Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Clinton Re: Ways and Means Subcommittee Meeting (2 pages)	6/29/93	P5
002. briefing paper	Ways and Means Health Subcommittee (3 pages)	6/29/93	P5
003. memo	Chris Jennings to Hillary Clinton Re: Meeting with Senator John Chafee (2 pages)	6/30/93	P5

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

FOLDER TITLE:
June 1993 [6]

gf92

RESTRICTION CODES

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

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

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

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

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COVERAGE

- All citizens and legal residents entitled to nationally guaranteed benefit package

- Guaranteed benefits include:

  Typical employee benefits: inpatient and outpatient hospital services, services of physicians and other licensed professionals, outpatient prescription drugs, laboratory and diagnostic services, pregnancy-related services, post hospital nursing home, home health, and rehabilitation services

  Additional benefits: preventive services (immunizations, mammogram); mental health and substance abuse services; some dental care

  Benefit changes over time: A national board reviews coverage periodically to reflect changes in medical practice.

- Out-of-pocket costs:

  Fee-for-service plan:

Deductible:	$200 per person; $400 per family
Coinsurance:	20%
Limit:	$3000 - $4000 per family

  No out-of-pocket costs for clinical preventive services. Separate deductible and co-payment for prescription drugs and mental health services.

  HMOs and other organized delivery systems available with lower cost sharing, e.g. $10 per visit.

  Benefits beyond the guaranteed package: Employers can supplement cost-sharing for employees and purchase extra benefits for employees, but only with after-tax dollars. Individuals may purchase services beyond the guaranteed package with their own, after-tax dollars.

SOURCES OF COVERAGE

- Coverage for all workers financed through mandated contributions from all employers and employees.

  Employers pay 80% of alliance average premium up to 7.6 percent of each employee's wages. (Employers who now pay more than 80% may continue to do so.) **For small employers who employ low-wage workers, employers will pay a lower percentage of each employee's wages.**

  Employees pay 20% of alliance average premium up to 1.9 percent of wages. For employees reaching the payroll cap, unearned income is applied toward the premium.

  Self-employed and those with unearned income pay premium up to 9.5% of income.

- **Medicare:** Initially remains a distinct program, modified to include coverage for prescription drugs.

  When state systems for the population under age 65 are in full operation, states can seek federal approval for integration of Medicare program.

- **Medicaid:** Medicaid beneficiaries have same choice of plans as others. Premiums are financed by continuing current Medicaid expenditures (maintenance-of effort requirements), and used to contract with alliance plans. All plans are required to cover Medicaid beneficiaries.

  States also continue to provide to current eligibles, working or not working, Medicaid services (for example, extended rehabilitation services) beyond the guaranteed benefit package, under current rules.

- **Other federal programs:**

  Department of Veterans Affairs: All veterans receive choice of VA health plan or other plans offered to general public. Current beneficiaries are guaranteed protection of current benefit levels. Management flexibility is allowed to enable VA system to compete successfully with other plans.

Department of Defense: Department reports on integration with broader system one year following enactment. Objective is to promote development of DOD health plans as option for DOD beneficiaries, subject to commitment to military readiness requirements. Current beneficiaries are guaranteed protection of current benefit levels.

Indian Health Service: Resources enhanced consistent with providing native Americans guaranteed benefit package. Tribes receive funds directly from Indian Health Service. Individual Indians may choose to enroll either in IHS plan or in plans available to general public.

Federal Employees: Federal employee program fully integrated into program established for the general public.

- **Workers Compensation and Auto Insurance:** Individuals injured at work and covered by workers' compensation or injured in auto accidents receive health benefits through their health plans with payments made (under a fee schedule) by workers compensation and auto insurers.

NATIONAL HEALTH BOARD

- President appoints (with advice and consent of Senate) 7-member board to set national policy and oversee overall health system. Members will be selected based on experience and expertise in health care finance and delivery, consumer protection, business, state government and service to vulnerable populations.

- Board has responsibility to review and update the guaranteed benefit package, to implement and enforce constraints on health plan premiums (the national budget) and develop and oversee quality management and improvement program.

HEALTH ALLIANCES

- States must establish one or more alliances (purchasing groups). Non-compliance leads to financial penalties (subsidies, tax preferences) and federal enforcement.

- Alliance areas are defined by the state but may not segregate populations by race, income, or health status. Only one alliance serves each area.

- Alliances may be state agencies or non-profit organizations, directed by boards representing employers, employees and other consumers.

- All except the largest employers (up to 5000 employees) are required to make their premium contributions to an inter-alliance fund.

- Alliances are responsible for ensuring that all citizens and legal residents enroll in plans; that plans provide guaranteed benefit package, provide consumer information, meet quality standards, offer dispute resolution mechanisms, serve underserved and low-income populations.

- Alliances must offer consumers a choice of at least one plan which is fee-for-service.

- A state could require an alliance to offer only one plan, contracting directly with providers -- in other words, a single-payer system.

- Alliances are purchasers, not regulatory agencies. Their primary responsibility is to negotiate premiums with health plans and to provide consumers information to evaluate and choose among plans.

- Large employers and Taft-Hartley plans with more than 5000 employees are not required to participate in the regional alliances but they may participate in regional alliances if they purchase coverage at an experience rate. Those not participating in the regional alliances must offer employees a choice of plans and ensure compliance with rules governing the regional alliances, as above.

HEALTH PLANS

- Plans contract with alliance to provide guaranteed benefits within negotiated per person payment. Fee-for-service plans, like other plans, must operate within per capita constraint.

- Plans must charge same premium for all enrollees, must accept all applicants and may not terminate coverage.

- Plans whose enrollees are disproportionately old or high-risk receive extra payments (risk adjustments).

- Plans must participate in federally established quality management and improvement program.

- Plans must meet solvency requirements, enforced by the state. State-established guaranty funds protect in the event of bankruptcy.

- Plans must provide consumer grievance and appeals procedures.

- Plans may be required to contract with essential community providers, serving low-income people in their communities.

- Plans may be made up of (owned by) providers or may contract with selected providers for services. Terms of provider payment will range from fee-for-service to salary arrangements.

COST CONTAINMENT

- **Open issue: short-term controls under discussion.**

- When new system is fully implemented, health plan premiums are constrained as follows:

  Federal law establishes per capita spending limit nationally for guaranteed benefit package.

  A national board determines state premium targets by adjusting national average premium to reflect each states' population characteristics (age, gender, health status) and historical costs, relative to the national average.

  The targets are increased annually based on a national formula to reflect inflation (e.g. CPI + a fixed percentage).

  State health plan premiums, on average, cannot exceed state premium target, as described below.

- Initial enforcement of premium targets is the responsibility of the federal government. If targets are not achieved, the federal government sets premiums directly and may set provider payment rates.

- States assume responsibility for enforcing premium targets after initial implementation. If alliance fails in negotiation, state achieves target by freezing enrollment, surcharging high-cost plans to encourage enrollment in low-cost plans, regulating provider rates directly, or regulating premiums.

QUALITY MANAGEMENT AND IMPROVEMENT

- National Board establishes and implements quality management and improvement program with uniform annual performance reports on: selected measures of outcome, consumer satisfaction and access to care. The federal government provides funding for, and a clearinghouse for, outcomes research and practice guideline development.

- Clinical Laboratory Improvement Act reform under discussion for improvement and streamlining.

ADMINISTRATIVE SIMPLIFICATION

- Develop single, standard insurance claim form for all insurers, establish standard rules for reimbursement and standardize insurance transactions, including billing.

- Streamline coordination of benefits among plans, providers and patients.

- Require states to coordinate licensing and certification visits to hospitals and other health care institutions from government agencies and outside organizations.

- Establish standard and unique provider numbers for providers, patients and institutions.

PROTECTING UNDERSERVED POPULATIONS

- Federal government supports health services for high-risk populations and invests in health care system in underserved rural and urban areas.

- Federal support continues for services such as transportation and translation that ensure access for vulnerable and underserved populations.

- Health alliances assure participation in new system by contracting with essential community providers -- also called "safety net" providers -- or requiring health plans to do so.

MALPRACTICE REFORM

- Health plans required to establish alternative dispute-resolution mechanisms.
- Contingency fees in malpractice cases limited to no more than one-third of total recovery.
- States required to impose limit on awards for non-economic damages, allow periodic -- rather than lump sum -- payments at request of either party and reduce damages by amount of payments for medical costs covered.
- States have option to pursue enterprise liability.

FRAUD AND ABUSE

- Federal law establishes criminal penalties for health care fraud.
- Civil monetary penalties established for submitting false or fraudulent medical claims, routinely waiving co-payments, unbundling charges, failing to report required information, submitting false or fraudulent statements, denying care to eligible individuals.
- Extends prohibitions against kickbacks and self-referrals to all health plans but allows "safe harbor" exceptions.

BANKRUPTCY AND ANTITRUST

- McCarran-Ferguson exemption is amended for health insurers to assure that anti-trust law applies.
- Physicians and other providers who hold an equity stake in a non-fee-for-service plan can negotiate or set prices collectively for services in the plan.
- Institutional providers may enter into cooperative arrangements to share services if a state actively supervises their activities under a state policy intended to replace competition with regulation.

HEALTH CARE WORKFORCE DEVELOPMENT

- Total number of first-year residency positions limited to 110% of graduates of U.S. medical and osteopathic schools, with total limited to produce 50-50 distribution between specialists and generalist practitioners.

- New process developed to involve public and private sector in distributing residency slots among geographic regions based on population.

- Expands training settings eligible for Graduate Medical Education funding to include community-based sites outside hospital.

- Expands National Health Service Corps to 16,000 professionals, provides 4,000 scholarships each year and expands loan-forgiveness program to include health professions other than doctors.

- States are prohibited from enacting scope of practice laws that restrict practice of health professionals for reasons other than skill or training.

- Increases funding and loans for training of non-physician health professionals.

PUBLIC HEALTH AND PREVENTION

- States required to maintain current level of support for public health and prevention.

- Federal block grants to states to support core public health activities, including health status surveillance and monitoring, disease prevention and control.

- Grants support prevention objectives in **Healthy People 2000**, with funds allocated to states by formula based on needs and per capita. Activities targeted to prevention of chronic and infectious disease.

ACADEMIC HEALTH CENTERS AND MEDICAL RESEARCH INITIATIVES

- Unique costs of Academic Health Centers are spread across all health plans in the community.

- National Institutes of Health supports prevention research in priority areas, including child health, reproductive health, chronic illness, mental health and substance abuse, AIDS and HIV infection, tuberculosis and infectious disease.

LONG-TERM CARE

- **Home and community-based care:** New federally-financed, state administered program established for home and community-based care. Program has following characteristics:

  -- Array of services defined by the state (to include **at least** personal care services) available to severely disabled persons of all ages.

  -- State establishes mechanisms to determine eligibility, develop care plans, coordinate services and assure quality.

  -- Federal funding capped for each state based on estimated numbers of eligible patients and per capita spending. Funding increases annually with consumer price index plus a fixed amount.

  -- Eligible individuals entitled to $500 per month in services; additional benefits may be provided on a funds-available basis.

  -- Individuals with incomes above 150% of poverty pay 20% of service costs.

- **Improvements in Medicaid nursing home benefits:**

  -- All states required to establish medically needy programs, allowing individuals with incomes exceeding eligibility levels to "spend down" to become eligible for Medicaid.

  -- Nursing home residents allowed to retain $12,000 (up from the current $2,000) in assets and $100 per month (up from the current $30) in income.

- **Private long-term care insurance**

  -- Preferred tax treatment now accorded health insurance medical spending is extended to cover long-term care insurance premiums and expenses.

  --States required to establish a plan for regulating the content and sale of long-term care insurance policies.

- **Tax incentives for working-age persons with disabilities**

  -- Disabled individuals are entitled to tax credits for work-related personal assistance services.

SPEECH BY SENATOR JOHN H. CHAFEE
The American Health Care Association
Washington, D.C. May 12, 1993

Thank you for including me in your symposium. Your agenda is an impressive one -- you should come away from this conference with a good sense of the direction health care reform is taking, as well as how nursing homes will be affected.

Health Care Reform will prove to be the most arduous and dramatic domestic policy undertaking in the last fifty years, and it will affect all Americans. The American health care system has considerable strengths, but it also has distressing flaws.

What are these flaws? Seems to me there are three. First, the cost of health care and health insurance is becoming a mounting burden on many individuals and our national budget. Individual premiums, copayments and charges are soaring. The government's share of the health care bill -- $230 billion in fiscal year 1993 -- represents a full one-sixth of all federal spending. Not an auspicious fact for deficit hawks.

You know the statistics: America spent $752 billion on health care in 1991 -- 13.2 percent of our GDP. The Health Care Financing Administration projects that, left unchecked, U.S. health care spending could climb to 32 percent of GDP by the year 2030. While in 1991, per capita spending on health care was $2,868 -- in 2030, it would could be as much as $48,000 for every man, woman and child in America! The nation cannot sustain these costs.

Second, appropriate medical care is simply unavailable to millions of Americans. We are pretty familiar with the discouraging gaps -- 37 million of our fellow citizens are without medical insurance. In addition, many poor and disabled who are covered by insurance -- I am referring to Medicaid -- have insufficient health care because there are no doctors to see, especially in rural and inner city areas.

And third, because businesses must include their large employee health benefit expenditures in the price of their products, health care costs are eroding our competitive position internationally. It was reported in last Thursday's (May 6) New York Times, Robert L. Ozment, director of insurance at Ford Motor Company, said his company spent $1.35 billion, or 19 percent of payroll, on health benefits for active workers, retirees and dependents last year. "That is more than the $1.1 billion that Ford spent on steel," he said in an interview.

What is the answer? The answer is that we all need to change. Providers will need to make changes in the way they practice medicine, and we as consumers will need to accept changes in the way we get medical care.

It is difficult for me to discuss the details of the

President's plan, as many key decisions have yet to be made. You are fortunate to have Judy Feder here later this morning, to shed some light on deliberations at the White House.

I will fill you in on the Republican plan.

You may know that in July 1990, I was asked by Senator Dole to establish and chair a Task Force to help all Republican Senators develop expertise on our nation's complicated health care system, and to begin the search for solutions to the problems that plague it. Thirty-five Republican members of the Senate are and have been participating in the endeavor.

After a year of work, in the fall of 1991, I was joined by twenty-three of my Republican colleagues in introducing legislation that we believed was an achievable first step in reforming our system. That program included insurance market reform, the establishment of small group purchasing organizations, medical liability reform, repeal of state mandated benefits, repeal of state anti-managed care laws, creating equity in the tax code, reduction of administrative costs, expansion of community health centers, and other elements.

Soon after introduction, however, I and many of my colleagues were concerned that our bill did not do enough to control health care costs. We have spent considerable time discussing cost containment options, and many of us believe that a managed competition approach is the route to take.

It is a bit awkward for me, as the leader of the Republican group, to divulge the precise details of our plan, while I am still trying to build and maintain consensus behind a strong idea. So I will avoid premature disclosure right now, but will give you an indication of what our proposal will look like by outlining the pitfalls likely to be encountered by any reform proposal. I do think it is fair to say that our bill will focus less on "managed," and more on "competition."

Obstacles to enacting a health care reform proposal will not be found on the Republican side of the aisle. The potential for trouble is evident in the fact that, although the Democrats have controlled both houses of Congress since 1986, any consensus on health care reform has and still eludes them. When the President's plan -- which we anticipate to be based on managed competition, with some form of external price controls -- is presented to the Senate, you will surely see objections from a number of Democrats. There may well be some in the liberal and some in the conservative wing of the party who will not be able to support it.

In neither house of Congress have the Democrats been able to coalesce around a single health care reform proposal. Although the Democratic leadership in the House and Senate, for the time being, are deferring to the President on this issue, there is still support among many Democrats for other types of reform.

In early March, a group of 4 Democratic Senators and 54 Democratic Members of the House introduced a Canadian-style, single-payor bill. This same group disavows the managed competition proposal which is the basis of the President's reform package.

On the other hand, price controls and mandatory employer contributions will cause rebellion amongst the conservative Democrats, with their small business constituents. Thus, for any program to succeed, bipartisan cooperation is required.

To me, the managed competition approach has appeal because it allows competition within set boundaries of benefits and with standards for insurance.

Proceeding with managed competition is going to present all of us with some extremely tough decisions, however.

For example, managed competition revolves around a single uniform benefit package which will be applied nationwide. Who will set that package -- Congress or a Federal Board? More importantly to you, however, is the issue of whether or not long-term care coverage will be included.

Both Democrats and Republicans would like to address the issue, and both parties are considering a number of options. Clearly, cost will be one of the biggest factors in deciding how or whether long-term care is included in reform. Republicans would like to see long-term care provided in the private sector for those who can afford to purchase long-term care insurance.

Toward that end, we are considering changes in the tax code and in insurance marketing practices in an effort to encourage individuals to purchase insurance, and to encourage insurers to market long-term care products. Can we deduct the cost of acute care insurance - it's not clear about the deductibility of long-term care insurance. Just how we will deal with low-income populations has not been resolved.

Back to managed competition...is Congress willing to limit the amount an employee can count as a tax-free fringe benefit? It is not so politically difficult to limit employer deductibility of health insurance premiums. But capping employees is a different story. The UAW will hardly rise and cheer for that! Yet tax exemptions only for the value of the standard benefit package is at the heart of managed competition.

What, if any, will be the contribution required from the employer? President Clinton seems to have advocated that employers pay a substantial amount of the premium, maybe 80%. That will have a serious impact on small businesses. We must be cautious in how we approach this issue.

More tough decisions. Will we be willing to undertake medical

liability reform, which is critical to bringing health care costs under control? I believe that it must be included.

Are Americans willing to accept a health care system which would limit choice through managed care?

What happens to Medicare, Medicaid, and Veterans health programs under managed competition? Are these all changed to conform to the standard package? My choice would be to phase these populations into the same program as private patients.

Are we willing to raise taxes to finance care to those who remain uninsured?

Many of us worry that the costs of health care reform are not being considered adequately as the President presses ahead with his economic recovery programs. He is tapping a variety of new or additional sources of revenue -- such as increasing the personal and corporate rates, extending the Medicare payroll tax, making cuts in Medicare benefits -- but none of this money is for health care reform, which has been projected to cost as much as $100 billion per year when fully implemented. It will all be absorbed by the time health care reform comes along.

On top of the great need to find a way to finance a health care reform proposal, Members of the Senate Finance Committee also must grapple with a budget reconciliation bill in the coming months. We are charged with finding $35 billion in spending cuts within our Committee's jurisdiction. The bulk of these cuts will likely come from Medicare, and to a lesser degree -- Medicaid.

According to the Congressional Budget Office, we can achieve $1.75 billion over the next five years by tightening Medicaid's estate-recovery processes, and limiting the ability of individuals to transfer assets in order to qualify for Medicaid long-term care coverage. I would like to be able to tell you not to worry about the elimination of return on equity payments, but given the level of cuts that must be achieved, I wouldn't count anything out until the ink from President Clinton's signature is dry.

In addition, there are a number of spending items that many of us would like to see included in a budget reconciliation package, not the least of which is the elimination of the 3-day hospital stay requirement. Needless to say, this is going to be a difficult year.

Back to the thorny issues of health care reform. Perhaps the most politically volatile issue of the health care reform debate will be how to contain costs. On one end of the spectrum we have pure regulation -- price setting for physicians, hospitals, and other providers. On the other end we have plans relying on pure competition and consumers to control costs.

Although President Clinton has embraced the concept of managed competition, he has stated that he will also use a nationwide

budget to contain health care costs. The Republicans oppose this.

If total medical expenditures are capped and the caps are enforced, difficult decisions would have to be made about what services would be covered, who would benefit and how quickly. The word "rationing" emerges. Clearly, under such a system, Americans who now enjoy unlimited coverage would experience some reduction in benefits or services.

There will be a big push this year to get health care reform enacted, but I fear one year may be an overly optimistic goal. However, I do think it is possible to get the details worked out and build a consensus and achieve passage in 1994.

Regardless of the complexion of the ultimate reform package -- whether the managed competition model survives, or we turn in some as yet unforeseen direction, one thing is certain. In order to bring national health spending down, we need to bring about a much greater emphasis on preventive medicine, including education about healthy behaviors. We absolutely have to convince people not to abuse alcohol and drugs, not to smoke, not to drive fast, not to own guns, always to wear seatbelts and motorcycle helmets. The gargantuan expenditures caused by these avoidable practices have to be curbed. Handgun injuries alone cost $4 billion a year, not including rehabilitation services! Any health care legislation will certainly reflect that shift in focus, to some degree.

I am one who has believed all along that it is possible -- in fact, imperative -- to put political partisanship aside and develop a sensible health reform package that will meet the compelling needs of our nation. This is a thrilling moment in our country's history. The political will do something momentous and worthwhile is there. We must not allow this opportunity to pass.

Thank you.

Comparison of Chafee/Dole legislation to Clinton proposal

Senator Chafee,as you know, has organized 23 Republicans to craft a Republican Health Care Task Force Proposal, and he hopes that a significant number of them will join him in introducing Republican health care reform legislation.

While many of the provisions are likely to be borrowed from Chafee/Dole, last year's Republican offering, we also anticipate some changes in the bill that will make it more comprehensive.

Attached is a comparison of our proposal with what we anticipate will be in their bill.

ISSUE	OUR PLAN	LIKELY CHAFEE PLAN
Mandates	We will mandate employers and employees-- which many believe is the only realroute to universal coverage absent a broad-based tax.	It is likely that Chafee's bill will mandate individuals (new from Chafee/Dole), but is highly unlikely that there will be any mandate on employers.
Malpractice Reform	Tort reform and ADR	Chafee/Dole would reform the medical liability system through federal pre-emption of state tort laws and would create a system to encourage early settlements of disputes.
Financing	Either premium or payroll-based financing, plus cigarette tax.	No specific financing mechanism specified in Chafee/Dole, although the estimated cost of the program was $150 billion over 5 years.
Primary and preventive	Plan shifts focus to greater emphasis on early intervention and primary and preventive care, and through incentives to encourage more practitioners to go into primary care	Same
Medicaid/Medicare integration	Would integrate Medicaid populations and eventually Medicaid funding, would allow states to apply for waiver to include Medicare population	Chafee/Dole would set up a waiver board for Medicare, Medicaid, and PHS grants for statewide demonstration programs.

ISSUE	OUR PLAN	LIKELY CHAFEE PLAN
Benefits Package	Our plan will define a comprehensive benefits package that all health plans will offer.	Unlike Chafee/Dole, which did not define a benefits package, Chafee said Friday that their plan will also establish a standard, minimum package of benefits that any plan would have to offer.
Insurance Reform	Our plan will reform the insurance market in a number of ways: it will pool purchasing power through health alliances, it will eliminate exclusions to insurance such as "pre-existing conditions" and will provide guaranteed issue and guaranteed renewability, meaning everyone has access to reasonably priced insurance and no one can be dropped.	The Chafee plan is likely to include many of the same insurance reforms, although the purchasing cooperatives (alliances) are likely to be much smaller. Since the bill will not require employers to buy insurance, many small businesses that would otherwise be pooled will remain ouside the system. For those who do provide insurance, either no one will be required to buy through the alliance, only employers with 100 or fewer employees will be required to join. **Chafee is convinced large purchasing cooperatives with a major administrative role will result in "new government bureaucracies"-- his view of alliances are really passive buying arms for small businesses and individuals.**

Memorandum

June 30, 1993

TO: Ira C. Magaziner
Chris Jennings
Steve Edelstien

FR: Peter Harbage, Katherine Houston, Christine Heenan

RE: Congressional Correspondence

Since January, your office has received 94 pieces of mail from Members of Congress. Attached is a synopsis of the concerns that have been expressed by these Members, the First Lady, and the President.

Also, please find a Correspondence Log attached. This document briefly summarizes each letter you have received, who sent it, when it was sent, and how we responded. In the future, you will receive an update to this log on a bi-weekly basis.

25 Letters dealt with Social Issues

4 Strengthen Care in Rural Areas
3 Strengthen Care in the Inner City
3 Requests Coverage be Extended to U.S. Territories
(All From Congressman Romero-Barcelo)
2 Strengthen Primary Care System
2 Strengthen Prenatal Care System
2 Support End-of-Life Decisionmaking
2 Strengthen Long Term Care System
2 Primary Care System
2 Protect Academic Health Centers
1 Preventative Care System
1 Communities and Schools incorporating health issues
1 Requests Undocumented Persons Should Be Covered

19 Letters Were Forwarded from Constituents

4 Administrative Simplification
4 General Concerns
3 Cost Control
2 Rural Concerns
1 Consider Other Countries
1 Inner City Concerns
1 Concerned about lack of Doctors on the Task Force
1 Supporting the Protection of Business Interests
1 Supporting more money for Preventive Care
1 Supporting More Primary Care

17 Letters Discussed Economic Issues

5 Urging Protection of the Pharmaceutical Industry
(One letter was signed by the NJ Delegation)
3 Concerned that Prescription Drug Prices Rise too Fast
2 Presented Ideas Regarding Administrative Simplification
1 Urging Protection of Small Business
1 Presents Cost Control Ideas
1 Want Medicare Covered by Health Care Plan
1 Supports Malpractice (Tort) Reform
1 Supports Smart Card

4 Letters Discussed Tax Issues

2 Against wine excise to pay for health care plan
(One was from the CA Delegation)
1 Supports Tax Increase if improves Long-Term Care
1 Against the tobacco tax
1 Against the gun tax

Several Letters Dealt With Miscellaneous Topics

10 Recommended Certain People to Serve on the Task Force

9 Speaking Requests Were Received

4 Letters Recommended a Specific System
2 Recommended the Single-Payor System
1 Supported Managed Competition
1 Presented Health Care Recommendations

3 Expressed Their General Support for HC Reform

2 Discussed Possible Problems With Allowing Companies to Opt Out of the System (Both Form Wellstone)

1 State Flexibility
(Signed by CA Delegation asking that MICRA be allowed to continue)

Correspondence Log

Name	Date Received	Correspondence Regarding	Response
Congressman John Porter Sent to ICM	January 29	Sent legislation regarding his own single-payor proposal which uses competition and global budgets to contain costs	Thank You Note Sent
Congressman Glenn Poshard Sent to HRC	February 2	Forwarded h.c. plan from a constituent, Gary Stanley. It was a 100 page proposal covering several aspects of health care, suggests a tax and administrative simplification ideas	No Response Necessary -- FYI
Senator Lieberman Sent to ICM	February 7	Forwarded suggestion from former Mayor Ed Koch to evaluate existing health care systems in other countries	Thanked him, agreed that reviewing existing systems in other countries is valuable
Senator Herb Kohl Sent to ICM	February 18	Forwarded a constituent letter with a proposal to create a standardized electronic billing and audit program	Forwarded letter to working group focused on preventive health care

Congressman William Thomas Sent to WJC	February 23	Wrote a very supportive letter on importance of h.c. reform	Response sent thanking him for support -- said encouraged by common thinking
Congressman William H. Zeliff Sent to HRC	February 24	Established a Congressional Task Force on Health Care in Hew Hampshire and wrote w/ its 20 point results	No Response Necessary -- FYI
Congressman Jack Reed Sent to ICM	March 2	Forwarded letter from Dr. Christopher Morin -- of R.I. supporting administrative simplification and a reduction of bureaucracy	Steve asked to respond; Christine called Reed to thank him
Congressman Tom Barrett Sent to WJC	March 4	Recommends Dr. Richard Boser for a position on h.c. Task Force	General thank you note sent
Congressman Charles Wilson Sent to ICM	March 8	Recommends Linda Lea McIntosh for h.c. Task Force	General Thank You Note Sent
Senator Nunn Sent to HRC	March 9	Offered work of Center for Strategic and International Studies for the benefit of the task force	No response necessary -- FYI
Senator Roth Sent to HRC	March 10	Outlined his proposal regarding managed competition	No response necessary
Senator Byron Dorgan Sent to Lois Quam	March 10	Recommended Reba Walker for Task Force	Recommendation was forwarded to staff
Russell D. Feingold Sent to HRC	March 11	Regarding S. 52, a proposal to address long-term care for patients who are just discharged from the hospital	No Response Necessary (Sent to HRC)

Senator Jim Sasser Sent to Janet Reno	March 12	Expressed concern over Pharmaceutical industry's eventual approach to Justice Dep't for exemption to anti-trust and how that would cause prices to soar.	No Response Necessary -- FYI
Congressman Jim Nussle Sent to HRC	March 12	Expresses concerns about unique problems of rural Am. and how h.c. proposal should address this	No Response Necessary -- FYI
Senator Bill Cohen Sent to Janet Reno	March 16 (Date of Letter)	Concerned about the rising costs of prescription drugs	No Response Necessary -- FYI
Senator Paul Wellstone Sent to ICM	March 17	Recommended Nicole Lurie, M.D., to physician's advisory panel	Thanked him for recommendation
Senator Sam Nunn Sent to ICM	March 17	Forwarding letter from Dr. Claresa S. Levatan regarding general ideas on health care reform	General thank you note sent
Senator Robert Byrd Sent to ICM	March 19	His constituent Robert H. Blake want to meet w/ Ira to discuss h.c. services in rural areas	Meeting was conducted
Congressman Richard Durbin Sent to CJ	March 19	Introduced a bill to create a Prescription Drug Price Review Board --if drugs are overpriced, manufac. patent could be revoked	Thank You for Interest
Congressman Andy Jacobs Sent to ICM	March 22	Recommends David Dyar for h.c. Task Force	Thank you for interest

Congressman Newt Gingrich Sent to ICM	March 22	Forwarded letter from constituent offering cost saving strategies/easing personnel shortages in hospitals	General thank you note sent
Senator Nunn Sent to ICM	March 23	Forwarded Davild L. Bowman's letter regarding controlling costs, and Mr. Bowman asked to work on the task force	Thanked him for suggestions and interest, and said that resume and suggestions were forwarded
Senator Nunn Sent to ICM	March 23	Forwarded a constituent letter with a paper on providing care in the inner city	Thanked him for suggestions, which he said were forwarded
Senator Pell Sent to ICM	March 26	Suggested that WJC come to R.I. to meet with Women & Infants Hospital in their annual meeting.	Passed on suggestion to appropriate office
Congressman Romano Mazzoli Sent to ICM	March 26	Recommends Henry Wagner for h.c. Task Force	Response sent
Senator Metzenbaum, David Pryor Letter to Janet Reno (FYI)	March 28	Expressed concern that, if drug companies were exempt from anti-trust laws, prescription drug prices would skyrocket	No response necessary -- FYI
Congressman Barbara B. Kennenlly Sent to ICM	March 29	Supports increases in funds for prenatal care and pregnancy prevention, i.e., Hartford Action Plan for Infant Health	Thank you for interest; The plan looks helpful; I hope that other areas are as innovative as you
Senator Matthews Sent to ICM	March 29	Suggested reviewing Tennessee's Health Care Reform Package as a source of information; sent plan along with note	Thanked him, proposal is valuable, and is being used by working groups

Senator Paul Simon Sent to ICM	March 30	Recommended Dr. Aida Giachello for Task Force	Thanked him, and said rec. had been passed onto staff
Senator John Glenn Sent to HRC	March 29	Letter in Support of the Applegate letter which asked Ira to contact P. Tibbs who works with information systems	No response necessary
Congressman Calvin Dooley Sent to ICM	March 30	Wrote supporting a persons right to choose the amount of care they want for end-of-life decisions; Supports Advanced Directives	Thanked him; Told that ICM was sensitive to issue from work in RI; Health care would not address this issue
Senator Paul Wellstone Sent to ICM	April 1	Expressed his concern over allowing companies with 1,000 or ore employees to opt out of obtaining coverage through a purchasing cooperative	(Could not find response on file)
Congressman Romero-Barcelo Sent to ICM	April 1	Supports health care reform for all Americans, including people in the territories	
Senator Sam Nunn Sent to ICM	April 5	Forwarded a constituent letter which proposed "CoCare", a way to have HC providers with one another to keep costs down	Thanked him for the proposal and said working groups would use the suggestions
Senator Bob Krueger Sent to ICM	April 5	Concerned over representation of doctors on Task Force	Appreciated concerns, stated that doctors and hospital administrators have been included

Senator Arlen Specter Sent to ICM	April 6	Recommended Jay Feldstein to Task Force	Thanked him for recommendation
Senator Lieberman Sent to ICM	April 7	Wants the plan to include the special needs of medical centers	Sent material on Academic Health Centers
Congressman Dale Kildee Sent to ICM	April 7	Working on re-authorizing Elemen. & Second. Ed. Act (ESEA) -- encourages communities to coordinate health, ed., and social services to schools.	No response necessary
Congressman Phil Sharp Sent to ICM	April 7	Met with officials at Eli Lilly (pharmaceutical manufacturer); would like you to meet with Eli reps.	Response sent
Governor Mike Sullivan of Wyoming Sent to ICM	April 9	Supports the Smart Card idea; the Western Governors Association is considering using smartcards for maternal and child primary care	Thanked for support
Senator Moynihan Letter to the Senator from The Buffalo City Council	April 13	City Council passed a resolution that endorsed a single-payer health care system	No Response Necessary -- FYI
Congressman Douglas Applegate Sent to ICM	April 13	Stresses the importance of info. systems in reducing h.c. costs; asks for a meeting b/w a constituent and Task Force member	Agreed w/ the importance of info. systems; referred constituent to staff member
Senator Bill Bradley Sent to ICM	April 14	Recommends that Dr. Stanley Bergen be placed on the Task Force	Thanked for their recommendation

Senator Paul Wellstone Sent to ICM	April 15	Concerned with the policy that companies will be allowed to opt out of the plan; Concerned that the HC proposal will allow for racial and medical discrimination	
Senator Patty Murray Sent to HRC	April 16	Introduced her own bill to enact a tax on hand-guns and ammunition to offset the cost of a health care system	No Response Necessary -- FYI
State Representative Shon (Hawaii) Sent to ICM	April 17	Proposes that a network of primary care facilities be created in order to assure enough people get care	Agreed that a network of facilities could be helpful; called Hawaii a leader in health reform
Senator John Breaux Sent to ICM	April 18	Recommends that Dr. David Paone be placed on the Task Force	Told that we would contact Dr. Paine
Congressman Jose Serrano Sent to ICM	April 19	Request to speak at the Hispanic Caucus on April 22	Letter not received until June 1; No response sent
Senator Krueger Sent to ICM	April 20	Forwarded a constituent letter expressing concern over doctors' representation on Task Force	Appreciated concerns, states that doctors and administrators were on Task Force
Senator John Kerry Sent to ICM	April 21	Forwarded letter from constituent indicating she would send a plan soon; package as yet not received	Thanks for interest; will await the proposal, and forward it to appropriate staff
Senator Sam Nunn Sent to ICM	April 21	Recommended Mr. Stanley Jones	Thanked him, said resume was passed onto staff

Congressman Fred Grandy Sent to ICM	April 22	Request to appear at the Siouxland Conference on health care reform	A Task Force Representative was sent
Senator Pell Sent to ICM	April 23	On behalf of John Nazarian, invited him to speak to R.I. College for Commencement	Had to decline invitation, wrote note thanking him
Congressman Peter Blute Sent to ICM	April 23	Invited by Fall River Area Chamber of Commerce & Industry to be main speaker at their Coffee Conference for Feb. 1994.	Wrote saying miss New England and will try to go; Chamber of Commerce is important
Senator David Pryor Sent to HRC and Janet Reno	April 27	Sent "Pharmaceutical Marketplace Reform" Report to HRC from Comm. on Aging, with concerns about drug co.'s being exempt from anti-trust laws	No Response Necessary -- FYI
Congressman Robert Walker Sent to ICM	April 29	Request Dr. Susan Kennif to be on h.c. Task Force	Thanked and said would follow up on request
Senator Sam Nunn Sent to ICM	April 28	Urged a meeting with Ms. Ann B. Howard and the National Home Health Service Alliance	Thanked him for letter, agreed that input from this group would be valuable
Senator Sam Nunn Sent to ICM	April 29	Passed on a constituent letter from John Sherman w/ a proposal to lower h.c. costs	Thanked him and said that Mr. Sherman's suggestions were passed onto the working group studying cost
Senator Dianne Feinstein Sent to ICM	May 3	Forwarded letter from Chairman and CEO of Gap, Inc. about his self-insured h.c. plan and background on Gap	Will send follow-up letter after Gap meeting w/ Ira; Thank you note sent

Congressman Maurice Hinchey Sent to ICM	May 4	Sent info. regarding the New York State Primary Care Service and Ed. Consortium	Thanked him for info.
Governor E. Benjamin Nelson of Nebraska Sent to ICM	May 6	Thanks you for discussing h.c. reform with him; wants Medicare recipients to be included in proposal	Medicare will initially remain a distinct federal program; however when states have new system organized, will integrate Medicare
Congressman Pat Danner Sent to WJC	May 7	Preventive care should be a focus of HC proposal; provided info. on a vaccination program in her district	Response sent; We hope that other areas are as innovative as yours
Senator Sam Nunn Sent to ICM	May 11	Forwarded letter from State Representative E.M. Childers on h.c. reform regarding cost control	Sent general thank you note
Senators George J. Mitchell and Tom Daschle	May 11	Thanks for attending conference for Democratic Senators in Jamestown	No response necessary
Congressman Don Edwards Phone call taken by Howard Paster	May 16	Expresses concerns about funding sources for h.c.; increased excise taxes on wine should not be used to pay for h.c.	No response necessary
Congressman John Dingell Phone call taken by Howard Paster	May 16	Expresses concerns about funding sources for h.c.; strongly opposes taxing guns and ammunition as a way to pay for h.c. -- he's a board member of the NRA.	No response necessary
Senator Tom Harkin Sent to ICM	May 20	Invites you to talk w/ summer interns sponsored by Democrats 2000	Wrote and said you would try to attend

Congressman Romano Mazzoli Sent to ICM	May 24	Sent article on substance abuse & how it contributes to inner city and youth problems -- include this in h.c. proposal	Thank you for information
Senator Hollings Memo sent to Joy Epstein, Alan Davis, and Rich Hamburg	May 25	In this meeting, Hollings expressed that he would vote for a reform package, even it if had a tobacco tax (although he wouldn't like it); personally, he appreciates the risks of tobacco use	No response necessary; FYI
Congressman Newt Gingrich Sent to ICM	May 25	Forwarded letter from constituent Dr.Michael R. Papciak, a pediatrician who suggested several strategies for improving the care of children	General thank you note sent
Congressman Ilean Ros-Lehtinen Sent to ICM	May 25	Forwarded letter from constituent on "InsureLinc" to reduce admin. costs	General thank you note; Said that the information would help the task force
Byron Dorgan Sent to HRC	May 27	Concerned that rural areas will be unprotected by the plan	No response necessary (HRC)
Congressman Steve Neal Sent to ICM	June 2	Invites you to speak at the North Carolina Congressional Chamber of Commerce D.C. Seminar 9/21/93	Will try to go
Congressman Vic Fazio Sent to ICM	June 3	Invited you to Health Summit 1993 in Sacramento	Response sent, declined invitation, said someone from White House will attend July forum

Congressman Butler Derrick Sent to ICM	June 9	He and the South Carolina Chamber of Commerce invite you to be keynote speaker at a 6/29/93 meeting on h.c. reform	General thank you note sent
New Jersey Delegation Sent to WJC	June 10	Requests that reps. of pharmaceutical industry are consulted by the Task Force; explains importance of this industry	The Admin. is sensitive to the needs of this industry and HRC & WJC have met with industry
Congressman Jose Serrano Sent to WJC	June 10	Requested that all residents of US are covered by nat'l insurance including undocumented persons	Undocumented persons will not be covered; state laws covering undocumented people will be continued
Alex McMillan Sent to ICM	June 10	Thanked Ira for having the 7:30 meetings; stressed the importance of a bi-partisan effort in order to achieve reform; enclosed a copy of his malpractice bill	Stressed importance of bi-partisanship & communication b/w Congress and the White House; thanked him for sending a copy of his bill and applauded his efforts at finding workable solutions
Congressman Peter Blute Sent to WJC	June 10	Concerned that a biotech. corp. may halt construction of a factory in his district due to uncertainty surrounding h.c. reform	No final decisions have been made regarding this policy; the Admin. is sensitive to needs of pharmaceutical manufacturers.
Congressman Carlos A. Romero-Barcelo Sent to WJC	June 11	Requests that American health benefits be extended to all Americans, including those in territories	No response given yet

Congressman Sam Gibbons Sent to ICM	June 11	Forwarded constituent mail regarding the importance of primary care	Thanked him for his interest
Senator Carl Levin Sent to ICM	June 11	Asks about "medical futility cases", "heroic measures" and how they will be included in the h.c. plan	Wrote saying understand ethical and moral struggles -- says will use prior directives and surrogate decision making and consumer info.
Senator Paul Simon Sent to WJC	June 14	Supports a tax increase to provide comprehensive long-term care and thinks Americans will too change	Wrote and avoided tax issues in letter
Congressman James Clyburn Sent to ICM	June 15	Requests that Ira speak at the South Carolina Hospital Association meeting	Sent not saying that Ira would try to speak
California Delegation Sent to WJC	June 16	Requests that the h.c. proposal grant states flexibility; asks that Calif. by allowed to keep MICRA	States will have the flexibility to solve their own unique problems; no specific comment on MICRA
Congressman McNulty Sent to WJC	June 17	Expresses general thoughts on h.c. reform; wants policies that are already in the health plan	We agreed on his points
California Delegation Sent to WJC	June 21	Concerned about higher excise taxes on wine being used to finance h.c. reform.	Replied that no decisions have been made; We will consult with the delegation if any such tax is going to take place

Congressman Romero-Barcelo Sent to WJC	June 21	Requests (again) that American health benefits be extended to all Americans, including those in territories	CJ to handle response
Congressman Amo Houghton Sent to ICM	June 23	Shared info. on Western NY Rural Health Networking Project	Thank you not sent; with message for Houghton's wife from ICM
Congressman Thomas Sawyer Sent to ICM	June 18	Forwarded a constituent letter concerned with rural issues; Asked Task Force to contact the constituent	Said the Administration is very concerned with rural issues; Said CH would contact constituents
Congressman Slaughter Sent to HRC	June 18	Requests that cities be able to opt out of the Health Care plan in the same manner that companies will be are allowed to do; Details the HC policy of Rochester, NY as part of her argument that this city in particular should be able to opt out	No Response Necessary -- FYI

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Chris Jennings to Hillary Clinton Re: Meeting with Senator John Chafee (2 pages)	6/30/93	P5

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
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FOLDER TITLE:
June 1993 [6]

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RESTRICTION CODES

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

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

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

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

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