/14/93	P5
002. memo	Chris Jennings to Hillary Clinton Re: Conversation with Senator Pryor (1 page)	3/7/93	P5

COLLECTION:
Clinton Presidential Records
Domstic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] - Senator Pryor [1]

Gary Foulk

gf143

RESTRICTION CODES

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

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

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

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

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

M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Conversation with Senator Pryor
cc: Melanne, Ira Magaziner, Howard Paster, Steve Ricchetti

March 7, 1993

This afternoon, I had a very good conversation with David Pryor about the ongoing debate around health care and reconciliation and, of more immediate note, the Byrd waiver/budget resolution issue. The long and short of the discussion:

Senator Pryor believes that there are no downsides to the President requesting assistance from Senator Byrd. He feels an attempt should be made because he believes that we should not so easily give up at least the option of reducing the number of required votes for health care by nine. Senator Pryor believes a one-on-one meeting (or even a phone conversation) between the President and Senator Byrd has great potential to be fruitful.

To those who argue that there would be a political risk to asking and not receiving assistance, or asking and receiving, but owing a chit to Senator Byrd, Senator Pryor disagreed. He believes that there are no risks. First, even if Senator Byrd rejected the request, he would keep it confidential since he would love having been called on by the President in the first place; in other words, he would never embarass the President. Secondly, even if a chit was required, Senator Pryor believes that health care and the difficulties of passing it merit giving a favor away.

Perhaps most interesting, Senator Pryor feels that the Administration should not turn its back on an opportunity it might later regret not taking. (Senator Pryor has heard Senator Byrd say too many times that he might have done something different if one President or another had bothered to ask him).

Lastly, Senator Pryor said he would be willing to call the President to share his views on this matter if you thought it would be of assistance or of some relevance. (Although, in his usual self-depricating way, he said he did not think he was necessarily the one to do it).

Steve: I have subsequently heard that there are those who believe that Byrd would require a deal on the line item. I am sure that is true, and Sen. Pryor was not