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INITIALS: NT DATE: 8-31-05

**~~CONFIDENTIAL~~ MEMORANDUM**
**NOT FOR DISTRIBUTION**

To: Hillary Rodham Clinton

From: Chris J.

Date: May 26, 1994

Re: Today's Democratic Members' Finance Meeting

cc: Melanne

At 11:30 this morning, the Finance Committee Democrats started meeting in an attempt to come to closure on the employer mandate issue. They'll likely be discussing a number of options (including the HSA employer requirement). Senator Mitchell believes strongly that it is extremely important that Democrats on the committee come to closure on the employer mandate issue and believes that a significant compromise is necessary to achieve that end.

It is certain that Senator Moynihan, with the support of Senator Mitchell, will outline a proposal which provides for a triggered employer mandate for firms of 20 or less. (The outlines of this proposal is attached in the document entitled "Possible Mitchell-Breaux-Boren-Like Compromise")

Should there not be unanimous support behind this proposal--which Senator Mitchell believes is likely (he thinks it will be an 8 to 3 vote; Boren, Breaux & Conrad being the nay sayers)--the Majority Leader is seriously contemplating offering an alternative.

The alternative he is considering incorporates much of the latest Breaux trigger mechanism concept that the Louisiana Senator is circulating. (The specifics of the possible Mitchell alternative is attached in the second document provided entitled "Alternative Compromise Proposal").

The primary difference from the Breaux trigger is that it provides for an absolute guarantee of universal coverage proposal by requiring that anyone who is not covered by their employer requirement (if the trigger is not pulled) or if they are a non-worker must purchase insurance for themselves. (In so doing, however, it provides for some significant out-of-pocket cost protections.)

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: May 18, 1994

Re: Latest Developments on the Finance Committee

Attached are some of the most recent documents that the Finance Committee is working off of during their deliberation on health reform options. You will find a 3-page questionnaire, a 3-page side by side, a brief analyzation and comparison of insurance reforms included in the major Senate bills, and a 3-page outline of resolved and unresolved health care reform issues. The schedule of items for consideration during the markup is also attached.

As you know, later today Senator Mitchell will be meeting with the President. Attached is the memo that I prepared for Pat to give to the President. As you can tell, we've made some progress, yet it continues to be a great challenge with the Finance Committee.

Melanne and I have been talking about setting up meeting with Jack Lew and myself to bring you up to date on the latest congressional activities. We'll await your call on a convenient time for you. I'll talk to you soon.

cc: Melanne Verveer

THE WHITE HOUSE

WASHINGTON

**MEMORANDUM**

To: Hillary Rodham Clinton

From: Chris Jennings

Date: August 18, 1994

Re: Thank You/Pep Phone Calls to Senators

cc: Melanne Verveer

The following is a list of members who have been or who have great potential to be effective health reform advocates on the Senate floor. We believe that this would be an opportune time for you to call and lift up these members' spirits as well as to urge them to be the effective spokespersons they are.

We are dividing the Senators up into three groups. The first group have been on the floor repeatedly and have been effective to varying degrees in arguing the case for Senator Mitchell's bill. The second group of Senators have made one or two appearances. The third list are members who would be great additions to the floor debate, but have not (for a variety of reasons) made it to the floor much. The call lists are as follows:

| Floor Dwellers | One or Two Appearance(s) | | Rare/If Ever |
|---|---|---|---|
| Daschle | Baucus | Murray | Bingaman |
| Kennedy* | Boxer | Pryor* | Bumpers |
| Mitchell | Dodd* | Simon | Mikulski |
| Reid | Feingold | | Sarbanes |
| Riegle | Glenn* | | |
| Rockefeller | Graham | | |
| Wellstone | Harkin | | |
| Wofford* | Leahy | | |

We believe it would be very helpful for you to make these calls as soon as possible. I would appreciate to hear the feedback from your conversations. I have asked our Congressional working group to cut out each of the statements from the Democrats as well as the most critically effective speeches from the Republicans for your use. As soon as they are available, we will get them to you. If you want to discuss any of these individual members prior to your calling, Melanne, Steve R. or I would be happy to brief you. I believe it would be useful for you to receive an up-to-the-moment briefing sometime tomorrow. We can bring you up-to-date on "rump" group developments, floor activities and individual members' assessments.

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* Priority as per Steve Ricchetti (he plans to call to brief you regarding these members' statements during the DPC luncheon today).

## TALKING POINTS: GROUP 1 & GROUP 2

Thank you for all of the strong comments you made on the Senate floor. I think you have made excellent points. It seems to me that we are having a hard time breaking through to the media on all of our messages except for the one that suggests that the public should have access to the same type of health care as do the President, the First Lady, the Cabinet and members of Congress. And what it all comes down to is the right wing Republicans are against assuring this and want to delay or stop health reform in its tracks, while Democrats appear to be committed to the public achieving the reform they need and want.

What do you think of this message? How do you think the debate is going? Is there anything else the Administration can be doing to assist your efforts?

## TALKING POINTS: GROUP 3

I know how hectic things are on the Senate floor. I believe the Republicans are very good at repeatedly stating their message of big government and taxes--notwithstanding the fact that Senator Mitchell's bill are neither. I think we need to get members like you on the floor who are particularly credible with the media and the Senate as a whole. I believe our strongest message is that the public should have access to the same type of health care as do the President, the First Lady, the Cabinet and members of Congress. I thought Senator Mitchell's statement yesterday was excellent in this regard [see attached].

What do you think of this message? How do you think the debate is going? Is there anything else the Administration can be doing to assist your efforts?

now in Congress. Improvements in health care are needed and desirable but I feel many of the plans include restrictions and mandates that are contrary to a good health care system and a free enterprise system that has made our country so successful and great.

I take the time to read these letters because these are the American people who are going to be impacted and affected by the decision that we make, sitting here inside the beltway, without talking with them, without having the opportunity to go out and speak with them. We are here making this decision that impacts them. They ought to be heard on the floor of the Senate. That is why I am taking the time.

Restrictions that would prevent you from choosing your choice of doctors is a horrible thought. Before I go to a doctor I check his dossier and I talk to people that know him. Let's face it, all doctors are not equal. Some are better than others. Not all ailments or illnesses fit into a standard mold. A doctor has to have a keen analytical or diagnostic ability to accurately identify, in a timely way, what is ailing a patient and what medication or treatment is best for that patient. It is not uncommon to change doctors when his or her prognosis does not render relief, or to get a second opinion before a serious medical or surgery procedure. Some doctors are more skilled than others and you want the doctor with the best track record and the one you can get along with.

These people are concerned. They are concerned. Let me put it even stronger—they are scared. They fear.

I am going to close with a quote from a gentleman who came to one of my 10 county meetings. We talked about health care, and he said to me, "Senator, I have known you more than 20 years. But let me tell you what bothers me. I am afraid of my Government. I am afraid of my Government. I don't want to be afraid of my Government. I want the Government to be afraid of me."

I yield the floor.

The PRESIDING OFFICER (Mrs. BOXER). The majority leader.

Mr. MITCHELL. Madam President, I want to address two subjects that were raised by the distinguished Senator from New Hampshire and several of our Republican colleagues with respect to the pending health care legislation. One involves the question of choice in health care. The other involves the role of Government in health care and the reaction of our colleagues to that.

The statement of the Senator from New Hampshire was filled with references to less Government involvement, no Government control, and fear of Government by Americans. That has, of course, become the dominant theme of the statements made by our Republican colleagues seeking to capitalize on a public sentiment of disillusionment with Government and even hostility to Government.

I would like to make two points with respect to that argument as it relates to this debate. First, it does not describe my bill. The statements are not correct as they relate to the bill which is pending before us. My bill does not provide for a Government-run health insurance system. It provides for a voluntary system of private health insurance. Indeed, in a significant respect, my bill is the opposite of what our colleagues are trying to portray it as. A large Government program is Medicaid, a Government program which provides health insurance to those Americans whose incomes are below the poverty line. Under my bill, that program would be virtually abolished and 25 million Americans who are now in one of the largest Government programs would be out of that Government program and would purchase their health insurance on the private market as do most other Americans.

It is simply inaccurate to characterize legislation which would virtually abolish one of the largest Government programs in existence and encourage and assist the people now in that program to purchase private health insurance, it is simply inaccurate to describe that as a Government-run program. It is not.

I recognize that our colleagues are having some success in this false portrayal. It is a pattern we have seen before. But success does not mean accuracy. We went through it just a year ago when we debated the President's economic plan, when the very same Senators now saying that this bill is a Government-run health insurance system said to the American people that the President's economic plan would raise everyone's taxes and was a tax on small businesses. They said it over and over again, it was reported by the press and, as a result, the American people believed it. Polls showed overwhelming majorities of Americans believed that their income tax rates would go up as a result of the President's tax plan, even though those statements were untrue and the beliefs were unfounded. It was an aggressive effort at misinformation which regrettably did succeed and, therefore, creates incentives for a similar campaign of misinformation now.

But I want to state clearly, so there can be no misunderstanding, the characterization is incorrect. My bill creates a voluntary system building on the current system of voluntary private insurance. It virtually abolishes one of the largest Government programs and takes 25 million Americans now in such a program and has them enter the private insurance market. So that is my first point. It is not a Government-run health insurance system.

But now my second point deals with the attitude of our colleagues toward Government insurance and Government health care and the vast gap between their rhetoric about it and what they do about it when it affects them and their families.

First, they say they are against Government health insurance and Government health care. Well, the largest Government health care system in the country, indeed the largest health care delivery system in the country, is the Veterans' Administration health care system. If they truly believed what they are saying here about Government health care systems, they would abolish the Veterans' Administration system. But, of course, they do not say that and they will not say that.

In fact, with respect to that Government health care system, their actions directly contradict their words. The very same Senators, our Republican colleagues who stand here and say, "We are against Government health care systems," when they go back to their home States, they go seek out the veterans and they run television ads promising the veterans that they will protect the veterans health care system, even though it is a Government-run health care system and it is the largest health care delivery system in the country. Their actions contradict their words.

The same is true with respect to Medicare. Medicare is a Government-run health insurance system, and nearly 40 million Americans, most of them elderly, participate in that system. And the Republican Senators who stand here and say they are against Government-run health insurance all support the Medicare system. They go back home and they seek out elderly citizens. They go visit senior citizens' centers and fall all over themselves in promising to their senior citizens that they will protect Medicare, and they run television ads seeking reelection, promising their senior citizens that they will protect Medicare, even though it is a Government-run insurance system. Their actions contradict their words.

The same is true with respect to Social Security, the largest of all Government programs, a Government-run system which includes health care by virtue of incorporating Medicare part A. Our Republican colleagues go back home and also seek out senior citizens and also run television ads promising to protect Social Security, which is a Government-run program.

So I hope the American people will not be fooled by the rhetoric they are hearing here today. And I hope the American people will also think about the irony of these Republican Senators getting up here day after day after day and denouncing Government health insurance and Government health care as bad for their constituents, even as they benefit from it themselves as individuals and their families. Every Member of this Senate participates in the Government-run health insurance system that is available to all Federal employees, and the Government pays 72 percent of the cost of that health insurance for these Republican Senators who are standing here telling their constituents that it is bad for the constituents even as they participate in it for themselves and their families.

You, American taxpayers, are paying through the Government 72 percent of the cost of health insurance in a Government-organized health insurance system for the very Republican Senators who are now telling you that you

should not want Government-run health insurance. And you are entitled to ask yourselves: If it is so bad for you, why is it so good for them and their families?

Has one of them stood up and said, "My constituents, Government health insurance is bad for you, and to prove how much I believe that statement, I'm going to voluntarily drop out of the Government insurance system, and I'm going to put my family in the same place where your family is"? Have you heard one say that yet? No, and you are not likely to.

I urge you to listen to the debate, and as these Republican Senators stand up and tell you, Mr. and Mrs. America, that Government health insurance is bad for you, ask yourself, "If it is so bad for me, how come it is so good for them and their families? And if they really believe it is bad for me, if that is what their conscience and conviction tells them, why do they not drop out of it for them and their families and put themselves in the same position I am, an average American who doesn't have access to that?"

That is just the insurance. Now let us talk about direct care. If one of these Republican Senators does not feel well, if he gets a headache, or stomach ache, he walks a few feet down the Capitol and he goes to the Office of the Capitol Physician, a Government employee. He is greeted by a clerk who is a Government employee, checked by a nurse who is a Government employee and then goes in to see the doctor who is a Government employee.

If Government health care is so bad, why do these Republican Senators insist on having it for themselves? And then if they get sick, if the doctor says, "You've got to go to the hospital," they go to the Bethesda Naval Hospital or the Walter Reed Army Hospital—Government hospitals.

Well, my gosh, ask yourself, Mr. and Mrs. America, if these Government facilities are so bad, why do these Republican Senators want to go there themselves? And it is not just Senators. President Reagan and President Bush were, in their capacities as President, the most powerful men in the world. They were independently wealthy, and they could have gone anywhere in the world when they got sick. And where did they go? Why, they went to these Government hospitals. And who can forget the photographs taken of them waving out the window to the public and the press in those Government hospitals. Why are you telling us that it is good enough for Presidents but it is not good enough for ordinary Americans?

Mr. and Mrs. America, leave aside politics. Leave aside health care. When a fellow walks up to you and says, "I've got something, and its good for me and my family, but you really don't want it for your family," you ask yourself: Who is he thinking about? You or him?

This debate has not been about health care reform. This debate has been about slogans. When the first Republican Senator stands up and says I believe so much in my conviction that Government health insurance is bad that I am going to withdraw myself and my family from the Government-organized health insurance system and I believe so much that Government health care is so bad that I am going to promise if I get sick never to talk to a Government doctor and, if I have to go to the hospital, never to go to a Government facility; when that happens, pay attention to what they say thereafter.

But until that happens, you can take what is being said as slogans, separated from the reality of daily lives. If they want it for their kids, if they insist on having it for their kids, if they will keep it for their kids, then why is it so bad for your kids?

I want to repeat what I said at the outset. My bill is not a Government health insurance system. It is not a Government health care system. It is the opposite. It is a private system, voluntary, in which people are encouraged to purchase private health insurance. And I have mentioned this debate about individuals and health insurance here only to make the point of the inconsistency of the arguments being made by our colleagues.

To summarize, they are all for the Veterans Administration, which is a Government health care system. They are all for Medicare, which is Government health insurance. They are all for Social Security, which is the largest Government program. Therefore, their statements here against Government participation simply do not ring true because they will not stand up and say they oppose those programs, they want to abolish them. And then their actions in placing themselves and their families in a Government-organized health insurance system and getting direct Government health care for themselves, even as they say to their constituents, "That is not good for you," I say be aware, on guard, listen carefully.

Now, just the other day one of our colleagues came out here and said, well, the insurance program we are under is not a Government program because although it is organized by the Federal Government and 72 percent of the cost is paid by the Federal Government, it is really a mechanism where private insurance plans can be made available to Federal employees.

Mr. President, the denial negates the original claim, because that is essentially what my plan would do. It would create a mechanism whereby employers would offer to their employees a minimum of three different types of private insurance plans, and employees would choose among them. There would be no requirement on the employer to pay for any part of the cost unless we did not reach 95 percent coverage by the year 2000, as I believe we will.

And so it is ironic that the explanation about the Government insurance plan effectively negates the original allegation about my plan being Government insurance in the first place. So our colleagues cannot have it both ways. If my plan is not Government health insurance, then their original argument falls. On the other hand, if the Government-organized, Federal employees program is Government health insurance, they are all participating in it, willingly, taking it for them and their families while they tell their constituents it is bad for them.

Madam President, I will have more to say on that subject. I now want to mention just briefly the subject of choice. The Senator from New Hampshire said if our plan is adopted, "Americans will lose their choice."

That statement is untrue, categorically untrue. There are two types of choice in health care. The first is in choice of health care plans. How much choice does the individual American have in selecting a health insurance plan? Right now, almost none. Most Americans are insured through employment. The employer negotiates a plan with the insurance company and presents it to the employee, and the only choice the employee has is to accept or reject that plan, to either participate in it or not to participate in it.

Under my plan, the individual employee will be offered a minimum of three different plans. They will have the same standard benefits package, but they will deliver care in three different ways: either in the form of traditional fee-for-service, or a health maintenance organization, or in some other form. So in the first dimension of choice, that of health plans, my bill will dramatically expand choice for almost all Americans. For the first time, individual Americans will be able to choose from more than one health plan.

Second, the element of choice in physician or other providers. It is simply not true that choice will be denied under my plan. Since everyone will be offered at least three types of plans, one of which must be traditional fee-for-service, every American will have the opportunity to continue to have the fullest freedom of choice with respect to physicians. No one will be denied that opportunity.

Interestingly enough, the current trend in the country is in the other direction. As costs of health care rise, employers are increasingly turning to managed plans, HMO-type plans in which the individual's choice is limited. So if we do not adopt health care reform, more and more Americans will be denied choice in provider. So you have a reduction of choice in the one area where it now exists and continuing lack of choice with respect to health plans.

So I think it is important that Americans understand that my bill will do the opposite of what our colleagues have alleged. It will greatly increase choice in health plans and it will preserve fully choice of providers. Anyone will still be able to see any doctor they want, choose anyone they want to see in nurses or any other form of provider.

I hope that we all understand that.

Finally, the statement was made, "Don't throw out the entire system," thereby creating the implication, since the remarks were on my bill, that my bill does throw out the entire system. Madam President, it does not. It builds on the current system. It says that most Americans now receive their insurance through employment, and we should continue that. We should encourage those who do not have insurance to get it. And what we ought to do is to try to increase the number of Americans who have health insurance through a voluntary system of guaranteed private health insurance.

Now, what my bill does do is to provide health security for the 85 percent of Americans who now have health insurance but do not have health security.

Right now many of them face the incredible situation where their health insurance could be canceled if they become sick. Think about that. A person buys health insurance to protect himself in case he becomes sick, and then when he becomes sick the policy is cancelled. My bill will prevent that from occurring. It will prohibit that from occurring.

Second, right now, a person can be denied health insurance on the basis of a preexisting condition, something that affects millions of Americans. My bill will prohibit denying on the basis of preexisting condition. By contrast, the Republican bill would permit that to continue on an ongoing basis. My bill will phase out the preexisting condition exclusion completely by a time certain in sharp contrast to the Republican bill which permits the denial for preexisting condition to continue.

My bill will make it possible for a person to change jobs without the fear of losing his or her insurance. That is a real problem today. My bill will make it possible for people who are between jobs, temporarily unemployed, to continue with insurance. The insurance will be private, it will be guaranteed, it will be renewable, and it will not be able to be canceled. I think that is what Americans want who have health insurance. Yes. They are happy to have health insurance. But many of them are concerned about their lack of security, the fact that they do not know for sure whether it is going to be canceled tomorrow, whether the premiums are going to be doubled, or whether it will cover what they want when they become sick.

So, Madam President, I emphasize that my plan will increase choice. It will prohibit current insurance practices which leave Americans who have insurance insecure, and it will encourage those who do not have insurance to get it. It will abolish one of the largest Government programs that have those people enter the private insurance market. It is a voluntary system. And I ask Americans to keep that mind as they listen to the debate.

Madam President, I yield the floor.

Mr. HATFIELD addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. HATFIELD. Madam President, I would like to comment briefly on the majority leader's remarks, at least a few of them.

I think that it is the duty of the leader, as the majority leader or as the minority leader, to represent a party position or a political perspective. I admire both Senator MITCHELL and Senator DOLE for their able and professional way of carrying out those duties.

But I also think that the American people are alert enough and wise enough to know that the leadership of the U.S. Senate on either side of the aisle cannot easily categorize, as the majority leader has today, the Republicans all in one position and the Democrats all in another position. That is just an inaccurate portrayal of this issue, and the things that divide us on this issue.

I happen to be participating with what we call the mainstream coalition. These are at least nine Democrats who are not happy with the Mitchell bill. These are at least 9 or 10 Republicans who are not happy with the Dole-Packwood bill. But nevertheless, they are trying to seek to join together in a bipartisan effort to create a piece of legislation to lead us to wise, effective, economical health reform.

So I just want to clarify the record on that point, that my leader, Senator DOLE, as much as Senator MITCHELL's contingent of Democrats, are not easily divided as has been portrayed this afternoon.

Second, I would like to indicate just for clarification that somehow we have a coverage that is a Government operation, our own medical coverage. I would like to clarify that record to say that Blue Cross-Blue Shield is one of the many contractors with the Federal Government. I gain my health care from Blue Cross-Blue Shield where the Federal Government is in contract the plan, and like many private industries, pays a portion of our health care premiums. Portraying that somehow the Members of the Congress, in particular Republican Members, are getting this great benefit out of the Government operation, as we have heard today, is just not accurate. So I want to clarify the record on that point.

I might also say we have thresholds, or we have deductibles. We have copayments. And yes we may go to see the Capitol physician but we pay a premium. I pay a fee for that kind of service. So this is not some broad-based freebie as that is being portrayed here today.

Madam President, the Senate has embarked on a very historic debate, and health care is probably one of the most important social issues that I think we will probably debate this entire century. During the last several months, we have heard a lot about the need for health security, that health care is a right that can never be taken away. I subscribe to that. And we have all heard the tragic stories of those who have fallen between the cracks in our health care system and have faced huge financial losses when faced with a health crisis. We have heard about the uninsured, and the cost shifting that occurs as between those of us who are insured to those who are uninsured who seek their health care services in hospital emergency rooms.

There is no doubt that our current health care system is not meeting the needs of a large segment of our country. We all share a commitment to achieve the finest health care delivery system possible in the United States to be extended to all in the United States. That is the purpose of this debate.

I would like to take the perspective as an appropriator. Let me use the old jingle that is often used, that authorizations—and that is what both the Mitchell bill and the Dole-Packwood bills represent, authorizations—are but a hunting license for an appropriation. We on the appropriations committees have found that there has been much action to authorize many programs in this century by the U.S. Congress, and then somehow it ends up in our lap to try to find the money for it. It is awfully easy to make promises. It is awfully easy to paint great broad brushes of new credits or new entitlements or new subsidies or new coverage. But someone at some point has to provide the money.

Let me say also that having been involved in Government for a few years, I am not willing to put my entire expectation and hope and trust on some kind of prospective savings. We have been through many of these experiences in the past. Under President Franklin Roosevelt, we had the Browley Commission; under President Truman we had the Hoover Commission I; and, under President Eisenhower, Hoover Commission II, studying the reorganization of the executive branch of Government and projecting the savings that could be achieved out of those reorganization proposals.

The first year out we found there were some savings that could be directly attributed to those reorganization efforts. But as time went on in the outyears, those savings disappeared pretty quickly.

So to undertake a program that is so heavily dependent upon prospective savings of changes and so forth, I am a little bit dubious. I am not saying we have not achieved some, of course, but to say that we are going to fund a portion of this health care program under

THE WHITE HOUSE

WASHINGTON

# MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: November 9, 1994

Re: Presentation to Principals

cc: Melanne Verveer

Attached is a packet of materials in preparation for tomorrow's meeting. Obviously these documents, particularly the financing documents, are extremely sensitive. The talking points include a list of political/strategic questions that hopefully will help form the policy option discussion. These questions will be read aloud by Carol, Bob, or myself, but will not be printed and distributed to the participants. The documents to follow include:

- NEC/DPC Talking Points
- **Outline of Strategic Questions**
- **Ten Year OMB & CBO Deficit Table** (which illustrates how little deficit reduction you obtain in the first 5 years if you have only Medicare "extenders" to draw from.)
- **Coverage Options and their Costs**
- **Previously Proposed Sources of Funding**

We will have clean documents for tomorrow's meeting. If you have any questions or concerns about this meeting, please do not hesitate to call me.

* Documents in bold will be distributed to meeting participants.

**MEMORANDUM**

To: Hillary Rodham Clinton

From: Chris Jennings

Date: October 20, 1994

Re: Update on Health Care Working Group

cc: Melanne Verveer

First of all, I want to thank you for all of the support that you have given me since I have been here. I particularly appreciate your recent support of me when the subject of a coordinator for Bob and Carol came up. There is no question that the new roll will be a tremendous challenge. As of today, however, I am pleased to report that it seems to be working quite well.

I intend to keep you up-to-date, giving you periodic reports on our progress in producing policy options. Also, I will keep you apprised of success or lack thereof in keeping all parties feeling and being integrally involved in the development of the options, as well as the degree to which they are feeling positive about our process.

Yesterday, we had a very constructive meeting with the NEC/DPC health policy working group. I prepared the attached talking points for Bob's and Carol's use, and I made the presentation of the specific issues the group will be initially focusing on for the purposes of the policy choice discussions we will have after the elections.

We will be preparing background information for you and the rest of the NEC/DPC group on each of the issues outlined in section IV of the attached. With only minor modifications, the working group has approved of the six issues. I am quite happy to go into more detail with you regarding the six core issues. As information is produced, I will forward it on to you and Melanne.

If you have any questions, please do not hesitate to call me. If you and Melanne would like to schedule periodic meetings with Carol, Bob, and/or myself at any time, I would be most happy to arrange them.

p.s. Melanne asked that the attached transcripts from Donna Shalala's interview and today's AP story on it be forwarded over to you. I am also enclosing the Q&A's that Laurie and I worked on for prep before the President's press conference.

# AGENDA AND TALKING POINTS FOR 11/19 NEC/DPC MEETING

I. Welcome, Update on Process, Appreciation for Assistance

II. Definition of Structure of Roles and Responsibilities for Staff

III. Outline Tight Timeframe

IV. Discussion of Specific Issues Within Workplan -- Turn to Chris

(1) Coverage options

(2) Insurance reform options

(3) State flexibility options

(4) Cost containment options

(5) Financing options

(6) Regulatory options
* Second tier non-core issues

V. (RETURN TO CAROL AND/OR BOB) Outline Need for Intense and Quiet Staff Work on Background Information, Policy Options, and Quantitative (numbers-run) Analysis

VI. Reiterate Sensitivity of Any Leaks About this Work Getting Out

VII. Will Keep In Touch, Thank You, Closure of Meeting

# AGENDA AND TALKING POINTS FOR 11/19 NEC/DPC MEETING

## I. Welcome, Update on Process, Appreciation for Assistance

- Will be a very open process where all views/approaches/alternatives are aired

- Pleased with early cooperation, assistance, and advice. We feel it has been and will continue to be constructive. (Cite, for example, Alice's memo and perhaps Donna's further elaboration of President's, HRC's, Leon's, and your feeling that proposals be viewed in context of laying foundation for achieving President's eventual goal.)

- Appreciation of principals' dedication of senior staff resources to help with this effort. Their and your (the principals') involvement has already been immeasurably helpful (in terms of helping structure issues and background information that should receive priority consideration.). Such help will be requested and needed throughout the process. (Detailed discussion re this to follow).

- Assuming approval of an "issues to be analyzed" workplan, which Chris will outline in a moment, we should be getting first-cut information on some of these issues beginning as early as next Monday.

## II. Definition of Structure of Roles and Responsibilities for Staff

- Role of Chris as defined and implemented with regard to Bob and Carol, and discussion of how you want him to interact with the Departments, as well as OMB, CEA, etc.

- Role of Jennifer Klein -- analogous to Sylvia and Jeremy, i.e., is empowered to facilitate and direct policy work in a manner consistent with desires and discussions of you, the principals', and Chris. Further clarification of anyone else's role that you (Carol or Bob) feels is necessary/advisable.

- As we've stated previously, Bill and Gene will play an integral roll in helping Chris and us focus on health policy issues within the context of the budget and other domestic policy priorities. They will also participate in and contribute to all discussions regarding health care policy options -- both in terms of the substance and the process of developing these options. We and or Chris will keep you apprised of other staff roles on this subject.

## III. Outline Tight Timeframe

- Very little time left before significant policy/political meetings take place immediately after the election. (Perhaps outline other high priority scheduling/policy conflicts?)

- Hope to have package options outlined for first perusal for this group, with input and political/strategic direction from Pat, George and others on or about November 10th. (Obviously, no final decisions or recommendations will be made at this time, but will help set the stage on what and how recommendations are made/presented.)

- As a result, we may want to have further discussions to determine how we want some of these options layed out before such a meeting takes place. If we think this is advisable, we think that we should tentatively target November 7th for such a discussion to take place. Because of the sensitivity to the political timeframe, we do not plan on circulating paper at this time. However, it does seem advisable to get direction, particularly with regard to presentation of options, from this group before the larger group meets.

- In any event, after the November 10th meeting, we will need to move quickly in a tight calendar before and immediately after Thanksgiving to make any policy option presentations that, in particular, have any impact with regard to ongoing budget priority discussions.

## IV. Discussion of Specific Issues Within Workplan -- Turn to Chris

- Keep in mind that all options, ranging from staking out no position to strongly advocating the same or another comprehensive reform approach, are still on the table. The discussion that follows assumes this fact, but concentrates on the interim steps that we were asked to pay particular attention to at this time.

  The issues that we have selected for your consideration have been chosen because they can be, if done properly, used to create a solid foundation on which to move towards the President's goal of universal coverage and cost containment. Obviously, the final choice that we make in regard to what if any issue we choose to pursue will depend heavily on the President's eventual choices on his budget and policy priorities after the election. The six issues that seem to best capture what principals' senior staff believe are important for consideration by you are:

  - coverage
  - insurance reform
  - state flexibility
  - cost containment
  - financing
  - regulatory options

- Obviously, there are many other high priority issues that all the departments would like to explore. By not listing them here, we are in no way suggesting that other issues should not be considered, but we do believe they should be considered outside the context of these core issues. (For example, we are aware that HHS has a Medicare reform initiative now being reviewed).

- Without going into great detail, I'd like to discuss what type of issues we would consider under each of these six issue headings and how we are now thinking about structuring them. Jen and I, speaking for Bob and Carol, would like to invite you to add, subtract, modify, or clarify this list. (Ask to not be interrupted until end.)

**(1) Coverage options**

- A wide variety of coverage options should be considered, including:
  - low income families
  - kids only
  - welfare to work populations
  - in-between job (unemployment) protections
  - elderly (likely only consider if Medicare cuts high)
  - combinations, different benefit package assumptions and zero option, etc.
- To make it user friendly to the numbers-driven world we work in, structure options to illustrate how much coverage you can buy for different dollar amounts.
- Options considered will include an examination of feasibility, advisability and cost of different administrative options for each subsidy scheme. As such, the relationship between coverage and the appropriate Medicaid role will be carefully explored.
- In order to get these options scored, we must immediately move to get them modeled and sent through OMB, HHS and their actuaries, and others to get the type of cost estimated package options that you will want to have. We are planning to have a staff meeting for a first cut review on these models tomorrow. All models would be subject to sign-off by the principals.

**(2) Insurance reform options:**

- Benefits and risks of alternative insurance reform in a non-universal coverage market.
- Graduated (from minimal to major) insurance reform options and implications and trâdeoffs in each alternative. (For example, the more subsidies you provide from above options may require much more significant insurance reform to guard against adverse selection.) Background information on this issue is being prepared for your staff to review on Friday.

**(3) State flexibility options:**

- Options for providing incentives or removing potential barriers to state-based reform efforts. We plan on looking at Medicaid and ERISA waiver options for group consideration.

- Obviously because of strong opinions on these issues, particularly with regard to ERISA, this needs to be done in context of both policy and political (competing priorities of business, labor and states) feasibility, as well as it must be understood that any such option enhances, rather than detracts from, the likelihood of national comprehensive reforms.

- All three Departments have an essential role to play on this issue and Jen and I, along with Kathy Way of Carol's staff, will watch this very closely.

**(4) Cost containment options:**

- Private sector options must reviewed in detail. (CJ will discuss orally all issues, including market reforms that could also involve an analysis of medical savings accounts, commission options, and various tax cap alternatives).

- Public sector options will be reviewed. (Medicare and Medicaid savings, as well as any savings emerging from proposals from HHS dealing with standardization of forms and fraud and abuse).

**(5) Financing options:**

- Linkage to public cost containment is very closely associated with financing.

- Review of alternatives already proposed is underway. Revenue options will, of course, be done by Treasury.

**(6) Regulatory options:**

- Many Departments have regulatory reviews underway with expressed purpose of developing initiatives that can be helpful to health reform legislative and/or policy goals. I am advised that the Departments of Labor and HHS have these reviews well underway. Options need to be reviewed.

  There are also important second tier non-core issues. Many of these issues are being represented by departments in this room and elsewhere. The fact that these issues are not listed in no way connotes that they are unimportant, but the NEC/DPC working group concluded that we should try to limit our current analysis to a number of structural core reform options.

Lastly, in an attempt to provide a sense of where Congress ended up on the many health reform bills, we are in the process of developing a side-by-side to compare notable health care reform initiatives by both Republicans and Democrats. We hope that this will be useful.

**V. (RETURN TO CAROL AND/OR BOB) Outline Need for Intense and Quiet Staff Work on Background Information, Policy Options, and Quantitative (numbers-run) Analysis**

- In order for us to get this information prepared and circulated amongst ourselves for consideration and discussion in a timely manner, the staff work will need to get it done quickly and quietly. This is particularly the case with regard to any options relating to numbers/cost-revenue issues.

- Chris will be consulting you throughout this process to make certain that you are comfortable with how this is being done and who is doing it. But it must get done soon.

- On some fronts we can move quickly and build on the information base we have either through our own work or those of the alternatives that have been outlined in the Congress. However, there most definitely will be exceptions to this that will entail new and detailed work, analysis and consideration. The targeting and administration of subsidies and the advisability and feasibility of providing for state flexibility in a non-universal coverage proposal serve as two particularly good examples.

**VI. Reiterate Sensitivity of Any Leaks About this Work Getting Out**

- At the risk of beating a dead horse, we must continue to reiterate the importance of holding this information close. If any of these options get out into press or onto the Hill prior to early consultation, we have major problems that could undermine the whole process -- even if a leak occurs after the election.

**VII. Will Keep In Touch, Thank You, Closure of Meeting**

- As new information on substance or scheduling becomes available, we will be in touch. Thank you all again for all your help and cooperation. I think we are off to a great start.

**Health Care Qs and As - October 20, 1994**

Q. **Is the new health care process a recognition that the Task Force was a failure?**

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

Q. **Secretary Shalala said yesterday that you will be presenting recommendations to Congress on health care reform and that these recommendations will be part of your budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?**

A. I have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible it won't.

Q. **So, Secretary Shalala misspoke yesterday?**

A. Secretary Shalala was speculating on possible options. Again, no decisions have been reached. In fact, I have not even discussed options yet. Secretary Shalala herself said that decisions have not been made.

Q. **Secretary Shalala also said that obvious revenue sources will be cuts in Medicare and a tobacco tax. Are these your options that you are considering given that they were in your original plan?**

A. Let me first say that this Administration will not slash Medicare. In my original proposal, we took the Medicare savings and used them to provide benefits to older Americans. We - like every bill that came out of Committee - had a tobacco tax. Again, however, no decisions on any financing options for any proposal has even been discussed let alone decided.

Q. **Secretary Shalala indicated that you would be producing a scaled back health care plan. Does this mean that you will give up on your goal of universal coverage?**

A. Throughout this debate on health care reform, I have repeatedly stated that covering every American and controlling escalating health care costs should be our goals. My commitment to this mission has not changed. I still believe that every American deserves health care coverage. Every month that we don't act to reform our system, 100,000 more Americans will lose their insurance. And, if we want to ensure that the deficit that we have worked so hard to contain does not balloon again over time, we need to address rising health care costs. Americans will spend $982 billion on health care services in 1994 - nearly 14 percent of our gross domestic product. If this trend continues, we will spend $2.1 trillion on health care in 2001 - 20% of our GDP.

There are obviously decisions that need to be made on how to proceed on health care reform. The one thing that is sure is that we are serious about continuing our fight for reform.

Q. **Will you veto a bill that does not achieve universal coverage?**

A. I still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. The latest NYT/CBS News poll (September 8-11) stated that nearly 70% of the public believes that every American deserves health care coverage. We must continue to work toward achieving what the American people want and deserve.

Q. **Secretary Shalala said that you have not decided if you will call for an employer mandate next year. You have repeatedly stated that an employer mandate is the best way to provide coverage for every American. Are you backing away from requiring employers to share in their employees health care costs?**

A. I still believe that shared responsibility, which builds on the current system where nine out of ten Americans get private insurance through the workplace, is the best way to ensure that all Americans have health coverage. As I have repeatedly said I am open to any kind of new idea.

Q. **Is the new health care process a recognition that the Task Force was a failure?**

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

Date: 10/20/94 Time: 16:58

Shalala: Government to Scale Back Health Care Reform Plans in 1995

WASHINGTON (AP) The Clinton administration, chastened by public opposition to its sweeping health reforms, will try a more modest and ''shrewder'' approach next year, Health Secretary Donna E. Shalala said Thursday.

Shalala said Americans feared that President Clinton's original plan would have ushered in a government-run health system.

''Whatever we propose in the future, it seems to me, cannot have that handicap,'' she told health reporters.

''We're going to try to be shrewder and more strategic about what things need to be done first,'' said Shalala, who took a back seat to Hillary Rodham Clinton and White House aide Ira Magaziner in framing the original, 1,342-page Clinton health care proposal.

Next time, the administration likely will recommend health changes as part of the regulatory budgetary process, with the president making key decisions by mid-December on what changes to seek in 1995, Shalala said.

''The question is: How much of this are you going to bite off?'' said Shalala.

''We are still enthusiastic about going back in and fighting the good fight on health care reform,'' said the secretary of health and human services.

''You get another kick at the cat and hopefully we've learned some things over the last couple of years,'' Shalala said. ''We'll try to refine our strategy this time around.''

She said the president won't abandon his goals of expanding health coverage and containing medical costs.

''We have to lay out for the president some options that will get where he wants to get, but not necessarily with the same road map that we used before,'' Shalala said.

''People in the United States told us ... they were very gun shy over taking on the whole system, every aspect of it'' in health reform, she said. ''They would like it to be in stages and see what the implications are of each piece as we move along.''

The Clinton proposal would have guaranteed health care for all by forcing every employer and individual to buy coverage starting in 1998, steering most Americans into huge, new insurance-purchasing pools, and imposing standby controls on premiums.

Democrats and Republicans alike picked apart Clinton's plan and eventually killed health reform entirely for this year.

Shalala said jawboning may have persuaded physicians, hospitals, drug companies and other providers to hold down increases, but medical prices are still rising twice as fast as inflation, and working Americans are still losing their health coverage.

''The problems are still out there,'' said Shalala.

Clinton has not decided yet whether to try again for an employer mandate, she said, ''but I think the public has spoken out on that issue and we have to take their views into account.''

''The public was against a government-run health care plan'' and ''they interpreted employer mandates as the government imposing a point of view on how the whole system should be financed,'' she said.

Other options for expanding coverage include ''using cigarette tax money and anything else you can scare up to extend the Medicaid program'' to the working poor, she said.

Already passed is a law expanding Medicaid to cover all children in poverty by 2002, she noted, adding, ''One possibility is to accelerate that.''

Instead of a socialized health care system, she said, the government could regulate the health insurance market the way the Securities and Exchange Commission oversees financial markets.

Shalala said she has found in her travels around the country ''a very anti-government feeling that government can't get anything right.''

It applied to government at all levels and was based on people's real experiences, not ''something that some (radio) talk show host had fed,'' she said.

''With all of our good intentions, we walked right into that with health care reform,'' she said.

APNP-10-20-94 1658EDT

Notes from Secretary Shalala's Oct. 20 meeting with the Health Communicators' Breakfast.

[Discussion of charts]

The problems are still out there. The Clinton Administration will have to come back. Time ran out; someone rang the bell. We will pick up the momentum again.

Q: What format?

A: We're thinking through our strategy on the budget, welfare reform, health care reform. We get another kick at the cat. Hopefully we learned some things in the last 2 years that will enable us to refine our strategy.

Q: What have you learned?

A: Public clearly told us the idea of taking on every piece of the system makes them very nervous. A big target creates problems. It's the same as with the Republican contract, it creates a lot of negatives. We need to decide what needs to be done first. We haven't decided which. The public perceived it as too much and sent us a message that they want reform but they want it in stages.

Q: Reconciliation?

A: Something will have to be done with the budget. The President will submit proposals on Medicare, Medicaid, welfare, etc. This will not just be a discretionary budget. It is a natural vehicle, it has discipline in terms of time frames. The budget will look at entitlements. The Entitlement Commission will demand that.

Q: Insurance reforms?

A: Got to think about how to do it without disrupting the system.

Q: Are you saying costs are your focus not coverage?

A: Both. We will emphasize both. We can't do welfare reform without expanding coverage for welfare recipients and working people. They need cost containment as much as anyone.

Q: Reconciliation could take financing away?

A: We haven't made those decisions yet. Deficit reduction is a priority but we also want to get going on health care reform.

Q: Question still is how do you pay for it?

A: There are no tricks here. There are two obvious sources of revenue: Medicare savings and cigarette taxes. They are on everyone's list. No reason to believe we won't go back. I don't kid myself that the politics of the moment on Medicare may change.

The question is what size of cuts will be proposed.

Q: Medicare pays less than costs now?

A: Have to talk about both private sector and public sector costs. No way to back away from that discussion. What's government's contribution to helping private sector get more disciplined. Not a top down discussion of what government can do to the private sector to change behavior. We have a full-blown health care system, not like 30 years ago when we created Medicare and Medicaid. The private sector wants help. They don't want to pick up the costs of the uninsured.

Q: Elements of reform?

A: There's no new analysis being done here. The question is how much you bite off. Our attitude is to find our appropriate role in costs and coverage.

Q: Employer mandate?

A: Still a stumbling block. Options include expanding Medicaid to cover the working poor. Congress already passed legislation for kids and it's being phased in over a long period of time. The Kids First proposal would accelerate that. Another option is to create large pools. Like the SEC, get the market straight and enforce rules.

Q: Employer mandate?

A: President hasn't made a decision on that. The public has spoken and we will take that discussion into account in providing options for the President. Perhaps we can get where we want to go but take a different road. The public viewed the mandate as a proxy for a government run system. Perception was the President's plan was a government-run system. I would argue that it wasn't but taking on every aspect of the system fed that. We should do things that would be helpful. Resources are more limited now than when we started.

Q: Universal coverage? Comprehensive reform?

A: Comprehensive reform can be taking strong steps in the right direction. We're not going to drop our overall goals. A way for everyone to get good insurance; strengthen the private system. Huge plans are difficult to get through Congress. Need a vision of where you want to go. The health care system is different than two years ago.

Q: Moynihan's opinion?

A: We'll talk to him after the election about his insights on health care and welfare reform. Moynihan always had large goals and moved toward them.

Q: Long term care?

A: States want to do more experimentation. Point of reform is you can't leave state experimentation out. Have to look at states' role.

Q: Would California need a waiver if it passes single payer?

A: Probably. We'd have to see what they ask for; it has to be budget neutral. I make it a habit not to talk about waiver requests, particularly those that haven't been made.

Q: Have you been campaigning?

A: Doing a lot of campaigning. Minimum of 2 days a week and all of next week. About 10 states: NY, IA, CA, WA, TX, MA. I'm finding the same thing I did during health care reform. A very anti-government feeling. A feeling that the government can't get anything right. It's consistent. Not just with Washington but with politicians in general, bureaucrats, state and local officials. It's a challenge. It's pretty rigid. So much so that most people think that Social Security is a private system.

I also hear that most people have had negative experiences with government. This may be reinforced by talk show hosts but they're not shaping public opinion. We walked into that with health care reform.

Q: Same with welfare reform?

A: No. That's seen as reducing the amount of government involvement in people's lives. Instead of health care reform that never leaves you it's a transitional program.

Q: Medicare underpays?

A. Vladeck is working on a Medicare strategy. Some things to make it more efficient. Some new approaches. A major integrity effort to combat waste, fraud, and abuse.

Q: Isn't most waste overutilization?

A: Not only. We have to make sure the system is not being ripped off.

Q: Individuals can't report overcharges?

A: No excuses about not doing something about that. Make it a priority for carriers. OIG is underfunded because of discretionary caps.

Medicare underpaying is an interesting argument. We're accused of underpaying and they're accused of overutilization. Everybody's making money.

Q: More managed care under Medicare?

A: Want to offer a wider range. Have to work on pricing. We clearly would like a lot more flexibility.

Q: Don't HMOs shift costs to fee for service?

A: You can cost shift only as long as someone is willing to pay the bill. There is tremendous cost shifting going on in the system. Employers are shifting costs to their employees and shifting people to managed care. Some of those costs are being shoved back and some efficiencies are resulting. Question is are we getting quality under managed care. Just starting to get information on that.

Q: Underutilization?

Data is so fragmented we can't answer that. Governors are desperate to slow costs; employers too. Trying to stabilize costs. HMOs are leaning on drug companies for price discounts. With all this going on, are people getting better care or as good care? We have a generation used to fee for service and one used to managed care.

Q: What do you mean by "ran out of time?"

The mainstream bill was out there. It was different but it had elements. I think Congress would have passed something if they didn't run out of time. Not because they lacked interest. Not because they ran into a brick wall of opposition.

Q: On quality, won't the government be interfering in medicine?

A: Information and choices. Quality comes from a competitive system with consumer information.

Q: Budget vehicle?

A: Have to identify financing. Go through the same committees. Timing. Tradeoffs within the budget.

Q: Will the President present a plan this year?

A: Yes, he will present a plan.

Q: What if Republicans control the Senate?

A: I'm not even thinking about it. I'm working like mad to make sure of it.

Q: Are providers driving up costs?

A: Not necessarily because they're evil. They want to do everything for their patients. People demand the very best of care

and they push the professionals. A culture of health care in this country to push to the maximum. We're all paying the bill.

Q: White House staffing changes? Ira?

A: Most of the analytical work has been done. The question is picking among the basic elements. Financial and political choices. We're having a collegial discussion of the strategy. Ira is very much part of that discussion. Chris Jennings is on my payroll and he's coordinating this. Most of the work has been done. We need a financial and a political strategy. How much to bite off with as much public support and bipartisan support. More of a strategic discussion.

Q: Why December?

A: That's when the President makes his decisions on the budget.

Q: Medicare spending?

A: The increases may be a little lower than expected. That's not new. It will reduce the deficit a bit but it limits our options on financing.

Q: Bipartisan?

A: Particularly in the Senate. Process is important. It sets tone and attitudes. President will talk to the leadership after the elections. Senator Dole says he wants to do health care reform next year. President will talk to the leaders about the agenda.

Q: Will GOP by willing to bargain?

A: It's realistic to assume that no member of Congress is asking to be elected to do nothing -- except the Congressman from California who's running for the Senate. The public wants something done. They've told us what they don't want now we need to make a case for what needs to be done. Our goals remain the same: costs, quality, coverage. We want to nudge the system along, not run it. People out there without insurance are Democrats and Republicans.

Q: Will the President use his veto pen?

A: President will speak for himself.

Q: Deficit reduction?

A: Going to be a debate within the Administration on that. President is committed to expanding coverage and it will cost money. No new tricks out there.

Q: GOP contract?

A political exercise. Same problem as Health care reform. Negative coalitions. Hit from every direction. Not a major vision of COP view for the future. A package of ideas for the election.

Q: Vaccines for children a success?

A: Small piece of an overall effort. Infrastructure expansion, clinic hours, education, outreach, physician involvement. VFC is an attempt to give kids without coverage access. Part of a larger strategy. Had hoped to sign all contracts by Oct. 1, Price contracts were done; delivery contracts weren't. I apologize for that. As soon as the delivery contracts are signed, we will get this system going. We're going to get it done a few months late.

Drug companies are happy they will get to deliver the vaccines. They have ongoing relationships with the doctors they want to protect.

Q: Drug companies say they get 50% of their costs?

A: Ask them: What are their costs? What do they charge in Canada? We don't know. We ought to pay a fair price and it should be negotiated. If they say the price is too low, they have to provide the data to Congress. Last thing I want to do is put an industry out of business. Lay out their case, the facts. I believe drug companies have the same goals we have. They want to make a decent income. We have to look at the overall program and two years from now look at the results. We need a system that automatically vaccinates each generation of kids.

Q: First Lady's profile?

A: I don't give her advice on her profile. I'm a fan and a friend.

Q: If FDA says tobacco a drug, how pay for health care?

A: I'd be ecstatic if less people smoked, particularly young people. We'd save a lot of money. Pricing of cigarettes is a piece of that.

Q: Health care on campaign?

A: Yes, because it's me. They ask me about health care, welfare, Head Start, Social Security. I don't get a lot of questions about GATT or NAFTA.

Q: What are you hearing?

A: Don't want the government to run health care. Horror stories of what the system is doing to people. Tell the President to keep going. The test of this Administration is how much we learned in the first two years. We learned a lot.

Q: Prescription drugs for the elderly?

A: Haven't heard about it too much. Hear more about long term care and flexibility.

Q: Doesn't LTC alternative cost more?

A: Issue is quality of life. My mother used to take me to nursing homes to visit some of her clients. I've seen institutional care. The key is making people's lives better.

Q: Rumors of your leaving?

A: I'm not leaving.

Q: Problems with Social Security transition?

A: No. Very smooth. No administrative problems.

# Preface to *Health Care Choices for Today's Consumer*

## by Hillary Rodham Clinton

During the past two years, Americans from all walks of life have begun a historic dialogue about our aspirations for this nation's health-care system. In town meetings across the country, at senior centers, at medical schools, in business board rooms and union halls, and across kitchen tables, we are discussing the strengths and weaknesses of our health system -- and what we should do to make it more responsive to the needs of our families.

As I travel from one community to another, I hear the voices of hope and fear about health care in America. With eloquence, compassion and thoughtfulness, people speak about health care with an intimacy perhaps unlike any other issue. No issue appears to touch the concerns that we have about the well-being of our parents, our children, our families and ourselves more deeply than health care. This publication taps this concern and channels it in a constructive way by providing consumers valuable information they can use in making decisions.

As we all continue to push for needed health reform, we also have to assume greater responsibility for our own personal well-being. You can and should participate in the major decisions affecting your family's health. Your own actions will make a critical difference in the kind and quality of care you receive, as well as the bills you will pay. But, to act effectively, you need user-friendly consumer-oriented advice.

You may not agree with all of the advice here, but I think you will find it to be a helpful resource. As wiser health consumers, we can make better decisions about the health care we seek, and from whom we should seek it. When we confront choices about family doctors, specialists, dentists, insurance companies, managed care plans, hospitals, and mental health needs, we should be empowered with information to make effective and affordable decisions.

That is the purpose of this book. *Health Care Choices for Today's Consumer* is a comprehensive guide to help you and your family ensure that you receive the best and most affordable health care available. It comes to you from Families USA, an organization that is a thoughtful and effective advocate for the American health-care consumer. For many years, Families USA has provided national advocacy leadership for the improvement of our nation's health-care system. This Families USA book enables increasing numbers of consumers to become more confident and effective decision-makers in the health-care marketplace.

**MEMORANDUM**

To: Melanne Verveer

From: Chris Jennings

Date: October 14, 1994

Re: Families USA Preface

Attached you will find an edited preface for the Families USA book. Per your request, we have added a sentence indicating that the First Lady does not necessarily endorse everything in the book.

Please let me know if there are any additional changes required. Ron Pollack has asked me to fax him a final version by 4 pm today. Thanks Melanne.

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That is the purpose of this book. *Health Care Choices for Today's Consumer* is a comprehensive guide to help you and your family ensure that you receive the best and most affordable health care available. It comes to you from Families USA, an organization that I know as a thoughtful and effective advocate for the American health-care consumer. For many years, Families USA has provided national advocacy leadership for the improvement of our nation's health-care system. This Families USA book enables increasing numbers of consumers to become more confident and effective decision-makers in the health-care marketplace.

# MEMORANDUM

To: All Interested Parties

Re: Getting The Real Health Care Story Out

At least if not more important as producing materials that document an accurate portrayal of how the health care reform initiative was developed is the decision about how best to use this information and to whom it should be distributed. In many ways, providing information internally has great potential to backfire. No explanation as to why this is the case is necessary.

It is far more important to provide appropriate and targeted information to outside validators who have credibility with the media and public at large. We therefore need to spend more time thinking about who would be most appropriate to contact as well as who in the Administration should contact them.

The following is a first cut list of people who are most likely to be helpful. This list includes the persons' name, a possible theme that they would highlight and a suggested Administration contact person to initiate the outreach effort. Obviously, we can and should modify this list. Ira and others need to review and add suggestions/modifications.

## OUTREACH TO SYMPATHETIC INDIVIDUALS WHOSE OPINIONS ARE VALUED BY THE MEDIA

| PERSON | THEME | ADMINISTRATION CONTACT |
|---|---|---|
| Henry Aaron | Sound economics of reform/Balance of markets and regulation | Judy Feder |
| Drew Altman | Need for reform/Interests groups/Public opinion | Judy Feder |
| Stuart Altman | Need for reform (especially cost) | Chris Jennings |
| Robert Ball | Historical context/Need for long-term care as part of reform/Need for comprehensive reform | TBD (to be determined) |
| Senator Breaux | | TBD |
| Governor Chiles | States/Need for reform | John Hart |
| Rick Curtis, NAIC | Problems in the insurance market without reform/ What was wrong with Republican plans | Gary Claxton |
| Senator Daschle | Interest groups/Conservative Republicans/Blocked reform | Chris Jennings |
| Governor Dean | States/Who blame rests with/Need for reform | John Hart<br>Ira Magaziner |
| Rep. John Dingell | Blame rests with those who oppose reform | Jack Lew<br>Melanne Verveer |
| Arthur Flemming | Historic perspective/Never gone so far before (draft op-ed piece has been completed) | Melanne Verveer<br>Chris Jennings |
| John Holahan | Need for reform | Judy Feder |

| | | |
|---|---|---|
| Dr. C. Koop | Outreach effort validation/Conservative approach | Melanne Verveer<br>Lynn Margherio |
| Jack Lewin | States/Who blame rests with/Need for reform | Judy Feder<br>John Hart |
| Larry Lewin | Need for reform | Walter Zelman |
| Senator Mitchell | | TBD |
| James Mongan | Historical context/Need for reform/Interest groups | TBD |
| Marilyn Moon | Need for reform | Judy Feder |
| Ron Pollack | Interest groups/Need for reform | Melanne Verveer<br>Chris Jennings |
| Senator Pryor | | Chris Jennings |
| Senator Reid | | TBD |
| Uwe Reinhardt | Interest Group pressure/Need for reform/ Plan was criticized unfairly for bureaucracy | Chris Jennings |
| Senator Rockefeller | Need for reform/Interest groups/Blame | Judy Feder |
| Governor Roemer | States/Need for reform | John Hart |
| John Rother | Need for reform/Credit for long-term care | Chris Jennings |
| Josh Wiener | Long-term care commitment | Judy Feder<br>Robyn Stone |

- This list will be amended with other people who have varied backgrounds and influence. For example, business, academic health and mental health advocates could be provided (respectively by Caren Wilcox, Lynn Margherio and Skila Harris). Please see preliminary business list attached.

- In order to successfully implement any outreach strategy, we must move quickly before any written or oral statements by these individuals are viewed as no longer relevant and or untimely.

TO: CHRIS JENNINGS

FROM: CAREN WILCOX

DATE: SEPTEMBER 21, 1994

RE: BUSINESS/HEALTH CARE SUPPORTERS

Hank Barnette - Bethlehem Steel

Ron Zeigler - NACDS

Craig Cole - Brown & Cole

Letita Chambers - Chambers Associates

Jim Moody - Chambers Associates

Henry Simmons - Nat. Leadership Coalition

Charles Corry - USX Corp.

James Perrella - Ingersoll-Rand

Steven Burd - Safeway

Jack Futterman - Pathmark

David Hoag - LTV Corp.

Leonard Hadley - Maytag Corp.

Small Business:

Kathleen Piper - Piper Flowers

Garth Sheriff - Sheriff Architects

Brian McCarthy - McCarthy Flowers

Judith Wicks - White Dog Cafe