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001. form	Hillary Rodham Clinton Scheduling Meeting Request [partial] (1 page)	3/2/93	b(6)
002. schedule	Monthly Calendar Hillary Rodham Clinton [partial] (1 page)	3/93	b(6)

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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]
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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]

[illegible] Tuesday March 2nd

PHOTOCOPY
PRESERVATION

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

FAX TRANSMISSION FROM THE CONGRESSIONAL HISPANIC CAUCUS

DATE March 1, 1993

Please deliver the following message to:

NAME Tim Tittle

TELECOPIER NUMBER 546-2239

FROM Rick Lopez

TELECOPIER NUMBER: (202) 225-7569

TELEPHONE NUMBER: (202) 226-3430

Number of pages (including this cover sheet) 10

NOTES: Retrying previous fax
→ First part will be 7 pages
→ Second part will be 10 pages.

- o protecting the civil rights of Hispanics, women and other minorites in all avenues of American life;
- o empowering the disenfranchised through the electoral process;
- o monitoring the implementation of immigration laws; and
- o providing affordable, quality housing for middle and low income Americans.

Congressional Hispanic Caucus Members of the 103rd Congress are:

José E. Serrano, Chairman, (D-NY)
Lucille Roybal-Allard, Vice-Chair, (D-CA)
Ed Pastor, Secretary/Treasurer, (D-AZ)
Matthew G. Martinez, (D-CA)
Ros-Lehtinen, (R-FL)
E (Kika) de la Garza, (D-TX)
Xavier Becerra, (D-CA)
Henry Bonilla, (R-TX)
Lincoln Diaz-Balart, (R-FL)
Carlos Romero-Barcelo, (D-PR)
Bill Richardson, (D-NM)
Esteban E. Torres, (D-CA)
Ron de Lugo, (D-VI)
Solomon P. Ortiz, (D-TX) Ileana
Luis Gutiérrez, (D IL)
Robert Menéndez, (D-NJ)
Frank Tejeda, (D-TX)
Nydia Velázquez, (D-NY)
Robert Underwood, (D-Guam)

Associate Members of the 103rd Congress, include:

Gary Ackerman, (D-NY)
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Joe Barton, (R-TX)
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Nancy Pelosi, (D-CA)
Charles B. Rangel, (D-NY)
Steven Schiff, (R-NM)
Patricia Schroeder, (D-CO)
James Traificant, (D-OH)
Craig Washington, (D-TX)

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

HISPANICS IN CONGRESS PAST AND PRESENT

HOUSE

Joseph Marion Hernandez (W-FL)	1822-1823
Jose Manuel Gallegos (D-NM)	1853-1856; 1871-1873
Miguel Antonio Otero (D-NM)	1856-1861
Francisco Perea (R-NM)	1863-1865
Jose Francisco Chaves (R-NM)	1865-1867
Trinidad Romero (R-NM)	1877-1879
Mariano Sabino Otero (R-NM)	1879-1881
Romualdo Pacheco (R-CA)	1879-1883
Tranquillino Luna (R-NM)	1881-1884
Francisco Manzanares (D-NM)	1884-1885
Pedro Perea (R-NM)	1899-1901
Julio Larringa (U-PR)	1905-1911
Luis Muñoz Rivera (U-PR)	1911-1916
Ladislas Lazaro (D-LA)	1913-1927
Benigno Cardenas Hernandez (R-NM)	1915-1917; 1919-1921
Felix Cordova Davila (U-PR)	1917-1932
Nestor Montoya (R-NM)	1921-1923
Dennis Chavez (D-NM)	1931-1935
Joachim Octave Fernandez (D-LA)	1931-1941
Jose Lorenzo Pesquera (NP-PR)	1932-1933
Santiago Iglesias (C-PR)	1933-1939
Bolivar Pagan (C-PR)	1939-1945
Antonio Manuel Fernandez (D-NM)	1943-1956
Jesus T. Pinero (PD-PR)	1945-1948
Antonio Fernos-Isern (PD-PR)	1949-1965
Joseph Manuel Montoya (D-NM)	1957-1964
Henry B. Gonzalez (D-TX)	1961-
Edward R. Roybal (D-CA)	1963-1992
E (Kika) de la Garza (D-TX)	1965-
Santiago Polanco-Abreu (PD-PR)	1965-1969
Manuel Lujan, Jr. (R-NM)	1969-1988
Jorge Luis Cordova (NP-PR)	1969-1973
Herman Badillo (D-NY)	1971-1977
Ron de Lugo (D-VI)	1973-1979; 1981-
Jaime Benitez (PD-PR)	1973-1977
Baltasar Corrada (NP-PR)	1977-1984
Robert Garcia (D-NY)	1978-1989
Tony Coelho (D-CA)	1979-1989

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

Members of the Congressional Hispanic Caucus - 103rd Congress

José E. Serrano (D-NY)
Chairman
336 Cannon HOB
(202) 225-4361
AA: Ellyn Toscano
Appt. Sec.: Virginia Johnson

Lucille Roybal-Allard (D-CA)
Vice-Chair
1717 Longworth HOB
(202) 225-1766
AA: Henry Contreras
Appt. Sec.: Adriana Moreno-Nevarez

Ed Pastor (D-AZ)
Secretary-Treasurer
408 Cannon HOB
(202) 225-4065
AA: Gene Fisher
Appt. Sec.: Joan Shyccss

E (Kika) de la Garza (D-TX)
1401 Longworth HOB
(202) 225-2531
AA: Bernice McGuire
Appt. Sec.: Rika Clark

Ron de Lugo (D-VI)
2427 Rayburn HOB
(202) 225-1790
AA: Sheila Ross
Appt. Sec.: Lorraine Hill

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2445 Rayburn HOB
(202) 225-7742
AA: Lencho Rendón
Appt. Sec.: Vicky Hoffpauier

Bill Richardson (D-NM)
2349 Rayburn HOB
(202) 225-6190
AA: Isabelle Watkins
Appt. Sec.: Isabelle Watkins

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1740 Longworth HOB
(202) 225-5256
AA: Albert Jacquez
Appt. Sec.: Mary Ann Bloodworth

Ileana Ros-Lehtinen (R-FL)
127 Cannon HOB
(202) 225-3931
AA: Mauricio Tamargo
Appt. Sec.: Lisette Díaz

Xavier Becerra (D-CA)
1710 Longworth HOB
(202) 225-6235
AA: Elsa Márquez
Appt. Sec.: Jean Fong

Henry Bonilla (R-TX)
1529 Longworth HOB
(202) 225-4511
AA: Steve Ruhlen
Appt. Sec.: Christine Pellerin

Lincoln Diaz-Balart (R-FL)
509 Cannon HOB
(202) 225-4211
AA: Jeffrey Bartel
Appt. Sec.: Lidia Rodríguez

Members of the Congressional Hispanic Caucus - 103rd Congress
Page 2

Luis Gutiérrez (D-IL)
1208 Longworth HOB
(202) 225-8203
AA: Doug Scofield
Appt. Sec.: Maggie Muir

Robert Menéndez (D-NJ)
1531 Longworth HOB
(202) 225-7919
AA: Michael Hutton
Appt. Sec.:

Carlos Romero-Barcelo (D-PR)
1517 Longworth HOB
(202) 225-2615
AA: Pedro Rivera Casiano
Appt. Sec.: Maria Ubarri

Frank Tejeda (D-TX)
323 Cannon HOB
(202) 225-1640
AA: Jeff Mendelsohn
Appt. Sec.:

Nydia Velázquez (D-NY)
132 Cannon HOB
(202) 225-2361
AA: Karen Ackerman
Appt. Sec.: Joyce Power

Robert Underwood (D-Guam)
507 Cannon HOB
(202) 225-1188
AA: Terry Schroeder
Appt. Sec.: Angie Borja

COMMITTEES - 103rd CONGRESS

José E. Serrano (D-NY)
- -Appropriations
- -Sub-committees
  - -Foreign operations
  - -Labor, Health and Human Services, and Education

Lucille Roybal-Allard (D-CA)
- -Banking, Finance, and Urban Affairs
- -Small Business

Ed Pastor (D-AZ)
- -Appropriations
  - -Energy
  - -Natural Resources
  - -Agriculture
- -Steering and policy

E (Kika) de la Garza (D-TX)
- -Agriculture (chairman)

Ron de Lugo (D-VI)
- -Education and Labor
- -Natural Resources
- -Public Works and Transportation
- *Select Committee on Narcotics Abuse and Control

Matthew G. Martínez (D-CA)
- -Education and Labor
  - -Human Resources (chairman)
  - -Labor Management Relations
- -Foreign Affairs
- -International Security, organizations, and Human Rights

Solomon P. Ortiz (D-TX)
- -Armed Services
- -Merchant Marine and Fisheries
- *Select Committee on Narcotics Abuse and Control

Bill Richardson (D-NM)
- -Natural Resources
  - -Energy and Commerce
- *Select Committee on Intelligence and Aging

Esteban E. Torres (D-CA)
- -Appropriations

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- -Government Operations

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- -Judiciary
- -Education and Labor
- -Science, Space, and Technology

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- -D.C., Labor, Health and Human Services

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- -Merchant Marine and Fisheries

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- Veterans Affairs

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- -Veteran Affairs

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- -Banking
- -Small Business

Robert Underwood (D-Guam)
- -Armed Services
- -Natural Resources
  - -National Parks, Forests, and Public Lands
  - -Insular Affairs

CARLOS A. ROMERO-BARCELÓ
PUERTO RICO

WASHINGTON OFFICE
1317 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-5401
(202) 225-2615

DISTRICT OFFICE
P.O. BOX 4761
OLD SAN JUAN, PR 00902
(809) 723-6336

Congress of the United States
House of Representatives
Washington, DC 20515-5401

COMMITTEES:
EDUCATION AND LABOR
SUBCOMMITTEES:
ELEMENTARY, SECONDARY AND VOCATIONAL EDUCATION
LABOR-MANAGEMENT RELATIONS
HUMAN RESOURCES

NATURAL RESOURCES
SUBCOMMITTEES:
NATIONAL PARKS, FORESTS AND PUBLIC LANDS
INSULAR AND INTERNATIONAL AFFAIRS

MEMORANDUM

TO: Congressman José Serrano
Chairman Hispanic Caucus
Attention Rick

FROM: Congressman Romero Barceló

DATE: February 10, 1993

RE: Meeting with Health Care Task Force

---

1. Is The Health Care Task Force aware that Puerto Rico receives only 79 million dollars a year in Medicaid?

If we were treated as a state we would receive 1.2 billion dollars a year. The above situation creates serious health care deficiencies in Puerto Rico which further creates problems for cities and states in the mainland and social dislocations for the U.S. citizens in Puerto Rico. That is: a) medical indigents in Puerto Rico have to go to deficient public health care facilities. Many of them move to one of the fifty states in the mainland for medical care and for serious surgical interventions; b) the elderly medical indigents who are paid their Medicaid Insurance as any other U.S. citizen in the mainland cannot afford the deductible that they have to pay in Puerto Rico and they either end up in deficient health care facilities in Puerto Rico or move to the mainland in order to receive treatment at private health care facilities, where the deductible is paid by Medicaid.

2. Do you know that medical indigent veterans in Puerto Rico who have no health care insurance must go to Veteran's Hospital because they have no Medicaid coverage to go to a private hospital, thus overcrowding the Veteran's Hospital?
Why should veterans in Puerto Rico have less rights to adequate health care than veterans in the 50 states ? Did not they risk their lives the same?

LUIS GUTIERREZ
4TH DISTRICT, ILLINOIS

Congress of the United States

House of Representatives

Washington, DC 20515-1304

TO: Chairman Jose Serrano
FROM: Cong. Luis V. Gutierrez
DATE: February 11, 1993
RE: Questions for Hillary Clinton

Pursuant to your memo dated February 8, 1993, I am pleased to submit the following questions to be submitted to Mrs. Clinton. I understand that some of these questions will form part of the discussion between members of the Caucus and Mrs. Clinton next week.

I believe that if the main objectives of health care reform are to contain costs and increase access, these by themselves will not guarantee a significant improvement of the health status of our population. A health reform should address the following:

1. How does increasing access impact the health status of minority groups, for example, reducing the low birth weight rates experienced by minorities?

2. Will market driven initiatives to reform health care enhance the health awareness of these population groups?

3. How does increasing access reduce the burden of our inner city hospitals in attending a disproportionate share of low income and Medicaid patients?

4. How will cost containment initiatives affect the resources of inner city hospitals that attend mainly low income and minority patients?

5. How will health care reform be coordinated with respect to already established initiatives at the state level?

6. How will market driven initiatives of health care reform reduce the pressure on states in allocating resources to health services?

7. What kind of education reform initiatives will be part of a comprehensive proposal of health care reform?

3. Is President Clinton's Administration aware of these inequities? Are there any actions being considered to address these problems?

The above might give you an idea of why the lack of funds and adequate health care services for the medical indigents in Puerto Rico has contributed to create the following problems:

a) Our island has the second highest AIDS rate in the U.S., just behind Washington, DC.

b) More than 150,000 Puerto Rican children suffer from some sort of severe or moderate mental condition, or are functionally handicapped and in need of mental health care services.

c) Puerto Rico has the highest infant mortality rate in the Nation.

d) The average weight of infants at birth in Puerto Rico is the lowest in the nation.

e) More than 100,000 people in Puerto Rico are dependent or addicted to narcotic drugs.

It is therefore important that the President's Task Force take cognizance of these facts and issues in Puerto Rico as they discuss the federal policy and suggest continuation, elimination or changes to existing health care programs.

LINCOLN DIAZ-BALART
21ST DISTRICT, FLORIDA
COMMITTEE ON
FOREIGN AFFAIRS
COMMITTEE ON
MERCHANT MARINE
AND FISHERIES
CHAIRMAN
CUBAN RESEARCH COMMITTEE
TASK FORCE ON LATIN AMERICAN
AND CARIBBEAN AFFAIRS

Congress of the United States
House of Representatives
Washington, DC 20515-0921

PLEASE REPLY TO:
WASHINGTON OFFICE:
☐ 509 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0921
(202) 225-4211

DISTRICT OFFICE:
☐ 8525 N.W. 53RD TERRACE
SUITE 102
MIAMI, FL 33166
(305) 470-8555

QUESTIONS ON HISPANIC HEALTH CARE

FOR MRS. HILLARY CLINTON

(1) Do you see minority H.M.O's as capable of participating in the process of competitive bidding for managed care with a grace period within which to become federally qualified in order to ensure health care to minority groups, i.e. Hispanics, Afro Americans and Haitians?

(2) Under what conditions should these companies, licensed in their state and in good standing be able to compete with giant national firms that will participate in the program?

(3) How do you ensure that in competitive managed care the large national companies will not "under bid" and take losses for the first few years driving away competition?

(4) Should the federal agency for health care reform set rates for members of managed care organizations?

CONTACT: Brenda Lopez-Ibanez
Health LA
225-4211

• Sequence
• Legislative Achievements?
• Sequence / Agenda March 1, 1993

only members (+ assoc invited)

MEETING WITH CONGRESSIONAL HISPANIC CAUCUS

DATE: March 2, 1993
LOCATION:
TIME: 2:30 p.m.
FROM: Kim Tilley

I. PURPOSE

To discuss with members of the caucus their concerns regarding health care reform

II. BACKGROUND

In the 103rd Congress, there are eighteen Members of Congress in the Congressional Hispanic Caucus (2 women and 15 men). 15 Demo / 3 Repub

The Congressional Hispanic Caucus was organized in December 1976 as a bipartisan organization dedicated to "voicing and advancing, through the legislative process, issues affecting Hispanic Americans in the U.S. and the insular areas." Some Expand

Legislative Agenda

- Educational Reform - assuring access to a quality education for all American youth and adults;
- Health Care Reform - improving the health care delivery system;
- Employment and Training - expanding and promoting employment opportunities for Hispanics and others;
- Housing, Community Development and Small Business - revitalizing the economies of our depressed urban and rural communities and providing afordable, quality housing for middle and low income Americans;
- Family and Children - helping to maintain robust Hispanic families;
- Immigration - promoting an equitable and reasonable immigration policy (e.g. repealing the employer sanctions provisions of the Immigration Reform and Control Act;

- Civil and Voting Rights - protecting the civil rights of Hispanics, women and other minories in all avenues of American life

NOTE: The Caucus has expressed concern about Hispanics being fully included in the Administration and in the Health Care Task Force in particular. Aside from significant Cabinet representation (Secretary Cisneros and Secretary Pena), a list has been compiled of health care task force members who are of Hispanic descent.

III. PARTICIPANTS

Rep. Jose Serrano, Chair - Congressional Hispanic Caucus
(participant list follows)

IV. PRESS PLAN

Arrival/Departure - Open Press
Meeting - Closed except for pool spray

V. SEQUENCE OF EVENTS

IV. REMARKS

o HRC opening remarks
o Dialogue

- o protecting the civil rights of Hispanics, women and other minorites in all avenues of American life;
- o empowering the disenfranchised through the electoral process;
- o monitoring the implementation of immigration laws; and
- o providing affordable, quality housing for middle and low income Americans.

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Greg Laughlin, (D-TX)
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Jim McDermott, (D-WA)
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Patricia Schroeder, (D-CO)
James Traficant, (D-OH)
Craig Washington, (D-TX)

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

FAX TRANSMISSION FROM THE CONGRESSIONAL HISPANIC CAUCUS

x 2896
J. Hart

DATE March 1, 1993

Please deliver the following message to:

NAME Tim Tibbs

TELECOPIER NUMBER 546-2239

FROM Rick Lopez

TELECOPIER NUMBER: (202) 225-7569

TELEPHONE NUMBER: (202) 226-3430

Number of pages (including this cover sheet) 17

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-Dawn-
-7450-

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

*** M E M O R A N D U M ***

To: Kim Tilley
From: Rick Lopez
Re: Caucus Meeting with Mrs. Hillary Rodham Clinton
Date: March 1, 1993

Enclosed, please find the following documents:

1) Draft of the Caucus' Legislative Agenda- this is a confidential draft agenda that may give Mrs. Clinton a perspective of the Caucus' legislative goals for this Congressional session

2) Caucus' Biography

3) Past and Present Hispanics in Congress

4) Roster of Congressional Hispanic Caucus Members

5) Member's Committee and Sub-Committee

6) Health questions submitted by Rep. Luis Gutierrez Rep. Lincoln Diaz-Balart, and Rep. Carlos Romero-Bacelo.

I hope that the furnished information serves helpful. Please feel free to call me at 226-3430 if you require any additional information.

557 Ford House Office Building, Washington, D.C. 20515 • (202) 226-3430 Fax: (202) 225-7569

WASHINGTON OFFICE:
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Congress of the United States
House of Representatives
Washington, DC 20515-3216

SUBCOMMITTEES:
LABOR/HEALTH
HUMAN SERVICES/EDUCATION
FOREIGN OPERATIONS,
EXPORT FINANCING AND
RELATED PROGRAMS

CHAIRMAN, CONGRESSIONAL
HISPANIC CAUCUS

ASSOCIATE MEMBER, CONGRESSIONAL
BLACK CAUCUS

Biographical Sketch January 1993

José E. Serrano (Democrat-Liberal), was born in Mayaguez, Puerto Rico on October 24, 1943. His family moved to the South Bronx from Puerto Rico in 1950. He attended public school and completed courses for credit at Lehman College, City University of New York. Congressman Serrano served in the 172nd Support Battalion, Fort Wainright, Alaska, in the U.S. Army Medical Corps.

Prior to his election to Congress, Mr. Serrano had a distinguished sixteen-year career in the New York State Assembly including six years as chairman of the Education Committee. First elected in 1974, he was reelected seven times to represent the same Bronx communities.

In March 1990, he won a special Congressional election by an overwhelming majority and was sworn in as a member of the House of Representatives for New York's 18th district. He was elected the following November to serve a full two-year term and again in November 1992 to a second full term.

The first bill of which Congressman Serrano was prime sponsor (P.L. 101-600), which provides funding for successful school drop-out programs, was signed into law by President Bush on November 16, 1990.

Congressman Serrano has cosponsored of a number of major bills including the Civil Rights Act, the Family and Medical Leave Act, the Higher Education Act and the bill which extended unemployment benefits.

In the 1992 session, two major bills he authored were the Voting Rights Improvement Act, to extend and broaden a key section of the original legislation mandating bilingual registration and voting in certain areas with a heavy minority population, and the Classroom Safety Act, to provide funds for programs to protect students and teachers and to discourage crime, violence, and drugs and gang-related activities in schools where such problems are prevalent.

Mr. Serrano has also been a leader in encouraging Congressional action on the proposed referendum posing three choices for the future political status of Puerto Rico: statehood, independence, or retaining its present commonwealth relationship with the United States.

Through his first full term, Congressman Serrano served on the Committee on Education and Labor and the Committee on Small Business.

When the House of Representatives reorganized in December 1992, the leadership appointed Mr. Serrano to the prestigious Appropriations Committee where he will serve on two important panels, the Subcommittee on Labor, Health and Human Services, and Education, and the Subcommittee on Foreign Operations.

In December, Congressman Serrano was also elected to a two-year term as Chairman of the Congressional Hispanic Caucus.

-0-

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

THE CONGRESSIONAL HISPANIC CAUCUS

The Congressional Hispanic Caucus, organized in December 1976, is a bipartisan group of nineteen Members of Congress of Hispanic descent. The Caucus is dedicated to voicing and advancing, through the legislative process, issues affecting Hispanic Americans in the United States and the insular areas.

Organized as a Legislative Service Organization under the rules of Congress, the Caucus is comprised solely of Members of the United States Congress. Under these rules, Associate Membership is offered to dues paying Members of Congress who are not of Hispanic decent but who wish to support the Caucus and assist its efforts on behalf of Hispanics across the nation. With its Associate Members, Caucus membership represents sixteen states and three insular areas.

Although every issue that effects the quality of life of all U.S. citizens is a Congressional Hispanic Caucus concern--from peace and conflict to education and the environment--there are national and international issues that have a particular impact on the Hispanic community. The Caucus monitors legislative action as well as policies and practices of the Executive and Judicial branches of government.

Agenda items for the 103rd Congress include:

- o assuring access to a quality education for all American youth and adults;
- o improving the nation's health care delivery system;
- o expanding and promoting employment opportunities for Hispanics and others;
- o revitalizing the economies of our depressed urban and rural communities;

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

HISPANICS IN CONGRESS PAST AND PRESENT

HOUSE

Joseph Marion Hernandez (W-FL)	1822-1823
Jose Manuel Gallegos (D-NM)	1853-1856; 1871-1873
Miguel Antonio Otero (D-NM)	1856-1861
Francisco Perea (R-NM)	1863-1865
Jose Francisco Chaves (R-NM)	1865-1867
Trinidad Romero (R-NM)	1877-1879
Mariano Sabino Otero (R-NM)	1879-1881
Romualdo Pacheco (R-CA)	1879-1883
Tranquillino Luna (R-NM)	1881-1884
Francisco Manzanares (D-NM)	1884-1885
Pedro Perea (R-NM)	1899-1901
Julio Larringa (U-PR)	1905-1911
Luis Muñoz Rivera (U-PR)	1911-1916
Ladislas Lazaro (D-LA)	1913-1927
Benigno Cardenas Hernandez(R-NM)	1915-1917; 1919-1921
Felix Cordova Davila (U-PR)	1917-1932
Nestor Montoya (R-NM)	1921-1923
Dennis Chavez (D-NM)	1931-1935
Joachim Octave Fernandez (D-LA)	1931-1941
Jose Lorenzo Pesquera (NP-PR)	1932-1933
Santiago Iglesias (C-PR)	1933-1939
Bolivar Pagan (C-PR)	1939-1945
Antonio Manuel Fernandez (D-NM)	1943-1956
Jesus T. Pinero (PD-PR)	1945-1948
Antonio Fernos-Isern (PD PR)	1949-1965
Joseph Manuel Montoya (D NM)	1957-1964
Henry B. Conzalez (D-TX)	1961-
Edward R. Roybal (D-CA)	1963-1992
E (Kika) de la Garza (D-TX)	1965-
Santiago Polanco-Abreu (PD-PR)	1965-1969
Manuel Lujan, Jr. (R-NM)	1969-1988
Jorge Luis Cordova (NP-PR)	1969-1973
Herman Badillo (D-NY)	1971-1977
Ron de Lugo (D-VI)	1973-1979; 1981-
Jaime Benitez (PD-PR)	1973-1977
Baltasar Corrada (NP-PR)	1977-1984
Robert Garcia (D-NY)	1978-1989
Tony Coelho (D-CA)	1979-1989

Congress of the United States
Congressional Hispanic Caucus
103rd Congress

Members of the Congressional Hispanic Caucus - 103rd Congress

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Appt. Sec.: Virginia Johnson

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AA: Henry Contreras
Appt. Sec.: Adriana Moreno Nevarez

Ed Pastor (D-AZ)
Secretary Treasurer
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AA: Gene Fisher
Appt. Sec.: Joan Shycoss

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Appt. Sec.: Rika Clark

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Appt. Sec.: Lorraine Hill

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Appt. Sec.: Vicky Hoffpauier

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Appt. Sec.: Isabelle Watkins

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Members of the Congressional Hispanic Caucus - 103rd Congress
Page 2

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Appt. Sec.: Maria Ubarri

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AA: Jeff Mendelsohn
Appt. Sec.:

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AA: Karen Ackerman
Appt. Sec.: Joyce Power

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Congressional Hispanic Caucus
NEWS RELEASE

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

For Immediate Release
July 8, 1992

Contact: **Rick López**
(202) 226-3430

HOUSE CLEARS PACKAGE INCLUDING HISPANIC CAUCUS HIGHER ED BILL
Ortiz Calls Bill "Important Step" for Hispanic Education

Washington, D.C. – Congressman Solomon P. Ortiz, Chairman of the Congressional Hispanic Caucus, announced today that the House of Representatives passed a legislative package which included provisions from the "Hispanic Access to Higher Education Act of 1992" and other measures to increase the participation and success of Hispanic students in higher education.

"Today's action is an important step in improving the educational opportunities for the nation's Hispanic community," stated Ortiz. "By including provisions of the Hispanic Caucus higher education proposal, this legislation will help to ensure that the higher educational programs of the federal government recognize the unique needs of Hispanic students."

"Hispanics have the highest drop out rates in the country and Hispanic drop out's leave school earlier than any other group of students," stated Ortiz. "To address the Hispanic drop out problem, S 1150 establishes an early intervention program to help Hispanics and others to remain in school and enroll in higher education." The early intervention program would make available federal funds to schools and community organizations for the purpose of providing counseling and support services to at-risk minorities and other low-income students.

Other programs included from the Caucus higher education proposal as part of S 1150 are a teacher training program designed to increase the number of qualified, minority teachers and a new study to increase our understanding of why some Hispanics, minorities and other low-income individuals participate or succeed in higher education.

In addition to measures from the Caucus higher education proposal, S 1150 also included a new $45 million institutional development program for Hispanic Serving Institutions (HSIs), defined as colleges and universities in which more than 25 percent of the students are Hispanic.

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

Congressional Hispanic Caucus
NEWS RELEASE
557 Ford Building, Washington, D.C. 20515 • (202) 226-3430

For Immediate Release
August 7, 1992

Contact: Rick López
(202) 226-3430

HISPANIC CAUCUS BILINGUAL VOTING BILL PASSES SENATE

Action Clears Bill For President's Signature

Washington, D.C. - Congressman Solomon P. Ortiz, Chairman of the Congressional Hispanic Caucus, announced that the Senate passed the Caucus bilingual voting bill (HR 4312) today, clearing the bill for the President's signature. HR 4312, the Voting Rights Language Assistance Act of 1992, was introduced by the Congressional Hispanic Caucus on February 25.

"The Senate has now joined the House in endorsing bilingual voting," stated Ortiz. "It is clear that Congress, and America, is solidly committed to bringing Hispanics and other language minorities into the political process."

"Seven years ago, I sued to have the federal bilingual voting mandate enforced in New York City," stated Congressman José E. Serrano, sponsor of HR 4312. "Today I feel very proud of being a participant in the Hispanic Caucus effort to open the political system to Hispanics and others across the entire country."

Under a provision of current law which expired on August 6, bilingual registration and voting assistance is mandated in counties where more than 5 percent of voting age citizens need bilingual assistance. The Caucus bill would reauthorize the provision until the year 2007.

In addition, HR 4312 would ensure that eligible Hispanic citizens are better covered by the bilingual voting provisions. The current 5 percent formula has left out densely populated counties like Los Angeles County, California, Queens County, New York, and Cook County, Illinois. The Caucus legislation would ensure that Hispanic communities will receive bilingual voting assistance if at least 10,000 voting age citizens need the assistance or if they meet the 5 percent standard.

Before passing HR 4312 by a vote of 74 to 21, the Senate soundly defeated two amendments offered by Alan Simpson (R-WY) which would have weakened the bill. The first amendment, which would have reduced the authorization period from 15 years to 5 years and would have increased the new benchmark from 10,000 to 20,000 persons, was defeated by a vote of 32 to 63. Under the second Simpson amendment, a jurisdiction would only have to provide bilingual voting assistance if they received all of the costs of the assistance from the federal government. The amendment was defeated by a vote of 35 to 60.

The House of Representatives passed HR 4312, without amendment, on July 24 by a vote of 237 to 125.

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

HISPANIC REPRESENTATION

Here is a breakdown of Hispanics included among the cluster leaders and the task force leaders. Of the twelve cluster groups, there are four Hispanics in leadership positions.

GROUP I : New System Organization - Henry Montas

GROUP II : New Systems Coverage

Task Force 6: Benefits Package - Bob Valdez

GROUP III : New Systems Infrastructure

Task Force 9 : Quality Management - Risa Lavizzo-Mourey

Task Force 12 : Facilitating Prof. Dev. - Ciro Sumaya

- María Echevarría

7346

AFRICAN AMERICAN REPRESENTATION

Here is a breakdown of the African Americans included among the cluster leaders and the task force leaders. Of the twelve cluster groups, there are four African Americans in leadership positions.

GROUP I : New System Organization - SallyAnn Payton

Task Force 2 : Special Issues in Purchasing Coops. - Claudia Baquet

Group VIII : Health Policy Initiatives - Aaron Shirley, Mark Smith

THE WHITE HOUSE
WASHINGTON

Mon 3/1/93

- Black Caucus
- Hispanic "
- 55/Med quotes

> still on? anything else

- HATCH ~~Congress~~ Act
- Rena Cmon - 4

hrg Thurs - Gays in the Military

- Check NIH/ MOTORVOTER
  Kassebaum/Healey

~~campaign~~ said during

BC — Yes got no longer monitors st by at ##.

Robert Rear NYT (pros yes Medicare & cuts) but NH private #

① true about BC stmt?

② true

E Drew

Russert — Deficit July/interview

Betty Ford Center Profile

The Betty Ford Center is recognized an international leader in the field of alcohol and drug dependency treatment.

Since it was founded in 1982, Betty Ford Center is proud to have treated more than 20,000 people, their families and their children, who are in recovery having broken the cycle of their disease thanks to the Center's professional staff and innovative, successful treatment programs.

The Center's mission is to provide the most affordable, effective treatment possible for individuals, 18 and older, and to offer counseling and support to their families for their codependency.

The Center offers a wide range of services including:
- An 80-bed, Inpatient Program,
- An Intensive Outpatient Program,
- A 5-day Family/Codependency Program,
- A 30-day Children's Program,
- A Professional-in-Residence Program, also including medical students
- An International Consultation program.

The Center believes that effective treatment, as well as careful follow through will lead to a meaningful, productive and happy life, without the use of alcohol and other mind altering drugs. Consequently, Betty Ford Center also supports an extensive network for vital continuing care through organizations, including its own Alumni chapters, as well as Alcoholics Anonymous and Narcotics Anonymous.

Treatment for the diseases of alcohol and drug dependency at Betty Ford Center is built around a 112 staff member, interdisciplinary team of physicians, nurses, chemical dependency counselors, clinical psychologists, other health care professionals, nutritionists and experts in spirituality. Much of the program is based on the Twelve Steps of Alcoholics Anonymous, but each patient's recovery program is carefully tailored to their specific needs and history of abuse.

BETTY FORD CENTER PROFILE, page 2

IN PATIENT PROGRAM

The Center treats approximately 1,000 patients per year in its 80-bed facility. The length of stay is determined by the individual needs of the patient.

Recognizing the very distinct needs of women, the Center is very proud of its long-standing commitment to its "Women's Program" which focuses on those special needs as an integral part of the treatment process.

Included as part of treatment for all patients is a 5-day Family Program for a family member or close, loved one to help break the cycle of their addiction.

About half of the patients come from California. The remaining 50% come from around the United States and from many foreign countries

The inclusive cost of the inpatient program is about $360. per day., and is covered by most insurance policies.

Scholarship money is also available to anyone who needs assistance.

INTENSIVE OUTPATIENT PROGRAM

This six week program consists of thirty (30), 4-hour, evening sessions for the chemically dependent person, as well as the family member/codependent.

The inclusive cost for this program is $3,345. per person.

CONTINUING CARE PROGRAM

Successful recovery occurs gradually and requires attention, care and support. This program is specifically designed and available to everyone who has completed any of the special programs at Betty Ford Center.

The Continuing Care Program runs for 52 weekly sessions.

FAMILY/CODEPENDENCY PROGRAM

Is available to anyone from a chemically dependent family, whether or not they have a family member in treatment at the Center.

The 5 day program is based on the fact that alcoholism and drug dependency is a family disease, and it's designed to help family members learn about chemical dependency, how their lives have been affected, and how they can change those lives, and themselves, to break that addiction and their disease.

CHILDREN'S PROGRAM

Is a unique component of Betty Ford Center offering children, ages 8 to 18, an opportunity to break free of their pain and the effects of the disease through creative therapy, including art, play and individual counseling, among others.

At least one parent is required to participate in the Children's Program. The fee is minimal and scholarships are offered.

BETTY FORD CENTER PROFILE, page 5

PROFESSIONALS-IN-RESIDENCE (PIR)

Is a powerful tool designed to share the experience and knowledge of the diseases of alcoholism and chemical dependency. The program, begun in 1986, is a 5-day course for professionals (teachers, clergy, law enforcement and judicial officers, attorneys, physicians, nurses, personnel managers, social workers, &c.).

Participants learn about the Center's approach to treatment by living with patients or attending the Family programs. Special lectures are also designed to teach and provide intensive course work.

Each summer, the PIR program also enables medical students from the United States, Canada and Puerto Rico to learn first hand about the effects of and treatment for the disease. Working with the staff and observing the patients affords these future doctors a once-in-a-lifetime, learning opportunity.

A very important PIR program is currently underway with the NCAA - The National Collegiate Athletic Association. This PIR helps athletic directors, coaches, and teachers new ways of recognizing the dangers of alcoholism and drug dependency, as well as explaining steps which can lead to successful treatment and productive lives.

INTERNATIONAL CONSULTATION

The Center's world renown reputation for excellence and success in the treatment of alcoholism and drug dependency disease has led to its becoming known and copied as the "Betty Ford model."

The Center's expertise is now available and already being shared with programs around the world, including Sweden, Finland, India and Mexico, among others.

Along with providing training at the Center, a Betty Ford staff member is assigned to each international site to continue offering help and guidance in the development process, as well as on-going expertise and counseling.

BETTY FORD CENTER PROFILE, PAGE 4

TRAINING PROGRAMS, SPECIAL CONFERENCES

Betty Ford Center maintains an extensive network of programs, which run throughout the year and around the nation, as an outreach sharing its research and knowledge, both for professionals and with the lay person, in the fields of alcoholism and drug dependency.

These include the Annual Conference on Chemical Dependency, held annually, which brings together hundreds of the country's foremost experts in the field of addictions treatment. Also included are Recovery Days for Women, special day-long sessions held throughout the United States, to help address the very special needs of women facing addiction, and to provide information about treatment.

In Rancho Mirage, the Center supports the free Alcohol and Other Drugs Awareness Hour, a regular, weekly series of events held year round for local citizens, not just former patients, who want to know more the use, misuse and abuse of alcohol and other drugs, as well as information about the disease and treatment.

The Center also supports the Betty Ford Center Alumni Association, a network of thousands of alumni in more than 45 chapters across the United States and Canada. Last year, more than 1,350 alumni returned to the Center to celebrate their sobriety on the occasion of the Center's 10 Anniversary!

At Betty Ford Center we know treatment programs work. They save lives. They save families. While recovery truly is a lifelong process, and alcoholism and drug dependency are lifelong diseases, our programs help stop the cycle of use, abuse and desparation. They are, in the very best sense of the word, a new beginning and an end to the disease including its pain and suffering.

Key Officers and Executives of Betty Ford Center:

Betty Ford, Co-Founder and Chairman of the Board
Leonard Firestone, Co-Founder
Edwin Johnsen, Vice President of the Board
John T. Schwarzlose, President
Michael S. Neatherton, Administrator
Gail N. Shultz, Medical Director
Mark Greenberg, Clinical Director
Anne Vance, Director of Training and Consultation
Robert J. Lindsey, Community Relations Director

CASA Goals

- To determine what prevention and treatment programs work, for whom, under what circumstances.
- To inform the American people of the social and economic costs of substance abuse and addiction, and of the opportunities to reduce those costs.
- To ensure that professionals in industry, education and health care recognize--and have the tools to fulfill--their responsibility to prevent and combat substance abuse.
- To move the issue of substance abuse into the mainstream of America's medical, social, educational, economic and political discourse.

Priority Projects

- Assess the effectiveness of chemical-dependency treatment programs. Develop protocols for exemplary programs.
- Raise public awareness about the impact of substance abuse throughout society and the relationship of substance abuse to other public health threats, e.g., the deadly combination of substance abuse, AIDS and tuberculosis.
- Conduct demonstration program testing a combination of programs targeted at 11- to 13-year-olds who are experimenting with alcohol and other drugs (under way in Austin, Bridgeport, Memphis, and Seattle.)
- Develop multisite demonstration program providing after-care drug treatment, employment and other services to ex-offenders who have received drug or alcohol treatment while incarcerated.
- Conduct multisite demonstration program providing services to homeless people who are mentally ill and chemically addicted.
- Assess the costs of substance abuse to the Medicaid program and identify opportunities to reduce those costs. This project will develop a model to estimate costs that can be applied to other public programs and private insurers.
- Commission a series of papers by leading scholars that assess the costs and consequences of substance abuse to all aspects of society and identify promising ways to deal with the problem. Hold conference where papers will be presented.
- Establish a national commission on the roles and responsibilities of institutions of higher education, parents and students with respect to substance abuse on college and university campuses.
- Establish a working group of top Employee Assistance Program directors to examine the role and responsibilities of employers and identify the critical elements in organizing and operating effective EAPs.
- Assess the status of women's health and substance abuse, and issue a report on the subject.
- Issue a study on the use of acupuncture in drug treatment.
- Assess the role of teachers, health professionals and clergy in addressing the problem of substance abuse.
- Collect and analyze existing sources of data on the social and economic costs of substance abuse and addiction; identify important program development and policy and research activities.
- Issue an annual report on the state of addiction in America.

Board of Directors

James E. Burke

Chairman, Partnership for a Drug-Free America; Chairman, President's Drug Advisory Council; former Chairman and CEO of Johnson and Johnson

Joseph A. Califano, Jr.

Chairman of the Board and President of CASA; Special Assistant to President Lyndon B. Johnson (1965 to 1969); Secretary of Health, Education, and Welfare from 1977 to 1979.

Betty Ford

Former First Lady; currently Chairman of the Betty Ford Center in Rancho Mirage, California.

Douglas A. Fraser

Former President of the United Auto Workers; currently Professor of Labor Studies at Wayne State University

Honorable Barbara C. Jordan

Former Congresswoman from Texas; currently Professor at the LBJ School of Public Affairs at the University of Texas at Austin

Donald R. Keough

President and Chief Operating Officer of The Coca-Cola Company

LaSalle D. Leffall, Jr., M.D.

Chairman of the Department of Surgery at Howard University College of Medicine, and former President of the American Cancer Society

Manuel T. Pacheco, Ph.D.

President of the University of Arizona; former President of the University of Houston-Downtown

Linda Johnson Rice

President and Chief Operating Officer of the Johnson Publishing Company, Inc. (Ebony, Jet, etc.)

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Vice Chairman of The Bear Stearns Companies Inc.

Michael I. Sovern

President of Columbia University

Frank G. Wells

President and Chief Operating Officer of the Walt Disney Company

M E M O R A N D U M

TO: Hillary Rodham Clinton/Kim Tilley March 1, 1993
FR: Chris Jennings
RE: Tuesday Meeting with Senator Wellstone

Tomorrow, at 12:00 noon, you are scheduled for a meeting with Senator Paul Wellstone. He has requested a meeting with you to discuss his single payor legislation and its role within the overall health reform debate, as well as to talk about how he can be helpful to the Administration's work on reform. In attendance will be Shiela Wellstone (the Senator's wife who has been doing a great deal of health reform work at the State level and is particularly interested in and concerned about domestic violence) and Ellen Schaefer (the Senator's health staff person)

This Wednesday (March 3rd), Senator Wellstone intends to introduce the Senate companion (with Senators' Inouye, Metzenbaum, and Simon) to the single-payor legislation that will be introduced in the House by Congressman McDermott. The 1995 new Federal costs required by this bill amounts to approximately $551 billion. It is payed for by increases in income taxes, payroll taxes, corporate taxes and other revenue raisers. By 1996, however, overall private/public spending will be less than what it would be under current projections.

Both Senator Wellstone and Congressman McDermott will state in their floor remarks that they have every intention of working closely with the Clinton Administration on health reform and suggest that they are open to alternative approaches. They will say that they are comfortable taking this position because they believe that there is a great deal of common ground between the health reform principles and goals that have been outlined by the Clinton Administration and where their bill is.

Although the liberal Senator from Minnesota is not overly influential within the Senate, Senator Wellstone and his supporters are critical to assuring that the most active health reform advocates in the nation (the single-payor fans) are strongly behind whatever Administration bill is eventually introduced. It is, therefore, highly advisable that he and his bill are treated with respect by all within the Administration. You may want to assure him that the Administration, if asked, will state that the Wellstone bill is a constructive contribution to the debate and that the Administration will continue to work closely with Senator Wellstone, Congressman McDermott and their supporters.

March 2, 1993

Meeting with **CONGRESSIONAL BLACK CAUCUS MEETING**

DATE: March 1, 1993
LOCATION:
TIME: 1:00 p.m.
FROM: Kim Tilley

I. PURPOSE

To discuss CBC's views on proposals for the implementation of a national comprehensive health care program.

II. BACKGROUND

In the 103rd Congress, there are 40 Black Members of Congress, nine women and thirty-one men.

The Congressional Black Caucus was formed in 1970 when the thirteen Black Members of the U.S. House of Representatives joined together to strengthen their efforts to address the legislative concerns of Black and minority citizens. It is bipartisan.

CBC received its first national recognition when its Members met with former President Richard Nixon in March 1971 and presented to him a list of 60 recommendations for governmental action on domestic and foreign issues. Since then, CBC has remained actively involved in a wide range of legislative initiatives. (See CBC Achievements.) Most noteworthy is the CBC Alternative Budget which CBC has produced for the past thirteen years. As might be expected, the CBC Alternative Budget has historically departed significantly from Administration Budget recommendations.

CBC states that it introduced more than 400 individual bills in the 102nd Congress and co-sponsored 11,000 legislative measures.

III. PARTICIPANTS

Kweisi Mfume (em-FOO-may), Chair of the Congressional Black Caucus

All 40 members of the CBC were invited (participant list follows). Key legislative staff will sit in as well.

IV. PRESS PLAN

Arrival/Departure - Open Press
Meeting - Closed after pool spray

NOTE: There is a possibility you may be asked about the Harold Ford case and the Hubbell connection. CBC has been asked if it approached you to weigh in on Harold Ford's behalf with the Judiciary Department because of your connection to Hubbell. CBC's response has been that they weren't even aware of the connection and that as far as they were concerned, the purpose of Tuesday's meeting is to focus exclusively on health care reform and CBC's proposals.

V. SEQUENCE OF EVENTS

o Representative Mfume introduces HRC;
o HRC - brief remarks;
o Representative Mfume introduces Representative Stokes (remarks);
o " " introduces Representative Cardiss Collins (remarks);
o " " introduces Representative Conyers (remarks);
o Questions from other members.

IV. REMARKS

o HRC opening remarks
o Dialogue

BLACK MEMBERS OF CONGRESS

With the convening of the 103rd Congress, a total of 89 Black Americans had been elected to the Congress in the history of this nation: 4 in the Senate and 85 in the House. The following is a list of Black members, their parties, states, and years of service. In addition to these 89, John W. Menard (R-LA), won a disputed election in 1868 but was not permitted to take his seat in Congress.

SENATE

Hiram R. Revels (R-MI)	1870 - 1871
Blanche K. Bruce (R-MI)	1875 - 1881
Edward W. Brooke (R-MA)	1967 - 1979
Carol Moseley-Braun (D-IL)	1993 -

HOUSE

Joseph H. Rainey (R-SC)	1870 - 1879
Jefferson F. Long (R-GA)	1870 - 1871
Robert B. Elliott (R-SC)	1871 - 1874
Robert C. DeLarge (R-SC)	1871 - 1873
Benjamin S. Turner (R-AL)	1871 - 1873
Josiah T. Walls (R-FL)	1871 - 1873
Richard H. Caine (R-SC)	1873 - 1875; 1877 - 1879
John R. Lynch (R-MI)	1873 - 1877; 1882 - 1883
James T. Rapier (R-AL)	1873 - 1875
Alonzo J. Ransier (R-SC)	1873 - 1875
Jeremiah Haralson (R-AL)	1875 - 1877
John A. Hyman (R-NC)	1875 - 1877
Charles E. Nash (R-LA)	1875 - 1877
Robert Smalls (R-SC)	1875 - 1879
James E. O'Hara (R-NC)	1883 - 1887
Henry P. Cheatham (R-NC)	1889 - 1893
John M. Langston (R-VA)	1890 - 1891
Thomas E. Miller (R-SC)	1890 - 1891
George W. Murray (R-SC)	1893 - 1895; 1896 - 1897
George W. White (R-NC)	1897 - 1901
Oscar DePriest (R-IL)	1929 - 1935
Arthur W. Mitchell (D-IL)	1935 - 1943
William L. Dawson (D-IL)	1943 - 1970
Adam C. Powell, Jr. (D-NY)	1945 - 1967; 1969 - 1971
Charles C. Diggs, Jr. (D-MI)	1955 - 1980
Robert N.C. Nix (D-PA)	1958 - 1978
Augustus F. Hawkins (D-CA)	1963 - 1990
John Conyers, Jr. (D-MI)	1965 -
William L. Clay (D-MO)	1969 -
Louis Stokes (D-OH)	1969 -
Shirley Chisholm (D-NY)	1969 - 1982
George W. Collins (D-IL)	1970 - 1972
Ronald V. Dellums (D-CA)	1971 -
Ralph H. Metcalfe (D-IL)	1971 - 1978
Parren H. Mitchell (D-MD)	1971 - 1986
Charles B. Rangel (D-NY)	1971 -
Walter E. Fauntroy (D-DC) *Delegate*	1971 - 1990
Yvonne B. Burke (D-CA)	1973 - 1979
Cardiss Collins (D-IL)	1973 -
Barbara C. Jordan (D-TX)	1973 - 1978
Andrew Young (D-GA)	1973 - 1977
Harold E. Ford (D-TN)	1975 -
Julian C. Dixon (D-CA)	1979 -
William H. Gray, III (D-PA)	1979 - 1991
Mickey Leland (D-TX)	1979 - 1989
Melvin Evans (R-VI) *Delegate*	1979 - 1980
Bennett McVey Steward (D-IL)	1979 - 1980
George W. Crockett (D-MI)	1980 - 1990
Mervyn M. Dymally (D-CA)	1981 - 1992
Gus Savage (D-IL)	1981 - 1992
Harold Washington (D-IL)	1981 - 1983
Katie Hall (D-IN)	1982 - 1984
Major Owens (D-NY)	1983 -
Edolphus Towns (D-NY)	1983 -
Alan Wheat (D-MO)	1983 -
Charles Hayes (D-IL)	1983 - 1992
Alton R. Waldon, Jr. (D-NY)	1986 - 1987
Mike Espy (D-MI)	1987 -
Floyd Flake (D-NY)	1987 -
John Lewis (D-GA)	1987 -
Kweisi Mfume (D-MD)	1987 -
Donald M. Payne (D-NJ)	1989 -
Craig A. Washington (D-TX)	1989 -
Barbara-Rose Collins (D-MI)	1991 -
Gary Franks (R-CT)	1991 -
Eleanor Holmes Norton (D-D.C.) *Delegate*	1991 -
William Jefferson (D-LA)	1991 -
Maxine Waters (D-CA)	1991 -
Lucien Blackwell (D-PA)	1991 -
Eva Clayton (D-NC)	1992 -
Sanford Bishop (D-GA)	1993 -
Corrine Brown (D-FL)	1993 -
Jim Clyburn (D-SC)	1993 -
Cleo Fields (D-LA)	1993 -
Alcee Hastings (D-FL)	1993 -
Earl Hilliard (D-AL)	1993 -
Eddie Bernice Johnson (D-TX)	1993 -
Cynthia McKinney (D-GA)	1993 -
Carrie Meek (D-FL)	1993 -
Mel Reynolds (D-IL)	1993 -
Bobby Rush (D-IL)	1993 -
Bobby Scott (D-VA)	1993 -
Walter Tucker (D-CA)	1993 -
Mel Watt (D-NC)	1993 -
Albert Wynn (D-MD)	1993 -

MEMBERS OF THE CONGRESSIONAL BLACK CAUCUS

Representative Earl F. Hilliard, a Democrat from Alabama, represents the 7th District. He was elected on November 3, 1992.

Representative Ronald V. Dellums is a Democrat from California, representing the 8th district, which includes Oakland. The Chairman of the Armed Services Committee, he has been a member of Congress since 1971.

Representative Julian C. Dixon is a Democrat from California, representing the 28th district, which includes Culver City.

Representative Walter R. Tucker III is a Democrat from California, representing the 37th District. He was elected in November 1992, after facing no major party opposition.

Representative Maxine Waters is a Democrat from California's 29th district, including Los Angeles. Representative Water's district includes the area which erupted in riots caused by the first Rodney King trial verdict.

Representative Gary A. Franks is a Republican from Connecticut's 5th district, which includes Waterbury. He sits on the Health and the Environment Subcommittee where he is the 8th of 10 Republicans. He is also the sponsor of H.R. 892 -- Parental Responsibility Act

Delegate Eleanor Holmes Norton is a Democrat from Washington DC. She has been a delegate since 1990. She sits on the House Committee on the District of Columbia, where she is the 4th of 7 Democrats, as well as on the Fiscal Affairs and Health Subcommittee where she is the 5th of 4 Democrats.

Representative Corrine Brown is a Democrat from Florida, representing the 3rd District. She was elected on November 3, 1992, defeating Don Weidner in Florida's new 3rd District. Weidner staunchly supported tort and health care reform and made that the central issue of his candidacy. Brown won the election with 60 percent of the vote. She sits on the House Committee on Veterans' Affairs Hospitals and Health Care Subcommittee where she is the 13th of 13 Democrats.

Representative Alcee L. Hastings, Democrat from Florida, representing the 23rd District Elected: November 1992.

Representative Carrie P. Meek is a Democrat from Florida, representing the 17th District Instructor, Health and Physical Education, Florida A&M University, Tallahassee, 1958-1961. Meek is credited with convincing legislators and voters to back a half-cent sales tax dedicated to fund Jackson Memorial Hospital, Dade's public hospital.

Representative Sanford Bishop Jr. is a Democrat from Georgia, representing the 2nd District. He was elected in November 1992 defeating Republican Jim Dudley. He sits on the House Committee on Veterans' Affairs Hospitals and Health Care Subcommittee where he is the 11th of 13 Democrats

Representative John Lewis is a Democrat from Georgia, representing the 5th district, which includes Atlanta. He was elected in 1986, and sits on the House Committee on Ways and Means Health Subcommittee where he is the 7th of 7 Democrats.

Representative Cynthia McKinney, Democrat-Georgia, 11th District. She was elected in November 1992.

Sen. Carol Moseley-Braun is a Democrat from Illinois Elected: November 1992. Braun is the first black Democrat and the only black woman ever elected to the U.S. Senate.

Representative Melvin J. Reynolds is a Democrat from Illinois, representing the 2nd District. He was elected in November 1992.

Representative Bobby Rush is a Democrat from Illinois, representing the 1st District. founder of the Illinois Black Panther Party.

Representative Cleo Fields is a Democrat from Louisianna, representing the 4th District. He was elected in November 1992, defeating Democrat Charles Jones, a state senator, in a runoff election. As a state senator, Fields voted against bills to ban most abortions. He authored and helped pass a Louisiana law that established drug-free zones near school campuses, as well as a law that created an inner city development program.

Representative William J. Jefferson is a Democrat from Louisianna, representing the 2nd district, which includes New Orleans. He was first elected in 1990. He sits on the House Ways and Means Social Security Subcommittee, where he is 3rd of 5 Democrats.

Representative Kweisi Mfume is a Democrat from Maryland, representing the 7th district, including parts of Baltimore. He was elected in 1986.

Representative Albert R. Wynn is a Democrat from Maryland, representing the 4th District. He was elected in November of 1992. Wynn's politics closely resemble those of President Clinton, with whom he made appearances at several of Clinton's Maryland campaign stops.

Representative Barbara-Rose Collins is a Democrat from Michigan, representing the 13th district, which includes Detroit. She was first elected in 1990.

Representative John Conyers, Jr. is a Democrat from Michigan, representing the 1st district, including Detroit. He was elected in 1965, and is the Chair of the Government Operation Committee.

Representative William L. Clay is a Democrat from Missouri, representing the 1th district, of St. Louis. He was elected in 1969.

Representative Alan Wheat is a Democrat from Missouri, representing the 5th district, which includes Kansas City. He was elected in 1983. He sits on the house committee on the District of Columbia Fiscal Affairs and Health Subcommittee where he is the 4th of 4 Democrats.

Representative Donald M. Payne is a Democrat from New Jersey, representing the 10th district, including Newark. He was elected in 1988.

Representative Floyd H. Flake is a Democrat from New York, representing the 6th district, including Roosedale. He was elected in 1986

Representative Major R. Owens is a Democrat from New York, representing the 12th district, of Brooklyn. He was elected in 1983.

Representative Charles B. Rangel is a Democrat from New York, representing the 16th District, including parts of New York City. He is the sponsor of H.R. 1150 -- Controlled Substances Act, Amendment; Controlled Substances Import and Export Act, Amendment.

Representative Edolphus Towns is a Democrat from New York, representing the 11th district, including Brooklyn. He was first elected in 1983. Representative Towns held the position as Medgar Evers College deputy hospital administrator from 1965-71. He sits the House Committee on Energy and Commerce Health and the Environment Subcommittee, where he is the 8th of 16 Democrats.

Representative Eva M. Clayton is a Democrat from North Carolina, representing the 1st District. She was first elected in November 1992. She held the position of Director, North Carolina Health Manpower Development Program, University of North Carolina at Chapel Hill.

Representative Melvin Watt is a Democrat from North Carolina, representing the 12th District. He was elected in November 1992. He has been the co-owner of an elderly care facility since 1989.

Representative Louis Stokes is a Democrat from Ohio, representing the 21st district, including Warrensville Heights. He was first elected in 1969. Representative Stokes sits on the House Committee on Appropriations Labor, Health and Human Services, Education, and Related Agencies, where he is the 4th of 9 Democrats.

Representative Lucien E. Blackwell is a Democrat from Pennsylvania, representing the 2nd district, of Philadelphia. He was first elected in 1991.

Representative James E. Clyburn is a Democrat from South Carolina, representing the 6th District. He was elected in November 1992. Clyburn's many positions on boards include the Sickle Cell Anemia Foundation, and the Center for Cancer Treatment.

Representative Harold E. Ford is a Democrat from Tennessee, representing the 9th district, which includes Memphis. He was first elected in 1975, and is now undergoing trial for fraud.

Representative Eddie Bernice Johnson is a Democrat from Texas, representing the 30th District. He was elected in November 1992. He attended nursing training at Notre Dame, in 1955.

Representative Craig Washington is a Democrat from Texas, representing the 18th district, including Houston. He was first elected in 1989. He sits on the House Committee on Energy and Commerce Health and the Environment Subcommittee where he is the 13th of 16 Democrats.

Representative Robert C. Scott is a Democrat from Virginia, representing the 3rd District. He was elected in November 1992. As a state assembly member and senator, Scott did his share of legwork in the statehouse, championing everything from Medicaid services expansion. Scott totes the Democratic line on health care, opting for the "pay or play" approach, and taxes, supporting a tax increase for the rich to help the poor.

CBC ACHIEVEMENTS

- 1971 – CBC officially established.
- 1972 – Convened hearings on "Racism in the Media." Held National Policy Conference on "Education for Black Americans."
- 1973 – Following Nixon's State of the Union Message, CBC delivered "True State of the Union Message" on the House floor.
- 1974 – Introduced the Humphrey-Hawkins Full Employment and Balanced Growth Act to reduce both unemployment and inflation which passed in 1977.
- 1975 – Established the CBC National Action Alert Communications Support Network in congressional districts throughout the country.
- 1976 – Created the CBC Foundation, a tax-exempt organization which conducts educational and social policy research.
- 1976 – Instituted the Congressional Black Caucus Graduate Intern Program to increase the number of Black professionals working for Congressional Committees.
- 1977 – Authored and orchestrated the successful passage of an amendment to the Public Works Employment Act which provided for 10% of the $4 billion of federal funds authorized for programs to be spent with minority firms.
- 1977 – National Black Leadership Roundtable established officially.
- 1978 – CBC Members led 1,000 persons in a silent march across the Capitol to lobby support for the Hawkins-Humphrey full employment bill.
- 1979 – Mobilized public opposition to the Motti Anti-Busing Amendment which declared busing to achieve racial balance in public schools to be unconstitutional.
- 1980 – Introduced legislation to insure humane treatment for the plight of the Haitian refugees or the "Black Boat People."
- 1980 Published the Black Voter Guidelines for 1980 Elections.
- 1980 – Introduced the first CBC Constructive Alternative Budget.
- 1981 – Orchestrated and supported passage of an amendment to extend the Voting Rights Act.
- 1982 – Sponsored legislation and mobilized national constituency support for the successful passage of a bill to designate the birthday of Martin Luther King, Jr. a national holiday.
- 1984 – Authored provisions for a $10 million health care and training initiative establishing biomedical research centers at minority institutions.
- 1985 – Forced the House and Senate to protect critical domestic programs from Gramm-Rudman cuts.
- 1986 – Passed sweeping South Africa sanctions bill and four major federal minority set-asides – most notable $32 billion in the House Defense Authorization bill.
- 1987 – Defeated Bork Supreme Court Nomination – CBC convenes unprecedented consultations with Japanese & Israeli Prime Ministers and nine African & Caribbean Heads of State.
- 1988 – Conducted major Congressional foreign and domestic policy hearings, "Black America in Crisis – Issues '88" – Marked 125th Anniversary of the Emancipation Proclamation and Congress Bicentennial with Black patrimony presentations to the Library of Congress and the nation's leading Black archival institutions.
- 1989 – Co-founded the Parliamentary Black Caucus in the British Parliament, London, England and participated in the inaugural ceremonies.
- 1990 – Created federal requirements within the Financial Institutions Reform, Recovery and Enforcement Act of 1990 requiring participation by minority institutions in the Savings & Loan Bailout through contracting with Federal Deposit Insurance Corporation (FDIC) and the Resolution Trust Corporation (RTC).
- 1991 – Orchestrated passage of Civil Rights Act. Supreme Court Justice Thurgood Marshall swears in CBC for 102nd Congress. Led opposition to Clarence Thomas nomination to the U.S. Supreme Court.

PUTTING PEOPLE FIRST

The Congressional Black Caucus Position on Health Care Reform

The American health care system is in need of major surgery. Bandaid solutions will not cure what ails it. It is a national disgrace that 35 million Americans lack health insurance, 25% more than a decade ago. Sixty million more are underinsured, many only an illness away from bankruptcy. Children make up one quarter of the uninsured; over two-thirds of the uninsured are in working families, with the breadwinner working full-time. Three out of ten Americans feel locked into their jobs -- afraid to pursue a better or higher paying job out of fear of losing health coverage. Too many families are seeing their health benefits erode as insurance companies cut back on covered services and reduce lifetime coverage limits.

Minority Americans suffer an even greater burden as illness and death fall disproportionately on their families as compared to white Americans. The incidence of cancer, hypertension, diabetes, AIDS, infant mortality, homicide and chemical dependency, take a devastating toll on our communities. In addition, African Americans and Hispanics account for over 50% of the number of Americans added to the rolls of the uninsured between 1977 and 1987. They are also disproportionately represented in the kinds of families at the greatest risk of being uninsured -- families where no one is working and families that are poor.

We take great hope in President-elect Clinton's commitment to ensuring comprehensive health care to all Americans, while getting costs in line with the general rate of inflation. To that end, we strongly urge that the President-elect and the Congress work together to create a national health insurance program with the following features:

1. Universal Coverage. All citizens and nationals should be entitled to receive comprehensive benefits.

2. Comprehensive Benefits. The following comprehensive benefits should be provided:

- **Acute Services:** All hospital and clinic care; physicians, dentists and other practitioners; all necessary tests.
- **Preventive Services:** Including immunizations; pre-natal and post-natal care; well baby and well child care (under 18 years); mammograms and Pap smears; dental and eye exams; family planning services.
- **Prescription Drugs:** All necessary prescription drugs

needed for the treatment or prevention of illness.

- **Drug and Alcohol Abuse Treatment:** Inpatient, outpatient and community-based services to provide treatment on demand.

- **Mental Health Services:** Inpatient, outpatient and community-based services.

- **Long-term Care:** Institutional/nursing home services; home and community-based care services; respite or temporary care such as day care.

3. Deductibles and Co-payments. There should be only minimal deductibles and co-payments on a sliding scale, with a maximum chargeable amount per service and/or per year.

4. Freedom to change jobs or move to another region. People should have complete freedom to change jobs or move because coverage should not depend on their place of employment or on whether they had a preexisting medical condition.

5. Freedom to Choose Providers. Our present high-quality system of private, non-profit, or public hospitals should still deliver health care. People should have complete freedom to choose their own health provider.

6. Role of the Federal Government. The Federal Government should guarantee the provision of comprehensive benefits to all citizens and nationals. It should establish an independent national health insurance board to oversee the implementation of the national health insurance program, which should establish a national budget for health spending. The board should set minimum standards and policies for the provision of health care. Consumers should play a significant role in all decision-making of the board and in advisory bodies to the board.

7. Strong Cost Containment. The national health insurance program should have the power to contain costs and plan for the efficient distribution of health facilities through:

- **Health Care Budget:** The Federal Government should set and adhere to an annual health insurance budget to control costs.

- **Managed Care Networks:** Consumer-oriented managed care networks should be strongly promoted as an alternative to fee-for-service medicine. Offering a continuum of care at a fixed annual price, they should be required to provide a wide range of services. At least one-third of the board of each managed care entity should be members

in place and there should be prohibitions against physician incentive plans that limit utilization and reduce medically-necessary care.

- **Hospital Global Budgets:** Negotiations with hospitals should establish an annual lump-sum budget for all services. This will provide stable funding, make hospitals more efficient, limit unnecessary services, and contain costs.

- **Physician Fees:** Fees should be negotiated with physicians and other practitioners to control the rate of increase and limit unnecessary services.

- **Capital and Technology Controls:** Planning entities including consumers, providers and public officials should determine when and where to build new hospitals and clinics and buy new equipment. This will limit duplication that results in unnecessary procedures, underutilized equipment, and increased prices.

- **Prescription Drug Prices:** Prescription drug prices should be negotiated to limit excessive increases and provide a fair rate of reimbursement.

8. Emphasis on Primary and Preventive Care. Health care should be reoriented towards primary care and prevention by requiring medical schools, as a condition of public reimbursement, to achieve a national goal of producing at least 50% primary care physicians; currently our schools produce fewer than 30%. The Federal Government should also greatly expand research on primary care and prevention.

9. Assistance to the Medically Underserved. Special attention should be given to expanding health services to medically underserved communities. In particular, significant increases in funding are needed to expand community-based health care facilities and programs and to educate and train primary care practitioners who practice in underserved communities.

10. Financing. Premiums collected from individuals to finance a national health insurance program should be significantly progressive, based on ability to pay. Premiums on employers should place the greatest burden on the most profitable corporations, limiting the effect on small businesses.

URGENT HEALTH NEEDS OF AFRICAN-AMERICAN AND OTHER MINORITY COMMUNITIES

No matter what type of health insurance is enacted, we believe that the following fundamental issues also must be addressed if we are to improve the health status of African-Americans and other minorities:

ACCESS TO AND COST OF COMPREHENSIVE HEALTH CARE

1. Minority Americans should have access to a minimum package of benefits that include preventive and acute services for those specific health problems for which they are disproportionately at-risk.

The excess incidence of chronic illness and serious diseases that afflict Minority Americans requires basic health benefits that increase access to preventive and primary health care. This includes prenatal and well-baby care, mental health services, substance abuse treatment, and prescription drugs. Early detection and screening programs for cancer and other illnesses must also be provided.

2. Access to community-based services should be greatly expanded and collaborations with hospitals encouraged to increase access to primary care.

A major expansion of school-based health clinics, health care for residents of public housing, and health centers for the homeless, including a doubling of the number of Community and Migrant Health Centers is especially critical to the minority community. C.H.Cs should be encouraged to collaborate with hospitals to increase access to primary care.

3. Coverage for services provided by alternative care-givers should be equivalent to the coverage that would be available if provided by a physician.

Coverage for services received from a nurse, midwife, nurse-practitioner, nutritionist, physician assistant, or other non-physician provider should be equivalent to the coverage that would apply if the same services were provided by a physician. In addition to expanding access to affordable primary and preventive care it would lower costs for the services provided.

4. Historically Black Hospitals should be adequately supported and reimbursed for the health services provided to minority communities.

These facilities have played a key role in addressing the critical health problems of minorities, serving the indigent and

underserved, providing trauma care and AIDS-related care, and increasing the number of minority health professionals.

5. The specific needs and experiences of minority patients and providers must be accomodated in crafting the standards and policies for any managed care systems.

African-American patients and providers must have easy access to membership in managed health care systems, and severity of illness which the patient presents must be factored into the reimbursement.

HEALTH CARE PERSONNEL

1. The number of minority health providers should be increased for the purpose of improving the minority community's access to care.

Minority physicians and other health professionals have historically tended to practice in low-income areas, serve minorities, and engage in the general practice of medicine or primary care specializations. For these reasons, increased support of the programs in the Disadvantaged Minority Health Act is essential.

2. National Health Service Corp funding should be increased in order to double the number of primary care physicians in areas with a shortage of health care professionals.

Doubling the number of primary care physicians who could serve through Community Health Centers and other preventive care for medically underserved communities.

PUBLIC HEALTH

1. The epidemic of violence and its impact on our minority communities mandates that decisive action be taken to develop a multi-faceted public health approach to violence.

Strategies to prevent violence should emphasize the socio-economic conditions in the minority communities in hich violence manifests itself. Examining the root causes of violence -- such as the easy accessibility of firearms, employment opportunities, and education -- should be the framework for our deliberations.

2. Women's rights of reproductive choice should be guaranteed.

For minority women, many of whom are poor and suffer high rates of medical complications related to pregnancies, the ability to exercise this choice has been limited in recent years.

We encourage an increase in research on alternative forms of contraception and the immediate reversal, through legislation and otherwise, of policies relating to a woman's right to choose.

3. Public education and access to a national vaccinations system and treatment for contagious childhood diseases should be expanded.

The Center for Disease Control has recommended that a national vaccination system be instituted to prevent the outbreak and spread of measles, mumps, and other diseases, as well as to avoid the onset of entirely preventable conditions, such as polio and diphtheria. Rapid treatment of diagnosed cases also must be assured.

4. Environmental hazards to minority communities, such as lead poisoning and exposure to toxics, must be mitigated and regulations must be established to limit the impact of environmental risks on the health of minority communities.

Studies have shown that a disproportionate share of facilities that emit substances which pose potential health hazards are sited in communities where their greatest impacts are absorbed by minority residents. "Environmental equity" must be promoted and regulations must be embraced to limit the influx of environmental hazards into these communities.

5. Public health education and outreach programs targeted to minorities at the community level must be promoted.

The specific health problems of the minority community should be the focus of outreach efforts that are racially, socio-economically and linguistically diverse in order to penetrate cultural barriers.

TREATMENT OF AND RESEARCH ON PARTICULAR CONDITIONS

1. Research on the health problems of African-Americans and other minorities must be expanded, with minority researchers and institutions as major participants.

Since illnesses often manifest themselves differently in Minority Americans, targeted research will provide a more accurate assessment of the health needs of minority populations.

2. Efforts to prevent and control the spread of HIV virus and the AIDS epidemic, as well as efforts to treat patients, must target the African-American and Hispanic-American communities, as detailed by the National Minority AIDS Council.

Currently, the African-American and Hispanic-American populations are experiencing the sharpest growth in the numbers

of new cases of HIV and AIDS. These communities must, therefore, be targeted for curbing the spread of the disease and in crafting treatment innovations, including the development of new drugs.

3. Treatment of hypertension through early detection, pharmaceutical, and other options should be a top priority.

Hypertension (or high blood pressure), endemic among African-Americans, is often undetected until it becomes severe or results in complications, leading to less effective and more costly treatment. Access to free blood-pressure exams, other early detection methods, and treatment once diagnosed must be assured.

4. Additional funding and dedication is needed at the Federal level to help already financially impaired cities to respond quickly and effectively to outbreaks of Tuberculosis.

The recent resurgence of T.B. as a serious threat to public health in American cities requires a greater Federal role and increased Federal funding to combat this disease.

5. Patient education and training on monitoring and complying with a regimen to control certain conditions must be covered.

Many complications and deaths relating to hypertension, diabetes, tobacco smoking and substance abuse stem from a failure of patients to fully understand and receive support with their regimen. Covering classes as well as other tools for these situations would lessen the incidence of costly complications.

March 1, 1993

MEETING WITH CONGRESSIONAL HISPANIC CAUCUS

DATE: March 2, 1993
LOCATION:
TIME: 2:30 p.m.
FROM: Kim Tilley

I. PURPOSE

To discuss with members of the Congressional Hispanic Caucus their views and concerns regarding health care reform.

II. BACKGROUND

In the 103rd Congress, there are eighteen Members of Congress in the Congressional Hispanic Caucus (3 women and 15 men). There are currently 20 Hispanic Members of Congress; Henry Gonzales (D-TX) and Matthew Martinez (D-CA) are not members of the Caucus.

The Congressional Hispanic Caucus was organized in December 1976 as a bipartisan organization dedicated to "voicing and advancing, through the legislative process, issues affecting Hispanic Americans in the U.S. and the insular areas."

Legislative Agenda

- Educational Reform - assuring access to a quality education for all American youth and adults;
- Health Care Reform - improving the health care delivery system;
- Employment and Training - expanding and promoting employment opportunities for Hispanics and others;
- Housing, Community Development and Small Business - revitalizing the economies of our depressed urban and rural communities and providing affordable, quality housing for middle and low income Americans;
- Family and Children - helping to maintain robust Hispanic families;
- Immigration - promoting an equitable and reasonable immigration policy (e.g. repealing the employer sanctions provisions of the Immigration Reform and Control Act);

- Civil and Voting Rights - protecting the civil rights of Hispanics, women and other minorities in all avenues of American life

ISSUES OF CONCERN

1) Inclusion of Hispanics The Caucus has expressed concern about Hispanics being fully included in the Administration and in the Health Care Task Force in particular. This concern dates back to the campaign, during the end of which they felt they had not been given enough credit for their activities. Although a relatively small group in Congress, they felt they had played a significant part in the election of President Clinton in certain key states such as Colorado, New Mexico and New Jersey. This situation was further exacerbated during a health care meeting which took place during the transition. The Caucus Members, already perturbed by the campaign, were made angrier when no Hispanics were included in the health care transition team. Evidently the level of the Members' discontent was not known to the transition people prior to the meeting so steps, which could have been taken to ease their frustrations, weren't taken leaving the Members feeling even more taken for granted. While pleased with having two Hispanic Cabinet members, they are very concerned about the lack of Hispanic appointments to date in the upper- and mid-levels where the "hands-on" work takes place.

Suggested Response: You are not sure of the numbers, but the Task Force is constantly evolving and people are being brought in as needed for their expertise. You are aware, that people recommended by the Caucus have been included, such as the three consultants from HHS, and you are grateful for their involvement and you

2) Puerto Rico Many Caucus members are concerned about the economic package's impact on Puerto Rico. They were already concerned that there is no one single person coordinating the Administration's policy on Puerto Rico and that necessary attention, therefore, is falling through the cracks; the economic package further underscores that belief. A memo follows further detailing their concerns about the economic package.

III. PARTICIPANTS

Rep. Jose Serrano, Chair - Congressional Hispanic Caucus
(participant list follows)

IV. PRESS PLAN

Arrival/Departure - Open Press
Meeting - Closed except for pool spray

V. SEQUENCE OF EVENTS

- o Rep. Serrano - opening remarks & introduces HRC;
- o HRC opening remarks and turns meeting back over to Rep. Serrano;

- o Rep. Serrano will present his own questions and concerns first (1) Hispanic involvement, 2) universal access - including migrant farm workers and undocumented aliens and 3) health care reform in the broader sense of addressing bilingual needs, education, etc.) and will then ask the Members (in order of seniority) for their one question or concern;
- o HRC response (NOTE: The Members hope they will get some information and specific responses to their questions. Following are some questions a few Members submitted in advance for your information.)

IV. REMARKS

CONGRESSIONAL HISPANIC CAUCUS

Congressional Hispanic Caucus Members of the 103rd Congress are:

José E. Serrano, Chairman, (D-NY)
Lucille Roybal-Allard, Vice-Chair, (D-CA)
Ed Pastor, Secretary/Treasurer, (D-AZ)

Ros-Lehtinen, (R-FL)
E (Kika) de la Garza, (D-TX)
Xavier Becerra, (D-CA)
Henry Bonilla, (R-TX)
Lincoln Diaz-Balart, (R-FL)
Carlos Romero-Barcelo, (D-PR)
Bill Richardson, (D-NM)
Esteban E. Torres, (D-CA)
Ron de Lugo, (D-VT)
Solomon P. Ortiz, (D-TX) Ileana
Luis Gutiérrez, (D-IL)
Robert Menéndez, (D-NJ)
Frank Tejeda, (D-TX)
Nydia Velázquez, (D-NY)
Robert Underwood, (D-Guam)

Associate Members of the 103rd Congress, include:

Gary Ackerman, (D-NY)
ichael Andrews, (D-TX
Joe Barton, (R-TX)
Howard Berman, (D-CA)
James Bilbray, (D-NV)
Richard Bryan, (D-NV)
John Chafee, (R-RI)
Ronald Coleman (D-TX)
Gary Condit, (D-CA)
Julian Dixon, (D-CA)
Christopher Dodd, (D-CT)
Robert Dornan, (R-CA)
Chet Edwards, (D-TX)
Don Edwards, (D-CA)
Vic Fazio, (D-CA)
Floyd Flake, (D-NY)
Thomas Foglietta, (D-PA)
Martin Frost, (D-TX)
Pete Geren, (D-TX)
Richard Gephardt, (D-MO)
Duncan Hunter, (R-CA)
Edward Kennedy, (D-MA)
Barbara Kennely, (D-CT)
Gerald Kleczka, (D-WI)
Mike Kopetski, (D-OR)
John LaFalce, (D-NY)
Larry LaRocco, (D-ID)
Greg Laughlin, (D-TX)
John Lewis, (D-GA)
William Lipinski, (D-IL)
Nita E. Lowey, (D-NY)
Thomas Manton, (D N
Jim McDermott, (D-WA)
Michael McNulty, (D-NY)
Patsy Mink, (D-HI)
Eleanor Norton, (D-DC)
Nancy Pelosi, (D-CA)
Charles B. Rangel, (D-NY)
Steven Schiff, (R-NM)
Patricia Schroeder, (D-CO)
James Traificant, (D-OH)
Craig Washington, (D-TX)

CONGRESSIONAL HISPANIC CAUCUS
103RD CONGRESS

♦ **Rep. Xavier Becerra (D-CA)**
Becerra is a new member of Congress, representing the 30th district of California. Becerra, from Los Angeles, served in the California Assembly and worked on health and human services issues for the state. Becerra has taken seats on the House Education and Labor; Judiciary and Science and Technology Committees.

♦ **Rep. Henry Bonilla (R-TX)**
Bonilla is a new member of Congress. He represents the newly expanded 23rd district of Texas, spanning from San Antonio to Laredo. Bonilla serves on the House Appropriations Full Committee and the Labor, Health and Human Services, Education and Related Agencies Subcommittee.

♦ **Rep. Kika de la Garza (D-TX)**
de la Garza has represented the lower Rio Grande valley of southern Texas since 1969. de la Garza is the Chairman of the House Committee on Agriculture.

♦ **Rep. Ron de Lugo (D-VI)**
de Lugo has served as the delegate to the House of Representatives from the Virgin Islands since 1969. de Lugo serves on the Education and Labor; Public Works and Transportation; and Natural Resources Committees. He is the Chairman of the subcommittee on Insular and International Affairs of the Natural Resources Committee.

♦ **Rep. Lincoln Diaz-Balart (R-FL)**
Diaz-Balart is a new member of Congress. He represents the newly formed, conservative and heavily Cuban-American 21st district of Florida. Diaz-Balart ran for Congress in 1982 as a Democrat. He switched to the Republican party by 1986 when he took a seat in the Florida House and served as national co-chair for "Hispanics for Bush" in 1988. Diaz-Balart, taking a mandate from his Miami constituents, has pledged his commitment to ending Castro's rule in Cuba.

♦ **Rep. Luis Gutierrez (D-IL)**
Gutierrez is a new member of Congress, representing the newly formed 4th district of Illinois. This former social worker, City Councilman and schoolteacher has promised to be a "commuter Congressman," spending as much time in Chicago as in Washington. Gutierrez has taken seats on the Banking, Finance and Urban Affairs Committee; on the Veterans Affairs Committee; and on its Hospitals and Health Care Subcommittee.

♦ **Rep. Robert Menendez (D-NJ)**
Menendez is a new member of Congress; representing the newly formed, primarily Hispanic, 13th district of New Jersey. He is the first Hispanic elected to represent New Jersey in the House. While in the New Jersey legislature, he cast a deciding vote to approve their Health Care Reform Act, which ensures that no one be denied hospital care. Menendez has taken seats on the Foreign Affairs and the Public Works and Transportation Committees.

Menendez joined the President at Rutgers University yesterday for his National Service address and is himself a graduate of Rutgers University School of Law.

♦ **Rep. Solomon Ortiz (D-TX)**
Ortiz has served the Corpus Christi region of Texas since 1983. Ortiz served as Chairman of the Hispanic Caucus in the 102nd Congress and sits on the Armed Services and Merchant, Marine and Fisheries Committees. Ortiz has introduced legislation to establish a new veterans medical facility in Texas.

♦ **Rep. Ed Pastor (D-AZ)**
Pastor was elected in 1991 to represent the 2nd district of Arizona, comprised mostly of the Phoenix area. Pastor serves as Secretary-Treasurer to the Hispanic Caucus and sits on the House Appropriations Committee. He has introduced a concurrent resolution concerning health care as a human right.

♦ **Rep. Bill Richardson (D-NM)**
Richardson has served in the House of Representatives since 1983. Representing the northern 3rd Congressional district, his constituents comprise most of the Spanish-speaking and Indian populations of New Mexico. Richardson serves on the Energy and Commerce and the Natural Resources Committees and the Select Committee on Intelligence. He is the Chairman of the Subcommittee on Native American Affairs of the Natural Resources Committee.

♦ **Rep. Carlos Romero-Barcelo (D-PR)**
Romero-Barcelo is the newly elected delegate from Puerto Rico. He serves on the House Committees on Education and Labor and Natural Resources.

♦ **Rep. Ileana Ros-Lehtinen (R-FL)**
Ileana was elected in 1989 to represent Florida's 18th district. A native Cuban, she represents the conservative Miami district and serves on the Foreign Affairs and Government Operations Committees.

♦ **Rep. Lucille Roybal-Allard (D-CA)**
Roybal-Allard is a new member of Congress, representing Los Angles in California's 33rd Congressional District. Roybal-Allard, a Mexican-American, is carrying on her family's legacy. Roybal-Allard's father, Edward Roybal, retired this year after serving the House for 30 years. Roybal-Allard serves as the Vice-Chair of the Hispanic Caucus. She is a strong advocate for energy, environment and women's issues.

♦ **Rep. Jose Serrano (D-NY)**
Serving his second term in Congress, Serrano represents New York City's Bronx area. Serrano is the Chairman of the Hispanic Caucus. He serves on the Appropriations Committee as well as its Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. Serrano was among the members of Congress who joined the President to jog for the American Heart Association several weeks ago.

♦ **Rep. Frank Tejeda (D-TX)**
Tejeda is a new member of Congress, representing the rural, Hispanic region south of San Antonio, Texas. The five military installments surrounding San Antonio comprise much of his constituency. Tejeda has taken a seat on the Armed Services Committee and the Veterans Affairs Committee as well as its Subcommittee on Hospitals and Health Care. Tejeda's interest in Veterans Affairs is heightened by his service in Vietnam, for which he was awarded a Purple Heart.

♦ **Rep. Esteban Torres (D-CA)**
Torres has served the 34th district of California since 1983. His district spans out of Los Angeles and to the East. He is committed to reducing gang warfare, violence and crime in his district. Torres sits on the Appropriations Committee.

♦ **Rep. Robert Underwood (D-Guam)**
Underwood is the new delegate to Congress from Guam. He is half Chamorro, the native race of Guam and is a chief advocate of self determination and increased control of Guam's natural resources. Underwood has taken seats on the Armed Services and Natural Resources Committees.

♦ **Rep. Nydia Velazquez (D-NY)**
Velazquez is a new member of Congress from New York's newly formed 12th district. She represents the lower east side of New York, including Manhattan, Brooklyn and Queens. Velazquez is a native of Puerto Rico and is deeply concerned with urban issues, including housing and access to health care. Velazquez has taken seats on the Banking and Urban Affairs and the Small Business Committees.

MEMORANDUM

To: Chris Jennings
cc: Charlotte Hayes
Kim Tilley

Date: March 1, 1993

From: Jeffrey Farrow

Re: Hispanic Caucus Puerto Rico/Territories Concerns

Two insular issues may come up in tomorrow's meeting with the Hispanic Caucus: Medicaid Funding and Section 936. They may be brought up by the Members from the islands (Romero, de Lugo, and Underwood) or those originally from Puerto Rico who represent migrants from the island (Serrano, Velazquez, and Gutierrez.)

Medicaid Funding:

The health care access problem in the insular areas is a problem of access to adequate care. Insular governments provide universal care for these 3.9 million Americans; but lack the resources to provide adequate services. Caps on Medicaid are a primary reason.

For example, the cap for Puerto Rico provided $79 million in FY '92; state-like Medicaid participation would have provided $1.12 billion. State-like treatment for American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands would have been $69 million in FY '92 versus $7.3 million provided under the cap.

The situation has resulted in serious health care deficiencies.

- o Puerto Rico has six of the 10 hospitals under the U.S. flag with the worst incidence of infant mortality. Its neonatal mortality and low birthweight rates are the highest among U.S. Hispanic populations; but it provides less in services to pregnant women and children than do the states and does not fund family planning.

- o Puerto Rico also provides less to the needy aged and disabled and does not fund nursing facilities or home care.

- o Puerto Rico has the second highest AIDS rate under our flag...but does not have the funds for AZT.

The situation has also caused needy Puerto Ricans to migrate to states and encouraged support for statehood.

The problems are similar in other islands. All want more funding.

There had been talk of using revenue from reducing the tax exemption on U.S. corporate income from insular areas (tax code Sec. 936) to pay for an increase and Romero may suggest this

tomorrow. But the inclusion of a major limitation on 936 benefits in the economic plan (to raise $7 billion) makes it unrealistic.

Another potential funding source -- at least for Puerto Rico and the Virgin Islands -- is the excise tax on alcohol. The islands currently get back the first $10.50 per gallon on the rum they produce and claim a right to the amounts over that which are now withheld by the federal government.

If alcohol taxes are increased, the increase could be used to pay for increased care in the islands. De Lugo may suggest this.

Section 936:

Romero supports the proposal to limit 936 benefits based on wages paid because it would eliminate the greatest economic impediment to statehood and strengthen statehood against commonwealth in the status referendum planned for this year. But there is substantial opposition to it because of the economic harm it could cause.

The critics include statehooders like Gov. Rossello and Democrats like state chair Hernandez Agosto, who says he was promised during the campaign that 936 would not be harmed.

The current 936 exemption is the basis of Puerto Rico's economy (300,000 of the 1 million jobs.) And the potential impacts of the proposal are so great that the issue may come up tomorrow.

Gutierrez, who supports independence, and Velazquez, who formerly worked with the commonwealth leadership, will probably work with island leaders to have the proposal moderated.

The goal may be to limit the 936 cuts to the pharmaceuticals that have caused the most criticism of the provision. The criticism is that pharmaceuticals receive far more in tax benefits than they pay in wages...although job creation was the purpose of the exemption. For example, pharmaceuticals account only account for a fifth of the 100,000 plus direct jobs created by 936 although they get half the $2.7 billion a year in tax credits.

Limiting the exemption based on wages paid will harm other manufacturers as well as pharmaceuticals and makes no provision for the $15 billion in 936 profits reinvested tax free in Puerto Rico or elsewhere in the Caribbean. Its possible consequences include significant increases in Puerto Rico's 17% unemployment rate, migration to states, and demands for social programs funding as well as in support for statehood. They also include decreases in the island's local revenue.

Serrano, who is close to statehood leaders, is concerned about the economic problems that the proposal may cause; but is deferring to Romero on it.

DRAFT

A legislative agenda for the Congressional Hispanic Caucus
103rd Congress, First Session

EDUCATIONAL REFORM -
Giving Latinos greater access to the educational system

- overhaul the largest federal education programs included in the Elementary and Secondary Education Act:
  - permit language minorities to equally participate in Chapter 1 educational services and substantially increase emphasis on teacher training
  - reshape the Bilingual Education Act to ensure participation of language minorities in broader educational reform efforts
- dramatically increase funding for the Bilingual Education Act and other language/literacy training
- fully fund Head Start; assure equitable participation of language minorities in Head Start programs
- oppose development of a national test that limits educational and employment opportunities of Latinos and others
- establish comprehensive social service and youth opportunity centers at or near schools for students and out-of-school youth
- begin funding institutional development program for Hispanic Serving Institutions of higher education
- fund outreach and technical assistance to TRIO college prepatory program applicants; fund model program community partnership and counseling grant program
- fully fund teacher training programs of Title 5 of Higher Education Act

HEALTH CARE REFORM -
Removing financial and non-financial barriers to quality health care

- measure all health care insurance proposals against the following CHC principles for good reform
  - ♦ cover all Americans, including migrant and

seasonal farmworkers and U.S. territories

- ◆ include basic package of coverage and benefits
- ◆ emphasize preventive health care
- ◆ contain health care costs

- expand and improve federal programs to supplement health care insurance reform
  - expand community health centers and migrant health centers to serve more low-income, minority communities
  - establish Hispanic Health Initiative at the Department of Health and Human Services so that all federal health programs specifically address underservice of Latinos and others by federal programs
  - establish program to increase supply of Latinos and bilingual health care professionals
  - require all federal health research to include appropriate samples of ethnic and racial minorities and women
  - ensure that federal AIDS treatment and prevention efforts better address the needs of the Latino community
- significantly increase funding of Hispanic Centers of Excellence in health professions education
- improve delivery of bilingual services by the Social Security Administration

EMPLOYMENT AND TRAINING -
Ensuring that Latinos and others can fully contribute to the nation's economic growth

- Economic stimulus/infrastructure package
  - invest in physical infrastructure, including rehabilitation and construction of schools, health care and job training facilities
  - invest in human resources infrastructure, including incentives to fill shortages of health care and education providers

- incorporate effective nondiscrimination and affirmative action requirements in investment package; outreach to the Latino and other minority communities
- provide on-the-job training for higher skilled jobs
- guarantee meaningful participation by Latino and other minority businesses

- establish integrated school-to-work transition program
  - target efforts to small business settings
  - distribute training equitably between low and high skilled workers
  - devote resources to language/literacy skills
  - include out-of-school youth in the National Association of Education Progress (NAEP) to better inform school-to-work policies
  - establish Youth Centers for out-of-school youth
- combat discrimination in federal employment by overhauling equal opportunity complaint processing system

HOUSING, COMMUNITY DEVELOPMENT AND SMALL BUSINESS-
Rebuilding Hispanic communities

- reauthorize the Cranston-Gonzalez Housing Act
- combat redlining and discrimination in housing and mortgage lending
- create community development banks to increase availability of capital to small businesses and individuals in Hispanic and other low-income communities
- provide one-year moratorium on graduation of businesses from 8(a) program
- reform federal small business programs drawing on recommendations of the U.S. Commission on Minority Business Development

DRAFT

FAMILY AND CHILDREN -
Helping to maintain robust Hispanic families

- pass the Family and Medical Leave Act
- reauthorize the School Lunch and Child Nutrition Act
- increase funding for the Women, Infants and Children program

IMMIGRATION -
Promoting an equitable and reasonable immigration policy

- repeal the employer sanctions provisions of the Immigration Reform and Control Act
- create independent commission to investigate allegations of abuse by the Immigration and Naturalization Service
- fund State Legalization and Impact Assistance Grants
- fund the Office of Special Counsel at the Department of Justice to investigate employer sanctions' based discrimination

CIVIL AND VOTING RIGHTS -
Protecting the civil liberties of Hispanics and others

- monitor implementation of bilingual provisions of the Voting Rights Act
- ensure that elected minority officials are not unfairly stripped of duties by overturning Presley v. Etowah County Commission and Rojas v. Victoria Independent School District
- pass the National Voter Registration Act of 1993 (Motor Voter Bill)
- fund Equal Employment Opportunity Commission (EEOC) outreach to underserved populations

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Congress of the United States

House of Representatives

Washington, DC 20515-5401

EDUCATION AND LABOR
SUBCOMMITTEES:
ELEMENTARY, SECONDARY AND VOCATIONAL EDUCATION
LABOR-MANAGEMENT RELATIONS
HUMAN RESOURCES

NATURAL RESOURCES
SUBCOMMITTEES:
NATIONAL PARKS, FORESTS AND PUBLIC LANDS
INSULAR AND INTERNATIONAL AFFAIRS

MEMORANDUM

TO: Congressman José Serrano
Chairman Hispanic Caucus
Attention Rick

FROM: Congressman Romero Barceló

DATE: February 10, 1993

RE: Meeting with Health Care Task Force

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1. Is The Health Care Task Force aware that Puerto Rico receives only 79 million dollars a year in Medicaid?

If we were treated as a state we would receive 1.2 billion dollars a year. The above situation creates serious health care deficiencies in Puerto Rico which further creates problems for cities and states in the mainland and social dislocations for the U.S. citizens in Puerto Rico. That is: a) medical indigents in Puerto Rico have to go to deficient public health care facilities. Many of them move to one of the fifty states in the mainland for medical care and for serious surgical interventions; b) the elderly medical indigents who are paid their Medicaid Insurance as any other U.S. citizen in the mainland cannot afford the deductible that they have to pay in P to Rico and they either end up in deficient health care facilities in Puerto Rico or move to the mainland in order to receive treatment at private health care facilities, where the deductible is paid by Medicaid.

2. Do you know that medical indigent veterans in Puerto Rico who have no health care insurance must go to Veteran's Hospital because they have no Medicaid coverage to go to a private h pital, thus overcrowding the Veteran's Hospital?
Why should veterans in Puerto Rico have less rights to adequate h lth care than veterans in the 50 states ? Did not they risk their lives the same?

3. Is President Clinton's Administration aware of these inequities? Are there any actions being considered to address these problems?

The above might give you an idea of why the lack of funds and adequate health care services for the medical indigents in Puerto Rico has contributed to create the following problems:

a) Our island has the second highest AIDS rate in the U.S., just behind Washington, DC.

b) More than 150,000 Puerto Rican children suffer from some sort of severe or moderate mental condition, or are functionally handicapped and in need of mental health care services.

c) Puerto Rico has the highest infant mortality rate in the Nation.

d) The average weight of infants at birth in Puerto Rico is the lowest in the nation.

e) More than 100,000 people in Puerto Rico are dependent or addicted to narcotic drugs.

It is therefore important that the President's Task Force take cognizance of these facts and issues in Puerto Rico as they discuss the federal policy and suggest continuation, elimination or changes to existing health care programs.

XAVIER BECERRA
30TH DISTRICT, CALIFORNIA

Congress of the United States

House of Representatives

Washington, DC 20515-0530

PROPOSED QUESTIONS FOR MRS. HILLARY RODHAM CLINTON
SUBMITTED BY CONGRESSMAN XAVIER BECERRA
MARCH 1, 1993

1) In light of the fact that the vast majority of Latino physicians are solo practitioners, how will the Clinton Administration's health care reform plan ensure that Latino physicians are not excluded from a system of managed competition? Additionally, what kind of technical assistance, if any, can the Administration provide so that most solo practitioners can compete?

2) One of the factors that tends to be overlooked in the health care reform debate is the availability of providers needed to meet the growing demand for health services -- the supply side of the equation. What strategies can the Administration undertake to ensure an adequate future supply of Latino and other ethnic minority providers to administer care for specific populations?

3) Given the relative shortage of primary care physicians vis-a-vis specialists, to what extent should we a) retrain specialty physicians, and b) increase the use of mid-level providers, and how?

4) Many Latino patients depend on community clinics, migrant and rural clinics and public health departments to receive health services because of the availability of culturally-sensitive services at these facilities. How does the Administration plan to incorporate culturally specific models of care within the scope of managed competition?

5) How will the Administration monitor and evaluate the quality of care provided by the "players" in a managed competition environment (keeping in mind that the quality of care includes quality of service and cultural/linguistic compatibility)?

POSSIBLE QUESTIONS FOR HILLARY RODHAM CLINTON
FROM CONGRESSMAN HENRY BONILLA (R-TX-23)
CONGRESSIONAL HISPANIC CAUCUS
MARCH 2, 1993

1. Is the Health Care Task Force still on schedule to produce the final report by May 1?

2. What are the roles of telecommunications, electronic medical records and the individually carried records in the plan?

3. I represent a district that has over 600 miles of border with Mexico. Five percent of care is drop in care. Eighty percent of drop in care comes from across the Mexican border. What is the task force doing to address the largest cross border differential of health care in the world that exists on the U.S. and Mexican borders? Is there a possibility of giving a disproportionate amount of money to hospitals that treat these patients?

4. You have traveled to hear the American people's ideas and recommendations. You traveled to Pennsylvania and Massachusetts in recent weeks to listen to common Americans. Why don't you come to Texas? Specifically to the University of Texas at San Antonio Health Science Center to listen to the doctors and administrators who have to devise a way to care for and pay for undocumented and migrant workers.

5. Is the task force discussing the possibility of allowing a 100 percent write off for small business medical costs to mirror the write off for larger corporations?

6. I want to commend your task force for appointing Dr. Ciro Valent Sumaya, a pediatrician and Director of the UTHSC-SA South Texas Health Research Center. What is the percentage of Hispanics on the task force? What is the percentage of Hispanics on the task force who are practicing physicians?

7. In rural America, quality, effective, 20th century health care is scarce. Under a managed competition scenario it might take a density of 180,000 in population in a 400 square mile area to be effective. What is the task force going to propose for those areas, like rural west Texas, with low population density?

U. . House of Representatives
Committee on Natural Resources
Washington, DC 20515-6201

March 1, 1993

The Honorable Jose Serrano
Chairman
Congressional Hispanic Caucus
U. S. Congress
Washington DC 20515

Dear Chairman Serrano:

I have been advised that the issues that we plan to raise in tomorrow's meeting with Mrs. Clinton must be submitted by 5:00 pm today.

The concerns I will express will be straightforward and simple, and will reflect the territories' overriding concern that we not be excluded from the policy changes proposed by Mrs. Clinton's Health Care Reform Task Force.

As you understand better than most, our federal health policy has always contained serious and pervasive inequities in the treatment of U.S. territories, and we want very much to see these inequities eliminated.

This, then, will be the gist of my comments. I look forward to seeing you tomorrow.

Sincerely,

RON DE LUGO
Chairman
Subcommittee on Insular and
International Affairs

TTEE ON
FOREIGN AFFAIRS

COMMITTEE ON
MERCHANT MARINE
AND FISHERIES

CHAIRMAN
PUBLICAN RESEARCH COMMITTEE
ASK FORCE ON LATIN AMERICAN
AND CARIBBEAN AFFAIRS

Congress of the United States
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LINCOLN DIAZ-BALART

QUESTIONS ON HISPANIC HEALTH CARE

FOR MRS. HILLARY CLINTON

(1) Do you see minority H.M.O's as capable of participating in the process of competitive bidding for managed care with a grace period within which to become federally qualified in order to ensure health care to minority groups, i.e. Hispanics, Afro Americans and Haitians?

(2) Under what conditions should these companies, licensed in their state and in good standing be able to compete with giant national firms that will participate in the program?

(3) How do you ensure that in competitive managed care the large national companies will not "under bid" and take losses for the first few years driving away competition?

(4) Should the federal agency for health care reform set rates for members of managed care organizations?

CONTACT: Brenda Lopez-Ibanez
Health LA
225-4211

LUIS GUT

Congress of the United States

House of Representatives

Washington, DC 20515-1304

TO: Chairman Jose Serrano
FROM: Cong. Luis V. Gutierrez
DATE: February 11, 1993
RE: Questions for Hillary Clinton

Pursuant to your memo dated February 8, 1993, I am pleased to submit the following questions to be submitted to Mrs. Clinton. I understand that some of these questions will form part of the discussion between members of the Caucus and Mrs. Clinton next week.

I believe that if the main objectives of health care reform are to contain costs and increase access, these by themselves will not guarantee a significant improvement of the health status of our population. A health reform should address the following:

1. How does increasing access impact the health status of minority groups, for example, reducing the low birth weight rates experienced by minorities?

2. Will market driven initiatives to reform health care enhance the health awareness of these population groups?

3. How does increasing access reduce the burden of our inner city hospitals in attending a disproportionate share of low income and Medicaid patients?

4. How will cost containment initiatives affect the resources of inner city hospitals that attend mainly low income and minority patients?

5. How will health care reform be coordinated with respect to already established initiatives at the state level?

6. How will market driven initiatives of health care reform reduce the pressure on states in allocating resources to health services?

7. What kind of education reform initiatives will be part of a comprehensive proposal of health care reform?

Representative Ed Pastor, D-AZ

Questions directed at First Lady Hillary Rodham Clinton, appearing before the Congressinal Hispanic Caucus on March 2, 1993

1. As you may already know, I have introduced a congressional resolution expressing the sense that access to basic health care is a fundamental human right for all residents of this country. As Chair of the Task Force on National Health Care Reform, will you incorporate the concept of access to health care as a basic human right within the health care reform proposal developed by the White House?

2. Migrant and seasonal farmworkers in this country today are predominantly people of color. They are the lowest paid workers in one of the most hazardous industries. They rarely have employer-provided health insurance and the federally funded network of migrant health centers only reaches about 15% of all farmworkers. Moreover, because of residency and other requirements, farmwokers fall through the existing safety net of programs such as Medicaid. Yet, farmworker adults and children have serious health problems.

What is the Administration doing to ensure that migrant and seasonal farmworkers and their families have access to affordable health care under any new health care reform plan?

I am concerned that the migrant lifestyle and low wages paid to farmworkers may continue to impedede their access to health care. How will you help ensure that during a transition into a new health insurance system, providers such as community and migrant health centers continue to help fill the niche and provide the safety network they are now supplying?

3. The southern border states experience a large influx of individuals seeking health care on the U.S. side. Given the economic disparities between between the U.S. and Mexico, the number of "drop-ins" to our border hospitals is not likely to diminish in the near future. Do you envision the federal government making allowances in its compensation to states who carry a disproportionate share of the health care costs?

FRANK TEJEDA
28TH DISTRICT, TEXAS

Congress of the United States
House of Representatives
Washington, DC 20515-4328

March 2, 1993

Questions for Hilary Rodham Clinton, Director of the White House Task Force on Health Policy, from Congressman Frank Tejeda.

1. The Clinton Administration has emphasized prevention in health care as a long-term money saving investment. Studies have indicated a strong link between hazardous waste and disease:

   a. What steps will the Clinton Administration take to clean environmental hazardous wastes in the regions of South Texas?

   b. What specific steps will the Administration take to bring clean drinking water and appropriate sewage treatment facilities to South Texas counties, such as Starr County?

2. Specifically, how will the Administration direct money, physicians and medical facilities to rural communities?

3. Areas such as South Texas have large populations of Hispanics with distinct linguistic and cultural experiences. How will the Clinton Administration's plan address these unique needs of the Hispanic community, and specifically the rural Hispanic community?

4. What incentives, if any, will the Clinton Administration offer to increase and expand the number of rural medical facilities and physicians, specifically in South Texas and similarly impoverished areas?

5. Many rural communities in Texas have no primary care physicians or hospitals. How will the Clinton Administration address the problem of a lack of primary care providers? Will the Administration support proposals for federal aid and/or incentives to medical education institutions to increase the number of primary care physicians? Does the Administration plan to repair or strengthen existing programs, such as the Health Careers Opportunity Program (HCOP) and Hispanic Centers of Excellence? If so, will the Administration target underrepresented populations, such as Hispanics, to become primary care physicians?

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Congress of the United States
House of Representatives
Washington, DC 20515-0534

ESTEBAN E. TORRES
34TH DISTRICT, CALIFORNIA

CONGRESSMAN ESTEBAN E. TORRES' QUESTIONS
for Hispanic Caucus Meeting
with First Lady Hillary R. Clinton
March 2, 1993

1) When the President talks about "universal coverage," who exactly does he mean will be covered?

2) Will the President's Health Care Reform Package address the issues of the Working Poor, Migrant Workers and Illegal Aliens?

3) Will programs to increase the numbers of Hispanic and bilingual physicians and other health care providers be a part of the health care reform package?

4) Will the President raise the health insurance deduction for small businesses from 25% to 100% (as it exists now for corporations)?

5) President Clinton has stated his support and commitment to childhood vaccination and immunization. Will President Clinton be supporting the U.N. Convention on Rights of the Child, thereby reaffirming the United States stance on providing universal health and welfare coverage for all American children?

Pleased to hear the President's pledge to the Special Supplemental Food Program for Women, Infants and Children (WIC).

6) Did you know that California, and all the Western states, serve a disproportionately low number of eligible women and children because funding is not commensurate with our needs?

Congresswoman Nydia Velazquez
Questions for Hillary Clinton
Hispanic Health Policy Meeting
March 2, 1992

1. Trends in AIDS diagnosis and HIV infection show that the virus will continue to disproportionately impact communities of color, particularly the African American and the Hispanic/Latino communities. In 1991 the reported number of AIDS cases rose 5% overall as compared to 1990. However, cases increased by 11.5% in the Hispanic community, 10.5% in the African American community, and decreased by 0.5% among whites. What role will this devastating impact of HIV and AIDS in the Hispanic community play in the development of a universal health care reform package?

2. Between 1983 and 1986, only 62% of mainland Puerto Rican mothers received prenatal care within the first trimester of pregnancy, compared to 82.7% of non-Hispanic Whites. Puerto Ricans also had the highest infant mortality rate of 12.3%, which is 3% greater than the rate of the general population; and Puerto Rican mothers are almost twice as likely to give birth to underweight babies (9.4%) than non-Hispanic Whites (5.7%). Judging from these statistics, we need a special focus on women's health care and health needs. What reforms will you include to address the critical health needs of Puerto Rican and all Hispanic women?

Congress of the United States
Congressional Hispanic Caucus
102nd Congress

FAX TRANSMISSION FROM THE CONGRESSIONAL HISPANIC CAUCUS

DATE March 1 1993

Please deliver the following message to:

NAME Kim Tilli

TELECOPIER NUMBER 456-2239

FROM Rick Lopez

TELECOPIER NUMBER: (202) 225-7569

TELEPHONE NUMBER: (202) 226-3430

Number of pages (including this cover sheet) #3

NOTES: _____

• Is the CBC Budget out yet - If yes, what was there a press release
• sequence
• #'s correct?
• who was invited (just CBC members)
• braun included

March 2, 1993

CONGRESSIONAL BLACK CAUCUS MEETING

EM 100 MAY

DATE: March 1, 1993
LOCATION:
TIME: 1:00 p.m.
FROM: Kim Tilley

I. PURPOSE

To discuss CBC's views on proposals for the implementation of a national comprehensive health care program.

II. BACKGROUND

correct?

In the 103rd Congress, there are 40 Black Members of Congress (nine women and thirty-one men.)

The Congressional Black Caucus was formed in 1970 when the thirteen Black Members of the U.S. House of Representatives joined together to strengthen their efforts to address the legislative concerns of Black and minority citizens. It is bipartisan.

CBC received its first national recognition when its Members met with former President Richard Nixon in March 1971 and presented to him a list of 60 recommendations for governmental action on domestic and foreign issues. Since then, CBC has remained actively involved in a wide range of legislative initiatives. (See CBC Achievements.) Most noteworthy is the CBC Alternative Budget which CBC has produced for the past thirteen years. As might be expected, the CBC Alternative Budget has historically departed significantly from Administration Budget recommendations.

CBC states that it introduced more than 400 individual bills in the 102nd Congress and co-sponsored 11,000 legislative measures.

III. PARTICIPANTS

EM

Kweisi Mfume (m-FOO-may)
All 40 members of the CBC were invited (participant list follows). Key legislative staff will sit in as well.

IV. PRESS PLAN

Arrival/Departure - Open Press
Meeting - Closed after pool spray

NOTE: There is a possibility you may be asked about the Harold Ford case and the Hubbell connection. CBC has been asked if it approached you to weigh in on Harold Ford's behalf with the Judiciary Department because of your connection to Hubbell. CBC's response has been that they weren't even aware of the connection and that as far as they were concerned, the purpose of Tuesday's meeting is to focus exclusively on health care reform and CBC's proposals.

V. SEQUENCE OF EVENTS

IV. REMARKS

o HRC opening remarks
o Dialogue

HISTORY AND BACKGROUND

The Congressional Black Caucus was formed in 1970 when the 13 Black Members of the U.S. House of Representatives joined together to strengthen their efforts to address the legislative concerns of Black and minority citizens. African American Representatives had increased in number from six in 1966 to nine, following the 1970 elections. Those Members believed that a Black Caucus in Congress, speaking with a single voice, would provide political influence and visibility far beyond their numbers.

The Caucus received its first national recognition when its Members met with former President Richard Nixon in March, 1971 and presented to him a list of 60 recommendations for governmental action on domestic and foreign issues. The President's response, considered inadequate by the Caucus, further strengthened their efforts to work together in Congress.

Today, there are 40 Black Members of Congress, nine women and thirty-one men representing many of the largest and most populated urban centers in this country, together with some of the most expansive and rural Congressional districts in the nation. These Members, now as in the past, have been called upon to work as advocates for America's varied constituent interests – developing an ever-expanding legislative agenda – as well as addressing the concerns of their own particular districts.

The visions and goals of the original 13 Members, "to promote the public welfare through legislation designed to meet the needs of millions of neglected citizens," have been reaffirmed through the legislative and political successes of the Caucus. The CBC is involved in legislative initiatives ranging from full employment to welfare reform, South African apartheid and international human rights, from minority business development to expanded educational opportunity. Most noteworthy is the CBC Alternative budget which the Caucus has produced for the past twelve years. Historically, the CBC Alternative Budget policies depart significantly from Administration Budget recommendations as the Caucus seeks to preserve a national commitment to fair treatment for urban and rural America, the elderly, students, small businessmen and women, middle and low income wage earners and the economically disadvantaged and a new world order. CBC Members introduced more than 400 individual bills in the 102nd Congress and co-sponsored an unprecedented 11,000 legislative measures.

In the twenty-three years since its founding, Caucus Members have been successful in rising to strategic positions on House Committees to affect needed changes in federal policies. At the close of the 102nd Congress, a CBC Member held the office of Chief Deputy Whip of the House of Representatives, four African Americans chaired full House standing committees, one Select Committee, and thirteen Caucus Members held Subcommittee Chairmanships.

Democrat and Republican, they are the "conscience of the Congress."

Amelia L. Parker
Executive Director

CONGRESSIONAL BLACK CAUCUS

H2-344 THE FORD BUILDING, WASHINGTON, D.C. 20515

FAX

TRANSMITTAL SHEET

DATE: _____

TO: _____

ATTENTION: Kim Tilley

FAX PHONE NUMBER: 456-22-39

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FROM: Amelia Parker

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Congressional Black Caucus
Congress of the United States

H2-344 House Annex #2
The Ford Building
Washington, D.C. 20515
202 — 226-7790

February 17, 1993

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

Dear Mrs. Clinton:

On behalf of the Congressional Black Caucus, it is my pleasure to invite you to join the Members of the Caucus for a working luncheon on Wednesday, February 24, 1993 to discuss our views on proposals for the implementation of a national comprehensive health care program. This is an issue which we have championed for many years, and your commitment to this crucial initiative serves to underscore the importance that this Administration attaches to passage of this measure. We look forward to a having the opportunity to explore, in detail, the fundamental elements which we perceive as essential to addressing the needs of the underserved and unserved populations in this nation.

We have attached a copy of the health care proposals submitted to the Transition Team which should provide a framework for our discussions. Amelia Parker, CBC Executive Director, will be in contact with your office to confirm other logistical matters. We look forward to having an opportunity to explore this and other issues with you.

Sincerely,

KWEISI MFUME
Chairman
Congressional Black Caucus

enclosure

cc: Ms. Maggie Williams

Congressional Black Caucus
Congress of the United States

H2-344 House Annex #2
The Ford Building
Washington, D.C. 20515
202 — 226-7790

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Sincerely,

KWEISI MFUME
Chairman
Congressional Black Caucus

enclosure

cc: Ms. Maggie Williams

URGENT HEALTH NEEDS OF AFRICAN-AMERICAN AND OTHER MINORITY COMMUNITIES

No matter what type of health insurance is enacted, we believe that the following fundamental issues also must be addressed if we are to improve the health status of African-Americans and other minorities:

ACCESS TO AND COST OF COMPREHENSIVE HEALTH CARE

1. Minority Americans should have access to a minimum package of benefits that include preventive and acute services for those specific health problems for which they are disproportionately at-risk.

The excess incidence of chronic illness and serious diseases that afflict Minority Americans requires basic health benefits that increase access to preventive and primary health care. This includes prenatal and well-baby care, mental health services, substance abuse treatment, and prescription drugs. Early detection and screening programs for cancer and other illnesses must also be provided.

2. Access to community-based services should be greatly expanded and collaborations with hospitals encouraged to increase access to primary care.

A major expansion of school-based health clinics, health care for residents of public housing, and health centers for the homeless, including a doubling of the number of Community and Migrant Health Centers is especially critical to the minority community. C.H.Cs should be encouraged to collaborate with hospitals to increase access to primary care.

3. Coverage for services provided by alternative care-givers should be equivalent to the coverage that would be available if provided by a physician.

Coverage for services received from a nurse, midwife, nurse-practitioner, nutritionist, physician assistant, or other non-physician provider should be equivalent to the coverage that would apply if the same services were provided by a physician. In addition to expanding access to affordable primary and preventive care it would lower costs for the services provided.

4. Historically Black Hospitals should be adequately supported and reimbursed for the health services provided to minority communities.

These facilities have played a key role in addressing the critical health problems of minorities, serving the indigent and

in place and there should be prohibitions against physician incentive plans that limit utilization and reduce medically-necessary care.

- **Hospital Global Budgets:** Negotiations with hospitals should establish an annual lump-sum budget for all services. This will provide stable funding, make hospitals more efficient, limit unnecessary services, and contain costs.

- **Physician Fees:** Fees should be negotiated with physicians and other practitioners to control the rate of increase and limit unnecessary services.

- **Capital and Technology Controls:** Planning entities including consumers, providers and public officials should determine when and where to build new hospitals and clinics and buy new equipment. This will limit duplication that results in unnecessary procedures, underutilized equipment, and increased prices.

- **Prescription Drug Prices:** Prescription drug prices should be negotiated to limit excessive increases and provide a fair rate of reimbursement.

8. Emphasis on Primary and Preventive Care. Health care should be reoriented towards primary care and prevention by requiring medical schools, as a condition of public reimbursement, to achieve a national goal of producing at least 50% primary care physicians; currently our schools produce fewer than 30%. The Federal Government should also greatly expand research on primary care and prevention.

9. Assistance to the Medically Underserved. Special attention should be given to expanding health services to medically underserved communities. In particular, significant increases in funding are needed to expand community-based health care facilities and programs and to educate and train primary care practitioners who practice in underserved communities.

10. Financing. Premiums collected from individuals to finance a national health insurance program should be significantly progressive, based on ability to pay. Premiums on employers should place the greatest burden on the most profitable corporations, limiting the effect on small businesses.

underserved, providing trauma care and AIDS-related care, and increasing the number of minority health professionals.

5. The specific needs and experiences of minority patients and providers must be accomodated in crafting the standards and policies for any managed care systems.

African-American patients and providers must have easy access to membership in managed health care systems, and severity of illness which the patient presents must be factored into the reimbursement.

HEALTH CARE PERSONNEL

1. The number of minority health providers should be increased for the purpose of improving the minority community's access to care.

Minority physicians and other health professionals have historically tended to practice in low-income areas, serve minorities, and engage in the general practice of medicine or primary care specializations. For these reasons, increased support of the programs in the Disadvantaged Minority Health Act is essential.

2. National Health Service Corp funding should be increased in order to double the number of primary care physicians in areas with a shortage of health care professionals.

Doubling the number of primary care physicians who could serve through Community Health Centers and other preventive care for medically underserved communities.

PUBLIC HEALTH

1. The epidemic of violence and its impact on our minority communities mandates that decisive action be taken to develop a multi-faceted public health approach to violence.

Strategies to prevent violence should emphasize the socio-economic conditions in the minority communities in hich violence manifests itself. Examining the root causes of violence -- such as the easy accessibility of firearms, employment opportunities, and education -- should be the framework for our deliberations.

2. Women's rights of reproductive choice should be guaranteed.

For minority women, many of whom are poor and suffer high rates of medical complications related to pregnancies, the ability to exercise this choice has been limited in recent years.

We encourage an increase in research on alternative forms of contraception and the immediate reversal, through legislation and otherwise, of policies relating to a woman's right to choose.

3. Public education and access to a national vaccinations system and treatment for contagious childhood diseases should be expanded.

The Center for Disease Control has recommended that a national vaccination system be instituted to prevent the outbreak and spread of measles, mumps, and other diseases, as well as to avoid the onset of entirely preventable conditions, such as polio and diphtheria. Rapid treatment of diagnosed cases also must be assured.

4. Environmental hazards to minority communities, such as lead poisoning and exposure to toxics, must be mitigated and regulations must be established to limit the impact of environmental risks on the health of minority communities.

Studies have shown that a disproportionate share of facilities that emit substances which pose potential health hazards are sited in communities where their greatest impacts are absorbed by minority residents. "Environmental equity" must be promoted and regulations must be embraced to limit the influx of environmental hazards into these communities.

5. Public health education and outreach programs targeted to minorities at the community level must be promoted.

The specific health problems of the minority community should be the focus of outreach efforts that are racially, socio-economically and linguistically diverse in order to penetrate cultural barriers.

TREATMENT OF AND RESEARCH ON PARTICULAR CONDITIONS

1. Research on the health problems of African-Americans and other minorities must be expanded, with minority researchers and institutions as major participants.

Since illnesses often manifest themselves differently in Minority Americans, targeted research will provide a more accurate assessment of the health needs of minority populations.

2. Efforts to prevent and control the spread of HIV virus and the AIDS epidemic, as well as efforts to treat patients, must target the African-American and Hispanic-American communities, as detailed by the National Minority AIDS Council.

Currently, the African-American and Hispanic-American populations are experiencing the sharpest growth in the numbers

of new cases of HIV and AIDS. These communities must, therefore, be targeted for curbing the spread of the disease and in crafting treatment innovations, including the development of new drugs.

3. Treatment of hypertension through early detection, pharmaceutical, and other options should be a top priority.

Hypertension (or high blood pressure), endemic among African-Americans, is often undetected until it becomes severe or results in complications, leading to less effective and more costly treatment. Access to free blood-pressure exams, other early detection methods, and treatment once diagnosed must be assured.

4. Additional funding and dedication is needed at the Federal level to help already financially impaired cities to respond quickly and effectively to outbreaks of Tuberculosis.

The recent resurgence of T.B. as a serious threat to public health in American cities requires a greater Federal role and increased Federal funding to combat this disease.

5. Patient education and training on monitoring and complying with a regimen to control certain conditions must be covered.

Many complications and deaths relating to hypertension, diabetes, tobacco smoking and substance abuse stem from a failure of patients to fully understand and receive support with their regimen. Covering classes as well as other tools for these situations would lessen the incidence of costly complications.

PUTTING

The Congressional Black Cauc Jim Sensitive are Reform

The American health care sy ... major surgery. Bandaid solutions will not cure ... it. It is a national disgrace that 35 million American ... lack health insurance, 25% more than a decade ago. Sixty million more are underinsured, many only an illness away from bankruptcy. Children make up one quarter of the uninsured; over two-thirds of the uninsured are in working families, with the breadwinner working full-time. Three out of ten Americans feel locked into their jobs -- afraid to pursue a better or higher paying job out of fear of losing health coverage. Too many families are seeing their health benefits erode as insurance companies cut back on covered services and reduce lifetime coverage limits.

Minority Americans suffer an even greater burden as illness and death fall disproportionately on their families as compared to white Americans. The incidence of cancer, hypertension, diabetes, AIDS, infant mortality, homicide and chemical dependency, take a devastating toll on our communities. In addition, African Americans and Hispanics account for over 50% of the number of Americans added to the rolls of the uninsured between 1977 and 1987. They are also disproportionately represented in the kinds of families at the greatest risk of being uninsured -- families where no one is working and families that are poor.

We take great hope in President-elect Clinton's commitment to ensuring comprehensive health care to all Americans, while getting costs in line with the general rate of inflation. To that end, we strongly urge that the President-elect and the Congress work together to create a national health insurance program with the following features:

1. Universal Coverage. All citizens and nationals should be entitled to receive comprehensive benefits.

2. Comprehensive Benefits. The following comprehensive benefits should be provided:

- **Acute Services:** All hospital and clinic care; physicians, dentists and other practitioners; all necessary tests.

- **Preventive Services:** Including immunizations; pre-natal and post-natal care; well baby and well child care (under 18 years); mammograms and Pap smears; dental and eye exams; family planning services.

- **Prescription Drugs:** All necessary prescription drugs

needed for the treatment or prevention of illness.

- **Drug and Alcohol Abuse Treatment:** Inpatient, outpatient and community-based services to provide treatment on demand.

- **Mental Health Services:** Inpatient, outpatient and community-based services.

- **Long-term Care:** Institutional/nursing home services; home and community-based care services; respite or temporary care such as day care.

3. Deductibles and Co-payments. There should be only minimal deductibles and co-payments on a sliding scale, with a maximum chargeable amount per service and/or per year.

4. Freedom to change jobs or move to another region. People should have complete freedom to change jobs or move because coverage should not depend on their place of employment or on whether they had a preexisting medical condition.

5. Freedom to Choose Providers. Our present high-quality system of private, non-profit, or public hospitals should still deliver health care. People should have complete freedom to choose their own health provider.

6. Role of the Federal Government. The Federal Government should guarantee the provision of comprehensive benefits to all citizens and nationals. It should establish an independent national health insurance board to oversee the implementation of the national health insurance program, which should establish a national budget for health spending. The board should set minimum standards and policies for the provision of health care. Consumers should play a significant role in all decision-making of the board and in advisory bodies to the board.

7. Strong Cost Containment. The national health insurance program should have the power to contain costs and plan for the efficient distribution of health facilities through:

- **Health Care Budget:** The Federal Government should set and adhere to an annual health insurance budget to control costs.

- **Managed Care Networks:** Consumer-oriented managed care networks should be strongly promoted as an alternative to fee-for-service medicine. Offering a continuum of care at a fixed annual price, they should be required to provide a wide range of services. At least one-third of the board of each managed care entity should be members

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. form	Hillary Rodham Clinton Scheduling Meeting Request [partial] (1 page)	3/2/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Tuesday March 2 [1993]

2014-0483-S
sb326

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.
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RR. Document will be reviewed upon request.

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b(3) Release would violate a Federal statute [(b)(3) 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]

(WJC-6153)

Evelyn

HILLARY RODHAM CLINTON SCHEDULING
MEETING REQUEST

DATE: Mar 2
LOCATION: HRC's office
TIME: any time
REQUESTED BY: Betty Ford
CONTACT: Anne Cullen
CONTACT PHONE:
619/ 324-1763

BF req.

I. PURPOSE OF MEETING Betty Ford wants to meet w/ HRC – Joe Califano and John Schwarzlose, who runs the BF Center, also want to come to talk about substance and abuse

II. BACKGROUND

III. PARTICIPANTS

see above Tipper Gore (Sch.) Ina, Tipper AL + sub. abuse

IV. PRESS PLAN
photo op w/ BF

V. MEETING AGENDA

see above

** CONTACT WILL BE RESPONSIBLE FOR INFORMING PARTICIPANTS OF ALL MEETING LOGISTICS (e.g., Time, Location, etc.)

==========

(For Scheduling Office Only)

STATUS:

NEXT STEP:

Betty Ford 4-8-18 38k 10-4057 001
John Schwarzlose [redacted] (b)(6) hdqs of BF Center
Joseph Califano – Smithberg ABase

February 18, 1993

Maggie:

Betty Ford is coming to town on March 2 and would like to come with Joe Califano and John Schwarzlose (the person you were supposed to meet with who runs the Betty Ford Clinic) to talk about substance abuse. I suggested to Ann Cullen, Ford's assistant, that Hillary meet with Betty Ford alone and then have the three of them meet with Ira or something. She didn't think that was a bad idea, but will Califano (a former HEW secretary under Johnson) be insulted? March 2 is open.

① why groups together?

convince trmt for AL + drug dep needs to be increased, w/ lt a # saver

Schwarzlose supporting / he prove, facts & figures

Califano — CASA —
Ctr on Addiction & Sub Abuse
Pol. new (1yr or so) Mus Focus on their board.
Doing research as to what really works treating addictions

Nat'l resour where all N drs as th

(212) 841-5210 Califano
Joanne McCauley

Tues

Center on Addiction
and Substance Abuse
at Columbia University

CASA
152 West 57th Street
New York, NY 10019
(212)841-5200

Telecopy Cover Sheet

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Comments: Please let me know if there is anything else that you need. My direct number is 212/841-5217.

CASA at a Glance

WHAT: The only national organization to bring under one roof all professional disciplines needed to examine the impact on all aspects of society of all types of substance abuse--from illegal drugs to pills, alcohol and tobacco. Founded in 1992 in affiliation with Columbia University, CASA will work with experts in medicine, law enforcement, business, law, economics, communications, teaching, social work, and the clergy to determine and combat the impact of substance abuse on the judicial system, housing, prisons, children, families, the safety and viability of urban life, health care, crime, business productivity and competitiveness, and education.

WHY: The country cannot begin to deal with other basic problems unless it seriously deals with addiction--the nation's number-one public health problem and the number-one crime problem.

WHERE: 152 West 57th Street, N.Y., N.Y. 10019; tel. (212) 841-5200; fax (212) 956-8020.

WHO:

Chairman and President: Joseph A. Califano, Jr., Secretary of Health, Education and Welfare, 1977-79.

Exec. Vice President and Medical Director: Herbert D. Kleber, M.D., Deputy Director for Demand Reduction, Office of National Drug Control Policy, 1989-91.

Sr. Vice President and Director of Program Demonstration: William J. Grinker, Commissioner, New York City Human Resources Administration, 1986-89.

Vice President and Director of Policy and Research: Jeffrey C. Merrill, Vice President, The Robert Wood Johnson Foundation, 1984-91.

A diverse staff of 38, including policy analysts, an economist, health services researchers, a psychiatrist, a psychologist, an anthropologist, lawyers, an expert in employee assistance programs, administrators, a financial expert, a computer specialist, a librarian, a communications expert, and a Commonwealth Fund/Harkness Fellow.

Board of Directors: James E. Burke, Chairman of the Partnership for a Drug-Free America; Mr. Califano; Betty Ford, Chief Executive Officer of the Betty Ford Center; Douglas A. Fraser, former President of the UAW and current professor of Labor Studies at Wayne State University; Hon. Barbara C. Jordan, former U.S. Congresswoman who currently holds the Lyndon B. Johnson Centennial Chair in National Policy at the LBJ School of Public Affairs at the University of Texas at Austin; Donald R. Keough, President and Chief Operating Officer of The Coca-Cola Company; LaSalle D. Leffall Jr., M.D., former President of the American Cancer Society and current professor and Chairman of the Dept. of Surgery, Howard University College of Medicine; Manuel T. Pacheco, Ph.D., President of the University of Arizona; Linda Johnson Rice, President and Chief Operating Officer of Johnson Publishing Company; E. John Rosenwald Jr., Vice Chairman of The Bear Stearns Companies; Michael I. Sovern, President of Columbia University; Frank G. Wells, President and Chief Operating Officer of The Walt Disney Company.

Funding Sources: Carnegie Corporation of New York, The Annie E. Casey Foundation, The Commonwealth Fund, The Charles A. Dana Foundation Inc., The Ford Foundation, William Randolph Hearst Foundation, The Robert Wood Johnson Foundation, Kaiser Family Foundation, The Pew Charitable Trusts, The Prudential Foundation, The Rockefeller Foundation, and contributions from corporations including Automatic Data Processing, Inc., Champion International Corporation, The Chase Manhattan Bank, Chemical Bank, Chrysler Corporation Fund, The Coca-Cola Company, Walt Disney Company, Ford Motor Corporation, Glaxo, Inc., Hershey Foods Corporation, Kmart Corporation, Mobil Corporation, Northrop Corporation, NYNEX Corporation, Pfizer Inc., Primerica Corporation, Reliance Group Holdings, Inc., Safeway Stores, Inc., Sony USA, Inc., Warnaco, Inc.

February 1993

MEMORANDUM

To: Chris Jennings
cc: Charlotte Hayes
Kim Tilley

Date: March 1, 1993

From: Jeffrey Farrow

Re: Hispanic Caucus Puerto Rico/Territories Concerns

Two insular issues may come up in tomorrow's meeting with the Hispanic Caucus: Medicaid Funding and Section 936. They may be brought up by the Members from the islands (Romero, de Lugo, and Underwood) or those originally from Puerto Rico who represent migrants from the island (Serrano, Velazquez, and Gutierrez.)

Medicaid Funding:

The health care access problem in the insular areas is a problem of access to adequate care. Insular governments provide universal care for these 3.9 million Americans; but lack the resources to provide adequate services. Caps on Medicaid are a primary reason.

For example, the cap for Puerto Rico provided $79 million in FY '92; state-like Medicaid participation would have provided $1.12 billion. State-like treatment for American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands would have been $69 million in FY '92 versus $7.3 million provided under the cap.

The situation has resulted in serious health care deficiencies.

- o Puerto Rico has six of the 10 hospitals under the U.S. flag with the worst incidence of infant mortality. Its neonatal mortality and low birthweight rates are the highest among U.S. Hispanic populations; but it provides less in services to pregnant women and children than do the states and does not fund family planning.

- o Puerto Rico also provides less to the needy aged and disabled and does not fund nursing facilities or home care.

- o Puerto Rico has the second highest AIDS rate under our flag...but does not have the funds for AZT.

The situation has also caused needy Puerto Ricans to migrate to states and encouraged support for statehood.

The problems are similar in other islands. All want more funding.

There had been talk of using revenue from reducing the tax exemption on U.S. corporate income from insular areas (tax code Sec. 936) to pay for an increase and Romero may suggest this

tomorrow. But the inclusion of a major limitation on 936 benefits in the economic plan (to raise $7 billion) makes it unrealistic.

Another potential funding source -- at least for Puerto Rico and the Virgin Islands -- is the excise tax on alcohol. The islands currently get back the first $10.50 per gallon on the rum they produce and claim a right to the amounts over that which are now withheld by the federal government.

If alcohol taxes are increased, the increase could be used to pay for increased care in the islands. De Lugo may suggest this.

Section 936:

Romero supports the proposal to limit 936 benefits based on wages paid because it would eliminate the greatest economic impediment to statehood and strengthen statehood against commonwealth in the status referendum planned for this year. But there is substantial opposition to it because of the economic harm it could cause.

The critics include statehooders like Gov. Rossello and Democrats like state chair Hernandez Agosto, who says he was promised during the campaign that 936 would not be harmed.

The current 936 exemption is the basis of Puerto Rico's economy (300,000 of the 1 million jobs.) And the potential impacts of the proposal are so great that the issue may come up tomorrow.

Gutierrez, who supports independence, and Velazquez, who formerly worked with the commonwealth leadership, will probably work with island leaders to have the proposal moderated.

The goal may be to limit the 936 cuts to the pharmaceuticals that have caused the most criticism of the provision. The criticism is that pharmaceuticals receive far more in tax benefits than they pay in wages...although job creation was the purpose of the exemption. For example, pharmaceuticals account only account for a fifth of the 100,000 plus direct jobs created by 936 although they get half the $2.7 billion a year in tax credits.

Limiting the exemption based on wages paid will harm other manufacturers as well as pharmaceuticals and makes no provision for the $15 billion in 936 profits reinvested tax free in Puerto Rico or elsewhere in the Caribbean. Its possible consequences include significant increases in Puerto Rico's 17% unemployment rate, migration to states, and demands for social programs funding as well as in support for statehood. They also include decreases in the island's local revenue.

Serrano, who is close to statehood leaders, is concerned about the economic problems that the proposal may cause; but is deferring to Romero on it.

- Civil and Voting Rights - protecting the civil rights of Hispanics, women and other minories in all avenues of American life

ISSUES OF CONCERN

1) Inclusion of Hispanics The Caucus has expressed concern about Hispanics being fully included in the Administration and in the Health Care Task Force in particular. This concern dates back to the campaign, during the end of which they felt they had not been given enough credit for their activities. Although a relatively small group in Congress, they felt they had played a significant part in the election of President Clinton. This situation was further excerbated during a health care meeting which took place during the transition. The Caucus Members, already perturbed by the campaign, were made angrier when no Hispanics were included in the health care transition team. Evidently the level of the Members' discontent was not known to the transition people running the meeting so steps, which could have been taken to ease their frustrations, didn't happen leaving the Members feeling even more ~~bruised.~~ While pleased with having two Hispanic Cabinet members, they ~~wish to make sure~~ Hispanics ~~are included in~~ the upper- and mid-levels where the "hands-on" work takes place.

Suggested Response: You are not sure of the numbers, but the Task Force is constantly evolving and people are being brought in as needed for their expertise. You are aware, that people recommended by the Caucus have been included, such as the three consultants from HHS, and you are grateful for their involvement and you

2) Puerto Rico Many Caucus members are concerned about the economic package's impact on Puerto Rico. A memo follows further detailing their concerns and who may be expected to speak about this issue.

III. PARTICIPANTS

Rep. Jose Serrano, Chair - Congressional Hispanic Caucus
(participant list follows)

IV. PRESS PLAN

Arrival/Departure - Open Press
Meeting - Closed except for pool spray

V. SEQUENCE OF EVENTS

- o Rep. Serrano - opening remarks & introduces HRC;
- o HRC opening remarks and turns meeting back over to Rep. Serrano;
- o Rep. Serrano will present his own questions and concerns first (1) Hispanic involvement, 2) universal access - including migrant farm workers and undocumented aliens and 3) health care reform in the broader sense of addressing

bilingual needs, education, etc.) and will then ask the Members (in order of seniority) for their one question or concern;

- o HRC response (NOTE: The Members hope they will get some information and specific responses to their questions. Following are some questions a few Members submitted in advance for your information.)

IV. REMARKS

Cassie x7767

CBC

Ve Jordan set up mtgs
BC interest
good relationship

(Julie) will meet curbside at Horseshoe
5 min.
- Mfume intro her
- HRC remarks, turn back to Mfume
- Mfume intro Stokes, Collins, Conyers
HC Brain Trust

HJS
X Puerto Rico update

Chris
Jeff Fuller — MEMO Re:
Texas

Re Charlotte No groundwork — just Feser contentious; no HRC rep on coke transi group
"Have sw people they recommended to HRC; others consulting, meeting advice

HJS
4 consultants — brought on through HHS
- 3 they recommend
(2) Cmte staff 300-400
- another three
(3) constantly evolving — COC — Montez
as needed for expertise as well dynamic process

Very Competitive

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. schedule	Monthly Calendar Hillary Rodham Clinton [partial] (1 page)	3/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Tuesday March 2 [1993]

2014-0483-S
sb326

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]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

- arrival/departure - open
- pool spray

March 1993

HILLARY RODHAM CLINTON

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1 9:00-10:00am Inner Office Mtgs 2:00pm Pvt Mtg w/Alan Greenspan	**2** 9:00-10:00am Inner Office Mtgs 12:00pm Wellstone 1:00pm Black Caucus 2.30pm Hispanic Caucus Mtg w/Betty Ford ? 4:00 - 5:30 dinner	**3** 9:00-10:00am Inner Office Mtgs 10:00am AFL-CIO Mtg ? 3:00pm Governor's Mtg ?	**4** 7:30pm March of Dimes Award Ceremony ? New Orleans Trip	**5** 9:00-10:00am Inner Office Mtgs 12:00pm Scheduling Mtg	**6** Washington, DC
7 Washington, DC	**8** 9:00-10:00am Inner Office Mtgs 7:30pm Al Hunt Dinner	**9** 9:00-10:00am Inner Office Mtgs 4:00pm Black Comm. Crusade - WH Tea Marian Wright Parker	**10** 9:00-10:00am Inner Office Mtgs 12:00pm NAACP Legal Lunch	**11** 9:00-10:00am Inner Office Mtgs	**12** 12:00pm Scheduling Mtg Hlth Care Conf TAMPA	**13** Washington, DC
14 Billy Bolger St. Patrick's Day Call-In Washington, DC	**15** Iowa Regional Hearing (Day Trip)	**16** 9:00-10:00am Inner Office Mtgs 3:00pm Western Hemisphere First Ladies Tea	**17** 9:00-10:00am Inner Office Mtgs *St. Patricks Day*	**18** 9:00 am Inner Office Mtgs Poss. West Coast Trip	**19** 8:30am-2:30pm Tollgate Meetings 12:00pm Scheduling Mtg	**20** Washington, DC (b)(6) 002
21 (b)(6) 002 Washington, DC	**22** 9:00-10:00am Inner Office Mtgs Michigan Regional Hearing	**23** 9:00-10:00am Inner Office Mtgs	**24** 9:00-10:00am Inner Office Mtgs	**25** 9:00-10:00am Inner Office Mtgs	**26** 12:00pm Scheduling Mtg Washington, DC Hearings	**27** Gridiron Washington, DC
(b)(6) 002						
28 Washington, DC (b)(6) 002	**29** 8:30am-2:30pm Tollgate Mtg 9:00-10:00am Inner Office Mtgs (b)(6) 002	**30** 9:30am Children's Hospital Event	**31** 9:00-10:00am Inner Office Mtgs			

February

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28						

April

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2/28/1993

"Hard-hitting... an incomparable introduction." — *Los Angeles Times*

AMERICA'S HEALTH CARE REVOLUTION

An acclaimed survey and analysis that explodes conventional thinking about the nation's major social crisis

Joseph Califano

Former Secretary of Heath, Education, and Welfare

JOSEPH A. CALIFANO, JR.

HEW NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

For release upon delivery
Expected at 2 p.m. June 19, 1977

Remarks by

Secretary of Health, Education, and Welfare

Joseph A. Califano, Jr.

before the American Medical Association

Fairmont Hotel, San Francisco

June 19, 1977

I think it's a good thing for you and me to meet face to face; to exchange views fully and freely in a spirit of mutual respect and candor.

As professionals, we must remember that doctors and lawyers are never as good as our patients and clients say we are when their illness is cured or their case is won--and never as bad as they say we are when they get the bill.

In the short time that I've been in office, I have enjoyed the most cordial relationships with the officers and executives of the American Medical Association. They have kept me informed of your views -- especially when they diverged from mine!

- more -

And I have tried to be open and candid with them--including acknowledgement of mistakes when we think we've made them.

This meeting is part of the essential, continuing communication that must exist between organizations like the AMA and a Secretary of Health, Education, and Welfare. So I'm grateful to you for your hospitality. And I know that the overriding objective we all share is better health for all Americans.

It is against the background of this shared objective that I accepted your invitation to address the opening session of the American Medical Association's National Convention.

I thought it important for you to understand first hand how the new Administration views the health care industry and how we view the doctors who shape so much of that industry.

Americans would like to cling to some hallowed images of medical care in our nation: images that reach back to the placid past of our grandparents.

One cherished image is that of the stern but wise family doctor of Victorian years, jouncing in his buggy from house to house, dispensing pithy wisdom along with the castor oil.

A second image is of more recent vintage: it is the flickering image of the television doctor: first, young Dr. Kildare, then Dr. Ben Casey, and finally, the reassuring, confidently omniscient Marcus Welby, M.D. Unlike you, Dr. Welby has only one patient at any given time. And there's another difference: all of his patients get well within the hour.

But the reality of modern medical practice today, as you well know, is much more complicated than Norman Rockwell covers for The Saturday Evening Post or television films.

It is our perception of that reality I would like to discuss today: the problems of medical practice and public policy that it poses for you and for me; and some urgent action that all of us--the administration and the Congress, physicians and citizens--must take as we begin to deal with those problems.

For we have set ourselves an ambitious goal in America: a high standard of health care for everyone--at manageable cost.

The extraordinary talent of so many doctors has encouraged us to set our sights high. The genious of a few has provided discoveries that have given millions of our citizens superb quality care. The dedication of many has saved lives and eased pain and misery for generations of Americans.

We know that quality care is available for many Americans. We want to make that quality care available for all Americans. We seek to do it at reasonable cost. The achievement of these two goals at the same time--quality care for all, at reasonable cost--is what we are about.

The quality care objective has long characterized American medicine and physicians, but reasonable cost has not been the strong suit of either American medicine or most of its physicians. We see that not as the fault of affluent doctors--but as the most serious shortcoming of the health care system.

If we are to meet these dual ambitious goals, or even approach them, we must first see the nation's health care system clearly for what it is.

To do that, we must pull the camera back; back from the past; back from fiction, with its narrow, close-up view of Dr. Welby. When we do that there comes into view a vast, sprawling, complex, highly expensive and virtually non-competitive industry--one of the nation's largest though least understood industries, a unique system of economic relationships that are commanding, and controlling, an ever larger share of our nation's resources.

We perceive health care in America today as big business.

To be sure, health is not just another industry; the enduring strength and high quality of the doctor-patient relationship is a vital element in the medicine of the 1970's, just as it was a generation ago--and generations before that.

But the term industry is still an apt one--and it provides a critical perspective on the health care system for public policy makers.

With expenditures of $139 billion in 1976, the health care industry is the third largest in the United States. Only the construction industry and agriculture are larger.

- o In 1975, 4.8 million people worked in the health industry. That was 5.1 percent of the national workforce--slightly more than one American worker in 20.

- In the same year, 375,000 physicians were in practice in America: one for every 570 citizens.
- Health care spending was 5.9 percent of the Gross National Product in 1965. It was 8.3 percent in 1975. And, at present inflation rates, it could reach 10 percent of GNP by 1980. In that year, spending on health care will, without some kind of restraint, have ballooned to $230 billion, $1,000 for each man, woman and child in America.

The giants of corporate America have moved in to obtain their share of the health industry--major companies like IBM and Bausch & Lomb. Many of the major pharmaceutical companies are in the Fortune 500. The profits of these drug companies are far above the average for large corporations in America.

We perceive health care as an inordinately complex and fragmented industry. It contains over 7,000 hospitals with a total capacity of 1.5 million beds, 16,000 skilled nursing homes, with a capacity of 1.2 million beds; thousands of laboratories and hundreds of suppliers of drugs, expensive medical equipment and other medical products.

Decisions in this industry are made--by a host of private and public institutions--without adequate planning at the state and local level.

We perceive health care as a very costly industry. The median income of the average American family was $13,700 in 1975. In that same year, the average family expenditure for health care was nearly $1,600, more than 10% of the median income.

An average hospital stay cost less than $350 in 196[illegible]. It now costs over $1,300. Private health insurance premiums have jumped 20-30 percent in just the last year alone.

And the American people paid doctors a total of $25.3 billion in 1976.

We perceive the health care industry as virtually non-competitive. The features of the competitive marketplace that have served our people so well in other industries--to promote efficient allocation and utilization of resources--are just about non-existent in the health care industry.

- o The patient--the consumer--may select his family doctor--but he does not select his specialist, his hospital, the services he is told he needs, the often expensive medical tests to which he is subjected. The physician is the central decision-maker for more than 70 percent of health care services.
- o Increasingly, the patient--the consumer--does not pay directly for the service he (or she) receives. Ninety percent of the hospital bills are paid by third parties--private insurance companies, Medicare, Medicaid.
- o These reimbursement mechanisms usually operate on a cost-plus or fixed-fee-for-service basis, the most expensive and least efficient ways to function.
- o Most public and private benefit packages are heavily biased toward expensive in-patient care.

- o The unavailability of price and quality information keep the consumer of health care services dependent on the decisions of the health care provider, who plays a dominant role in determining demand for health services and whose financial well-being is determined by the price charged.
- o The ability to restrict access to competitors--hospital credential committees that can deny or delay privileges to Health Maintenance Organizations, for example--provide special levers of market control.

These are some of the dominant economic features of the health care industry--features which provide many powerful incentives to spend more, and few, if any, incentives to spend more efficiently.

We must face a basic fact: there is virtually no competition among doctors or among hospitals. And, just as important, there is precious little competition among pharmaceutical companies or among laboratories. For pharmaceutical and medical device and equipment research has become big business, with patent monopoly pots of gold at the end of the research rainbow.

These economic features pose severe problems in allocating and utilizing health care resources in the most effective way possible--problems that, although grounded in the economics of health care, relate ultimately to the broad national goal of providing, with limited resources, quality health care to all Americans at reasonable cost.

We do not perceive the health care industry as a world of good people and bad people. Doctors are not bad and para-professionals good. Hospitals do not wear black hats while government policy makers wear white ones. That is not the point.

The point is that doctors, hospitals, pharmaceutical companies, nursing home operators--all the inhabitants of this non-competitive, free spending, third party-payor world--act exactly as the incentives motivate them to act: conscious of quality, insensitive to cost.

The result, inevitably, is a set of economically classic structural problems.

First: Our health resources, abundant as they are, are not well-distributed, either economically or equitably.

In the past ten years, we have made considerable strides toward opening access to health care for many people. But major problems remain:

-- We have not done a very good job over the past ten years of helping rural Americans get ambulatory care. The typical rural citizen is twice as likely never to have had a physical examination, as the typical citizen of a large metropolitan area. Many rural women fail to receive basic early cancer detection examinations.

-- In our inner cities, minority citizens still lag far behind others in their access to physician care. Polio immunization rates for black children under the age of four are one-third lower than the rates for white children.

-- Here in the State of California, of 1.2 million eligible poor children, only 20,000, --less than two percent-- have been reached by a joint State-Federal early screening diagnostic and treatment program. Only 12,000 of these children--1 percent--have been treated. This Administration has proposed new legislation--the Child Health Assessment Program--to correct this intolerable situation on a nation-wide basis.

Yet, while some are starving for health care, obesity is commonplace for others. Nationwide we have an excess of some 100,000 hospital beds. There are enough cat scanners in Southern California for the entire western United States.

We have made progress in absolute numbers in ending the doctor shortage of 10 years ago; but doctors are unevenly distributed, geographically and by specialty. Manhattan has 800 doctors per 100,000 people; Mississippi, fewer than 80. In some disciplines, we have too many specialists, while the desperate need for primary care physicians in many rural areas persists.

And so we face a major national challenge: to redirect the flow of new health resources into underserved areas and to underserved groups so that ultimately all Americans will have fair access to quality health care. And we must ask: Can we do this in an industry with virtually no competition? Indeed in an industry where the economic incentives move in the opposite direction?

Second, not only are our health care resources poorly distributed--they are often not organized as efficiently as they might be.

As physicians have moved to more lucrative practices in the suburbs, for example, the burden of providing primary medical care in our inner cities has fallen increasingly on the outpatient departments of large metropolitan hospitals. Yet the cost of this kind of care is high. For many patients, two or three times higher than the same services offered in other settings, such as Health Maintenance Organizations and community health centers.

We have not made much progress in using non-physician health professionals to take some burdens off the physician--even though we know that nurses, physician assistants and other primary health practitioners can less expensively assume many tasks traditionally performed by physicians, without lowering the quality of care. Liscensure laws are essential to preserve and maintain professional standards, but they should not be permitted to inhibit the development of new patterns of care.

Third, with little incentive to be cost effective in the use of skills and resources, it is no wonder that our present health-care system emphasizes acute care over prevention. Because of this, we are needlessly risking illness and sometimes even lives and recklessly consuming resources that could be used to meet other urgent needs.

Today the health-care challenge is dramatically different from what it was ten or twenty years ago. Today the leading killers are not communicable diseases, but accidents, heart disease, cancer, cirrhosis of the liver--which are often caused by people's lifestyles or by hostile influences in the environment.

Yet, our health-care system is not really geared to the field of prevention aimed at these killers.

We could literally save thousands of lives that are now being stunted or lost--if we could reduce the ravages of:

-- Cigarette smoking, which kills through cancer, heart attack, and emphesema.

-- Alcoholism, and its toll in mortality, morbidity and the destruction of family life.

-- Obesity, with its sinister companions, diabetes and hypertension; and

-- Accidents, which kill and maim in the office, at home, and on the highway.

In the case of each of these killers, we already have enough knowledge to make major lifesaving gains. What we lack is sufficient will and ingenuity in educating our fellow citizens about how to live more safely and sensibly. And we sorely lack a health-care system with economic incentives as strong to prevent as they now are to cure, one which makes prevention as profitable for providers as treatment now is.

Fourth, our system of health insurance in America is an expensive and inequitable crazy quilt.

Some eighteen million Americans--most of them unemployed or employed in small non-manufacturing businesses--have no health insurance at all.

Another nineteen million Americans--most of them with incomes between $5,000 and $10,000--have no group insurance, only skimpy individual coverage that is at best inadequate.

Nearly half the population under age 65 does not have insurance that is sufficient to cover major medical expenses. National Health Insurance to protect all Americans from the crushing burden of medical expenses is essential. And I am pleased to note that you agree on the need and have been developing your own plan.

Which brings me to the overarching problem of the health care industry in America: The problem of runaway costs. In part because of these other problems I have sketched, the cost of medical care is soaring today.

Not only is health care spending devouring an ever larger share of our Gross National Product, but, under current projections:

- o Total health expenditures will double by 1980;
- o Hospital costs paid for by Medicare and Medicaid will double even sooner;
- o If unchecked, total hospital costs could reach $220 billion by 1985;
- o Health care is rising at a rate of two and one half times the rise in the cost of living.

This rapid inflation imperils the ability of uninsured people to get health care at all. It gobbles tax dollars at such a rate that they are not available for other public priorities. The federal government spends 12 cents of every taxpayer dollar on health care. The average American worker works one month each year to pay health care costs.

Clearly, the health care industry, as presently structured, has become a problem for all of us--patients, physicians, providers of care, and public officials. Certainly we can understand why the American consumers and taxpayers--and more and more top executives of large corporations--are demanding that something be done.

Thus far, the Administration has pressed forward on the cost front, as you know. The President has sent to the Congress legislation that would control the precipitous rise in hospital costs--the most inflationary sector in the health industry.

But we recognize that the proposal we have put forward--a limit on increases in total hospital revenues--is merely a stop-gap solution that is a necessary transition to more profound structural, long-term reform.

For the long term we must begin to organize health resources more effectively, distribute health care benefits more equitably, emphasize prevention and primary care, and establish a fair and effective system of national health insurance.

Why have I spoken to you at such length about all these problems: Because you, more than any other members in the health care system, are its leaders and decision makers.

In past generations, your profession has led this nation to some striking achievements: a longer lifespan for our citizens; lower infant mortality, the near-elimination of many infectious diseases, a rigorous system of medical education.

In the future, we must not only protect those life-saving gains; we must face another, wholly new set of challenges:

-- The challenge of dramatically improving the cost-efficiency of our health care system;

-- The challenge of re-directing our health efforts towards prevention as well as acute care.

Those are not challenges laid down by a government bent on ever-increasing regulation. They are demands that come from the American people and public officials, and increasingly from many of your own member physicians who are urgently concerned about both the medical and economic health of our people.

So the government--representing the people and the consumers--must play an increasing role in health care. We will fulfill our responsibility best with your help and cooperation: but we must fulfill our responsibility nonetheless.

There are hard choices ahead; there are difficult decisions. We ask you to help us to act thoughtfully; to join with us in seeking solutions to these problems.

I believe that the American people would prefer, --as I, and presumably you, would prefer--that the leadership in solving these problems come from within the health care system--from you--rather than from outside of it.

Some physicians are, in fact, providing such leadership.

- o A large group of physicians are now partners with us in the management and operation of the PSRO program. These physicians are establishing standards, reviewing quality and sharply examining the appropriateness of care given by other physicians. We intend to expand and strengthen the PSRO program.
- o Recently, a leading obstetrician expressed serious concern about rising O.B. costs and spoke out for dramatic consolidation of facilities to produce quality obstetrical care.
- o Medical schools and a growing number of physicians are responding to our need for primary care.
- o Some surgical specialists are taking the lead in a critical self-examination of excess surgery.
- o More and more physicians are joining and starting HMOs.

These are progressive steps. We hope many more physicians will begin taking them.

The story is told that Winston Churchill once paid a visit to his doctor because he was feeling terrible. His doctor, after carefully examining him, said, "Mr. Prime Minister, if you want to feel better, I suggest you cut back drastically on your consumption of brandy and cigars."

Whereupon Churchill fixed a withering stare on his doctor and replied: "My good man, I have no intention of doing either. That is why I have come to you."

And that, in fact, is what all of us have been doing for too long in this field of health care: using our affluence to cure problems, rather than our ingenuity and self-discipline to prevent them. We have not been willing to confront the hard fact that resources are limited and that we must find new methods to provide quality health care to all Americans at reasonable cost.

Now, the cost of our indulgence--like the cost of Mr. Churchill's indulgence--is catching up with us. We can no longer buy our way out of our difficulties. We must think our way out.

Thank You.

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