Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Meeting with Senate Democrats at Democratic Policy Committee Annual Democratic Conference (8 pages)	4/22/93	P5
002. profiles	Profiles of Democratic Senators (6 pages)	nd	P5
003. memo	Chris Jennings to Hillary Clinton Re: Meeting with Chairman John Dingell (2 pages)	4/25/93	P5
004. memo	Chris Jennings to Hillary Clinton Re: Congressional Leadership Meeting (1 page)	4/26/93	P5
005. memo w/attach	Chris Jennings to Hillary Clinton Re: House Leadership and Chairman Meeting (6 pages)	4/27/93	P5
006. memo	Karen Politz to Chris Jennings Re: House Leadership Meeting Agenda (4 pages)	4/1/93	P5
007. memo	Chris Jennings to Howard Paster, Steve and Lorraine Re: Ways and Means Subcommittee on Health/ Interaction Meetings (2 pages)	4/4/93	P5
008. memo w/attach	Chris Jennings to Steve R. Re: Republican Members and Staff Meetings/Contacts (4 pages)	4/9/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23755

FOLDER TITLE:
HRC Memos- HSA [2]

gf129

RESTRICTION CODES

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

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

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"Average person's health spending, 1994"

Explanation of categories:

Average personal income is 1991 personal income from the Economic Report of the President, projected by rate of increase in GDP (using HCFA GDP projection) to 1994.

Average person's health bill is national health expenditures divided by population.

Health insurance is the sum of employer and employee contributions to health insurance premiums and individual policy premiums.

Medicare payroll tax is the sum of employer and employee contributions to Medicare hospital insurance trust funds and premiums paid by individuals to HI & SMI trust funds.

Workers' compensation, disability/industrial inplant is the sum of employer payments for workers' compensation and temporary disability insurance and cost of inplant health services.

Out-of-pocket is out-of-pocket spending by individuals.

Other spending at health facilities is non-patient revenue raised by health care providers (e.g, through parking fees, gift shop profits, etc.).

Federal taxes, fees, & other payments represents health expenditures made by the federal government. This is the sum of federal contributions for federal employees' health insurance premiums, contributions to Medicare HI trust fund, Medicare expenditures from general revenue sources, federal share of Medicaid, and other health programs.

State & local taxes, fees, & other payments represents health expenditures made by state and local governments. This is the sum of state and local contributions for their employees' health insurance premiums, contributions to Medicare HI trust fund, state/local share of Medicaid, and other health programs.

Assumptions in estimating "Avg. person's health spending, 1994"

1. Full cost to businesses for health insurance premiums and Medicare payroll tax is borne by employees, therefore, cost is not passed to consumers.

2. Federal health spending is fully financed by revenues and Medicare taxes and does not contribute to the federal budget deficit.

3. Cost-shifting by hospitals and other providers is implicitly reflected largely within the cost of health insurance. A very small portion may be reflected within state and local hospital subsidies.

Average person's health spending without health reform	1994	2000	Average Annual Growth Rate
Average personal income	$22,369	$32,447	6.40%
Average person's health bill	$3,696	$6,167	8.91%
Health insurance	$1,044	$1,742	8.91%
Medicare payroll tax	$434	$725	8.91%
Workers' comp/disability/industrial inplant	$100	$167	8.91%
Out-of-pocket	$782	$1,305	8.91%
Other spending at health facilities	$113	$188	8.91%
Federal taxes, fees, & other payments	$643	$1,073	8.91%
Federal employees' health premiums	$53	$88	8.91%
Federal contributions to Medicare HI	$11	$19	8.91%
Medicare (general revenue)	$169	$283	8.91%
Medicaid	$246	$411	8.91%
Other federal health programs	$174	$290	8.91%
State & local taxes, fees, & other payments	$569	$950	8.91%
State/local employees' health premiums	$149	$248	8.91%
State/local contributions to Medicare HI	$24	$39	8.91%
Medicaid	$186	$310	8.91%
Hospital subsidies	$81	$135	8.91%
Other programs	$130	$218	8.91%

Average person's health spending without health reform	2000	% of Personal Income
Average personal income	$32,447	
Average person's health bill	$6,167	26%
Health insurance	$1,742	7%
Medicare payroll tax	$725	3%
Workers' comp/disability/industrial inplant	$167	1%
Out-of-pocket	$1,305	5%
Other spending at health facilities	$188	1%
Federal taxes, fees, & other payments	$1,073	5%
Federal employees' health premiums	$88	0%
Federal contributions to Medicare HI	$19	0%
Medicare (general revenue)	$283	1%
Medicaid	$411	1%
Other federal health programs	$290	1%
State & local taxes, fees, & other payments	$950	4%
State/local employees' health premiums	$248	1%
State/local contributions to Medicare HI	$39	0%
Medicaid	$310	1%
Hospital subsidies	$135	0%
Other programs	$218	1%

	'94		'95		'96		'97		'98		'99		'00	
age person's health spending fOUT health reform	1994	% of Personal Income	1995	% of Personal Income	1996	% of Personal Income	1997	% of Personal Income	1998	% of Personal Income	1999	% of Personal Income	2000	% of Personal Income
age personal income	$22,369		$23,801		$25,328		$26,946		$28,669		$30,500		$32,447	
age person's health bill	$3,896	17%	$4,050	17%	$4,429	18%	$4,828	20%	$5,246	22%	$5,884	24%	$6,187	26%
alth insurance	$1,044	5%	$1,144	5%	$1,251	5%	$1,363	6%	$1,481	6%	$1,605	7%	$1,742	7%
dicare payroll tax	$434	2%	$476	2%	$520	2%	$567	2%	$616	3%	$668	3%	$725	3%
rkers' comp/disability/industrial inju	$100	0%	$110	0%	$120	1%	$131	1%	$142	1%	$154	1%	$167	1%
t-of-pocket	$782	3%	$857	4%	$937	4%	$1,021	4%	$1,110	5%	$1,202	5%	$1,305	5%
er spending at health facilities	$113	1%	$123	1%	$135	1%	$147	1%	$160	1%	$173	1%	$188	1%
deral taxes, fees, & other payments	$643	3%	$704	3%	$770	3%	$840	4%	$912	4%	$989	4%	$1,073	5%
Federal employees' health premiums	$53	0%	$58	0%	$63	0%	$39	0%	$75	0%	$81	0%	$88	0%
Federal contributions to Medicare HI	$12	0%	$13	0%	$15	0%	$16	0%	$16	0%	$19	0%	$21	0%
Medicare (general revenue)	$169	1%	$186	1%	$203	1%	$221	1%	$241	1%	$261	1%	$283	1%
Medicaid	$246	1%	$270	1%	$295	1%	$322	1%	$350	1%	$379	1%	$411	1%
Other federal health programs	$174	1%	$191	1%	$209	1%	$227	1%	$247	1%	$268	1%	$290	1%
te & local taxes, fees, & other payme	$569	3%	$624	3%	$682	3%	$744	3%	$808	3%	$876	4%	$950	4%
State/local employees' health premiums	$140	1%	$163	1%	$178	1%	$194	1%	$211	1%	$229	1%	$248	1%
State/local contributions to Medicare H	$24	0%	$26	0%	$28	0%	$31	0%	$33	0%	$36	0%	$39	0%
Medicaid	$186	1%	$203	1%	$222	1%	$242	1%	$263	1%	$285	1%	$310	1%
Hospital subsidies	$81	0%	$89	0%	$97	0%	$106	0%	$115	0%	$125	0%	$135	0%
Other programs	$130	1%	$143	1%	$156	1%	$170	1%	$185	1%	$201	1%	$218	1%

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FOLDER TITLE:
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April 24th Revised House List
See April 20th memo

DRAFT ONLY, SUBJECT TO REVIEW

TOP 15 TARGETED HOUSE MEMBERS

DEMOCRATS:

McCurdy	OK
Cooper	TN
Valentine	NC
Murtha	PA
Chapman	TX
Rowland	GA
Glickman	KS
Volkmer	MO
Dooley	CA

REPUBLICANS

N. Johnson	CT
Leach	IA
Boehlert	NY
Goss	FL
Houghton	NY
Shays	CT

TOP 85 TARGETED HOUSE MEMBERS

DEMOCRATS

Condit	CA
Waters	CA
Schroeder	CO
Gibbons	FL

Hutto	FL
Bishop	GA
Darden	GA
Johnson	GA
Poshard	IL
Long	IN
Roemer	IN
Hayes	LA
Meehan	MA
Minge	MN
Peterson	MN
Montgomery	MS
Skelton	MO
Swett	NH
Andrews	NJ
Hughes	NJ
Pallone	NJ
Payne	NJ
Torricelli	NJ
LaFalce	NY
Serrano	NY
Hefner	NC
Lancaster	NC
Rose	NC
Price	NC
Applegate	OH

DRAFT ONLY, SUBJECT TO REVIEW

Fingerhut	OH
Kaptur	OH
Stokes	OH
Brewster	OK
English	OK
Foglietta	PA
Kanjorski	PA
Margolies-Mezvinsky	PA
Spratt	SC
Johnson	SD
Clement	TN
Ford	TN
Gordon	TN
Lloyd	TN
Tanner	TN
Andrews	TX
Brooks	TX
Coleman	TX
de la Garza	TX
Edwards	TX
Green	TX
Gonzalez	TX
Ortiz	TX
Pickle	TX
Sarpaulis	TX
Tejeda	TX

DRAFT ONLY, SUBJECT TO REVIEW

Wilson	TX
Sheperd	UT
Boucher	VA
Pickett	VA
Inlee	VA

REPUBLICANS

Huffington	CA
Castle	DE
Ros-Lehtinen	FL
Snowe	ME
Morella	MD
Blute	MA
Ramstad	MN
Roukema	NJ
Saxton	NJ
Smith	NJ
Zimmer	NJ
Fish	NY
Gilman	NY
Lazio	NY
Molinari	NY
Quinn	NY
Soloman	NY
Walsh	NY
Hoke	OH

Regula	OH
McDade	PA
Weldon	PA
Matchley	RI
Petri	WI

TOP 15 MEMBER ON THE FW LIST

Gingrich	GA
Armey	TX
Thomas	CA
Burton	IN
Walker	PA
Rohrbacher	CA
Kasich	OH
Hyde	IL
DeLay	TX
Dornan	CA
Drier	CA
Sundquist	OK
Cox	CA
McCollum	FL

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002. profiles	Profiles of Democratic Senators (6 pages)	nd	P5

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M E M O R A N D U M

TO: Requestors for Information on Meetings with Republicans
FR: Chris Jennings
DATE: April 27, 1993

From the onset of the Administration's work on the health care reform proposal, the Health Care Task Force and its Work Groups have made a concerted effort to reach out to House and Senate Republicans for their guidance and support. We believe it is essential to have their involvement to make the package as strong as possible and to assure it prompt and necessary passage. We are therefore concerned that there is any perception that the White House, in any way, has not actively sought the advice and participation of Republicans from the beginning.

It is very important to note that the President has insisted on significant Republican involvement from the moment he established the Health Care Task Force. On January 26th, he requested that the House and Senate Democratic and Republican Leadership appoint representatives to the Task Force. Senator Dole chose himself and Representative Michel appointed Representative Dennis Hastert (R-IL) to serve on his behalf.

Since that time, Mrs. Clinton and/or Ira have attempted to hold meetings on a virtually weekly basis with House and Senate Republicans and/or their staffs. The House has chosen to send its Members to the meetings, while the Senate Health Care Task Force has chosen to send staff. The Senate Republican Task Force has suggested that more active Member-level discussions be delayed until we have a better sense about what our final proposal will be. As these decisions are made, we will reach out to these Members again. It is essential to remember, however that we have always encouraged and been open to meeting with Republican Senators.

To help clear up any misperception with regard this issue, I have attached a list of the numerous meetings that Mrs. Clinton, Ira Magaziner, Judy Feder and their designees have held with Republicans over the last two and half months. I hope you will find this information to be helfpul. Please do not hesitate to contact me with any questions at 456-2645.

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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]
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. memo	Chris Jennings to Howard Paster, Steve and Lorraine Re: Ways and Means Subcommittee on Health/ Interaction Meetings (2 pages)	4/4/93	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
Chris Jennings (Health Security Act)
OA/Box Number: 23755

FOLDER TITLE:
HRC Memos- HSA [2]

gf129

RESTRICTION CODES

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

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Not to HRC

MEMORANDUM

DRAFT 1

To: Distribution
Re: Health on the Hill

April 5, 1993

Summary. This memorandum goes to great lengths to make two concise points. First, we have some timing decisions to make to ensure that passage of the health care bill this year is compatible with timely enactment of the economic plan. Second, we have to make some procedural decisions in concert with the Hill Leadership over the manner in which the health care bill will be considered in Committee and on the floors of both Chambers. Answering the second point properly means narrowing the possibilities that the Health care bill is undermined procedurally in the Senate. The intent of this discussion is preserve the Administration's ability to adopt the health care proposal *this* year.

Schedule

The House schedule is currently uncertain. House Committees are not processing legislation for the floor. Consequently, were the House to return to work on April 19, it might have no legislation to consider. The recess may be extended to the week of April 26. Upon their return, House Committees will conduct hearings and mark-ups with the intent of bringing reconciliation to the floor in the week preceeding Memorial Day. This schedule could conceivably slip to early June. Given the size and scope of this deficit reduction, investment, and tax package, we must assume that all other work in Committees stops for all intents and purposes during the hearing/mark-up period, as does other action on the House Floor, for a period extending a week (three working days) during reconciliation. Since this bill is a tax measure, it must originate in the House.

The Senate schedule is similarly confused, although reconciliation is one of few semi-predictable legislative activities by the Senate (due to limits on debate, prohibitions on filibusters, and germaneness limitations on amendments).

Once the Senate adopts our bill, the House and Senate will meet in the mother-of-all-conference committees to reconcile the differences between their two bills. Our intent is for final adoption before the August recess. *Adequately covering the House and Senate committees, House and Senate floors, and each of the 407 507 subconferences on the reconciliation bill will be the most daunting task of the Administration to date for our legislative affairs and lobbying departments.*

The Committees whose resources will be most stretched by reconciliation are those most implicated by the health care plan -- Ways and Means, Finance, Energy and Commerce, Labor and Human Resources, and Education and Labor.

Clearing the reconciliation bills presumably enables the House and Senate Appropriation Committees to begin work on the Appropriation bills. Our intent with these bills must be to pass all by the dawn of the 1994 fiscal year, October 1, 1993. Thus, these bills assume priority handling amidst the reconciliation process.

The riddle here is one of timing. If much of the Committee process is congested, given over to the substance of the economic plan, how can timely consideration of the health plan also occur? If the House and Senate work the health care bills under the regular order, does that foreclose early votes affirming the President's health care plan? Are their alternative procedural means for securing an early vote, thus maximizing our persuasion during a time when actual consideration is foreclosed? Are we correct to assume that the August recess is sacrosanct?

As to timing, let's assume a decision to go forward in Mid- to Late-May for unveiling all or part of the health care plan. Use of the regular order to process the legislation will likely mean erratic Committee consideration over the summer, and after Labor Day. As detailed below, the regular order can be narrowed in the House, not so in the Senate. Under the best of circumstances, we could foresee action in the House during the fall, and the possibility of a filibuster tying up the Senate for an indeterminate period. No predication can be made as to when we could expect Conference and a law. And there is no assurance we can accomplish either.

Under any scenario, the bottleneck is in the Senate, and obtaining 60-votes required under the regular order is as much a function of public pressure as anything else. Assuming the right substance and lobbying, the House should be able to complete work on a law this year using the regular order. The use of the regular order in the Senate only assures consideration of the entirety of the Clinton health care plan (for significance, see below).

To achieve an early vote, and to lock the Congress into a schedule for passage this year, we would be required to send along the health care bill as a <u>reconciliation measure</u>. Under this scenario, reconciliation measure must be proceeded by adoption of a Second Concurrent Budget Resolution. Passage of this resolution, would lock both the Senate into dates and deadlines, and passage of the resolution would be an early Congressional victory for health care.

Procedurally, this idea conveys few advantages in the House, but for the symbolic importance of dates and deadlines. In the Senate, this process assures passage *but only of a deficit reduction bill*. The so-called "Byrd Rule" enables Senators to offer points of order against provisions which do not reduce the deficit. Sixty votes are required to waive the points of order. Under these circumstances, we can:

1. Use the regular order. House passes the Clinton bill. Senate is tied up in two successive filibusters -- on the motion to proceed and on consideration. Public pressure is required to round-up sixty votes in both instances to impose cloture. Unlike the House, the Senate must respect no rules of germaneness. But assuming the skillful use of lobbying and public pressure, we might be able to round up 60 votes for a result.

2. Use reconciliation. House passes the Clinton bill. The Senate considers the legislation under time limits, germaneness limits and the Byrd Rule. Non-deficit reducing substance is excised on the Senate floor. The House and Senate meet in conference to work out the differences between a good bill and a stripped down version. The conference approves a good bill. Focused public pressure is once again required to obtain the 60-votes needed to preserve measures deemed extraneous under the Byrd Rule in the final conference agreement. If we find those sixty votes, we get a law.

To restate the obvious: While the substance is obviously controversial, there is apparently great disquiet in the Capitol over whether we understand the inter-activity between reconciliation and health, procedurally, and in terms of timing and counting votes for both measures. We need strategic agreement among ourselves and between us and the Hill on timing and process. This can work, but it will come apart if we don't get these pieces right.

<u>Miscellaneous intelligence</u>

- **Intensify Hill consultation to ventilate concerns by the Committee chairs about the compatibility of the reconciliation and health care schedules. recommendation: the President and Mrs. Clinton to hold three working dinners in close succession to talk process and hear concerns about substance (these are necessary to complement the consultation that has already occurred):**

  -- Working Dinner 1, Mitchell, Foley and Gephardt.

-- Working Dinner 2, House of Representatives consultation: Dingell, Rostenkowski, Waxman, Stark, Ford, P. Williams, Gephardt, Kennelly, Derrick, Gonzalez, Brooks, Sabo, Montgomery, Obey, Conyers and Bonior. Members only.

-- Working Dinner 3, Senate consultation. Moynihan, Kennedy, Breaux, Boren, Kerrey, Byrd, Pryor, Rockefeller, Sasser, Biden, Nunn, Metzenbaum, Bradley.

<u>These discussions on timing, and follow-ups on substance, must be aimed at reaching strategic agreement with the Hill on these issues. It can literally spell the difference between success and failure.</u>

- *Do not expect -- and do not request -- early media appearances involving Members of Congress and the Administration upon release of the plan. This rules out, on strong recommendations from the Hill, planning town meetings in the immediate aftermath of a Joint Session address.*

- There is great concern that CBO is going to screw us on savings, etc., just as it did on the budget. Do we have a Reichauer strategy?

- We need a discussion with the Hill leadership about the possible interplay between our health strategy and the work nearing completion by the Joint Committee on Reorganization of the Congress. It is considering issues which can impact and derail much of what is discussed herein.

- Foley's relations with the Democratic Caucus, especially the freshmen, are remarkably bad.

- Abortion and the politics of the House/Senate, especially House rules, is a big problem.

Background on Procedure

House/Ordinary Process

- **Introduction.** The bill must originate in the House if it includes tax measures. The Speaker is likely to refer the legislation, minimally, to Ways and Means and to Energy and Commerce. Depending upon the substance, an original referral could also go to Education and Labor and/or Judiciary. *Under the normal procedure, such multiple referrals can kill a bill.*

- **Multiple referrals won't kill our bill.** It is within the Speaker's discretion to attach time limits on the consideration of Committees for legislation referred to them. This can occur at multiple levels; for example, no time limits on the Committees of original jurisdiction, and tight time limits on the Committees which receive the bill sequentially, following adoption by the primary Committees. The Speaker can also put time limits on every Committee that receives the bill, such as Ways and Means and Energy.

- **Following hearings and mark-up.** The bill goes to the Rules Committee following a timely reporting by all Committees of the health care bill. The Leadership would be apt to ask the Rules Committee for a *modified closed rule*, permitting a limited number of amendments -- depending upon the substance of the bill -- probably only substitutes. Wildcards include taxation and abortion, to name but two.

- **Assuming adoption of the rule.** Floor consideration can take place in a specified period of time, with a specified number of amendments, and with a know-able schedule for concluding work. The bill, assuming passage, then goes to the Senate.

[• **Announcement (small consideration).** The President can choose whether to send up his health bill as "a message from the President" or as "an Executive Communication." The former provides more hoopla and message opportunities. (Keep in mind.)]

House/Reconciliation

- To have the health bill considered under reconciliation, this legislation must be mandated by passage of a concurrent budget resolution. Since it is probably the case that *the original budget resolution adopted by the Congress last week cannot be construed to mandate a second reconciliation measure devoted to health*, a reconciliation bill must be triggered by a second concurrent budget resolution.

(It would be unique to have a second reconciliation bill. It would not be unique to have a second budget resolution; that is, traditionally, the normal process).

- *Starting with a second budget resolution.* The second budget resolution would come to the floor under debate limited by House rules, with amendments specified by the Rules Committee. *It can, however, be amended.* The advantages of doing a second resolution are: (1) it provides us the opportunity to get an early symbolic vote on health care, (2) going the reconciliation route enables us to lock Congress into a schedule for considering our bill, (3) procedural advantages obtain in the Senate -- such as a twenty-hour time limit, germaneness requirements, and a bar against filibusters. The principal disadvantage in the House is that we would have to lobby House Budget and House floor in order to avoid a substantive or symbolic defeat.

- Upon adoption of the second concurrent resolution, the Committees could begin work on the health care bill, the generalities of which would be spelled out in the reconciliation instructions of the Second Concurrent Resolution.

Senate/Ordinary Process

- **Committee process.** In contrast to the House, referrals are generally to the Standing Committee which has jurisdiction over a preponderance of the subject matter. *Only by unanimous consent can another Committee obtain a referral under the Senate rules.* The Senate Finance Committee is the likely Committee of jurisdiction. The Committee will have hearings and mark-up the bill. Assuming it passes, the bill goes to the floor.

- **Floor consideration.** Assuming no time agreement -- which can only be obtained by *unanimous consent* -- the Senate will undertake three stages of consideration for passage of the bill: the Motion to Proceed (debatable and subject to the filibuster); consideration (open-ended debate, anything is germane, subject to filibuster); and, final passage.

- *On the motion to proceed,* a filibuster can occur. To break the filibuster, a cloture petition must be filed. Essentially, two days of debate can be chewed up by this process. Cloture can only be invoked with the concurrence of 60 votes. After cloture is obtained, thirty hours of further debate is allowed.

- *Once the bill is up.* Consideration is again open-ended, with no rules of germaneness applying to the legislation. If cloture is offered and voted on the bill, the following obtain: a 30-hour time limit, a germaneness requirement, and a limitation on amendments to those filed before the voting of the cloture petition (1-day for first-degree amendments; 1-hour for second degree amendments).

Senate/Reconciliation

- To have the health bill considered under the rules of reconciliation, this legislation must be mandated by passage of a concurrent budget resolution. Since it is probably the case that *the original budget resolution adopted by the Congress last week cannot be construed to mandate a second reconciliation measure devoted to health*, a reconciliation bill must be triggered by a second concurrent budget resolution. (It would be unique to have a second reconciliation bill. It would not be unique to have a second budget resolution; that is, traditionally, the normal process).

- *Starting with a second budget resolution.* The second budget resolution would come to the floor under limited debate (50 hours), and it cannot be filibustered. *It can, however, be amended.* The advantages of doing a second resolution are: (1) it provides us the opportunity to get an early symbolic vote on health care, (2) going the reconciliation route enables us to lock Congress into a schedule for considering our bill, (3) procedural advantages obtain in the Senate -- such as a twenty-hour time limit, germaneness requirements, and a bar against filibusters.

- The disadvantages of this route are: (1) We have to do a full court lobby operation on passage of the second resolution, and (2) the "Byrd Rule" applies to floor consideration in the Senate of the health bill. *This means that non-deficit reducing provisions of the health care bill (spending, health insurance purchasing cooperatives, medical malpractice and, conceivably, private sector cost controls) would be subject to a point of order, which can only be waived with 60 votes.* Thus, even if the House passes our complete passage as written, the Senate might only be able to process finally a bill primarily devoted to reducing federal costs applying to health care.

- *Playing out the reconciliation strategy.* Worst case, the House passes our bill, the Senate passes a stripped-out/stripped version of our bill, and the two bodies go to conference. Even if the House passes a conference report to our liking, *the Byrd rule applies to conference reports.* Ultimately, our ability to win Senate adoption of the Clinton Health Plan Conference report rests upon our ability to round up 60 votes to waive a Byrd Rule point of order.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
008. memo w/attach	Chris Jennings to Steve R. Re: Republican Members and Staff Meetings/Contacts (4 pages)	4/9/93	P5

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