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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	From: Hillary Rodham Clinton, To: Daniel Jones [partial] (1 page)	9/19/94	b(6)
001b. note	From: Pam, To: HRC [partial] (1 page)	nd	b(6)
001c. letter	From: Constituent, To: Hillary Clinton [partial] (1 page)	4/12/94	b(6)

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HRC Health Care Correspondence 94 - I, J

2014-0159-S
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RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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]

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THE WHITE HOUSE

January 18, 1994

Mr. R. William Ide III
Long, Aldridge & Norman
One Peachtree Center
Suite 5300
303 Peachtree Street
Atlanta, Georgia 30308

Dear Bill:

Thank you for your letter and kind comments about health care reform. I apologize for the delay in responding.

I appreciate your commitment to new ways of thinking about the judicial system and its response to illegal drug use. The demands placed on my schedule by health care reform make it difficult for me to give this matter the attention it truly deserves. Therefore, I have asked Bruce Reed, the President's Deputy Assistant for Domestic Policy, and Jose Cerda, who is dealing specifically with these issues on our domestic policy staff, to meet with you to discuss your proposal. They will be in touch with you soon.

It was good to hear from you and I look forward to learning more about your idea.

Sincerely yours,

Hillary

Hillary Rodham Clinton

~~cc:~~ Bruce Reed
Jose Cerda

cc: Patti

R. WILLIAM IDE III
President
American Bar Association
750 North Lake Shore Drive
Chicago, IL 60611
Telephone: 312/988-5109
Fax: 312/988-5100

AMERICAN BAR ASSOCIATION

Direct Personal Replies to:
Long, Aldridge & Norman
One Peachtree Center
Suite 5300
303 Peachtree Street
Atlanta, GA 30308
404/527-4000
404/527-8460 Direct Dial
Fax: 404/521-9343
ABA/net: !IDEWMIII

1993

November 9, 1993

Hillary Clinton
The White House
Washington, DC 20500

Dear Hillary:

I know that you are tremendously busy with health care reform and, by the way, you are doing a terrific job. We had discussed last August the possibility of a meeting to talk about a shift of direction in the justice system with respect to the use of illegal drugs. I am particularly concerned about the need to send a new signal to the country regarding our intolerance in this area.

It is my sense that Congress will not be able to do that this term. However, the Administration, in concert with the private sector, could make great strides in this area. In order to motivate the public, the direction has to come from the very top and I would greatly appreciate the opportunity to make the case to you for a specific proposal that I have in mind. I realize your schedule is quite busy but if you could work me in for a half hour sometime, it would be greatly appreciated. Many thanks and I look forward to hearing from you.

Sincerely,

Bill

R. William Ide III

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1994

health - working group RL

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

To: Hillary Rodham Clinton

From: Chris Jennings

Date: October 20, 1994

Re: Update on Health Care Working Group

cc: Melanne Verveer

First of all, I want to thank you for all of the support that you have given me since I have been here. I particularly appreciate your recent support of me when the subject of a coordinator for Bob and Carol came up. There is no question that the new roll will be a tremendous challenge. As of today, however, I am pleased to report that it seems to be working quite well.

I intend to keep you up-to-date, giving you periodic reports on our progress in producing policy options. Also, I will keep you apprised of success or lack thereof in keeping all parties feeling and being integrally involved in the development of the options, as well as the degree to which they are feeling positive about our process.

Yesterday, we had a very constructive meeting with the NEC/DPC health policy working group. I prepared the attached talking points for Bob's and Carol's use, and I made the presentation of the specific issues the group will be initially focusing on for the purposes of the policy choice discussions we will have after the elections.

We will be preparing background information for you and the rest of the NEC/DPC group on each of the issues outlined in section IV of the attached. With only minor modifications, the working group has approved of the six issues. I am quite happy to go into more detail with you regarding the six core issues. As information is produced, I will forward it on to you and Melanne.

If you have any questions, please do not hesitate to call me. If you and Melanne would like to schedule periodic meetings with Carol, Bob, and/or myself at any time, I would be most happy to arrange them.

p.s. Melanne asked that the attached transcripts from Donna Shalala's interview and today's AP story on it be forwarded over to you. I am also enclosing the Q&A's that Laurie and I worked on for prep before the President's press conference.

AGENDA AND TALKING POINTS FOR 11/19 NEC/DPC MEETING

I. **Welcome, Update on Process, Appreciation for Assistance**

II. **Definition of Structure of Roles and Responsibilities for Staff**

III. **Outline Tight Timeframe**

IV. **Discussion of Specific Issues Within Workplan -- Turn to Chris**

- (1) **Coverage options**
- (2) **Insurance reform options**
- (3) **State flexibility options**
- (4) **Cost containment options**
- (5) **Financing options**
- (6) **Regulatory options**
  * **Second tier non-core issues**

V. **(RETURN TO CAROL AND/OR BOB) Outline Need for Intense and Quiet Staff Work on Background Information, Policy Options, and Quantitative (numbers-run) Analysis**

VI. **Reiterate Sensitivity of Any Leaks About this Work Getting Out**

VII. **Will Keep In Touch, Thank You, Closure of Meeting**

AGENDA AND TALKING POINTS FOR 11/19 NEC/DPC MEETING

I. Welcome, Update on Process, Appreciation for Assistance

- Will be a very open process where all views/approaches/alternatives are aired

- Pleased with early cooperation, assistance, and advice. We feel it has been and will continue to be constructive. (Cite, for example, Alice's memo and perhaps Donna's further elaboration of President's, HRC's, Leon's, and your feeling that proposals be viewed in context of laying foundation for achieving President's eventual goal.)

- Appreciation of principals' dedication of senior staff resources to help with this effort. Their and your (the principals') involvement has already been immeasurably helpful (in terms of helping structure issues and background information that should receive priority consideration.). Such help will be requested and needed throughout the process. (Detailed discussion re this to follow).

- Assuming approval of an "issues to be analyzed" workplan, which Chris will outline in a moment, we should be getting first-cut information on some of these issues beginning as early as next Monday.

II. Definition of Structure of Roles and Responsibilities for Staff

- Role of Chris as defined and implemented with regard to Bob and Carol, and discussion of how you want him to interact with the Departments, as well as OMB, CEA, etc.

- Role of Jennifer Klein -- analogous to Sylvia and Jeremy, i.e., is empowered to facilitate and direct policy work in a manner consistent with desires and discussions of you, the principals', and Chris. Further clarification of anyone else's role that you (Carol or Bob) feels is necessary/advisable.

- As we've stated previously, Bill and Gene will play an integral roll in helping Chris and us focus on health policy issues within the context of the budget and other domestic policy priorities. They will also participate in and contribute to all discussions regarding health care policy options -- both in terms of the substance and the process of developing these options. We and or Chris will keep you apprised of other staff roles on this subject.

III. Outline Tight Timeframe

- Very little time left before significant policy/political meetings take place immediately after the election. (Perhaps outline other high priority scheduling/policy conflicts?)

- Hope to have package options outlined for first perusal for this group, with input and political/strategic direction from Pat, George and others on or about November 10th. (Obviously, no final decisions or recommendations will be made at this time, but will help set the stage on what and how recommendations are made/presented.)

- As a result, we may want to have further discussions to determine how we want some of these options layed out before such a meeting takes place. If we think this is advisable, we think that we should tentatively target November 7th for such a discussion to take place. Because of the sensitivity to the political timeframe, we do not plan on circulating paper at this time. However, it does seem advisable to get direction, particularly with regard to presentation of options, from this group before the larger group meets.

- In any event, after the November 10th meeting, we will need to move quickly in a tight calendar before and immediately after Thanksgiving to make any policy option presentations that, in particular, have any impact with regard to ongoing budget priority discussions.

IV. Discussion of Specific Issues Within Workplan -- Turn to Chris

- Keep in mind that all options, ranging from staking out no position to strongly advocating the same or another comprehensive reform approach, are still on the table. The discussion that follows assumes this fact, but concentrates on the interim steps that we were asked to pay particular attention to at this time.

  The issues that we have selected for your consideration have been chosen because they can be, if done properly, used to create a solid foundation on which to move towards the President's goal of universal coverage and cost containment. Obviously, the final choice that we make in regard to what if any issue we choose to pursue will depend heavily on the President's eventual choices on his budget and policy priorities after the election. The six issues that seem to best capture what principals' senior staff believe are important for consideration by you are:

  - coverage
  - insurance reform
  - state flexibility
  - cost containment
  - financing
  - regulatory options

- Obviously, there are many other high priority issues that all the departments would like to explore. By not listing them here, we are in no way suggesting that other issues should not be considered, but we do believe they should be considered outside the context of these core issues. (For example, we are aware that HHS has a Medicare reform initiative now being reviewed).

- Without going into great detail, I'd like to discuss what type of issues we would consider under each of these six issue headings and how we are now thinking about structuring them. Jen and I, speaking for Bob and Carol, would like to invite you to add, subtract, modify, or clarify this list. (Ask to not be interrupted until end.)

(1) Coverage options

- A wide variety of coverage options should be considered, including:
  - low income families
  - kids only
  - welfare to work populations
  - in-between job (unemployment) protections
  - elderly (likely only consider if Medicare cuts high)
  - combinations, different benefit package assumptions and zero option, etc.
- To make it user friendly to the numbers-driven world we work in, structure options to illustrate how much coverage you can buy for different dollar amounts.
- Options considered will include an examination of feasibility, advisability and cost of different administrative options for each subsidy scheme. As such, the relationship between coverage and the appropriate Medicaid role will be carefully explored.
- In order to get these options scored, we must immediately move to get them modeled and sent through OMB, HHS and their actuaries, and others to get the type of cost estimated package options that you will want to have. We are planning to have a staff meeting for a first cut review on these models tomorrow. All models would be subject to sign-off by the principals.

(2) Insurance reform options:

- Benefits and risks of alternative insurance reform in a non-universal coverage market.
- Graduated (from minimal to major) insurance reform options and implications and tradeoffs in each alternative. (For example, the more subsidies you provide from above options may require much more significant insurance reform to guard against adverse selection.) Background information on this issue is being prepared for your staff to review on Friday.

(3) State flexibility options:

- Options for providing incentives or removing potential barriers to state-based reform efforts. We plan on looking at Medicaid and ERISA waiver options for group consideration.

- Obviously because of strong opinions on these issues, particularly with regard to ERISA, this needs to be done in context of both policy and political (competing priorities of business, labor and states) feasibility, as well as it must be understood that any such option enhances, rather than detracts from, the likelihood of national comprehensive reforms.

- All three Departments have an essential role to play on this issue and Jen and I, along with Kathy Way of Carol's staff, will watch this very closely.

(4) Cost containment options:

- Private sector options must reviewed in detail. (CJ will discuss orally all issues, including market reforms that could also involve an analysis of medical savings accounts, commission options, and various tax cap alternatives).

- Public sector options will be reviewed. (Medicare and Medicaid savings, as well as any savings emerging from proposals from HHS dealing with standardization of forms and fraud and abuse).

(5) Financing options:

- Linkage to public cost containment is very closely associated with financing.

- Review of alternatives already proposed is underway. Revenue options will, of course, be done by Treasury.

(6) Regulatory options:

- Many Departments have regulatory reviews underway with expressed purpose of developing initiatives that can be helpful to health reform legislative and/or policy goals. I am advised that the Departments of Labor and HHS have these reviews well underway. Options need to be reviewed.

  There are also important second tier non-core issues. Many of these issues are being represented by departments in this room and elsewhere. The fact that these issues are not listed in no way connotes that they are unimportant, but the NEC/DPC working group concluded that we should try to limit our current analysis to a number of structural core reform options.

Lastly, in an attempt to provide a sense of where Congress ended up on the many health reform bills, we are in the process of developing a side-by-side to compare notable health care reform initiatives by both Republicans and Democrats. We hope that this will be useful.

V. (RETURN TO CAROL AND/OR BOB) Outline Need for Intense and Quiet Staff Work on Background Information, Policy Options, and Quantitative (numbers-run) Analysis

- In order for us to get this information prepared and circulated amongst ourselves for consideration and discussion in a timely manner, the staff work will need to get it done quickly and quietly. This is particularly the case with regard to any options relating to numbers/cost-revenue issues.

- Chris will be consulting you throughout this process to make certain that you are comfortable with how this is being done and who is doing it. But it must get done soon.

- On some fronts we can move quickly and build on the information base we have either through our own work or those of the alternatives that have been outlined in the Congress. However, there most definitely will be exceptions to this that will entail new and detailed work, analysis and consideration. The targeting and administration of subsidies and the advisability and feasibility of providing for state flexibility in a non-universal coverage proposal serve as two particularly good examples.

VI. Reiterate Sensitivity of Any Leaks About this Work Getting Out

- At the risk of beating a dead horse, we must continue to reiterate the importance of holding this information close. If any of these options get out into press or onto the Hill prior to early consultation, we have major problems that could undermine the whole process -- even if a leak occurs after the election.

VII. Will Keep In Touch, Thank You, Closure of Meeting

- As new information on substance or scheduling becomes available, we will be in touch. Thank you all again for all your help and cooperation. I think we are off to a great start.

Notes from Secretary Shalala's Oct. 20 meeting with the Health Communicators' Breakfast.

[Discussion of charts]

The problems are still out there. The Clinton Administration will have to come back. Time ran out; someone rang the bell. We will pick up the momentum again.

Q: What format?

A: We're thinking through our strategy on the budget, welfare reform, health care reform. We get another kick at the cat. Hopefully we learned some things in the last 2 years that will enable us to refine our strategy.

Q: What have you learned?

A: Public clearly told us the idea of taking on every piece of the system makes them very nervous. A big target creates problems. It's the same as with the Republican contract, it creates a lot of negatives. We need to decide what needs to be done first. We haven't decided which. The public perceived it as too much and sent us a message that they want reform but they want it in stages.

Q: Reconciliation?

A: Something will have to be done with the budget. The President will submit proposals on Medicare, Medicaid, welfare, etc. This will not just be a discretionary budget. It is a natural vehicle, it has discipline in terms of time frames. The budget will look at entitlements. The Entitlement Commission will demand that.

Q: Insurance reforms?

A: Got to think about how to do it without disrupting the system.

Q: Are you saying costs are your focus not coverage?

A: Both. We will emphasize both. We can't do welfare reform without expanding coverage for welfare recipients and working people. They need cost containment as much as anyone.

Q: Reconciliation could take financing away?

A: We haven't made those decisions yet. Deficit reduction is a priority but we also want to get going on health care reform.

Q: Question still is how do you pay for it?

A: There are no tricks here. There are two obvious sources of revenue: Medicare savings and cigarette taxes. They are on everyone's list. No reason to believe we won't go back. I don't kid myself that the politics of the moment on Medicare may change.

The question is what size of cuts will be proposed.

Q: Medicare pays less than costs now?

A: Have to talk about both private sector and public sector costs. No way to back away from that discussion. What's government's contribution to helping private sector get more disciplined. Not a top down discussion of what government can do to the private sector to change behavior. We have a full-blown health care system, not like 30 years ago when we created Medicare and Medicaid. The private sector wants help. They don't want to pick up the costs of the uninsured.

Q: Elements of reform?

A: There's no new analysis being done here. The question is how much you bite off. Our attitude is to find our appropriate role in costs and coverage.

Q: Employer mandate?

A: Still a stumbling block. Options include expanding Medicaid to cover the working poor. Congress already passed legislation for kids and it's being phased in over a long period of time. The Kids First proposal would accelerate that. Another option is to create large pools. Like the SEC, get the market straight and enforce rules.

Q: Employer mandate?

A: President hasn't made a decision on that. The public has spoken and we will take that discussion into account in providing options for the President. Perhaps we can get where we want to go but take a different road. The public viewed the mandate as a proxy for a government run system. Perception was the President's plan was a government-run system. I would argue that it wasn't but taking on every aspect of the system fed that. We should do things that would be helpful. Resources are more limited now than when we started.

Q: Universal coverage? Comprehensive reform?

A: Comprehensive reform can be taking strong steps in the right direction. We're not going to drop our overall goals. A way for everyone to get good insurance; strengthen the private system. Huge plans are difficult to get through Congress. Need a vision of where you want to go. The health care system is different than two years ago.

Q: Moynihan's opinion?

A: We'll talk to him after the election about his insights on health care and welfare reform. Moynihan always had large goals and moved toward them.

3

Q: Long term care?

A: States want to do more experimentation. Point of reform is you can't leave state experimentation out. Have to look at states' role.

Q: Would California need a waiver if it passes single payer?

A: Probably. We'd have to see what they ask for; it has to be budget neutral. I make it a habit not to talk about waiver requests, particularly those that haven't been made.

Q: Have you been campaigning?

A: Doing a lot of campaigning. Minimum of 2 days a week and all of next week. About 10 states: NY, IA, CA, WA, TX, MA. I'm finding the same thing I did during health care reform. A very anti-government feeling. A feeling that the government can't get anything right. It's consistent. Not just with Washington but with politicians in general, bureaucrats, state and local officials. It's a challenge. It's pretty rigid. So much so that most people think that Social Security is a private system.

I also hear that most people have had negative experiences with government. This may be reinforced by talk show hosts but they're not shaping public opinion. We walked into that with health care reform.

Q: Same with welfare reform?

A: No. That's seen as reducing the amount of government involvement in people's lives. Instead of health care reform that never leaves you it's a transitional program.

Q: Medicare underpays?

A. Vladeck is working on a Medicare strategy. Some things to make it more efficient. Some new approaches. A major integrity effort to combat waste, fraud, and abuse.

Q: Isn't most waste overutilization?

A: Not only. We have to make sure the system is not being ripped off.

Q: Individuals can't report overcharges?

A: No excuses about not doing something about that. Make it a priority for carriers. OIG is underfunded because of discretionary caps.

Medicare underpaying is an interesting argument. We're accused of underpaying and they're accused of overutilization. Everybody's making money.

Q: More managed care under Medicare?

A: Want to offer a wider range. Have to work on pricing. We clearly would like a lot more flexibility.

Q: Don't HMOs shift costs to fee for service?

A: You can cost shift only as long as someone is willing to pay the bill. There is tremendous cost shifting going on in the system. Employers are shifting costs to their employees and shifting people to managed care. Some of those costs are being shoved back and some efficiencies are resulting. Question is are we getting quality under managed care. Just starting to get information on that.

Q: Underutilization?

Data is so fragmented we can't answer that. Governors are desperate to slow costs; employers too. Trying to stabilize costs. HMOs are leaning on drug companies for price discounts. With all this going on, are people getting better care or as good care? We have a generation used to fee for service and one used to managed care.

Q: What do you mean by "ran out of time?"

The mainstream bill was out there. It was different but it had elements. I think Congress would have passed something if they didn't run out of time. Not because they lacked interest. Not because they ran into a brick wall of opposition.

Q: On quality, won't the government be interfering in medicine?

A: Information and choices. Quality comes from a competitive system with consumer information.

Q: Budget vehicle?

A: Have to identify financing. Go through the same committees. Timing. Tradeoffs within the budget.

Q: Will the President present a plan this year?

A: Yes, he will present a plan.

Q: What if Republicans control the Senate?

A: I'm not even thinking about it. I'm working like mad to make sure of it.

Q: Are providers driving up costs?

A: Not necessarily because they're evil. They want to do everything for their patients. People demand the very best of care

and they push the professionals. A culture of health care in this country to push to the maximum. We're all paying the bill.

Q: White House staffing changes? Ira?

A: Most of the analytical work has been done. The question is picking among the basic elements. Financial and political choices. We're having a collegial discussion of the strategy. Ira is very much part of that discussion. Chris Jennings is on my payroll and he's coordinating this. Most of the work has been done. We need a financial and a political strategy. How much to bite off with as much public support and bipartisan support. More of a strategic discussion.

Q: Why December?

A: That's when the President makes his decisions on the budget.

Q: Medicare spending?

A: The increases may be a little lower than expected. That's not new. It will reduce the deficit a bit but it limits our options on financing.

Q: Bipartisan?

A: Particularly in the Senate. Process is important. It sets tone and attitudes. President will talk to the leadership after the elections. Senator Dole says he wants to do health care reform next year. President will talk to the leaders about the agenda.

Q: Will GOP by willing to bargain?

A: It's realistic to assume that no member of Congress is asking to be elected to do nothing -- except the Congressman from California who's running for the Senate. The public wants something done. They've told us what they don't want now we need to make a case for what needs to be done. Our goals remain the same: costs, quality, coverage. We want to nudge the system along, not run it. People out there without insurance are Democrats and Republicans.

Q: Will the President use his veto pen?

A: President will speak for himself.

Q: Deficit reduction?

A: Going to be a debate within the Administration on that. President is committed to expanding coverage and it will cost money. No new tricks out there.

Q: GOP contract?

6

A political exercise. Same problem as Health care reform. Negative coalitions. Hit from every direction. Not a major vision of COP view for the future. A package of ideas for the election.

Q: Vaccines for children a success?

A: Small piece of an overall effort. Infrastructure expansion, clinic hours, education, outreach, physician involvement. VFC is an attempt to give kids without coverage access. Part of a larger strategy. Had hoped to sign all contracts by Oct. 1, Price contracts were done; delivery contracts weren't. I apologize for that. As soon as the delivery contracts are signed, we will get this system going. We're going to get it done a few months late.

Drug companies are happy they will get to deliver the vaccines. They have ongoing relationships with the doctors they want to protect.

Q: Drug companies say they get 50% of their costs?

A: Ask them: What are their costs? What do they charge in Canada? We don't know. We ought to pay a fair price and it should be negotiated. If they say the price is too low, they have to provide the data to Congress. Last thing I want to do is put an industry out of business. Lay out their case, the facts. I believe drug companies have the same goals we have. They want to make a decent income. We have to look at the overall program and two years from now look at the results. We need a system that automatically vaccinates each generation of kids.

Q: First Lady's profile?

A: I don't give her advice on her profile. I'm a fan and a friend.

Q: If FDA says tobacco a drug, how pay for health care?

A: I'd be ecstatic if less people smoked, particularly young people. We'd save a lot of money. Pricing of cigarettes is a piece of that.

Q: Health care on campaign?

A: Yes, because it's me. They ask me about health care, welfare, Head Start, Social Security. I don't get a lot of questions about GATT or NAFTA.

Q: What are you hearing?

A: Don't want the government to run health care. Horror stories of what the system is doing to people. Tell the President to keep going. The test of this Administration is how much we learned in the first two years. We learned a lot.

Q: Prescription drugs for the elderly?

A: Haven't heard about it too much. Hear more about long term care and flexibility.

Q: Doesn't LTC alternative cost more?

A: Issue is quality of life. My mother used to take me to nursing homes to visit some of her clients. I've seen institutional care. The key is making people's lives better.

Q: Rumors of your leaving?

A: I'm not leaving.

Q: Problems with Social Security transition?

A: No. Very smooth. No administrative problems.

Date: 10/20/94 Time: 16:58

Shalala: Government to Scale Back Health Care Reform Plans in 1995

WASHINGTON (AP) The Clinton administration, chastened by public opposition to its sweeping health reforms, will try a more modest and ''shrewder'' approach next year, Health Secretary Donna E. Shalala said Thursday.

Shalala said Americans feared that President Clinton's original plan would have ushered in a government-run health system.

''Whatever we propose in the future, it seems to me, cannot have that handicap,'' she told health reporters.

''We're going to try to be shrewder and more strategic about what things need to be done first,'' said Shalala, who took a back seat to Hillary Rodham Clinton and White House aide Ira Magaziner in framing the original, 1,342-page Clinton health care proposal.

Next time, the administration likely will recommend health changes as part of the regulatory budgetary process, with the president making key decisions by mid-December on what changes to seek in 1995, Shalala said.

''The question is: How much of this are you going to bite off?'' said Shalala.

''We are still enthusiastic about going back in and fighting the good fight on health care reform,'' said the secretary of health and human services.

''You get another kick at the cat and hopefully we've learned some things over the last couple of years,'' Shalala said. ''We'll try to refine our strategy this time around.''

She said the president won't abandon his goals of expanding health coverage and containing medical costs.

''We have to lay out for the president some options that will get where he wants to get, but not necessarily with the same road map that we used before,'' Shalala said.

''People in the United States told us ... they were very gun shy over taking on the whole system, every aspect of it'' in health reform, she said. ''They would like it to be in stages and see what the implications are of each piece as we move along.''

The Clinton proposal would have guaranteed health care for all by forcing every employer and individual to buy coverage starting in 1998, steering most Americans into huge, new insurance-purchasing pools, and imposing standby controls on premiums.

Democrats and Republicans alike picked apart Clinton's plan and eventually killed health reform entirely for this year.

Shalala said jawboning may have persuaded physicians, hospitals, drug companies and other providers to hold down increases, but medical prices are still rising twice as fast as inflation, and working Americans are still losing their health coverage.

''The problems are still out there,'' said Shalala.

Clinton has not decided yet whether to try again for an employer mandate, she said, ''but I think the public has spoken out on that issue and we have to take their views into account.''

''The public was against a government-run health care plan'' and ''they interpreted employer mandates as the government imposing a point of view on how the whole system should be financed,'' she said.

Other options for expanding coverage include ''using cigarette tax money and anything else you can scare up to extend the Medicaid program'' to the working poor, she said.

Already passed is a law expanding Medicaid to cover all children in poverty by 2002, she noted, adding, ''One possibility is to accelerate that.''

Instead of a socialized health care system, she said, the government could regulate the health insurance market the way the Securities and Exchange Commission oversees financial markets.

Shalala said she has found in her travels around the country ''a very anti-government feeling that government can't get anything right.''

It applied to government at all levels and was based on people's real experiences, not ''something that some (radio) talk show host had fed,'' she said.

''With all of our good intentions, we walked right into that with health care reform,'' she said.

APNP-10-20-94 1658EDT

Health Care Qs and As - October 20, 1994

Q. **Is the new health care process a recognition that the Task Force was a failure?**

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

Q. **Secretary Shalala said yesterday that you will be presenting recommendations to Congress on health care reform and that these recommendations will be part of your budget. Are you going to submit a new plan and, if yes, have you given thought to what these recommendations will include?**

A. I have not had a chance to think exactly about where we will go or even in what form any such proposal would be presented. Could recommendations be submitted as part of the budget? Yes, but it is also possible it won't.

Q. **So, Secretary Shalala misspoke yesterday?**

A. Secretary Shalala was speculating on possible options. Again, no decisions have been reached. In fact, I have not even discussed options yet. Secretary Shalala herself said that decisions have not been made.

Q. **Secretary Shalala also said that obvious revenue sources will be cuts in Medicare and a tobacco tax. Are these your options that you are considering given that they were in your original plan?**

A. Let me first say that this Administration will not slash Medicare. In my original proposal, we took the Medicare savings and used them to provide benefits to older Americans. We - like every bill that came out of Committee - had a tobacco tax. Again, however, no decisions on any financing options for any proposal has even been discussed let alone decided.

Q. **Secretary Shalala indicated that you would be producing a scaled back health care plan. Does this mean that you will give up on your goal of universal coverage?**

A. Throughout this debate on health care reform, I have repeatedly stated that covering every American and controlling escalating health care costs should be our goals. My commitment to this mission has not changed. I still believe that every American deserves health care coverage. Every month that we don't act to reform our system, 100,000 more Americans will lose their insurance. And, if we want to ensure that the deficit that we have worked so hard to contain does not balloon again over time, we need to address rising health care costs. Americans will spend $982 billion on health care services in 1994 - nearly 14 percent of our gross domestic product. If this trend continues, we will spend $2.1 trillion on health care in 2001 - 20% of our GDP.

There are obviously decisions that need to be made on how to proceed on health care reform. The one thing that is sure is that we are serious about continuing our fight for reform.

Q. **Will you veto a bill that does not achieve universal coverage?**

A. I still believe that every American deserves health care coverage. Our goal is universal coverage. And we're going to do everything possible to assure that Americans have health care coverage when they need it. And we're going to do everything possible to control escalating health care costs.

The American people still overwhelmingly support universal coverage. The latest NYT/CBS News poll (September 8-11) stated that nearly 70% of the public believes that every American deserves health care coverage. We must continue to work toward achieving what the American people want and deserve.

Q. **Secretary Shalala said that you have not decided if you will call for an employer mandate next year. You have repeatedly stated that an employer mandate is the best way to provide coverage for every American. Are you backing away from requiring employers to share in their employees health care costs?**

A. I still believe that shared responsibility, which builds on the current system where nine out of ten Americans get private insurance through the workplace, is the best way to ensure that all Americans have health coverage. As I have repeatedly said I am open to any kind of new idea.

Q. **Is the new health care process a recognition that the Task Force was a failure?**

A. We are simply moving health care through the same policy process that we use for other major domestic policy issues. The Domestic Policy Council (DPC) and the National Economic Council (NEC) will coordinate our future health reform efforts. We are just beginning this process and it will be a while before decisions are reached.

THE WHITE HOUSE

January 10, 1994

Carol Johnson Johns, M.D.
203 East Highfield Road
Baltimore, Maryland 21218

Dear Carol:

Thank you for your letter and I apologize for not responding sooner.

I appreciate your informing me of your views on the potential closure of the Uniformed Services University of the Health Sciences. The information you have shared is of interest.

With best wishes for a happy and healthy New Year, I remain

Sincerely yours,

Hillary

Hillary Rodham Clinton

bcc: Ira

I passed on the information — thanks.

Carol Johnson Johns M.D.
203 East Highfield Road
Baltimore, Maryland 21218
November 4, 1993

First Lady,
Hillary Rodham Clinton
The White House
Washington, D.C. 200

Dear Hillary,

This is yet another letter from your Wellesley colleague. Thank you for your courteous and good replies to my previous concerns. I write of a major issue with regard to your important Health Care Reform. Hopkins is still singing your praises for both June at our Centennial and last week at the Homewood campus.

Closure of the Uniformed Services University of the Health Sciences (USUHS) is threatened. In truth, it is a superb resource for well trained and dedicated primary care physicians. They are also superbly practiced military physicians capable of dealing with all varieties of disasters and health and disease crises. They have dealt with such circumstances in their Bushmaster exercises, as well as all through their training. They are all trained as future leaders of large integrated health care systems. USUHS matriculants are selected for their deep commitment to serving the most needy citizens of our nation. They validate their commitment by entering Graduate Medical Programs in primary care medicine at a rate of 70%, already exceeding your goal of 50%. The USUHS curriculum, 25 weeks longer than the typical medical school, traditionally emphasizes preventive medicine, occupational health, health promotion and wellness. Furthermore, it offers opportunities for medical training for individuals who otherwise might never consider it a potential affordable reality. **This really is your medical school** available for your direction.

Some specious calculations have suggested it should be closed because of costs, compared with other medical schools. For reasons not clear to me, but probably the undue influence of a small number of poorly informed persons, the Gore report includes the recommendation for its closing.

Carol Johnson Johns M.D.
203 East Highfield Road
Baltimore, Maryland 21218

Two bills are presently before Congress to effect this closing. **Rather than a saving, I believe this will be the ultimate travesty and waste.** In truth, USUHS is an economical source for a cadre of senior practitioners and career medical leaders.

It has been my privilege to serve as the Vice-Chair of the Board of Regents which is advisory to the Department of Defense. I know this school well and hold it in highest regard. It is very different from Johns Hopkins and brings a special richness and balance. I write as a concerned private citizen. I believe **an executive action could remove this from the list in the Gore report and preserve an immensely valuable resource.** There are many other features that are relevant and highlight its importance.

Nancy Gary, M.D., Dean of USUHS, one of rare women Deans of Schools of Medicine, spoke with you at the Institute of Medicine. She would be pleased to come and talk with you at your convenience. She can be reached at (301) 295-3016. The University would also be pleased to have you visit and see for yourself the fine students and program. James A. Zimble, M.D. President, former Surgeon General of the Navy, will be pleased to welcome you in Bethesda or at the upcoming Bushmaster exercise near San Antonio. This is an impressive event that clearly demonstrates the quality of the students and their training. **I urge you to make this University your high priority before it is lost to the future.** If I can be of assistance, please call me at home, (410)235-9891 or at the office, (410)955-3467.

Thank you for your attention to yet one more vital matter.

Very sincerely yours,

Carol

Carol Johnson Johns M.D.

cc Secretary of Defense
Les Aspin
Ass't Secretary of Defense for Acquisitions
John Deutsch

THE WHITE HOUSE

WASHINGTON

March 21, 1994

Ms. Jennifer Johns
1000 W Schwartz
Carbondale, IL 62901

Dear Ms. Johns:

Thank you for sending your sensitive and powerful video. I think that it accomplishes both of your goals -- it provides support to those who have lost someone they love to breast cancer and sends a clear message that we must all work to prevent this terrible disease.

As you well know, the statistics on the increasing incidence of breast cancer are overwhelming. According to the National Breast Cancer Coalition, one in nine women in the United States will develop breast cancer in her lifetime. Over two and a half million women in the United States have breast cancer today, and this year another 182,000 American women will be diagnosed with the disease -- approximately one woman every three minutes.

The President's health reform proposal addresses the threat of breast cancer aggressively and comprehensively. Women of any age will be covered for clinician visits, which include clinical breast exams, and screening mammograms, and will pay a standard copayment (for example, $10) when they need these services. All women over 50 will receive routine mammogram screening every other year at no cost. Clinician visits will be covered without cost sharing every three years for women ages 20 to 39 and every other year for women ages 40 to 64. Furthermore, women who are defined to be at risk for breast cancer may receive additional clinician visits and mammograms at no cost.

The health reform proposal also builds on our commitment to invest in research on breast cancer. This year, the National Institutes of Health increased its breast cancer research budget by 44 percent, from $208 million to almost $300 million. Under the President's plan, new research initiatives will target the prevention of disease effecting women, including breast cancer, reproductive health and osteoporosis.

Thank you again for the video and your support. Your strength means so much to me and to so many other women who have lost someone to breast cancer.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

cc: The Honorable Patty Murray

THE WHITE HOUSE

May 12, 1994

Ms. Linda Johnson
6209 West 67th
Overland Park, Kansas 66612

Dear Linda:

Thank you for your letter and for coming to the White House to learn more about the President's health care reform initiative. We deeply appreciate the League's support, your letters to Rep. Slattery, and any and all outbursts on behalf of reform no matter how opinionated!

With kind regards, I am

Sincerely yours,

Hillary

Hillary Rodham Clinton

Thanks

Hillary Rodham Clinton
White House
Washington, D.C.

May 5, 1994

Dear Hillary:

While it seems extremely casual to say "Dear Hillary", it seemed even stranger to say "Ms. Clinton"--especially since I'm not from Arkansas.

I am hereby expressing my appreciation for your invitation to the informative briefing I attended on Monday, May 2. It was an exciting and inspiring afternoon.

As a member of the League of Women Voters, and a social worker with 20 years' experience in health care, I have been very concerned about what may or may not happen to health care reform this year. Although I have both mentally and actually written several letters to you in the past, this is the first one that I've mailed. However, having now been identified as an "opinion leader", it gives me hope that my often impassioned, opinionated outbursts might actually be listened to.

I am, of course, delighted that there may be a chance for universal health care coverage this year. I am also pleased that Medicaid will be included, and would support integrating Medicare into the Health Security Act, as well. I have written Rep. Slattery encouraging him to vote to move the legislation out of committee. You may also be interested to know that the League of Women Voters of Kansas sent him a resolution last weekend encouraging him to support the Clinton or McDermott plan.

Once again, thank you for both the invitation and information.

Sincerely,

Linda Johnson

Linda Johnson
6209 W. 67th
Overland Park, KS 66202

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	From: Hillary Rodham Clinton, To: Daniel Jones [partial] (1 page)	9/19/94	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:
HRC Health Care Correspondence 94 - I, J

2014-0159-S
sb289

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential 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]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

September 19, 1994

Mr. Daniel M. Jones
Area Director
Onslow County Area Mental Health,
Developmental Disabilities and
Substance Abuse Services
215 Memorial Drive
Jacksonville, North Carolina 28540

Dear Mr. Jones:

Thank you for writing to bring to my attention the successful effort to help 0619 (b)(6) I commend you and Susan Beveridge for your tremendous work in arranging for the medication and support that (b)(6) so desperately needs. 0619

As you pointed out in your letter, the public mental health system provides essential services for individuals with mental illness, developmental disabilities and substance abuse disorders. Any health care reform legislation must leave in place this "safety net" for those individuals who need ongoing support. Only with the continuing contribution of dedicated servants like you will all individuals -- even the most disadvantaged citizens of our nation -- get the services that they need.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. note	From: Pam, To: HRC [partial] (1 page)	nd	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:
HRC Health Care Correspondence 94 - I, J

2014-0159-S
sb289

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6(b)

2. [redacted] was feeling suicidal because of her inability to pay her bills and her medical expenses. Only 42 years old, she wrote, "There is no help for me anywhere and I am afraid. I will not be a burden for my family and I will not go to a nursing home I would rather die then go there."[sic]

Immediately, Susan Beveridge of this office referred the letter to the North Carolina Mental Health Services. Two case workers were sent to try to help [redacted] They determined that she is living with her 23-year-old daughter and is confined to a wheelchair as a result of a rare degenerative disease.

[redacted] sole income is a monthly $450 Social Security Disability check. Her medical bills and medications often total $175 per month, leaving her with little or no money for other expenses. She has a spend down of $205 monthly to be met before Medicaid kicks in. Her caseworker is providing access to mental health services and help in obtaining her medicines free of charge through the indigent drug program.

I have attached [redacted] letter to you and a recent letter to you from Daniel Jones, an Area Director in North Carolina.

Jen — HRC would like you to respond to Daniel Jones. This material came out of Alice Pushkar's correspondence report. Pam

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001c. letter	From: Constituent, To: Hillary Clinton [partial] (1 page)	4/12/94	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti
OA/Box Number: 13598

FOLDER TITLE:
HRC Health Care Correspondence 94 - I, J

2014-0159-S
sb289

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April 12th, 1994

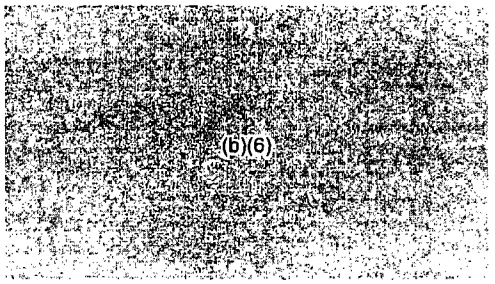
Hillary Clinton
Pennsylvania Ave.
Washington DC

Dear Hillary:

I reside in North Carolina and I am currently on Social Security Disability. My medical bills come to approximately $175.00 a month. My Social Security check comes to $447.00 a month. NC has a law that states a person has the amount of $242.00 on which to live anything over that amount is counted against them when filing for medicaide. I know of no place where a person can live on $242.00 a month. My deductable for medicaide is $1230.00 every six months. If I had $1230.00 a month I would not need medicaide. My rent comes to $250.00 and I have other bills such as electricity, kerosene, phone and food. This does not matter i am only allowed $242.00 a month. I am seriously considering suicide because I can not live like this. There is no help anywhere for me and I am afraid. I will not be a burden for my family and I will not go to a nursing home I would rather die then go there, I am only 42 years old.

I need help and I need it yesterday. I realize that you are busy but you are there because we put you there, you have to help or I will have no choice but to end this misery.

Help me to live,



001C

ONSLOW COUNTY

AREA MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

DANIEL M. JONES
AREA DIRECTOR

216 Memorial Drive
Jacksonville, N.C. 28546
Telephone 353-5118

ERWIN M. PATLAK, M.D.
CLINICAL DIRECTOR

September 6, 1994

Mrs. Hillary Rodham-Clinton
Office of Agency Liaison
Room 6, OEOB
The White House
Washington, DC 20500

Dear Mrs. Rodham-Clinton:

Too often successful interaction is not reported. It is my pleasure to advise you of the commendable effort of Susan Beveridge of your Agency Liaison staff. Ms. Beveridge, in reviewing mail to you, discovered a letter from a lady in our community considering harming herself. Ms. Beveridge faxed to my office all necessary information and we were able to provide appropriate supportive services. In a follow-up conversation with Ms. Beveridge I was expressing concern for indigent individuals who could not afford medications which would allow them to remain productive within the community. Ms. Beveridge forwarded to me a listing of pharmaceutical companies willing to provide free medication with a physician's prescription. I am happy to report we have begun the process and we are experiencing success. Our Medical/Clinical Director has shared the information with other psychiatrists in the eastern region of North Carolina. I would like to express gratitude on behalf of those individuals for whom we are responsible for your support of the Agency Liaison office.

As a service provider to the public, many of whom are without funds, I continue to be concerned for those individuals who must choose between food or mental wellness. As health care reform develops will there be a "safety-net" for those individuals requiring prolonged out-patient services? The individuals for whom I am concerned are those who are capable of remaining in the community but may require life long support. These are the individuals best served by and currently served through the public mental health system.

As reform continues I would be greatful if you could provide me with information, either proposed or being considered, that is relevant to mental health, developmental disabilities, and substance abuse services.

I would very much like to meet with you to hear from you your ideas regarding mental health coverage for all citizens and how I can support your efforts.

Sincerely,

Daniel M. Jones
Area Director

DMJ:lrh