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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings to Hillary Clinton Re: Calls to Senators (6 pages)	10/17/93	P5
002. memo	Chris Jennings to Hillary Clinton Re: Senator Daschle's Likely Senate Cosponsorship List (2 pages)	10/18/93	P5
003. memo	Chris Jennings to Hillary Clinton Re: Chairman Moynihan, Liz Moynihan/Finance Committee Staff Director (1 page)	10/18/93	P5
004. memo	Chris Jennings to Hillary Clinton Re: Senator Bob Kerrey (2 pages)	10/19/93	P5
005. memo	Chris Jennings to Hillary Clinton House CoSponsorship Update and Requested Call List (7 pages)	10/24/93	P5

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

FOLDER TITLE:
October 1993 HSA [1]

gf108

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Hispanic Caucus

To: Chris Jennings

From: Richard A. Veloz

Re: Congressional Hispanic Caucus

Date: 10/7/93

c.c. Ira Magaziner

I've attached material that the Congressional Hispanic Caucus distributed at a Press Conference yesterday announcing the Introduction of their health bill known as the "Minority Opportunity Enhancement Act of 1993" (M-HOPE).

It is designed to target specific DHHHS programs in the areas of community-based health care capacity, minority health professional education, and research on minority health.

In previous announcements and meetings, the Congressional Hispanic Caucus supports our bill, but is taking a strong stand on **two basic issues**; the **Undocumented Worker**, and strong assurances that our **health card** not be used as part of a verification process to determine eligibility for health services or as a National I.D. card for other purposes unrelated to billing and record-keeping purposes.

Two other issues of concern relate to assurances that the **"Essential Community Providers"** provision in our bill does not decrease funding to medically underserved and disadvantaged communities by leaving funding distribution entirely up to states through waivers or block grants, and that national and local **Health Alliance Governing Boards** have racial and ethnic representation as a criteria for state certification.

At a meeting with the Hispanic Caucus and Secretary Shalala and Judy Feder on September 15th, it was agreed to allow staff from the Hispanic Caucus to meet with DHHS drafters of the bill to provide input on these issues. I understand that this Friday, October 8, Judy Feder, Cliff Gaus and someone from DHHS Legislative Counsel Office will begin this process. Follow up meetings are scheduled for next week.

Congressional Hispanic Caucus
NEWS RELEASE

557 Ford Building, Washington, D.C. 20515 • (202) 226-3430

Statement of Rep. José E. Serrano
Chairman of the Congressional Hispanic Caucus
On Introduction of the Minority Health
Opportunity Enhancement (M-HOPE) Act of 1993

October 6, 1993

Welcome and thank you for attending this afternoon's press conference.

On behalf of the Congressional Hispanic Caucus (CHC), I am proud to announce that the Caucus will be introducing the "Minority Health Opportunity Enhancement Act of 1993," known as the M-HOPE Act.

The M-HOPE Act improves several programs within the U.S. Department of Health and Human Services (DHHS) to better meet the needs of Hispanics and other language minority communities.

Allow me first to state that this legislation does not attempt to broadly reform the U.S. health care system. It is not intended in any way to compete with the Administration's health care reform plan. Instead, the M-HOPE Act compliments the Clinton Administration's or any other effort to reform our nation's health care system by targeting existing DHHS programs.

Let me also clarify that the Hispanic Caucus has adopted a set of comprehensive health care reform principles. Based on these principles the Caucus has released an initial statement on the Administration health care plan. We are continuing to work with the Administration to assure that their plan would also embody the principles endorsed by the Caucus.

That said, I believe the introduction of the M-HOPE Act is historic. It marks the first time the Caucus has developed legislation to strengthen and enhance community-based health care capacity, minority health professional education, and research on minority health.

There is a clear need to increase and enhance the health opportunities of Hispanic Americans.

Hispanics have poor health status. Hispanics are twice as likely to be diagnosed as suffering from diabetes as the general population and their incidence of tuberculosis is twice as high. Furthermore, while Hispanics represent 9% of the total U.S. population, they account for 16% of all AIDS cases.

Hispanics lack access to timely and adequate health care. One third of Hispanics lack health insurance coverage and Hispanic children are uninsured at twice the rate of other children. Hispanics do not receive proper screening or preventive care since they often lack a regular source of medical care.

In addition, a host of cultural and non-financial factors affect the appropriateness and availability of health care services for Hispanics. Many inner-city and rural Hispanic communities lack the infrastructure and health care delivery system to meet local demand. Furthermore, there is an insufficient supply and distribution of health care workers in Hispanic communities.

The M-HOPE Act takes a serious look at existing programs at the U.S. Department of Health and Human Services (DHHS) and reviews their responsiveness to the health needs of Hispanics.

Our findings were deeply troubling.

First, we found that two of the four criteria used in designating medically underserved areas exclude Hispanics. The 65-and-over factor works against Hispanics since we are a young population. Also, this criteria places high emphasis on infant mortality. Yet, although Hispanic communities experience poor health status, this factor fails to consider Hispanic health needs. The M-HOPE Act attempts to remedy this inequity by including factors that more suitably measure health status and medical underservice, such as uninsurance and morbidity rates.

Second, although Hispanics are grossly underrepresented in the health professions, Hispanic participation is very poor in key programs that focus on increasing minority health professionals. The M-HOPE Act addresses this inequity by encouraging certain programs to more equitably allocate resources and services among all groups served. It also includes an outreach and peer review process to ensure that such efforts are inclusive and target all racial and ethnic groups.

Third, data are critical in setting public health priorities. Yet, basic data on Hispanic health are non-existent or seriously lacking. The M-HOPE Act strengthens existing initiatives within the National Center for Health Statistics and the Agency for Health Care Policy and Research to increase research on ethnic minorities.

Lastly, the bill focuses attention on the lack of linguistically and culturally appropriate services for limited-English-proficient populations. The M-HOPE Act builds on existing efforts by the community and migrant health centers to reduce language and cultural barriers to care. In addition, the bill directs the Secretary of DHHS to issue regulations establishing limited-English-proficiency as a barrier to health care access.

Let's be clear. The M-HOPE Act sends a strong message to the Department of Health and Human Services that it must do a better job in serving the health needs of Hispanics and other language minorities. Many DHHS initiatives should be more attentive to integrating the Hispanic community, with greater Hispanic involvement within the administrative offices and at the drafting stages.

Hispanics, however, are poorly represented within the DHHS labor force. Regrettably, only 5% of persons employed at DHHS are Hispanic. Hispanics have little input in shaping DHHS's policy priorities. Of the top level DHHS manager and policy positions, 2.7% were Hispanic. According to the latest figures from DHHS, similar dismal staffing patterns exist within all agencies, including the Public Health Service.

It is difficult to comprehend these low levels at a time when Hispanics are a growing presence in the U.S. population. Hispanics represent one out of every 11 persons in the U.S. Including the U.S. citizens who reside in Puerto Rico, Hispanics are projected to be the largest ethnic minority by the year 2005. In just seven years, Hispanic children will be the second largest minority group under the age of 18.

The M-HOPE Act attacks a pattern of neglect by DHHS in addressing the health care needs of Hispanics. Of course, the Caucus recognizes that these and other problems in serving Hispanic communities at DHHS did not appear overnight. Secretary Shalala has demonstrated an early interest in listening to our serious concerns about how things have been done in the past. It is my hope that she would embrace our proposal and use it as a blueprint for improving the service of Hispanics by DHHS programs.

I must acknowledge the work and commitment of the two other principal sponsors of this legislation, Congressmen Bill Richardson and Luis Gutierrez. This was a triple effort. I thank them deeply for their leadership on this important issue.

Congressman Bill Richardson, in his key role as a member of the Committee on Energy and Commerce, was there when the Disadvantaged Minority Health Improvement Act was originally drafted. He lent his expertise then and does so now to put forward legislation that addresses health injustices of vulnerable communities.

Congressman Luis Gutierrez, as Chair of the CHC Health and Judiciary Task Force, has taken a key leadership role in spearheading Caucus efforts that advocate for the health needs of Hispanics. This legislation represents one of his biggest efforts yet.

Thank you and let me turn the podium over to Congressman Richardson.

# # # #

Congressional Hispanic Caucus
NEWS RELEASE

557 Ford Building, Washington, D.C. 20515 • (202) 226-3430

For Immediate Release
September 22, 1993

Contact: **Rick López**
Darryl Figueroa

Washington, D.C. -- The statement of Congressman José E. Serrano, Chairman of the Congressional Hispanic Caucus, on the Administration's health care plan is as follows:

As Chairman of the Congressional Hispanic Caucus (CHC), Mr. Serrano applauds the principles that underlie President Clinton's health care reform plan. These principles form the core of an effective and equitable overhaul of our nation's inefficient and often unfair health care system. The CHC insisted in early April that these principles form the basis for national health care reform. They include:

- ***Universal Coverage*** — The Clinton Plan on the principle of universal coverage represents a historic step forward for the nation and, especially, for the Hispanic community. By dramatically broadening health insurance coverage, the Clinton Plan will help ensure that health care becomes a right, not a worry, for the Hispanic community. Under the current system:

  » Hispanics are more likely than any other population groups in the U.S. to lack health insurance. A staggering 39% of Hispanics under 65 are uninsured and Hispanic children are twice as likely as other American children to be uninsured.

  » Hispanics lack private or public health insurance coverage despite the fact that they work and play by the rules. Eighty (80) percent of Hispanics without insurance are fully employed.

  » Because of their uninsured status, Hispanics are forced to pay more of their disposable income on health care. Providing health insurance coverage may be the single most important stroke to lifting many Hispanics from poverty.

- ***Comprehensive Benefits*** — The comprehensive, preventive benefits package in the Clinton Plan will save Hispanics and the health system money, while improving the quality of life. A focus on providing comprehensive, preventive health care services relieves human suffering and premature deaths resulting from poor health. Under the current system:

  » Hispanics are the least likely to have a usual source of medical care, the medical attention they receive is often in an emergency room, and they do not receive proper screening and prevention treatment.

  » Hispanics are disproportionately affected by diabetes and HIV, and suffer from excess incidence of obesity, kidney problems, and certain cancers, therefore need a full range of medical services.

There remains, however, a number of significant concerns that must be addressed by the Clinton Plan to meet the health service needs of Hispanics. Caucus Members have met with senior Administration officials to discuss these concerns and expect to revisit these issues with them.

- ***Undocumented Persons*** — It makes sense to address the health needs of the undocumented. The CHC believes that it is important to enforce our nation's immigration laws. However, failure to address health issues of undocumented persons:

  » Poses a public health threat for all Americans since communicable diseases do not distinguish between geographic boundaries or citizenship status;

  » Would likely result in continued skyrocketing health care costs since persons will continue to delay treatment until an illness is so severe they need more expensive and urgent care; and

  » Would likely result in discrimination against all minorities, regardless of citizenship or residency status, and create an economic incentive to turn away patients who look or sound foreign.

- ***Health ID Card*** — The CHC does not oppose the use of a health card for health-related billing and record-keeping purposes. However, stronger safeguards must be in place to secure against:

  » The misuse of a health card for unrelated identification purposes, or as a *de facto* national ID card; and

  » The use of a health card as part of a verification process to determine eligibility for services, since it may be used as a tool to discriminate against those who look or sound foreign.

- ***Essential Community Providers*** — Many Hispanics and disadvantaged communities currently obtain health care through a fragile network of "safety-net" providers. For this reason, health care reform must maintain and strengthen a viable public health network through:

  » Substantial investment to empower medically underserved and disadvantaged communities to develop responsive, community-based health care systems; and

  » Effective federal oversight and by not funds entirely at the discretion of states through waivers or block grants. As the Medicaid experience has shown, many states do not have a good track record of meeting the needs of their poor and Hispanic constituents.

- ***Hispanic Working-Poor Individuals and Families*** — Hispanic Americans must be assured appropriate health services and incorporation in a new system through:

  » assurance that national, regional, and local governing boards have racial and ethnic representation; and

  » vigorous oversight, monitoring, and enforcement to ensure uniform, equitable, non-discriminatory treatment for all.

Congressional
Hispanic Caucus

NEWS RELEASE

557 Ford Building, Washington, D.C. 20515 • (202) 226-3430

SUMMARY OF:
THE MINORITY HEALTH OPPORTUNITY ENHANCEMENT (M-HOPE) ACT OF 1993

BACKGROUND: The **M-HOPE Act** would improve several programs within the U.S. Department of Health and Human Services (DHHS) to ensure that they better meet the needs of the Hispanic and other language minority communities. The **M-HOPE Act** amends the Disadvantaged Minority Health Improvement Act, which will be reauthorized this year, and would address the following:

- Low participation rates of Hispanics and other language and cultural minorities in Public Health Service (PHS) programs;
- Lack of research and data collection needed to assess the health status and illnesses affecting Hispanic and other language and cultural minorities, by subgroup;
- Mechanisms that have unfairly deflected DHHS resources from many Hispanic and other language and cultural minority communities; and
- Lack of linguistically and culturally appropriate services.

The **M-HOPE Act** sends a strong message to the Department of Health and Human Services (DHHS) that it must do a better job in serving the health needs of all racial and ethnic minorities.

MAJOR PROVISIONS:

- Establish an Office of Minority Health (OMH) within each PHS Agency to oversee and monitor racial/ethnic minority initiatives and directives, in coordination with the existing OMH at the Office of the Assistant Secretary for Health.
- Modify the current index for designating Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs) and the Health Professional Shortage Areas (HPSAs) since current criteria are not sensitive to the needs of Hispanics.
- Encourage certain programs to more equitably allocate resources and services among all groups served and include a Peer Review and Outreach Process to ensure that efforts target all racial/ethnic minorities.
- Establish limited-English-proficiency as a barrier to health care access.
- Strengthen the Hispanic Centers of Excellence (HCOEs) program to increase the low number of Hispanic health professionals.
- Strengthen existing initiatives within the National Center for Health Statistics (NCHS) and the Agency for Health Care Policy and Research (AHCPR), to increase research on ethnic minorities.

Congressional Hispanic Caucus
NEWS RELEASE

557 Ford Building, Washington, D.C. 20515 • (202) 226-3430

HISPANIC HEALTH CARE FACT SHEET

HISPANICS AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

- Hispanics are a growing presence in the U.S. Hispanics represent one out of every 11 persons in the U.S. Including the U.S. citizens who reside on the Island of Puerto Rico, Hispanics are projected to be the largest ethnic minority by the year 2005.

- Hispanic employment is dismal at all staffing levels within the U.S. Department of Health and Human Services (DHHS), particularly at high policy and administrative levels.

  - As of June 30, 1993, only 5% of the total 124,376 persons employed at DHHS were Hispanic. Of the 12,098 manager and top level policy positions at DHHS (GS/GM 14 and above and equivalents), 2.7% were Hispanic.

  - In the first quarter of FY93, 2.7% of the professional positions at the Health Resources and Services Administration (HRSA) were held by Hispanics, and none held senior executive service (SES) positions.

  - About 1.6% of the federal labor force at the National Institutes of Health (NIH) during the first quarter of FY93 were Hispanic. During the same period, 0.4% of NIH manager positions were held by Hispanics.

- Hispanic participation in HHS programs that target underserved communities is very poor.

HISPANIC HEALTH STATUS:

- Hispanics are twice as likely to be diagnosed as suffering from diabetes than the general population (6% versus 3%). Hispanics have three times the risk of developing diabetes compared to non-Hispanic Whites.

- The incidence of tuberculosis among Hispanics is over twice that of the total population (23% versus 10%).

- While Hispanics represent 9% of the U.S. population, they account for 16% of all AIDS cases.

- Hispanics disproportionately suffer from excess incidence of certain cancers: death due to stomach cancer is twice as high for Hispanics as for non-Hispanic Whites, and cervical cancer among Hispanic women is double that for non-Hispanic white women.

HISPANIC ACCESS TO HEALTH CARE:

- Hispanics are the single group most likely to be uninsured. The latest Census figures indicate that in 1992, 33% of Hispanics were uninsured, compared to 14% of Whites and 20% of Blacks. In 1992, 26% of Hispanic children were uninsured, about twice the rate of White (12%) and Black (14%) children.

- Hispanics do not receive timely and adequate health care. In 1987, over one-fourth of all Hispanics (28%) lacked a regular source of health care, compared to 17% of Whites and 23% of Blacks.

- Hispanics often receive medical attention in an emergency room, and thus do not receive proper screening or prevention treatment. Nearly 10% of Hispanic identified the hospital emergency room as a regular source of medical care, compared with 4% of Whites.

The Congressional Hispanic Caucus is an organization of Hispanic Members of Congress promoting Hispanic interests.

cc: Melanne Verveer, Chris Jennings, Steve Ricchetti

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1st Lady compliment

THE WHITE HOUSE

WASHINGTON

October 15, 1993

The Honorable Daniel Patrick Moynihan
Chairman
U. S. Senate Committee on Finance
Washington, D. C. 20510

Dear Chairman Moynihan:

It was an honor to testify before your committee on September 30. Following up on my testimony, I would like to take this opportunity to clarify my statement about how we can and must move to slow growth on health care costs.

As I indicated in response to your question, the President strongly believes that there is tremendous waste and inefficiency in the health care system. Through market restructuring and economic incentives, we believe we can achieve both one-time and ongoing savings. In my testimony, I went into some detail on how these savings will result from increased consumer choice, consumer sensitivity to value and costs, administrative simplification, and through changes in incentives to providers.

By the end of the decade, we believe these market changes, subject to the back-up discipline of the premium limits we propose, can and must slow our current growth rates in health care spending to the rate of increase in inflation and population. Even with these market changes, we are assuming that increases in current spending will still raise our health care spending as a share of GDP from 14 to 17 percent. No other nation in the world comes close to either level. (The next highest allocation of GDP to health care -- 10 percent -- comes from Canada.) To allow a greater absorption of our resources -- rather than a reallocation of resources -- as we pursue reform seems unconscionable.

Once the health care marketplace has changed, however, appropriate long-run growth rates become a more open question. There will always be upward pressure on health expenditures from the development of new technology and the aging of the population. Once we have restructured our health care system, we can and should accommodate those pressures by allowing real growth in health care spending.

With new incentives in place to promote efficient resource use, health care expenditure growth need not absorb a disproportionate share of our economic resources. It is important to note, however, that our current estimates provide ample room to allow for greater growth rates in the out years and still maintain stable financing of the health benefits package and Medicare expansions we propose.

Mr. Chairman, we are confident that we, like other countries, will be able to meet our citizens' health care needs without sacrificing the resources necessary to satisfy their many other equally legitimate needs and wants. The challenge we must face together is how to turn the current system around so that we, as a nation, have the capacity to respond effectively to a changing population in the next century. The President believes that to begin immediately and aggressively is our best hope for achieving that goal.

Sincerely yours,

Hillary

Hillary Rodham Clinton

MEMORANDUM

TO: Hillary Rodham Clinton October 21, 1993
FR: Chris Jennings
RE: Prescription Drug Issue
cc: Ira, Mike Lux, Melanne, Steve, Jack, Charlotte, Distribution

As you know, the pharmaceutical industry has rather publicly raised concerns about a number of provisions of the President's health reform proposal. In particular, the Pharmaceutical Manufacturers Association, as well as the biotech industry, are targeting the breakthrough drug committee, the authority for the Secretary to negotiate with manufacturers over the costs of new drugs for Medicare coverage, and the Medicare rebate.

Because of the industry's visibility and lobbying prowess, it is easy to reach the conclusion that the manufacturers and their allies are the only parties interested in the drug coverage and cost containment issue. Obviously this is not the case, but more importantly the groups are starting to provide very public endorsements of our prescription drug provisions. It is interesting to note that some of these groups, like Consumers Union, have indicated that they believe we have already given in too much to the industry.

The organizations who have already written in represent tens of millions of consumers, pharmacists, and advocates for the elderly and the ill. The latter categories are particularly important to us because they have decided not to buy into the "no more investment in needed research" scare tactics by some in the industry. **These vulnerable populations, who more than anyone need breakthrough medicines; yet they are still confident that their are more than enough incentives for the industry to continue to invest in R&D.**

Here's the list and their letters of endorsement for your information:

AFSCME Retiree Program
AIDS Action Council (representing 1,000+ AIDS organizations)
American Association of Retired Persons
American Society on Aging
Association for Gerontology and Human Development in Historically Black Colleges and Universities
Consumers Union

Families USA
Gerontological Society of America
Green Thumb, Inc.
Leadership Council of Aging Organizations
National Association of Chain Drug Stores
National Association of Foster Grandparent Program Directors
National Association of Meal Programs
National Association of Nutrition and Aging Services Programs
National Association of Retail Druggists
National Association of Retired Senior Volunteer Program (RSVP) Directors
National Association of Senior Companion Directors
National Association of State Units on Aging
National Caucus and Center on Black Aged, Inc.
National Consumers League
National Organization for Rare Disorders
National People's Action
Older Women's League
PKR Foundation
Reflex Sympathetic Dystrophy Syndrome Association
Rett Syndrome Association

attachments

WASHINGTON POST 10/21/93

JACK ANDERSON and MICHAEL BINSTEIN

Drug Industry Seeds the 'Grass Roots'

The letters look like any other constituent mail that streams into the office of Rep. Ron Wyden (D-Ore.) each day. Only in these letters, the prepared text is crossed out and replaced with a more personalized message: "This junk mail came to me from these drug companies. Pretty phony and self-serving. You should be aware of the source if you receive any."

Sometimes the most sophisticated lobbying efforts end with the most unsophisticated results.

This time, the drug companies stirred up a mini-rebellion among Wyden's constituents. The "junk mail" Wyden was warned about actually was part of a growing phenomenon in influence-peddling: using direct mail to generate grass-roots pressure on a single issue.

The grass-roots approach has been popular since the 1980s, when lobbyists discovered that many members of Congress care far more about what their constituents think than the opinions of high-paid lobbyists. But in this case, "grass roots" meant ghostwritten.

Wyden became a target because of his influence on the prescription drug issue. In recent years, drug companies have been deluged with criticism for hiking prices and making record profits while health care costs are exploding. Wyden has been one of the chief provokers of the pharmaceutical industry.

Thus, Wyden began receiving letters signed by constituents but actually written by pharmaceutical interests. The letters, addressed to Wyden, were sent to constituents with their names at the bottom. All that was needed was a signature and a postmark, and Wyden would receive a letter asking him to go easy on the pharmaceutical industry.

To throw members of Congress off the scent, each of the letters was made to look a little different. When members get a form letter, it's not taken as seriously as a personal letter. So the anonymous authors varied the exact wording, the letter font and even the color of the paper. Nobody was fooled.

"I resent the fact that the pharmaceutical lobby thinks we are this stupid . . . of course these folks need regulating. They have proved most unable to regulate themselves," one constituent wrote at the bottom of his letter. Drawn across the text of the letter was a large circle with a slash through it, along with the word "Not" in capital letters.

"Unless American drug companies can curb their immense profits and, at least, provide some accountability on research, I feel our only recourse is for government control," wrote another. "This, in my opinion, is the biggest piece of [profanity] I have ever been asked to back," wrote a third. Wyden received dozens of similar responses.

"I think the message here is that some of these slick and fancy campaigns, particularly on the health care issue, are starting to backfire," Wyden told our associate Jan Moller. But, he added, "I haven't found many campaigns that have backfired like this."

Drug companies have made no secret of their stand in the health care debate. Since President Clinton announced the formation of his health care task force last winter, relations between the administration and the pharmaceutical industry have ranged from open warfare to an uneasy detente.

When the administration came out firing last spring, drug companies retaliated with a series of large newspaper ads and editorials defending their pricing policies and stressing their record of developing new drugs. It's not that the drug companies hate the entire Clinton plan. They like the fact that prescription drugs are covered under Clinton's "standard benefits package." It's the "price control" feature that makes them fume.

Fearing trouble, some drug companies broke from the industry's chief lobbying arm, the Pharmaceutical Manufacturers Association (PMA), and formed their own coalition to fight price controls. With a $1 million budget, RX Partners employs some of the heaviest hitters in the Washington influence game, including former president Jimmy Carter's press secretary, Jody Powell.

That leaves unanswered the question of who's been sending mail to Wyden's office. An unscientific survey of several drug companies and lobbyists found no one eager to take responsibility. "I am absolutely certain that it's not our work," a PMA spokesman told us.

The first person we reached at RX Partners wasn't sure, but added that "everyone involved in the prescription drug industry is involved in something like this. . . . Part of our program is, of course, working on the grass roots." Shortly thereafter, another representative from RX Partners called to assure us that his group had absolutely nothing to do with any direct-mail form letters.

AIDS Action council

October 15, 1993

Dear Mrs. Clinton:

As the Washington voice of over 1000 member AIDS organizations, we applaud your efforts in formulating the health care reform proposal. As you know, instituting change takes courage. The innovative health plan put forward overhauls a system that needs drastic change, and we are thrilled to witness the brave acts of a new administration.

Affordable prescription drug coverage is of utmost importance to AIDS communities. People living with AIDS and those individuals who are HIV positive are groups most vulnerable to escalating drug prices. As AIDS research progresses, AIDS communities will become even more defenseless against ascending drug costs since prescription medication will undoubtably be a major contributor to any cure, vaccine or treatment.

Therefore, a number of specific factors within the health plan deserve specific commendation. The cost containment measures are necessary and long-needed provisions to ensure that prescription drug coverage remain affordable under the Medicare drug benefit. As you know, many AIDS patients receive medical care through the Medicare system. Both the cost containment provisions and the inclusion of prescription drug coverage under Medicare are necessary to make important drugs affordable and available as well as keep premium increases in check.

The proposed Breakthrough Drug Committee established under the National Drug Board is an important and overdue mechanism to keep drug prices at a reasonable level. Giving the Committee the ability to review new drug prices, as opposed to setting prices, strikes a careful balance. Review of drug pricing will ensure that important research and development efforts will be maintained through adequate corporate profits. In instances of federal involvement in drug research, government review of the prices of jointly developed products is a sensible and equitable measure. The prohibitive costs of AIDS treatment such as AZT and Foscavir are warnings that price review is necessary.

Again, our congratulations for your efforts in proposing one of the most important pieces of legislations in recent history. We look forward to the system reforms offered within the proposal to becoming a reality in the near future.

Sincerely,

Daniel T. Bross
Executive Director

1875
Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300

Consumers Union
Publisher of Consumer Reports

October 19, 1993

Mrs. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mrs. Clinton:

The Administration's draft health care plan acknowledges the importance of prescription drugs to the health care of American consumers by including prescription drug benefits in the standard benefit package that would protect all Americans, young and old. It also recognizes the need to rein in the high costs of prescription drugs by requiring rebates for prescriptions purchased through Medicare and Medicaid, by encouraging health care plans to negotiate lower prices, by authorizing the National Health Board to study the reasonableness of launch prices for "breakthrough drugs," and by calling on the National Health Board to study to pricing of prescription drugs when there is evidence that they might be unreasonable.

The enclosed article "Do We Pay Too Much for Prescriptions?" in the October issue of Consumer Reports provides strong evidence for the need for expanded scrutiny of prescription drug pricing, and for regulation that goes beyond the provisions of the draft health plan. We believe that it is too late for voluntary industry efforts to limit price increases -- prescription drug prices should be rolled back and then subject to regulation in order to offer American consumers fair prices for prescription drugs.

Key facts reported in the article are:

-- Drug prices rose faster in the 1980's than health care costs overall. Total U.S. pharmaceutical sales revenues more than tripled during this decade, even though the volume of drugs sold hardly budged.

-- During 1992, the pharmaceutical industry had the highest return on sales, the highest return on assets, and the highest return on stockholder equity of any industrial group in the Fortune 500. Its 11.5 percent return on sales was more than four times as high as the average of all Fortune 500 companies, and almost twice that of the second-most profitable industry.

-- The prescription drug industry spends about 30 to 50 percent more selling and promoting its products than it does inventing and testing them.

Washington Office
1666 Connecticut Avenue, Suite 310 • Washington, D.C. 20009-1039 • (202) 462-6262

-- Billions of taxpayer dollars every year support government research that pharmaceutical companies are then allowed to use for their profit -- with very little payback to the government and, until very recently, no restraint on price. For example, in the case of the drug Ceredase (an enzyme therapy for Gaucher's disease) National Institute of Health scientists played a major role in the development of the drug (e.g., NIH discovered the missing enzyme, figured out how to harvest it from human placentas, modified it chemically to treat the disease, and gave the drugmaker-- Genzyme -- $9 million to spend on early clinical research). After spending $29.4 million of its own, Genzyme got marketing approval in 1991 and went on to sell $37 million worth of the drug that year. The drug costs up to $300,000 a year in severe cases.

-- The Office of Technology Assessment recently reported that during the 1980s, pharmaceutical companies on average earned about 15 to 30 percent **more** profit each year than needed to attract adequate investment capital.

-- All large industrialized countries except the U.S. impose some regulations on drug prices. This results in U.S. consumer paying more for drugs than people in many other counties. For example, the General Accounting Office reported in 1992 that average prices for drugs were 43 percent higher in the U.S. than in Canada.

No doubt, prescription drug manufacturers will oppose all efforts to step up the scrutiny of prescription drug prices. The time has come to put the interests of American consumers above the profiteering of the pharmaceutical industry.

We look forward to working with you and the Administration as the health reform plan works its way through the legislative process.

Sincerely,

Linda Lipsen
Legislative Director

Gail Shearer
Manager, Policy Analysis

LEADERSHIP COUNCIL
of
AGING ORGANIZATIONS

Dr. Daniel Thursz, Chairman

October 15, 1993

Dear Mrs. Clinton:

The Leadership Council of Aging Organizations (LCAO) commends the President and his Administration for putting forth a comprehensive, innovative and constructive health reform proposal. The proposal promises many vital improvements for older Americans, including prescription drug coverage in Medicare, early retiree coverage that is secure and affordable, enhanced quality measures, and increased choices for families and individuals.

We particularly note the importance of the proposed long-term care program which would offer essential support for home and community-based services for seriously disabled persons, regardless of age, that can keep them independent and support families and other caregivers. This measure represents a vital and overdue recognition that our health care system must be more responsive to the situation of those with chronic illnesses and disabilities.

We are also pleased that an outpatient prescription drug benefit for Medicare beneficiaries is included in the proposal. As you know, the combined effects of high prices, heavy utilization, and the absence of affordable insurance coverage for prescription drugs have significantly reduced access to needed drug therapies for older Americans. As a result, older Americans are more vulnerable to avoidable health problems and more likely to receive unnecessary and more expensive medical care.

Moreover, we commend the President for including effective cost containment mechanisms as an essential part of the Medicare drug benefit. We are concerned, however, that pharmaceutical manufacturers are already engaged in a major lobbying effort to eliminate any meaningful cost containment provisions from the proposed plan. In fact, we understand that the industry's leading association is attempting to scare Medicare beneficiaries into believing that the President's cost containment efforts will result in the absence of Medicare coverage for important breakthrough drug therapies. We do not believe this is true.

In this regard, we strongly encourage the President to remain firm in his commitment to contain prescription drug costs under the Medicare drug benefit. If effective cost containment is

THE NATIONAL COUNCIL ON THE AGING, INC., 409 Third Street SW, Washington, DC 20024
(202)479-1200 · TDD (202)479-6674 · FAX (202)479-0735

eliminated from the proposal, the Medicare drug benefit may quickly become unaffordable to both taxpayers and beneficiaries. This was clearly the case during the development of the Medicare Catastrophic Coverage Act (MCCA). Due to the lack of effective cost containment, the projected cost of the MCCA drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through Congress.

The pharmaceutical industry argues that every dollar sought by policymakers to contain drug prices will come directly out of research and development of important breakthrough medications. We believe this is simply false. Much more than legitimate research and development activities go into the manufacturer's price of a drug. Thus, drug manufacturers have many choices as to where they can be more efficient and cut costs. In fact, according to a recent study by the Senate Special Committee on Aging, only 16 percent of the manufacturer's price of a drug goes toward research and development compared to the 36 percent that goes toward profits, marketing, and advertising. In addition, drug manufacturers' revenue will increase substantially under the President's plan as millions of Americans who currently lack coverage for prescription drugs will gain coverage. Much of this revenue could be used for legitimate research and development endeavors.

The Leadership Council of Aging Organizations commends the President and his Administration for proposing a meaningful health care reform plan that includes important long-term care benefits and vital Medicare drug coverage. We urge the Administration to stand firm on the cost containment provisions included in the plan so that these important benefits will remain affordable to both taxpayers and beneficiaries.

Sincerely,

Daniel Thursz
Chairman

(see next page for organizations that have signed-on.)

The following Leadership Council of Aging Organization members have signed-on to this letter:

AFSCME Retiree Program
American Association of Retired Persons
American Society on Aging
Association for Gerontology and Human Development in Historically Black Colleges and Universities
Families USA
Gerontological Society of America
Green Thumb, Inc.
National Association of Meal Programs
National Association of Nutrition and Aging Services Programs
National Association of State Units on Aging
National Association of Retired Senior Volunteer Program (RSVP) Directors
National Association of Foster Grandparent Program Directors
National Association of Senior Companion Directors
National Caucus and Center on Black Aged, Inc.
Older Women's League

NARD
Charles M. West, P.D.
Executive Vice President

COMMUNITY RETAIL PHARMACY
Health Care Reform Coalition

The Coalition Representing Retail Community Pharmacy in America.

NACDS
Ronald L. Ziegler
President & Chief Executive Officer

September 17, 1993

The President
The White House
Washington, DC 20500

Dear Mr. President:

On behalf of the Community Retail Pharmacy Coalition for Health Care Reform we commend you, Mrs. Clinton, and the members of the President's Task Force on Health Care Reform for your efforts to reform America's health care system.

The Coalition, composed of the National Association of Chain Drug Stores and the National Association of Retail Druggists, represents the totality of community retail pharmacy in America.

Specifically, we are pleased with your recognition of the importance of community retail pharmacy and its cost saving and critical role in the delivery of preventive patient care.

We believe your commitment to reform and the security it will bring to all Americans deserves the strong and active support of community retail pharmacy.

Our Coalition -- through our 112,000 community retail pharmacists and our more than one million employees -- is prepared to communicate aggressively the merits of the evolving plan in our efforts to further enhance and solidify public support for your health care reform proposal. We will bring enthusiastic support through the interaction of community retail pharmacists with millions of patients each day in more than 60,000 drug stores.

NARD (representing independent retail pharmacy)
205 Daingerfield Road, Alexandria, Virginia 22314
Tel: (703) 683-8200, Fax: (703) 683-3619

National Association of Chain Drug Stores
413 N. Lee Street, Alexandria, Virginia 22314
Tel: (703) 549-3001, Fax: (703) 836-4869

The Coalition can be especially effective in working with our pharmacists to convey the value of new prescription drug coverage to the many uninsured and elderly patients who visit their pharmacy each day. We especially applaud your expansion of Medicare benefits to include pharmacist services and prescription drug coverage that will provide cost savings to the health care system as well as additional high-quality services to Medicare beneficiaries.

The Coalition looks forward to being a continuing participant and supportive resource throughout the public policy process on this important initiative.

Sincerely,

Ronald L. Ziegler
President and Chief Executive Officer
National Association of Chain Drug Stores

Charles M. West, P.D.
Executive Vice President
National Association of Retail Druggists

National Consumers League
Founded 1899

815 Fifteenth Street, NW • Suite 928-N • Washington, DC 20005 • (202) 639-8140 • FAX (202) 737-2164

October 15, 1993

The President
The White House
Washington, DC

Dear Mr. President:

The National Consumers League commends your courage and commitment to reform our nation's health care system. your plan recognises the importance of consumers as genuine participants in their own care, emphasizing primary and preventive care. We are particularly pleased with the proposal that would provide out-patient drug benefits as part of a nationally guaranteed benefits package.

The League has long sought a drug benefit for Medicare beneficiaries. We applaud your inclusion of this important provision in the American Health Security Act and commit our support to work to assure that this be part of the final legislative proposal. Of particular importance we endorse your inclusion of effective cost containment mechanisms as an essential part of the Medicare drug benefit. We encourage you to remain firm in your commitment to this principle.

NCL is a national consumer organization that has members in every state and a network of community organizations eagerly awaiting universal health care reform. The consumers we represent need to be assured that their medications are available, affordable, and appropriate for their care.

Sincerely,

LINDA F. GOLODNER
President

National Organization for Rare Disorders, Inc.

NORD • 100 Rt. 37, P.O. Box 8923 • New Fairfield, CT 06812-1783 • (203) 746-6518

. . . out of the darkness, into the light . . .

October 14, 1993

Mrs. Hillary Rodham Clinton
The White House
Old Executive Office Bldg.
Washington, DC 20503

Dear Mrs. Clinton:

The National Organization for Rare Disorders (NORD) strongly supports the Breakthrough Drug Committee and other pharmaceutical cost control measures outlined in the President's health reform proposal.

We are certain that health reform is doomed to failure unless there are stringent measures to keep price hikes in line with inflation, particularly prescription drug prices. In addition, the nation sorely needs a mechanism for holding down the prices of new drugs that reach the market.

NORD represents approximately twenty million Americans who suffer from more than 5,000 rare "orphan diseases." Each of these ailments afflicts fewer than 200,000 Americans. Most of these disorders are serious, debilitating, chronic and some are fatal. The populations we represent often have great difficulty obtaining or retaining health insurance, and treatment very often requires expensive pharmaceuticals that must be taken throughout life.

For this reason, NORD has been an outspoken critic of the outrageous increases in pharmaceutical prices over the last decade. The following paragraph from the article, "Do We Pay Too Much for Prescriptions," in the October issue of Consumer Reports, is ample testament to the industry's single-minded and insensitive pursuit of profits:

> "Last year the pharmaceutical industry had, as usual, the highest return on sales, the highest return on assets, and the highest return on stockholder equity of any industrial group in the Fortune 500. Its 11.5 percent return on sales was more than four times as high as the average of all Fortune 500 companies -- and almost twice that of the second-most profitable industry. Eight drug companies were among the 25 companies with the biggest absolute profits."

We believe in the free market system and the importance of profit as an incentive for research and development. However, we also believe there is a distinction between profit making and profiteering, particularly when these profits are being made at the expense of essentially helpless sick people.

While we have seen some evidence that the industry is beginning to rein in its wholesale price increases for drugs on the market, we continue to receive reports of increases at the retail level. Moreover, we have seen little sign of moderation in the price of new drugs, particularly "orphan drugs." Ceredase, for instance, a drug used to treat a rare genetic disorder called Gauchers Disease, is the most expensive drug in history. It costs over $300,000 for the first year of treatment and drops off to a "mere" $140,000 annually thereafter! Since many of the breakthrough drugs currently in the pipeline at FDA are designated as "orphan drugs", NORD is particularly fearful of what the companies may charge for these new medications. The proposed Breakthrough Drug Committee, even though it could use more enforcement powers, is an absolute must for health care reform.

The pharmaceutical industry will not lose money under your health reform program. They will make up for price restraints through higher sales volume and a sorely needed reduction of their outrageous marketing expenses. Therefore, we urge you to retain the provisions for pharmaceutical cost containment, and especially the Breakthrough Drug Committee, which will hopefully be able to moderate the prices of new drugs.

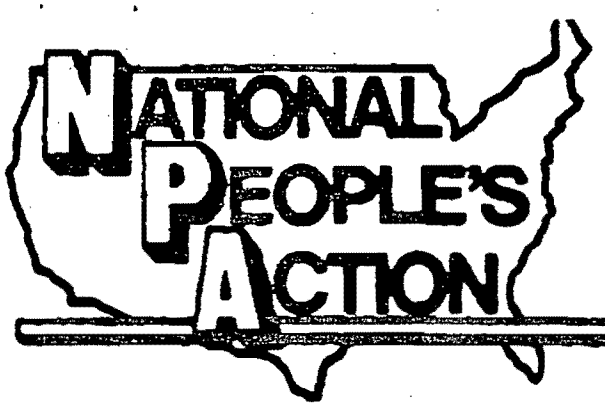
Very truly yours,

Abbey S. Meyers

Abbey S. Meyers
Executive Director

ASM:aa

cc: Chris Jennings ✓
Ira Magaziner



NEIGHBORHOODS *First*

October 20, 1993

Mrs. Hillary Rodham Clinton
The White House
Old Executive Office Building
Washington, D.C. 20500

Dear Mrs. Rodham Clinton:

National People's Action, a grassroots coalition of over 300 community groups, is writing to inform you of our recent negotiations with the Pharmaceutical Manufacturer's Association, and to request your assistance in resolving the following matter. We are also requesting that you seriously reconsider the "voluntary" proposal approach to restrain the cost of prescription drug prices for the pharmaceutical industry.

NPA and PMA Negotiations

NPA started a series of negotiations with the PMA in April 1993 in Washington, D.C. One of the major objectives of our leadership was to address the high cost of prescription drugs for low to moderate income individuals, and increasing people's knowledge of the pharmaceutical industry's Indigent Drug Program. The pharmaceutical industry's program provides prescription drugs free or at a reduced rate for individuals with low to moderate incomes.

In June of 1993, the PMA agreed to advertise its low income drug program in 10 cities. NPA leadership requested that the program be advertised in neighborhood newspapers that reflect the racial and ethnic diversity of the cities. The PMA agreed to this. The PMA also agreed to show the ads to leadership for review before placing the ads. Enclosed is a copy of the letter in which they agree to advertise the program.

In addition to the agreement for advertising we requested the PMA to fund and market local groups for doing outreach on the low income drug program in low and moderate income neighborhoods. See paragraph 2 for reference to this request.

However, it's now October, and they have refused to give us a date as to when the ads will be completed for our review. We know that the PMA has nothing to lose - and in fact is probably stalling on advertising its program.

810 N. Milwaukee Ave. • Chicago, Illinois 60622-4103 • (312) 243-3038

With only voluntary price controls for the drug companies in the President's health care plan there is no incentive for the drug industry to advertise its current program. The drug industry will continue to be subsidized for research and development, and now universal access for prescription drugs. The cost will be passed on to the taxpayers -while the drug companies continue to make unheard of profits when compared to other industries.

While NPA is in favor of comprehensive health care and prescription drug coverage for all Americans, NPA believes that the pharmaceutical industry can do its part presently, by utilizing its low income drug program.

The PMA has been very reluctant to advertise its low income drug program which could make the difference between life or death from some individuals. NPA wants the PMA to be accountable to the promises it made to meet the prescription drug needs of low to moderate income individuals. When the PMA developed this program their publicized intention was to meet a crucial need in the community. Now, they are doing all they can to keep the program a secret.

Cost Containment Proposal

NPA strongly urges that the final health care plan includes strong mechanisms to contain the cost of prescription medications used under the Medicare program. We remember all too well that a major omission with the outpatient prescription drug benefit in the Medicare Catastrophic Coverage Act was a lack of specific cost containment measures on pharmaceuticals. As a result, the cost of that benefit skyrocketed, and with it, the premiums that Medicare beneficiaries would have had to pay to finance the program.

The cost of prescription drugs is a matter of life and death for not only seniors, but many other Americans on limited incomes. Too many Americans have to make choices between buying food and paying for their medications. A prescription drug benefit would go a long way toward correcting this unacceptable situation. However, a prescription drug benefit must not exempt the pharmaceutical industry from gouging the American taxpayer with its astronomical profits. It is crucial that the President's plan address the excessive costs of prescription drugs for all Americans. The only way that this will happen is through a **cost containment proposal.**

NPA strongly encourages you to implement measures that will require pharmaceutical companies to limit both the annual increase in their weighted average price to the rate of inflation and the increase in price of individual retail pharmaceutical products to the rate of inflation. This specific price increase cap on retail pharmaceutical products is needed to protect consumers that purchase their medications out of pocket against continuing excessive price increases.

NPA requests your support on both of these issues.

Sincerely,

Gale Cincotta

Gale Cincotta, Chairperson

PKR
FOUNDATION

922 Walnut Street
Kansas City MO 64106
816-421-1869
fax 816-421-7208

for research in polycystic kidney disease

October 15, 1993

Mrs. Hillary Clinton
The White House
Washington, D. C. 20503

Dear Mrs. Clinton,

It is important to include pharmaceutical cost containment measures in the President's health reform package.

Competition will help, but there also needs to be a plan in place to report to the public if the price of a medication is unreasonable.

I'm not certain that a "Breakthrough Drug Committee" is the best plan, but obviously HHS need be involved.

Thank you for your commitment and leadership.

"Hang in there!"

Sincerely,

Julian Dyke
President

JD:das

REFLEX SYMPATHETIC DYSTROPHY SYNDROME ASSOCIATION
(RSDSA) – Founded in 1984

116 Haddon Avenue
Suite D
Haddonfield, New Jersey 08033
(609) 795-8845

HELP US

THE PAIN

October 20, 1993

Hillary Clinton
The White House
Old Executive Bldg.
Washington, DC 20503

Dear Mrs. Clinton,

Most people with RSDS live in constant fear of loosing everything they have, physically and financially. Many have several prescriptions medications that they must take daily for many years or for the rest of their lives. Because RSDS is a little known rare disease, a large number of those afflicted with RSDS are denied disability compensation and insurance, leaving them unable to obtain their much needed medications and treatments.

We ask that you make every effort to retain the pharmaceutical cost containment measures in the President's health care reform plan.

Sincerely,

Rosalyn Davis

Rosalyn Davis
Executive Director

cc: Abbey S. Myers, NORD
Nelson Hendler, MD
Gary Bennett, PhD
Frank Davis
Concetta Renkun, MD
Adrienne Elias, Esq.

INTERNATIONAL
RETT
SYNDROME
ASSOCIATION

October 15, 1993

Mrs. Hillary Clinton
The White House
Old Executive Office Building
Washington, D.C. 20503

Attn: Chris Jennings

Dear Mrs. Clinton

On behalf of the parents of the Rett Syndrome Association, we wish to urge the administration to retain the "Breakthrough Drug Committee" and other pharmaceutical cost containment measures in President Clinton's health reform plan. Our organization represents over 2000 families that will be affected by this measure.

We thank you in advance for your consideration in our behalf.

Sincerely,

Kathy Hunter

Kathy Hunter
President

9121 PISCATAWAY RD., # 2-B ■ CLINTON, MD 20735 ■ (301) 856-3334 ■ FAX (301) 856-3336

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo w/attach	Chris Jennings to Hillary Clinton Re: Calls to Senators (6 pages)	10/17/93	P5

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

FOLDER TITLE:
October 1993 HSA [1]

gf108

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]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

October 13, 1993

The Honorable Daniel Patrick Moynihan
Chairman
U.S. Senate Committee on Finance
Washington, DC 20510

Dear Chairman Moynihan:

It was an honor to testify before your Committee on September 30. Following up on my testimony, I would like to take this opportunity to clarify my statement about how we can and must move to slow growth on health care costs.

As I indicated in response to your question, the President strongly believes that there is tremendous waste and inefficiency in the health care system. Through market restructuring and economic incentives, we believe we can achieve both one-time and ongoing savings. In my testimony, I went into some detail on how these savings will result from increased consumer choice, consumer sensitivity to value and costs, administrative simplification, and through changes in incentives to providers.

By the end of the decade, we believe these market changes, subject to the back-up discipline of the premium limits we propose, can and must slow our current growth rates in health care spending to the rate of increase in inflation and population. Even with these market changes, we are assuming that increases in current spending will still raise our health care spending as a share of GDP from 14 to 17 percent. No other nation in the world comes close to either level. (The next highest allocation of GDP to health care -- 10 percent -- comes from Canada.) To allow a greater absorption of our resources -- rather than a reallocation of resources -- as we pursue reform seems unconscionable.

Once the health care marketplace has changed, however, appropriate long run growth rates become a more open question. There will always be upward pressure on health expenditures from the development of new technology and the aging of the population. Once we have restructured our health care system, we can and should accommodate those pressures by allowing real growth in health care spending.

With new incentives in place to promote efficient resource use, health care expenditure growth need not absorb a disproportionate share of our economic resources. It is important to note, however, that our current estimates provide ample room to allow for greater growth rates in the out years and still maintain stable financing of the health benefits package and Medicare expansions we propose.

Mr. Chairman, we are confident that we, like other countries, will be able to meet our citizens' health care needs without sacrificing the resources needed to satisfy their many other equally legitimate needs and wants. The challenge we must face together is how to turn the current system around so that we, as a nation, have the capacity to respond effectively to a changing population in the next century. The President believes that to begin immediately and aggressively is our best hope for achieving that goal.

Sincerely yours,

Hillary Rodham Clinton

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	Chris Jennings to Hillary Clinton Re: Senator Daschle's Likely Senate Cosponsorship List (2 pages)	10/18/93	P5

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Chris Jennings to Hillary Clinton Re: Chairman Moynihan, Liz Moynihan/Finance Committee Staff Director (1 page)	10/18/93	P5

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. memo	Chris Jennings to Hillary Clinton Re: Senator Bob Kerrey (2 pages)	10/19/93	P5

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OA/Box Number: 23754

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October 1993 HSA [1]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. memo	Chris Jennings to Hillary Clinton House CoSponsorship Update and Requested Call List (7 pages)	10/24/93	P5

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Chris Jennings (Health Security Act)
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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]

MEMORANDUM

TO: Ira
FR: Steve, Chris, Jack
RE: Congressional Resource Priorities

October 29, 1993

In response to your request at lunch, we have compiled the following list of resource priorities which we believe are essential to more productively fulfil the President's charge on health care reform.

LOBBYING

In order to effectively represent the Administration on the bill, our principle health care lobbyists must be free of other non-lobbying related responsibilities (e.g., drafting briefing memos, drafting legislative language, responding to material requests, and doing policy analysis.) We must extend our direct contact with Members and their staffs to every Member of the key Committees of jurisdiction -- (and eventually, to a number sufficient to secure passage in both Houses.) We believe that additional, dedicated personnel (detailed) from the Departments (one from each of the three major Departments -- HHS, Labor, and Treasury) will be necessary to effectively cover the Committees and Caucuses.

POLICY DECISION MAKING

A process must be established to coordinate policy choices which have been vetted for political, substantive and economic implications. To effectively sustain a constructive and responsive Congressional dialogue, a person or set of people must be invested with the authority to make day to day policy decisions about what represents an acceptable health reform plan from the Administration's perspective.

RESOURCES

1. **Materials.** We need a person, location and process for maintaining and delivering materials requested by Members of Congress. (This will free up staff such as Steve Edelstein and Christine Heenan to generate and update the materials necessary to be responsive to the Congress.)

2. **Congressional Surrogates.** We have been innundated with requests for surrogate speakers to appear at a variety of events sponsored by Members. Charlotte Hayes has been attempting to manage this process, but the dearth of available Administration personnel capable of describing the plan has made it difficult to be adequately responsive. Contributing to this problem is a lack of travel funds available for Administration surrogates. We must make it a priority to train a politically and policy knowledgable cadre of surrogates to meet this need.

3. **Research.** It is important that we develop congressional district specific data on health care infrastructure and the impact of reform on industries, health care professionals, and consumers. We need to be able to demonstrate the beneficial aspects of health reform to groups of constituents within Members Districts.

4. **Monitoring Hearings and Clearing Testimony.** As the Congressional hearing process further develops, we will have an increasing problem in both prepararing witnesses and responding to Committee generated questions and requests. This necessary function illustrates the necessity for additional personnel to be dedicated to the Congressional relations effort.

MISCELLANEOUS RESOURCE NEEDS

There are ongoing, basic resource requirements which remain unfulfilled and are essential to assuring an efficient and credible Legislative Affairs unit. Leaving these resource needs unmet contribute to a perception (if not reality) of disorganization and unprofessionalism.

* One person needs to be located to answer phones full time to handle all legislative calls. (Person needs to keep a log sheet of all Congressional calls). Currently, we rely on a volunteer workforce who cannot be relied on to give us complete and professional phone coverage. It is a totally unacceptable situation that creates unnecessary ill will on the Hill.

* Room(s) near policy operation (Ira) must be provided as soon as possible. Jack and Chris are temporarily housed in Lynn's and Christine's offices, with no room for support staff (even if it was available).

* Basic equipment and resource requirements include:

  1 Fax (because of confidentiality concerns).

  2 cellular phones (Jack and Chris)

  1 White House pager for Chris

  White House Car access for Chris J.

  Computers hooked up to White House Oasis system hook up

SCHEDULING OF PRINCIPLES

We believe that to fortify Congressional involvement and support on our behalf we need a short and long term strategy for including Members important to us on health reform in POTUS and FLOTUS travel plans, local speaking engagements and meetings, and social activities. To do this most effectively -- understanding competing short-term priorities, we need to more closely coordinate with Presidential scheduling and, to the extent possible, assure that priority is given to health related requests on a sustained basis.

MEMORANDUM

TO: Distribution
FR: Chris Jennings
RE: 40 Percent Pay More Issue
cc: Hillary Rodham Clinton

October 31, 1993

In recent days, there have been many in the press who have suggested that the Administration has been misleading about the numbers of Americans who would pay more under the Health Security plan. I was reminded that this is not the case, at least so far as the First Lady is concerned, when I was reading through some hearing transcripts today.

Specifically, during the First Lady's testimony before the Senate Finance Committee on September 30th -- over a month ago, she specifically cited how many people would pay the same or less, and by implication, how many would not. She also touched on the "with rights and benefits come responsibilities" theme. What follows are some relevant remarks taken directly from the transcripts of her opening oral statement:

> "Under our health security plan, employers and individuals who pay premiums today will continue to do so. And six of every ten Americans who currently have insurance will pay the same or less than they do today for coverage that is as good or better than what they get today....
>
> "We estimate that approximately 63 percent of Americans who currently have health insurance will pay the same or less than they pay today for coverage that is as good or better than what they get now.
>
> "Every individual will have to take responsibility and pay something.... And it is an idea that some would argue is a pretty old-fashioned one because it builds on the system we have. It was advocated, as you pointed out, Mr. Chairman, by President Nixon, introduced by Senator Packwood, and it will provide a familiar way for Americans to know they will be secure....

"Even with this approach though, there will be people who have every right to ask, why do I have to pay anything. They will say, for example, I am young and healthy and I will not get sick. Or, I have fought hard for my health benefits. I already pay a lot and I do not want to pay a penny for anything else. Or, in the case of small business, I do not think I can afford to pay anything.

"We believe the answer to these questions goes beyond responsibility and directly to the heart of what health care reform and health security is all about...."

We have done well in the past, and will continue to do so in the future, on the Hill, in the media and with the general public when it is perceived we are being as honest and direct as possible. When the inevitable occurs and the debate becomes even more heated and detailed, the rank and file in the Congress will be much more open to taking our position if they perceive that the public finds us more credible than our opponents. I believe that openly acknowledging the cost increase elements of our package will help us in this regard.

Hopefully, Mrs. Clinton's past comments can help us better make our case and maintain our credibility. Other statements previously made by the First Lady and other Administration officials in the past few weeks may also help bolster our position. Just a thought...

DISTRIBUTION: Maggie, Ira, Melanne, Jeff, Bob, Marla, Christine, Meeghan, Kim, Stan, Mandy, Steve, Jack, Steve E., Mike, John, etc.

has been distributed

October 15, 1993

TO: Ira Magaziner
Carolyn Gatz
Christine Heenan
Greg Lawler
Lynn Margherio
Meeghan Prunty

FROM: Chris Jennings

SUBJECT: Dole/Chafee Provisions

For your information, attached are copies of the quality provisions and the medical malpractice provisions of the Dole/Chafee health plan.

have a presumptive defense against malpractice claims.

F. Products: drugs and devices
   1. All medical liability reforms listed above apply.
   2. If approved by the Food and Drug Administration (FDA) and used properly, no punitive damages will be allowed.
   3. If FDA approval was based upon misleading or false information, the prohibition on punitive damages will not apply.

4. Quality Assurance

Purpose: to ensure that health plans have an approved quality assurance plan, to establish national standards for reporting quality information, and to expand the availability of information available to health plans and health care providers on practice guidelines and outcomes.

Intended result: to maintain the high quality of care in our current health care system and to provide information to consumers on the quality of each health plan to assist in selecting a health care plan.

A. Health insurance plans must have a recognized quality assurance program as defined by the Secretary of HHS. In developing such standards, HHS must consult with recognized private sector entities engaged in quality assurance, such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, or other recognized organizations.
B. Plans must provide quality data including information on outcomes and effectiveness in the format developed by the Secretary of HHS in conjunction with the Federal Administrative Standards Panel.
C. AHCPR is directed to expand its present research agenda to include the following:
   1. A fund investigator to initiate research on the relationship between treatments and outcomes.
   2. Priorities for the research community to strengthen the research base.
   3. Effectiveness trials in collaboration with medical specialty societies and qualified health plans.
   4. A clearinghouse and other registries on clinical trials research data.
   5. Continued and expanded development of practice guidelines to provide information to health care practitioners and plans.
D. Additional funding will be made available for medical research.

C. Oversight and implementation of standards
HHS is responsible for oversight, enforcement, and implementation of data standards; and for establishment of a certification procedure for database, computer and network vendors.

3. Medical Liability Reform

Purpose: to resolve disputes more effectively and efficiently; to reduce the practice of defensive medicine, unnecessary tests and procedures; to identify and correct bad practices; and to ensure that those who are the victims of negligence are fairly compensated.

Intended result: to lower medical costs and to improve quality of care.

A. Mandatory, non-binding Alternative Dispute Resolution (ADR)
   1. Parties must participate in an alternative dispute resolution system established by the state.
   2. Plans are required to explain this process in their descriptive materials to beneficiaries.

B. Litigation
   1. If one of the parties in the dispute wishes to challenge the result of ADR, he/she may do so
   2. If the decision rendered in court is less favorable to him/her than in ADR, he/she shall pay all legal fees subsequent to ADR.

C. Damages
   1. Non-economic damages are capped at $250,000.
   2. Malpractice awards shall be reduced for any collateral source payments to which the claimant is entitled.
   3. Periodic Payments
      Claimant will be required to accept periodic payment as opposed to lump sum on awards exceeding $100,000.
   4. Punitive damages
      50% of a punitive damage award shall be paid to the State for activities approved by the Secretary of HHS to improve monitoring, education, and disciplining of health care providers in that State.

D. Reform of Procedures
   1. Statute of Limitations

a. except for minors, no health malpractice action may be initiated more than two years after the date on which the alleged injury should have been discovered, and in no event later than four years after the date of the occurrence.

b. with respect to injuries alleged to have occurred to minors (under 6 years of age), no health malpractice action may be brought after reaching 12 years of age.

2. Joint and Several Liability
For non-economic and punitive damages, liability for payment of damages shall be based on the degree of contribution to the negligent act.

E. Practice Guidelines Rebuttable Presumption
Providers following practice guidelines approved by the Agency for Health Care Policy and Research (AHCPR) shall have a presumptive defense against malpractice claims.

F. Products: drugs and devices

1. All medical liability reforms listed above apply.
2. If approved by the Food and Drug Administration (FDA) and used properly, no punitive damages will be allowed.
3. If FDA approval was based upon misleading or false information, the prohibition on punitive damages will not apply.

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A. Health insurance plans must have a recognized quality assurance program as defined by the Secretary of HHS. In developing such standards, HHS must consult with recognized private sector entities engaged in quality assurance, such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for

WASHINGTON POST 10/21/93

JACK ANDERSON and MICHAEL BINSTEIN

Drug Industry Seeds the 'Grass Roots'

The letters look like any other constituent mail that streams into the office of Rep. Ron Wyden (D-Ore.) each day. Only in these letters, the prepared text is crossed out and replaced with a more personalized message: "This junk mail came to me from these drug companies. Pretty phony and self-serving. You should be aware of the source if you receive any."

Sometimes the most sophisticated lobbying efforts end with the most unsophisticated results.

This time, the drug companies stirred up a mini-rebellion among Wyden's constituents. The "junk mail" Wyden was warned about actually was part of a growing phenomenon in influence-peddling: using direct mail to generate grass-roots pressure on a single issue.

The grass-roots approach has been popular since the 1980s, when lobbyists discovered that many members of Congress care far more about what their constituents think than the opinions of high-paid lobbyists. But in this case, "grass roots" meant ghostwritten.

Wyden became a target because of his influence on the prescription drug issue. In recent years, drug companies have been deluged with criticism for hiking prices and making record profits while health care costs are exploding. Wyden has been one of the chief provokers of the pharmaceutical industry.

Thus, Wyden began receiving letters signed by constituents but actually written by pharmaceutical interests. The letters, addressed to Wyden, were sent to constituents with their names at the bottom. All that was needed was a signature and a postmark, and Wyden would receive a letter asking him to go easy on the pharmaceutical industry.

To throw members of Congress off the scent, each of the letters was made to look a little different. When members get a form letter, it's not taken as seriously as a personal letter. So the anonymous authors varied the exact wording, the letter font and even the color of the paper. Nobody was fooled.

"I resent the fact that the pharmaceutical lobby thinks we are this stupid . . . of course these folks need regulating. They have proved most unable to regulate themselves," one constituent wrote at the bottom of his letter. Drawn across the text of the letter was a large circle with a slash through it, along with the word "Not" in capital letters.

"Unless American drug companies can curb their immense profits and, at least, provide some accountability on research, I feel our only recourse is for government control," wrote another. "This, in my opinion, is the biggest piece of [profanity] I have ever been asked to back," wrote a third. Wyden received dozens of similar responses.

"I think the message here is that some of these slick and fancy campaigns, particularly on the health care issue, are starting to backfire," Wyden told our associate Jan Moller. But, he added, "I haven't found many campaigns that have backfired like this."

Drug companies have made no secret of their stand in the health care debate. Since President Clinton announced the formation of his health care task force last winter, relations between the administration and the pharmaceutical industry have ranged from open warfare to an uneasy detente.

When the administration came out firing last spring, drug companies retaliated with a series of large newspaper ads and editorials defending their pricing policies and stressing their record of developing new drugs. It's not that the drug companies hate the entire Clinton plan. They like the fact that prescription drugs are covered under Clinton's "standard benefits package." It's the "price control" feature that makes them fume.

Fearing trouble, some drug companies broke from the industry's chief lobbying arm, the Pharmaceutical Manufacturers Association (PMA), and formed their own coalition to fight price controls. With a $1 million budget, RX Partners employs some of the heaviest hitters in the Washington influence game, including former president Jimmy Carter's press secretary, Jody Powell.

That leaves unanswered the question of who's been sending mail to Wyden's office. An unscientific survey of several drug companies and lobbyists found no one eager to take responsibility. "I am absolutely certain that it's not our work," a PMA spokesman told us.

The first person we reached at RX Partners wasn't sure, but added that "everyone involved in the prescription drug industry is involved in something like this. . . . Part of our program is, of course, working on the grass roots." Shortly thereafter, another representative from RX Partners called to assure us that his group had absolutely nothing to do with any direct-mail form letters.

BIG BUS.

MANUFACTURING HELPS AMERICA GROW

JERRY JASINOWSKI
President

October 21, 1993

The President
The White House
Washington, DC 20510

Dear Mr. President:

I want to express my regrets over the way the NAM handled our press comments on the Administration's health care plan. Because the lead of the press release was negative, and our press office mistakenly released my letter to you, the story turned out much more negative than was appropriate.

As I have consistently said to the press, your health care proposal has far more positive elements than problems, and it is the best health care package that has been proposed thus far. I will put even more emphasis on those positive elements in the days ahead, particularly as you release your final plan next week.

I personally am upset with what has happened because Ira Magaziner has made such a special effort to acknowledge our criticisms. On a substantive level our dialogue could not have been more constructive. Moreover, Ira cautioned us about how we expressed our criticisms to the press, and we were the ones who inadvertently failed to be more judicious in our comments to the press.

In sum, your White House staff has been fully responsive on the health care issue, and I regret NAM has not handled our press comments more appropriately.

Sincerely,

Jerry J. Jasinowski

NATIONAL ASSOCIATION OF MANUFACTURERS
1331 Pennsylvania Avenue, NW, Suite 1500 - North Tower, Washington, DC 20004-1703, (202) 637-3106

bc-nam-health-clinton 10-21 117-1021 HEALTH r w bc-manufacturers-health GW PR FX CH

Letter from National Association of Manufacturers To President

To: National Desk, Health Writers

Contact: White House Press Officem 202-456-2100

WASHINGTON, Oct. 21 /U.S. Newswire/ -- The text of the following letter from the National Association of Manufacturers (NAM) was released today by the White House:

The President
The White House
Washington, D.C. 20051

Dear Mr. President:

I want to express my regrets over the way the NAM handled our press comments on the administration's health care plan. Because the lead of the press release was negative, and our press office mistakenly released my letter to you, the story turned out much more negative than was appropriate.

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In sum, your White House staff has been fully responsive on the health care issue, and I regret NAM has not handled our press comments more appropriately.

Sincerely,

/s/ Jerry J. Jasinowski -0-/U.S. Newswire 202-347-2770/

**** filed by:US-F(--) on 10/21/93 at 14:35EDT ****
**** printed by:WHPR(JOPP) on 10/21/93 at 14:58EDT ****

APPWP
Association of Private Pension and Welfare Plans

James A. Klein
Executive Director

October 14, 1993

Mr. Ira Magaziner
Senior Domestic Policy Advisor
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Ira:

The APPWP very much appreciated the opportunity to meet with you on a few occasions during the initial months that the White House Task Force on Health Reform was developing the President's plan. As I underscored during my introduction of you at the APPWP annual meeting in May, we commend you and the Task Force for the thoughtful process you applied in consulting with groups like ours that have a significant stake in the health care reform effort.

Naturally, we were quite disappointed that in the final months prior to the announcement of the plan, we were denied the opportunity to meet with you despite indications that our previous visits had been mutually productive.

We believe that the APPWP comes the closest of any national business group in embracing -- in specific terms -- the six goals of health care reform enunciated by the President. Certainly, as the only business group to have endorsed a specific employer mandate, we applaud the President's commitment to achieving the goal of "security" for all Americans.

Enclosed is our analysis of the positive, negative and unanswered elements of the President's proposal. As is evident from the document, there are a number of provisions about which we have serious concerns. This analysis serves as the basis for our efforts to improve the President's plan as we work with our allies in the Congress. We certainly also would like to work with the Administration in reforming the health care system.

Sincerely,

James A. Klein
Executive Director

enclosure

cc: C. Jennings
M. Yager

1212 New York Avenue, N.W. • Suite 1250 • Washington, D.C. 20005 • (202) 289-6700 • FAX (202) 289-4582