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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Re: Health Care Reform Communications (24 pages)	5/26/93	P5

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] - Senator Rockefeller (WV) [1]

gf144

RESTRICTION CODES

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

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

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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(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]
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Rockefeller

Remarks of Senator John D. Rockefeller IV
Sloan-Kettering Cancer Center
New York, New York
December 16, 1993

Thank you. I begin by showering praise on Dr. Paul Marks -- and thanking Sloan-Kettering for arranging my visit. My family has a rather long, philanthropic history with Sloan-Kettering, but I know that your hospitality has absolutely nothing to do with that. I have always succeeded on charm and good looks, and nothing else.

As some of you suspect, I grew up in this city. While I have now lived in, and represented, a rural state -- West Virginia -- for more than half my life, I cherish my roots and my family here in New York. I hope that enables me to have a real appreciation for the importance of your work. I certainly know something about the expectations and obligations that fall on your shoulders -- in trying to perform some of the best medical research and treatment in the world, while responding to the health care needs of the very poor, the very old, and the very sick.

I have tried not to be intimidated about speaking to you, and instead, to think about my obligations and expectations -- and what thoughts to share with you. We are on the eve of an historic year when our country may finally commit itself to a specific path of health care reform. As a Senator totally dedicated to this goal, I find this visit a chance to reflect on the issues of reform that pertain to you and your institutions -- to academic health centers and the workforce of health professionals.

This is also an opportunity to express my intent to work with you every step of the way in the stretch that awaits us -- an intense period of ten months in which we must produce a final legislative product, pass it in both houses, and get it signed into law.

I start with a basic premise that most Congressional leaders in health care and most key officials in the Clinton Administration want your institutions to function and thrive in a reformed health care system -- so that you can continue your critically important missions in education, research, and patient care. But, before getting into the details of what I mean by that, I should say something about the bigger picture to set the context.

I am a proud, original cosponsor of the President's Health Security Act. I sincerely believe this legislation, formally introduced just before Thanksgiving, is our best hope for comprehensive reform. It provides the framework needed to achieve our overarching mutual goals and should be the basis

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate

WASHINGTON, DC 20510-4802

FROM THE OFFICE OF SENATOR JAY ROCKEFELLER

FAX COVER SHEET

TO: Chris Jennings

OFFICE:

FROM: Tamera Stanton

DATE: 12/16

 # OF PAGES (INCLUDING COVER): 9

Problems with transmission call (202) 224-6472

MESSAGE:

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for the remaining legislative process.

For most of the year, largely due to the First Lady's extraordinary leadership, the Administration and its health care allies dominated the public stage. We built excitement for the President's plan. We showed the pundits and the press that health reform is good politics, because the demand for action was coming directly from the public -- from the middle-class, from small business owners and workers, from physicians, hospitals, and institutions like yours.

But in the past few months, while the Administration was immersed in the gritty work of translating the President's plan into a bill, the guardians of the status quo stepped right into the breach. They didn't need legislative language to oppose the President's plan. They didn't feel any obligation, whatsoever, to give the plan a fair hearing before taking out ads and airing commercials -- all designed to strike terror in the hearts of Americans over the plan.

Thanks to the deep pockets of the Health Insurance Association, and other nay-sayers, Washington is once again full of questions about whether serious reform can really be passed. Lines are being fed right from the forces that would like to keep things just as they are: Universal coverage should be dropped, they say. Cost containment is too controversial. Why should government dictate any changes in health care? Let the private market, the insurance companies, continue to dictate whether or not our fellow Americans -- and your patients -- can get insurance and have peace of mind about their health care.

You know the responses to these questions. While reform or change will not be easy, sticking with the status quo is what we all should fear and tremble over.

Moreoever, in the recent months, health care history has started to repeat itself. Once again, we have seen Senator after Congressman cook up their own special recipe for health reform -- so now we have an entire cookbook of plans, sure to confuse the best of us.

Most of the plans have merit. Some have a lot of merit. But I say this about all of them: every reform proposal should be measured by the same rigorous standards that have been applied to the President's. Every plan should be judged on whether it meets the fundamental tests of reform -- universal coverage and cost containment. And the test of meeting the need for a responsive health care workforce and a recognition of the unique role of academic health centers. Only through fair comparisons, can the public possibly judge what is in their interests.

Another observation on the recent months may answer your own concerns about relying on Medicare and Medicaid to partly finance health care reform. My friends, it has been made abundantly clear that the choice is not between health reform and business-as-usual. All over Congress, troops are organizing to capture the very same money for a very different mission -- and it is called deficit reduction. To me, the choice now is between devoting health care resources to health care, or to a reckless course if Congress gets conned into passing something called a Constitutional amendment to balance the budget. You need to help your representatives make the right choice.

The President's plan restructures the way health care is provided, including the way our health care workforce is trained. A serious health reform proposal must deal with these issues. A fundamental point of reform is to ensure that those who are on the front lines providing the full range of health care services to our communities are able to continue doing so. Fundamental to that goal is taking the right steps so that we are <u>able to deliver</u> the kind of health care that all Americans deserve to have.

In helping to lead the fight in Congress for health reform, I am putting special emphasis on workforce reform and the promotion of primary care. Not because I don't think the kind of specialty care that institutions like Sloan- Kettering provide is terribly important. It is. It should be fostered.

It is because I think it's time to recognize the direct relationship between the mix and distribution of our health care workforce, and its ability to provide the care that people need, when and where they need it. Unless we intervene, and change that mix, we simply will not live up to the promise of true access for all Americans.

As I began by noting, while I was born in this city, with access to the best health care facilities, for the last 30 years of my life I have lived in the beautiful mountain state of West Virginia. I originally went as a VISTA worker to a town called Emmons. Then, and ever since, I have seen and struggled over the ravages of inadequate and inaccessible health care. As a Governor, I grappled with how a state can improve access to care for its citizens without the help of health reform on a national level.

West Virginia has three medical schools that do a tremendous job of training and caring for patients in need. Even with those resources, there is still a lot of unmet need. As you can imagine, it takes considerable commitment, from the state and its health care professionals, to support and cultivate three medical schools in a state our size. But we

have supported these institutions through some very lean and mean economic years. We do it because we feel it's our obligation, and because we want to invest in the long-term benefits of the training, the research, and the care provided through these schools.

I want reform to assist my own state's centers in meeting their mission to improve the health status of its community, just as I want it to bolster your good efforts -- and for the same reasons.

After thinking a long time about the role of workforce in health reform, and the special issues connected to academic health centers, I decided to develop my own legislation on just this set of issues. Working with Congressman Henry Waxman, another health care leader, I have tried to spell out our view of what it will take to produce the necessary workforce.

Therefore, as I finish by discussing these issues and the President's plan, I will mention ideas in my bill. While doing so, I ask you to focus on the basic question of whether or not these ideas will be good for the country and our overall health care system, along with what they will mean for your institutions. And if you still object, think about whether or not you can suggest other viable alternatives or approaches that will help us achieve our mutual goals.

To start, I would say the ideas in the President's bill that aim directly at improving support for academic health centers are not where the fierce debate will take place -- there is acceptance for the ideas of continuing support for your research efforts; transitional relief for the changes that will come from regulating the physician workforce; and issues having to do with which specialized services merit guaranteed contract rights.

We all want to make sure that patients in need are provided access to the excellent health care that your centers have been counted on for. How much money is needed to preserve, protect, and fairly compensate academic health centers for this unique role will be something to sort out. I think we all want to accomplish the same thing -- practical constraints will be our biggest problem.

The sharper debate is over workforce reform, as you well know. And it is on this front where I hope to persuade you to be less resistant to change, and as constructive as you can possibly be in this essential part of reform.

Now, we all know that in a reformed health care system, demand for primary care providers will increase, as will

demand for other well-trained primary care professionals.

But, here we face the major dilemma: demand for primary care practitioners is going up, but fewer students, especially physicians, are choosing this career path. And even though many of you are specialists, whose contribution will always be essential, I think you understand that primary care providers have been undervalued and underused in our current system.

Simply put, the workforce provisions in the President's bill are designed to change the incentives in our current system so we produce more of the kinds of providers that for years have been neglected -- and who, clearly, will be needed in much greater numbers in future years if we are to succeed in building a more rational, stable system of care for all Americans.

This shift must affect how you run your training programs, and in some instances, the structure that you currently use to provide that care.

The President's proposal, and my own legislation, recognizes this and attempts to ease you through the transition to a reformed system where uncompensated care is a remnant of the past. Both bills draw heavily from the recommendations of the Physician Payment Review Commission on how we can best achieve workforce reform. As you well know, workforce reform is intrinsically tied to the provisions that deal with academic health centers.

Now, I want to make a point-by-point case for the changes embodied in the President's plan and what I believe we must pursue:

One: I share the belief that an all-payer fund should support the costs of graduate medical education and buttress the work of academic health centers is common sense. Medicare should not bear the sole explicit burden for services that benefit everyone who uses the health care system.

On a related subject, while we're talking about funds to promote the common good, like training of our nation's health care workforce, I understand that you support Senator Harkin's idea of a dedicated trust fund for biomedical research. I will take a serious look at it. The financing of that fund, of course, will be key in determining its political viability. Another reminder to help kill the balanced budget amendment.

Two: I think consensus is forming around the threshold decision that we need to ensure some control over the number of residencies in this country, and that those approved residencies should be properly allocated. Just how a

National Council on Graduate Medical Education will do that will be an issue of much debate. As a representative of a small state, I want to see small, quality residency programs able to continue producing residents that practice in their states -- in underserved areas, to be more precise. Candidly, I am nervous about the hopes, or designs, of some who want to end up with regional training centers that are supposedly going to farm out their residents to smaller states like West Virginia. I fear this may be an effort to allow some centers to continue to churn out specialists in the numbers that they do today, without regard to the need for these positions in our workforce. I don't think that is a road we want to take, or an approach that should be encouraged, tacitly or explicitly.

Third point: The President's legislation recognizes that our current system trains professionals in all the wrong proportions. The bill says that we should have at least a 55 percent mix of generalists to specialists -- I think that's a goal that we all basically share. Specifically, the idea is to ensure that we are no longer paying to train health care professionals that we do not need. This raises the concern that we may be forcing this change too fast. I confess to you that I am the ringleader here. I think we absolutely need to commit to a tough timeline, and say when to begin training in the right mix. 1998 is five years from now. With proper planning, I think we can make the necessary adjustments. I am open to your views on this. By I feel emphatically that to produce real change in the real world, we have to agree on a time-table with some ambition.

Fourth: One of my main concerns with the President's proposal is that there is no cap on the overall number of residents trained. That decision is left to the new Council. Without a cap on the number of residencies, the goal of at least 55 percent of all residencies being primary care providers can be subverted. Let's be honest, some of your institutions may find it easier to do just that. More primary care providers could be trained solely to offset the number of specialists. That scenario would mean we've done nothing to control the imbalance that currently exists, which could lead to serious problems as a result of increased volume of services. A cap is essential to insuring that our new primary care emphasis improves our current system.

Fifth, like you, I share the concern about just how the allocation process will work. Congress, and all those involved in the training of our workforce, deserve to know how those allocations will be made. Specifically, as I have said, I am concerned that there will not be sufficient protections for quality residency programs in small and rural states. We should know how approved residency programs will be divvied

up. Criteria should guard against the "big guys" overpowering the "little guys" and therefore thwarting our attempts to improve the distribution of providers.

Sixth point. I support changing the current formula for determining payments for graduate medical education training to eliminate the huge variation that currently exists for paying to train residents.

The last point I will make on this subject is there is a great deal of controversy over who controls the dollars that are used for training. There is debate about what the President's legislative language actually calls for. No doubt, this will be one of the issues causing the loudest hue and cry. For my part, I have a simple philosophy: whoever, or whatever entity, incurs the costs of training health care professionals should be reimbursed for that service, directly. That means if a training program incurs the costs, they should get the dollars. That doesn't mean that the money necessarily has to go directly to the program. Medical schools could pool the reimbursement for their individual programs. If community hospitals are doing the training, they should get the money. I know this is not a simple task, but I think we can figure out a way to do it. I also know this will upset some traditional relationships, but I think it is a fair principle and is common sense. It also reflects the direction that medicine is moving already, even absent national health care reform.

I recognize that workforce reform is about altering existing relationships and funding pipelines. But unless we succeed in making these changes, it is more than likely that we will allow health reform to become a hollow promise -- proclaiming universal coverage for care from professionals who are nowhere in sight.

I want to conclude by laying all my cards on the table. We may not agree on every detail, now, or even at the end of this process. But I readily admit to you that all the President's and the First Lady's efforts to overhaul our nation's health care system -- to give the promise of health care security to the American people -- will be much more difficult if we do not have the active support of our nation's 132 academic health centers. You are the health care "elite" -- the Titans in this debate.

Your voices count, and that is precisely why I am here to make my case to you. What you think and say about health care reform, particularly its effects on academic health centers and workforce reform, reverberates in the halls of Congress. And I want our voices to reinforce one another -- rather than add to a clatter of dissenting views and demands.

My hope is that you will do everything you can to work through the details of this legislation with me and my colleagues, and consider carefully the consequences for your institutions and the people that you serve. If we blow this historic opportunity to achieve comprehensive reform, we will share the blame.

Americans recognize that academic health centers are the jewel in the crown of our health care system. They may not know the jargon, but they do know where they want to be cared for if they get cancer, or any number of serious illnesses. They turn to you. They put their faith in you. They rely on your unmatched expertise, in their fight for life.

Today, we are talking about the fight for a decent, stable, compassionate health care system. This patient is also very sick. A few aspirin or a simple treatment will not do the job. In order to make the system whole, we have to administer a bold, serious regimen of changes in policy and behavior.

If we can work out the steps together, we will all be winners. Your institutions will retain their special role in health care. But you will also look around, here in New York, in the rest of the region, and across the country -- and you will see patients, neighbors, and family members who can get good health care, wherever they live. Whether they have a great job, or are in between jobs. Whether they are healthy, or have something called a pre-existing condition.

Please help, today and in the weeks and months to come. Commit your support to the framework and the goals of the President's proposal, and then help strengthen the pillar that will hold up the future of our academic health centers and our health care workforce. We'll have to be very courageous and very creative. As physicians or part of health care, that is not new to you. The challenge now before you and me is to give all we can to build a health care future that our great nation deserves.

Chris - 7/15

The latest

TAMERA M. STANTON
LEGISLATIVE DIRECTOR

show & tell! Best.

SEN. JOHN D. ROCKEFELLER IV
WEST VIRGINIA

724 HART BUILDING
WASHINGTON, D. C. 20510
(202) 224-6472

Remarks by Sen. Jay Rockefeller
at the primary care conference
"HEALTH REFORM'S FRONT LINES"
sponsored by the
ALLIANCE FOR HEALTH REFORM
Washington, DC
July 15, 1993

Good afternoon. I can't tell you how pleased I am to be with you today -- thanks to the vagaries of today's Congressional schedule, I could not join you this morning as I wanted to. But my news is that we held the first meeting of the conference deliberations on the President's economic package this morning, and that's almost as important as primary care.

I am extremely proud to be here as chairman of the Alliance for Health Reform, an organization I set up two years ago to help educate the country about the urgent need for reform. If all of America's opinion leaders and policy makers were as well educated as this audience on the need to reform our health care system, a mission like ours wouldn't be necessary.

Today's program could not be more timely. Our country stands on the brink of comprehensive, fundamental reform of its fatally flawed health care system.

For the first time in a generation, we have a real chance to defuse the ticking bomb of health care costs that threatens nothing short of an economic meltdown in just a few short years.

We have a real chance to make quality, affordable health care a reality for the tens of millions of Americans who now lack it -- and a real chance to bring peace of mind to the majority of Americans who have coverage, but rightly fear that they, too, could lose that security any time.

But there is a secret about health care reform that we have to let out: there is no reform plan that can succeed unless it reverses the current imbalance in our health professional work force. You in this room understand that. You probably even know that only one American physician in three has a primary care practice, and only one American medical student in seven even plans to have one in the future.

And it's not simply a question of raw numbers. We may be heading for an oversupply of physicians, but the physician-to-population ratios in rural counties are only about a third of those in urban areas. West Virginia is a vivid example of how people are suffering -- and occasionally even dying -- because doctors are quite literally too few and far between.

In our anxiously awaited new health care system, it seems certain that there will be an even greater demand for well-

trained primary care professionals. And there is the dilemma: demand for primary care practitioners is going up, but fewer students are choosing this career path.

You understand the reasons. Many of you have spent your professional life writing and speaking about them. There is the culture of specialization in medical schools -- few generalist role models on the faculty, and virtually no experience providing care outside of hospital settings. There are the crushing debt levels, and the higher relative incomes of specialty practice.

Having led the battle to reform Medicare's payment system for physicians, I am doing my best to reshape this part of the equation, but the Medicare system still rewards high-tech procedures better than it does more cognitive services.

We are gradually recognizing this need to change. The array of groups that have endorsed the goal of having half of our physicians engaged in primary care is large and growing. The tough part is getting anyone to agree that, in order for us to make a palatable primary care omelet, some status quo eggs will need to be cracked open.

This is not a theoretical concern for this Senator. For years, I have been confronting the way these trends affect West Virginians. Even though we support three medical schools, our small state doesn't have enough primary care providers where our people need them.

As chairman of the Senate Medicare subcommittee, I am more determined than ever to chart a different course. That means working hand in glove with the Administration to incorporate the right steps into the health reform plan they are putting together. If you have listened to Hillary Rodham Clinton, you know she understands the importance of this aspect of the proposal.

And as you will hear from Henry Waxman later this afternoon, he and I are hoping to provide a bright line of guidance to the Administration and our colleagues in Congress with legislation we will introduce next week. It draws heavily from the recent recommendations of the Physician Payment Review Commission, then chaired by our wonderful new Assistant Secretary for Health, Phil Lee.

Because the health care system is not yet reformed, our bill is crafted to fit current law. It would redirect the money Medicare spends on graduate medical education -- and how many people outside this room understand that Medicare will spend $5.5 billion this year on GME? -- to reflect better the needs of the people for more generalists and fewer specialists.

Our proposal will set a target of a 50/50 mix of generalists and specialists among residencies, and caps the number of

residents overall. It sets up a national health work force board to implement the new work force policy, and requires the board to work with the physician community to make sure the right decisions are made.

We encourage Medicare payments for services in non-hospital settings, and suggest a closer examination of how -- and to what extent -- Medicare graduate medical education dollars could be spent to educate nurses and other providers.

We propose to revitalize and fully fund the National Health Service Corps. We will act to make primary care practice more attractive, including further steps to reverse the disparity between reimbursement for procedural and non-procedural services, and help eliminate the "hassles" and administrative costs of practice.

And while it's not part of our Medicare-related bill, I can tell you that I support -- and look forward to supporting in the context of health reform -- the concept of having all payers, not merely Medicare, share in the cost of health professional education, just as all payers share in the fruits of that education.

As I talk to my colleagues in Congress, I am enthusiastic about the reception this proposal will receive on Capitol Hill, from both Democrats and Republicans. As I talk to Mrs. Clinton and others working on health reform for the Administration, I am confident that we are blazing the trail in the direction the President will propose as part of his plan. And I hope we can tap into the thoughtful good will of many of you directly affected by this issue.

I commend to you all the outstanding work of the Alliance for Health Reform study panel, chaired by my good friend Reed Tuckson, and its report on this topic, "Commanding Generalists." I can tell you first-hand how seriously the study panel took its work. When I stopped by one during lunchtime of a study panel session, I had just come from a long meeting with the First Lady on this subject, and I shared with the panel members some of what we had talked about. Reed let me go on for about five minutes, and then he said, "Are you about finished? We have some work to do here." So I finished my story, and my sandwich, and let Reed and his colleagues get on with the task.

And to all of the study panel members, congratulations for a spectacular job. The report will be extremely helpful as we try to educate Congress and the American people on why this issue is so central to our broad health reform effort. The fact that so many well-informed and well-respected people have taken the time and trouble to lay out a comprehensive list of options for action sends exactly the right signals to those who need to decide what

actions to take.

Many words of thanks, also, for the W. K. Kellogg Foundation, and Ron Richards, for helping to fuel this debate. I know the Community Partnerships Initiative is making a difference in West Virginia. With the Kellogg funding as the catalyst, and the active support of the Governor, we are hoping literally to reshape how -- and where -- health professionals are educated in our state. This study panel project is a good way to make sure the excellent track record these initiatives are building doesn't get lost.

Make no mistake, this is one of the thorniest tasks in all of health reform. It affects important interests and values. It proposes to alter existing relationships and funding pipelines. But unless we succeed in making these changes, we risk allowing health reform to become a hollow promise -- proclaiming universal coverage for care from professionals who are nowhere in sight.

You have already heard from the study panel, and you will soon hear from Henry Waxman and the Administration, in the person of my former Pepper Commission staff director, Judy Feder. Listen closely to their presentations, and the panel of stakeholders.

And then I ask for your help, today and in the weeks and months to come. Voice your legitimate concerns about their weaknesses. But don't let the advocates for the status quo take center stage. You can stop them better than I. And I repeat, if we fail to reform our primary care machinery, we will eventually fail in our larger reform task

Let us seize this moment for deeds, for real change. That means outmaneuvering the guardians of gridlock. That means making reform a reality. Thank you.

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Meeting with Senator Rockefeller
cc: Melanne, Steve, Distribution

August 9, 1993

Tomorrow you are scheduled to meet with Senator Jay Rockefeller. He will be accompanied by Tamera Stanton, his Legislative Director, and Mary Ella Payne, his Health Legislative Assistant. In order to assure that you could see Chairman Dingell before he departed for the August recess, we had to reduce the time allocated for this meeting from two hours to one.

BACKGROUND

Senator Rockefeller has been looking forward to a substantive policy/political discussion with you for months. Last week, he had a very constructive discussion with Ira in which the chemistry appeared to be extremely positive.

During the meeting, he raised several concerns including: (1) we may be raising expectations too high; (2) that defending the concept of non-competing alliances will be difficult (although he agrees that it is the right thing to do); and (3) we should probably not start out with a proposal that caps punitive damage awards (because of the Democratic politics unless we have a good deal of Republicans and physicians groups on board from the start). He was also extremely interested in the status of our cost containment and financing discussions.

Earlier today, Senator Rockefeller joined the President in West Virginia for the budget speech. During his comments, he spoke favorably of both the President and yourself, as well as putting in a strong plug for health reform.

According to his staff, Senator Rockefeller is interested in a broad array of conversation topics. First and foremost, he wants to bring you up-to-date on the Health Project. He believes the groups are working well together and are making progress on establishing the necessary staff infrastructure for running the Fall campaign for health reform.

In addition, Senator Rockefeller has a number of high priority issues he would like to discuss beyond those discussed in his meeting with Ira and myself. He wants to know the specifics of the size of Medicare cuts the Administration is contemplating to help finance much of the reforms. (He is concerned that they may well be too deep for his liking.) The Senator would like to discuss the status of the premium financing mechanism. He would like to discuss how the reform will be phased in and how the alliances will be governed. He is also interested in discussing his belief that we must be very rigid about our definition of who is eligible to form a corporate alliance and who is not.

Lastly, he would like to conclude the meeting with some political advice, which he may or may not wish to share with you privately. In any event, you would probably be well advised to solicit his opinion on as many issues as you can. (That was the only criticism his staff said Ira did not do enough in his otherwise very successful meeting.)

TALKING POINTS

Senator Rockefeller would be extremely interested to hear you lay out the likely timetable for internal policy decisions. He would also like to know when the Congress and, in particular, himself will have the opportunity to see numbers and paper on the proposal.

Since he has looked forward to this meeting for a long time, you may wish to reiterate your desire for this to be the first of a number of meetings with Senator Rockefeller and/or his staff in August and early September.

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Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8990

FOLDER TITLE:
[HSA] - Senator Rockefeller (WV) [1]

gf144

RESTRICTION CODES

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

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

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

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

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