Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Health Care/Reconciliation Senate Member Meeting (2 pages)	6/21/93	P5
002. memo	Chris Jennings to Hillary Clinton Re: Meeting with Representative Andrews (5 pages)	6/21/93	P5
003. list	Agenda for Meeting with First Lady Hillary Clinton Social Security numbers redacted (3 pages)	6/22/93	P6/b(6)
004. memo	Chris Jennings to Hillary Clinton Re: Health Care/Reconciliation Senate Member Meeting (2 pages)	6/21/93	P5
005. memo w/attach	Chris Jennings to Hillary Clinton Re: House and Senate "Message" Meeting (3 pages)	6/21/93	P5
006. memo	Chris Jennings to Hillary Clinton Re: House Single-Payor Meeting (5 pages)		P5
007. draft	Medicaid Goals (50 pages)	6/23/93	P5
008. list	Congressional List (7 pages)	nd	P5

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

FOLDER TITLE:
June 1993 HSA [3]

gf89

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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Date: June 21, 1993

To: Chris Jennings
Ira Magaziner

From: Louise Rodriguez - Working Group on Drugs

Subj: Anticipated Economic Impact on Enactment of Drug Provisions

1. There are several recommended policies affecting drug prices which, if enacted, will result in increased prices to managed care and hospitals:

a. Short term cost controls: The cost controls are designed to provide product specific controls to the retail class of trade. The level of control to the hospital and managed care sector is less (e.g., controls are across a company's entire product line). To the degree that a manufacturer's price increases during the control period, it will always be in the managed care and hospital sector.

b. Shift to Managed Competition: Managed care and hospitals have traditionally received deep discounts. As an increasing amount of care is shifted from the fee-for-service (retail) environment to the managed care environment, discounts to managed care and hospitals must decrease to assure that pharmaceutical manufacturers receive the same return. Managed care and hospitals will be charged higher prices.

c. Elimination of "Discriminatory" Pricing: As the short term cost control policy is phased out, the discriminatory pricing provision comes into effect. As acknowledged in the NARD/NACDS scoring of the legislative proposal, already escalating managed care and hospital prices can be expected to further increase as a result of this provision. Only the magnitude of the increase is disputed -- many think it will be higher. You should also know that there is also disagreement regarding the assumption that retail prices will decrease. (Experience with OBRA 90 demonstrated that manufacturers will act quickly eliminate discounts, but they do not necessarily offset price increases with lower prices to other customers.)

2. I urge you to seek the insight of managed care representatives regarding the impact of the proposed policy changes prior to formal adoption of these policies.

Louise R. Rodriguez

Louise R. Rodriguez

Date: June 21, 1993

To: Chris Jennings
Ira Magaziner

From: Louise Rodriguez - Working Group on Drugs

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Louise R. Rodriguez

Louise R. Rodriguez

POLITICAL CONSIDERATIONS
OF THE DISCRIMINATORY PRICING PROVISION

The provision will be supported by:

-National Association of Retail Druggists
-National Association of Chain Drugstores

This constituency believes that the provision will result in lower prices to retail pharmacies and will improve the competitive position of retail pharmacies relative to other providers of pharmacy services (including non-profit institutions). NARD/NACDS have stated that savings will be passed on to consumers.

The provision will be supported by:

- Wholesalers and distributors

Wholesaler and distributor revenue is generated through a negotiated percentage mark-up on all pharmaceuticals sales managed through their systems. If pharmaceutical prices rise, this group will reap a windfall.

The provision will be opposed by:

- Managed Care

This constituency believes that their traditionally deep discounts (given on the basis of their not-for-profit status) will vanish. There is also concern among those that contract for pharmaceutical services that rebates paid to the managed care organizations will be eliminated as an indirect effect of the law. There is concern that managed care will also lose the deeper prices usually achieved though formularies. Higher prices would result in higher premiums which would be paid by consumers and/or employers.

The provision will be opposed by:

- Hospitals

This constituency fears that the traditionally deep discounts (given on the basis of their not-for-profit status) will be eliminated. There is concern that they will also lose the bargaining leverage of formularies. Higher prices would result in higher charges to third party payors or patients.

The provision will be opposed by:

- Federal Agencies (VA, DoD, PHS)

The Agencies will lose discounts mandated under P.L. 102-585,

a law enacted to correct high pharmaceutical prices which followed the enactment of OBRA 90. Agencies will lose the exemption which permits them to receive deep discounts under the Robinson-Patman Act. The Agencies would lose any non-volume based discounted price, including those on the Federal Supply Schedule (FSS). The Agencies would lose the ability to negotiate lower pharmaceutical prices through formularies. Higher prices will result in higher expenditures which will be managed by reducing care to patients or reducing the number of patients cared for.

The provision will be opposed by:

- State and local governments with health care facilities

Governments will have higher expenditures because they will lose their deep discount exemption under the Robinson Patman Act. Governments will lose any non-volume-based discounted price. Governments will lose the ability to negotiate lower pharmaceutical prices through formularies.

The provision will be opposed by:

- Veterans
- Veterans Service Organizations
- VA
- State governments

State veterans homes will lose low FSS prices as a result of the provision. States and VA share the expense of higher prices that result from the law. State veterans homes will be forced to care for fewer patients or provide less medical care per veteran.

The provision will be opposed by:

- Veterans
- Veterans Service Organizations

As VA expenditures rise dramatically, there will be fewer medical care dollars available for pharmaceuticals or other medical care through VA medical centers. To the degree that veterans perceive that "a level playing field" comes at the expense of care to veterans, they will be offended by legislation.

The provision will be opposed by:

- Any not-for-profit health entity, including Planned Parenthood, Ryan White Clinics, AIDS clinics, etc.

The provision eliminates nominal prices given to clinics or entities which serve the indigent. Higher prices will result in care being provided to fewer patients.

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Chris Jennings (Health Security Act)
OA/Box Number: 23754

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AGENDA FOR MEETING WITH FIRST LADY HILLARY CLINTON

ON HEALTH CARE REFORM

TUESDAY, JUNE 22, 1993 -- 3:00 P.M.

I. Introductions

II. Remarks by First Lady

III. Brief Presentations by the Texas Medical Center Delegation

A. Denton Cooley, MD -- Centers of Excellence

B. Charles LeMaistre, MD -- Clinical Research and Disease Prevention

C. Red Duke, MD -- Trauma Care and Preventative Care

D. Mark Wallace, FACHE -- Pediatric Health Care and the Role of Teaching Hospitals

E. Pat Starck, PhD -- New Ideas for Meeting Demand for Primary Care

III. Discussion of Academic Health Centers and Health Care Reform

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003. list	Agenda for Meeting with First Lady Hillary Clinton Social Security numbers redacted (3 pages)	6/22/93	P6/b(6)

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ATTENDEES TO THE WHITE HOUSE

Hon. Michael A. Andrews
ss#:
DOB: P6/b(6)

Charles A. LeMaistre, M.D.
M.D. Anderson Cancer Center
ss#:
DOB: P6/b(6)

Larry McIntire, Ph.D.
Rice University
Biomechanical Engineering
ss#:
DOB: P6/b(6)

William Donovan, M.D.
The Institute for Rehabilitation and Research
ss#:
DOB: P6/b(6)

James Willerson, M.D.
The University of Texas Health Science Center
ss#:
DOB: P6/b(6)

Robert D. Wells, Ph.D.
Director of Institute of Bioscience and Technology
Texas A&M University
Biochemistry and Biophysics
ss#:
DOB: P6/b(6)

Jim Cuthbertson
C.E.O.
Texas Heart Institute
ss#:
DOB: P6/b(6)

Denton Cooley, M.D.
Texas Heart Institute
ss#:
DOB: P6/b(6)

James "Red" Duke, M.D.
Trauma Expert
University of Texas Health Science Center
ss#:
DOB: P6/b(6)

Bobby Alford, M.D.
Baylor College of Medicine
ss#:
DOB: P6/b(6)

William T. Butler, M.D.
President
Baylor College of Medicine
ss#:
DOB: P6/b(6)

O. Howard Frazier, M.D.
Texas Heart Institute
ss#:
DOB: P6/b(6)

David Low, M.D., Ph.D.
University of Texas Health Science Center
ss#:
DOB: P6/b(6)

Larry Mathis
C.E.O.
Methodist Hospital
ss#:
DOB: P6/b(6)

Mark Wallace
C.E.O.
Texas Children's Hospital
ss#:
DOB: P6/b(6)

Michael Jihn
C.E.O.
St. Luke's Hospital
ss#:
DOB: P6/b(6)

Tom Caskey, Ph.D.
Baylor College of Medicine
Institute for Molecular Genetics
ss#:
DOB: P6/b(6)

Richard Wainerdi, Ph.D.
C.E.O.
Texas Medical Center
ss#:
DOB: P6/b(6)

Lois Moore
President and C.E.O.
Harris County Hospital District
ss#:
DOB: P6/b(6)

Pat Starck, Ph.D.
Dean
University of Texas School of Nursing
ss#:
DOB: P6/b(6)

Walter Mischer
C.E.O.
Hermann Hospital
ss#:
DOB: P6/b(6)

Charles Balch, M.D.
M.D. Anderson Cancer Center
ss#:
DOB: P6/b(6)

ATTENDEES TO THE WHITE HOUSE

Denton Cooley, MD
Texas Heart Institute

Having performed the world's first heart transplant in 1968, then the world's first artificial heart implant a year later, Dr. Cooley is one of the world's most highly respected heart surgeons. For over 40 years, Dr. Cooley has led in developing techniques for the repair and replacement of diseased hearts. Founder of the Texas Heart Institute, perhaps the nation's most respected cardiovascular care center, Dr. Cooley has been awarded the Medal of Freedom, and the Rene Leriche Prize, the International Surgical Society's highest prize.

Charles A. LeMaistre, MD
M.D. Anderson Cancer Center

President of the internationally-esteemed M.D. Anderson Cancer Center, Dr. LeMaistre is also a professor of medicine and author of numerous articles on respiratory diseases, oncology, and the health risks of smoking. He is past president of the American Cancer Society, a frequent consultant to the National Institutes of Health, and is chairperson of the NASA/NIH Joint Advisory Committee on Behavioral Research.

William T. Butler, MD
Baylor College of Medicine

President of Baylor College of Medicine, Dr. Butler also serves as Professor of Microbiology and Immunology and of Internal Medicine. In 1990 he was named Distinguished Professor. An accomplished educator and administrator, Dr. Butler is an acclaimed professional and community leader.

David Low, MD, PhD
UT Health Science Center

Dr. Low is President of the UT Health Science Center and a well-respected researcher and author on neurology and the electrophysiology of the central nervous system. He holds professorships in the Department of Neurology, the School of Public Health and the Graduate School of Biomedical Sciences at the UT Health Science Center.

Bobby Alford, MD
Baylor College of Medicine

Dr. Alford is Executive Vice President and Dean of Medicine at Baylor College of Medicine, as well as Chairman of Otorhinolaryngology and Communicative Sciences. Often recognized as one of the best doctors in America, Dr. Alford specializes in otolaryngology research, and has served on several advisory councils -- including Chairman of the NASA Aerospace Advisory Committee and the Advisory Committee for the Redesign of the Space Station.

Charles M. Balch, MD
M.D. Anderson Cancer Center

Head of the division of Surgery and Anesthesiology at M.D. Anderson Cancer Center, Dr. Balch is a nationally recognized expert on melanoma and breast surgery. He is the immediate past president of the Society for Surgical Oncology and is a member of the Board of Directors for the American Society of Clinical Oncology. He is also the author of numerous books and articles.

Pat Starck, PhD
UT Health Science Center

As Professor and Dean of Nursing at UT Health Science Center, Dr. Starck is a not only an authority on care and rehabilitation techniques, but also a prodigious author on the profession and vocation of nursing. She served the First Lady's Health Care Task Force.

Tom Caskey, Ph.D.
Baylor College of Medicine

Director of the Human Genome Center at Baylor College of Medicine, Dr. Caskey ranks as one of the world's leading researchers in molecular genetics. Chairman and Professor of Molecular Genetics at the Institute of Molecular Genetics at Baylor, Dr. Caskey has served on numerous boards and professional organizations and has authored numerous articles on inherited disease and mammalian genetics. He has recently been selected to serve on the National Academy of Sciences.

James "Red" Duke, MD
UT Health Science Center

A well-respected trauma physician, as well as a professor of Clinical Sciences and of surgery at UT Health Science Center, Dr. Duke is a founding member of the American Trauma Society and established the internationally recognized LifeFlight program at Hermann Hospital, where he remains medical director of its trauma and emergency services. Dr. Duke is probably best known for his nationally-syndicated television segment "Texas Health Reports."

James Willerson, MD
UT Health Science Center

Director of Cardiology Research and co-director of the Cullen Cardiovascular Research Laboratories at the Texas Heart Institute, Dr. Willerson is Chairman of the Department of Internal Medicine at UT Health Science Center. Author of seven texts and nearly 500 scientific articles, Dr. Willerson also serves as editor-in-chief of Circulation, the medical journal of the American Heart Association.

Robert Wells, Ph.D.
Texas A&M University
Institute of Biosciences and Technology

An internationally-recognized authority on the biochemistry of hereditary processes, Dr. Wells holds the Welch Foundation Chair in Chemistry and Texas A&M Institute of Biosciences and Technology. Best known for his work on

unusual DNA structures, Dr. Wells served as a John Simon Guggenheim Memorial Fellow at the Salk Institute for Biological Studies at the University of California at San Diego from 1976 to 1977.

William Donovan, MD
Texas Institute for Rehabilitation and Research
Medical Director and Chairman of the Department of Physical Medicine and Rehabilitation for the Texas Institute for Rehabilitation and Research, Dr. Donovan is a highly-respected clinician and researcher into spinal cord injury and amputation.

O. Howard Frazier
Texas Heart Institute
A cardiovascular surgeon, Dr. Frazier is Chief of Transplantation at St. Luke's Episcopal Hospital and serves as chief of Cardiopulmonary Transplantation and co-director of the Cullen Cardiovascular Research Laboratories at the Texas Heart Institute. Author of more than 200 scientific articles, Dr. Frazier is widely recognized for developing and testing heart assistance devices for patients awaiting transplantation.

Larry McIntire, MD
Rice University
Chairman of the Institute for Biosciences and Bioengineering, Dr. McIntire is recognized for his work on the cellular biochemical systems and processes. Dr. McIntire has coauthored more than 300 articles and presentations in his field.

Larry Mathis
Methodist Hospital
As President and Chief Executive Officer of the Methodist Hospital System, Mr. Mathis heads one of the country's largest and most prestigious hospitals. Mr. Mathis is currently chairman of the American Hospital Association, and a member of several national and state health care organizations.

Mark Wallace
Texas Children's Hospital
Mr. Wallace is Executive Director and Chief Executive Officer of Texas Children's Hospital, the nation's largest pediatric hospital. Texas Children's also has a teaching affiliation agreement with Baylor College of Medicine.

Michael Jhin
St. Luke's Hospital
As President and Chief Executive Officer of St. Luke's Hospital, Mr. Jhin leads a 949-bed tertiary care teaching hospital that is internationally respected for its cardiac program and is a major teaching affiliate of Baylor College of Medicine and the UT Health Science Center.

Jim Cuthbertson
Texas Heart Institute

President and Chief Executive Officer of the Texas Heart Institute, Mr. Cuthbertson heads the country's largest and well-respected cardiovascular care center. Under Mr. Cuthbertson's direction, the center has expanded and streamlined its operations, and its operational revenues have more than doubled.

Walter Mischer, Jr.
Hermann Hospital

Elected to the Board of Trustees of Hermann Hospital in 1980 at age 30, Mr. Mischer now serves as Chief Executive Officer of one of Texas' most well-respected teaching and charitable hospitals.

Lois Moore
Harris County Hospital District

As President and Chief Executive Officer of the Harris County Hospital District, Ms. Moore administers the district's three hospitals and ten community health clinics. With 5,100 employees, the hospital district is one of Harris County's largest employers.

Richard Wainerdi, Ph.D.
Texas Medical Center

As President and Chief Executive Officer of the Texas Medical Center, Dr. Wainerdi is administrator for the world's largest medical education, research and health care center. Dr. Wainerdi holds several adjunct professorships in medicine and biomedical engineering and is the other of nearly 200 articles on molecular chemistry nuclear activation analysis.

Key Health Care Reform Issues for

Academic Health Centers

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

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

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

Graduate Medical Education. How should the costs and income from training new health care providers be set under the new system?

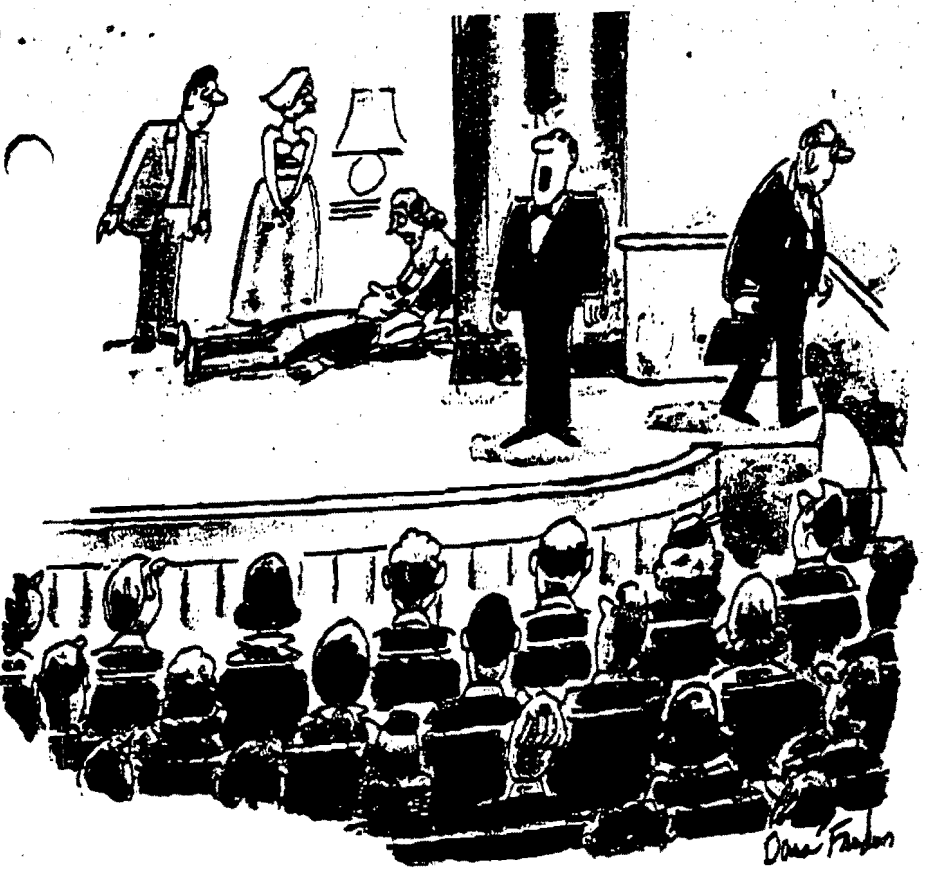
Indirect Medical Education Costs. How should the health care system distribute the additional health care delivery costs associated with training new physicians?

Clinical Research. How will clinical research be paid for under the new system when today no systematic funding mechanism today exists?

Health Care Report Cards. How will reports on outcomes be adjusted to account for the greater complexity of cases seen at academic health centers?

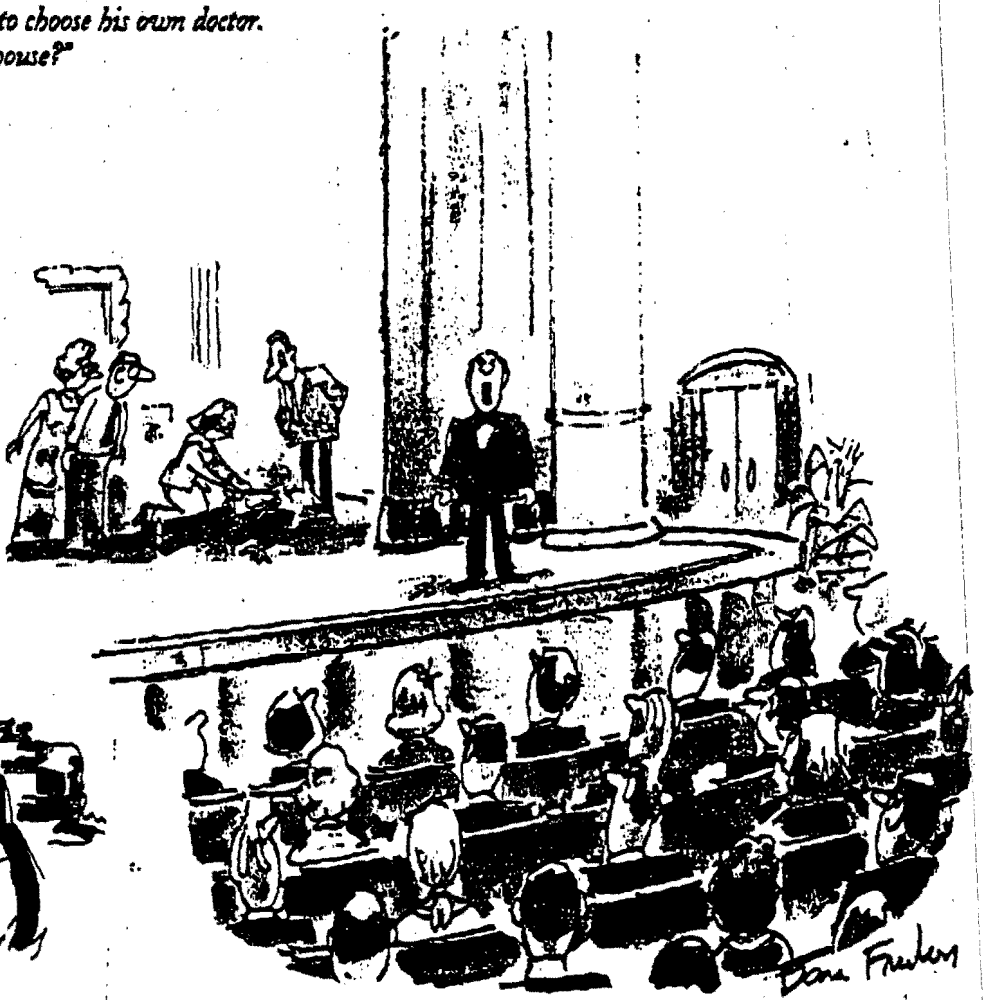
Quality of Care. How can the quality of health care delivery be assured for the treatment of conditions like cancer where the medical outcome does not necessarily reflect the quality of treatment?

Outcomes Research and Practice Guidelines. How should academic health centers participate in the development of practice guidelines and in outcome research?



"It seems the patient wishes to exercise his right to choose his own doctor. Is there another doctor in the house?"

"I've been thinking I'll hold off choosing a specialty until I see how Hillary's scheme shakes out, ferwiz."



"Are there several doctors in the house, so we can have a little managed competition?"

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. memo w/attach	Chris Jennings to Hillary Clinton Re: House and Senate "Message" Meeting (3 pages)	6/21/93	P5

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

FOLDER TITLE:
June 1993 HSA [3]

gf89

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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MEMORANDUM

To: Ira Magaziner, Melanne Verveer, Chris Jennings

From: Shirley Sagawa

Re: Abortion issue

Date: June 22, 1993

This memo is to make you aware of a health care/abortion issue that was raised on the national service bill and how it was addressed.

The national service bill provides that every participant who does not otherwise have access to health care receive health care benefits. Eighty-five percent of the cost of the premium is paid by the federal government with the remainder paid by the local program sponsor. The minimum benefits that must be included in the plan will be set by the federal government. Participants who already have health insurance through a spouse, parent or otherwise do not receive health care benefits.

At the request of the Catholic Conference, the House Education and Labor Committee added a religious tenets exception. This exception provided that religious programs need not comply with the minimum benefits requirements if it would conflict with the religious tenets of the program sponsor. Women's groups, however, raised concerns that this exception created a situation in which the federal government paid for a substandard health care plan.

The following compromise resolved the issue, although both sides say this should not be considered a precedent for health reform: The religious tenets exception was dropped. To receive federal support for the health care benefits, a program must provide the minimum benefits. A program wanting to provide an alternative package of benefits may do so only if it is of equal value to the minimum benefits package and is paid for 100 percent by the local program. The cost of the premium paid by the local program in such a case may be counted against the required match of federal funds.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. memo	Chris Jennings to Hillary Clinton Re: House Single-Payor Meeting (5 pages)		P5

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June 1993 HSA [3]

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U.S. REP. JIM MCDERMOTT'S CHECKLIST OF CRITERIA FOR MEASURING HEALTH CARE REFORM PROPOSALS

1. Does it provide insurance coverage to every American?

Nearly 40 million Americans do not have health insurance coverage today. That total increases by 100,000 each month. An almost equal number (nearly 40 million) are dangerously under-insured. Any reform proposal must extend quality coverage to these Americans.

2. Is that coverage portable, stable and continuous?

A major problem for people who have insurance is the fear that they will lose it if they move to another job, due to a "pre-existing condition" which won't be covered under their new employer's plan, or other restrictions and inadequacies in the plan offered by their new employer.

3. Is the standard benefit package comprehensive enough to prevent the need for a large secondary insurance market which leads to two-tier medicine and uncontrollable costs?

In a democracy, it is important to have a quality health care system available to all. If the standard benefit package guaranteed to all citizens provides only minimal benefits, then some people will look for a "better deal." People will try to either "buy out" of the national system or buy more private insurance. If the standard package of benefits is a generous one, people will stay in the system, preserving the ability to control costs.

4. Does it allow individuals or families to choose their own physician or other health care provider?

Americans cite the ability to choose their own physician as the single most important aspect of any health care plan, even over cost and convenience. They do so by large margins. One of the fundamental elements of healing is the relationship between the healer and the patient. If the patient has no choice, you take away an essential element of the health process.

-- more --

5. Does it guarantee coverage regardless of physical condition or the presence of a pre-existing condition?

Increasingly, insurance in this country is only available for those things for which you do not need insurance. If you have a cancer, insurance companies will cover everything but cancer. If you have heart problems, they will cover everything but heart problems. Any reform plan must correct this fundamental problem.

6. Does it provide for effective, verifiable cost-containment?

Currently, America's health care system essentially has no cost controls. We cannot, as a nation or as individuals, afford this any longer. Any reform plan must have verifiable cost-containment.

7. Does the cost-containment apply to the entire health care delivery system without loopholes or exemptions for the secondary insurance market or self-insured entities?

It is increasingly difficult to control costs and stop wasteful spending if large numbers of people are "outside the system." To be effective, cost-containment measures must be applied to the entire health care delivery system.

8. Is there one simplified federal administrative system that applies to all Americans, rather than multiple bureaucracies which do the same thing for different groups?

A central goal of any health care reform plan should be to simplify the system to make it understandable for ordinary citizens and to make it easier to identify and eliminate waste. Over-lapping layers of federal health care bureaucracies for separate benefit programs needlessly waste health care dollars. Waste is also an unavoidable aspect of having 1,500 different private health insurance companies. According to the GAO, Americans incur nearly $60 billion a year in unnecessary health care costs simply because of all the different forms and paperwork issued and required by so many different companies.

9. Does the health care delivery system enhance access to health care in rural areas and the inner cities?

More than 35% of Americans live in rural areas or inner cities. Both have been chronically under-served by the current health care system. Any national health care system must correct this inadequacy.

-- more --

10. Does it eliminate interference between doctors and patients by insurance companies second guessing medical decisions and allow health professionals to make their own medical decisions?

Maintaining America's high quality of health care must be a fundamental goal of whatever health care reform plan America adopts. The current system's case by case random reviews, which inserts insurance companies between the patient and the health care provider through "pre-certification" requirements for hospital admissions, length of hospital stays, and even for specific medical procedures, have not been effective in controlling health care costs. What we need is a system that allows doctors to make their own medical decisions, but which also teaches them how to deliver better medicine by developing better practice patterns.

11. Does the system dramatically reduce administrative costs of the health care budget?

Almost a quarter of all health care dollars in America are consumed by administrative expenses of insurance companies. This is simply unacceptable. If we are to make the kinds of savings necessary to finance comprehensive health care coverage for all Americans this figure must be reduced. And it can be reduced. For example, under Canada's "single payer" system, for example, only 3 percent of all helath care dollars are consumed by administrative expenses.

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Date: Tuesday, June 22, 1993 12:42 pm
Subject: Health care reform meetings

We are to set up a series of 9 meetings including:
- the 6 (Klepner, Ellwood, Apfel, Lee, Vladeck, Feder)
- Ken Thorpe
- the 4 (Chris Bladen, ASPE, Barbara Cooper, HCFA, 690-5500 Kerry Weems, ASMB 690-6151, Cliff Gaus, PHS, 401-7736) - Ira Magaziner, -- his assistant is Marge Tarmy; Jennifer Kline, Greg Lawler, Lynn Margherio, and Carolyn Gatz will represent him
- Chris Jennings

These meetings are leading up to a revised draft plan by July 2, so they should all take place by Wednesday, June 30 if possible.

The meetings should cover the following topics; lead HHS staff people are listed for each:
Benefits.... Atul Gawande
Medicaid/Low-Income issues... Atul Gawande
Overall Administration...Gary Claxton, Nancy DeLew, Wayne Sulfridge
Coverage and Financing...Ken Thorpe
Budgets/Cost Control...Barbara Cooper, Ken Thorpe
Startup/Implementation...Gary Claxton
Medicare....Barbara Cooper
PHS issues including workforce....Cliff Gaus, Cheryl Austein
Long-Term Care...Mary Harahan, Robyn Stone

We would like to discuss benefits and Medicaid Wednesday morning June 23 starting at 10:15 to approximately 1:15 pm. Additional meetings will be held next Monday, Tuesday and Wednesday mornings and early afternoon in order to allow time for staff work and to coordinate with the schedules of Ira Magaziner and his representatives.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. draft	Medicaid Goals (50 pages)	6/23/93	P5

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008. list	Congressional List (7 pages)	nd	P5

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