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Subgroup/Office of Origin: Public Liaison

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OA/ID Number: 4274

FolderID:

Folder Title:

Health Care and Business 1993 [binder] [1]

Stack:

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Row:

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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	[Personally Identifiable Information] [partial] (6 pages)	04/16/1993	b(6)

COLLECTION:

Clinton Presidential Records
Public Liaison
Alexis Herman
OA/Box Number: 4274

FOLDER TITLE:

Health Care and Business 1993 [binder] [1]

2012-0741-F

rs2637

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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P5 Release would disclose confidential advice 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]
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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]

IF FOUND PLEASE RETURN:

Hon. Alexis Herman
(202) 456-2930

—
**HEALTH CARE
AND
BUSINESS**

1993
—

Clinton Presidential Records Digital Records Marker

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

AIDS

Divider Title: _____

April 16, 1993
9:30
Indian
Treaty Room

And
Bob must have
you don't have
to say it all

TO: IRA MAGAZINER
CAROL RASCO
ALEXIS HERMAN
MOLLY BROSTROM
CHRISTINE HEENAN

FROM: BOB HATTOY

RE: Invitees to Health Care Task Force meeting with AIDS organizations and service providers.

(This meeting is scheduled for Friday, April 16, 9am - 12 noon in the Indian Treaty Room).

(If you have any problems, additions or comments regarding these choices call me at 456-2866 by 12:00 noon on Wednesday.

1). BILL BAILEY: Washington, DC

- *American Psychological Association
- *Legislative analyst and lobbyist for HIV prevention issues

2). TERRY BESWICK: Washington, DC

- *HRCF-largest Gay & Lesbian political organization in the U.S.
- *AIDS research policy analyst
- *AIDS treatment activist

3). LEONARD BLOOM:

Los Angeles, CA

- *CEO of AIDS Project Los Angeles
- *support and maintain quality of life for people living with AIDS
- *provide vital human services to people with AIDS
- *works to decrease the number of HIV cases, the level of fear and discrimination related to AIDS issues and to focus on education and prevention.

4). ANNE BROOMFIELD:

Baltimore, MD

- *Greater Baltimore HIV & Health Services Planning Council
- *recipient of Ryan White Title I funding
- *African-American

5). DAN BROSS:

Washington, DC

- *Executive Director of The Whitman-Walker Clinic
- *Clinic provides AIDS care, testing, counseling and prevention

6). PAT CHRISTEN:

San Francisco, CA

- *Executive Director, San Francisco AIDS Foundation
- * she has been involved with organization for over 6 years, started as volunteer

7). MARTIN DELANEY:

San Francisco, CA

- *Executive Director, Project Inform in San Francisco
- *Founding Director in 1987
- *former businessperson
- *AIDS treatment and research issues

8). SONDRA ESTEPA:

New York, NY

- *Executive Director of The Latino Commission on AIDS
- *focuses primarily on outreach to the Latino community
- *AIDS prevention, education, research and treatment services
- *provide policy analysis and advocacy on AIDS issues effecting Latino community

9). DR. RUTH FINKELSTEIN: New York, NY

- *Director of Public Policy at the GMHC in New York
- *AIDS research issues

10). ELIZABETH GLAZER: Los Angeles, CA

- *Director of The Pediatric AIDS Foundation
- *issues directly related to children with AIDS

12). DEBRA FRAZER-HOWZE: New York, NY

- *Executive Director/CEO of Black Leadership Commission on AIDS
- *promote leadership and education on AIDS-related issues within the African-American community
- *enhance service providers and input on public policy & funding
- *African-American

13). JIM GRAHAM: Washington, DC

- *Executive Director of The Whitman-Walker Clinic
- *clinic is the primary community-based AIDS service provider in the DC area

14). MARK HARRINGTON: New York, NY

- *Treatment Action Group (TAG) leader, 5 years
- *small activist group, spinoff of ACT-UP
- *focus on AIDS research issues

15). MARK ISHAUG:

Chicago, IL

- *Director of Public Policy for The AIDS Foundation of Chicago
- *involved with state and local lobbying effort on AIDS-related issues
- *National Care Coalition to increase funding for the Ryan White Care Act
- *Illinois Gay & Lesbian Task Force Policy Committee

16). MATHILDE KRIM, PhD.:

New York, NY

- *Chair, the American Foundation for AIDS Research (AmFAR)
-one of the original founders over 6 years ago in New York
- *former cancer researcher

17). DR. BILLY JONES:

New York, NY

- *Executive Director of Health and Hospitals Corporation
- *African-American

18). JEFF LEVI:

Washington, DC

- *Director of Public Policy for The AIDS Action Council
- *represents community-based organization issues from research, drug development and regulation, health care financing and public health response
- *lobbying, policy analysis, research and grassroots organizing

19). TODD SUMMERS:

Boston, MA

- *Executive Director of The AIDS Housing Corporation
- *advocacy on housing, legislation, funding for AIDS health care needs and issues
- *Boston AIDS Consortium
- *Project ABLE

20). SANDY THURMAN:

Atlanta, GA

- *Executive Director of AID Atlanta
- *responsible for planning and administering all programs and services for the Southeast's largest and oldest community-based service organization

20). REGGIE WILLIAMS:

San Francisco, CA

*Executive Director of The National Task Force on AIDS Prevention based in San Francisco

*multi-racial AIDS prevention organization-targets gay men of color

*HIV +, with organization for over 6 years

*African-American

21). PHIL WILSON:

Los Angeles, CA

*National Minority Gay & Lesbian Association

*AIDS Project Los Angeles

*African-American

Withdrawal/Redaction Sheet

Clinton Library

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April 16, 1993
9a
Roosevelt

TO: IRA MAGAZINER
CAROL RASCO
ALEXIS HERMAN
MOLLY BROSTROM
CHRISTINE HEENAN

FROM: BOB HATTOY

RE: Invitees to Health Care Task Force meeting with AIDS organizations and service providers.

(This meeting is scheduled for Friday, April 16, 9am - 12 noon in the Roosevelt Room in the West Wing of The White House).

1). REGINA ARAGAN: San Francisco, CA

415/864-3099

(b)(6)

*State policy director for The San Francisco AIDS Foundation

2). BILL BAILEY: Washington, DC

202/336-6066

*American Psychological Association

*Legislative analyst and lobbyist for HIV prevention issues

3). CORNELIUS BAKER: Washington, DC

202/898-0414

(b)(6)

*Director of National Association of People With AIDS

4). TERRY BESWICK: Washington, DC

202/628-4160

*HRCF-largest Gay & Lesbian political organization in the U.S.

*AIDS research policy analyst

*AIDS treatment activist

5). LEONARD BLOOM: Los Angeles, CA

213/962-1600 X223

*CEO of AIDS Project Los Angeles

*support and maintain quality of life for people living with AIDS

*provide vital human services to people with AIDS

*works to decrease the number of HIV cases, the level of fear and discrimination related to AIDS issues and to focus on education and prevention.

6). ANNE BROOMFIELD: Baltimore, MD

410/706-7585

*Greater Baltimore HIV & Health Services Planning Council

*recipient of Ryan White Title I funding

*African-American

7). PAUL DEDONATO: San Francisco, CA

415/864-4376

*Health care finance expert

8). SONDRA ESTEPA:

New York, NY

212/675-3288

(b)(6)

- *Executive Director of The Latino Commission on AIDS
- *focuses primarily on outreach to the Latino community
- *AIDS prevention, education, research and treatment services
- *provide policy analysis and advocacy on AIDS issues effecting Latino community

9). DR. RUTH FINKELSTEIN:

New York, NY

212/337-1230

- *Director of Public Policy at the GMHC in New York
- *AIDS research issues

10). JIM GRAHAM:

Washington, DC

202/797-3509

- *Executive Director of The Whitman Walker Clinic
- *clinic is the primary community-based AIDS service provider in the DC area

11). DAVID HARVEY:

Washington, DC

202/289-5970

- *Coordinator of policy analysis for The National Pediatric HIV Resource Center
- *strongly recommended by Elizabeth Glaser to take her place

12). DEBRA FRAZER-HOWZE:

New York, NY

212/614-0023

(b)(6)

- *Executive Director/CEO of Black Leadership Commission on AIDS
- *promote leadership and education on AIDS-related issues within the African-American community
- *enhance service providers and input on public policy & funding
- *African-American

13). DR. BILLY JONES:

New York, NY

212/788-3332

- *Executive Director of Health and Hospitals Corporation
- *African-American

14). PAUL KAWATA:

Washington, DC

202/544-1076

- *Executive Director of The National Minority AIDS Council
- *provides leadership for people of color and Asian-Pacific Americans
- *provides technical assistance and training on public policy

15). JEFF LEVI:

Washington, DC

202/986-1300 X17

- *Director of Public Policy for The AIDS Action Council
- *represents community-based organization issues from research, drug development and regulation, health care financing and public health response
- *lobbying, policy analysis, research and grassroots organizing

16). CHRISTINE LUBINSKI:

Washington, DC

202/986-1300 X46



*Deputy Executive Director for Programs for The AIDS Action Council

*DC-based lobbying organization represents over 900 community-based AIDS services providers

17). JANE SILVER:

Washington, DC

202/331-8600



*American Foundation for AIDS Research (AmFAR)

*Highly recommended by Dr. Mathilde Krim to take her place at meeting in her absence

18). PETER STALEY:

New York, NY

212/505-5483



*Treatment Action Group (TAG)

*small activist group, spinoff of ACT-UP

*focus on AIDS research issues

19). TODD SUMMERS:

Boston, MA

617/432-0885



*Executive Director of The AIDS Housing Corporation

*advocacy on housing, legislation, funding for AIDS health care needs and issues

*Boston AIDS Consortium

*Project ABLE

20). SANDY THURMAN:

Atlanta, GA

404/872-0600

(b)(6)

*Executive Director of AID Atlanta

*responsible for planning and administering all programs and services for the Southeast's largest and oldest community-based service organization

21). PHIL WILSON:

Los Angeles, CA

213/962-1600 X572

*National Minority Gay & Lesbian Association

*AIDS Project Los Angeles

*African-American



Health Care Reform Statement of Principles

The following are the criteria against which the HIV/AIDS community will measure the various proposals for health care reform. HIV/AIDS poses the same challenges to the health care system as any chronic disabling condition. The reformed health care system must be able to meet the needs of all Americans -- and all Americans are at risk of becoming disabled, whether the cause of their disability is HIV, Alzheimer's, stroke, multiple sclerosis, or any other condition.

To be acceptable, any proposed administrative structure must meet all of the following criteria:

UNIVERSAL COVERAGE

Coverage should be universal and uniform. All U.S. residents should be covered by the health plan and receive the same set of benefits. Whether or not coverage and benefits are tied to employment; the method for accessing health care and the scope of benefits should be the same regardless of employment status.

COMPREHENSIVE COVERAGE

All medically necessary health care should be part of any benefits package, including coverage for in-patient and out-patient primary health care services, including full gynecological services, preventive health services such as prenatal and well-baby care, prescription drugs (including off-label use of approved drugs and ancillary and actual costs of experimental treatments), hospice care, long- and short-term home and community-based services, substance abuse treatment, mental health services, outpatient rehabilitation services, dental care, vision care, and the healing arts. Case management should be provided to link people with appropriate health and social services.

18~5

Connecticut Ave NW

Suite 700

Washington DC

20009

Fax 202 986 1345

Tel 202 986 1300

FREEDOM OF CHOICE

Individuals should be free to choose their own health care provider. Individuals should not be required to join a plan or delivery system if the individual does not believe that program will meet his or her needs. In addition, individuals should be allowed to change providers if they are not satisfied with the care provided. This is particularly important for people with HIV infection, given that a relatively small number of physicians are experienced in treating people with HIV and there is no credentialing process that identifies those qualified or experienced with HIV disease.

NO FINANCIAL BARRIERS TO CARE

Payment for coverage should be based on ability to pay, not based on a flat premium schedule. Out-of-pocket payments should also be based on income. If there is a system of copayments or deductibles, it should be designed so as to prevent sick people from being disproportionately burdened. (For example, if copayments are based on a per visit or a per prescription basis, sick people will pay a larger portion of their income for health care coverage.)

GOVERNMENT RESPONSIBILITY

The federal government must exercise its authority to assure that health care is delivered equitably and cost effectively through the following:

- Global budgeting, which sets targets for health care spending by sector and is the most effective way of assuring appropriate distribution of scarce health care resources while reining in inflation in the health care field.
- Undertaking initiatives to redistribute the availability of health care (especially health care practitioners) to underserved areas and populations, including appropriate education and financial incentives to increase the number of primary care providers.
- Guaranteeing the involvement of consumers in all aspects of decisionmaking associated with any new health care system.

- **Guaranteeing the confidentiality of all aspects of patient involvement with the health care system.**
- **Achieving quality assurance through establishment of federal standards of care and minimum standards for quality assurance methods.**
- **Requiring nondiscrimination in accessing the health care insurance system, whether demographic or based on preexisting medical conditions.**
- **Assuring that appropriate care is given to all Americans, meaning that the appropriate services are given for the appropriate level of need.**
- **The government must assure access to care under existing mechanisms *during a transition to the new health care system.***
- **The government must not "de-institutionalize" the traditional public health programs even after a new system of health care delivery is established.**
- **The government must assure full disclosure to and appropriate education of all participants regarding access and options within the new system.**

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AMH NOTES

Divider Title: _____

Put in
H/c
binder
under AMH
~~notes~~

Sep 14, 1993

Agenda for 2:30 Washington Rep. Briefing:

Welcome

Alexis Herman
Assistant to the President and
Director of Public Liaison

Overview of Health Plan

Roger Altman
Deputy Secretary at Treasury

Followup/Q & As

Ira Magaziner
Senior Advisor for Policy Development

(Note; Ira is with Mrs. Clinton on
Capital Hill meeting with the House
Energy and Commerce Committee. He is
expected to arrive late, at around
3:00pm.

I think just gathering for the
panel is better, given that many
things have not yet determined
their positions. Just output may
also be more effective since there
will want to receive options ~~and~~ on
an individual basis may be delayed
into it.

I would like to
say at the end

that for those companies
who care about the issue
we will want to stay

Closely connected. We are
concerned that while the
dialogue continues we have
a successful launch. If
you are generally supportive
now and we can
say this we need to
know this now.

Should I ask for the
ability to get back with
them for support through
an individual or should it be
a quiet strategy to get
support for the 22?

They are here to help
Roger answer question.

Marina Weiss -

+

~~scribble~~

Brad Delong

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10
40
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1470 by the year 2000

China & Japan are in the 90s are

1. Sound Business Principles Underlying the efforts
 - Competition & Common Cost Concerns
 - Self-Financing / Certain types
 - Paper must use the borrowing

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1/18/1968 10:12 -

water covered throughout
and no more to go

u 4/24

Sta
mark

THE AMERICAN HEALTH SECURITY ACT

A BRIEF DESCRIPTION FOR BUSINESS

1. Puts the health care system on sound business footing and gets costs under control.

The plan brings growth in health care costs in line with inflation by increasing competition in health care, increasing consumer awareness of the cost and quality of their health care, reducing administrative costs and limiting increases in insurance premiums.

- Most employers and employees will join together in alliances, which are large purchasing pools that will increase buying power and lower costs. Health plans and providers will compete to do business with these alliances on the basis of quality, service and price.

Companies with more than 5,000 employees will be able to act as their own health alliance as long as they adhere to national standards for choice, quality, and comprehensive, affordable care.

Administrative burdens of both employers and providers will be significantly reduced. This is accomplished through:

1. One comprehensive benefits package.
2. A single standard form for insurance reimbursement, claims submission and clinical records.
3. Economies of scale for businesses pooled in the regional alliances.
4. Changes to the health portion of worker's compensation and automobile insurance systems.
5. Malpractice reform.

- Consumers pay less for low-cost plans and more for high-cost plans, creating incentives for cost-conscious choice. A single, comprehensive package

of health benefits and reliable information about the price and performance of health plans will give the consumers the information necessary to make these choices.

- Health plans receive fixed premiums based on the risk characteristics of their patients. They will have incentives to reduce costs by focusing on preventative and primary care.
- If savings attained through effective competition and reductions in administrative costs don't achieve the spending goals, there will be, as a backstop, a limit on the rate of increase in premiums. This brings to health care spending the kind of cost discipline which is commonplace in business.
- Like the private sector, the growth in major government programs, including Medicare and Medicaid, will be restrained.

2. Preserves the tax deductibility of health insurance and treats self-employed people fairly.

Employers' premium payments will continue to be tax deductible for employers and will not be included in employees taxable incomes.

- **Employers are free to continue for ten years to offer whatever** additional benefits they are offering today, and to deduct these payments from taxes. In ten years, when the benefits package is fully phased-in, it will offer as much as the best plan today.
- Currently, the self-employed can only deduct 25 percent of the cost of their health insurance. This increases to 100 percent.

3. Offers consumer choice and security.

Consumers will have more choice than today about doctors, plans and treatments. They will be guaranteed a comprehensive benefits package which meets the full range of health needs, including primary, preventive and specialized care. Each alliance will offer consumers a choice of plans which must include a fee-for-service plan. Consumers will be able to choose their own doctors. Consumers' out-of-pocket costs for health services are (a) limited to ensure

financial protection and (b) standardized to ensure simplicity in choosing among health plans. Health coverage continues without interruption if people lose or change jobs, start a small business, move from one area to another, or become ill or confront a family crisis.

4. Finances the system responsibly.

Payments for health coverage will come from two shares: contributions by individuals and families, and contributions by employers. There will be discounts available for small firms, low-wage firms and for low-income individuals. This works as follows:

Employer Contributions

- All employers contribute to the purchase of health coverage for all of their employees, paying 80 percent of the weighted average premium. The required contribution (for employers in regional alliances) is capped at 7.9 percent of payroll. Firms with less than 50 employees are capped at a lower level -- 3.5 to 7.9 percent -- based on the average wage of their firm.

If the individual premium was \$1,800 and the family premium was \$4,200, the maximum cost per employee before discounts would average about \$2,240 per year.

Approximately \$1,440 (80 percent of \$1,800) for a single worker and approximately \$2,240 for a worker with a family (80 percent of \$4,200 divided by 1.5 which is the average number of workers in a family).

Individual Contributions

- Individuals pay 20 percent of the premium for an average cost health plan chosen through an alliance. Individuals or families who choose a less expensive plan pay less, and those who chooses a more expensive plan pay more. Low-income families participating in regional alliances with income below 150 percent of the poverty line receive discounts based on family income and the average premium in their alliance.

5. Emphasizes quality.

The plan improves the quality of health care by creating standards and guidelines for practitioners, reorienting quality assurance to measuring outcomes rather than the regulatory process. It also increases the national commitment to medical research and the promotion of primary medical care. The plan brings to the health care system the discipline and learning that businesses all over the country have discovered associated with these private sector quality initiatives. The result will be a health care system held accountable for quality improvement.

6. Lifts the burden of early retirees from all companies.

Retired people not yet eligible for Medicare (between the ages of 55 and 65) who have worked for at least 10 years will be subsidized for the employer's share of their premium. If employers are contractually obligated (or choose) to pay retiree health benefits, the companies will pay only the 20 percent family share. This will relieve all of the nation's companies, including many of our most important manufacturing companies, of the burden of early retiree health care costs and allow them to have globally competitive cost structures. It will also allow all early retirees, who find their health care costs to be prohibitively expensive, to enjoy high quality health care at affordable prices.

THE AMERICAN HEALTH SECURITY ACT
HELPS THE PROBLEMS OF LARGE BUSINESSES

1. REDUCES THE COSTS OF INSURANCE FOR EMPLOYERS
2. INCREASES JOBS BY IMPROVING WORKERS' HEALTH, SECURITY, AND MOBILITY
3. GIVES BUSINESSES MARKET CLOUT AS PURCHASERS OF HEALTH CARE
4. PRESERVES THE TAX DEDUCTIBILITY OF HEALTH INSURANCE
5. GIVES BUSINESSES ACCESS TO HIGH QUALITY HEALTH CARE
6. REDUCES THE ADMINISTRATIVE BURDEN ON BUSINESSES
7. PROVIDES DISCOUNTS TO MANY BUSINESSES
8. SUBSIDIZES THE HIGH COST OF EARLY RETIREES AND MAKES U.S. MANUFACTURING COMPANIES COST-COMPETITIVE
9. PRESERVES A LOCAL HEALTH CARE SYSTEM
10. PROVIDES AN ECONOMIC FOUNDATION FOR BUSINESSES TO PROSPER IN THE FUTURE

1. Reduces the costs of insurance for employers.

- The cost of insurance for businesses' health costs have risen at an annual rate of almost 15 percent. Under reform, these costs will be brought under control by increasing competition in health care, increasing consumer awareness of the cost and quality of their health care, reducing administrative cost and limiting increases in premiums. The business sector as a whole will gain savings as the rate of cost growth slows.
- Today, many employers are paying over 10 percent of payroll for health insurance. Under reform, all employers in the regional health alliances will pay no more than 7.9 percent of payroll.

Today, employers that insure their employees bear a large "cost shift" (amounting to \$25B) from the uninsured. Under reform, that burden is lifted.

- Today, in many cases, employers pay the entire insurance bill for a family, while the employees of a worker's spouse pays nothing at all. Under reform, the costs of families are spread over all firms.

2. Increases jobs by improving workers' health, security, and mobility.

Businesses will enjoy numerous benefits from having an

insured work force in the form of reduced costs of absenteeism, turnover, training and errors. Additionally, the plan makes health insurance "portable." Plans will be prevented from excluding individuals with pre-existing conditions. And all employees will be insured against potential catastrophe. This increases the mobility of workers, the flexibility of employers, and contributes to increases in employment nationally.

3. Gives businesses market clout as purchasers of health care.

Today, many businesses are disadvantaged as purchasers of health insurance. By pooling their resources in large purchasing groups, businesses will benefit enormously from the economies of scale, purchasing power, administrative simplification and sophistication of the alliances.

4. Preserves the tax deductibility of health insurance.

Employer premium payments will continue to be tax-deductible for employers and **will not be included in employee's taxable income.** Employers are free to continue for 10 years to offer whatever benefits they are offering today and to deduct these payments from their taxes. In ten years, when the benefits package is fully phased-in, it will offer as much as the best plans today.

5. Gives businesses access to high quality health care.

Given the cost of health care for businesses today, many can afford to offer only bare-bones insurance, if any, to their employees. In the future, all businesses and their employees will have access to a comprehensive benefit package equivalent in quality to the best plans that are available today.

6. Reduces the administrative burden on businesses.

Today, businesses face a blizzard of paperwork which severely taxes their administrative resources. Under reform, a single streamlined system will reduce the burden of paperwork on business. Unlike the current system, there will be (1) a single, comprehensive benefit package, (2) one standard form for reimbursement and claims submission, (3) changes to the health care portion of worker's compensation and automobile insurance and (4) malpractice reform.

7. Provides discounts to many businesses.

Premium costs for all businesses in the regional alliances will be limited to a maximum of 7.9 percent of payroll. Additionally, low wage workers of these firms will also be receive discounts for the employee contribution. These discounts are not available today and represent a tremendous benefit to business.

8. Subsidizes the high cost of early retirees and makes U.S. manufacturing companies cost-competitive.

Today, many businesses, including the country's largest manufacturing companies, are at a substantial competitive disadvantage in global markets because of the high cost of their retirees' health care. Under reform, employees who retire early will be subsidized for the employers' share of their health care premium. This will relieve many of the nation's most important manufacturing businesses of this burden and allow them to have globally competitive cost structures. It will also allow all early retirees between the ages of 55 and 65, who find their health care costs prohibitively expensive, to enjoy high quality health care at affordable prices.

9. Preserves a local health care system.

The plan promotes localized health care through the corporate and regional alliance. These employers and employees will have first-hand knowledge of how their premium contributions are spent and will have an opportunity to have a meaningful voice in the design and operation of their health care system.

10. Provides an economic foundation for businesses to prosper in the future.

Today, health care costs are growing largely out of control. Left unchecked, rising health care costs will consume

- 120 percent of the projected increase in wages,
- 60 percent of the growth in the federal budget, and
- almost two-thirds of the increase in GDP for the rest of the decade.

Health care costs will grow from 14 percent of GDP today to 19 percent without even an expansion of coverage. This will significantly increase the burden of health care on business and will increasingly make the U.S. economy uncompetitive internationally. By getting health care costs under control, this reform will reduce future deficits, freeing resources to be invested in our economy in ways that will promote economic growth and job creation.

LARGE EMPLOYERS AND HEALTH CARE:

Questions and Answers

Q. My company already offers health insurance that provides low cost, affordable care. Will it be able to continue and will I be able to remain outside of the health alliance?

A. As long as they adhere to national standards for choice, quality, and comprehensive affordable care, companies with more than 5,000 employees will be able to act as their own health alliances. As the regional alliances prove their ability to reduce costs and provide high quality health care, larger companies will have the opportunity to join the regional alliances.

Q. I'm afraid that the new system will not really control costs. How can I know this approach will control costs?

A. In the last five years, health care costs for employers have risen almost 15 percent every year. That's why a tough approach to controlling costs is a cornerstone of the Health Security plan. Providing health care to every American and a comprehensive benefits package will cut uncompensated care costs. Stimulating competition, increasing consumer awareness of the cost and quality of their health care, streamlining administration, and folding in the health portion of workers' compensation and auto insurance health coverage will dramatically reduce costs nationwide. In addition, premium increases in the whole system -- including Medicare and Medicaid -- will be limited as a backstop to contain costs. This will bring to health care the kind of discipline which is commonplace in business.

Q. How will this plan end cost-shifting that drives up health costs?

A. Today, large businesses are charged for the many weaknesses in the health care system. They pay higher premiums to cover the cost of treating patients who do not have insurance and for public health care programs, such as Medicaid. Major employers also purchase insurance for their workers' spouses, who often work at companies that don't provide health benefits. That creates a system that isn't fair. The Clinton plan for health reform will relieve large business of these burdens.

Q. Will the federal government micro-manage the new health care system?

A. No. Just the opposite is true. The plan promotes localized health care through alliances whose participants (i.e., the employers and employees) will have first-hand knowledge of how their premium contributions are spent and will have an opportunity to have a meaningful voice in the design and operation of their health care system. Large businesses (with more than 5,000 employees) will be able to operate as their own health alliances as long as they adhere to national standards for choice, quality, and comprehensive, affordable care. They will also have the option of joining the regional alliance if it is cost-effective and convenient for them.

Q. I've heard that the numbers on which you are basing this plan are shaky. Can we be confident that you have analyzed this plan rigorously?

A. Yes. At the very beginning of this process the President asked for a commitment to undertake a historical attempt to bring together some of the best minds in the country to help us design a financing package for health care reform. We have fulfilled that commitment. The numbers and analysis that underline the President's proposed plan for health security represent months of rigorous analysis which brought together analysts from various federal agencies for the first time. We brought together actuaries from various branches of government. We had an outside group of private economists and actuaries who audited the work that was done by that team from within the government, and they've examined and validated the costs and savings projections. The cost and savings projections in the draft document are solid, credible, and conservative.

Q. My company operates in a number of different states. Today, I provide health benefits for my employees through one system. Under reform, will I have to change the way my employees get coverage?

A. No. Large employers will be free to operate as their own health alliances, as long as they adhere to national standards for choice, quality, and comprehensive, affordable care. Small groups of employees in distant locations, however, will have the opportunity to receive health care through the local regional alliances if that is more convenient and cost-effective.

- Q. I employ lots of part-time workers. Will I be required to pay for all of their health care?**
- A. No. Businesses will be required only to pay a pro-rated share of the employer portion of the health care premium for part-time workers. Businesses will be required to pay nothing for the health care of part-time workers who are full-time students and who are under the age of 22.**
- Q. My company hires independent contractors to perform many services for us. Will I be required to pay all the costs of their health care?**
- A. No. Truly independent contractors are considered self-employed and will be responsible for all the costs of their own health care, i.e., both the employer and the employee portion. We will adapt the current IRS rules which determine an individuals status as an independent contractor to prevent companies from converting employees into independent contractors in order to avoid these costs.**
- Q. My company is a large manufacturer experiencing very difficult international competition. Won't this plan add to my costs and make us even less competitive?**
- A. In fact, just the opposite is true. Today, many U.S. companies operate at a disadvantage in global competition in part, because of the cost of their health insurance. This plan is designed to get costs under control by increasing competition among health providers, increasing consumer incentives to reduce costs, reducing administrative waste, and imposing discipline on both private and public health care spending. Without this disciplined approach to cost control, your health care costs will continue to spiral out of control and make your competitive position even worse. The plan also lifts the burden of early retirees from your company and, as a result, contributes significantly to your global cost competitiveness. In fact, the plan was specifically designed to help control your costs and compete globally.**
- Q. Doesn't this plan eliminate the tax benefits which I have today?**
- A. No. Health care premium payments will continue to be tax deductible for employers and will not be included in your employee's taxable income. If you offer a plan more generous than the nationally guaranteed benefit plan, you will still be able to deduct the cost of your premium for 10**

years. In ten years, when the benefit package is fully phased-in, it will offer as much as the best plans today.

Q. I provide a generous health care plan today. Won't this plan require me to provide my employees with worse care?

A. No. As long as your employees have a choice among plans which offer the nationally guaranteed benefits package, you will be able to provide your employees with whatever additional health care benefits you would like. As long as that plan was in force at the beginning of this year, your premium costs will continue to be tax deductible for 10 years.

Q. This plan sounds complicated. Isn't it really going to drive up my administrative costs?

A. No. Health care is admittedly a complicated subject. The existing health care system is vastly more complex than our plan. We have emphasized and, we believe, achieved significant administrative simplification in this plan. And, you can also choose to join the regional alliance and, as a result, shift a fair amount of your remaining administrative responsibilities to the regional alliance, which will enjoy significant economies of scale.

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PUBLIC LIAISON OCTOBER 10 - 23

October 1993

October 10	SUNDAY	October 10
October 11 COLUMBUS DAY	MONDAY	October 18
	8:45am Religious Breakfast (BC) Family Dining Room 2:30pm Women's League for Conservative Judaism (Amy) 450	
October 12	TUESDAY	October 19
	2:00pm Computerland Washington Summit (Amy) 450	
October 13	WEDNESDAY	October 20
9:30am NAFTA Briefing/Maryland-Virginia (Doris) 450 2:00pm Auto Industry/Health Care (Amy) 472 3:00pm ~~Meeting on Mort Halperin Nomination (MY) 472~~ 5:30pm Hispanic Heritage Month Reception (SAV) State Flr	NAFTA PRODUCTS DAY SOUTH LAWN	
October 14	THURSDAY	October 21
Photo w/ Commander of Sal Army (Danny) Oval Photo with U.S. Olympic Committee (Danny) Oval 8:00am Business Liaison Meeting (Amy) 476 2:30pm Hungarian American Council (MD) 180 3:00pm Bausch & Lomb/Health Care (MY) 450 3:00pm Steel Industry/Health Care (Amy) 476 <i>ITC</i> 9:30pm NAFTA Briefing/Alabama-Georgia (Doris) 450.	Photo with Negro Baseball League (Danny) Oval Photo with Campus All-Stars (Danny) Executive Leadership Council Dinner 9:30am NAFTA Briefing/California (Doris)	
October 15	FRIDAY	October 22
3:00pm Rubber & Plastics Companies (Amy) 476	3:30pm Italian American CEO's (Amy/MD) Roosevelt Room 4:30pm Reception for Italian American Foundation (MD) 474 <i>John T. ...</i>	
October 16	SATURDAY	October 23
	7:30pm Speech to National Ital Am Found Dinner (B)	

*Tentative//Tuesday 10/12 8:30am

10/12/1993

10/12/93

- Amy - Barbie - Phone time
mail

1 good Body (Lynn Ballister)

- Larry (mail / rent)
Car & Service

25% - 30% - 50%

25 - 30 units

Students

- No Savings report
- Car & Service Budget
- Organized Com & Work

John Lewis -

Women
John Pugh
Edward
Bess
AL
L

Phone
- John Pugh
- John Pugh

~~John~~ Chris - 1 person
Mary Vicky

John Pugh
John Pugh

PUBLIC LIAISON OCTOBER 10 - 23

October 1993

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October 16	SATURDAY	October 23 7:30pm Speech to National Ital Am Found Dinner (BC)

Jefferson - School of American
Diplomacy - only
2 questions

Teen Pregnancy is not -
higher - "Not Proud of Parent"

Local Model Program
in key country
where no teen preg
no abortion, etc.
3 year experiment

Written response on
OCC

- Massachusetts & Kennedy
Council on / FHS -
not a threat to women
w/ OCC

- General Letter of Response
"OCC has failed"

Mon

NFIB
Forrest

Tues

NFIB
Forrest
~~FBI~~ Director
POW Families

Wed

Gays
Viet Nam

Thurs

Lee Brown

Fri

Base Closing

Put in Notebook

8 am Senior Staff Meeting Agenda

Wednesday, June 23

- Overview of communications issues.....Mark Gearan
David Gergen
- Schedule for today, rest of week.....Marcia Hale
- Major current project report
(Reconciliation).....Leon Panetta
Howard Paster

- Brief reports by Policy Councils

- Carol Rasco, DPC
- Bob Rubin, NEC
- Tony Lake, NSC

*Health Care - HHS Health - on Council / Finance
* Aids Commission on Monday
* a week for Fri - meeting of the tribes
Crisis Bill - Pres reviewing
Pesticide Program on negotiation
Community Development Bank / Howard Smith
Wait until the recess - we need more
work*

- Departmental Report

- Eli Segal, National Service

*Out of two committees - will come to the floor
the next - present before July 4th - Senate will move ahead
Conference the middle of July - 74 co-sponsors for yet
some*

- Many of an Aids Cargo on Fri

- Police Event for Thursday

- Presidential Briefing on NAFTA on Friday

*Don't
Mayer
310 -
289-1181*

Seg up
Finance

- I DO not destroy existing system in name of reform
- II Out of Control - no all engine
- III Always had two systems - i.e. medicine, medicinal
- IV Reform is being discussed in context of finance as opposed to integrated system
Task is not complete
- V Revenue does not = revenue - if you have problem of revenue
- VI Every hospital can't be the basis of controlling cost - Cost control
we need reorg of our delivery system

~~Presentations~~

Question

- I Opportunities + demand
making choices about who to do with
- II Values + Traditions
- III Simple Questions

I

But is to science what physics is to -?
We are exploring Breukling

Early detection of diseases, insurance for
multiple patients, some people in at risk, etc...
would need medical care of...

Value suggestion of mental & community ^{we had} ^{energy as} ^{a disease}
(C) We have also constructed it as aging is
a disease - because as you age
you get ~~ident~~ disease, Alzheimer, etc...
Problems of aging aren't to be solved if
we can't treat disease, etc...

(A) Studying ought to be on functional
autonomy - the
spectrum of health - treated,
disease

What are the diseases you want to prevent
Who & where

Cost & Time ^{need} in there

✓ The ^{have} moved you into & from

Results
would
be

Present some ^{Common} ^{Base}
Cost ^{Costs} and ^{Proper} ^{Cost}
Increase in ^{Special} ^{not} ^{be}
In

Per for ^{who} ^{one} ^{not}

These fault pretty much into
system is come & again in
private system

A continuation of come in
what we

⑧ Challenges and looking at system
reform - but delays by checks
of cost controls
Preparation involved of the
come

⑧ Change in remuneration system
as a response to the reform
Appt. Prophecy
very Cash Problem

Use

If we really reform the system

Emphasized self interest will checks
including the power which has at the expense of the
moderate class

⑧ I finally understand
NO real published program

Like we understand what we are

giving up for who we are
giving - Real problem

and

Questions

Rated Noted Pabing -

we end up making public policy
based on negotiation means and
approach and I.O. Serious effort
core / Challenge is to get
system in place as approach to
compared parts

Then

*

Confer of presentation

Inadequate script advice
Changes from minute I.O. Cattle

Any, Teenage Pregnancy, Abortion -
Insurance that all relevant would
likely & spend it

How much of cast is deformed
medico - pathy 50-60%ie

Set up frame

I Reemphasize: Largest decrease
reduces purchase,
Change nature of credits

II Of course going to increase by 100 mil
what will you lose of

Have me get here: ref

Have me train
allied lead

Heard Parents / Dismiss Parents
Need to Court case

Apphia Stet & land court
day PTC

Send copy in

Concern for the parent
relationship

What time do you have
to leave?

The plan now is to

- Shake a few hands

- Press avail (per Lin)

- Meet w/ Walter + Ong (5 min)

- Departure

We're scheduled to leave at Noon
but we can be a little flexible

I multiple goals

II not any

III most important ~~nothing~~

± Long Beach - all in 1

On delivery system the proposal - and we
have one meeting around it for the delivery
Q. taken in our analysis

we've had it back and

pricing & production. One helps well be
even synthesis - is pay for care
but not for pay over

Integrated proposal will have to run
areas / various practices & facilities

II Therapy

Reg reform 300,000 rail

Dev Reform can stimulate the reform

20-25% of the cost could be
better allocated or eliminated

~~Delivered~~

Bob milled - Fine Chicago
walnut - ref

Young
sent

~~Delivered~~

Jack Henry - Mosato
40070 of rehabilitate

Overview

I

Area of elem. aggregate,

1.0.

2131 - *kin*
6246 - *muh*

622-
1070

622770



Clinton Presidential Records Digital Records Marker

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AMH BUSINESS CONF.

Divider Title: _____

TENTATIVE AGENDA

May 6-8, 1993

The Williamsburg Inn, Williamsburg, Virginia

BC Office • Rooms 3139/40 - The Williamsburg Inn

Thursday, May 6

7:00 p.m.

Chairman's Reception

East Lounge & Terrace, The Williamsburg Inn

8:00-10:00 p.m.

Dinner: Regency Dining Room -- Taverns

Friday, May 7

7:00 a.m.

Buffet Breakfast

The Williamsburg Lodge & Conference Center

8:30 a.m.

Robert E. Allen convenes the Session

Rooms A & B

Program Introduction

Virginia Room

Panel Discussion: The Economy

D. Wayne Calloway

Moderator: Mr. Dennis Weatherstone

Chairman & CEO, J. P. Morgan & Co. Incorporated

Dr. Martin S. Feldstein, President & CEO

National Bureau of Economic Research, Inc.

-- and --

Selected Business Council Members

Health Care: A System in Crisis**"Attitudes & Opinions"**

Mr. Humphrey Taylor, President & CEO

Louis Harris and Associates, Inc.

B R E A K

Refreshments available in Rooms A & B

"Health Care Realities & Visions"

Dr. Reed V. Tuckson, President

Charles R. Drew University of Medicine & Science

Dr. Samuel O. Thier, President

Brandeis University

Panel Discussion:

Moderator: Dr. Mary Jane England, President

"Health Policy Viewpoints"

Washington Business Group on Health

Dr. Uwe E. Reinhardt, Professor

Woodrow Wilson School, Princeton University

Dr. Alain C. Enthoven, Professor of Management

Graduate School of Business, Stanford University

12 Noon

A D J O U R N

12 Noon-2:30 p.m.

Business Council Buffet Luncheon

East Lounge, The Williamsburg Inn

7:00 p.m.

Reception & Dinner: Dress - Black Tie

Virginia Room, Williamsburg Lodge

Speaker: Mrs. Hillary Rodham Clinton

and Conference Center

Saturday, May 8

7:00 a.m.

Buffet Breakfast

The Williamsburg Lodge & Conference Center

8:00 a.m.

Session Convenes

Rooms A & B

Health Care: Reforming the System

Virginia Room

"Congressional Outlook on Health Care"

The Honorable Nancy L. Kassebaum

U. S. Senator (R-Kansas)

Panel Discussion:

Moderator: Ms. Judy Woodruff

"Business Role on Health Care"

Washington Correspondent

The MacNeil Lehrer NewsHour

-- and --

Selected Business Council Members

"The Business-Government Partnership"

The Honorable John D. Rockefeller, IV

U. S. Senator (D-West Virginia)

"Justice Department - Overview & Agenda"

The Honorable Janet F. Reno

The Attorney General of the United States

12:00 Noon

A D J O U R N

12 Noon-2:30 p.m.

Business Council Buffet Luncheon

East Lounge, The Williamsburg Inn

**The Business Council
Indicated Attendance - May 1993 Meeting**

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April 29, 1993 10:28 AM

<u>Name</u>	<u>Title & Company</u>
Mr. Frank A. Shrontz	Chairman & CEO, The Boeing Company
Mr. Andrew C. Sigler	Chairman & CEO, Champion International Corporation
Mr. John F. Smith, Jr.	CEO & President, General Motors Corporation
Mr. L. B. Smith	Former Chairman & CEO, A. O. Smith Corporation
Mr. Roger B. Smith	Retired Chairman & CEO, General Motors Corporation
Mr. Sherwood H. Smith, Jr.	Chairman, President & CEO, Carolina Power & Light Company
Mr. William S. Sneath	Retired Chairman & CEO, Union Carbide Corporation
Frank Stanton	President Emeritus, CBS, Inc.
Mr. William C. Steere, Jr.	Chairman & CEO, Pfizer Inc
Mr. Robert C. Stempel	Retired Chairman & CEO, General Motors Corporation
Mr. Robert D. Stuart, Jr.	Former Chairman & CEO, The Quaker Oats Co. ✓
Mr. W. Reid Thompson	Chairman, Executive Committee, Potomac Electric Power Company
Mr. Michael H. Walsh	Chairman & CEO, Tenneco Inc.
Mr. Dennis Weatherstone	Chairman & CEO, J. P. Morgan & Co. Incorporated
Mr. John L. Weinberg	Senior Chairman, Goldman, Sachs & Co.
Mr. William L. Weiss	Chairman & CEO, Ameritech
Mr. John F. Welch, Jr.	Chairman & CEO, General Electric Company
Mr. George H. Weyerhaeuser	Chairman, Weyerhaeuser Company
Mr. Joseph H. Williams	Chairman & CEO, The Williams Companies, Inc.
Mr. T. A. Wilson	Chairman Emeritus, The Boeing Company
Mr. Robert C. Winters	Chairman & CEO, Prudential Insurance Company
Mr. Edgar S. Woolard, Jr.	Chairman & CEO, E. I. du Pont de Nemours & Company
Mr. Walter B. Wriston	Former Chairman & CEO, Citicorp
Mr. Thomas H. Wyman	Former Chairman & CEO, CBS, Chairman, S. G. Warburg & Co., Inc.
Mr. John A. Young	Retired Chairman & CEO, Hewlett-Packard Company

The Business Council
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April 29, 1993 10:28 AM

<u>Name</u>	<u>Title & Company</u>
Mr. Edmund W. Littlefield	Retired Chairman & CEO, Utah International Inc.
Mr. Howard M. Love	Retired Chairman & CEO, National Intergroup, Inc.
Mr. James T. Lynn	Retired Chairman & CEO, Aetna Life & Casualty Company
Mr. Richard J. Mahoney	Chairman & CEO, Monsanto Company
Mr. Robert H. Malott	Chairman, Executive Committee, FMC Corporation
Mr. J. W. Marriott, Jr.	Chairman, President & CEO, Marriott Corporation
Mr. John F. McGillicuddy	Chairman & CEO, Chemical Banking Corporation
Mr. Robert E. Mercer	Retired Chairman & CEO, The Goodyear Tire & Rubber Company
Dr. Ruben F. Mettler	Retired Chairman & CEO, TRW Inc.
Mr. Buck Mickel	Chairman & CEO, RSI Holdings, Inc.
Mr. Michael A. Miles	Chairman & CEO, Philip Morris Companies Inc.
Mr. G. William Miller	Chairman, G. William Miller & Co., Inc.
Mr. Roger Milliken	Chairman & CEO, Milliken & Company
Mr. Lee L. Morgan	Former Chairman & CEO, Caterpillar Inc. ✓
Mr. Howard Morgens	Chairman Emeritus, The Procter & Gamble Company
Mr. Richard M. Morrow	Retired Chairman & CEO, Amoco Corporation
Mr. John J. Murphy	Chairman & CEO, Dresser Industries, Inc.
Mr. Allen E. Murray	Chairman, President & CEO, Mobil Corporation
Mr. James J. O'Connor	Chairman & CEO, Commonwealth Edison Company
Mr. John D. Ong	Chairman & CEO, The BFGoodrich Company
Mr. Paul F. Orefice	Retired Chairman & CEO, The Dow Chemical Company
Mr. Charles W. Parry	Former Chairman & CEO, Aluminum Company of America ✓
Mr. Donald S. Perkins	Former Chairman & CEO, Jewel Companies, Inc.
Mr. Dennis J. Picard	Chairman & CEO, Raytheon Company
Mr. Harold A. Poling	Chairman & CEO, Ford Motor Company ✓
Mr. Edmund T. Pratt, Jr.	Chairman Emeritus, Pfizer Inc.
Mr. John S. Reed	Chairman & CEO, Citicorp
Dr. James J. Renier	Chairman & CEO, Honeywell, Inc.
Mr. John M. Richman	Former Chairman & CEO, Kraft Inc.
Mr. James D. Robinson, III	Former Chairman & CEO, American Express Corporation ✓
Mr. David Rockefeller	Former Chairman & CEO, The Chase Manhattan Bank, N.A.
Mr. Richard M. Rosenberg	Chairman & CEO, BankAmerica Corporation
Mr. Charles S. Sanford, Jr.	Chairman & CEO, Bankers Trust Company
Mr. Vincent A. Sarni	Chairman & CEO, PPG Industries, Inc.
Mr. Henry B. Schacht	Chairman & CEO, Cummins Engine Company, Inc.
Mr. Richard R. Shinn	Retired Chairman & CEO, Metropolitan Life Insurance Company
Mr. Walter V. Shipley	President & COO, Chemical Banking Corporation

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April 29, 1993 10:28 AM

<u>Name</u>	<u>Title & Company</u>
Mr. Robert J. Eaton	Chairman & CEO, Chrysler Corporation ✓
Mr. Walter Y. Elisha	Chairman & CEO, Springs Industries, Inc.
Mr. Robert F. Erburu	Chairman & CEO, The Times Mirror Company
Mr. William T. Esrey	Chairman & CEO, Sprint Corporation
Mr. E. Hervey Evans, Jr.	Former President & CEO, McNair Seed Company
Mr. James H. Evans	Retired Chairman & CEO, Union Pacific Corporation
Mr. Walter A. Fallon	Former Chairman & CEO, Eastman Kodak Company
Mr. John B. Fery	Chairman & CEO, Boise Cascade Corporation
Mr. George M. C. Fisher	Chairman & CEO, Motorola Inc.
Mr. Donald V. Fites	Chairman & CEO, Caterpillar Inc. ✓
Mr. Robert R. Frederick	Former Chairman & CEO, RCA Corporation
Dr. Thomas F. Frist, Jr.	Chairman & CEO, Hospital Corporation of America
Mr. H. Laurance Fuller	Chairman, President & CEO, Amoco Corporation
Mr. Clifton C. Garvin, Jr.	Former Chairman & CEO, Exxon Corporation
Mr. Richard L. Gelb	Chairman & CEO, Bristol-Myers Squibb Company
Mr. H. Krome George	Former Chairman & CEO, Aluminum Company of America ✓
Mr. John A. Georges	Chairman & CEO, International Paper
Mr. Louis V. Gerstner, Jr.	Chairman & CEO, IBM Corporation
Mr. Sam L. Ginn	Chairman & CEO, Pacific Telesis Group
Mr. Joseph T. Gorman	Chairman & CEO, TRW Inc.
Mr. Harry J. Gray	Chairman, Executive Committee, American Medical International, Inc. &
Mr. John W. Hanley	Former Chairman, President & CEO, Monsanto Company
Mr. H. J. Haynes	Retired Chairman & CEO, Chevron Corporation
Mr. Jack K. Horton	Retired Chairman & CEO, Southern California Edison Company
Mr. James R. Houghton	Chairman & CEO, Corning Incorporated
Mr. William R. Howell	Chairman & CEO, J. C. Penney Company, Inc.
Mr. Reginald H. Jones	Former Chairman & CEO, General Electric Company
Mr. Donald M. Kendall	Former Chairman & CEO, PepsiCo, Inc.
Mr. Robert D. Kennedy	Chairman & CEO, Union Carbide Corporation
Mr. Robert D. Kilpatrick	Retired Chairman & CEO, CIGNA Corporation
Mr. James W. Kinnear	Retired President & CEO, Texaco Inc.
Mr. Charles F. Knight	Chairman & CEO, Emerson Electric Co.
Mr. Thomas G. Labrecque	Chairman & CEO, The Chase Manhattan Bank, N.A. & The Chase
Mr. Ralph S. Larsen	Chairman & CEO, Johnson & Johnson ✓
Mr. William S. Lee	Chairman, President & CEO, Duke Power Company
Mr. Paul E. Lego	Retired Chairman & CEO, Westinghouse Electric Corporation ✓
Mr. Drew Lewis	Chairman & CEO, Union Pacific Corporation

The Business Council
Indicated Attendance - May 1993 Meeting

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<u>Name</u>	<u>Title & Company</u>
Mr. Paul A. Allaire	Chairman & CEO, Xerox Corporation
Mr. Howard P. Allen	Chairman, Executive Committee, SCEcorp and Southern California Edison
Mr. Robert E. Allen	Chairman & CEO, American Telephone & Telegraph Company
Mr. Warren M. Anderson	Former Chairman & CEO, Union Carbide Corporation
Mr. Samuel H. Armacost	General Partner, Weiss, Peck & Greer Investments
Mr. H. Brewster Atwater, Jr.	Chairman & CEO, General Mills, Inc.
Mr. William M. Batten	Retired Chairman & CEO, J. C. Penney Company and The New York Stock
Mr. Hans W. Becherer	Chairman & CEO, Deere & Company ✓
Mr. S. D. Bechtel, Jr.	Chairman Emeritus, Bechtel Group, Inc.
Mr. Winton M. Blount	Chairman & CEO, Blount, Inc.
Mr. Samuel W. Bodman, III	Chairman & CEO, Cabot Corporation
Col. Frank Borman	Chairman & CEO, Patlex Corporation
Mr. Lawrence A. Bossidy	Chairman & CEO, Allied-Signal Inc.
Mr. John G. Breen	Chairman & CEO, The Sherwin-Williams Company
Mr. Edward A. Brennan	Chairman, President & CEO, Sears, Roebuck & Co.
Mr. Charles L. Brown	Retired Chairman & CEO, American Telephone & Telegraph Company
Mr. John H. Bryan	Chairman & CEO, Sara Lee Corporation ✓
Mr. John E. Bryson	Chairman & CEO, SCEcorp & Southern California Edison Company
Mr. Donald C. Burnham	Retired Chairman & CEO, Westinghouse Electric Corporation
Mr. Willard C. Butcher	Retired Chairman & CEO, The Chase Manhattan Bank, N.A.
Mr. Louis W. Cabot	Retired Chairman & CEO, Cabot Corporation and Chairman, The
Mr. Philip Caldwell	Retired Chairman & CEO, Ford Motor Company and Senior Managing ✓
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Mr. Edward W. Carter	Chairman Emeritus, Carter Hawley Hale Stores, Inc.
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Mr. Richard A. Clarke	Chairman & CEO, Pacific Gas & Electric Company
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Mr. Charles A. Corry	Chairman & CEO, USX Corporation ✓
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Mr. John H. Daniels	Former Chairman, President & CEO, Archer Daniels Midland Co.
Mr. Robert F. Dee	Former Chairman & CEO, SmithKline Beckman Corporation
Mr. Frederick B. Dent	Chairman & CEO, Mayfair Mills, Inc.
Mr. Kenneth T. Derr	Chairman & CEO, Chevron Corporation
Mr. Livio D. DeSimone	Chairman & CEO, 3M
Mr. Charles D. Dickey, Jr.	Retired Chairman & CEO, Scott Paper Company ✓



Amy
AMH

Barry K. Rogstad
President

American Business Conference

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April 6, 1993

Ms. Alexis Herman
Director
Office of Public Liaison
Old Executive Office Building #122
17th and Pennsylvania Avenues, N.W.
Washington, D.C. 20500

APR 7 1993

Dear Alexis:

As I mentioned in my letter of April 2, the members of the American Business Conference were delighted with the opportunity to meet with Vice President Gore and Mack McClarty. At that meeting, the possibility of ABC playing an advisory role on healthcare within the administration was advanced and warmly received by our membership.

We were honored to be selected as the first business group invited to discuss healthcare reform. During our Membership Meeting, Ira Magaziner's thoughtful comments thoroughly impressed our members.

As you know, ABC has a strict rule that states we cannot represent or advance the interest of a specific member company or industry. Yet, within ABC, we have members who are knowledgeable about healthcare and healthcare savings. For example, Leon Hirsch, the C.E.O. of U.S. Surgical, has pioneered new surgical technologies which have resulted in huge healthcare savings. Bruce Lunsford of Vencor, Inc. has suggested still another way to gain additional income in order to finance universal health insurance. These are but two examples of how our members can contribute to the President's plan that promotes a cost effective healthcare system. I have enclosed two attachments.

I want ABC to be responsive to the White House invitation on this issue. If you would provide operational guidance, I will insure a quick and appropriate response by ABC.

I look forward to hearing from you.

Best regards,

Barry

Barry K. Rogstad

encs.

An Open Letter To President and Mrs. Clinton On Containing Health Care Costs

New surgical technology is reducing our national health care costs by billions of dollars while improving patient care and adding billions of hours to American productivity.

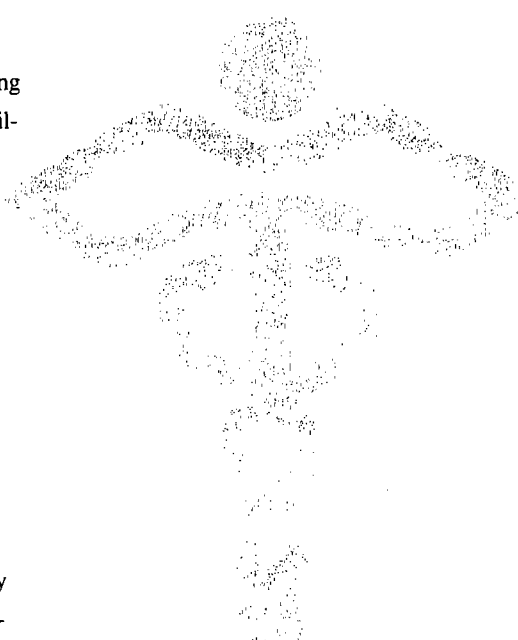
The exciting corollary is that the surgical instrumentation involved represents only two percent of American hospitals' operating budgets. However, the way we invest this two percent will impact the remaining 98% significantly.

Medical technology, properly used, can be a major factor in reducing the total costs of health care in America, while providing a better quality of life for everyone.

Just three years ago, all gallbladder surgery in the United States was performed through a six- to eight-inch incision. Patients were in the hospital five to eight days and endured a painful four- to six-week recovery period at home.

Today, thanks to new laparoscopic surgical techniques, the lengthy incision is replaced by four quarter inch punctures. Patients go home the next day and are back to full productivity within a week, and pain is almost totally eliminated.

- Last year, 500,000 Americans underwent laparoscopic gallbladder surgery.
- 3 million days of hospital stay costs were eliminated.



- 2.5 million weeks of insurance reimbursement were eliminated.
- 100 million hours were added to American productivity.

Gallbladder surgery is just the tip of the iceberg.

Hysterectomy patients, when operated on laparoscopically, go home in one to two days and are back to full function in ten days, compared to a four- to six-day hospital stay and six debilitating weeks of recovery time when the procedure is performed using the open technique.

Hernia patients are back to full function within a week. Patients requiring intestinal and lung surgery are also beginning to benefit from

laparoscopy. Arthroscopy, a cousin to laparoscopy, is revolutionizing knee surgery and reducing costs dramatically. There are dozens of other procedures where laparoscopic technology and other advanced surgical techniques can produce significant savings while enhancing patient care.

Most of these procedures are performed with economical, single use devices which eliminate the risk of AIDS or other blood-borne contamination during surgery.

If we are truly to rein in health care costs' explosive growth, it is imperative that your upcoming health care program recognize and provide incentives for the use of technologies and medical instrumentation that cut costs, and that the program does not shortsightedly cap the purchase of instrumentation or technology that may cost more up front, but can result in significant reductions in the overall cost of treating patients.

With 25 years of experience in surgical cost reduction technology, we would very much like to provide our advice and counsel. We hope you will give us the opportunity.

Sincerely,

Leon C. Hirsch
Chairman
United States Surgical Corporation

TAX STATUS OF TAX-EXEMPT HOSPITALS

RECOMMENDATION

We recommended that the estimated \$6 billion of annual unpaid taxes by non-profit hospitals be used to reduce healthcare spending and increase access before any other changes to the existing healthcare system are made.

BACKGROUND

There are currently 5,384 acute care hospitals in the United States. The ownership status of these hospitals determines the taxability of each of these facilities - not profitability; not the amount of charity care provided; and not the number of government (Medicare/Medicaid) patients.

The ownership matrix of these hospitals is as follows: Non-government, private non-profit hospitals - 3,191; investor-owned, for-profit hospitals - 749; and, state and local government hospitals - 1,444.

A recent study from HCIA, A Baltimore-based healthcare research company reported that the non-government, non-profit hospitals made 3.97% profit margin in 1991 while for-profit hospitals made 3.84% profit margin. (1) As a point of reference, all of the five most profitable hospitals in Kentucky in 1991 were "Non-Profit" hospitals, and only two of the top ten were for-profit hospitals. The only difference was that the non-profit hospitals paid no tax on this profit. Additionally, they paid no state and local property tax.

Using assumptions described below, the following amounts go unpaid by non-profit hospitals EVERY YEAR:

- Federal, State and Local income taxes \$4 Billion
- Property tax assessments \$2 Billion

ASSUMPTIONS

INCOME TAXES

Total Non Profit Hospitals	3,191
Total Staffed Beds	657,000
Average Occupancy	69%
Annual Patient Days	165 million
Average Annual Revenue (Est. \$1,500/Day)	\$250 billion
Profit Margin	4%
Annual Profit	\$10 billion
Est. Income Tax Rate (Fed, State, Local)	40%
Annual Income Taxes	\$4 billion

PROPERTY TAXES

Number of Staffed Beds	657,000
Estimated Valuation Per Bed	\$100,000
Total Value	\$66 billion
Estimated Mil. Rate	2.5%
Annual Property Tax	\$1.7 billion

REFERENCES:

- (1) *Modern Healthcare*; March 8, 1993; "Charity Care & the Law: Case is Far From Closed" - pg. 26
- (2) Number of Hospitals; Beds; Occupancy - American Hospital Association

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

BUSINESS COUNCIL

Divider Title: _____

The Business Council is a voluntary association of American business leaders whose members meet several times a year for the free exchange of ideas both among themselves and with representatives of the government.

In its most fundamental form, the Council seeks to foster understanding through discussion. From these discussions, it hopes to generate greater understanding of major public policy issues and to help create the consensus for solutions.

Since its founding more than half a century ago, The Business Council has been dedicated to service in the national interest. The Council membership is a group of current or former chief executive officers from a broad range of American companies. All major industries and all regions of the nation are represented among the members of The Business Council.

Because schedule demands on senior business executives are extensive, the Council provides an especially valuable opportunity to discuss major subjects in a broader ranging forum than is normally available in the course of business activities.

As part of its process, the Council invites leaders in government and other sectors to address the Council and to participate in its discussions. Council members hope that these discussions result in better understanding by their invited guests as well as by the members themselves.

Today the Council meets three times a year in a collegial atmosphere to share and explore ideas. As a gathering of peers from many fields, the Council is entirely an educational and deliberative forum. It never takes positions as an organization and does not advocate any policy or course of action.

Individual members sometimes do present their own views in public discussions. But they do so as individuals, rather than as representatives of the Council.

BACKGROUND

In 1933 Secretary of Commerce Daniel C. Roper decided that he could benefit from the advice and counsel of public-spirited leaders of demonstrated success in their conduct of business affairs. The idea had been formulated by investment banker Sidney J. Weinberg, who felt that the government had relatively little business expertise at its disposal when it made decisions affecting that segment of society. After discussing the idea with some of his business acquaintances, Mr. Roper selected about 50 men who agreed to serve without compensation of any kind as members of a new Business Advisory Council for the Department of Commerce.

In making those first selections Mr. Roper established a principle which has been followed ever since. He questioned no one's politics, insisting that only personal integrity, ability, experience and a willingness to serve the public interest be considered as qualifications.

From its inception the Council was determined to represent no formal constituency. Its opinions represented the collective judgment of a group of experienced business leaders who had also demonstrated their interest in the general welfare by participation in public and social issues.

The Council's first major assignment was to form the Industrial Advisory Board for the National Recovery Administration, to advise and assist in resolving pressing problems of the nation's recovery from the Great Depression. Simultaneously the Council established a number of

committees to address such issues as the Securities and Exchange Act, the Banking Act and the Social Security Act.

Council members worked closely with public officials responsible for those milestone policy enactments to help resolve the challenges of implementing the new laws. Another field in which the Council became active was labor relations, providing insights on policy and administrative issues.

The Council continued its role as an advisory body primarily to the Department of Commerce until 1961 when the members decided to broaden its scope. Council members felt that they should be available to serve all areas of government which requested their services. The action was welcomed by President John F. Kennedy who said that "the various government agencies would be glad to have such a group available for consultation." Renamed The Business Council, it serves as an independent forum for the interchange of ideas and the development of positive, practical recommendations for action.

Since its formation, the Council has been called upon by Presidents in turn for counsel and advice. The Council has also served regularly as a de facto reservoir of experienced talent to assist an administration in carrying out its public mandate. During the critical years of the Second World War, for example, more than 50 Council members were called into government service to assist in meeting the tremendous challenges facing the nation. Subsequent years have seen many Council members leave private life to serve in critical positions within government at the request of Presidents from both parties. Today, as it has for many years, the Council numbers among its members many business leaders who are serving in various roles as public servants. And from its membership the Council has provided experienced business leaders as voluntary leaders for a variety of special panels and commissions that help develop policy for the federal government.

The Business Council limits itself to 100 Active members, each of whom is selected on the basis of personal qualities and position as the chief executive officer of a leading private sector American business from commerce and industry. The Council seeks a wide representation of American business leaders, both from a broad range of industrial and service sectors as well as from a geographical basis. There are no political qualifications for membership.

There are four categories of membership:

- **ACTIVE** Presiding chief executive officers
- **GRADUATE** Presiding and former chief executive officers, under age 70
- **HONORARY** Former chief executive officers, age 70 or older
- **EMERITUS** Members who have not attended a Council meeting in the last three years

(Emeritus members do not pay dues; upon paying current dues and attending a Council meeting, Emeritus members revert to their appropriate categories, unless they have reached age 70, in which case they cannot become Honorary members, but remain Emeritus members)

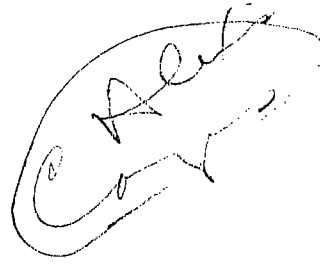
All Active, Graduate and Honorary members are accorded a full role in the discussions and semi-annual meetings of the Council in Hot Springs, Virginia. Only Active and Graduate members attend the annual Washington, D.C. meeting. Membership in all categories totals 271.

FORMER CHAIRMEN

1933	Gerard Swope	1960-61	Ralph J. Cordiner
1934	S. Clay Williams	1961-62	Roger M. Blough
1934-35	Henry P. Kendall	1963-64	F. R. Kappel
1936	George H. Mead	1965-66	W. B. Murphy
1937-39	W. Averell Harriman	1967-68	Albert L. Nickerson
1940-41	William L. Batt	1969-70	Fred J. Borch
1942-43	R. R. Deupree	1971-72	William M. Batten
1944-45	Thomas B. McCabe	1973-74	David Packard
1946	George M. Humphrey	1975-76	Edmund W. Littlefield
1947-48	John L. Collyer	1977-78	John D. deButts
1949-50	James S. Knowlson	1979-80	Reginald H. Jones
1951-52	Robert T. Stevens	1981-82	Walter B. Wriston
1953	John D. Biggers	1983-84	Clifton C. Garvin, Jr.
1954-55	Harold Boeschstein	1985-86	Ruben F. Mettler
1956-57	Eugene Holman	1987-88	S. D. Bechtel, Jr.
1958-59	S. D. Bechtel	1989-90	Roger B. Smith

OFFICERS 1991

Chairman - John F. Welch, Jr.
 Vice Chairman - Robert E. Allen
 Vice Chairman - H. Brewster Atwater, Jr.
 Vice Chairman - Walter V. Shipley
 Vice Chairman - John A. Young
 Executive Director - Jean H. Carter



To : Alexis Herman

Fax : (202) 456 - 2983

From : Philip E. Cassidy

Fax : (804) 221 - 8492

phone : (804) 221 - 8490

19 pages to follow.

REPORT TO THE BUSINESS COUNCIL ON THE ECONOMIC OUTLOOK

Presented by

**Dennis Weatherstone
Vice Chairman of the Business Council**

**Williamsburg, Va.
May 6-8, 1993**

Highlights:

- **The technical consultants are in broad agreement that the United States will remain on a path of moderate economic growth this year and next. Real GDP is expected to average about 3% in both 1993 and 1994, led by business equipment (especially computers, computer-based machinery, and communications equipment), housing, and consumer durables.**
- **Perceived risks to the growth forecast are weighted to the downside, however. Spending may be dampened by uncertainty about federal policy and the possibility of steep tax increases to finance deficit reduction and health care reform. Moreover, weak markets abroad are a concern.**
- **The technical consultants believe that inflation, as measured by the consumer price index, will remain in the 3% to 3 1/2% range this year and next. The average forecast calls for inflation to average 3.1% this year and then edge up to 3.5% by the second half of 1994. None of the consultants expect inflation to exceed 4% in 1993 or 1994. Firms are generally planning for profit growth to come from higher volumes and efficiency gains rather than from higher prices.**
- **Interest rates and exchange rates are likely to show little change in an environment of moderate growth and stable inflation. Short-term interest rates are expected to be flat this year and rise about 75 basis points during 1994; long-term rates are expected to hold near current yields through the end of 1994; and the dollar is expected to appreciate about 5% against the yen and DM by late-1993 and then hold its value through 1994.**

Note: The Technical Consultants to the Business Council met on April 27. Prior to the meeting, each consultant submitted detailed quantitative economic projections which provided a framework for discussion of overall economic conditions and the outlook.

The technical consultants are in broad agreement that the U.S. economy will remain on a path of moderate growth this year and next. Real GDP growth averaged 3.2% in 1992 and the consultants expect that growth will proceed at nearly identical rates of 2.9% this year and 3.2% in 1994 (all growth rates are measured on a fourth-quarter to fourth-quarter basis). While there is a recognition of widespread slowing in the first few months of 1993, as confirmed in first-quarter GDP growth of only 1.8% at an annual rate, this slowing is viewed as a temporary pause following a growth spurt in the fourth quarter of last year rather than the beginning of a protracted period of weakness.

The consultants show a striking uniformity in their outlook for moderate growth. None of the consultants expect either recession or boom in 1993 or 1994. All of the growth forecasts for 1993 are wedged between 2.4% and 3.4%, and all of the forecasts for 1994 are between 2.4% and 4.0%.

The consultants expect those sectors that have grown relatively rapidly over the past year to continue to lead the expansion in 1993 and 1994. Spending on business equipment is expected to lead growth, with projected volume gains of 11% this year and 10% in 1994 on top of the 13% growth last year. Orders and shipments for "high-tech" equipment including desktop and laptop computers and mobile communications equipment are growing especially rapidly, and this growth is seen as likely to continue at a rapid pace for the foreseeable future. Housing activity, which expanded 14% in 1992 is projected to rise another 11% this year and 6% in 1994, with help from recent reductions in mortgage rates. And, as usual in the early stages of a recovery, spending on consumer durables including autos are projected to post above-trend growth. The government sector should continue to be a drag on the economy.

Reports by the consultants on conditions in their specific industries generally support the consensus forecast. Representatives of the semiconductor and computer industries confirmed that the boom in "high-tech" equipment is continuing. Consultants from other capital goods industries reported solid growth in shipments of other types of producers' equipment, including construction equipment, communications equipment, trucks, and truck engines. Despite some weakness in the first quarter, consultants reported that general merchandise retailing and the auto industry are in a well-established, but irregular, uptrend. One representative of the financial services industry noted that credit card usage continues to increase. The only industries reporting noticeable weakness were rail and truck freight, but

this may have been associated with a short-term inventory correction rather than a more long-lived slowdown.

Improving domestic demand growth is being offset by slowing export markets. The consultants expect exports of goods and services to slow from 4.8% last year to 3.1% this year and then rebound in 1994 to 6.2% growth. Shipments to Europe and Japan are clearly weak, and there were differing views as to how well the high-growth markets of Asia (outside of Japan) and Mexico are holding up.

The technical consultants believe that 3% growth is consistent with a gradual decline in the unemployment rate from 7.0% currently to an average rate of 6.8% in the fourth quarter of this year and 6.4% in the fourth quarter of 1994. Most consultants reported, however, that their specific firms are not planning to add to payrolls to meet growing sales volumes. A representative of the U.S. Labor Department noted that the BLS had recently seen signs of a pickup in new business formation, which would help support job growth.

The technical consultants' forecast of the growth rate and the composition of growth for 1993 are nearly identical to the forecast made in April 1992. However, a year ago the consultants had expected that the 3% growth path could be reached with higher interest rates and a stronger dollar than are now seen as required.

The consultants are in general agreement that risks to the forecast are weighted toward the downside. Several consultants are concerned about federal fiscal policy and, in particular, the possibility that large tax increases to finance deficit reduction and health care reform, might derail consumer spending. A few worried that the prospect of higher excise taxes and associated increase in inflation might force up interest rates. Another source of downside risk to the forecast comes from weakening export markets. Both Continental Europe and Japan are widely recognized to be in recession, and some consultants noted a slowing in shipments to faster-growing markets including Mexico and Asian countries other than Japan. Although consultants perceived downside risks to the 3% growth forecast, these risks were generally not viewed as so severe that they might send the U.S. economy back into recession.

Failure of Congress to approve an Investment Tax Credit (ITC) is seen as having little impact on economic performance. Both purchasers and producers of equipment expressed the view that an ITC of the size that had been proposed by President Clinton would have little effect on capital spending decisions.

The consultants are also in broad agreement that inflation, as measured by the consumer price index, will remain in the 3% to 3 1/2% range this year and next. The average forecast projects consumer price inflation to hold at 3.1% this year and then gradually rise to 3.3% in the first half of 1994 and 3.5% in the second half of 1994. The consultants view the possibility of an upside break in inflation as remote, and none of the consultants expect inflation to reach 4% in either 1993 or 1994. The average consultants' forecast for 1993 consumer price inflation has been progressively lowered from 3.6% in the April 1992 survey to 3.3% in September 1992 and 3.1% in the April 1993 survey.

Consultants' discussions of corporate business plans and of industry attitudes mirrored this stable inflation outlook. Consultants quite generally expect downward price pressures to remain intense and indicated that recent highly-visible price reductions for specific branded goods were not isolated incidents. The consultants reported that corporations will continue to keep tight control on payrolls and inventories in the coming year and that corporate strategies are emphasizing cost reductions, rather than price increases, as a means of boosting profits. Several consultants related the boom in spending on computers and computer-based equipment to the potential of this equipment to boost productivity, and they expected continued productivity improvements in services-producing industries in coming years.

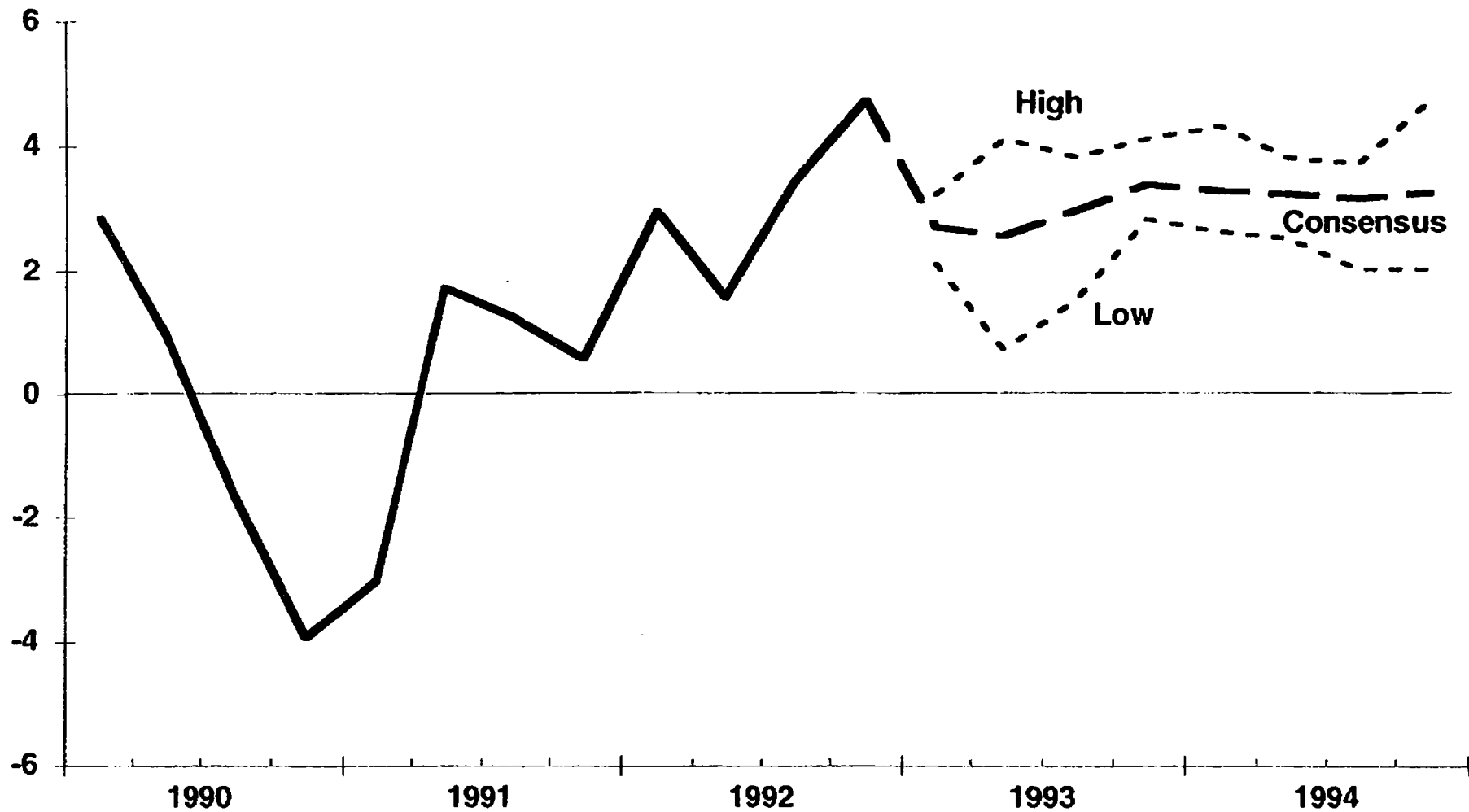
The consultants are in broad agreement that the forecast of 3% to 3 1/2% growth and 3% to 3 1/2% inflation is consistent with relatively stable interest rates and exchange rates. The Fed Funds rate, a benchmark short-term interest rate, is projected to edge up from an average 3.04% last quarter to 3.13% in the fourth quarter of this year and then to 3.88% in the fourth quarter of next year. Twelve of the sixteen respondents forecast Fed Funds to be between 3.50% and 4.00% in the fourth quarter of 1994. The consultants generally expect yields on the 30-year Treasury bond to remain in the 6 1/2% to 7 1/4% range through the end of 1994.

The consultants foresee some strengthening of the dollar on foreign exchange markets by the end of this year and then stability in 1994. The yen/dollar exchange rate is expected to rise to 117 yen/\$ by the fourth quarter of this year and only slightly further to 119 yen/\$ by the fourth quarter of next year. Similarly the DM/\$ exchange rate is expected to rise to 1.65 DM/\$ late this year and 1.68 DM/\$ late next year.

The consultants expect health care spending to continue to outpace GDP growth this year and next. As part of the forecasting exercise, the respondents also answered a questionnaire on future trends in health costs. A large majority of respondents thought that health care costs would continue to rise as a share of GDP, that the inflation rate of health care costs would exceed overall inflation by at least two percentage points through 1994, and that the current health care system is a competitive disadvantage for U.S. firms. A large majority of the consultants also reported that their companies have been taking a variety of actions to control increases in medical costs. About two-thirds of the attendees at the April 27 meeting thought that Congress would approve some form of general health care reform in 1994.

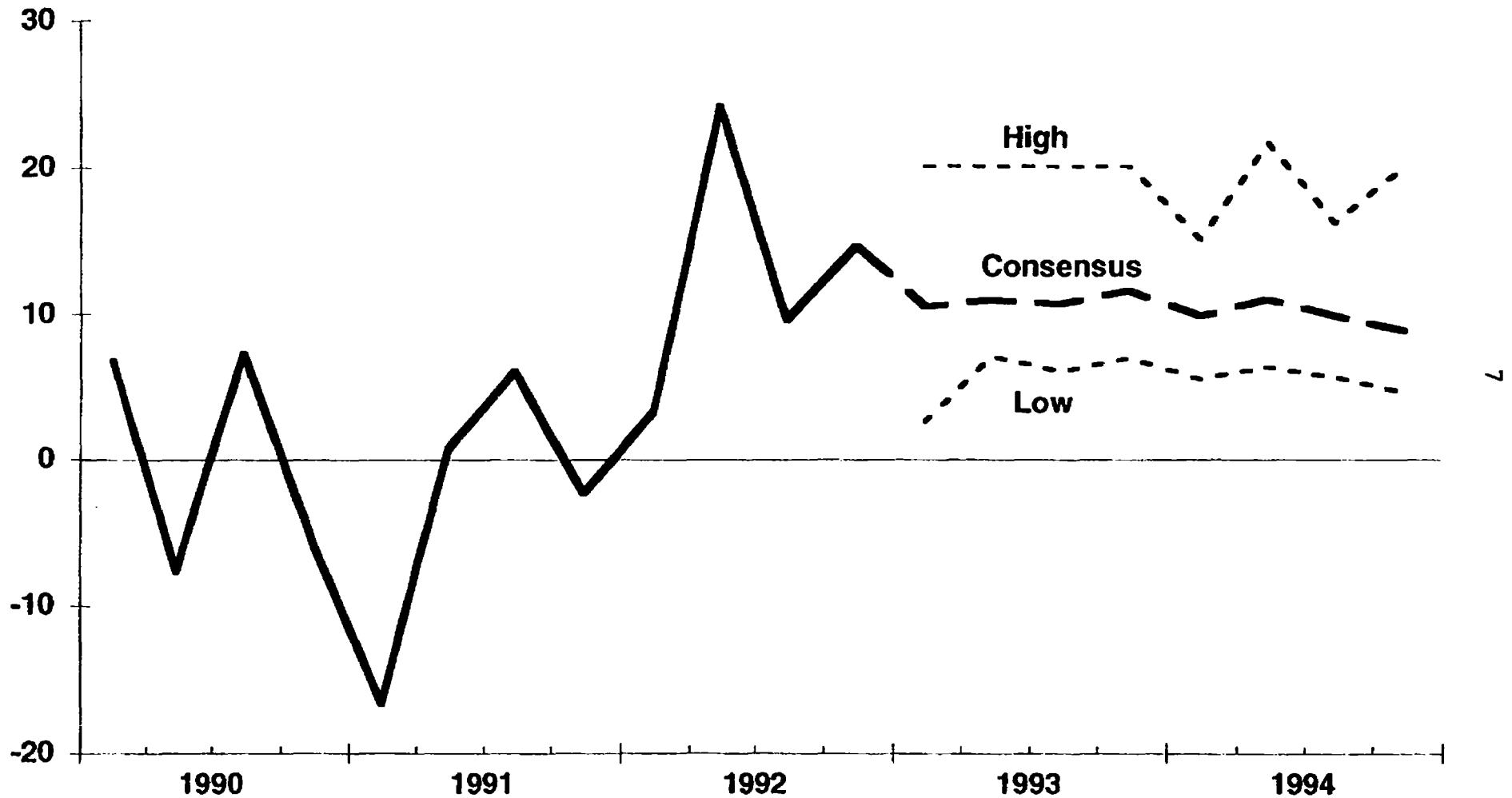
Real GDP - April '93 Forecast High, Low and Consensus Views

percent change at annual rate



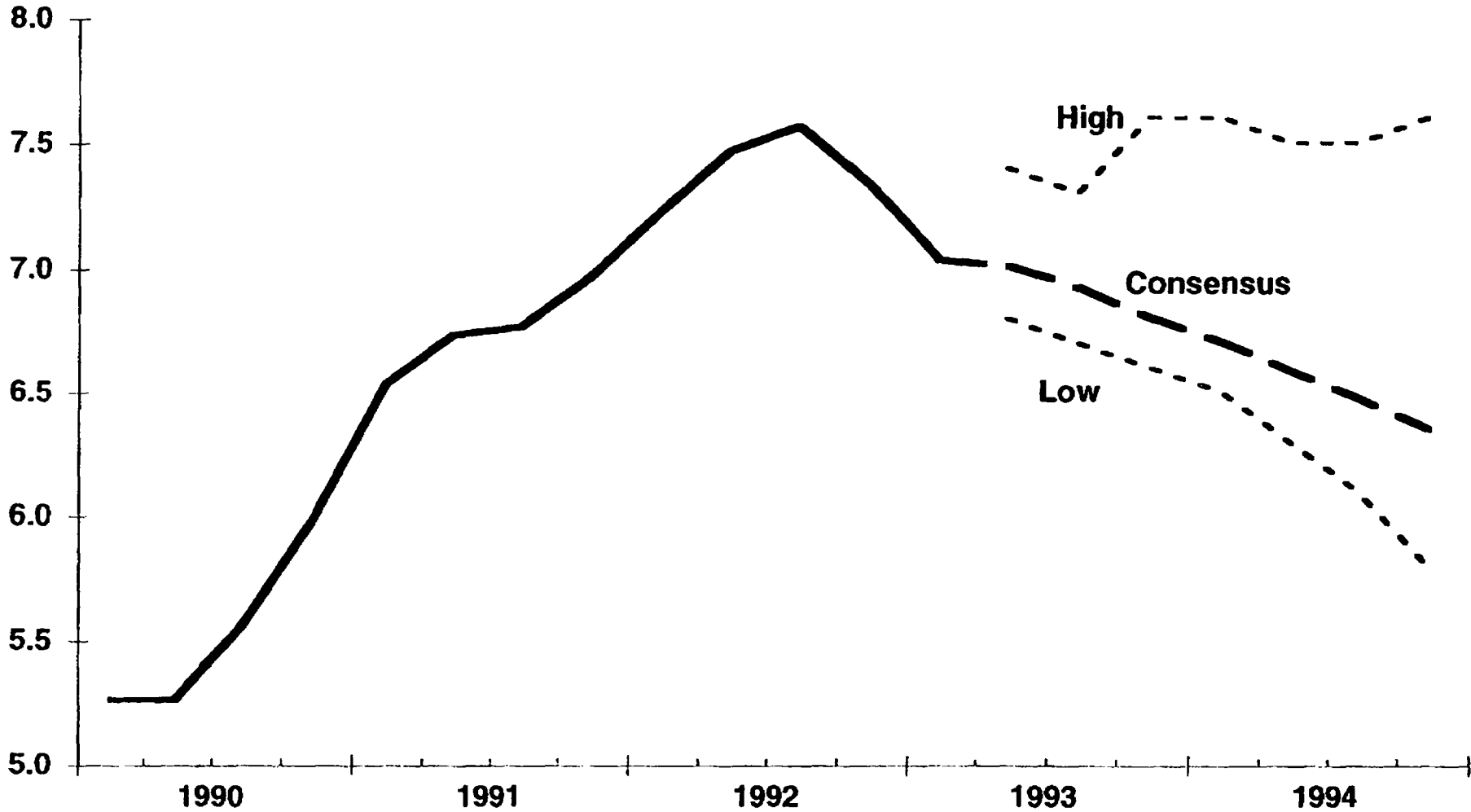
Real Capital Spending: Equipment - April '93 Forecast High, Low and Consensus Views

percent change at annual rate



Unemployment rate - April '93 Forecast High, Low and Consensus Views

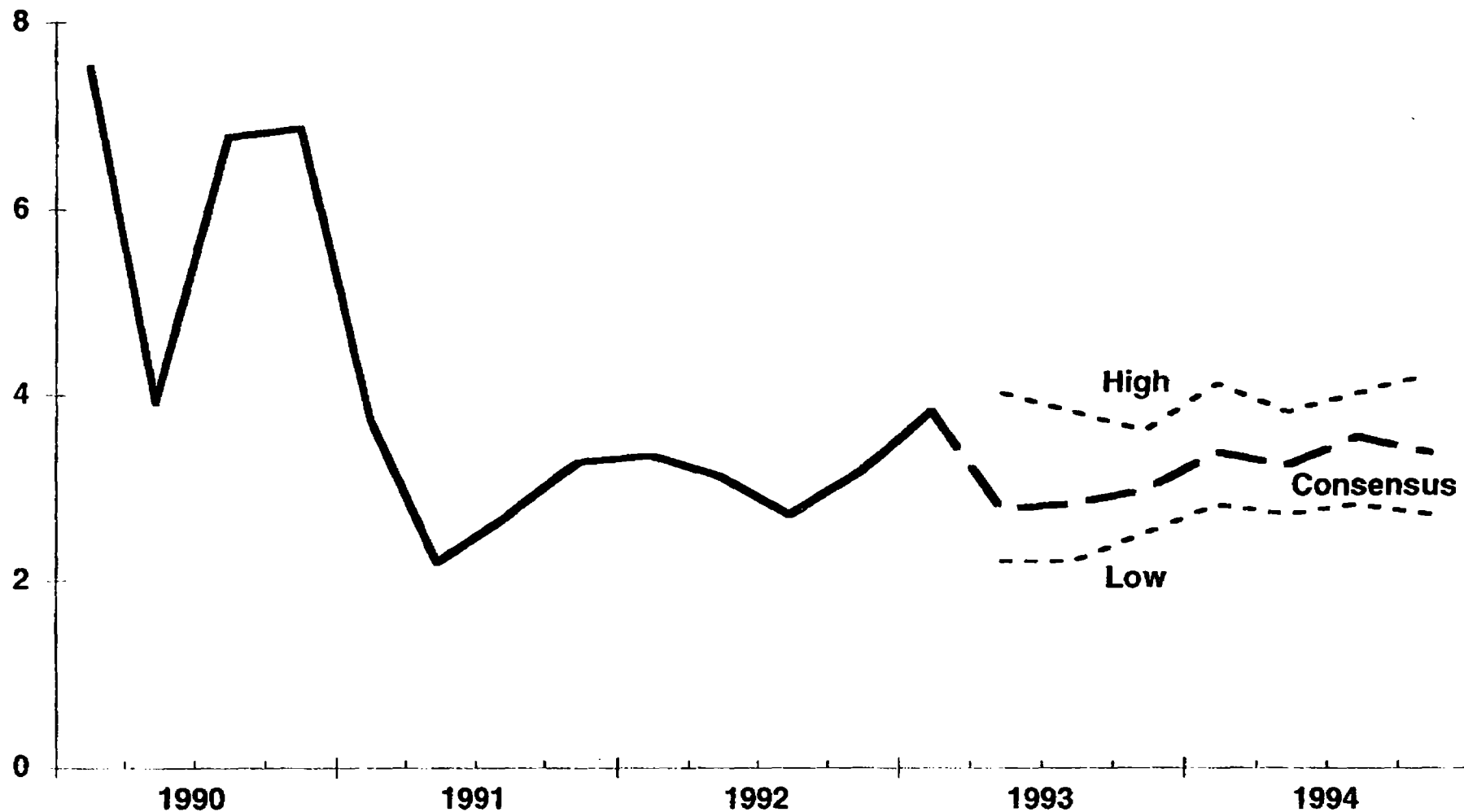
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Consumer Price Inflation - April '93 Forecast

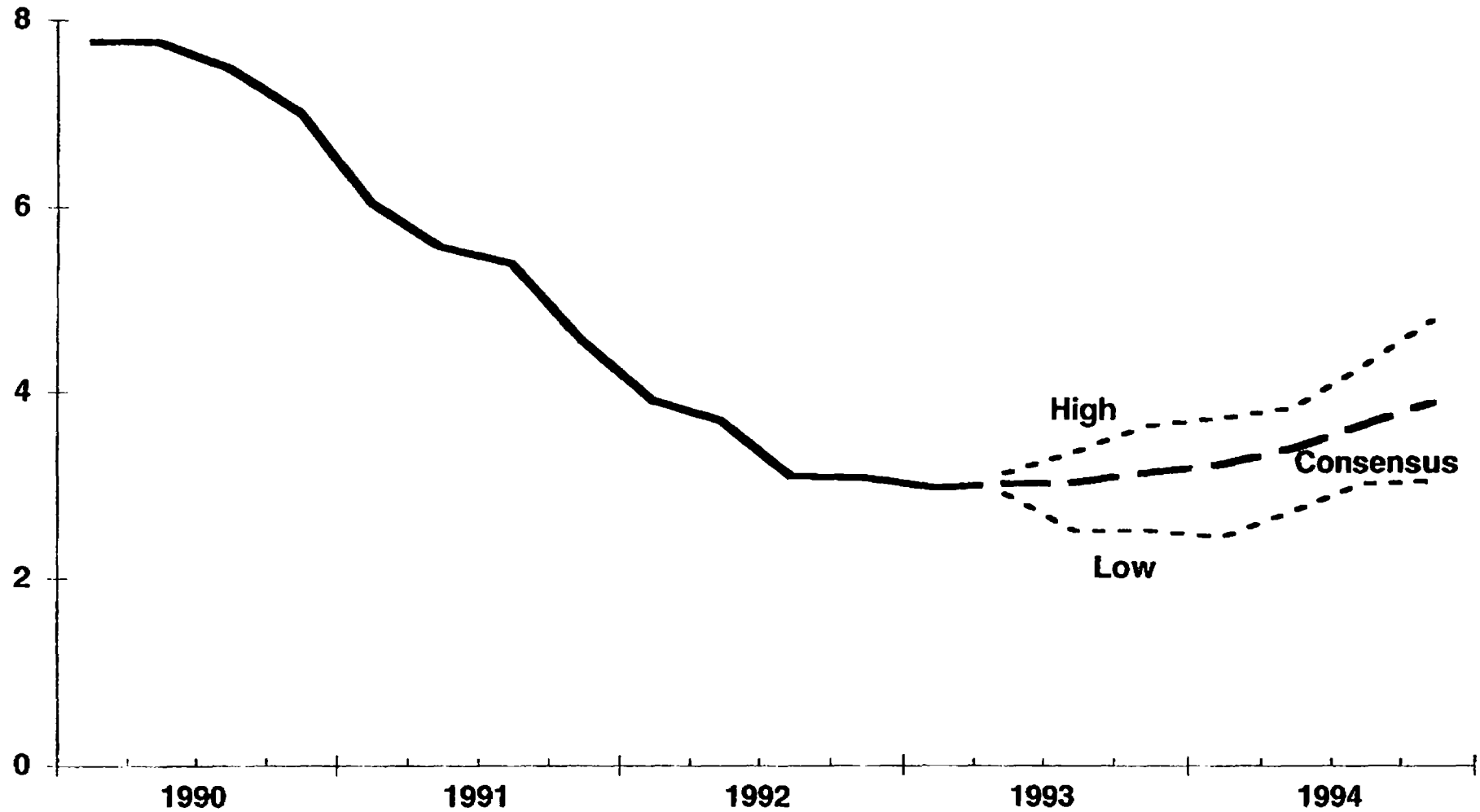
High, Low and Consensus Views

percent change at annual rate



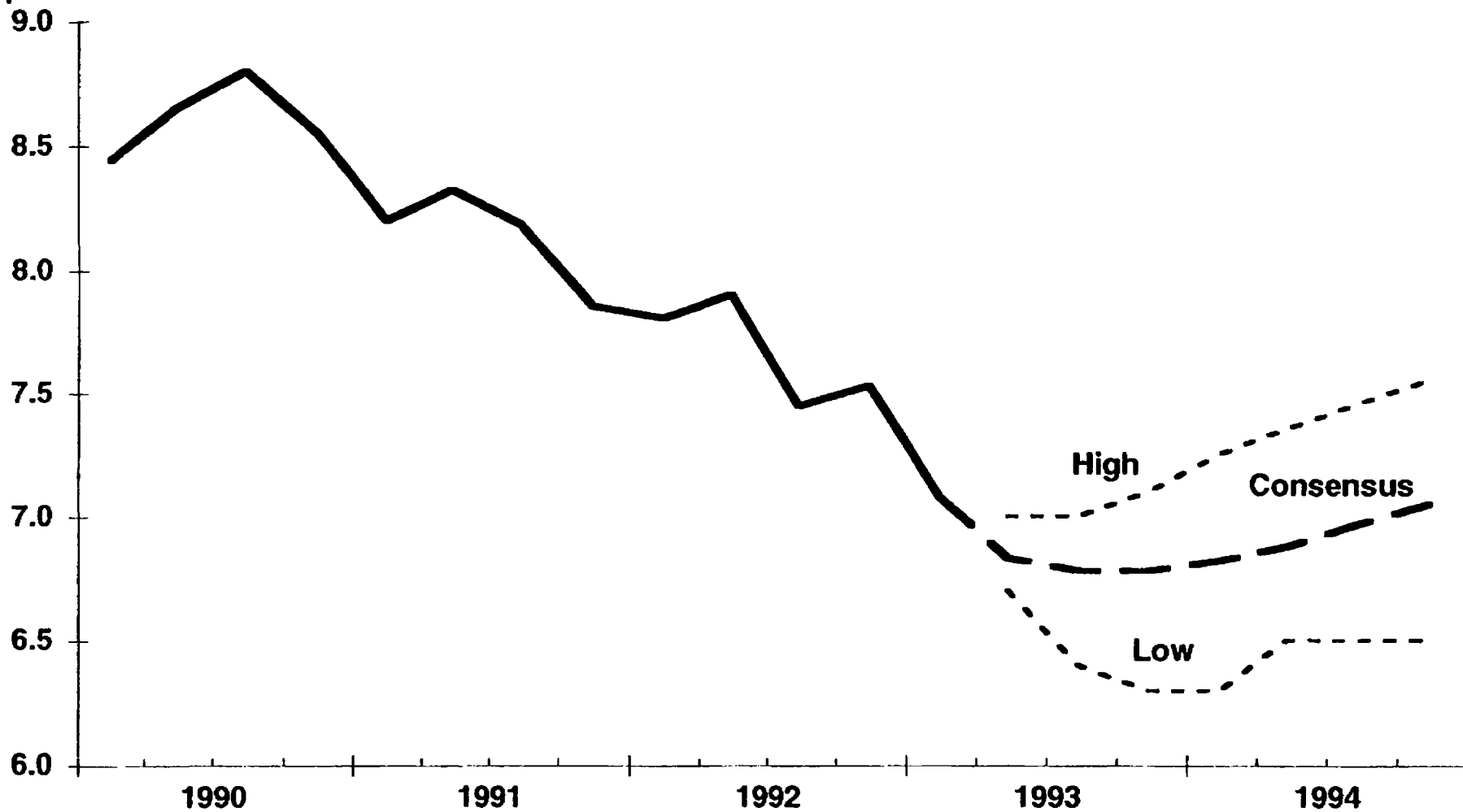
Interest Rates: 3-month Treasury Bills - April '93 Forecast High, Low and Consensus Views

percent



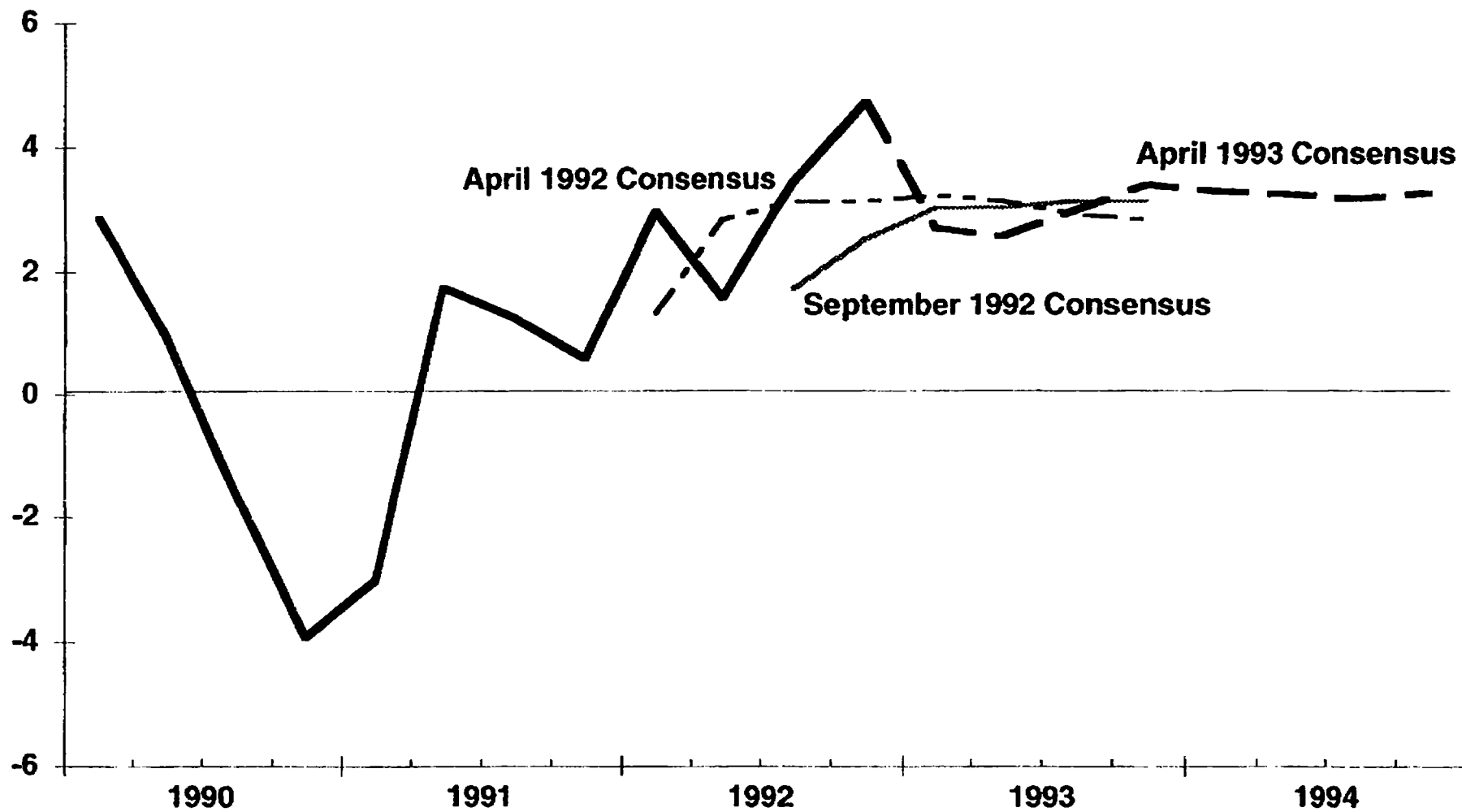
Interest Rates: 30-year Treasury Bonds - April '93 Forecast High, Low and Consensus Views

percent



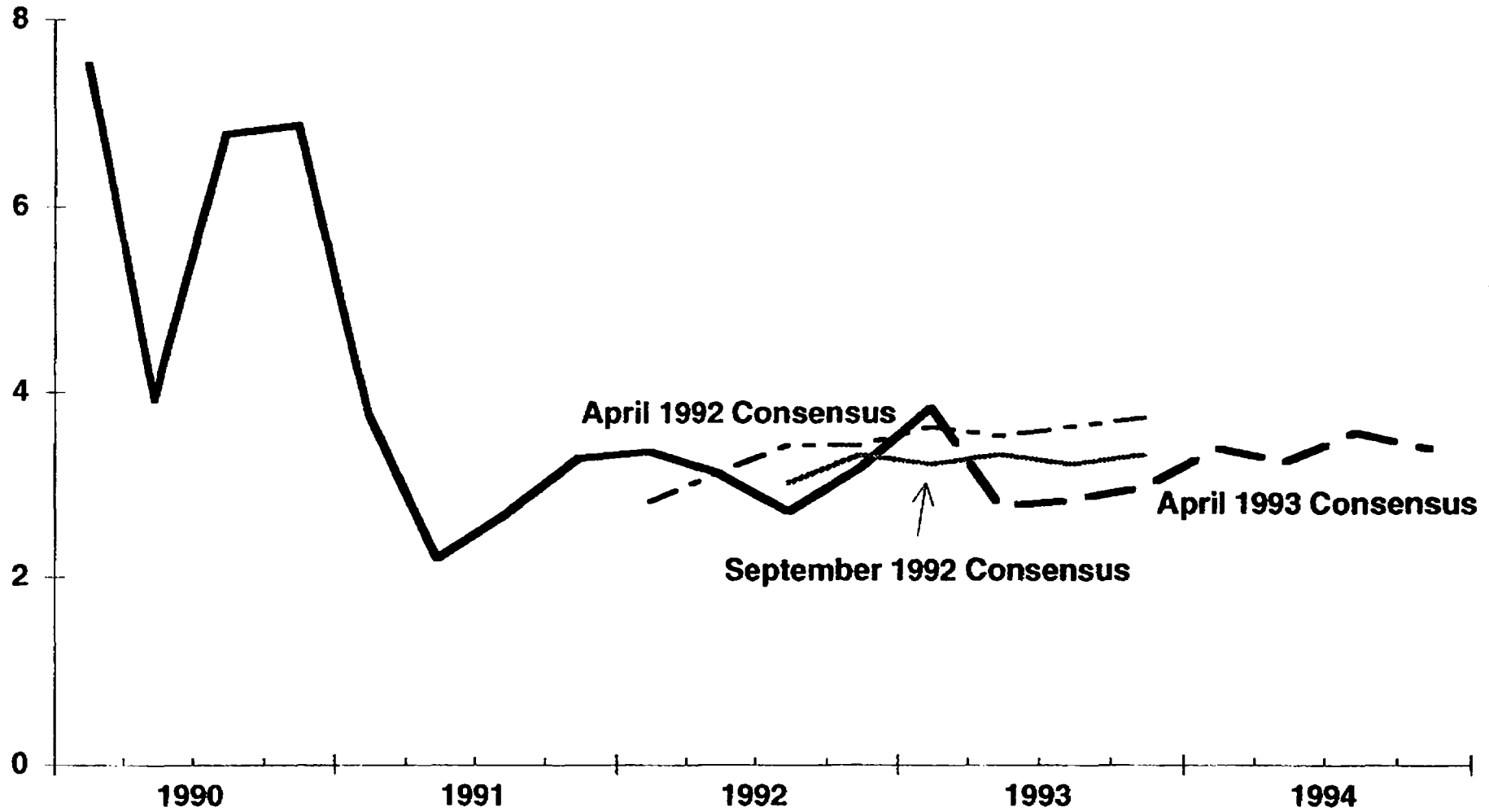
Real GDP Consensus Views

percent change at annual rate



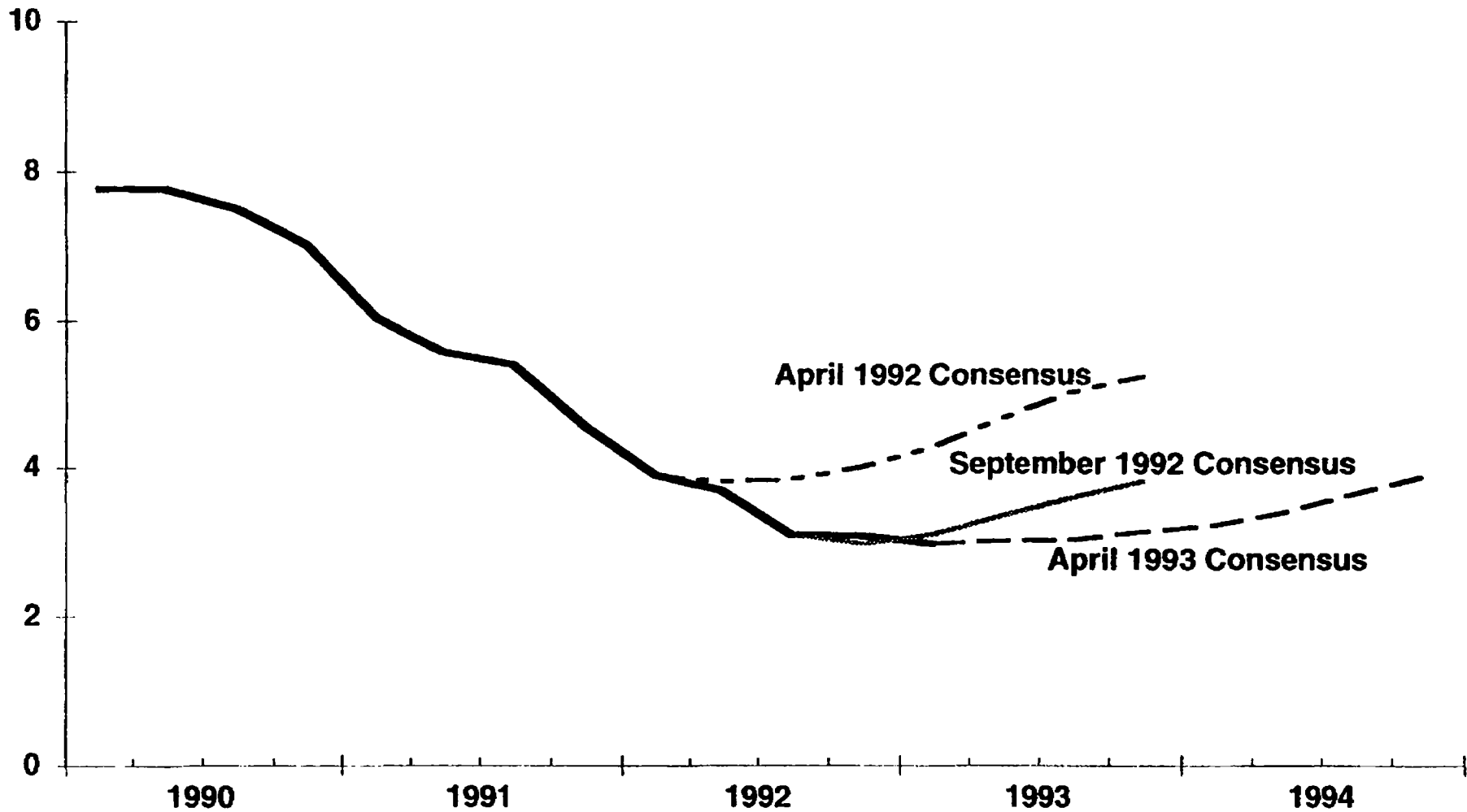
Consumer Price Inflation Consensus Views

percent change at annual rate



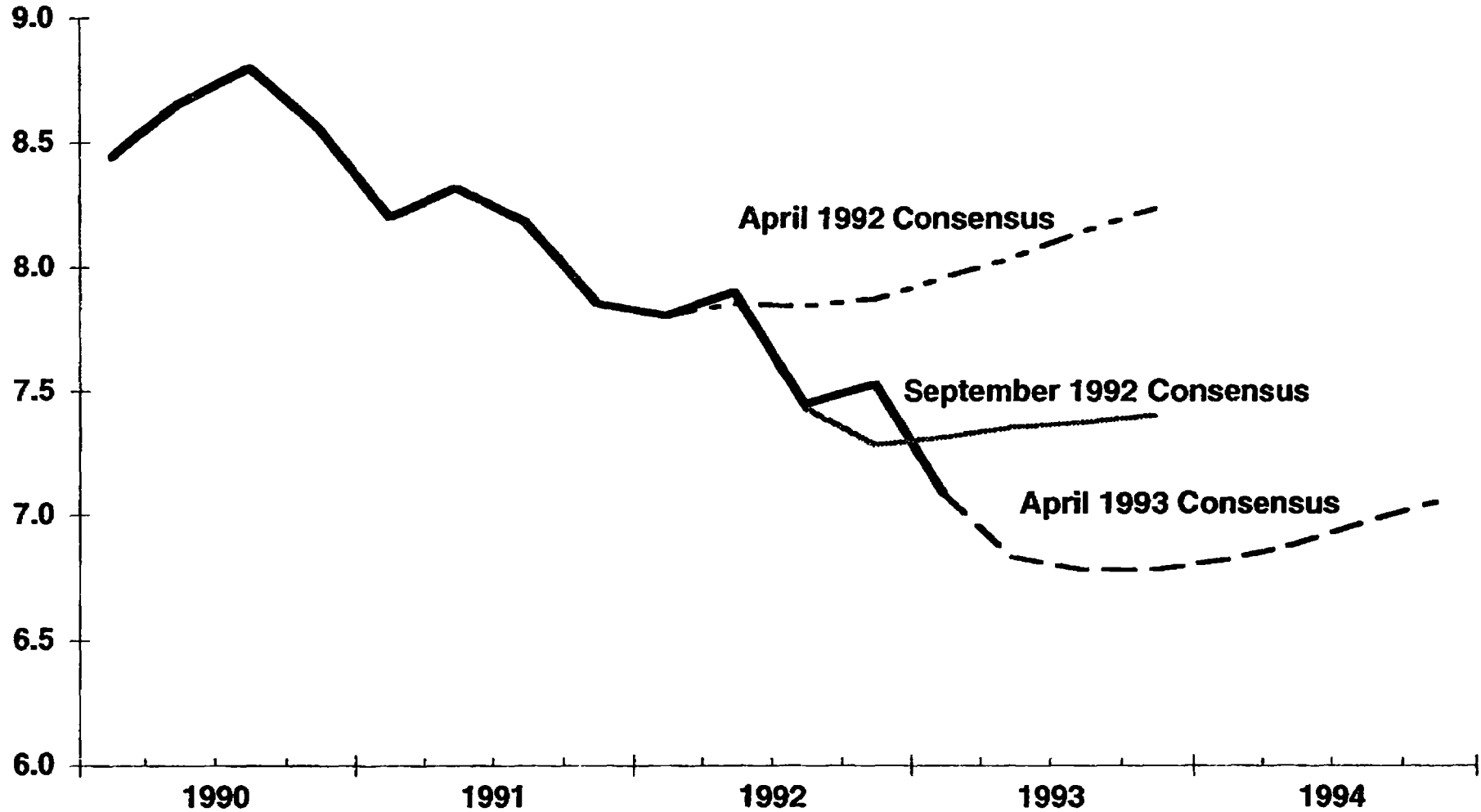
Interest Rates: 3-month Treasury Bills Consensus Views

percent



Interest Rates: 30-year Treasury Bonds Consensus Views

percent



**Results of the Technical Consultants
April 1993 Survey
Summary Table A**

		Avg	High	Low	Std Dev	Avg	High	Low	Std Dev
		% ch from year ago				% ch 4th qtr-4th qtr			
Real GDP	1993	3.1	3.5	2.8	0.2	2.9	3.4	2.4	0.3
	1994	3.2	3.6	2.7	0.2	3.2	4.0	2.4	0.4
Personal Consumption Exp.	1993	3.0	3.3	2.4	0.2	2.7	2.9	2.0	0.2
	1994	2.8	3.4	2.4	0.3	2.8	3.7	2.1	0.4
Consumer Durable Goods	1993	6.7	7.5	5.3	0.7	5.2	6.1	3.5	0.7
	1994	5.0	6.5	3.9	0.7	4.6	7.0	3.4	1.0
Consumer Nondurable Goods	1993	2.2	2.9	1.7	0.4	1.5	2.3	0.8	0.5
	1994	1.9	2.6	1.3	0.4	2.0	2.9	1.3	0.5
Consumer Services	1993	2.6	2.9	2.0	0.3	2.7	3.1	2.1	0.3
	1994	2.7	3.5	2.1	0.4	2.7	3.5	2.2	0.4
Nonresidential Fixed Invest.	1993	8.1	12.3	6.1	1.4	8.4	14.3	6.4	1.9
	1994	9.4	12.2	6.5	1.5	9.4	12.4	5.3	1.9
Nonresidential Structures	1993	-1.6	2.8	-5.9	1.9	1.6	7.5	-6.3	3.0
	1994	5.6	10.6	-3.6	3.9	7.3	13.1	-1.9	4.2
Producers' Durable Equip.	1993	12.0	17.6	9.7	1.8	11.0	18.7	7.5	2.6
	1994	10.7	14.6	7.9	1.9	10.0	14.9	6.1	2.3
Residential Fixed Invest.	1993	12.0	16.8	8.8	2.1	11.0	19.7	5.9	3.3
	1994	8.1	17.5	4.5	3.1	5.5	12.4	-0.7	3.2
Exports, Goods & Services	1993	4.1	5.2	2.3	0.8	3.1	5.9	0.6	1.2
	1994	5.1	8.4	2.8	1.6	6.2	10.0	2.5	2.2
Imports, Goods & Services	1993	7.6	9.1	5.1	1.1	6.5	9.0	3.7	1.6
	1994	6.8	10.9	3.9	1.9	6.8	9.4	2.9	1.8
Government Purchases	1993	-0.4	0.4	-1.0	0.4	-0.2	1.2	-1.0	0.6
	1994	0.6	1.9	-0.6	0.9	0.8	2.6	-1.0	1.1
Final Sales	1993	2.8	3.2	2.4	0.2	2.6	3.1	2.2	0.3
	1994	3.1	3.6	2.9	0.2	3.2	4.0	2.8	0.3
Sales to Domest. Purch.	1993	3.2	3.6	3.0	0.2	3.0	3.6	2.7	0.2
	1994	3.4	4.0	2.7	0.3	3.3	4.0	2.7	0.4

**Results of the Technical Consultants
April 1993 Survey
Summary Table B**

		Avg	High	Low	Std Dev	Avg	High	Low	Std Dev
		% ch from year ago				% ch 4th qtr-4th qtr			
Nominal GDP	1993	5.8	6.3	5.2	0.3	5.6	6.5	4.9	0.5
	1994	6.1	7.2	5.4	0.5	6.4	7.4	5.7	0.5
GDP Fixed Weight Index	1993	2.8	3.0	2.4	0.2	2.7	3.2	2.1	0.4
	1994	2.8	3.5	2.4	0.4	3.0	3.7	2.6	0.4
Consumer Price Index	1993	3.1	3.5	2.9	0.1	3.1	3.8	2.7	0.3
	1994	3.2	3.6	2.7	0.2	3.4	3.9	3.0	0.2
Corporate Profits (IVA/CCA)	1993	16.4	21.0	7.5	4.7	10.0	18.0	-1.2	6.0
	1994	8.8	16.7	2.7	4.4	8.2	18.2	1.5	4.7
Industrial Production	1993	4.1	5.0	3.3	0.4	4.2	5.5	3.1	0.6
	1994	4.1	5.2	3.3	0.5	4.1	5.9	3.2	0.6
Change in Business Inventory		bil 87\$, yr avg				bil 87\$, 4th qtr			
	1993	20.1	32.7	11.9	5.4	22.2	36.3	7.5	7.2
	1994	26.4	38.0	7.5	7.6	27.9	41.4	7.5	8.6
Net Exports	1993	-64.2	-53.0	-77.8	7.4	-71.6	-53.8	-89.9	9.9
	1994	-79.6	-54.0	-109.8	16.3	-79.6	-53.7	-117.6	19.4
Exports, Goods & Services	1993	596.8	602.9	586.4	4.5	606.4	623.2	591.8	7.3
	1994	628.3	653.5	615.1	11.0	644.3	679.3	623.0	15.0
Imports, Goods & Services	1993	661.7	670.8	646.5	6.6	679.0	694.5	660.9	10.1
	1994	708.3	741.7	681.9	17.8	725.4	760.1	692.3	21.3
Housing Starts		mil units, yr avg				mil units, 4th qtr			
	1993	1.329	1.394	1.298	0.0	1.407	1.550	1.350	0.1
	1994	1.438	1.527	1.375	0.0	1.436	1.536	1.350	0.1
Total Vehicle Sales	1993	13.9	14.2	13.2	0.3	14.3	14.8	13.5	0.4
	1994	14.7	15.2	13.6	0.5	14.9	15.5	13.8	0.6
Auto Sales	1993	8.7	9.0	8.4	0.1	9.0	9.5	8.5	0.2
	1994	9.3	9.7	8.7	0.3	9.4	9.9	8.7	0.4
Truck Sales	1993	5.3	5.4	5.1	0.1	5.4	5.7	5.2	0.2
	1994	5.6	5.9	5.3	0.2	5.7	6.0	5.3	0.2

**Results of the Technical Consultants
April 1993 Survey
Summary Table C**

		Avg	High	Low	Std	Avg	High	Low	Std
		percent. yr avg				percent. 4th qtr			
Unemployment Rate	1993	6.9	7.3	6.8	0.1	6.8	7.6	6.6	0.2
	1994	6.5	7.6	6.2	0.3	6.4	7.6	5.8	0.4
Federal Funds Rate	1993	3.05	3.19	2.76	0.1	3.13	3.49	2.50	0.2
	1994	3.54	4.25	3.00	0.4	3.88	5.00	3.00	0.5
3-Month Treasury Bill Rate	1993	3.02	3.24	2.74	0.1	3.12	3.62	2.50	0.2
	1994	3.52	4.03	2.95	0.4	3.87	4.75	3.03	0.5
30-Year Treasury Bond Yield	1993	6.87	7.05	6.65	0.1	6.78	7.10	6.30	0.2
	1994	6.93	7.40	6.52	0.3	7.05	7.55	6.50	0.3
Yen/US\$	1993	117.5	123.0	112.7	3.0	116.8	125.0	105.0	5.9
	1994	118.8	127.5	105.0	7.2	119.1	130.0	105.0	8.4
DM/US\$	1993	1.63	1.73	1.46	0.1	1.65	1.80	1.35	0.1
	1994	1.68	1.90	1.34	0.1	1.68	1.90	1.35	0.1

**Results of the Technical Consultants
April 1993 Survey
Comparison of Survey Results
Percent change, 1993 over 1992**

	Forecast as of:		
	<u>Apr-92</u>	<u>Sep-92</u>	<u>Apr-93</u>
Real GNP/GDP	3.1	2.7	3.1
Personal Consumption Exp.	2.8	2.2	3.0
Consumer Durable Goods	6.1	4.4	6.7
Consumer Nondurable Goods	1.7	1.7	2.2
Consumer Services	2.4	2.1	2.6
Nonresidential Fixed Invest.	6.8	5.3	8.1
Nonresidential Structures	2.4	-0.3	-1.6
Producers' Durable Equip.	8.4	7.6	12.0
Residential Fixed Invest.	8.0	9.0	12.0
Exports, Goods & Services	4.6	5.0	4.1
Imports, Goods & Services	5.8	4.7	7.6
Government Purchases	-0.6	-0.1	-0.4
Final Sales	2.6	2.4	2.8
Final Sales to Domest. Purch.	2.8	2.4	3.2
Nominal GDP	6.0	5.6	5.8
GDP Fixed Weight Index	2.4	2.8	2.8
Consumer Price Index	3.5	3.2	3.1
Corporate Profits (IVA/CCA)	15.2	14.3	16.4
Industrial Production	4.3	3.7	4.1
Housing Starts (mil units) *	1.304	1.343	1.329
Total Vehicle Sales (mil units) *	14.4	14.3	13.9
Auto Sales	9.7	9.3	8.7
Truck Sales	4.7	4.9	5.3
Unemployment Rate (%) *	6.6	7.2	6.9
Federal Funds Rate (%) *	5.01	3.49	3.05
3-Month Treasury Bill Rate (%) *	4.78	3.45	3.02
30-Year Treasury Bond Yield (%) *	8.09	7.36	6.87
Yen/US\$ *	133.92	127.65	117.53
DM/US\$ *	1.729	1.564	1.63

* 1993 average level

Results of the Technical Consultants
April 1993 Survey
Comparison of Survey Results
Percent change, 4th qtr 1993 over 4th qtr 1992

	Forecast as of:		
	<u>Apr-92</u>	<u>Sep-92</u>	<u>Apr-93</u>
Real GNP/GDP	3.0	3.0	2.9
Personal Consumption Exp.	2.8	2.6	2.7
Consumer Durable Goods	5.5	5.9	5.2
Consumer Nondurable Goods	1.7	1.9	1.5
Consumer Services	2.6	2.3	2.7
Nonresidential Fixed Invest.	7.8	6.0	8.4
Nonresidential Structures	4.2	1.9	1.6
Producers' Durable Equip.	9.2	7.6	11.0
Residential Fixed Invest.	6.9	9.4	11.0
Exports, Goods & Services	5.1	6.6	3.1
Imports, Goods & Services	5.7	5.1	6.5
Government Purchases	-0.4	-0.3	-0.2
Final Sales	2.8	2.8	2.6
Final Sales to Domest. Purch.	2.9	2.7	3.0
Nominal GDP	6.0	6.1	5.6
GDP Fixed Weight Index	2.5	3.0	2.7
Consumer Price Index	3.6	3.3	3.1
Corporate Profits (IVA/CCA)	10.8	13.3	10.0
Industrial Production	4.1	4.2	4.2
Housing Starts (mil units) *	1.303	1.382	1.407
Total Vehicle Sales (mil units) *	14.6	14.7	14.3
Auto Sales	9.8	9.6	9.0
Truck Sales	4.7	5.0	5.4
Unemployment Rate (%) *	6.4	7.0	6.8
Federal Funds Rate (%) *	5.46	3.85	3.13
3-Month Treasury Bill Rate (%) *	5.21	3.80	3.12
30-Year Treasury Bond Yield (%) *	8.23	7.40	6.78
Yen/US\$ *	133.23	128.19	116.84
DM/US\$ *	1.735	1.601	1.652

* 4th qtr, 1993 average level

The Business Council**FAX COVER SHEET****Date:**

April 19, 1993

Pages to Follow:1**Subject**

Copy of letter to Dr. Tyson

Deliver:

Alexis Hermann

Company:

Office of Public Liaison

Sent From:

Philip E. Cassidy

Telephone Number:

(202) 298-7650

FAX Number:

(202) 785-0296

888 17th Street, NW, Suite 506, Washington DC 20006

FAX #: (202) 456-2983

Alexis,

The 10:00 a.m. start time shown in the letter
is flexible.

Tomorrow
10:00 a.m.

THE BUSINESS COUNCIL

ROBERT E. ALLEN
Chairman

WAYNE CALLOWAY
Vice Chairman

H. LAURANCE FULLER
Vice Chairman

JAMES R. HOUGHTON
Vice Chairman

DENNIS WEATHERSTONE
Vice Chairman

888 Seventeenth Street, N.W.
Washington, D.C. 20006
Telephone: (202) 298-7650
FAX: (202) 785-0296

April 6, 1993

PHILIP E. CASSIDY
Executive Director

Ms. Laura D'Andrea Tyson
Chair
Council of Economic Advisors
Old Executive Building
17th & Pennsylvania Ave.
Washington, D.C. 20500

Handwritten:
Done
4/15/93 - 5221

Dear Ms. Tyson:

I'm writing on behalf of The Business Council to invite your participation in the economic program at our annual Spring meeting which is scheduled for May 7-8 at the Williamsburg Inn, Colonial Williamsburg, Virginia.

The Business Council, which is an association of American business leaders, meets periodically with government policymakers and other experts to facilitate a candid and off-the-record exchange of ideas on major issues. The Council is chaired by Robert Allen of the American Telephone & Telegraph Company, and I currently serve as vice chairman and am responsible for the economic program. The Council membership consists of other chief executive officers from the top 100 or so U.S. corporations, representing all sectors of the economy.

The economic program typically consists of a short presentation on the consensus economic forecasts of the Technical Consultants to the Business Council (a group of 20 business economists) followed by presentations by government officials, private economists, or members of the Council. My plan is to focus the program on the "performance of the economy in the context of the Administration's new economic plan." After a quick presentation of the economic forecasts, I would turn the program over to you and ideally one private-sector economist.

I know that the Council members would be intensely interested in how you see the economy developing and I hope that you will be able to participate. The session is scheduled for Friday morning, May 7 at 10:00 a.m. If this is inconvenient, we could possibly shift the schedule to Saturday morning. We'd also be happy to work out the arrangements to ensure that your stay is a productive, convenient and as enjoyable as possible.

Thank you in advance for considering the invitation.

Sincerely,

Handwritten signature of Dennis Weatherstone

Dennis Weatherstone
Vice Chairman

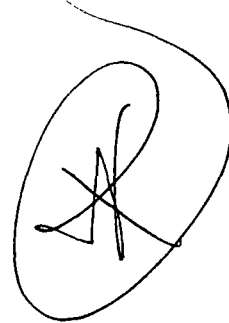
TYSON



WAYNE CALLOWAY
CHAIRMAN
CHIEF EXECUTIVE OFFICER

March 23, 1993

The Honorable Leon E. Panetta
Director
Office of Management and Budget
Old Executive Office Building
17th & Pennsylvania Avenue, N.W.
Washington, D.C. 20503



Dear Mr. Panetta:

I'm writing on behalf of The Business Council to invite your participation in our annual Spring meeting which is scheduled for Friday, May 7 and Saturday, May 8 in Colonial Williamsburg, Virginia.

As you know, The Business Council is an association of American business leaders that meets periodically with government policymakers and other experts to facilitate a candid and off-the-record exchange of ideas on major issues. The Council is presently chaired by Robert Allen of the American Telephone & Telephone Company, and I serve as vice chairman. The current membership consists of other chief executive officers from the top 100 or so U.S. corporations, representing all sectors of the economy.

Our May meeting has a dual focus which we believe has exciting potential. On Friday morning, we'll first discuss the Council's latest forecast for the economy. Then we'll devote the balance of the agenda on Friday and Saturday to the health care issue. Senator Jay Rockefeller is helping us formulate and lead the health policy program . . . and we've invited the First Lady to keynote our Friday dinner session.

During the final conference segment on Saturday morning, we plan to return to a broader discussion of the economy that more fully reflects the health reform implications discussed earlier. In this regard, we can't think of anyone whose insights would be more highly valued than yours.

We'd be delighted to host you during the conference. Whether or not you're able to spend the entire time with us, however, we'd be honored for you to lead the closing segment about the economy on the morning of Saturday, May 8. If you can join us, we'd be happy to provide transportation and logistical assistance to ensure that your involvement is as productive, convenient and enjoyable as possible.

Thanks in advance for considering the invitation. I really think your participation could help lead us all to new ground.

Sincerely,

A handwritten signature, likely of Wayne Calloway, is written in a cursive style. The signature is a stylized "W" followed by a series of loops and a final flourish.

- Carry - 1/2

- 1/2 / 1/2

THE BUSINESS COUNCIL

888 Seventeenth Street, N.W., Suite 506

Washington, D.C. 20006

(202) 298-7650

FAX: (202) 785-0296

Regular Meeting
The Williamsburg Inn, Williamsburg, Virginia

Thursday & Friday
May 6-8, 1993

TENTATIVE AGENDA

Thursday, May 6

7:00 p.m.	Chairman's Reception	East Lounge & Terrace The Williamsburg Inn
8:00-10:00 p.m.	Dinner: Regency Dining Room -- Taverns	

Friday, May 7

The Williamsburg Lodge & Conference Center

7:00 a.m.	Buffet Breakfast	Rooms A & B
8:30 a.m.	Robert E. Allen convenes the Session	Virginia Room
	Panel Discussion: The Economy	Moderator: Mr. Dennis Weatherstone Chairman & CEO J. P. Morgan & Co. Incorporated

-- and --

Selected Business Council Members

Health Care: A System in Crisis

Attitudes & Opinions

TBA *Humphrey Taylor*

B R E A K

Refreshments available in Rooms A & B

The Reality & The Vision

~~TBA~~ *Reed Tushnet*
San Thier

The Policy Viewpoints

TBA

12 Noon

A D J O U R N

12 Noon-2:30 p.m.

Business Council Buffet Luncheon

East Lounge, The Williamsburg Inn

7:00 p.m.

Reception & Dinner: Dress - Black Tie
Speaker: Mrs. Hillary Rodham Clinton

(Invited)

THE BUSINESS COUNCIL

888 Seventeenth Street, N.W., Suite 506

Washington, D.C. 20006

(202) 298-7650

FAX: (202) 785-0296

Regular Meeting
The Williamsburg Inn, Williamsburg, Virginia

Saturday
May 6-8, 1993

TENTATIVE AGENDA

Saturday, May 8

The Williamsburg Lodge & Conference Center

7:00 a.m.	Buffet Breakfast	Rooms A & B
8:30 a.m.	Session Convenes	Virginia Room
	<u>Health Care: Reforming the System</u>	
	The Congressional View	The Honorable Nancy Kassebaum U. S. Senator (R-Kansas)
	The Business View	Selected Business Council Members
	B R E A K	Refreshments available in Rooms A & B
	The Business-Government Partnership	The Honorable John D. Rockefeller, IV U. S. Senator (D-West Virginia)
12:00 Noon	A D J O U R N	
12 Noon-2:30 p.m.	Business Council Buffet Luncheon	East Lounge, The Williamsburg Inn

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

BUSINESS ROUNDTABLE

Divider Title: _____

March 22, 1993

To: Alexis Herman
From: Tom O'Hara
The Prudential
293-1676

Subject: Proposed Business Roundtable Health Task Force Meeting

Alexis, attached is the list of CEOs who are members of the Health Task Force. Four-five CEOs would most likely attend the meeting with Ira Magaziner and these four-five would come from the group I have marked on the list.

Tom

03/12/93

456-2983

Page: 1

THE BUSINESS ROUNDTABLE
Health, Welfare - Members

Mr. Duane L. Burnham
Vice Chairman, CEO & CFO
ABBOTT LABORATORIES
Abbott Park
1 Abbott Park Road
North Chicago, IL 60064-3599
(708)937-3210
(708)937-1511 [Fax]

Mr. Ronald Compton
Chairman
AETNA LIFE & CASUALTY COMPANY
151 Farmington Avenue
Hartford, CT 06156-0570
(203)273-0570
(203)273-6872 [Fax]

Mr. Lawrence A. Bossidy
Chairman
ALLIED-SIGNAL INC.
PO Box 3000R
101 Columbia Road
Morristown, NJ 07962-2496
(201)455-6551
(201)455-4002 [Fax]

Mr. Richard M. Rosenberg
Chairman
BANKAMERICA CORPORATION
Bank of America Center
PO Box 37000
San Francisco, CA 94137-0001
(415)953-7963
(415)398-8264 [Fax]

Mr. Vernon R. Loucks, Jr.
President & CEO
BAXTER INTERNATIONAL INC.
One Baxter Parkway
Deerfield, IL 60015-4625
(708)948-3600
(708)948-2005 [Fax]

Mr. Wilson H. Taylor
President & CEO
CIGNA CORPORATION
One Liberty Place
1650 Market Street
PO Box 7716
Philadelphia, PA 19192-1550
(215)761-6001
(215)761-5517 [Fax]

Mr. Hans W. Becherer
President & CEO
DEERE & COMPANY
John Deere Road
Moline, IL 61265-1792
(309)765-4448
(309)765-5772 [Fax]

Mr. Vaughn D. Bryson
President & CEO
ELI LILLY & COMPANY
Eli Lilly Corporate Center
Indianapolis, IN 46285
(317)276-5945
(317)276-9152 [Fax]

Mr. John D. Ong
Chairman
THE BFGOODRICH COMPANY
3925 Embassy Parkway
Akron, OH 44313-1799
(216)374-2729
(216)374-3338 [Fax]

Mr. David A. Jones
Chairman
HUMANA INC.
The Humana Building
500 West Main Street
Louisville, KY 40201-1438
(502)580-3645
(502)580-3690 [Fax]

03/12/93

Page: 2

Mr. John D. Nichols
Chairman
ILLINOIS TOOL WORKS, INC.
3600 West Lake Drive
Glenview, IL 60025-5811
(708)724-7500
(708)657-4392 [Fax]

Mr. Theodore H. Black
Chairman
INGERSOLL-RAND COMPANY
200 Chestnut Ridge Road
Woodcliff Lakes, NJ 07675-7700
(201)573-3334
(201)573-3406 [Fax]

Mr. J. Willard Marriott, Jr.
Chairman
MARRIOTT CORPORATION
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(301)380-8957 [Fax]

Mr. A.J.C. Smith
Chairman
PARSH & MCLENNAN COMPANIES
1166 Avenue of the Americas
New York, NY 10020-1011
(212)345-5125
(212)345-4647 [Fax]

Mr. Alan Seelenfreund
Chairman & CFO
MCKESSON CORPORATION
One Post Street
San Francisco, CA 94104-5292
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(415)983-8826 [Fax]

Mr. Robert G. Schwartz
Chairman
METROPOLITAN LIFE INSURANCE CO.
One Madison Avenue
New York, NY 10010-3681
(212)578-3092
(212)578-2564 [Fax]

Mr. Allen E. Murray
Chairman
MOBIL CORPORATION
3225 Gallows Road
Fairfax, VA 20037
(703)846-3000
(703)846-2670 [Fax]

Mr. William C. Ferguson
Chairman
NYNEX CORPORATION
1113 Westchester Avenue
White Plains, NY 10604-3610
(914)644-6430
(914)644-7649 [Fax]

Mr. William R. Howell
Chairman
J.C. PENNEY CO., INC.
PO Box 10001
Dallas, TX 75301-0001
(214)431-1902
(214)431-1977 [Fax]

Mr. William C. Steere Jr.
Chairman
PFIZER, INC.
235 East 42nd Street
23rd Floor
New York, NY 10017-5755
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(212)573-2200 [Fax]

Mr. Robert C. Winters
Chairman & CEO
THE PRUDENTIAL INS. CO. OF AMERICA
Prudential Plaza
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(201)622-4729 [Fax]

03/12/93

Page: 3

Mr. William D. Smithburg
Chairman
THE QUAKER OATS COMPANY
PO Box 9001
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Chicago, IL 60604
(312)222-7202
(312)222-8532 [Fax]

Mr. George V. Grune
Chairman
READER'S DIGEST ASSOCIATION, INC.
Pleasantville, NY 10570
(914)241-5450
(914)241-5959 [Fax]

Mr. Louis V. Gerstner, Jr.
Chairman
RJR NABISCO, INC.
1301 Avenue of the Americas
New York, NY 10019-6013
(212)253-5700
(212)969-9186 [Fax]

Mr. Joseph M. Clapp
Chairman
DADWAY SERVICES, INC.
1077 Gorge Boulevard
Akron, OH 44309
(216)384-2343
(216)258-2550 [Fax]

Mr. Donald R. Beall
Chairman
ROCKWELL INTERNATIONAL CORPORATION
2201 Seal Beach Blvd.
Seal Beach, CA 90740
(310)797-5127
(310)797-5020 [Fax]

Mr. M. Anthony Burns
Chairman
RYDER SYSTEM INC.
3600 NW 82 Avenue
Miami, FL 33166-6623
(305)593-3496
(305)593-4196 [Fax]

Mr. Robert D. Krebs
President & CEO
SANTA FE PACIFIC CORP.
1700 East Golf Road
Schaumburg, IL 60173
(708)995-6145
(708)995-6118 [Fax]

Mr. Edward A. Brennan
Chairman
SEARS, ROEBUCK AND CO.
Sears Tower
Chicago, IL 60684-0001
(312)875-1902
(312)906-1158 [Fax]

Mr. Michael W. Wright
Chairman
SUPERVALU INC.
PO Box 990
Minneapolis, MN 55440-0990
(612)828-4048
(612)828-8926 [Fax]

Mr. Edward H. Budd
Chairman
THE TRAVELERS CORPORATION
One Tower Square
Hartford, CT 06115-9001
(203)277-4993
(203)277-7979 [Fax]

Dr. Theodore Cooper
Chairman
THE UPJOHN COMPANY
7000 Portage Road
Kalamazoo, MI 49001-0103
(616)323-7094
(616)323-5251 [Fax]

Mr. William R. Toller
Chairman
WITCO CORPORATION
520 Madison Avenue
New York, NY 10022
(212)605-3807
(212)605-3826 [Fax]

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**Consultative Mtgs
w/ OPL**

Divider Title: _____

MEMORANDUM

TO: Mike Lux
Ira Magaziner

FROM: Nancy Bagley

RE: Health Care Meeting

DATE: February 27, 1993

Attached please find an updated list of the scheduled
consultative health care meetings. Please note that some room
numbers and times have been changed.

cc: ✓ Alexis Herman
Bob Boorstin
Danny Wexler
Steve Hilton
Steve Edelstein
John Hart
Christine Heenan
Anne Lewis
Judy Feder
Chris Jennings
Celia Fisher
Margery Tarmy
Flo McAfee
Debbie Fine
Molly Brostrum
Karen Pollitz
Melanne Verveer

1. **Long-Term Care Providers**
Monday, March 1st
2:00 - 3:30pm
Room 472 OEOB

National Association for Home Care
Dayle Berke, Director of Gov't Affairs

Lucia DiVinere, Director

Theresa Forster, Director

American Health Care Association (Nursing Homes)
Bruce Yarwood, Legislative Council

Paul Willging, Executive Vice President
David Seckman, Vice President

American Association of Homes for Aging
Sheldon Goldberg, President

Michael Rodgers, Senior Vice President

Valerie Wilbur, Director of Federal Affairs

National Institute on Adult Daycare
Dr. Daniel Thursz, President of The National Council on the Aging

Victoria Wagman, Assistant to the President for Public Policy at the National Council on Aging

Betty Ransom, Program Manager

Hospice Association of America
Janet E. Neigh, Executive Director

American Federation of Home Health Agencies
Ann B. Howard, Executive Director

Sally J. Herzog, CEO, Able Care

Janet Wolfe, Director, Munson Home Services

Vidas Organization
Ron Fried

American Association for Respiratory Care
Jill A. Eicher, Director

Bonnie Kane, RRT, Howard University College of Medicine

**National Committee to Preserve Social Security &
Medicare**

Bente E. Cooney, Senior Policy Analyst

OPL

Mike Lux

DNC

John Blount

Health Care Working Groups

Robyn Stone

2. **Insurance**
Monday, March 1st
3:30 - 5:00pm
Room 472 OEOB

Health Insurance Association
of America

2 representatives

Aetna

Pat Quinn, Attorney at Wilkinson, Baker, Knauer & Quinn

Prudential

Thomas G. O'Hara, Vice President

Cigna

Herbert Michael Schiffer, Vice President, Federal Affairs

Travelers

Roger Levy, Vice President , Government Affairs

Metropolitan Life

Ark Monroe, Attorney at Mitchell, Williams, Selig, Gates &
Woodyard

Mass Mutual

James Earnest Miller, Executive Vice President

NY Life

Faith Williams, Associate Legislative Vice President

Mutual of Omaha

Cecil Bykerk, Senior Executive Vice President

General American Life

Michael R. Hogan, Executive Vice President

National Council of Senior Citizens
Graphic Artists Union
National Farmers Union
National Hispanic Council on Aging
Neighbor to Neighbor
Network
Oil, Chemical and Atomic Workers
United Electrical Workers
United Church of Christ
Public Citizen

6. Hospitals
Friday, March 5th
2:00 - 3:30 pm
Room 476 OEOB

Three representatives from each of the following:

American Hospital Association
Catholic Hospital Association
Protestant Hospitals
Jewish Hospitals
University/Research Hospitals
Association of Children's Hospitals
Osteopathic Hospitals
Premier Hospital Alliance, Inc. - 1 rep.
National Association of Psychiatric Hospital Systems- 1 rep.
^Federation of American Hospital Systems 1- rep

Jim Roosevelt

7. Pharmacists
Friday, March 5th
4:00 - 5:30pm
Room 476 OEOB

Three representatives from each of the following:

American Pharmaceutical Association
American Society of Consultant Pharmacists
American Society of Hospital Pharmacists
National Association of Chain Drug Stores
National Association of Retail Druggists
People's Drug
Walgren's
Medco Containment Services, Inc. -1 rep.

CONSULTATIVE HEALTH CARE MEETINGS

HEALTH INDUSTRY

BC HRC AG IG IM DS OPL TF

PHYSICIAN GROUPS

American Medical Association	AG	IM (4)	DS (2)	OPL	
American College of Physicians	AG	IM	DS (2)	OPL	
American Acad. of Family Physicians		IM		OPL	
National Medical Association		IM		OPL	
American Academy of Pediatrics				OPL (2)	
American Soc. for Internal Medicine				OPL	
American Academy of Ophthalmology				OPL	
American College of Cardiology				OPL	
American College of OB/GYN				OPL (2)	
American Coll. of Prev. Medicine				OPL	
America College of Surgeons			DS	OPL	
College of American Pathologists				OPL	
Society on Gen. Internal Medicine				OPL	
Society of Thoracic Surgeons				OPL	
Physicians Who Care				OPL	
National Health Policy Council				OPL	
Mercy Clinic System				OPL	
First Hospital Corp.				OPL	
Kalamazoo Center for Med. Studies				OPL	
American Coll. of Emergency Phys.				OPL	
Association of Academic Surgeons		IM			
American College of Gynecologists			DS		
Physician for a Nat. Health Program				OPL	
Black Psychiatric Association				OPL	

GENERAL HEALTH PROVIDERS

American Nurses Association	HRC			OPL (2)	TF
Fed. Nurses & Health Prof. (AFT)	HRC			OPL	
NAPNAP	HRC			OPL	
Ass. for Pract. in Infection Control	HRC			OPL	
National Black Dental Association					
National Fed. for Spec. Nursing Org.				DS	
National Ass. of Social Workers		TG		OPL	
National Assc. of Health Ser. Exec.					TF
National Black Cau. of Health Workers					TF
Health Industry Manufacturers Assc.		IM			
Bureau of Health Professions			DS		

HOSPITAL REPRESENTATIVES

American Health Care System				OPL	
American Hospital Association		IM (2)	DS (2)	OPL	
American Protestant Health Ass.				OPL	
American Osteo. Hospital Ass.				OPL	
Association of Am. Medical Colleges				OPL	
City of Hope				OPL	
Federation of Am. Health Systems		IM (2)	DS	OPL	
Healthcare Fin. Management Ass.				OPL	
Jewish Hospital Representatives				OPL	

Nat. Ass. of Children's Hosp. & Rel.			OPL (2)
Nat. Ass. of Psychiatric Hosp. Sys.			OPL
National Council of Community Hosp.			OPL
Premier Hospitals Alliance, Inc.			OPL
The Catholic Health Association			OPL
National Ass. of Public Hospitals		IM	
Abbotsford Clinic Comm. Health Cen.		HRC	
St. Agnes Community Medical Center		HRC	
Fenwick Center (Immunization)	BC	HRC	
Rainbow Babies Children's Hos., OH			DS
Children's Hospital, Wash., DC			DS
Regional Medical Center, Memphis			DS
City of Hope			OPL
Dana-Farbar Cancer Institute			OPL
Fox Chase Cancer Center			OPL
Fred Hutchinson Cancer Res. Center			OPL
Johns Hopkins Oncology Center			OPL
Memorial Sloan-Kettering Cancer Center			OPL
USC-Kenneth Norris Jr., Cancer Hospital			OPL
Arthur G. James Cancer Hosp & Res Inst			OPL
Roswell Park Cancer Institute			OPL
The Univ. of Texas-M.D. Anderson Can Center			OPL

MEDICAL COLLEGES & ASSOCIATIONS

Association of American Medical Colleges	IM	DS	OPL
Association of Professors of Medicine			OPL
Nat. Ass. of Health Career Schools			OPL
Ass. of Med. Sch. Pediatric Dep. Chairmen			OPL
Am. Ass. of Coll. of Osteopathic Medicine			OPL
American Ass. of Colleges of Pharmacy			OPL
American Ass. of Coll. of Podiatric Med.			OPL
American Medical Student Association			OPL
Association of Minority Health Prof. Sch.			OPL
American Soc. for Healthcare Ed. & Train.			OPL
Association for Hospital Medical Education			OPL
Alliance for Continuing Medical Education			OPL
American Ass. of Colleges of Nursing			OPL
Association of Academic Health Centers			OPL
Harvard Medical School			OPL
Penn State, Milton S. Hershey Med. Center			OPL
Temple University, Health Sciences Center			OPL
University of Chicago, Pritzker Sch. Med.			OPL
University of Med. & Dentistry of NJ			OPL
American Association of Universities			OPL
University of Arkansas			OPL
Montefiore Medical Center			OPL
Stanford University			OPL
University of Southern California			OPL
Vanderbilt University			OPL
Johns Hopkins University			OPL

LONG-TERM CARE PROVIDERS

National Association for Home Care		OPL
American Health Care Association		OPL
American Ass. of Homes for Aging		OPL
National Inst. on Adult Day Care		OPL

OPL
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			OPL	
			OPL	
IM			OPL	TF
			OPL	
IM				
IM	DS		OPL	
IM			OPL	

Pharmaceutical Manufacturers Ass.	IM	DS	OPL
Generic Pharmaceutical Industry Ass.	IM		OPL
Nat. Ass. of Pharmaceutical Manufac.	IM		OPL
National Pharmaceutical Alliance	IM		OPL
Pfizer Inc.	IM	DS	OPL
Merck & Co., Inc	IM	DS	OPL
Johnson & Johnson	IM	DS	OPL
Eli Lilly and Company			OPL
SmithKline Beecham			OPL
Schering-Plough	IM		OPL
SYNTEX			OPL
Searle			OPL
Marion Merrell Dow, Inc.			OPL
Bristol-Myers Squibb			OPL
Upjohn Company			OPL
Glaxo			OPL
Warner-Lambert			OPL
American Home Products			OPL
Abbott Laboratories			OPL
IVAX			OPL
PAR Pharmaceutical			OPL
Group of Pharmaceutical Companies		DS	

American Pharmaceutical Association			OPL
American Soc. of Consultant Pharmacists			OPL
American Soc. of Hospital Pharmacists			OPL
Medco Containment Services	IM		OPL
National Ass. of Chain Drug Stores	IM	DS	OPL
National Ass. of Retail Druggists	IM	DS	OPL
National Pharmaceutical Association			

INSURANCE

Health Insurance Ass. of America	IM		OPL
Aetna Life & Casualty	IM	DS	OPL
Prudential Life Insurance		DS	OPL
CIGNA Corporation	IM	DS	OPL
Travelers	IM	DS	OPL
Metropolitan Life	IM	DS	OPL
Massachusetts Mutual Life Ins. Co.			OPL
New York Life Insurance Company			OPL
Mutual of Omaha Companies			OPL
General American Life Insurance			OPL
Phoenix Home Life Mutual Ins. Co.			OPL
Delta Dental Plans Association			OPL
American Family Life Ass. Co., Inc.			OPL
Blue Cross/Blue Shield Association	IM		OPL
Blue Cross/Blue Shield of Ohio	IM		
Independent Ins. Agents of America			OPL
Self Ins. Institute of America			OPL
Julia Norrell & Associates			OPL
The Principal Financial Group			OPL
American Health Insurance Agents			OPL
National Ass. of Health Underwriters			OPL
National Assc. of Prof. Ins. Agents	IM		
National Academy of Social Insurance		DS	

WORKERS COMPENSATION INSURERS

ITT Hartford		OPL
CIGNA Corporation		OPL
Kemper National Insurance Company		OPL
Aetna Life and Casualty Group		OPL
American Insurance Association		OPL
Health Policy & Strategy Ass.		OPL

WOMENS HEALTH CARE

Alan Guttmacher Institute		OPL
American Association of University Women		OPL (2)
American Medical Women's Association		OPL
Bass & Howes		OPL (2)
Campaign for Women's Health		OPL (2)
NARAL		OPL (2)
National Black Women's Health Project		OPL (2)
National Women's Health Network		OPL
National Women's Law Center		OPL (2)
Planned Parenthood Federation of America		OPL (2)
Women's Legal Defense Fund		OPL (2)

MENTAL HEALTH GROUPS

Children's Mental Health Research Group	TG	
American Psychological Association	TG	OPL
National Depressive/Manic Depressive Association	TG	
Mental Health Research Group	TG	
Carter Center	TG	

CONSUMERS

CONSUMER GROUPS

Citizen Action		IM	OPL
Consumer Federation of America	AG		OPL
Consumers Union			OPL
National Consumers League			OPL
Public Citizen			OPL
Families USA	BC	IM DS	OPL
National Farmers Union			OPL
National Council of Churches			OPL
Children's Defense Fund			OPL
Child Welfare League			OPL
Church Women United			OPL
United Church of Christ			OPL

SENIOR CITIZENS

AARP	BC	IM DS (2)	TF
National Council on Aging			OPL
National Council of Senior Citizens	BC	IM	OPL
Older Women's League			OPL
Nat. Cttee to Pre. Social Sec. & Medi.			OPL
National Hispanic Council on Aging			OPL

DISABILITY GROUPS

Nat. Ass. of Prot. & Advocacy System		OPL
Disability Rights Ed. Defense Fund		OPL
United Cerebral Palsy		OPL
The Arc		OPL
Epilepsy Foundation of America		OPL
American Speech-Language-Hear. Ass.		OPL
National Council on Independent Living		OPL
AIDS Action Council		OPL
Nat. Ass. of Dev. Disabilities Councils		OPL
Pres. Cttee on Employ. of People w/ Disa.		OPL
Disability Rights Education Fund		OPL
ADAPT of Texas		OPL
ADAPT		OPL (2)

CHILDREN & PRENATAL REPRESENTATIVES

Zero to Three/Nat Cent for Clin Infant Prog	OPL
Virginia Perinatal Association	OPL
National Ass of Dev Disa. Councils	OPL
Association for Care of Children's Health	OPL
National Easter Seal Society	OPL
Child Welfare League of America	OPL
National PTA	OPL
American Public Welfare Association	OPL
National Ass of Child Care Res & Ref Ag	OPL
Association of Mat & Child Health Prog	OPL
National Comm to Prevent Infant Mortality	OPL

National Black Child Development Institute			OPL
Child Care Action Campaign			OPL
Kids Count-Cent for Study of Social Policy			OPL
March of Dimes Birth Defects Foundation			OPL
National Head Start Association			OPL
Children's Defense Fund	DS		OPL
Save the Children	DS		
National Commission on Children Summit	DS		

COALITIONS

Campaign for Womens Health	IM		OPL
National Leadership Coal. for Health Care Ref.	IM		
Health Care Delivery Advisory Group	IM		
Hispanic Health Care Leaders	IM		
Rainbow Coalition		DS	
National Coal. of His. He & Hum. Ser. Org. (COSSMHO)		DS	
Long Term Care Home Health Care Coalition	IM		
Consortium for Citizens w/ Disabilities		DS	OPL
Generations United		DS	
National Child Abuse Coalition			OPL

• BUSINESS

BUSINESS ORGANIZATIONS

ARCO			TF
AT&T			TF
PEPCO			TF
American Business Conference	IM		
Association of Priv. Pensions & Welfare Plans	IM		
Business Roundtable	IM		
Chrysler	IM		
Ford	IM		
General Electric	IM		
General Motors	IM		
International Communications Industries Assc.	IM		
National Ass. of Small Bus. Investment Co.	IM		
National Association of Women Business Owners	IM		
National Retail Federation	IM		
National Small Business Legislative Council	IM (2)		
National Small Business United	IM	DS	
National Moving and Storage Association	IM		
National Federation of Independent Business	IM		
U.S. Chamber of Commerce	IM (2)	DS	

• LABOR

LABOR GROUPS

AFL-CIO	HRC	IM	DS	
AFSCME		IM	DS	OPL (3)
Communication Workers of America				OPL
Graphic Artists Guild				OPL
SEIU	HRC	IM		OPL (2)

Screen Actors Guild/AFTRA

IM

Employee Benefit

HRC

Brotherhood of Teamsters

OPL

Communication Workers of America

OPL

Oil, Chem. & Atomic Workers Int. Union

OPL

Unit. Elec., Radio & Machine Workers of America

OPL

ACTWU

OPL

United Auto Workers

DS (2)

• LAWYERS

LAW GROUPS

Trial Lawyers Association of America

IM

• INTERGOVERNMENTAL

INTERGOVERNMENTAL

Association of State & Teri. Health Officers

IM

National Governors' Association

IM

National Association of Insurance Comm.

IM

National Association of County Officials

IM

National Council of State Legislatures

IM

National League of Cities

IM

U.S. Conference of Mayors

IM

DS

DS (2)

American Public Health Association

OPL

• OTHER

Jackson Hole Group

IM

DS (3)

Brookings Institute

DS

Arkansas Able

DS

Pan American Health Organization

DS

American Foundation for AIDS Research

DS

South Main Center Association, Houston

DS

OFFICE OF PUBLIC LIAISON
ROUTING SLIP

*Need for
Tomorrow
mtg w/ I M*

APR 23 1993

DATE:

4/20

FROM:

Mike Lux

TO:

Alexis Herman

Amy Zisook

Doris Matsui

Andrew Morin

Flo McAfee

Chris Lin

Howie Davis

Dan Wexler

Marilyn DiGiacobbe

Dana Wyckoff

Mike Lux

Paul Jackson

Wendy Nishikawa

Debbie Fine

Ruby Moy

Steve Hilton

Other

THE ATTACHED IS FOR YOUR:

INFORMATION

X

ADVICE

ACTION

COMMENTS:

DRAFT

Schedule for White House Health Briefings:

Week of February 15

1)	AMA	small group	Ira	(already set)
2)	AHA	small group	Ira or Judy	
3)	HIAA	small group	Ira or Judy	
4)	NFIB	small group	Ira	

Meetings where they bring in only one to three of their top lobbyists/leaders for a conversational meeting with Ira.

Week of February 22/March 1

A. Meetings of thirty to forty people grouped in the following way:

- 1) Disability Groups
- 2) Consumer Groups (including some aging groups)
- 3) Insurance Companies
- 4) Insurance Agents
- 5) Physicians
- 6) Nurses (from ANA, SEIU, AFSCME)
- 7) Hospitals
- 8) HMOs
- 9) Consumer Groups
- 10) Drug Manufacturers
- 11) Pharmacists
- 12) Long-term Care Provider Groups
- 13) Single Payer Advocates (including some aging groups)

B. Meeting with the President and Mrs. Clinton with Leadership Council for Health Reform.

Week of March 8

Business meetings:

A.

- Series of meetings with CEOs, small business owners, trade associations, traditional business umbrella groups.

- Begin to emphasize invites to businesspeople from legislatively targeted states and districts.

B. Hearings

Week of March 15

Consumers:

- Series of meetings with:
 - labor unions
 - aging organizations
 - disabilities groups
 - general consumer groups
 - minority groups
 - children's groups
 - women's groups
- Continue to make heavy invites to people from targeted states and districts.

Week of March 22

Opinion leaders from targeted states/districts:

- Make the emphasis of the week to bring in cross-cutting groups of opinion leaders from the ten most important states or districts in the country (in terms of Congress).

All through April, we should set the meeting schedule based on two things:

- 1) Inoculation: emerging crises
- 2) Ginning up our allies

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Florida Health Program

Divider Title: _____

FLORIDA HEALTH CARE REFORM: TALKING POINTS

- * We commend Florida's leadership in addressing the crucial issue of health care reform. Floridians realize that we can wait no longer to reform our health care system; we must have health care reform this year.
- * Florida's plan is rooted in the private sector and builds on their employer-based system to make it easier for all businesses -- large and small -- to provide health care to their employees. We applaud Florida and Governor Chiles for bringing affordable health insurance within the reach of small businesses -- who are hit hardest by our current health care system.
- * Our national health care reform proposal will pick up where states like Florida left off -- to give American families the peace of mind they need and bring spiralling health care costs under control.
- * Within the broad guidelines of our national reform strategy, we are committed to giving states the flexibility to design a program that best meets the needs of their citizens.

Summary of Florida's Proposal

- * On April 3, 1993, the Florida legislature approved an innovative health care reform plan, which aims to increase security for all citizens and control health costs.
- * The Florida plan will create a community health purchasing alliance [CHPA] in each region throughout the state. These alliances will pool large groups of individuals and businesses, using this purchasing power to negotiate an affordable comprehensive health care package for its members.
- * Ninety-five percent of all Florida businesses employ 25 or fewer employees; insurance reforms to prevent these small companies from being discriminated against are an essential component of Florida's proposal. This plan will also create a partnership between insurers and providers, encouraging them to work together to provide a comprehensive package of benefits to all citizens and ensure them the highest quality care available.

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Health Care Groups Strategy

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

PRIVILEGED AND
CONFIDENTIAL

DETERMINED TO BE AN ADMINISTRATIVE

April 19, 1993

MARKING INITIALS: *W*

DATE: *7/13/11*

2012-07416

MEMORANDUM FOR HILLARY RODHAM CLINTON

SUBJECT: Interest Group Strategy on Health Care

FROM: Mike Lux

cc: Melanne Verveer
Bob Boorstin
Ira Magaziner
David Wilhelm

Celia Fisher
Chris Jennings
Alexis Herman
Steve Hilton

Given that we are approaching the end game in terms of our presentation of the health care package, and given we now have a good sense of our likely organizational opponents, I wanted to do an overview of what groups I think we must have enthusiastically on board in order to win this fight. We know the opposition will give it their all to stop us: we can't afford to have certain major groups who should be with us either sit it out or be lukewarm in their support.

Although they will not be our only opposition, I think our most active and effective opponents will be a coalition of three powerful small business groups: NFIB, National Restaurant Association, and Independent Insurance Agents of America. These three groups are large, extremely well funded, and have active members in every Congressional district. Worse, they have traditionally proven effective with our target group of conservative Democrats and moderate Republicans.

In order to counter this and our other opposition, I think it is absolutely vital that we do the following:

1. Attract a critical mass of large business CEO and small business owner endorsements. It is important to have a nationally impressive group to build a sense in the national media that our business support is broad and deep. It is even more important in targeted states to counter the grassroots efforts of our small business opposition. We have put together a

business outreach team, chaired by Alexis Herman, to begin building our business support for health care reform.

2. Gain the support of enough health industry groups to provide us credibility with the public. Among the most important:

- at least one, if not all, of the major pharmacists groups. As trusted small business people, they can provide us a lot of cover. Our best shot is with NARD.
- at least three or four physicians groups such as American College of Physicians, American Pediatric Association, American Association of Family Physicians, National Medical Association.
- American Nurses Association.
- National Association of Social Workers.

Overall, I think we are well on the way to accomplishing this goal.

3. Secure the enthusiastic support of labor, including the AFL-CIO, all of its major affiliates, and the NEA. If we don't have labor united and completely behind us, we'll never tie down the Democratic base in Congress, and we just won't have the muscle to put this over the top.

4. Gain the support of seniors groups, including the AARP, the National Committee to Preserve Social Security, and the National Council of Senior Citizens. These groups are the only constituency that have the grassroots ability to be a counterweight to the small business groups. Just as importantly, if they aren't on our side educating their members, it will be very easy for our opposition to stir up their fears about choice of doctor and rationing.

5. Gain the support of major national consumer groups, which are all single payer advocates. Most important are Citizen Action, Consumer Federation of America, and Consumers Union. From a media point of view, I think it's a disaster to not have the strong backing of most of the big national consumer groups. Our polling indicates that they have more credibility than any other group on the health issue. They also provide us with our second biggest grassroots network outside of seniors groups.

I honestly believe that unless we: (a) have the kind of business coalition I talked about already developed and ready to go, (b)

get the support of most of the provider groups I mentioned, and (c) get the strong support of all or most of labor, national seniors groups, and national consumers groups, that we are dead on arrival. We have to do all of these things to win. These are the must have groups: any other support we get on top of that is helpful, but in my view not essential.

Fortunately, I believe the package we are putting together will probably succeed in gaining that support. We continue to have many political hornet's nests to deal with, but we are better off in terms of interest group positioning (at this stage in the process) than I would have predicted. Our opposition will be fierce and effective, but the kind of coalition I have outlined can overcome that opposition.

14cc

THE WHITE HOUSE
WASHINGTON

March 9, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

MAR - 9 1993

SUBJECT: ORGANIZATIONAL STRATEGY ON HEALTH CARE

FROM: Mike Lux

It is an appropriate time right now to do an overall review of our health care outreach efforts and to build on the planning we've already done. In terms of the meeting calendar we laid out a month ago in internal planning meetings and memorandum, we are right on schedule, and many of the goals we had set out for ourselves have been met. However, the health care industry is so stressed out by what we are doing that the pressure cooker on us is going to continue to build.

Our primary focus in the first round of interest group meetings was the health industry itself, although we've had considerable dialogue on the consumer side as well (especially with aging groups and single-payer advocates.) Either in meetings between leaders of one major group with Ira and/or myself, or in small group meetings (25 or less) of industry representatives, we have now met with representatives of over 150 national associations or major businesses. Among those sectors we've met with are physicians, nurses, pharmacists, pharmaceutical manufacturers (including generics), insurance (both companies and agents), long-term care and hospice providers, managed care providers and hospitals. The goals of these meetings have been the following:

1. Give the health industry groups a clearer understanding of our process. This we've done. While they obviously aren't all happy with it, I believe most have come away with a much clearer understanding of our timeline and our process.
2. Send a clear message that those who want to be constructive are invited to continue talking with us. That has been done, and already the follow-up to these meetings has begun to make clear who is ready to really engage us in constructive dialogue, and who clearly is not.
3. Create and reinforce existing splits in provider ranks. While some (most publicly the AMA) have reacted very cynically to being invited to meet, others have indicated how pleased they are to be involved and that they may even be willing to help.

4. Be able to build our case to Congress and the media that while not everybody likes us, we have indeed reached out and had substantive conversations with many different groups. We have done a better job of actually doing that than we have of convincing the media that it's been done.

5. Substantively learn what different groups feel most strongly about and how their policy thinking is evolving. I know I've genuinely learned from these meetings, and I think Ira, the working group leaders, and the other staff who have participated have as well.

The other set of outreach we've had the most so far has been with consumer groups: senior citizens, disability groups, the AFL-CIO, and single-payer consumer groups. Those meetings and conversations have also been very useful for finding out what issues are most vital to whom, and how groups are trying to position themselves relative to the Administration. I also believe most of these groups, particularly the most important ones, feel very positive about our relationship with them right now. I will cover these groups more below when I talk about working with our probable allies.

Where We Go From Here

The following components of an interest group strategy are absolutely crucial to winning this fight:

1. Keep the health industry divided, sector from sector and within sectors. In other words, we need to both keep the different major sectors - doctors, hospitals, insurers, pharmaceuticals - shooting at each other; and we need to make sure some players in each sector are with us. I believe we have an excellent start on both goals. Some examples:

- While the AMA continues to attack us publicly, the AHA has been happy to take a very positive tone. And the AMA itself appears in some disarray internally, slapping at us in the media and reaching out to us through their letter at the same time.

- Pharmaceutical manufacturers are certainly not happy with us, but appear to be at least partly cowed by fear that further public attacks will drive down their stock prices even more. And both Johnson & Johnson and Merck appear to want to break ranks with their industry on major issues. Meanwhile, both generic manufacturers and pharmacists seem ready to play ball.

- HIAA also appears to be caught in its internal divisions as different sectors of the industry fear being sold out by each other.

2. Bring in enough big and small business support to counter those businesspeople, especially the small ones, who fear change. Because I felt the early urgency was in dealing with the health industry, and because I believe that our aggressive courting of business on the economic plan would carry over to health care because of the relationships built, we have not yet spent much time dealing with non-health related business. That will change in a big way this week. We've set up a series of meetings for Ira with all different kinds of businesses and their associations, and an aggressive business meeting schedule for Ira, myself, and others, will continue from this point forward.

3. Solidify and energize our most likely allies. Although who our allies are depends on how we end up policy-wise, I have high hopes that certain groups will help us a lot. In fact, one of our most important policy considerations must be that we craft a package that allows the groups that want to be enthusiastic to be enthusiastic. In the meantime, I think we need to spend a lot of our outreach time consulting, stroking and strategizing with that potential base. This includes:

- AFL-CIO and its affiliates, including key single-payer unions such as AFSCME, Teamsters, UAW, CWA and IAM.
- Aging groups, most importantly AARP, but also Families USA, National Council of Senior Citizens and the National Committee to Preserve Social Security and Medicare.
- Nursing groups, especially American Nurses Association.
- The other single-payer groups, including Citizen Action, Consumer Federation of America, the National Association of Social Workers, National Council of Churches, and National Farmers Union - who are more likely to go with us in the end. (There are some of those groups that are unlikely to ever be with us because we don't pass their purity test, but they will be isolated and insignificant if the single-payer unions and these other groups join us.)
- Women, children, and minority advocates.

Resource Allocation

I'm convinced our toughest hurdle in passing health care is managing the interest groups. We simply don't have the staff

time to do what the never-ending supply of groups want us to do, namely meet with them endlessly. We need to increase the amount of time we spend cultivating the business community and working with the base groups. We need to keep talking with the health industry to keep them divided and bring some of them inside, but we need to step up the courting of business and our most likely potential allies.

In order to keep health industry groups calm, we should schedule more meetings for them (not as much as they'd like but a reasonable level) with working groups. In addition, Secretary Shalala, Ira, Judy Feder, and myself should all continue to plan a couple of hours a day just for health industry meetings (and hopefully we can get some assists from others from time to time.)

All of the above listed people will need to spend considerable time meeting with business leaders and base groups as well. I, in particular, will step up my pace of meetings with the base groups. And I know Alexis Herman and Amy Zisook are planning to play a major part in business outreach on health care, just as they have on the economy.

Summary

More than any other issue, health care is where special interests have caused gridlock and a system that doesn't work for the American people. Managing our relationships with all these groups is therefore going to be a great challenge with people continuing to shoot at us from every direction. However, with a good pro-active strategy, the momentum we've got at this moment in history, and the great communicative power of you and the President, I'm still very optimistic.

cc: Alexis Herman ✓
Steve Hilton
Ira Magaziner

Bob Boorstin
Chris Jennings
Celia Fisher

Clinton Presidential Records Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

HEALTH CARE MTGS

Divider Title: _____

April 22, 1993

MEMORANDUM FOR RUBY MOY

FROM: MARILYN DIGIACOBBE

SUBJECT: AMH SCHEDULE
HEALTH CARE BUSINESS STRATEGY MEETING

To follow-up on our conversation of yesterday, I need a scheduled time this afternoon or tomorrow for a health care business strategy meeting. This is an internal meeting and can be held in AMH's office. We need 1 hour on Alexis' schedule for this meeting. Please let me know as soon as possible, because there are people in other departments who need to be notified of the meeting time.

Thank you.

**Blue Cross
Blue Shield**
of the Rochester area



Cleve Killingsworth
Senior Vice President

Gateway Centre
150 East Main Street
Rochester, New York 14647
716-238-4500

*Am4;
He will meet w/
Mike just if he
can it meet w/
you.*

APR 27 1993

April 26, 1993

Dear Ms. Herman:

It was good to meet you at the Executive Leadership Council's recognition dinner for Secretary O'Leary last Thursday.

As I mentioned during our talk, in view of the President's comments about the Rochester health care system, I believe that it is important that we work together to assure that Rochester health care leaders are supportive of his reform proposals. ||

I would like to schedule a meeting with you to learn more about the status of the proposals and to assess the implications on the Rochester system. In this way we can begin developing a strategy to build support.

I will call your office to discuss how you would like to proceed.

Sincerely,

Ms. Alexis Herman
Assistant to President Clinton
and Director of Public Liaison
The White House
West Wing
Washington, D.C. 20500

cc To Mr. Lutz
741

THE WHITE HOUSE
WASHINGTON

April 7, 1993
415
Roosevelt Room

APR 7 1993

TO: Wednesday 4:15 p.m. Health Care Meeting Participants
FROM: Carol H. Rasco *CH*
SUBJ: Agenda
DATE: April 7, 1993

As I have mentioned to some of you, the President hopes to keep this meeting somewhat limited in size to allow for a full discussion among the participants. In lieu of a traditional agenda the President has asked me to distribute the attached material which I used in briefing him on Tuesday as a follow up to the meetings held in my office Thursday through Monday. He agreed that we needed to start the next series of meetings with a full discussion of the "timeline" issues. This document is again only a starting point; it is not a document reflecting decisions already made....we encourage full discussion on all points.

We hope this afternoon at the conclusion of the meeting to give you a schedule of meetings for the next two weeks.

Thank you.

SUBJECT: Announcing a time schedule for unveiling your national health reform plan and introducing legislation

1. ACTION-FORCING EVENT

Recent press reports have created uncertainty around the timing of introduction of your national health reform plan. This uncertainty is having a major impact on both Congress and the general public and is diminishing chances for enactment of major reforms. Therefore, this week you should announce a schedule for unveiling the plan and introducing legislation.

This memorandum proposes a time frame for meeting your original deadline in a consistent fashion. It also identifies the separate stages, products, and sub-dates that meeting this time frame entails. Finally, we set forth the factors that you need to consider in deciding whether you wish either to proceed with this plan or to alter it in one or more respects.

2. BACKGROUND/ANALYSIS

You have stated that no other area of domestic policy is in greater need of comprehensive reform than the nation's health care system. At the heart of the problem -- the millions of uninsured persons, the millions more who are on the verge of losing coverage, and the inequitable access to quality care -- is one overriding dilemma: the system's enormous cost. The cost of American health care fundamentally threatens the private economy. It threatens the vitality of the federal, state and local governments. And it undermines the security of today's insured Americans in the future of their own health coverage.

For all of these reasons, health care ranks at the top of your policy agenda. In January you identified health reform as one of the centerpieces of your first Presidential term and appointed the First Lady to head a task force that would study the problem and recommend comprehensive reforms.

Immediately following your inauguration you formed an Interagency Task Force on Health Care Reform and announced that within 100 days a comprehensive plan would be prepared. After several months of major effort, Task Force staff have developed several proposals for you. Given the nearness of their completion date, a time line for unveiling the plan to the public and to the Congress is essential.

Phases for releasing the plan, with a proposed time line

It is increasingly evident that the task of unveiling the plan to both the American people and Congress actually entails several separate and identifiable phases, each with its own substantive and strategic considerations.

In my discussions with senior members of the Administration over the past several days, we have identified a series of activities that, taken together, constitute a three-part process for unveiling the plan. The first phase is the report of the Task Force. The second is your own major address to Congress and the American people. The third and final phase is the actual introduction of legislation.

This three-part time frame for this process begins this week, with your final decisions on a series of over-arching policy matters that must be resolved in advance of the final Task Force report.

The major points in this three-part process are the week of May 10th (when the Task Force reports to you), May 25th (when you speak to Congress) and the days immediately following the Memorial Day recess (when formal legislation is submitted to Congress).

The time schedule

1. You announce your national health reform time schedule this week.
2. In a series of meetings with the Cabinet and other key members of the Administration, you make final decisions with respect to those issues in which your direct and personal involvement is pivotal. **(Complete by April 15th)**
3. The Task Force formally presents its findings and recommendations to you. **(Between May 10th and May 15th)**
4. You announce the broad outlines of your decision and plan in a major address **(May 25th)**.
5. You submit legislation immediately following the recess **(June 1 or 2)**.

As these phases unfold, the following events are occurring, beginning when you make your final decisions:

○ Consultation with Congress at the Senior Staff level begins. Negotiations proceed from April 19th throughout May in order to permit as much policy consensus as possible.

○ Beginning after the Task Force presentation to you and before your speech to Congress you begin direct negotiations with Congress.

○ By May 5th, a preliminary legislative draft of the proposal is prepared, based on your final decisions and ongoing consultation with Congress. This draft embodies both your decisions, the Task Force recommendations, and modifications made as a result of the Congressional/ Senior Staff preliminary consultation process.

○ The draft is circulated for review to a highly select group of Administration officials and members of Congress.

○ The legislation also is used by members of the Administration to prepare budget, tax and impact analyses.

○ Your policy consultation process with Congress is completed and legislation is finalized by the Memorial Day speech.

○ The entire legislative package (including materials for the general public, press and accompanying materials for introduction) are developed throughout May.

We believe that these steps permit you to:

○ consolidate the position within the Administration through consultation with the Cabinet,

○ surface and test the broad principles of reform in advance of formal introduction of legislation,

○ begin to build public support in advance of the submission of legislation, and

○ assure consultation with Congress prior to the actual introduction of a bill while nonetheless maintaining control over the important initial legislative development stage

Considerations in accepting or modifying this proposed schedule

In determining whether this proposed schedule makes sense or should be modified at one or more points, we have identified the following issues for you to consider:

1. The urgency of the issue: Do you consider that completion of national health reform by early 1994 at the latest is essential? If so, then given the complexity of this issue, formal introduction of a bill should occur no later than the beginning of June. This is particularly true given the probable need to phase in the reforms because of budget considerations. Assuming 1994 passage, by 1996 coverage reforms should be under way. Later passage might delay these crucial effective dates.

2. The need to rally strong public pressure for reform: The monumental task of enacting sweeping national health reform will be possible only with broad and sustained public pressure. Your political, communications and outreach staffs have concluded that in order to most effectively reach the public and keep their involvement sustained over the many months that enactment could consume, you must launch the initial public phase of this effort no later than Memorial Day. A major public and grassroots campaign is now being readied. If the public unveiling of your broad plan outline is delayed until the summer, then communications experts raise concerns that the thrust of the message will be lost to the slower summer months.

3. The need for consultation with Congress prior to introduction of legislation: This schedule is designed for you to formally set in motion a short but adequate consultation period with Congress. By delaying introduction of the actual legislation until both you and your senior staff have had extensive policy and political consultations with the House and Senate, we hope to assure that the legislation which ultimately is introduced addresses as many concerns as possible and assures you of the broadest possible Congressional support.

4. The need to assure the most accurate cost, revenue, and economic impact estimation possible. By planning introduction of the legislation at the beginning of June, we have built in sufficient time for this essential companion (and detailed) body of work to be completed.

5. The Congressional schedule. In light of the budget reconciliation schedule, there is a need to balance the speed with which actual legislation is submitted to Congress against their need to complete work on the reconciliation package by Memorial Day. With very few legislative days left, and with the same Committee Members and staff essential to both Reconciliation and the health reform effort, the month of May is needed to complete the legislative negotiations while also completing action on reconciliation.

On a matter this crucial and complicated, careful consultation with Congress is also critical. The later date on which we propose introduction of actual legislation permits such consultation.

6. Time to adequately resolve several important remaining issues. Over the next 10 days your input on the most crucial and fundamental questions raised in this legislation will be essential if the May strategy we outline is to succeed. This proposed schedule permits your staff to complete this decision-making process with you while still meeting both the broad policy release and detailed legislation schedules outlined above. Follow-up memoranda on these decisions are now being prepared.

III. RECOMMENDATION

In light of these considerations, we recommend that you approve a three-part "unveiling" plan that assumes a Task Force release by May 10th to 15th, a major speech on May 25th, and the submission of legislation immediately following the Memorial Day recess. We also recommend that this week you publicly announce your schedule for proceeding.

Amit's
FYI

Memorandum

TO: Chris Jennings
FROM: Nancy Bagley
RE: Health Care Meetings
DATE: March 10, 1993

Attached are lists of all the organizations we have met with on Health Care and their breakdowns. Please note that many of the organizations were counted more than once if they had meetings on different issues. The breakdown of all Health Care meetings does not include Transition. It includes Carol Rasco, Ira, and Mike/OPL's lists.

cc: ✓ Alexis Herman
Mike Lux
Bob Boorstin

Health care

Breakdown of Meetings with Health Care Groups

1. Physician Groups	20
2. Consumer Provider Groups	8
3. Managed Care Groups	5
4. Long-Term Care Providers	8
5. Insurance Groups	33
6. Disability Groups	18
7. Drug Manufacturers	28
8. Nurse Groups (Non-Physician Groups)	8
9. Single Payer Advocates	20
10. Hospital Groups	25
11. Pharmacists Groups	10
12. Health Care Industry	22
13. Labor	1
14. Seniors	4
15. Business	10
16. Coalitions	3
17. Intergovernmental	9
18. Children's Health groups	3
19. Congressional	1
TOTAL HEALTH CARE GROUP MEETINGS	226

Breakdown of Meeting with Health Care Groups/ Transition

Disability Groups	8
Health Care Advocates	6
Single-Payer Advocates	17
Religious	7
Children's Health Advocates	22
Minority Groups	6
Rural Interest Groups	3
Mental Health Interests	12
Alcohol And Drug Abuse	5
Employers	21
Insurers	16
Physicians	15
Non-MD Professionals	14
Hospitals	15
Managed Care Providers	10
Other Providers	3
Long Term Care/Consumer	12
Long Term Care/Provider	8
Drug Manufacturers	12
Biotech Groups	6
Pharmacists	4
Purchasers	2
Rehabilitation	2

Laboratories	1
Pharmaceutical/Suppliers	3
Research/Academia	18
Administration/Electronic	4
TOTAL HEALTH CARE MEETINGS	237

HEALTH CARE MEETINGS/TRANSITION

American Academy of Family Physicians
Families USA
Acme Steel
Aetna
AIDS Action Council
Alliance for Aging
Alzheimer's Association
American Academy of Family Physicians
American Academy of Opthomology
American Academy of Pediatrics
American Academy of Physician Assistants
American Association for Marriage and Family Therapy
American Association for Respiratory Care
American Association of Homes for the Aging
American Association of Nurse Anethetists
American Association of Osteopathic Hospitals
American Association of Preferred Provider Organizations
American Association of Retired Persons
American Association of University Affiliated Programs
American Chiropractic Association
American College of Nurse Midwives
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American College of Surgeons
American Congress of Rehabilitation Medicine
American Dental Association
American Family Life Assurance Company
American Federation for Clinical Research
American Federation of Home Health Agencies
American Health Care Association
American Health Information Management Association
American Healthcare Systems Institute
American Heart Association
American Hospital Association
American Iron and Steel Institute
American Managed Care and Review Association
American Medical Association
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Pharmaceutical Association
American Physical Therapy Association
American Podiatric Medical Association
American Protestant Health Association
American Psychiatric Association

American Psychological Association
American Public Health Association
American Society for Internal Medicine
American Society of Consultant Pharmacists
American Society of Hospital Pharmacists
American Society of Microbiology
American Society of Tropical Medicine and Hygiene
American Speech-Language-Hearing Association
Arthritis Foundation
Association for Care of Children's Health
Association for Retarded Citizens
Association of Academic Health Centers
Association of American Medical Colleges
Association of Independent Research Institutes
Association of Maternal and Child Health Programs
Association of Minority Health Professions Schools
Association of Private Pension and Welfare Plans
Association of Schools of Allied Health Professions
Bethlehem Steel
BlueCross BlueShield Association
Catholic Health Association
Center for Science in the Public Interest
Cherokee Nation
Child Welfare League
Child Welfare League of America
Children's Defense Fund
Church Women United
Cigna
Citizen Action
Coalition for the Prevention of Alcohol Problems
College of American Pathologists
Columbia Hospital Corporation
Communicating for Agriculture
Consumers Union
COSSMHO-- Coalition of Hispanic Health and Human Services Provider
Cystic Fibrosis
Delta Dental Plans
Eli Lilly
Employee Assistance Professionals Association
Epilepsy Foundation of America
Erisa Industry Committee
Evangelical Lutheran Church in America
Families USA
Federation of American Health Systems
Federation of American Societies for Experimental Biology
FHP, Inc.
Foundation Health
General American Life
General Motors
Generations United
Generic Pharmaceutical Industry Association
Genetech, Inc.
GMIS, Inc.
Graphic Artists Union

Group Health Association of America
Health and Medicine Council of Washington
Health Care Financial Management Association
Health Care for America
Health Industry Distributors Association
Health Insurance Association of America
Healthcare Compare
Healthcare Leadership Council
Hereditary Disease Foundation
Howard University
IBM
Independent Insurance Agents of America
Industrial Biotechnology Association
Inland Steel
InterHealth
International Brotherhood of Teamsters
Interreligious Health Care Access Campaign
Johns Hopkins University
Johnson & Johnson
Joint Commission for the Accreditation of Healthcare Organizations
Kaiser Permanente
Lutheran General Health Systems
Managed Health Care Association
March of Dimes Birth Defects Foundation
Marion Merrell Dow
Massachusetts Mutual
Mental Health Law Project
Mental Health Policy Resource Center
Merck
Methodist Health Systems
MetPath
Metropolitan Life Insurance Company
Miami Baptist Hospital
Miscellaneous
Mutual of Omaha
NAACP
NAACP
National Alliance for the Mentally Ill
National Ass. of Alcoholism and Drug Abuse Counselors
National Association for Home Care
National Association for Infusion Therapy
National Association of Area Agencies on Aging
National Association of Chain Drug Stores
National Association of Children's Hospitals and Related
Institutions
National Association of Community Health Centers
National Association of Developmental Disabilities Councils
National Association of Life Underwriters
National Association of Manufacturers
National Association of Medical Equipment Suppliers
National Association of Pharmaceutical Manufacturers
National Association of Rehabilitation Facilities
National Association of Retail Druggists
National Association of Rural Electric Cooperatives

National Association of Social Workers
National Association Psychiatric Treatment Centers for Children
National Association Social Workers
National Center for Clinical Infant Programs
National Coalition for Cancer Research
National Coalition to Prevent Impaired Driving
National Commission to Prevent Infant Mortality
National Committee to Preserve Social Security and Medicare
National Congress of American Indians
National Council of Churches
National Council of Community Hospitals
National Council of Community Mental Health Centers
National Council of La Raza
National Council of Senior Citizens
National Council on the Aging
National Farmers Union
National Federation of Independent Businesses
National Health Law Program
National Hispanic Council on Aging
National Indian Health Board
National Institute on Adult Daycare
National Leadership Coalition for Health Care Reform
National Medical Association
National Mental Health Association
National Pharmaceutical Alliance
National Rehabilitation Coalition
National Retail Federation
National Rural Health Association
National Senior Citizens Law Center
National Small Business Legislative Council
National Small Business United
National Steel
Neighbor to Neighbor
NETWORK: A National Catholic Social Justice Lobby
New York Life
Novo Nordisk
Novo Nords
Oil, Chemical, and Atomic Worker Union
Pepsico
Pfizer
Phoenix Home Life
Physicians for a National Health Program
Physicians Who Care
Prudential
Public Citizen
Riverside Methodist Hospitals
Roche Pharmaceuticals
Save Our Security
Schering Plough
Searle
Self Insurance Institute

SmithKlineBeecham
Society of Thoracic Surgeons
Society on General Internal Medicine
St. Joseph's Hospital
Synergen, Inc.
Syntex
T Cell Sciences, Inc.
The Alan Guttmacher Institute
The Arc
The Leadership Council of Aging Organizations
The Long Term Care Campaign
The Oley Foundation
Travelers
U. S. Catholic Conference -- Department of Social Development
U.S. Chamber of Commerce
United Cerebral Palsy Associations
United Church of Christ
United Church of Christ, Office of Church in Society
United Electrical Workers
United Healthcare
United Methodist Church
Urban League
US Catholic Conference
US Health Care
Virginia Perinatal Association
Voluntary Hospitals of America
Washington Business Group on Health
Wellness Councils of America
Wheeling-Pittsburg Steel
Women's Legal Defense Fund

**MIKE LUX/OFFICE OF PUBLIC LIAISON MEETINGS
WITH HEALTH CARE GROUPS**

American Medical Association
American College of Physicians
American Academy of Family Physicians
National Medical Association
American Academy of Pediatrics
American Society for Internal Medicine
American Academy of Ophthalmology
American College of OBGYN
American College of Preventive Medicine
American College of Surgeons
College of American Pathologists
Society on General Internal Medicine
Society of Thoracic Surgeons
Physicians Who Care
American College of Emergency Physicians
Citizen Action
Consumer Federation of America
Consumers Union
Public Citizen
National Council on Senior Citizens
Consumer League
AARP
National Council on Aging
American Managed Care and Review Association
American Association of Preferred Providers
Group Health Association
Managed Health Care Association
HealthCare Compare Corp.
Managed Health Care Inc.
Health Care Working Groups
National Association for Home Care
American Health Care Association (Nursing Homes)
American Association of Homes for Aging
National Institute on Adult Daycare
American Association for Respiratory Care
Hospice Association of America
American Federation of Home Health Agencies
Vidas Organization
Health Insurance Association of America
Aetna
Prudential
Cigna
Travelers
Metropolitan Life
Mass Mutual
New York Life Insurance
Mutual of Omaha

General American Life
Phoenix Home Life
Delta Dental Plans
American Family Life Assurance Company
Blue Cross/Blue Shield
Independent Insurance Agents of America
Self Insurance Institute
Julia Norrell & Associates
The Principal Financial Group
Disability Rights Education Defense Fund
United Cerebral Palsy
The Arc
Epilepsy Foundation of America
American Speech-Language-Hearing Association
National Independent Living Center
AIDS Action Council
Employment of People with Disabilities
Pharmaceutical Manufacturers Association
Generic Pharmaceutical Industry Association
National Association of Pharmaceutical Manufacturers
National Pharmaceutical Alliance
Pfizer Inc.
Merck & Co., Inc.
Johnson and Johnson
Eli Lilly and Company
SmithKline Beecham
SYNTEX
Schering-Plough
Searle
Marion Merrell Dow, Inc.
Bristol-Myers Squibb
Upjohn Company
Glaxo
Warner-Lambert
American Home Products
Abbott Laboratories
IVAX
PAR Pharmaceutical
American Nurses Association
Service Employees International Union
American Federation of State, County and Municipal Employees
American Federation of Teachers
Association for Practitioners in Infection Control
National Association of Pediatric Nurse Associates and
Practitioners
AFSCME
Teamsters
International Association of Machinists
Communication Workers of America
ACTWU

Church Women United
American Public Health Association
Physicians for National Health Program
National Association of Social Workers
National Council of Senior Citizens
Graphic Artists Union
National Farmers Union
National Hispanic Council on Aging
Neighbor to Neighbor
Network
Oil, Chemical and Atomic Workers
United Electrical Workers
United Church of Christ
Public Citizen
Older Womens League
American Hospital Association
The Catholic Health Association
American Protestant Health Association
Jewish Hospitals
University/Research Hospitals
National Association of Children's Hospitals and Related
Institutions
American Osteopathic Hospital Association
American Association of Medical Colleges
Federation of American Health Systems
Primer Hospital Alliance
National Association of Psychiatric Hospital Systems
Healthcare Financial Management Association
American Pharmaceutical Association
American Society of Consultant Pharmacists
American Society of Hospital Pharmacists
National Association of Chain Drug Stores
National Association of Retail Druggists
Medco Containment Services, Inc.

Exhibit A

Page Four

1. ABC Home Health Services, Inc.
2. ✓ Opticians Association of America
3. American Group Practice Association
4. ✓ Camden-Clark Hospital
5. Alzheimer's Association
6. ✓ American Nurses Association
7. National Black Women's Health Project
8. ✓ National Committee to Preserve Social Security and Medicare
9. ✓ National Multiple Sclerosis Society
10. ✓ United Cerebral Palsy Association, Inc.
11. Health Care Leadership Council
12. Chartered Health Inc.
13. ✓ American Pharmaceutical Association
14. American Health Care Management
15. Interactive Health Network
16. ✓ Generic Pharmaceutical Industry
17. Health Industry Manufactures
18. ✓ Pharmaceutical Manufactures
19. ✓ Medics Pharmaceutical Corp.
20. ✓ Association of Maternal and Child Health Programs
21. ✓ National Association of Children's Hospital and Regulated
Institutes
22. ✓ National Commission on Infant Mortality
23. ✓ American Academy of Pediatrics

Meetings with Outside Groups
Ira Magaziner

March 10, 1993

Providers

American Hospital Association
American Medical Association
Association of Academic Surgeons
Federation of American Health Systems
Mayo Clinic
National Association of Public Hospitals

Health Care Industry

Health Industry Manufacturers Association
~~Home~~ Health Care Coalition

Insurance

Aetna
Blue Cross/Blue Shield
CIGNA
Health Insurance Association of America
Metropolitan Life
National Association of Professional Insurance Agents
Prudential
Travelers

Labor

AFL-CIO

Seniors

AARP

National Committee to Preserve Social Security and Medicare (2X)

Business

Chamber of Commerce
Chrysler
Ford
General Motors
International Communications Industries Association
National Association of Small Business Investment Companies
National Retail Federation
National Small Business Legislative Council
National Moving and Storage Association
National Federation of Independent Business (NFIB)

Pharmaceutical Manufacturers

Generic Pharmaceutical Industry Association
National Association of Pharmaceutical Manufacturers
National Pharmaceutical Alliance
Pharmaceutical Manufacturers Association

Pharmacists

National Association of Retail Drug Stores
National Association of Chain Drug Stores

Ira Meetings, cont.

Coalitions

National Leadership Coalition for Health Care Reform
Health Care Delivery Advisory Group

Intergovernmental

National Governors' Association
National Association of Insurance Commissioners
National Association of County Officials
National League of Cities

Meetings on Health Care

Carol H. Rasco

January 28

- ✓ -Governor Romer/NGA Staff
- ✓ -Family Voices (parents of disabled children)

February 1

- Governors at White House
- CHR spoke to COS of Governors

February 4

- ✓ -CHR spoke to Woman's Division of Atlanta Jewish Federation

February 5

- ✓ -Sen. Kennedy

February 8

- ✓ -Mike Wanger of Appalachian Regional Commission

February 11

- ✓ -National Council of Jewish Women
- ✓ -Federation of American Health System
- ✓ -Health Care Leadership Council

February 12 & 13

- 4 meetings with different groups in Mrs. Clinton's Office

February 16

- ✓ -American Jewish Committee
- ✓ -American Speech & Hearing Assoc.

February 18

- ✓ -5 major insurance firms

February 22

- ✓ -Southern Regional Institute on Children & Families

February 23

- ✓ -Coalition for American Children

February 25

- ✓ -Paul Ellwood

March 2

- ✓ -NARD rep.
- ✓ -National Urban League rep.

March 3

- ✓ -NARAL rep.

March 5

-National Commission on Children rep.

March 8

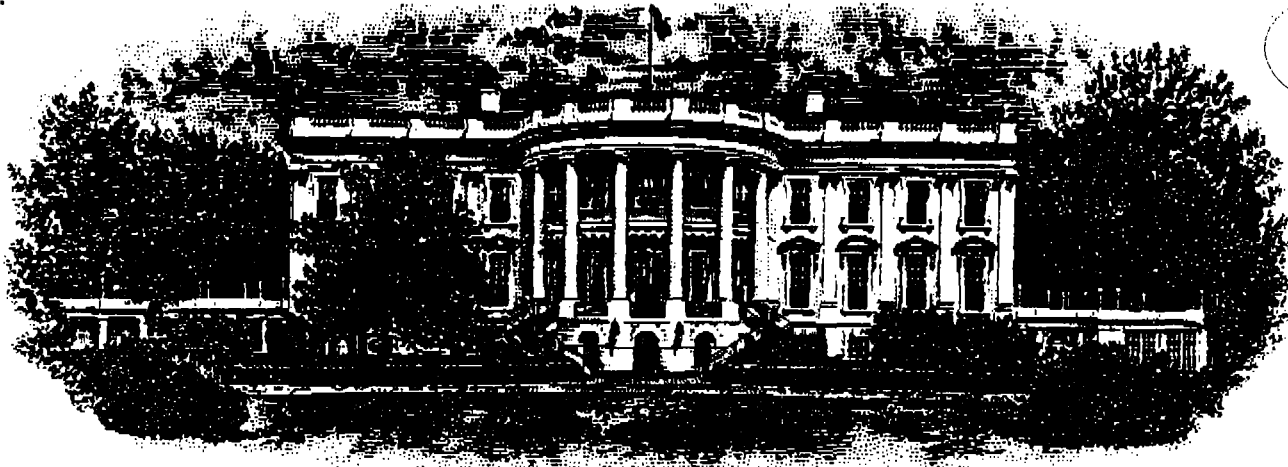
-Alpha Center: Rural Health Care

-Mayor of San Juan

March 9

-6 biotech firms

*NOTE: THIS LIST DOES NOT INCLUDE PRESS



OFFICE OF PUBLIC LIAISON

Alexis Herman, Director
(202) 456-2930
Fax (202) 456-6218

FACSIMILE TRANSMITTAL SHEET

Number of Pages (Including Cover) 7

To Alexis Herman

Fax Number _____

Office Number _____

Date 3/10/93

From NANCY BAGLEY

***** COMMENTS *****

IOWA PANELS

Panel #1: Cost Control

Sal Bognanni, ED, Health Policy Corp of Iowa	(Expert)
Dave Bostrom, Owner, All Pro Golf	(Small Bus)
Charles Bruner, PhD, ED, Child & Family Policy Cntr	(Children)
John Bryan, CEO, Sara Lee	(Big Business)
Charles Edwards, Publisher, The Des Moines Register	(Big Business)
Geraldine Felton Dean, College of Nursing	(Nurse)
Sheldon G. Gilgore, M.D., CEO, D.G. Searle Co	(Pharmaceut)
Steven Gleason, M.D., Mercy Medical Clinic System	(Doctor)
Casey Hayes, University of Iowa	(Disability)
Roger L. Holloway, CEO, Wabash General Hospital	(Hospital)
Brad Lint, Executive Director, Citizens Action	(Consumers)
David Lyons, Insurance Commissioner, State of Iowa	(Insurance)
Dave Neil, Regional Rep, UAW	(Labor)
Bill Peppmeier, Pgm MGR, General Relief Polk County	(Social Work)
Robert D. Ray, CEO, Blue Cross/Blue Shield	(Insurance)
Don Rowan, V.P., Iowa Council of Seniors	(Aging)
Mike Rusk, Director Rural Health Outreach	Grant/Benefits
Counseling	(Advocate)
Noreen Smith, Director, Indian Health Board	(Indian Rep)
Sr. Patricia Claire Sullivan, CEO, Mercy Health Cntr	(Hospital)
Sue Yeakel, Yeakel Pharmacy	(Pharmacist)
Daniel Pitts Winegarden, First Dep Insur Commis	(State)

PANEL #2: PEACE OF MIND

Chris Atchison, State Health Officer	(Public Health)
Katie & Julie Beckett, Waiver child star	(Consumers)
Kirk Bragg, AIDS Greater Des Moines	(HIV)
Steve Bragg, V.P. Human Resources, Rolscreen Co	(Big Business)
David Brasher, Director, Natl Federation of Independent Business	(Small Buss)
Susan Bredman, Physician Assistant	(PA)
Dick Van Dell, President, Heritage Health Plan	(HMO)
G. David Hurd, CEO, The Principal Financial Group	(Insurance)
Kenneth Kurisko, Regional Sales Trainer, Ross Labs/Abbott Labs	(Pharmaceut)
Paul Ogren, ED, Center for Health Access & Reform	(Expert)
Rev. Keith Ratlitt, ?	(Pastoral)
Lucia Riddle, ?	(HMO)
Ruth Rothstein, Chief, Bureau of Health Svs	(Hospital)
Martin Schwartz, Director of Health Affairs, Iowa Farm Bureau	(Insurance)
Tom Tonniges, Rural family doctor	(Doctor)
Jerry Waukau, Health Director, Menominee Tribe	(Native Am)
Eileen Webber, ER nurse	(Nurse)
Jim Wengert, AFL-CIO	(Labor)
Joanne Zimmerman, former Lt. Governor	(Nurse)

PANEL #3: PROBLEMS -- RURAL AMERICANS

Joan Christensen, Broadlawn Medical Cntr	(Subs Abuse/MSW)
Kevin Cunningham, CMO, HMO Iowa	(HMO)
Sara DeCoteau, Tribal Health Dir, Sisseton-Wahpeton Tribe	(Native Am)
Paul Von Ebers, Sr VP Health Benefits, BCBS	(Insurance)
James Fitzpatrick, Kossuth Co. Hospital	(Hospital)
Ron Franks, Dean, Univ of Minnesota-Duluth	(Expert)
Betty Grandquest, ED, IA Dept of Elder Affairs	(Con/Aging)
Herman Hein, Director, IA Stwide Perinatal Care Pgm	(Doctor)
Cheryll Jones, RN	(Nurses)
Eugene Lutz, local pharmacist	(Pharmacist)
Jim Merchant, Director, Institute on Agricultural Medicine, U of Iowa	(Other)
Larry Millroy, Benefits Director, Rockwell Intl	(Big Bus)
Dick Nelson, MCH Director, IA DOH	(Public Health)
Laurence Pearlman, CEO, Ceridien Corp	(Big Bus)
Jesse Singerman, Blooming Prairie Warehouse, Inc	(Womens Health)
Tom Slater, ED, State Public Policy Group	(Expert)
William Smith	(Disability)
Deborah Turner, OB/Gyn in rural area	(Doctor)
Tom Whyte, Owner, Whyte Tire Center (Small bus)	
Nyla Williams	(Disability)

IOWA

PANEL 1 CONTROLLING COSTS

SPEAKER 1(farmer --had to drop family coverage) Betty Lange

SPEAKER 2(Local public health-benefits of immunization)Paul Nannis

Paul Nannis is the Commissioner of the Milwaukee Health Department, who has an incredible story to tell about a measles outbreak which ran a tab of \$5 million for the city, where the costs to immunize at-risk populations would come to \$300,000.

SPEAKER 3(Small Bus owner struggling to retain coverage)Tom Child

PANEL 2: PEACE OF MIND

SPEAKER 1(Person whose coverage dropped after catastrophic illness)

SPEAKER 2 (Insurance agent who helps families)Russ Sporer
Russ Sporer is an independent insurance agent.

SPEAKER 3(Public Health Nurse discussing lack of generalists/primary care) Sandra Crandell

SPEAKER 4(Person who survived complex acute care in tertiary center and is pleased)

PANEL 3: PROBLEMS-RURAL AMERICANS

SPEAKER 1(Young Couple forced to travel long distance for OB care) Glee Christ

SPEAKER 2(Major rural town-recruitment and retention problems) Donna Slaon

Donna Slaon is Mayor of Ogden. She has been struggling to recruit a physician for the small town.

SPEAKER 3(Provider burn-out - rural doc/osteopath)Craig Thompson
Craig Thompson is a rural doctor and osteopath at Strawberry point Medical Center.

SPEAKER 4(Rural hospital administrator) Edward Maahs
Ed Maahs is a hospital administrator at Stewart Memorial Community Hospital.

SPEAKER 5(Manager or MD - rural HMO that works) Fritz Wenzel
Fritz Wenzel is at the Marshfield Clinic.

FLORIDA PANELS**Panel #1: Cost Control**

Patricia Bean, Asst Cty Administrator	(Pub Health)
Barbara Beernhart, E.D., Space Coast Disability Rights	(Disability)
Jim Bracher, Fl. Health Care Purch COOP	(Expert)
Gladys Branick, M.D.	(Doctor)
Bea Braun, Area Agency on Aging	(Senior)
Joe Cuellar	(Pharmacist)
Steve Freedman, Inst. for Child Health Policy	(Children)
Philip Frost, Chairman of the Bd., IVAX	(Drug Mfr)
Townsend Hawkes	(Attorney)
Gary Hickerson, Dir, Fin'l Services, Manatee Mem Hospital	(Hospital)
Kathy Hoover, League of Women Voters	(Expert)
Guy Langlais, Bus Mgr, IBEW	(Labor)
Peter Levin, Dean, USF School of Public Health	(Expert)
Scott Mahan, Medical student, USF	(Med Student)
Bill Mauk, John Alden Life Insurance	(Insurance)
Carol Roush, Dataland	(Small Bus.)
John Reiker, Dir Emp Bens, General Mills	(Big Business)
Aaron Smith, Dept Soc Wk, USF	(Soc worker)
Sharon Spano, parent advocate	(consumer)
Gary Strack, CEO, ORMC	(Hospital)

Panel #2: Peace of Mind

Chris Addams, Prudential Insurance
 Jim Albright, Bayfront Medical Center
 Linda Ash-Jackson, VP, Cigna
 David Bussone, Pres., Tampa General
 Tess Canja
 Henry Carlie, Florida NAACP
 Barbara Dimato, CEO, St. Anthony's
 Colleen Fix
 Jose Pedro Greer, Med. Dir, Pinellas Health
 Concern
 Cecil Harrell, Chair, Pharmacy Mgt Services
 Joshua High, VP, Ryder Systems
 Silvia Ibanez, PA
 Ken Kiehl, Fl. Acad of Family Practice
 Luis Miranda, M.D., Dep Dist Admin for Health
 Cindy Nagel, Fantastic Sam's
 Ree Sailors, Florida Health Access
 Sr. Paula Schwindinger, Pastoral Associate
 Terence Shirley, Tampa Community Health Ctr
 Pat Torenello, FEA
 Additional slot for HIV professional

(Insurance)
 (Hospital)
 (HMO)
 (Hosp Exec)
 (Senior)
 (Consumer)
 (Hospital)
 (Disability)

 (Doctor)
 (Pharmacist)
 (Big Business)
 (Phys. Asst)
 (Doctor)
 (Public Health)
 (Small Bus.)
 (Expert)
 (Social worker)
 (Public Health)
 (Labor)

Panel #3: Elderly Issues

Marilyn Bell, Central Fla Health Care Coalition
 Bob Bobo, owner, Davis Island Pharmacy
 Dan Casady
 Ellen Daley, Womenscare
 Margaret Lynn Duggar, fmr State Aging head
 Juliet Duhan, Administrator, Jewish Center Towers
 Bill Flaherty, Blue Cross/Blue Shield
 Gary Fritch, Medical Supply
 Sr. Mary Haskins, alzheimer's counselor
 Donna Humphreys, OBGYN Nurse Practitioner
 Rhoda Jennings, Senior Advocate
 Charles Mahan, State Health Officer, HRS
 Ana Miyares, Exec Dir, Time Dollar Network
 Ed Peddie, Santa Fe Health Systems
 Ramona Shedroff, Fl. State Council of Sen Cits
 Cecil Wilson, M.D.
 Susan Wilson, Exec Sec./Treas, AFL-CIO
 William Zubkoff, South Shore Hospital

(Business)
 (Pharmacist)
 (Disability)
 (Women's)
 (Senior)
 (Senior Hsg)
 (Insurance)
 (Med Technol)
 (Social work)
 (Nurse Prac)
 (Senior)
 (Public Health)
 (Senior Care)
 (HMO)
 (Consumer)
 (Doctor)
 (Labor)
 (Hospital Admin)
 (Small business)

one additional vacancy

THE WHITE HOUSE
WASHINGTON

JUN - 7 1993

June 3, 1993

MEMORANDUM FOR ALEXIS HERMAN, AMY ZISOOK AND CAREN WILCOX

SUBJECT: Business Targets on Health Care

FROM: Mike Lux

Mrs. Clinton has requested that we come up with a target list of individual businesses we should go after for health care endorsements. Based on conversations with Ira Magaziner and working with health reform coalitions, I have come up with the following list. Please make any additions of Clinton loyalists or others you think appropriate to target.

Business Target List

A & P

Acme Steel Co.
Adams National Bank
American Airlines
American Express
American Income Life Insurance
Apple Computer
Aveda Corp
Ben and Jerry's
Bethlehem Steel Co.
Blue Diamond Growers
Brown and Cole Stores
Burlington Coat Factory
Ceridian Corporation
Chrysler
Clavert Soical Ventures Partners/Calvert Group
Corestates Financial Corp.
Cox Enterprises
Crown American Corp.
Dayton Hudson
DelMonte Foods
Douglas, Emmett, and Co.
Fairwater Capital Corp (Alan Broadbent)
Ford
Franklin Research and Development Corp
General Motors
Georgia Pacific
Giant Food
Great Atlantic and Pacific Tea Company
Gross Electric Inc.
H.J. Heinz Co.
H.S. Dakin Co.
Hanna Anderson Corp
Home Depot
Hormel
Hunt-Wesson
Inland Steel Co.
International MultiFood
Iowa Realty
James River Corp
Johstown Corp
Keebler
Kodak
Levi Strauss
Liberty Mutual
Lincoln Telephone and Telegraph
Lockheed
LTV Steel Co.
Mars, Inc.

National Steel Co.
Norwest
Olympia West Plaza
Pacific Gas and Electric
Pioneer-Hybrid
Preferred Benefits
Quaker Oats
Reebok
Regis Corp
Rhino Records, Inc.
Rockefeller and Co.
Rodale Press
Rohm and Haas Co.
Safeway
Sara Lee
Scott Paper
Southern California Edison
Stonyfield Farm
The Nature Co
The Vons Companies
The Body Shop
The Echelon Group
Time Warner
U.S. Bancorp
UNC Ventures
United Airlines
UNUM Life Insurance Co.
Vermont National Bank
Westinghouse Electric
Wheeling-Pittsburgh Steel Co.
Wisconsin Public Service Corp.
Working Assets
Xerox

Clinton Presidential Records Digital Records Marker

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THE WHITE HOUSE
WASHINGTON

April 23, 1993

MEMORANDUM FOR MARCIA HALE, PATTI SOLIS, AND ALAN HOFFMAN

SUBJECT: Attached Letter

FROM: Mike Lux

The attached letter is from Kathryn Thompson, a Republican CEO who participated in the President's press conference with several other CEOs to show support for the economic package. Her proposal is for the President or Mrs. Clinton to speak to the membership of the Industrial League of Orange County about the health care package. The Industrial League of Orange County has a membership of over 1000 firms, and in attendance at the speech would be approximately 1500 senior level executives.

Business support for the economic package is crucial, and we will need to do several strategic hits to achieve this. I think this is a good opportunity.

Kathryn Thompson and Bob Nelson, who was a key coordinator for Republicans during the campaign, have also offered to help put this together with a series of positive responses from local business people, which we could further coordinate with several media hits.

INDUSTRIAL LEAGUE OF ORANGE COUNTY

March 4, 1993

Mr. Michael Lux
Special Assistant to the President
The White House
1600 Pennsylvania Avenue
Washington, DC

Allen Hoffman

Dear Mr. Lux:

RE: Speaking Engagement for Hillary Rodham Clinton
Before the Industrial League of Orange County

The Industrial League of Orange County wishes to invite Mrs. Clinton to speak before its membership on the subject of health care reform at a time convenient to her schedule.

The Industrial League is a business organization of over 1000 firms which employ more than 150,000 persons in Orange County, California. Our focus is on public policy issues affecting the economic vitality of our area. There is, of course, intense interest and hope among the senior executives comprising our membership that the administration and Congress will succeed in achieving significant reform of health care.

Recent speakers at Industrial League events have included Presidents Bush and Reagan, Prime Minister Thatcher, former HUD Secretary Kemp, Henry Kissinger, William Buckley and Moscow Mayor Gavrill Popov.

Depending on Mrs. Clinton's schedule we would like to arrange a meeting in April or May. We anticipate that the meeting would be attended by 1500 senior level executives of our member companies. However, we will be delighted to work with your office in meeting what ever date is convenient for her.

We look forward to a favorable and early reply. Please don't hesitate to contact me, if you or your staff have any questions (714/472-5814).

Sincerely,

Kathryn G. Thompson

Kathryn G. Thompson
Member of the Board

MAR - 3 1993

AmHS

URGENT

TO: Maria Haley
FR: Melinda Yee
RE: Proposed Asian Pacific American Congressional Delegation
Health Care Meeting with Mrs. Clinton
DATE: March 3, 1993

*Bruce
can you ask
senior staff
whenever they are
scheduling briefly
with minority
groups to
include
American
Asian
is another indication
that there is no
sensitivity to
Asian American
Main*

As seen in today's Washington Post, Mrs. Clinton met yesterday with Congressional members of the Black Caucus and the Hispanic Caucus. Unfortunately, this meeting did not include any of the Asian Pacific American delegation. This morning, I have already been called by Congressman Norman Mineta's Legislative Director Chris Stroebel who has conveyed the message that Congressman Mineta is extremely displeased and would like an explanation of why Asian Pacific Americans were not included in the meeting and on the agenda. Congressman Mineta was the author of the Asian Pacific American portion of the 1990 Disadvantaged Minority Health Improvement Act and has been the leading proponent of Asian Pacific American health concerns.

I would like to propose that Mrs. Clinton host a meeting with the following members to address the unique health concerns of the Asian Pacific American community.

Senator Daniel Inouye (D-HI)
Senator Daniel Akaka (D-HI)
Congressman Norman Mineta (D-CA)
Congressman Robert Matsui (D-CA)
Congresswoman Patsy Mink (D-HI)
Congressman Eni Faleomavaega (D-American Samoa)

As you are well aware, we have already received much political heat from the Asian Pacific American community regarding the lack of Asian Pacific American appointments. We need to rectify this current situation with the Asian Pacific American Congressional delegation immediately.

Please let me know if you have any questions.

cc: John Emerson
Jan Piercey
Maggie Williams
Alexia Herman
Regina Montoya
Rahn Emanuel

Howard Paster

THE WHITE HOUSE
WASHINGTON

March 5, 1993

MEMORANDUM FOR GEORGE STEPHANOPOULOS, BOB BOORSTIN AND
DEE DEE MYERS

SUBJECT: New York Times Health Interest Group Strategy

FROM: Mike Lux

The following groups have said they would be happy to speak to reporters about how pleased they are with our process, particularly in terms of the openness and inclusiveness issues:

AFL-CIO (Karen Ignani, Rex Hardesty, or Tom Donahue)
Citizen Action (Cathy Hurwit or Bob Brandon)
AARP (Jon Rother)
Leadership Coalition for Health Care Reform (Peggy Rhodes)
National Association of Social Workers (Sandy Harding)
American Hospital Association (Rick Wades)
American Nurses Association (Virginia Trotter Betts and Donna Richardson)

Both the American Hospital Association and Citizen Action were called yesterday by the NY Times reporter doing the story, and both had extremely positive quotes which he chose not to use.

cc: Ira Magaziner
Melanne Verveer
Alexis Herman ✓
Steve Hilton

Health care

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Louisiana Health Program

Divider Title: _____

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P.F.

HOUSE OF REPRESENTATIVES

SHERMAN N. COPELIN, JR.
SPEAKER PRO-TEMPORE

March 12, 1993

107 HARBOR CIRCLE
NEW ORLEANS, LOUISIANA 70126
(504) 246-1166
(504) 342-7263

**Hillary Rodham Clinton, Chair
Health Care Reform Task Force
Old Executive Office Building
1600 Pennsylvania Avenue
Washington, D.C. 20034**

Dear Mrs. Clinton:

Per my conversation with you staff, I am forwarding a brief description of Louisiana's current initiative to implement managed competition for our Medicaid enrollees. This model is now being discussed with the Health Care Financing Administration's Managed Care Unit in Baltimore who are extremely interested in the prospect of national application. The approach developed provides for an orderly transition from delivery of health care services on a fee-for-service basis to accountable health plan delivery under a managed competition model.

Utilizing the current options provided States under the Medicaid statutes and regulations, our Department of Health and Hospitals has designed a model which allows provision of health care services through competing health management plans. Through establishment of a state owned and operated Health Insuring Organization, under the statutes requirements enacted by Congress in 1988, Louisiana will establish the first statewide managed competition model in the United States. Our Health Insuring Organization will act as a health care umbrella allowing Health Maintenance Organizations and Prepaid Health Care Plans to market a basic benefits package to Medicaid enrollees beginning July 1, 1993.

As competition and market forces expand the size and number of managed care plans in Louisiana, we will move from voluntary enrollment to mandatory enrollment under a freedom of choice waiver, to allow expansion of Medicaid coverage to all optional groups. While full expansion of Medicaid coverage will increase the cost of providing health care services, the savings generated from full transition of current Medicaid enrollees will result in a net savings to the state and federal governments. At current expenditure levels for Medicaid in Louisiana, we project a total savings of \$630 million based on full transition of current enrollees to competing health care plans with a minimal savings of 15%. Net savings following full expansion of Medicaid to 360,000 uninsured residents are projected at \$60 million which would accrue to the federal and state governments.

*March 12, 1993
Hillary Rodham Clinton
page 2*

The flexibility of the model developed not only allows revitalization of our state teaching hospital system into the largest Health Maintenance Organization in the state, but also provides for full integration of all federal facilities and federal block grant programs for health care.

Following review of the attached briefing paper, I believe you will agree a formal briefing on this model will prove invaluable in addressing numerous national health care reform issues and enhance the development of managed competition for the nation.

Sincerely,



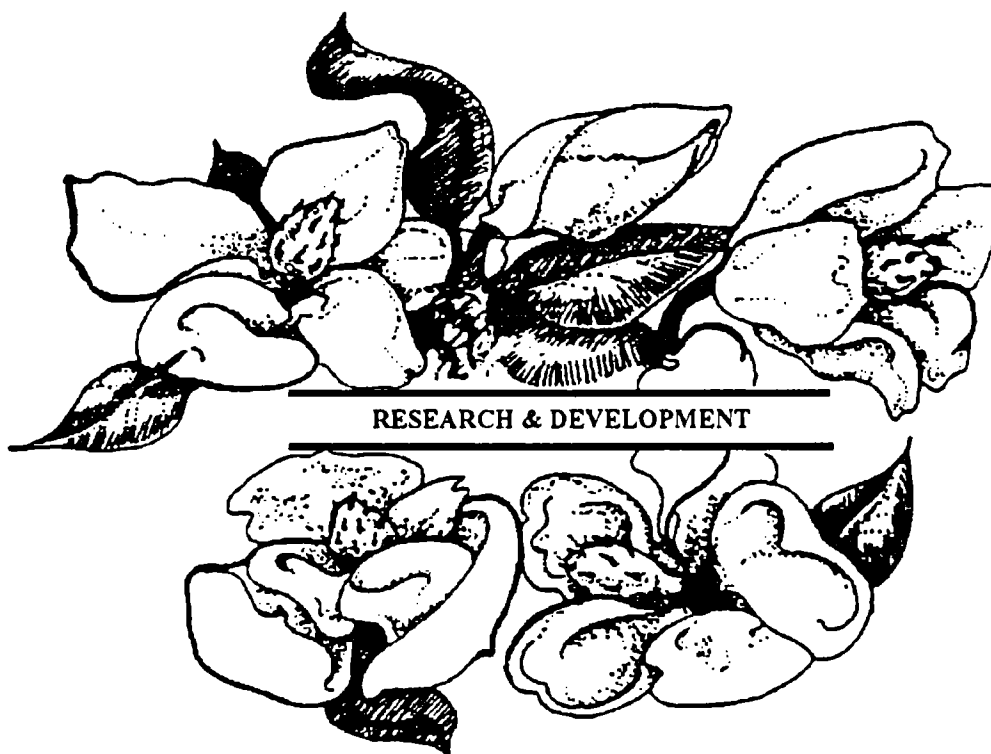
*Sherman N. Copelin, Jr.
Speaker Pro Tempore*

*cc: Ira Magaziner, Senior Adviser
Michael Lux, Public Liaison*

HEALTH CARE MANAGEMENT

A Conceptual Approach To Improving Health Care Access In Louisiana

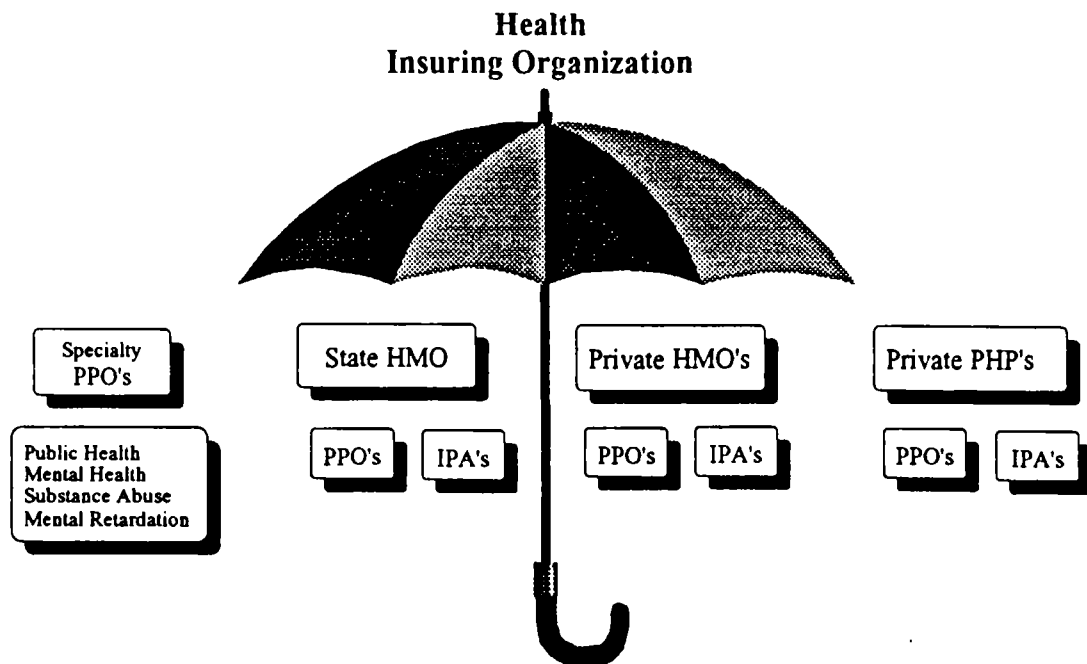
March 12, 1993



DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF THE SECRETARY
BUREAU OF RESEARCH & DEVELOPMENT

EXECUTIVE SUMMARY

- Of the 900,000 uninsured Louisiana residents, approximately 300,000 - 500,000 could be covered directly by Medicaid at a cost of \$608 million (\$438M federal & \$170M state for 360,000 active users of health care services).
- Utilizing the federal option of providing health care services under a state owned Health Insuring Organization will allow combining care management and competition i.e. managed competition, in advance of federal reform legislation to generate the savings needed to finance Medicaid expansion.
- Structuring the Health Insuring Organization as a Health Care Umbrella for competing health care management plans will facilitate expansion of managed care plans in urban areas and development of a rural market. Through initial use of voluntary enrollment, the transition from fee for service to managed competition will be driven by market forces and fueled by the financial incentives available to health care management plans.



- As plan capacity increases transition from fee for service to managed competition can be facilitated utilizing a freedom of choice waiver which will allow Medicaid enrollees a choice of competing health care plans.
- Through transition from fee for service and expansion of Medicaid coverage to optional groups, competing health management plans are provided with a potential market of over 1,000,000 enrollees while the net cost of providing health care is reduced by approximately \$60 million dollars per year.

The Louisiana HIO Proposal--A mini-model of the Clinton Plan

The Louisiana HIO proposal reflects the fundamental health care reform strategies of the Clinton plan for cost containment and expanded access. In addition, due to the state's long tradition of providing health care to the uninsured, restructuring the state health care network into an accountable health plan will assure continued viability of the teaching hospital and clinic system under national health care reform. This proposal allows the state to continue its strong tradition of providing health care to all its citizens; retains and enhances the state's major investment in the state charity hospital system and medical education programs; provides for full participation by federal facilities; and maximizes cost containment. The proposal can be viewed as the ideal "bridge" between the existing system and the national program under development.

The President's Concept: Establish Health Budget Targets Through a Centralized National Board

Louisiana's Proposal:

The health budget target would be effectively established by capitation of Medicaid and utilization of competition among health care management plans to maximize potential savings. This would be accomplished by development of a state-operated Health Insuring Organization (HIO) which would set capitated rates for managed care programs and link individual plan growth to financial stability and profit sharing. Savings achieved by improved primary care, resulting in fewer high-cost services such as hospitalization will act financial incentives for participating plans. Restructuring public facilities into a statewide HMO will maximize market penetration and provide a mini-umbrella for linking federal facilities and programs such as VA hospitals and Federally Qualified Health Centers. Restructuring public health care block grant programs into specialty service organizations will allow full coordination of specialty services and elimination of service duplication. The health budget target would, in effect, be the baseline cost following full transition of Medicaid and block grant programs.

The President's Concept: Expand Access to Health Care

Louisiana's Proposal:

The savings generated from the HIO capitated rate program would be used to expand Medicaid coverage to the fullest extent allowed under federal law. Louisiana currently covers approximately 600,000 citizens under Medicaid and the expansions could provide coverage for up to 500,000 additional persons with 360,000 active users of health care services.

As national health care reform expands health care coverage, the HIO will be capable of expansion or contraction to meet the needs of the residents of Louisiana.

The President's Concept: Create Managed Competition

Louisiana's Proposal:

Utilization of the HIO concept will provide the financial incentive for private insurance transition from indemnification models to health management models. By allowing market forces to react and drive expansion of health care management in the public sector, transition in the private sector will naturally follow. Conversion of basic indemnification models will result from changing dynamics in the health delivery system and provide the experience needed to assure provision of high quality care. The ability of health care management plans to expand into rural areas under the HIO will provide the financial incentives needed for growth and development of managed competition in the private sector with minimal disruption to businesses and industry.

The President's Concept: Establish Health Networks

Louisiana's Proposal:

The Louisiana proposal will maximize utilization of the state's unique public health care system. Services provided by the state's teaching hospitals and clinics will be networked with federally qualified health centers, rural health clinics, small rural hospitals and participating federal facilities to assure the availability of health care throughout the state. Federal block grant health care programs (public health, mental health, substance abuse, developmental disabilities, blind and deaf services), will be networked into a cohesive system to coordinate service delivery and fulfill their missions in their specialty areas, with central management oversight by the HIO.

The President's Concept: Improve Community Prevention and Primary Care

Louisiana's Proposal:

The state public health care system would be improved and re-oriented to track immunizations and screenings for all participating plan members and simplify the delivery of specialized services to women, infants and children.

EXPANDING ACCESS TO MEDICAL TREATMENT THROUGH HEALTH CARE MANAGEMENT

INTRODUCTION

Under federal statutes and regulations which govern the administration of Medicaid, states are provided with options designed to encourage the implementation of health care management initiatives and participation of health care management plans. The Louisiana Department of Health and Hospitals (DHH) proposes to utilize one of the more successful types of health care management, authorized under federal regulations, referred to as a Health Insuring Organization (HIO). Under this approach, the state would establish an HIO within the DHH to act as an administrative umbrella for increasing the availability of competing health care management plans such as Health Management Organizations (HMO's), Prepaid Health care Plans (PHP's), Preferred Provider Organizations (PPO's), and Independent Practitioner Associations (IPA's). Through competition and marketing of health plans to the Medicaid population, access to health care services would be increased while providing a strong financial incentive for expansion of the managed care market throughout the state. Savings resulting from provision of health care through managed competition model will not only reduce the cost of providing health care coverage but facilitate expansion of Medicaid to optional groups of uninsured residents.

In conjunction with establishing a Health Insuring Organization, the Department will also establish a state owned and operated Health Maintenance Organization composed of the state's teaching clinics and hospitals. Through subcontracting arrangements the HMO will be able to serve participating members in rural areas of the state and develop a public primary health care network composed of public and private programs and organizations. Through revitalization of the existing public facility infrastructure in the state and networking with existing underutilized facilities, the State's teaching hospital and clinic system will have the opportunity to once again be recognized nationally as a medical training model.

Under the HIO umbrella specialized health care services traditionally administered under federal block grant programs will be utilized to coordinate specialty care for all plan members and thereby eliminate waste and duplication of effort in the delivery of services. The following features of the proposed state HIO are designed to assure financial solvency and stability of the state's health care system.

- ♦ Through establishment of a state owned and operated HIO, traditional public sector services provided by the Louisiana Health Care Authority and DHH can be integrated while assured continued financing and utilization.
- ♦ Establishing capitated rates¹ for Medicaid on a risk basis and restricting capitation to the state operated HIO assures all competitive health care plans are administered by a single

¹ Rates are set based on the average cost of providing specific health care services as determined under an actuarially sound methodology approved by the federal government.



entity to assure quality and uniformity in service standards and rates. The federal government is guaranteed to pay no more than the current average Medicaid cost for health care services provided under the health care management program, and savings resultant from operation of the HIO are utilized for expansion of health care coverage and reduction of the cost of providing health care under Medicaid.

- ♦ Medicaid eligibility will be guaranteed for a six month period for any enrollee who chooses to receive services under the HIO as allowed under federal regulations. Through guaranteed eligibility, neither the state nor the health plans operating under the state's HIO umbrella will be exposed to any risk resulting from retroactive Medicaid ineligibility based on changes in enrollee income or resources during a certification period. Without this option, the state would be exposed to paying the full cost of health care services provided to enrollees whenever Medicaid determined eligibility should have ended based on changes which were not timely reported. Additionally, under this option, marketing of health care plans to Medicaid enrollees is enhanced through reduced bureaucratic requirements, increase access to primary and specialized care, and guaranteed coverage for a six month period.
- ♦ Utilizing waiver of 75/25 participation requirements² for the state HIO will expand the number of health care management plans available to Medicaid enrollees. Through increased availability of health care management plans, the percentage of Medicaid enrollees choosing to receive services under the HIO umbrella will increase.
- ♦ Utilizing 100% capitation, updated quarterly for new enrollees, reduces the state's exposure to cost overruns. Plans operating under the HIO umbrella will be offered premium payments on a risk or shared risk basis. To the extent the HIO assumes a part of the plans risk of potential losses, the HIO will require a greater share of any profits generated by the plan. These two options will be structured to assure the solvency of the HIO and encourage health care plans to participate.
- ♦ Establishing Medicare premium amounts for the HIO will allow health care management plans to market themselves to Medicare enrollees as well as Medicaid enrollees under the HIO umbrella. This feature will allow individuals who have dual coverage for Medicare and Medicaid to join a participating health care management plan.
- ♦ Establishing coordination and referral arrangements between participating health care management plans and the public service delivery system will assure continuing compliance with federal requirements, increased access to specialized services, and risk management for competing health care plans.

² Federally qualified HIO and PPO plans which are operated by states may serve low-income populations exclusively. Private HIO and HMO plans are required to meet a 75/25 minimum public/private participation rate to retain federal approval.

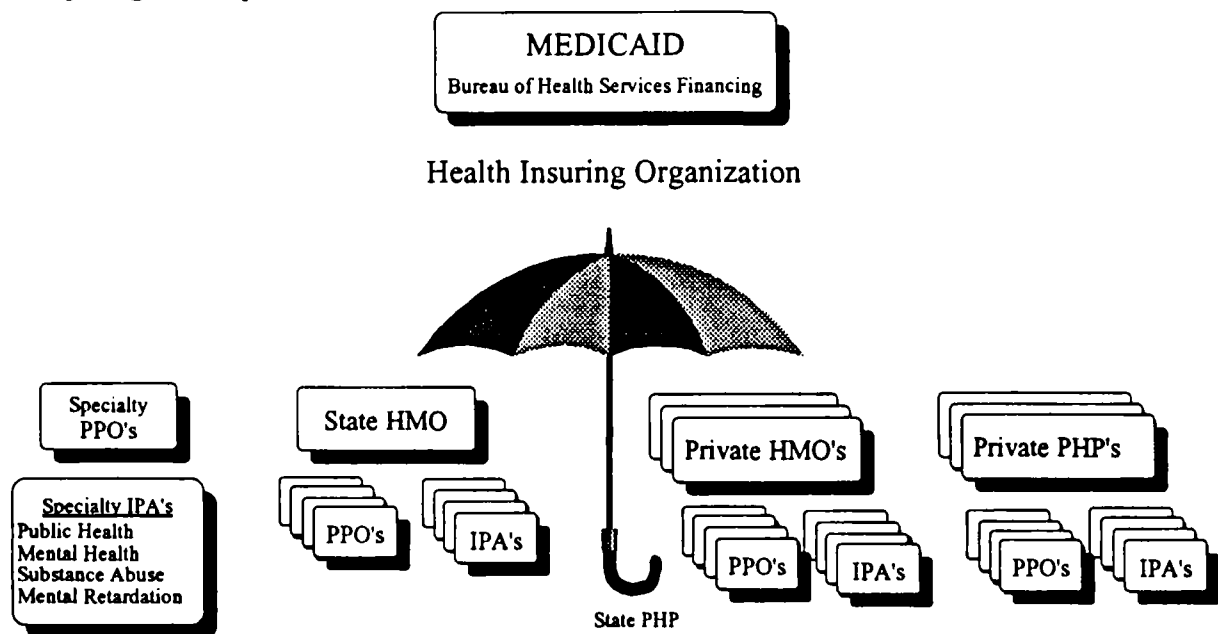


The HIO will improve access through availability of health care services from new and existing health management plans which will reduce utilization of Emergency Rooms for primary health care, long distance transportation, and the incidence of in-patient hospitalization. Savings generated by the HIO will facilitate expansion of Medicaid coverage. Utilizing this approach, the growth of health care management plans should increase significantly during the first year of operation. Sufficient enrollment and resultant savings are projected to allow phasing-in additional optional Medicaid coverage groups during the first year of HIO operation.

This approach will maximize federal funding for health care services in Louisiana, provide the financing needed to expand Medicaid coverage to over 360,000 uninsured residents under a health care management model which is compatible with health care reform proposals being considered by Congress, and provide a basis for private health care plans to evaluate and develop competitive health care plans for the private sector.

HIO ORGANIZATION

The following diagram illustrates how the state's HIO model provides for administration of competing health plans.



Multiple health care plans will market themselves to Medicaid enrollees under the HIO umbrella. The HIO will establish a uniform marketing protocol with Medicaid and coordinate plan member marketing efforts. Health Maintenance Organizations (HMO) and Prepaid Health care Plans (PHP) will be required to coordinate and administer a benefit package and allowed to include any of the following optional benefits:



MINIMUM BENEFIT PACKAGE

Hospitalization - Inpatient & Outpatient
Laboratory & X-Ray services
Physician services
Other practitioner services
Home Health services
Durable Medical Equipment services
Transportation services

OPTIONAL BENEFITS

Dental & Denture services
Clinic Pharmacy services
Rehabilitation services
Nursing Facility services

Preferred Provider Organizations (PPO) and Independent Practitioner Associations (IPA) will be allowed to enroll in conjunction with HMO's and PHP's³ for provision of any of the above listed services except hospitalization. The state PHP will administer and coordinate the following specialty services for all health care plans.

Public Health services	Mental Health services
Psychiatric Hospital services	Substance Abuse services
Mental Retardation/Developmentally Disabled services	

Specialty PPO's operating under the state PHP will coordinate and report to participating HMO's and PHP's, those services provided to plan members to assure: continuing compliance with federal requirements; reduced risk of plan cost overruns; and reduced duplication of effort.

State Prepaid Health Care Plan

The HIO umbrella will provide basic benefits through multiple competing plans and specialized health care services for Medicaid enrollees with special needs. The state PHP will administer and coordinate all specialized health care services for participating plans. Through administration and coordination of specialized services by agencies with established state wide networks the special needs of local populations can be accommodated. Participation in designing and delivering specialized health care services by local communities and organizations is maintained through use of existing public agencies and integration of private sector service delivery systems. Additionally, compliance with various federal mandates regarding the provision of specialized health care services is assured through administration by the agencies charged with responsibility for compliance.

State Health Maintenance Organization (HMO)

The state will establish a federally qualified public HMO to compete under the HIO umbrella utilizing state owned and operated clinics and hospitals. To assure statewide access the state HMO will contract with Federally Qualified Health Centers, Rural Health Clinics, rural hospitals and any federal facilities who have excess capacity and wish to participate in the health care network. Through revitalization of the existing public facility

³ The state Prepaid Health-Care Plan (PHP) will be available to all PPO's, IPA's, etc. to assure participation in the HIO is not artificially limited.



infrastructure in the state and networking with existing underutilized facilities, the State's teaching hospital and clinic system will have the opportunity to once again be recognized nationally as a medical training model. The regional structure of the Health Care Authority will facilitate decentralization of service administration and flexibility in designing services to meet the special needs of each geographic region of the state as well as fully utilizing publicly funded health care resources.

ENROLLMENT PERIODS

Medicaid enrollees choosing to receive services under the HIO umbrella will be guaranteed continuous eligibility for a six month period. Movement between plans will be restricted to prevent unnecessary paperwork and administrative costs. Medicaid enrollees will be free to change plans every six months or earlier for cause. During the first 30 days of coverage under any HIO participating health care plan, the Medicaid enrollee shall have the option of cancelling membership in the HIO and returning to Medicaid.

ADDITIONAL INFORMATION

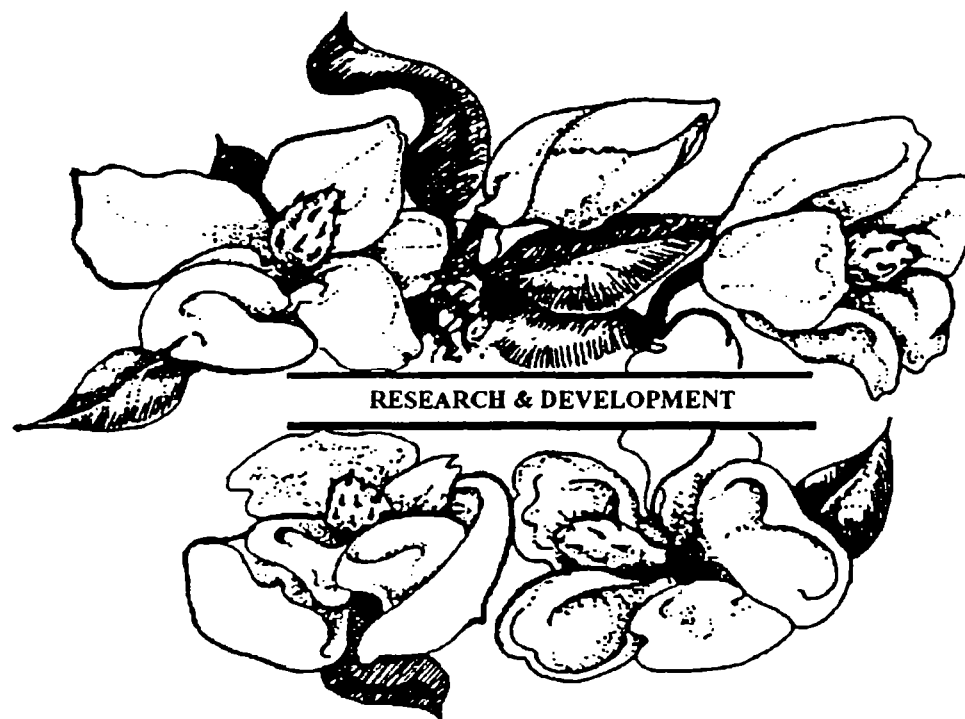
Additional information regarding Louisiana's Health Insuring Organization may be received by contacting:

Louisiana Department of Health and Hospitals
Bureau of Research & Development
Post Office Box 2870
Baton Rouge, Louisiana 70821-2870



HEALTH CARE MANAGEMENT

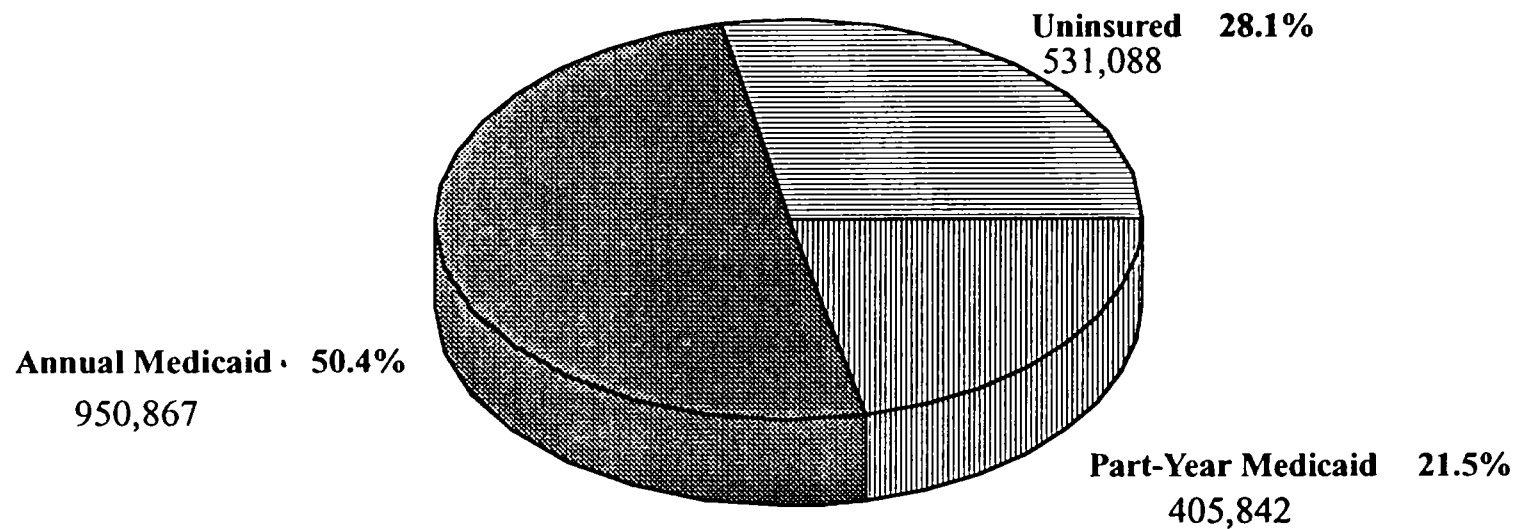
*A Conceptual Approach To Improving Health Care Access
In Louisiana*



RESEARCH & DEVELOPMENT

DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF THE SECRETARY
BUREAU OF RESEARCH & DEVELOPMENT

MEDICAID EXPANSION & UNINSURED LOUISIANA RESIDENTS



Further expansion of health care coverage for uninsured will result from national health care reform initiatives to expand the availability of public and private coverage.

MEDICAID OPTIONAL COVERAGE GROUPS

PREGNANT TEENAGERS LIVING WITH PARENTS

5,368 Potential Enrollees *(Medicaid currently provides coverage for pregnant teenagers in families with incomes below 133% of federal poverty level)*

PREGNANT WOMEN WITH INCOMES BELOW 185% OF THE FEDERAL POVERTY LEVEL

20,406 Potential Enrollees *(Medicaid currently provides coverage for pregnant women with incomes below 133% of federal poverty limit.)*

MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED CHILDREN WHO WOULD BE COVERED BY MEDICAID IF INSTITUTIONALIZED.

2,500 Potential Enrollees *(Medicaid currently covers institutionalized children and children who have been institutionalized.)*

AGED, BLIND, & DISABLED INDIVIDUALS WITH INCOMES BELOW 100% OF FEDERAL POVERTY LEVEL

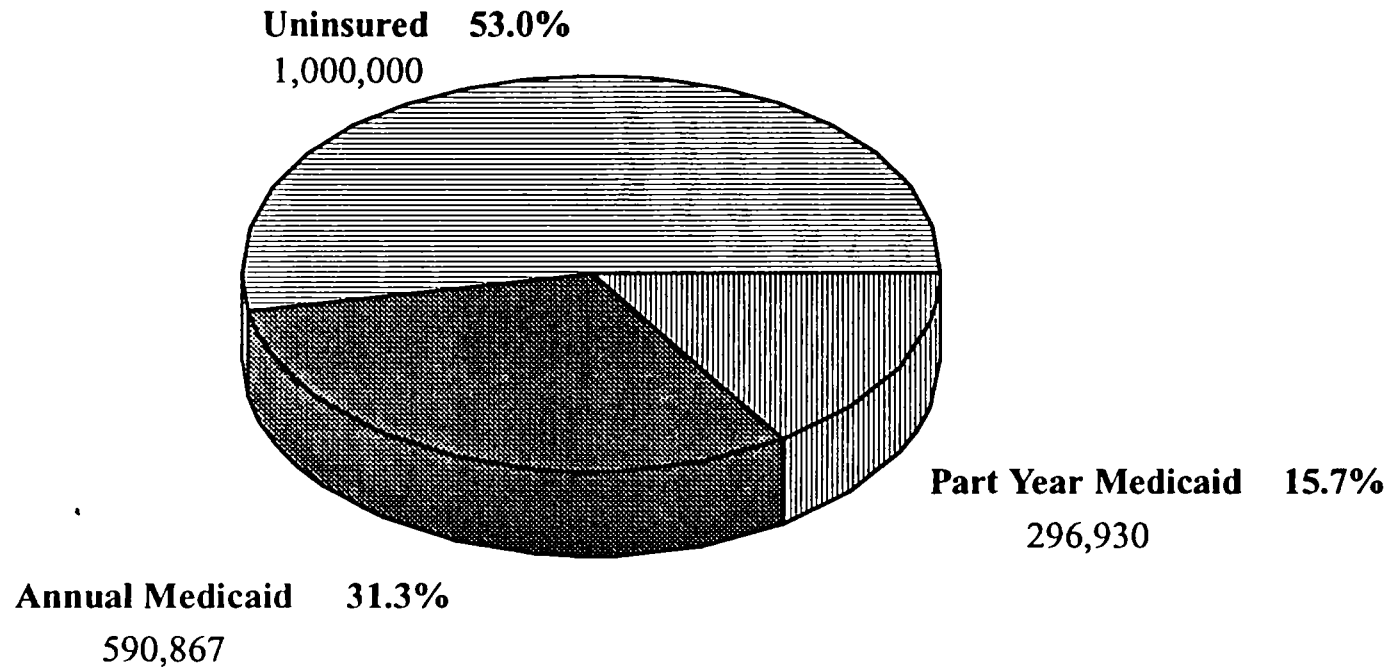
90,343 Potential Enrollees *(Medicaid currently provides coverage for institutionalized individuals and individuals with income below 50% of federal poverty level.)*

CHILDREN IN FAMILIES WITH INCOME BELOW 100% OF FEDERAL POVERTY LEVEL AND ONE PARENT OR GUARDIAN

350,295 Potential Enrollees *(Medicaid currently provides coverage to families with incomes below 30% of federal poverty level.)*

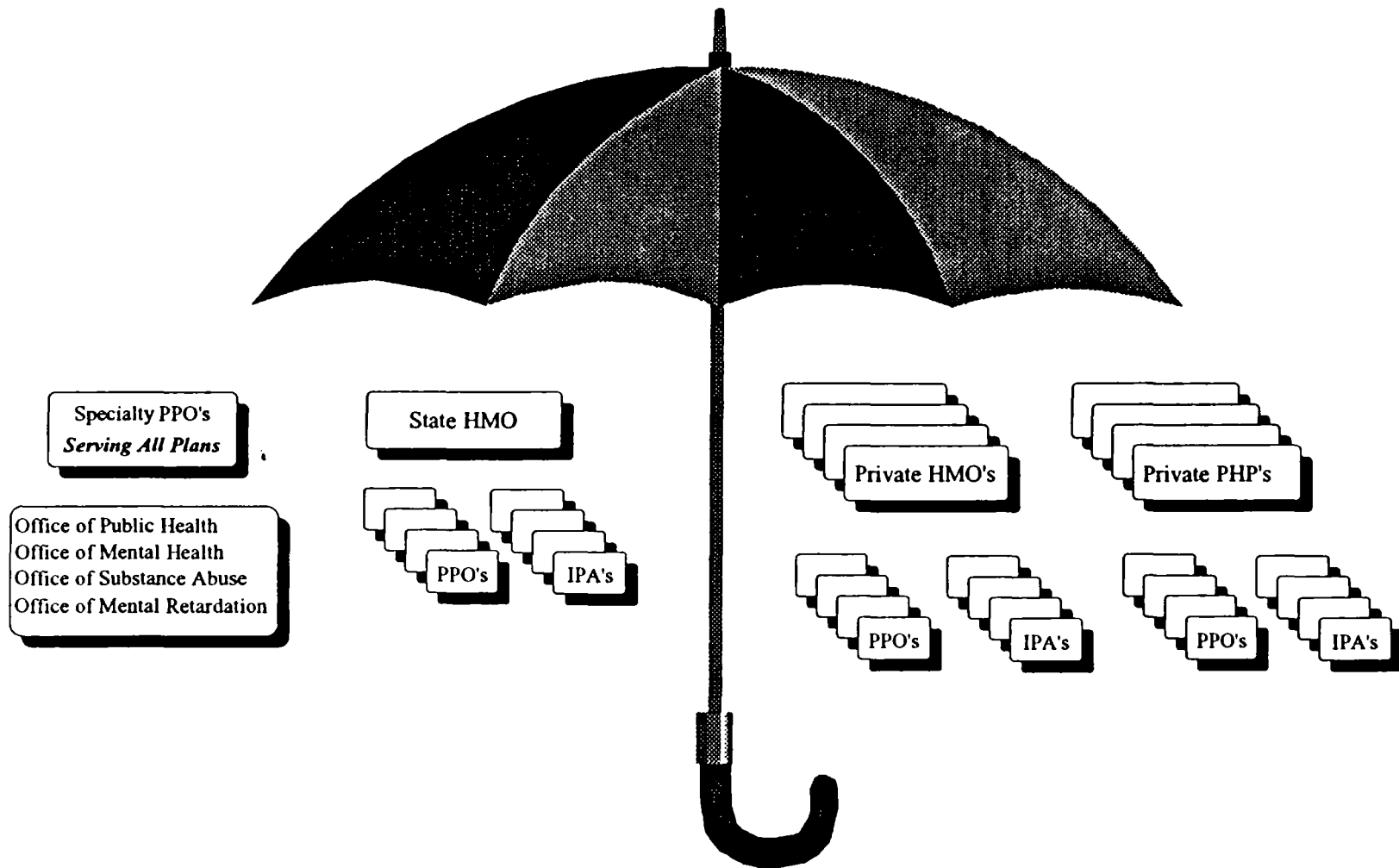
TOTAL = 468,912 POTENTIAL ENROLLEES

CURRENT MEDICAID & UNINSURED LOUISIANA RESIDENTS



Of the 1,000,000 uninsured individuals in Louisiana, some receive coverage under Medicaid for a portion of the year based on fluctuations in income and resources.

STATE HEALTH INSURANCE ORGANIZATION



MEDICAID OF LOUISIANA

STATE HEALTH INSURANCE ORGANIZATION

PREMIUM PAYMENTS FOR HMOs & PHPs

Medicaid Capitation Less:

DSH Payment Amounts

Mental Health Service Costs

Psychiatric Hospitalization Costs

Substance Abuse Service Costs

Mental Retardation Service Costs

Full Risk - 90% of Premium with no Profit Sharing

Shared Risk - 95% of Premium with Profit & Risk Sharing

PREMIUM PAYMENTS FOR STATE HMO & PPOs

Medicaid Capitation Less 5% with Profit Sharing

PARTICIPATING HEALTH CARE PLAN BENEFITS

Guaranteed six month enrollment period.

Limited liability for high cost specialized services.

Limited liability for catastrophic cases.

Linkage With State PPO Service System

Enrollment Center Certification For Medicaid

Simplified encounter data reporting requirements.

Introduction of members to plan prior to enrollment.

Management control of benefit package.

HEALTH CARE PLAN MEMBER BENEFITS

Guaranteed health care coverage for six months.

24 hour access to health care services.

24 hour transportation coverage.

MANAGED COMPETITION DEVELOPMENT

Individuals
Federal Government pays premiums for those with low incomes.

Small Businesses
Join cooperative to cut administrative costs and spread risk.

Large Businesses
Buy insurance directly from AHP

HEALTH PLAN PURCHASING COOPERATIVE

Acts as Broker for Multiple Plans

FUNCTIONS NOT YET DEFINED

SHOULD INCLUDE:

Acting as Reinsurer for All Plans

Maintains Reserves and Spreads Risk

*Funds Specialty Services for All Plans
{If included in minimum benefits}*

*Mental Health, Substance Abuse, Public Health,
Developmentally Disabled, Blind & Deaf Services*

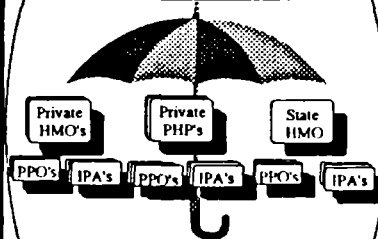
Specialty PPO's
Serving All Plans

Public Health
Mental Health
Substance Abuse
Developmental
Disabilities
Blind & Deaf Services

*Funded by federal
block grants and
HPPC if included in
minimum benefit
package*

GOVERNMENT BENEFIT PLANS

MEDICAID



AHP

PRIVATE INSURANCE COMPANIES

Indemnification

Private HMO's

Private PHP's

PPO's

IPA's

AHP

SELF INSURANCE PLANS

Indemnification

Private HMO's

Private PHP's

PPO's

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AHP

SELF INSURANCE PLANS

PRIVATE INSURANCE COMPANIES

GOVERNMENT INSURANCE PLANS

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