FOIA Number: 2018-0756-F

FOIA MARKER

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

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Kristine Gebbie

Subseries:

OA/ID Number: 8302

FolderID:

Folder Title:
[Miscellaneous Memos and Correspondence 1994] [loose] [2]

Stack:	Row:	Section:	Shelf:	Position:
S	66	5	2	1

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Ed Mallory to Participants in Interagency Working Group Meeting on AIDS; re: Working Groups to Develop HIV/AIDS Strategy Papers; [Partial] (1 page)	03/04/1994	P3/b(3)
002. fax	re: Interagency Group - Development of HIV/AIDS Strategy; [Partial] (1 page)	03/04/1994	P3/b(3)
003. fax	From: Nils Daulaire; Agency for International Development - Bureau for Policy and Program Coordination - Office of Strategic Planning; [Partial] (1 page)	03/04/1994	P3/b(3)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1994] [loose] [2]

2018-0756-F
jp4861

RESTRICTION CODES

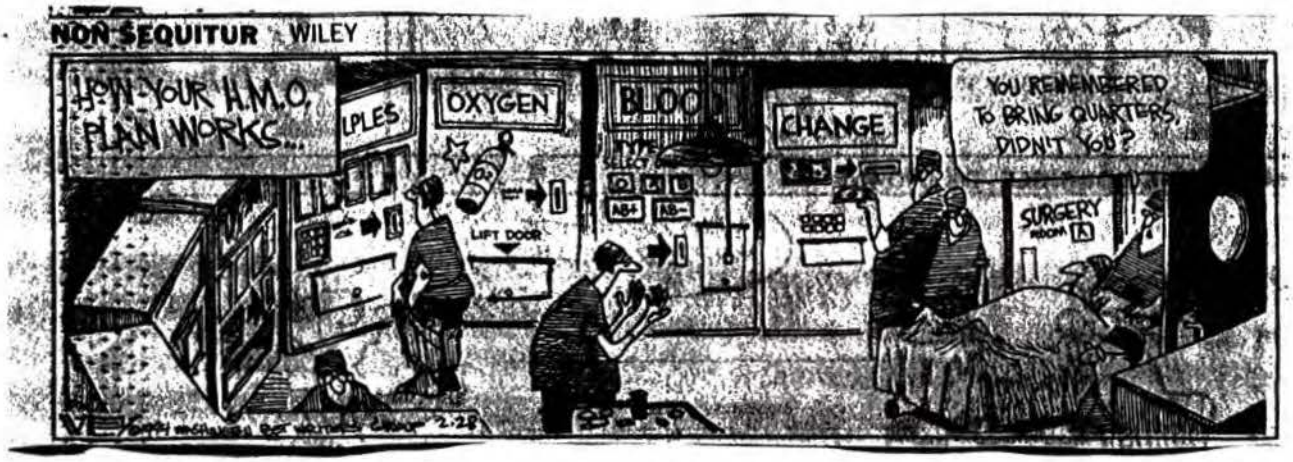
Presidential Records Act - [44 U.S.C. 2204(a)]

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.

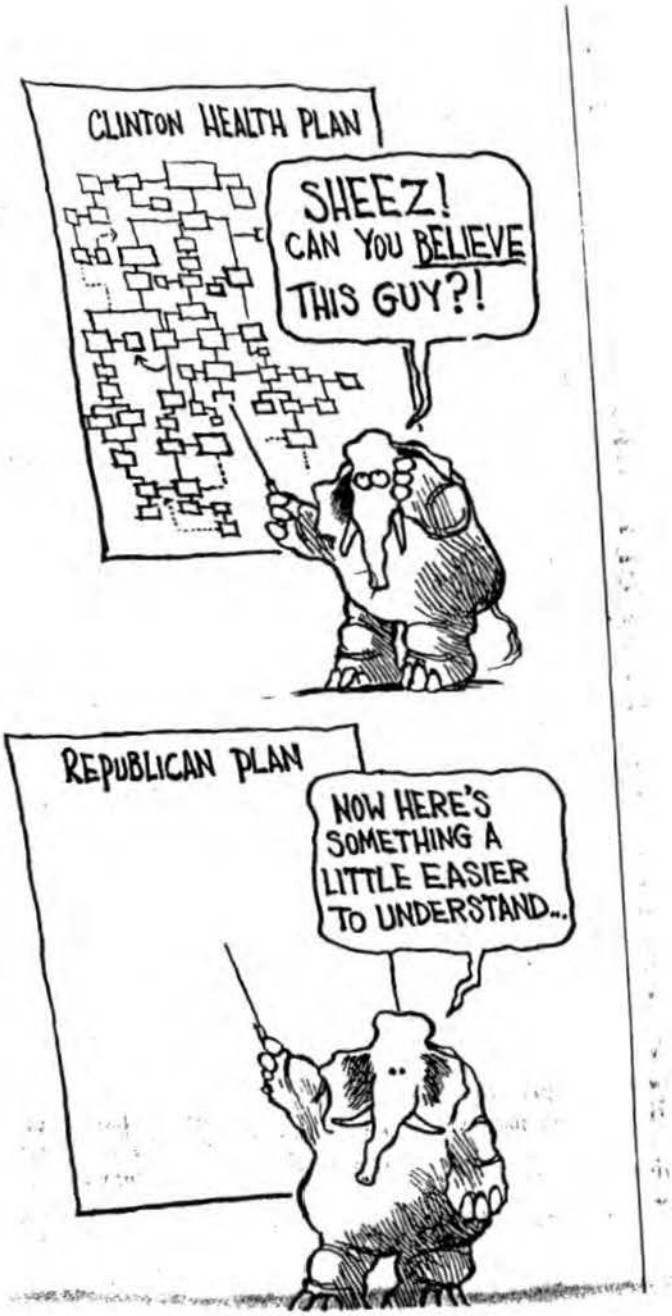
Freedom of Information Act - [5 U.S.C. 552(b)]

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]



George,
FYI — This is
a good one.

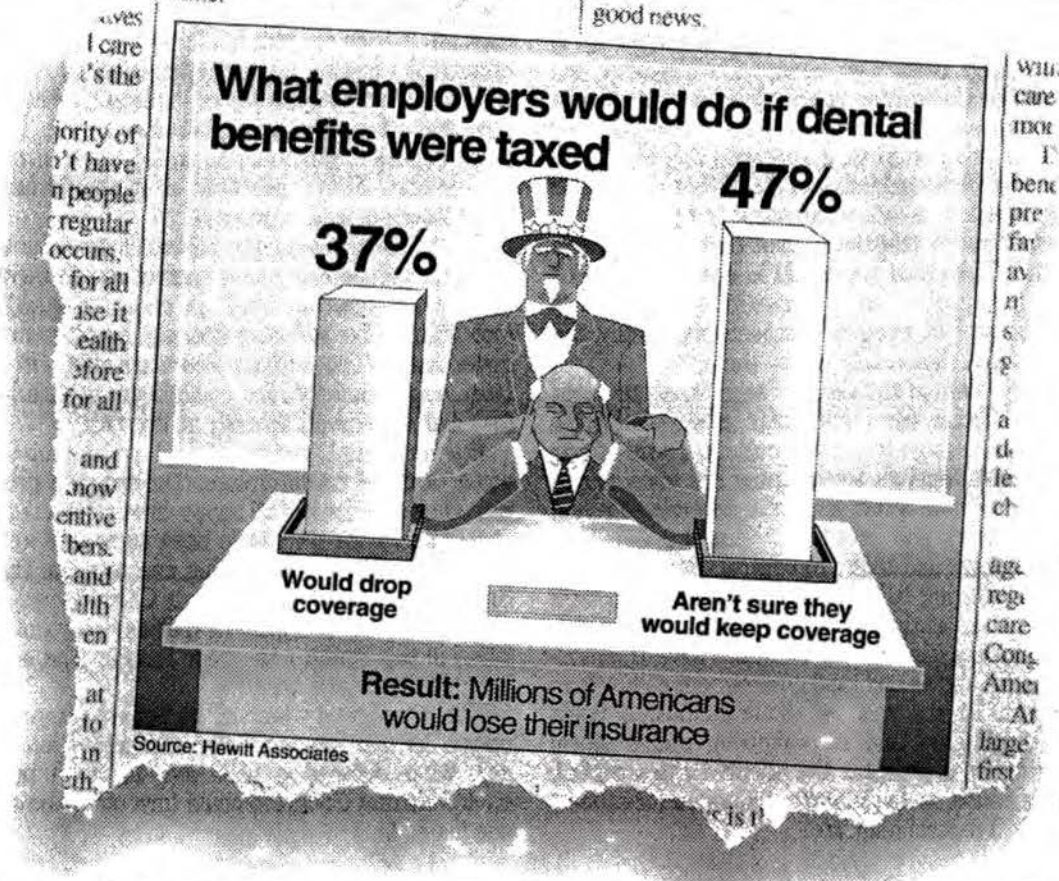
Alice
2/28/94



By Mike Thompson, State Journal Register, Springfield, Ill., Copley News Service

Jues 2/22/94

They call it health care reform—but some in Congress want to tax away America's dental benefits.



In one generation, dental prevention has become a major American health care success story. The reason? An emphasis on regular dental care, with the ease of access offered by dental benefits.

Today, some 95 million American workers and families have those benefits. But many of the health care reform proposals now before Congress would require employers or employees to pay taxes on benefits not in the basic core package. That could make dental coverage unaffordable, and 30 years' dramatic improvement in oral health could be reversed overnight.

Preventive dental care works for people of all ages. So why is Congress considering benefits taxes that would endanger dental coverage for millions of Americans, damage oral health, reduce productivity and cause labor-management strife?

At Delta Dental, America's first and largest dental benefits provider, we know first-hand the positive results of preventive dental care for our 25 million subscribers. The savings and health benefits are significant. But if dental coverage is taxed, the savings and the benefits will shrink as this unfair burden forces employers and employees to sacrifice their dental benefits.

THAT'S WHY WE OPPOSE TAXING DENTAL BENEFITS OUT OF EXISTENCE.

DELTA DENTAL

Working to help all Americans smile.

CHRISTIAN COALITION SAYS

DON'T LET A GOVERNMENT BUREAUCRAT IN THIS PICTURE.

How the Clinton health care plan will affect families.

✔ RATIONING.

The "Health Security Act" would impose price controls on premiums as part of a national health care budget (p. 986). The inevitable result of price controls is rationing. The Clinton plan requires that when medical needs outpace a state's health care budget, state governments must make "automatic, mandatory, nondiscretionary reductions in payments" to doctors and hospitals (p. 113). This will lead to extended waits and long lines for basic health care services. 565 of America's leading economists across a broad political spectrum have concluded that the plan will "reduce the quality of care and force long waits for such things as surgery."

✔ ABORTION.

The Clinton plan mandates abortion as a guaranteed basic benefit (p. 63). It would force millions of Americans to subsidize the taking of innocent human life against their consciences. According to a 1993 survey, 72 percent of the American people oppose taxpayer-funded abortion under a national health care plan. Abortion is not health care. It stops a beating heart and ends a human life. Al Gore once wrote, "In my opinion, it is wrong to spend federal funds for what is arguably the taking of a human life." Al Gore was right.

✔ LOSS OF CHOICE.

The doctor-patient relationship has always been sacrosanct. Families have chosen their own doctors who delivered their babies, nursed their children, and cared for their elderly—without interference from the government. But the Clinton plan would drive families into large health cooperatives (p. 99) and negate state laws that protect physician choice (p. 238). It would impose quotas on specialists graduating from medical school by 1998 (p. 509). Families should choose their doctors, not the government.

✔ LOST JOBS.

The Clinton plan would force small businesses to pay 80 percent of health care premiums through a mandated 7.9 percent payroll tax. One study has found that 85 percent of these mandated benefits would be paid for through reduced wages for working men and women. One survey found that 51 percent of small businesses would eliminate jobs or close their doors if slapped with a health care payroll tax. Other studies have found that a plan similar to the President's could cause up to one million people to lose their jobs, and put a total of 7.5 to 18 million jobs at risk. A pro-family health care plan is pro-jobs. The Clinton plan is neither.

✔ MIDDLE-CLASS CRIMINALS.

The "Health Security Act" federalizes a broad range of crimes dubbed "federal health care offenses" and "health care fraud." Otherwise law-abiding citizens would be subject to criminal penalties ranging up to 15 years in a federal penitentiary (p. 973). The Clinton plan relies on government coercion, not competition.

TO FIND OUT MORE ABOUT HEALTH CARE REFORM, CALL

1-800-472-7777

The Christian Coalition wants to keep you informed during this national health care debate. Call for your free health care "Action Kit" which keeps you updated on how health care reform will affect you and your family.

Christian Coalition

Paid for by the one million members and activists of the Christian Coalition, a citizen organization representing families and children

Selected Brief Chronology of Health Care Reform

November 21, 1993	Bill introduced
January 24, 1994	Strategy for passing health care reform (HCR) plan: compromise with liberals in the House, compromise with moderate Republicans in the Senate, and come back to something like Clinton's original proposal in a House-Senate Conference after the August recess, possibly as late as October.
January 24, 1994	National AIDS Policy Coordinator testifies before the Energy and Commerce Subcommittee on Health and the Environment on the President's Health Plan and Special Populations, including persons living with HIV/AIDS and disabilities.
January 25, 1994	President's State of the Union Address - threat of a veto if final bill does not include guaranteed health insurance.
	Major committees hold hearings on HCR through Spring break.
	Inflation rate for medical prices is at a 20 year low for 1993 (5.4%). The population without health insurance is estimated at 38.5 million.
	Daniel Patrick Moynihan (D-NY) a key player in the debate, rejects notion there is a health care crisis.
January 27, 1994	Congressional Budget Office (CBO) projects the deficit for the current fiscal year, ending September 30, will be $223 billion, $68 billion less than predicted a year ago. Deficit would lower to $166 billion by fiscal year 1996. CBO indicates is due to enactment of August 1993 major package of tax increases and spending cuts.
	Recall the President had stated that his plan will reduce the deficit by more than $50 billion over the next five years.
January 31, 1994	Nation's governors (through the National Governors Association) issue a bipartisan call for Congress to pass a HCR bill this year. Did not endorse the President's plan.

Senator Dole (R-KS) in a speech to the American Hospital Association (AHA) put aside his argument that here is no health care crisis and said he believes Republicans and Democrats can reach agreement on a bill this year.

Senator Moynihan (D-NY) backed away from earlier statement that there is no health crisis, saying there is an "insurance crisis."

February 1, 1994

Democratic critics complained the President may be giving too much before the negotiations begin. Senator Rockefeller (D-WVA) called these signals a "mistake." The President responds that we should be more flexible on the size of the alliances, have to have some way of showing how much taxpayer money is at risk" by a having a mechanism to constrain price increases.

White House issues a detailed rebuttal to the critique of the plan by Elizabeth McCaughey in the New Republic.

Senate Democrats lambast former Representative Gradison (R-OH) president of the Health Insurance Association of America (HIAA) for sponsoring TV ads to scare Americans from supporting HCR, featuring characters named Harry and Louise, expressing concern about Clinton's plan.

February 2, 1994

The Business Roundtable, representing 200 of the nation's largest companies, voted to support the health care bill sponsored by Representative Cooper (D-TN), and make it the "starting point" of its negotiations with Congress.

House Energy and Commerce Subcommittee on Health and the Environment holds first hearing on the Cooper bill, offering a preview of the "free-for-all" tone of the coming Congressional debate over the issue. [NOTE: This will be the first Committee of 5 to mark up health care legislation this year.]

February 3, 1994

US Chamber of Commerce publicly opposes the Administration's health plan, testifying that the burden of high employer premium contributions, rich benefits and

counterproductive regionalization and new federal and health alliance bureaucracy. The Chamber of Commerce represents 215,000 companies primarily those with less than 100 employees.

National Association of Manufacturers and four other business groups send letters to Representatives Cooper and Grandy, and Senator Chafee saying they support discussions among the three to draft a health plan based on "market competition reform."

February 4, 1994 — The First Lady denounces the insurance and drug industry, and a private sector health industry "rife with fraud, waste and abuse."

February 5, 1994 — A record number of students (45,000) applied to medical school this year, despite widespread concern that national health care reform will affect physicians' autonomy and salaries. [Compared to 26,000 in 1988, according to the Association of American Medical Colleges (AAMC)].

February 8, 1994 — CBO rules financing of HCR not as taxes; will use "miscellaneous or offsetting receipts" like grazing and mining fees and other payments the government receives from people who derive specific benefits (Medicare Part B payments goes in there as well).

Dr. Reischauer, director of CBO, testifies the Administration's plan would increase the deficit by $74 billion in its first six years. The primary reason is health insurance premiums cost 15% more than the Administration has estimated. Headlines assert there is a "$133 billion difference of opinion."

CBO finds plan will begin saving in year 2000.

President states "that's a Washington policy wonk deal. No serious person out in the real world would be troubled by it."

February 10, 1994 — The President seeks speedup in health plan - Ways and Means Chair promises bill before Easter recess in March, full Committee before Memorial Day (which may delay it until June). Energy and Commerce Chair has March 4 deadline.

American College of Surgeons endorsed the concept of a single-payer system. With 52,000 members (AMA has 295,000) joins the National Medical Association, Physicians for a National Health Program, and the American Medical Women's Association in supporting Representative McDermott's (D-WA) bill.

February 13, 1994 — Ads join "Harry and Louise" in debate on health care reform. Ads fall in two basic categories: things are terrible now and things could get a whole lot worse. The Pharmaceutical Manufacturers Association (PMA) runs one ad: "My brother is HIV-positive. We don't have 10 r 15 years to wait for a cure."

The response: "Right now pharmaceutical companies have 55,000 people searching for cures and 174 medicines in development to fight breast cancer, AIDS and Alzheimer's disease."

February 14, 1994 — An Urban Institute study finds most states would end up with more federal health care funds than they get now, and pay less out of State funds for the medical bills of low-income persons. States that are now the most restrictive in granting medical assistance to the poor generally would be the biggest winners.

February 15, 1994 — Governor Campbell (D-SC) demanded the Democratic National Committee withdraw an ad in which he is seen saying that the nation does no face a health care crisis. First Lady asks health maintenance organizations (HMOs) to enter the health reform ads and state how great they are and how happy consumers are with HMOs.

February 16, 1994 — Work begins to increase support of the Administration's bill among the elderly.

February 20, 1994 — Representative Stark (D-CA) states the "regional health alliances" keystone of the Administration's bill are in serious trouble. Two other key elements: the requirement that employers insure all workers and the cost controls on insurance premiums draw criticism in three of the five key subcommittees with jurisdiction over health care.

House and Senate committees review timetable that is aimed, perhaps optimistically, at getting bills to the House and Senate floors by the end of May.

Republicans are no less divided than Democrats over how to reform the health care system. United only by what they oppose in the Clinton plan: especially its price controls, bureaucratic superstructure, requirements for employer financing of insurance and mandatory insurance purchasing pools or alliances.

February 23, 1994 "Confusion and apprehension" dominate the public reaction to the Washington health care debate, according to members of Congress returning from the Presidents' Day break. Voters are having a hard time understanding the subject and seem increasingly cautious about endorsing large-scale change.

President visits Connecticut to stress the prescription drug benefit under Medicare (a $15 billion benefit) that can be financed through Medicare savings and gain support from the National Association of Retail Druggists and the National Association of Chain Drug Stores.

The Biotechnology Industry Organization (BIO) oppose the advisory council for breakthrough drugs which would review prices and make recommendations to the HHS Secretary who then could "blacklist" drugs priced too high -- which they consider price controls.

February 27, 1994 — Lewin-VHI Inc. predicts the Clinton plan would by 1998: nearly 1 in 4 households would see health care spending fall by $1000, while 1 in 6 would see it rise by that amount; half of businesses would see health spending per worker change by more than $1000, with winners edging out losers; firms that now offer health insurance would gain a cost advantage (shift of $30 billion); employers and employees would pay an extra 14% for health insurance to help pick up the cost of health insurance for working and nonworking poor; about $9.5 billion would be shifted to persons over 55 years old and up.

Trying to caluculate these various impacts from Clinton's or any other helath plan

requires giant computers, sophisticated software and decades of information about health care spending warn their projections are just "educated guesses" (including CBO, HHS, the Emmplyment Policies Institute, the Wyatt Co.).

Employer mandate would cause billions of dollars a year to shift, more significant is the requirement in all three that health plans must charge employers the same rate for abasic health insurance package.

Preparedby:ALitwinowicz:ONAP:690-5560:February 28, 1994.

THE WHITE HOUSE

WASHINGTON

February 28, 1994

APHA Awards Committee
APHA
1015 15th St. NW
Washington, DC 20005

This letter is in support of the nomination of William H. McBeath, MD, for the 1994 Sedgwick Memorial Medal of the American Public Health Association. I have had the pleasure of working with Dr. McBeath for many years as an active member of the American Public Health Association and a member of its Executive Board.

Awarding the Sedgwick Medal to Dr. McBeath would be an acknowledgment of his tireless commitment to public health and the Association. Serving as Executive Director during years which were turbulent for the Association and for the field of public health, Dr. McBeath strove to balance his understanding of the science of public health, his passion for a healthier public, and the policy demands of an outspoken and diverse Association membership. His good humor stood us all in good stead on many occasions; his wisdom provided depth to our understanding of many complex issues. Over the years to come, we will undoubtedly be the continuing beneficiaries of his efforts.

I am please to lend my support to this nomination. If I can provide any additional information or comment, please let me know.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

UNIVERSITY OF CALIFORNIA, LOS ANGELES

UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF PUBLIC HEALTH
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024-1772

February 18, 1994

Kristine M. Gebbie
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, NW, Suite 1060
Washington, DC 20503

Dear Kristine:

Enclosed is a copy of our nomination of Bill McBeath for the Sedgwick Memorial Medal.

If you would like to support this nomination, would you kindly write a short letter of one or two paragraphs, addressed to the APHA Awards Committee, stating why Bill deserves the Sedgwick medal. Please send your letter to us so that we may enclose it with our nomination. We should like to receive your letter by March 15th.

Please keep this matter completely confidential.

With many thanks,

Sincerely,

Ruth Roemer, JD

Milton I. Roemer, MD

Telephone: (310) 825-6958
FAX: (310) 825-8440

rr3(bm).ltr

Enclosure

SEDGWICK MEMORIAL MEDAL
1994 NOMINATION

For distinguished service and the advancement of public health knowledge and practice

(Please print or type)
Full Name of Nominee and Degree(s) William H. McBeath, M.D., M.P.H., LL.D.

Title and Organizational Affiliation Executive Director Emeritus, American Public Health Association

Address 15305 Basswood Court
Rockville, Maryland 20853

Telephone (business) _____ (home) (301) 929-9261

Describe below in detail the current creative work, distinguished achievements, or distinguished service which make this nominee worthy of the 1994 award, bearing in mind the award description. (Attach additional sheets as necessary.)

See attachment and copy of article from November 1993 Nation's Health

a. Positions (titles and dates) held during performance of work for which nomination is suggested:

Executive Director, American Public Health Association, 1973-1993

b. Publications relevant to particular achievements on which nomination is based:

See Attachment

c. Other honors and awards:

Member, Board of Directors, National Health Council
Past President, World Federation of Public Health Associations
Honorary Fellow, Royal Society of Health
Fellow, American College of Preventive Medicine
Delta Omega

Nominator's Name Ruth and Milton Roemer Signature _____

Address UCLA School of Public Health
Los Angeles, CA 90024-1772

Telephone (business) (310) 825 6958 (home) (310) 472 6618

Date _____

PLEASE NOTE: **A separate form must be submitted for each nomination. A current curriculum vitae must accompany this completed nomination form, but will not be accepted in lieu of this completed form. Nominations should be sent to the APHA Awards Committee, APHA, 1015 15th Street, NW, Washington, DC 20005. Nominations received after April 1, 1994 cannot be guaranteed consideration for the 1994 award.**

Publications relevant to particular achievements on which nomination is based

Among Dr. McBeath's publications we comment only on his Keynote Address, the 15th Margaret Baggett Dolan Lecture, to the Opening General Session of the 118th Annual Meeting of the American Public Health Association, delivered in New York City on October 1, 1990. The annual meeting theme that year was "Forging the Future: Health Objectives for the Year 2000." The address is entitled "Health for All: A Public Health Vision" and is published in the American Journal of Public Health, Vol. 81, no. 12, pp. 1560-65, December 1991.

After a masterly review of world health needs and of the renaissance of national prevention initiatives that emerged in the 1970s, Bill McBeath turns to health promotion in the 1980s and its centerpiece -- the 226 specific, quantifiable national health objectives. In analyzing the progress made towards achieving these objectives, he provides a candid assessment of accomplishments and deficiencies in this effort. He sets forth health priorities for the 21st century in the United States and calls on governments, health professionals, and APHA for leadership in attaining the goals of equity, a national health program, with universal coverage and comprehensive benefits, and access to better living standards. A scholarly and insightful analysis of health promotion and disease prevention activities from 1970 to 1990, this address will be a classic reference and guide for future public health scholars and practitioners.

Current creative work, distinguished achievements, and distinguished service

In October 1993, Dr. William H. McBeath completed 20 years of service as Executive Director of the American Public Health Association, the oldest and largest professional organization of public health workers in the world. In these 20 years, APHA's membership has risen to 50,000, and its contributions and influence have expanded enormously.

During those years, Dr. McBeath provided leadership for the Association's role in broadening and strengthening the scientific base for public health and in developing its advocacy role for improved environmental and personal health services. Many of the creative strategies of the Association to strengthen public health education and practice were proposed initially by Dr. McBeath, and all were supported by him. His wide knowledge of public health in its many dimensions enabled him to work effectively with the numerous disciplines in public health, with the 24 Sections of APHA, and with its Affiliated Associations, SPIGs, Boards, Committees, and Caucuses, to encourage their growth and increase their impact.

As concerned about problems of public health in the developing world as in our own country, Dr. McBeath played a leading role in strengthening the World Federation of Public Health Associations. Serving as Secretariat for the WFPHA, APHA helped public health associations to provide independent, professional support for public health programs and promoted the formation of new professional public health associations in a number of additional countries.

Dr. McBeath took office as Executive Director of the Association as President Nixon was leaving office in 1973. He served as Executive Director during the Ford, Carter, Reagan, and Bush Administrations, confronting during these years some of the most significant challenges to maintaining basic public health services. He also seized important opportunities to extend public health through protecting the environment and encouraging personal health promotion and disease prevention.

To give some notion of the scope of national health problems that Bill McBeath confronted during his years as Executive Director of APHA, one may mention the following examples. He worked with the first national health planning legislation between 1974, when the National Health Planning and Resources Development Act (P.L. 93-641) was passed, and 1986, when the national legislation was terminated, although many states continued to apply certificates of need. APHA's support of health planning at the national, state, and community levels was a personal commitment of Bill McBeath, who had served as Director of the Division of Medical Care in the Kentucky State Department of Health and as Director of the Ohio Valley Regional Medical Program in Louisville, Kentucky. Thus, Dr. McBeath was very much involved in the problems facing state and territorial health officials.

In 1973, the US Supreme Court opened a new era in reproductive health with its decision in Roe v. Wade, 410 U.S. 113 (1973), legalizing abortion on the ground of the fundamental right of privacy of the woman and her physician to choose abortion. During the years that followed, when legalized abortion was being implemented and attempts were being made to erode the right to choose, APHA, with Bill McBeath's unwavering support, played a leadership role to protect women's health and preserve reproductive freedom -- issuing policy statements, lobbying Congress, and participating in amicus briefs in cases before the courts.

During the period 1973-93 APHA, under Dr. McBeath's leadership, made important contributions to increased support for maternal and child health and for greatly expanded immunizations of children.

During Bill McBeath's tenure in APHA, the Association was active in achieving the robust growth of environmental protection legislation. The National Environmental Policy Act had been passed in 1969, and APHA was alert as a watchdog in implementing its goal to prevent or eliminate damage to the environment and stimulate the health and welfare of people. The Toxic Substance Control Act of 1976, the Resource Conservation and Recovery Act in the same year, with its emphasis on hazardous waste, revision of the Clean Air Act and the Clean Water Act in 1977, and the Superfund legislation of 1980 all called forth initiatives from APHA that Bill McBeath promoted.

In the mid-1980s, with the advent of the AIDS epidemic, the APHA Executive Board established a Special Initiative on AIDS. In the course of its implementation led by Dr. McBeath, one of its important activities has been the production of a series of authoritative, scientific reports on various specific aspects of the epidemic.

In all these and many other public health issues, numerous units of the Association and many of its members participated, but Bill McBeath was the single, most important monitor of the public health climate of the nation. He was skilled in keeping his eye on the issues, and he raised timely concerns with the officers, Executive Board, Governing Council, Program Development Board, and Action Board of APHA. As one member of APHA put it, "Presidents of the Association come and go, but Bill McBeath has been there as Permanent Undersecretary for the Association's responsibility for public health."

Within the Association, Bill McBeath undertook numerous imaginative strategies to increase membership, to improve the financial resources of the Association, to implement APHA's affirmative action policy, to strengthen the scientific base for public health policy and programs, and to expand APHA's advocacy role. An important contribution that he made was to enhance communication within the public health community and to enrich the knowledge of public health professionals. As Executive Editor of The Nation's Health, he encouraged its development as a first-class newspaper for public health workers. As Managing Editor of the American Journal of Public Health, he supported several successive editors in making AJPH a ranking scientific journal spanning the many fields of public health.

What qualities enabled Bill McBeath to carry on this demanding leadership role for so many years?

First, Bill McBeath has a sound and broad knowledge of public health in all its aspects and a deep, philosophical commitment to the public health movement. He is as comfortable dealing with arboviruses as with health insurance. He grounds every decision, every initiative, and every action in a thorough knowledge of public health theory and practice.

And he is true to that commitment. In his dealings with the Executive Board he has always kept the focus on the mission of the Association -- what is best for public health. Even when Board members disagreed with his position, he has had a remarkable capacity to stick to his principles, to hold the feet of Board members to the fire, so that they would recognize their duty as representatives of the public health membership of the Association. On occasion he had to teach the Board that its duty was to formulate policy, not to carry out

management functions. And, grappling with the day-to-day problems of the Association's management, he never lost sight himself of the ultimate objective of strengthening public health.

Secondly, perhaps as important as Bill McBeath's intellectual grasp of public health issues and his good judgment in dealing with them, is his remarkable ability to work with almost everyone, even those who disagree with him. And this he has been able to do without compromising his principles. APHA is composed, as we all know, of many disciplines, of varied interests, of groups and individuals with different concerns, but Bill McBeath has an uncanny ability to work with all of them. He inspired his staff, he encouraged the membership, he challenged the sections, affiliates, and committees of the Association, and he cooperated constructively with other organizations.

Thirdly, a key to Bill McBeath's leadership is his skill in translating ideas and goals into actions. When Bill Foege suggested in 1985 that APHA establish a special initiative on tobacco control, Bill McBeath turned that idea into a dynamic reality. A reflection of his ability to make things happen is the Association's achievements in the field of affirmative action. Espousing principles of non-discrimination is easy to do. Much harder is to assure that every component of an organization is constituted so as to bring into activity and responsibility representatives of all ethnic, racial, and geographic groups and representatives of the many disciplines within APHA. APHA's early recognition of the importance of diversity, as a matter of justice and as a source of vitality for the Association, is in large measure due to Bill McBeath's principles and his genius in implementing them.

Lest the Awards Committee think that Bill McBeath's distinguished service and his "advancement of public health knowledge and practice" are due only to his knowledge,

commitment, interpersonal skills, and to his talents as an administrator and manager, one should add that Bill McBeath has a not-so-secret weapon -- his enchanting wit. We believe that Bill McBeath thinks that a funny word (of which he has many) turneth away wrath. And through his wit he often expresses his sensitivity and warmth to his colleagues.

For 20 years of selfless and extraordinarily competent service to public health, we nominate Dr. William H. McBeath for APHA's most prestigious honor, the Sedgwick Memorial Medal. Honoring Bill McBeath in this special way expresses gratitude for his years of devoted work and does honor to the American Public Health Association.

Professional Resumé

William H. McBeath

Executive Director, **American Public Health Association**
Managing Editor, *American Journal of Public Health*
Executive Editor, *The Nation's Health*
(Executive Director Emeritus, effective 1 July 1993)

Board of Directors, **National Health Council**
Past-President, **World Federation of Public Health Associations**
Honorary Fellow, **Royal Society of Health**
Fellow, **American College of Preventive Medicine**
Delta Omega

Dept. of Health Services Administration, **George Washington** University
former academic affiliations with Universities of
Kentucky, Louisville, Cincinnati, Michigan, North Carolina, & Johns Hopkins

B.S., Georgetown College, 1953
M.D., University of Louisville, 1957
M.P.H., University of Michigan, 1964
LL.D., Georgetown College, 1980

1958-61: Flight Surgeon & Preventive Medicine Officer, **U.S. Air Force**
1961-62: Field Officer, Heart Disease Control Program, **U.S. Public Health Service**
1962-66: Director, Div. of Medical Care, **Kentucky State Department of Health**
1966-73: Director, **Ohio Valley Regional Medical Program**
1973-present: Executive Director, **American Public Health Association**

American Public Health Association
1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5656

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Ed Mallory to Participants in Interagency Working Group Meeting on AIDS; re: Working Groups to Develop HIV/AIDS Strategy Papers; [Partial] (1 page)	03/04/1994	P3/b(3)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1994] [loose] [2]

2018-0756-F
jp4861

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]

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

FACSIMILE

March 4, 1994

TO: Participants in interagency working group meeting on AIDS (See attached distribution list)

FROM: Ed Malloy, Director, Office of Science, Technology and Health

SUBJECT: Working Groups to develop HIV/AIDS strategy papers

The following is the list of working group chairs and contacts and selected themes which may be discussed:

Working Group	Chair	phone/fax
1) Scientific research Cooperation	Dr. William Paul, NIH/OAR contact: Linda Reck	301-496-0357/7769
2) Prevention	Dr. Nils Daulaire, USAID	202-647-8415/8595
3) "Diplomacy"	Dr. John Boright, State contact: Sharon Hemond	202-647-3004 647-4537/736-7336
4) "Security"	(b)(3)	
5) Donor Coordination	Dr. Helene Gayle, USAID	703-875-4494/4686

The Working Group designations are meant to be indicative, not comprehensive. For example, the Prevention group could include public information, education, women's empowerment as well as condom distribution. "Diplomacy" could include leadership mobilization, immigration, human rights, and sustainable development. The Donor Coordination group will consist of the chairs of the other groups as well as other participants deemed appropriate by the chair.

If you would like to join a specific group and have not been contacted by the chair, please contact the chair directly.

Each strategy paper should be no more than 5 pages in length. We have sent you a package of material which could be useful background for your work. If you haven't received the package, or if you have other questions or comments about the overall process, please call Sharon Hemond at 202-647-4537.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. fax	re: Interagency Group - Development of HIV/AIDS Strategy; [Partial] (1 page)	03/04/1994	P3/b(3)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1994] [loose] [2]

2018-0756-F
jp4861

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]

Interagency group - Development of HIV/AIDS strategy

		phone	fax
	(b)(3)		
✓	Mario DiStasio, DOL/OASP	202-219-6197	219-9216
✓	Kristine Gebbie, White House	202-632-1090	632-1096
	Nancy Hazleton, EOP/ONAP	202-690-5560	690-7560
	Shelley Smith, Peace Corps	202-606-3765	606-3024
	John Mazzuchi, OASD/HA	703-695-7116	614-3537
	C.F. Tyner, US Army	301-619-7377	619-2982
	Donald S. Burke, US Army	301-295-6414	295-6422
	Shirley Jackson, Ed/OERI	202-219-2218	219-1966
	Arthur Lawrence, HHS/OASH	202-690-6248	690-6960
	Linda Vogel, HHS/OASH	301-443-1774	443-6288
	Ken Bernard, HHS/OIH	301-443-9426	443-0742
	Linda Reck, NIH/OAR	301-496-0357	402-7769
	Ken Bridbord, NIH/FIC	301-496-2516	402-2056
	Carol Lancaster, USAID	202-647-8578	647-1770
	Helene Gayle, USAID	703-875-4494	875-4686
	Nils Daulaire, USAID	202-647-8415	647-8595
	(b)(3)		
	Elinor Constable, DOS/OES	202-647-1554	647-0217
	Ed Malloy, DOS/OES/STH	202-647-4075	736-7336
	Prudence Bushnell, DOS/AF	202-647-4493	647-6301
	Faith Mitchell, DOS/RP/POP	202-647-9718	647-8162
	Sandra O'Leary, DOS/EAP	202-647-6904	647-7350
	Sharon Hemond, DOS/OES/STH	202-647-4537	736-7336
	Rich Bruno, DOS/OES/STH	202-647-9542	736-7351

[ooa]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. fax	From: Nils Daulaire; Agency for International Development - Bureau for Policy and Program Coordination - Office of Strategic Planning; [Partial] (1 page)	03/04/1994	P3/b(3)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1994] [loose] [2]

2018-0756-F
jp4861

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]

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

BUREAU FOR POLICY AND PROGRAM COORDINATION
OFFICE OF STRATEGIC PLANNING

To:	DISTRIBUTION:	FAX:
	(b)(3)	
	Mario Distasio, DOL/OASP	202-219-9216
	Kristine Gebbie, White House	202-632-1096
✓	Nancy Hazleton, EOP/ONAP	202-690-7560
✓	Shelley Smith, Peace Corps	202-606-3024
✓	John Mazzuchi, OASD/HA	703-614-3537
	C.F. Tyner, US Army	301-619-2982
	Donald S. Burke, US Army	301-619-6422
	Shirley Jackson, Ed/OERI	202-219-1966
✓	Arthur Lawrence, HHS/OASH	
✓	Linda Vogel, HHS/OASH	301-443-6288

[003]

From: Dr. Nils Daulaire

Office Phone: 202-647-8415

Date: March 4, 1994

Number of Pages (with cover): 2

Prevention of HIV/AIDS Working Group

As you know, an interagency meeting on AIDS was held on February 15th. At this meeting, it was agreed that five working groups (on Scientific Research Cooperation, Prevention, Diplomatic Channels, U.S. Security Interests/Concerns, and Donor Cooperation) would convene to develop strategy papers on key aspects of the HIV/AIDS issue. The main objective for each group is to identify ways in which the U.S. can leverage its efforts to stem the spread of HIV/AIDS.

The first meeting of the working group on the Prevention of HIV/AIDS will be on Wednesday, March 9 at 2:00 pm in New State room 6941. If you are interested in participating in this working group, or if a representative in your office is interested, please attend this meeting. If you are unable to attend, but would like to participate, please call Lorraine Soisson (USAID/PPC/DC) at 202-736-4861. Thank you.

DANIEL K. INOUYE
HAWAII

PRINCE KUHIO FEDERAL BUILDING
SUITE 7325, 300 ALA MOANA BOULEVARD
HONOLULU, HAWAII 96850
(808) 541-2542

United States Senate

ROOM 722, HART SENATE OFFICE BUILDING
WASHINGTON D. C.
(202) 224-3934

March 4, 1994

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of the President
Washington, D.C. 20500

Dear Ms. Gebbie:

I am writing to share with you a copy of my recent testimony prepared for the Hawaii State Legislature on behalf of the prescription privilege legislation being pursued by the Hawaii Nurses' Association with the support of Governor Waihee.

Aloha,

Daniel K. Inouye

DANIEL K. INOUYE
United States Senator

DKI/pdw
Enclosure

Now, more than ever, the nurse practitioner needs to be fully utilized - by this I mean the ability to be able to realize every primary care function which includes" prescriptive authority". It is unjust and counterproductive to our entire health care system to attempt to control the Nursing profession through the use of unsubstantiated intimations relating to alleged diminished "quality of care" and by the ludicrous insinuation that nursing's independent practice could result in a "hazard to public safety". This is not the reality of the issue! The issue is for too long, nurses, the majority of whom are female, have been labeled by many physicians as being third class citizens doing fourth rate jobs. In my experience, the majority of physicians on a one-to-one basis are always highly laudatory as to the competence and dedication of nurses and are eager to testify for the actions of nurses as professional colleagues. Yet, when organized as a professional group, this sentiment changes in transmittal. Suddenly nurses become incapable of independent practice.

I speak to you today to voice my support for House Bill 3315/Senate Bill 2997 which relates to the regulation of nursing. This legislation grants advanced practice nurses limited authority to prescribe drugs. I was appalled to learn that for how progressive our state health care system purports to be, we rank among the few remaining states that have not granted this authority to our nurses - something of which we can certainly be ashamed! Forty-five out of fifty states have chosen to utilize their advanced practice nurses to their fullest extent which therefore at

DKI - 2-10-94

TESTIMONY TO THE HAWAII STATE LEGISLATURE

PRESCRIPTIVE PRIVILEGES FOR ADVANCED PRACTICE NURSES

I am very happy to present testimony today in support of Governor Waihee's Bill which recognizes the contributions that advanced practice nurses can make to our health care delivery system. This is a matter which has long been very dear to my heart. But, I speak not only from the heart, but more importantly, from years of knowledge and understanding of the value that advanced practice nurses contribute to the quality of health care in this country, and in particular, in Hawaii.

I am not speaking of defending the concept of advanced practice nursing - that has long been established as a proven contributor to our health care system, especially in the primary care setting. In fact, I have probably had more contact with nurses than most of my colleagues. Through the years I have worked on many significant nursing issues including appropriate reimbursement for nursing practice.

Throughout my youth we very seldom saw a doctor unless we were very ill. We usually saw a public health nurse, either at home or at school. Amazingly, this is the exact focus we need to take today in our quest to achieve health care for <u>all</u> Americans. Granted, it has been a long time since my youth, but some of the principles in delivering health care then certainly could apply to our current system.

a minimum must include prescriptive authority. How can we claim to have the best health care system in the United States while at the same time neglecting a professional group of caregivers who undoubtedly render appropriate and timely care? This highly qualified group of nurses have repeatedly increased access to care, decreased costs, and maintained the highest " quality of care" given. Are we so archaic in our thinking and arrogant in our assumptions that we can continue to underutilize their utmost capabilities? Prescriptive authority will serve to close the gap that currently limits these fine practitioners.

As we enter the era of health care reform, and look to the twenty-first century, it is apparent that efforts need to be furthered to promote the role that many advanced practice nurses are already filling in the areas of primary, preventive, and community care. Some years ago, in an effort to clarify my long standing belief that the care rendered by advanced practice nurses would result in positive clinical outcomes, I requested the U.S. Office of Technological Assessment to conduct a study on the comparison of quality of care provided by nurse practitioners and physicians. In 12 of the 14 studied areas, nurse practitioner care was rated higher than physician care. The unbiased results of this study are even more applicable today in the new arena of primary care.

Further studies have indicated that it will take until the year 2040 to produce an adequate supply of primary care physicians. If health care reform is able to expand care to the 37 million

uninsured, it will obviously be impossible to adequately provide primary care through physicians alone. Our beautiful state of Hawaii is fortunate to have perhaps the highest ratio of physicians to population in the nation, (and even perhaps in the world) - but fully 80% of Hawaii's 4,600 physicians and surgeons are specialists. This overabundance of specialists indicates that Hawaii is currently ill-equipped to enter the business of primary care without the full contribution of nurse practitioners.

It is refreshing to note that the University of Hawaii has recently undertaken the establishment of a nurse practitioner graduate program. I have long felt that advanced practice nurses are not being adequately utilized and that physicians' services are being used inefficiently. Here lies a tremendous opportunity to capitalize on this long overdue program.

In keeping with the principles of health care reform and its focus on primary care and prevention, the increased use of advanced practice nurses will result in greater patient satisfaction, easier access to care, and cost effective delivery. We can ill afford to ignore these crucial elements which encompass the essential ingredients in any successful health care system.

The advanced practice movement for nurses is not new or experimental. In fact, it's in its twentieth year. These nurses have long been utilized in various settings ranging from the inner-city health center to being the sole source of health care in rural areas. Some nurses deliver babies while others are trained in the field of preventive care, pediatrics, anesthesia, and family

medicine. The authority to prescribe drugs by advance practice nurses is also not a new concept, or an unproven one. Nurse practitioners have been prescribing medications for at least 10 years in some states, and now do so in varying capacities in 45 other states. It should be noted that many nurses such as the advanced practice nurses in the Pacific North West not only have prescription privileges, but have totally independent practices. Research clearly indicates the effectiveness, safety, and client acceptance of nurse practitioners. LaPlante and O'Bannon found in their research of nurse practitioner prescription practices only 2% of the prescriptions were changed after consultation with the collaborating physician, and only two drugs were changed to different drug categories. It is essential that Hawaii finally takes full advantage of this existing pool of resources as 90 percent of the country has done.

My purpose today is certainly not to ask you to place the quality of care for the residents of our state at risk, but rather to truly place Hawaii in the forefront of health care reform leading us into the next century. With this in mind, I heartily endorse the contents of H.R. 3315/S.B. 2997 which essentially establishes limited prescriptive authority for advanced practice nurses.

BEN MERRILL
534 S.E. GRAND AVENUE, APT. 11
PORTLAND, OREGON 97214

March 4, 1994

Dear Kristine:

I am sorry for the circumstances which cause me to write to you. The events in Portland have not been kind on me in the last two weeks and I suspect that they will be even harsher in the future until all the matters are fully aired and the fuller story can be told.

I want to apologize to you for any embarrassment I have caused you personally or the office professionally. The charges here do not reflect who I am or the people or causes I so firmly believe in.

My lawyers--all who are representing me free--believe that the judicial system needs to look at a much bigger picture of Ben Merrill than what is being reported in the local press and if you could, personally, see your way to a letter regarding my hard work and dedicated service, they believe it would help. If you find that you can, my lead counsel's name is:

Steve Houze
Attorney at Law
1001 S.W. 5th, Suite 1050
Portland, Oregon 97204

I am strengthened each day by my individual faith and the knowledge that the good things that men do far outlive any bad things about them that might be true. I need your prayers above all else.

Sincerely,

Ben Merrill

THE WHITE HOUSE

WASHINGTON

March 7, 1994

MEMORANDUM FOR ALL WHITE HOUSE OFFICE AND
EXECUTIVE OFFICE OF THE PRESIDENT STAFF

FROM: JOEL I. KLEIN JIK
Deputy Counsel to the President

SUBJECT: Retention of Documents and Communications

Today we have requested that White House Office employees produce any documents or communications related to contacts between White House staff members and officials of the Department of the Treasury and the Resolution Trust Corporation.

We are aware that staff may have other documents or communications relating to Madison Guaranty, Whitewater Development Corporation, and any related matters. While any such documents or communications need not be produced at this time, staff members should take all necessary measures to preserve and maintain any such documents. Such documents should not, under any circumstances, be discarded, altered or destroyed. Additionally, all staff members should not remove or transport documents or communications related to any of these matters from their offices in the EOP or White House complex.

Should any staff member have questions about these procedures, please contact one of the following liaisons in the Office of White House Counsel:

Chris Cerf	6-7180	190 OEOB
Vicki Divoll	6-7181	190 OEOB
Marvin Krislov	6-7903	126 OEOB
Cheryl Mills	6-7900	128 OEOB

- Kris Gebbie
FYI
Jan

file – Healthcare reform

JACKSON HOLE GROUP

Paul M. Ellwood, M.D.
President

RECEIVED
MAR - 9 1994
EXECUTIVE OFFICES

MAR 8 1994

MEMORANDUM

March 7, 1994

FROM: PAUL M. ELLWOOD M.D.
RE: MANAGED COMPETITION II

Enclosed please find an updated version of Managed Competition II. The document represents our current state of thinking regarding revisions to the original managed competition proposals, including an approach to universal coverage. We are soliciting selected feedback so that the document can be prepared for wide circulation starting March 16th. It will be difficult to incorporate any comments not received by March 14th. Please fax the enclosed reply form to (307) 739-1177 to expedite this process.

3/9/94

To: Ginna, Karen O'Conner, Donna Richardson, Judy Huntington, Jan Heinrich

From: Shirley

I believe we should send an ADA response to these questions. If Ginna agrees, I believe we should respond based on our principles. If you would give your answers (discuss with anyone you like) to me by the 12th, I will collate them with Ginna. Let me know if you have any questions. Thanks

Shirley

Mailing Address: P.O. Box 350 Teton Village, WY 83025
Fed-Ex/UPS: 6700 North Ellen Creek Road Jackson, WY 83001
307-739-1176 Fax: 307-739-1177

MANAGED COMPETITION II
FAX REPLY FORM
PLEASE REPLY BEFORE 3/14/94
FAX NUMBER (307) 739-1177

Universal Coverage

1) 2000 would be set as a target date for universal coverage.

☐ Agree ☐ Disagree

2) Universal coverage would be defined as 97% of Americans insured with standard benefits or traditional Medicare.

☐ Agree ☐ Disagree

3) A decision regarding mandating coverage would be deferred until more is know about the residual uninsured population—2000. No decisions on individual and employer mandates versus other forms of compulsory coverage would be made now.

☐ Agree ☐ Disagree

4) If universal coverage has not been achieved by 2000, Congress would commit itself to act in every subsequent year by either increasing low-income and Medicare funding and/or passing some form of mandated coverage.

☐ Agree ☐ Disagree

Comments:

Low-income Assistance

1) Low Income Subsidy Program, Part 1 (LISP 1): A subsidy program for the current categorically needy (those receiving AFDC and SSI benefits) acute care portion of the Medicaid program would be created to end Medicaid and merge it into the managed competition system.

☐ Agree ☐ Disagree

2) Initially, LISP 1 would be pooled separately, and the state would negotiate actuarially sound capitation rates for coverage in AHPs for this population.

☐ Agree ☐ Disagree

3) To avoid government imposed cost-shifting, AHPs would not be compelled to participate in the LISP 1 program.

☐ Agree ☐ Disagree

3) Low Income Subsidies Program, Part 2 (LISP 2): A subsidy program for individuals below 200% of poverty, and ineligible for LISP 1, would be created.

☐ Agree ☐ Disagree

4) LISP 2 eligible individuals below 100% of poverty would receive total payment vouchers; for individuals between 100% and 200% of poverty, subsidies would be graduated based on income.

☐ Agree ☐ Disagree

5) LISP 2 vouchers would be used through the appropriate sponsor, their large employer or the HPPC.

☐ Agree ☐ Disagree

Comments:

Medicare

1) Medicare would make a defined contribution toward AHP premiums. The defined contribution would be set at the national per capita average Medicare expenditures, adjusted for cost of living and health status, but not medical prices.

☐ Agree ☐ Disagree

2) Newly eligible Medicare recipients must continue to purchase health care from AHPs.

☐ Agree ☐ Disagree

3) Present Medicare recipients would retain their FFS option.

☐ Agree ☐ Disagree

4) The current regional AAPCC reimbursement program would be phased out.

☐ Agree ☐ Disagree

5) AHPs serving Medicare beneficiaries would be required to offer the same standard benefits package available to the general population.

☐ Agree ☐ Disagree

---

6)Reject above, AAPCC should be maintained with additional adjustment for health status.

☐ Agree ☐ Disagree

Comments:

Balanced Health Security Budget

1) Medicare and LISP expenditures would be financed through a balanced health security budget.

☐ Agree ☐ Disagree

2) Congress would set a balanced health security budget every year.

☐ Agree ☐ Disagree

3) The NHB would set a standard benefits package to keep the health security budget in balance.

☐ Agree ☐ Disagree

Comments:

Competing HPPCs

1) Multiple competing HPPCs would be allowed within a single health market region.

☐ Agree ☐ Disagree

2) HPPCs would not negotiate premiums, they would compete only on their administrative efficiency and customer service.

☐ Agree ☐ Disagree

3) HPPCs would still be the sole sponsors for employers with less than 100 employees and individuals in that tax preferential treatment for this population would be conditional upon purchasing coverage through a licensed HPPC.

☐ Agree ☐ Disagree

Comments:

POS Option

1) All sponsors would be required to offer at least one AHP with an out-of-plan provider option.

☐ Agree ☐ Disagree

Comments:

Defined Contribution for Large Employers

1) Large employers that pay for some portion of health coverage would be required to make a defined (flat dollar amount) contribution towards health coverage, regardless of plan chosen by employee, and the tax deduction and exclusion would be limited to the weighted average premium.

☐ Agree ☐ Disagree

Comments:

Medisave

1) Individuals who chose an AHP priced below the weighted average premium would be allowed to deposit the difference into a tax-free Medisave account.

☐ Agree ☐ Disagree

Comments:

MANAGED COMPETITION II

A DRAFT Proposal
February 1994

INTRODUCTION

Health care reform is stalling over a number of issues with the resulting danger that either ineffectual or even no legislation will pass. The Jackson Hole Group, the originators of managed competition, view this as unacceptable, and remain committed to comprehensive reform of the health system including universal coverage. Having come this close to achieving health care security for the American people, the task is now to craft a reasonable, affordable compromise out of the thoughtful proposals that face Congress in 1994.

Perhaps nothing threatens to undermine reform more than the unpredictability of costs and of the effectiveness of cost containment efforts. Estimating costs with even the most elaborate cost-estimation models produces point estimates that are very unreliable, particularly as one extrapolates into the future. Their principal value is in defining the relationship between variables. Other areas of uncertainty include the ability of different mandates to achieve universal coverage, the unpredictable effects of price controls or global budgets and whether it is possible to enforce them, the lack of capacity that may result from a continued shortage of primary care practitioners or delays in accountable health plan (AHP) formation, how employers will use savings, the effects of increased consumer involvement in the decision-making processes, and any savings that may be achieved by reducing the amount of ineffective care.

With these and other factors in mind, this document presents a revised version of the original managed competition proposals that takes into account the inherent uncertainties of reform and builds on the lessons learned since the proposals were first introduced. The document proposes a commonsensical approach to government health care financing that is always in balance, and a rational stepwise approach to universal coverage. Whatever reform measures are adopted it is imperative that they add to the reforms already underway in the private sector and in states, by strengthening incentives to reduce costs and improve quality, and that

they extend reforms to the small and non-group markets and public programs including Medicare.

MANAGED COMPETITION II

Prior to introducing the modifications under consideration to the original managed competition proposals, it is worth while revisiting the core elements of the managed competition model that remain unchanged. These are presented in Table 1.

ACCOUNTABLE HEALTH PLANS (AHPs) "The Providers"

AHPs are the engines of reform and would shift the emphasis in health care from disease and intervention to prevention and wellness. AHPs are organizations that:

- Both finance and deliver the full range of a nationally defined package of health benefits.
- Are accountable to the public for satisfaction of their members and the effect of their services on members' health.
- Comply with established solvency and underwriting standards, including community rating and guaranteed issue and renewal provisions.
- Adhere to uniform data reporting requirements as established by a National Health Board.

SPONSORS "The Health Plan Store"

Large employers, government, and HPPCs would all act as sponsors that facilitate individual choice of health plan. In general the role of the sponsor is to:

- Arrange for individuals to selects AHPs.
- Minimize the incentives and ability of AHPs to select good risks.
- Set rules to assure equitable coverage of all members of the sponsored group.

STANDARD BENEFITS "The Universal Entitlement"

A standard benefit package would:

- Facilitate side-by-side comparison of AHPs (increasing elasticity of demand), and promote efficiency through standardized claim forms and issuing requirements.
- Provide a rational vehicle for defining services to be made universally available to all Americans and put private and government programs on the same footing.
- Be continuously amended by the NHB and approved by Congress through a process insulated from inordinate political interference.
- Be based on scientific documentation of efficacy, including cost-effectiveness.

THE NATIONAL HEALTH BOARD (NHB) "The Referee"

The NHB would be an independent federal agency to guide, oversee, and facilitate a transition to a new health system. NHB powers and responsibility would be explicitly limited in legislation to:

- Recommending a standard benefits package to Congress,
- Balancing the "health security budget" (see below),
- Coordinating a standardized data reporting system,
- Setting standards for and registering AHPs and HPPCs,
- Disseminating information and making recommendations on risk adjustment,

Three years of circulation and application of the original managed competition proposals have led to a wealth of experience and feedback, leading to consideration of the following policy changes.

COST CONSCIOUSNESS OF CONSUMERS

Consumers will be cost and quality conscious only to the extent that they are responsible for the difference in cost between plans and informed about differences in quality. Many have questioned the logic of a limit on tax-free health benefits, especially those that enjoy rich tax free benefits packages, but a tax cap remains the best way to instill cost-consciousness, control government expenditures, and raise revenue for low-income subsidies without increasing marginal tax rates. A revised tax code would include:

- Equalizing tax treatment of health expenditures for employers and individuals, including expanding tax preferential treatment for individuals.

- Making preferential tax treatment and government subsidization contingent upon purchasing coverage through the appropriate sponsor (i.e., large employer or HPPC).

- Capping tax deductions and exclusions at the level of the weighted-average price AHP in the area (instead of at the level of the low-cost AHP). Consumers would be free to spend additional after-tax dollars on health care.

- Allowing those who choose an AHP priced below the tax cap to keep the difference in a tax-free health spending account (Medisave) to be used to defray the costs of copayments, deductibles, and benefits not included in the standard benefits package and/or an individual retirement account. Alternatively, to save the costs of administering tax-free spending accounts, individuals could simply submit receipts and deduct expenses against their taxable income for tax purposes.

We anticipate that because of a revised tax code, most employers would limit their contribution to health coverage for employees, regardless of plan chosen, to the tax-preferred amount. However, some employers with union contracts that require they pay the full price of any health plan an employee chooses may still find this difficult. Therefore a requirement that employers contribute a fixed dollar amount, regardless of plan selected by employee, may be necessary at some point to ensure full employee cost-consciousness.

HEALTH PLAN PURCHASING COOPERATIVES (HPPCs)

As introduced in the original managed competition proposals, HPPCs in a reformed system would act as sponsors for individuals and small employers, giving them the ability to pool risk, achieve economies of scale, and drive the competitive process through informed individual choice. It is important to stress that the JHG believes that HPPCs should not be regulatory or price setting agencies. HPPCs would not negotiate, or limit choice of AHPs, rather they would offer an informed set of choices so that individuals could weigh personal priorities in health plan selection. HPPCs that negotiate (i.e., refuse to offer plans whose prices are too high) would not only limit individual choice in health care, they would also threaten to undermine a functioning and competitive market by concentrating too much purchasing power in a single entity.

While many private sector initiatives are proving effective in holding down health costs, especially purchasing efforts of large employers, the problems associated with the small group and individual markets appear to be worsening. The need for HPPCs has not gone away. However, the original managed competition design of a single exclusive HPPC per geographic area has two weaknesses when examined in light of public concerns and the reality of implementation obstacles. First, monopoly HPPCs do not structurally prevent HPPCs from becoming regulators. Secondly, monopoly HPPCs leave some consumers with no choice in purchasing alternatives, and thus no protection from inefficiency. These concerns have led us to propose a system of competing HPPCs. To borrow an analogy, we believe it is preferable

to have the U.S. Postal Service serving the country with competition from Federal Express and other private carriers, rather than to have a non-competitive mail delivery system. States would be charged to make certain there is a "post office" but alternatives would be allowed provided they met specific standards outlined below.

HPPCs would still be the exclusive sponsors for the small group and individual markets in that tax preferential treatment of health expenditures would be conditioned upon purchasing coverage through a licensed HPPC. This competing HPPC structure would require special measures to ensure that the market is not undermined by adverse risk selection. Private sector organizations or associations could become licensed as HPPCs if they met criteria designed to ensure that all HPPCs open enroll, offer all AHPs, and conform to other HPPC standards including a requirement to cover entire HPPC regions and a prohibition against conflict of interest. AHPs would offer the same base community rate to all HPPCs in designated regions. HPPCs would compete only on their administrative overhead (the cost of which would be added to premiums) and their customer service. Competing HPPCs that negotiated premiums would undermine community rating in the small group market. In a system of competing HPPCs, states would have to take on the additional responsibilities of dividing their territory into HPPC regions, and coordinating risk adjustment and standardized data collection. Designed this way, competing HPPCs can still achieve the original HPPC goals, and should satisfy those that contend there is a need for significant reform of this market.

CHOICE

The original managed competition proposals did not limit what type of health care delivery organizations would compete in a reformed market. However, the public has clearly expressed that they value choice of physician and for this reason all sponsors should be required to offer at least one AHP with an out-of-plan option, which allows enrollees to use non-AHP providers at increased cost. A requirement for sponsors to offer at least one POS plan would best balance the public's priorities of more accountable, longitudinal health care

with the desire to maintain patient choice of physician. Experience is that only 5-10% of individuals with an out-of-network option exercise it, but the option is probably important to many more.

BALANCED HEALTH SECURITY BUDGET

The original managed competition proposals did not examine closely the financing aspects of attaining universal coverage, believing that public finance was an issue best left to individuals with expertise in this area. As various financing schemes have been proposed in legislation, it has become clear that the financing of health reform has implications for how structural aspects will interact. A managed-competition approach to structural reform requires a managed-competition approach to financing.

The establishment of a balanced health security budget would instill fiscal discipline into the health care system by guaranteeing that federal coverage costs do not grow faster than revenue, that private health security costs do not grow faster than the economy, and by promoting an honest and explicit debate regarding federal health care expenditures. One can think of it as a ledger that continuously matches revenues to expenses. Federal health spending covered by the balanced health security budget would include Medicare, LISP 1 and 2 (see below), and possibly the Federal Employee Health Benefits Program (FEHBP).

Under such a system, government health expenditures would be disbursed on a pay-as-you-go basis, and the health system would move toward universal coverage in carefully monitored stages. Legislators would agree either to raise enough money to pay for the standard benefits for the covered population or limit the scope of the health security benefits package or the subsidies available to individuals to help pay for them. Such an approach would ensure that the health security system is not undermined by excessive cost-shifting or open-ended entitlements.

To enforce the balanced health security budget, the NHB would be charged by Congress to continuously match available revenues to health priorities based on effectiveness, cost, and public values. If the rate of growth in expenditures exceeds the rate of increase in the budget, the NHB would either adjust the benefits package (the benefits package would be voted on in a manner similar to the military base closing procedure), slow the expansion in low-income subsidies or convey other recommendations to the Congress for keeping the budget in balance. If Congress failed to accept these recommendations it would have to appropriate more money. While it might be preferable to have an explicitly earmarked health tax as the funding source for the balanced health security budget, ultimately what matters is that Congress keeps the budget in balance, and that we focus the debate on the most explicit, reliable, and equitable sources of federal health care funding.

GETTING TO UNIVERSAL COVERAGE

The public is convinced of the need for universal coverage. We believe a requirement that everybody contribute to the cost of their health care through a system based on efficient, progressive taxes to finance those unable to pay for themselves, is still the best way to achieve universal coverage. However, given that it will take time to build strong health plans, to evaluate progress, to accumulate savings from managed competition, and to allow individuals to avail themselves of the reformed system, it is appropriate to first set up a universal access system by helping people who need it most (i.e., poorest of poor individuals through subsidies, plus individuals and small employers through purchasing cooperatives and insurance reform). A functioning universal access system should allow a smooth transition to universal coverage by 2000 if Congress passes legislation in 1994.

Under any health insurance system, it may be impossible to ensure every single citizen is actually covered by an AHP, therefore a definition of universal coverage should reflect this reality, much as the definition of full employment falls short of 100% employment. A reasonable working definition would be that universal coverage is attained when it can be

verified that 97% of the population have coverage. As reform proceeds, this percentage could be adjusted to reflect the point at which the additional cost of bringing individuals into the health security system through government actions such as a mandate or increased outreach is too great for the public to accept. At some point it makes sense to adopt a policy that promotes uniquely targeted care for the residual uncovered, rather than devoting limited resources to the difficult and expensive task of pulling every last individual into the private system.

If universal coverage, as defined by Congress, has not been achieved by 2000, Congress would have to act in every subsequent year by increasing Low Income Subsidy Program (LISP, see below) funding or passing a mandate until it is achieved. A requirement to take action in every year after 2000 should ensure that legislation attains universal coverage within a reasonable time frame.

Given that many lessons will be learned as experience with a reformed system is accumulated, reform should defer a decision on implementing a mandate until after 2000. By then broad low-income subsidies would be at or near full phase-in, competing AHPs would be functioning, group purchasing for all and health insurance reforms would have been in place for some time, and the residual uninsured population would likely be much less significant in number, and much different in character from the presently uninsured population. Only with good information regarding the number and percentage of uninsured by employment status and wealth can an informed decision be made regarding what type of compulsion, if required, would best lead to universal coverage. For example, if primarily low-income, unemployed individuals are uninsured it is unlikely that any form of mandate would be effective, instead changes to the LISP program would be required. On the other hand, if wealthy, non-working individuals were uninsured, a free-rider tax would probably be the most effective way of getting to universal coverage. Finally, if large numbers of employed individuals were uninsured, an employer mandate might be more appropriate. If universal coverage is not attained by 2000, and in a subsequent year a mandate is deemed the effective policy response, the two alternatives discussed in the appendix should be considered first.

Universal coverage will require that public programs are folded into a managed competition system and that a true universal access system is created in the interim. To facilitate this public spending would primarily be directed at three programs: LISP 1, LISP 2, and Medicare.

Low Income Subsidy Program, Part 1 (LISP 1): A subsidy program for the current categorically needy (those receiving AFDC and SSI benefits) acute care portion of the Medicaid program

Perhaps the greatest and most consistent challenge faced by state governments in recent years has been the dramatic increase in and unpredictability of costs in their Medicaid programs. While more states, like the private sector, now look to managed care as a means of tackling the cost and quality problem, still little over 10% of Medicaid beneficiaries are in true managed care programs like HMOs. This process needs to be accelerated if financial discipline is to be instilled and predictability of costs and accountability for quality is to be realized where neither have existed for some time.

States would be responsible for the administration of their respective LISP 1 programs, which would be fully funded in the first year of reform and designed as follows:

- The AFDC and SSI population would be maintained, at least initially, as a separate risk pool that is covered by AHPs (except where adequate AHP contracts cannot be negotiated).

- Each state, or contracted sponsor acting on behalf of the state, would base capitation rates for the LISP 1 population on actuarially sound estimates of the average reasonable costs across AHPs of delivering a standard benefit package adjusted to the special needs of this population. To avoid state imposed cost-shifting, AHPs would

not be compelled to participate in the program, and there would be room for negotiation around this rate.

- The federal and state governments would jointly contribute 100% of the price of benefits for LISP 1 beneficiaries. However, because states would be required to maintain their current level of financial commitment to Medicaid and uncompensated care (current expenditures would be trended forward according to LISP 1 experience), they would be relatively more at risk for their AFDC and SSI populations.

- Using a voucher, the LISP 1 eligible population could choose from among participating plans through their own LISP 1 HPPC at the time of annual open enrollment. For individuals who fail to select a health plan, the LISP 1 HPPC would choose one for them.

- Once the LISP 1 population had experience in managed care programs and their risk could be predicted with relative accuracy, they would move to the general HPPCs, where government would pay a competitive community rate on their behalf. The phase out of LISP 1 would be a logical part of ending welfare as we know it. Additional benefits that were not part of the standard benefits package available to the general population would be added on as wrap-around benefits funded jointly by states and the federal government and provided by AHPs.

- While costs for LISP 1 beneficiaries should be mitigated so coverage is within their reach, they like everyone else will be paying some portion of the cost of their care to instill some degree of cost-consciousness.

The rationale for initially maintaining the AFDC and SSI population as a separate risk pool rather than pooling them with the HPPC population stems from the belief that the former population may be above average risk. A separate risk pool would ensure explicit financing of the program and minimal cost-shifting. However, because of the potentially limited choice of

plans, it would move into the general HPPC and AHP programs as soon as costs and unique needs are understood. If the below poverty population is higher risk, then everyone should bear the additional costs, not just the HPPC-eligible population (i.e., individuals and small employers).

Low Income Subsidies Program, Part 2 (LISP 2): A subsidy program for individuals below 200% of poverty, and ineligible for LISP 1

According to the Employee Benefits Research Institute (EBRI) analysis of the March 1993 Current Population Survey (CPS), the below poverty uninsured population number some 10.8 million individuals or 28.1% of the uninsured, while the 100%-200% of poverty uninsured population represents an additional 32.5% of the uninsured, or 12.5 million individuals. In addition to the implicit subsidy available to everyone through preferential tax treatment of benefits up to the weighted average cost plan in a region, further subsidies need to be made available to this population to offer meaningful access to the health system. Though LISP 2 eligible individuals would receive subsidies in the form of vouchers, they would purchase their coverage through their local HPPC or large employer, depending upon employment status, thus minimizing the government's role in the program. For some LISP 2 eligible employees these funds may make it affordable to join their employer plan. LISP 2 funding would be phased in as funds accrue to the government (see table 2). The initial targets could be that LISP 2 eligible individuals below 100% of poverty would receive vouchers for 100% of the cost of the low-cost plan and subsidies for LISP 2 beneficiaries between 100% and 200% of poverty would phase out on a sliding scale.

The phase-in could be structured as follows:

Year 1		
	Financing Goal:	Up to X% of poverty eligible for LISP 2.
	Participation Goal:	Y% of eligible individuals should be covered.
Year 2		
	Financing Goal:	Up to X+% of poverty eligible for LISP 2.
	Participation Goal:	Y+% of eligible individuals should be covered.
Year 3		
	Financing Goal:	Up to X++% of poverty eligible for LISP 2.
	Participation Goal:	Y++% of eligible individuals should be covered.
Year 4		
	Financing Goal:	Full LISP 2 targets should be met.
	Participation Goal:	Y+++% of eligible individuals should be covered.

Table 2: Expansion of LISP 2 program.

Prior to the beginning of each year, the NHB would determine LISP 2 eligibility by reconciling the revenue made available by Congress, through the balanced health security budget, with the predicted participation rate. Expected failure to meet the eligibility target, as expressed in the financing goal, might trigger reduction in the benefits package upon the recommendation of the NHB, reduced eligibility for subsidization, or increased taxes upon approval of the Congress. Reduced eligibility for subsidies would be the default fallback written into the law, since it could be automatically calculated.

At the end of each year, participation in LISP 2 would be compared to the participation goal set forth for the year. Failure to meet this goal might result from insufficient subsidies (except for those fully subsidized), a complex or inefficient subsidization mechanism, inadequate outreach, or the fact that individuals simply chose not to purchase coverage—free riders. Possible policy solutions would include increased subsidization, a new subsidization

mechanism, or increased outreach and education. Although the subjective nature of these failures would prohibit automatically triggered responses, legislation could require the adoption of one of the preceding policies if goals were consistently missed. Policy will require evaluation of the tradeoff between devoting additional resources to expanding outreach and education activities and to increasing premium assistance levels.

State experimentation in subsidy levels, eligibility criteria, and phase-in strategy of LISP 2 would be encouraged to close in on an optimal LISP 2 design more quickly. For example, at some level, subsidies at only a percentage of their targeted level may provide meaningful access to health care, thereby making phase-in of the level of subsidization an appropriate policy. This would have the desirable effect of increasing the eligible population, minimizing the risk to the federal government of overshooting on spending, as well as ensuring a sliding scale phase down of subsidies to prevent a marginal tax rate cliff. Creating a true universal access system will require flexibility in and the ability to improve upon the design of the subsidy program to meet coverage targets: the full and partial subsidization points may need to be adjusted to achieve satisfactory access and a gradual enough benefit reduction rate.

The present Medicaid program creates substantial disincentives for going back to work, since beneficiaries completely lose coverage once they cross the eligibility threshold. Combined with the loss of other welfare benefits such as the earned income tax credit, food stamps, and housing subsidies, this threshold represents a disincentive to earn more. While any phase-out of health care subsidies would be an improvement over the current system, the pressing need to tackle welfare reform in conjunction with, or very soon after, health care reform is apparent. To increase incentives for work, the threat of higher health insurance costs associated with moving to a higher income bracket should be as small as possible. Minimizing this risk would necessitate a gradual phase-out of subsidies. Up until now this expanded entitlement has been regarded as too expensive. Ultimately, we are being asked to decide how much we are willing to pay in taxes for health care on behalf of those who cannot pay themselves.

Medicare.

The Medicare program ultimately should be structured the same as the rest of the health care delivery system. Medicare recipients should have the opportunity to receive the same standard benefits and provider choice as all other Americans. The standard AHP benefit will most likely be more comprehensive than current Medicare benefits, potentially eliminating the need for Medigap policies. Beneficiaries ought to have the opportunity to join AHPs, and the same motivation to save money and pursue prevention and health maintenance measures as the general population. This reform cannot be immediate, however, since many beneficiaries, particularly those with serious health problems, value the present program. Cost cutting measures as proposed by Congress and implemented by HCFA would continue to be utilized to control tradition Medicare expenditures. Medicare would start to be integrated into a managed competition environment as follows:

- The Medicare population would be maintained as a separate higher risk and cost group. Medicare beneficiaries would be eligible to join AHPs which must offer the full standard benefits package. Regional Medicare HPPCs would, at the time of an annual open enrollment period, allow present Medicare beneficiaries to choose between traditional HCFA administered Medicare, with the present Medicare benefits, and competing AHPs offering the standard package. Beneficiaries would have a greater choice of AHPs than present law permits, including AHPs that offer an out-of-plan provider option.

- For beneficiaries who chose an AHP, the federal government would make a defined contribution toward premiums. The defined contribution would be set as a function of the nation-wide average per capita expenditures for the Medicare program. This average would be adjusted by a regional index that reflected general differences in the cost of living and the health status of beneficiaries, but not differences in the cost of medical care. Beneficiaries who choose an AHP would be responsible for paying the difference between the government contribution and the cost of their plan of choice. Present employer sponsored retiree health benefits that pay for wrap-around coverage could be redirected

toward the difference between the government's defined contribution and an AHP's premium. Equally, employers and retirees might agree to reconfigurating retiree health benefits into a defined contribution such that those who join AHPs get the savings from their actions.

- Beneficiaries that age into the Medicare program would be required to continue purchasing coverage from AHPs.

- The price of AHPs available to Medicare beneficiaries would be based on a health status adjusted, market-determined community rate across the Medicare population within a Medicare HPPC region. AHPs could offer their services at whatever competitive price they thought would attract Medicare beneficiaries.

- Eligible low income beneficiaries would continue to receive premium and cost-sharing assistance.

- The present red tape that impedes HMOs from participation in the Medicare risk contracting program would be aggressively reduced. There would be a significant shift in public policy that supports the development of Medicare-oriented AHPs and encourages them to serve beneficiaries.

As AHPs find ways to improve efficiency, they should be able to offer rates that are at or below the defined contribution set by government, even though they offer the richer standard benefits package. The opportunity to obtain more benefits at no additional, or only slightly higher cost, as well as continuity of care through primary care physicians, the reduced paperwork, and the obviated need to purchase a Medigap policy, should motivate Medicare beneficiaries to join AHPs. However, present Medicare beneficiaries who place more value on the fee-for-service alternative would retain the opportunity to stay in the current system. The reliance on nationwide based AHP capitation rates should serve to eliminate the geographic inequities in the distribution of Medicare reimbursement.

If AHPs succeed in lowering their costs below fee-for-service Medicare program costs, the federal government could save significant amounts of money as Medicare beneficiaries choose to enroll in AHPs.

Appendix: Discussion of mandates

Combination of individual and employer mandates

Employer Mandate for Large Employers

- All employers with more than 100 employees would have to offer a choice of AHPs offering the standard health benefits package to employees, and their dependents, who work more than 30 hours a week and would be required to make a defined contribution of a minimum of [50-80]% of the price of the low cost plan to the health care premiums of their employees. To minimize employment effects, the mandated contribution requirement would be phased in over a period of time. A prorated contribution would be required for part-time workers who worked more than 1,000 hours per year and a payroll tax of X% would be paid for workers who work less than 1,001 hours per annum.

- To assuage effects on employers near the HPPC threshold size, there would be a gradation of their financial obligation in accordance with firm size (i.e., firm size 100-125, 20%; 126-150, 40%; 151-175, 60%; greater than 175, 80%.). These employers would not be relieved of their obligation to offer standard health care benefits. If the gradation was used in combination with a phase-in, the obligation for all firms would be phased in equitably.

Individual Mandate for Individuals and Small Employers

- Part-time workers working less than 1,001 hours per annum for an employer with more than 100 employees and all individuals not employed or those employed by firms with less than 100 employees would be obliged to purchase coverage through their local HPPC.

- At the direction of their employees, small employers would be required to make a monthly payroll deduction and send the amount to the appropriate HPPC.

A combination of employer and individual mandates best builds upon the current employment-based system, and would ensure that the 99% of companies above the 100-person threshold which currently offer coverage to their employees would continue to do so.

To the extent that large businesses compete with small businesses in the same industry, employee compensation packages would differ, but since there would be a mandate in both sectors, total compensation in any individual firm should not be different. However, if employees do not recognize the trade off between wages and benefits, small employers would have a hiring advantage. A combination of employer and individual mandates would increase the incentives for firms to game the threshold by engaging in such actions as hiring temporary personnel and splitting companies into separate entities. However, this may be mitigated by phasing in the percentage requirement with firm size.

Low income is the major determinant in access to health insurance, not size of firm in which one is employed. Therefore, for a combination approach to be equitable and efficient, the subsidization formula used would have to be consistent across mandate environments, and tied to income level not employment status, as in the LISP program. Individuals eligible for LISP subsidization would use their vouchers either through their large employer or the HPPC to defray the cost of coverage.

If, on the other hand, subsidies under the employer mandate were targeted at employers, as opposed to individuals, the employer mandate portion of the combined mandate would represent an inequitable and inefficient financing mechanism. Firm subsidies based on average payroll are inefficient because they subsidize high as well as low income individuals. For firms with high average payroll but some low income employees, subsidies would be insufficient, and employers would be forced to pick up the burden for government programs or lay off workers. For firms with low average payroll but some high income employees, the subsidies may be too generous, and the government would bear unnecessary costs.

The most expedient, efficient, and politically viable way to enforce the individual portion of the mandate would be through a free-rider tax. Individuals choosing not to purchase coverage would be required to pay a tax. Advantages of a free-rider tax are that it could be progressive and enforced by the IRS. The free-rider tax would be equal to a fixed amount plus a penalty that would be directly proportional to income. While such an enforcement strategy would not perfectly attain universal coverage, it would go a long way towards ending the free-rider problem while minimizing societal and economic dislocation.

Many legislative proposals, including the Administration's, have embraced employer mandates and subsidies targeted at firms because they allow the government to shift some of the burden of public programs onto employers and create the perception that no one is paying the price. While fiscally attractive to the government, this type of mandate perpetuates cost-shifting, and it is the kind of mandate that will cause the most economic dislocation because it effectively raises the minimum wage in many firms. To the extent that employers were unable to take the additional costs of health premiums out of wages, an employer mandate would cause some unemployment, especially in firms not currently offering coverage and in firms with low wage workers.

Individual Mandate

- All individuals would be required to purchase coverage as of the date of implementation, or pay a free-rider tax.

- All employers, while not required to finance coverage, would be required to offer coverage, either through the HPPC if they have fewer than 100 employees, or directly for large employers.

- Voucher eligibility and preferential tax treatment would be contingent upon purchasing coverage through the appropriate sponsor.

Adoption of an individual mandate has an inherent logic to it if one pursues a program of universal access first. Since individuals are already targeted for low income subsidies to make them more explicit, efficient, and equitable, it makes sense to target a mandate at individuals as well. An individual mandate could be easily and quickly implemented without disrupting present purchasing arrangements. It would satisfy those who believe the ultimate obligation to purchase health care should be on the individual, not employer, and that health care coverage should be divorced from employment status.

The greatest potential disadvantage of an individual mandate is the risk that companies that are currently active, value-based health purchasers will cease these activities, and will perform the minimum duties necessary to fulfill the obligation to offer coverage. It is not possible to predict the extent of this behavior. However, business leaders suggest that competitive forces in the labor market may be a strong enough force for maintaining an active employer role, especially if there is a stipulation that predicates tax preferred treatment of health expenditures on purchasing through the appropriate sponsor (the large employer for its employees). In addition, in a mandated environment, employees will value health purchasing that maximizes the wage portion of their compensation and secures quality health care. Employees of large firms (with no access to HPPCs) will look to their employers for purchasing expertise, since most employers purchase coverage for employees today. If large employers prove to be inefficient purchasers, it would be possible for employees to pressure their employers to go to secondary purchasers such as purchasing coalitions, to purchase coverage.

Another potential serious disadvantage of an individual mandate is that upon passage, all individuals might demand access to HPPCs. It is unlikely that Congress would have the political will to deny this. If the public then demanded that HPPCs exercise greater control over the cost of health care, the result could be slow, but steady, progression toward a great majority of the population in the HPPC—leading to regulation and possibly a single payer system. To some extent, competing HPPCs should mitigate this danger.

THE WHITE HOUSE
WASHINGTON

Kristine:

In spite of what this memo reads, I need to have the signature page returned to me by 2:00 p.m. today.

Thanks
for

TANYA delivered original sig pages!
Have in copy AB

THE WHITE HOUSE

WASHINGTON

March 7, 1994

MEMORANDUM FOR ALL WHITE HOUSE OFFICE AND
EXECUTIVE OFFICE OF THE PRESIDENT STAFF

FROM: JOEL I. KLEIN JIK
Deputy Counsel to the President

SUBJECT: Retention of Documents and Communications

Today we have requested that White House Office employees produce any documents or communications related to contacts between White House staff members and officials of the Department of the Treasury and the Resolution Trust Corporation.

We are aware that staff may have other documents or communications relating to Madison Guaranty, Whitewater Development Corporation, and any related matters. While any such documents or communications need not be produced at this time, staff members should take all necessary measures to preserve and maintain any such documents. Such documents should not, under any circumstances, be discarded, altered or destroyed. Additionally, all staff members should not remove or transport documents or communications related to any of these matters from their offices in the EOP or White House complex.

Should any staff member have questions about these procedures, please contact one of the following liaisons in the Office of White House Counsel:

Chris Cerf	6-7180	190 OEOB
Vicki Divoll	6-7181	190 OEOB
Marvin Krislov	6-7903	126 OEOB
Cheryl Mills	6-7900	128 OEOB

- Said to invite "None" in boxes. mpg. 5.
AB
12:20pm
3/7/94

THE WHITE HOUSE

WASHINGTON

March 7, 1994

MEMORANDUM FOR ALL WHITE HOUSE OFFICE STAFF

FROM: Mack McLarty
Chief of Staff

SUBJECT: Compliance with Grand Jury Subpoena

Attached is a memorandum from Joel Klein, Deputy Counsel to the President, specifying procedures to be taken by all staff to comply with the grand jury subpoena for documents issued by the Office of the Special Counsel. **It is imperative that all staff read this memorandum thoroughly to understand the scope of the request.** Moreover, all staff must search their trash, burn bags, electronic files and other records and files immediately, so that we can provide the grand jury with all responsive documents by Thursday, March 10 at 10 a.m., as the subpoena requires. As you all are aware, the grand jury subpoena creates a legal obligation to produce any responsive documents.

To coordinate compliance, each designated department representative must collect signed statements of compliance and all possibly responsive documents from his or her staff members, and provide these to the designated liaison from the Counsel's Office no later than 8 p.m. today. Each staff member's documents should be submitted to the department representative in an envelope with the staff member's signature clearly visible. Should any staff member have any concerns or questions about the scope of the request or any other related matter, he or she should contact the appropriate liaison from the Counsel's Office. Attached to this memorandum is a list of all White House departments with designated representatives as well as liaisons from the Counsel's Office.

Counsel Liaison Telephone and Room Numbers:

Chris Cerf	6-7180	190 OEOB
Vicki Divoll	6-7181	190 OEOB
Marvin Krislov	6-7903	126 OEOB
Cheryl Mills	6-7900	128 OEOB

Office	Office Representative	Counsel Liaison
Cabinet Affairs	Christine Varney	Marvin Krislov
Chief of Staff	Thomas McLarty	Cheryl Mills
Communications	Rahm Emmanuel	Cheryl Mills
Counsel's Office	Kathleen Whalen	Marvin Krislov
Domestic Policy	Carol Rasco	Chris Cerf
Envir. Policy	Katie McGuinty	Chris Cerf
First Lady Off.	Melanne Verveer	Cheryl Mills
Intergov. Aff.	Marcia Hale	Vicki Divoll
Legislative Aff.	Pat Griffin	Vicki Divoll
Man. & Admin.	David Watkins	Chris Cerf
Nat. Econ. Pol.	Bob Rubin	Chris Cerf
Office of Pres.	George Stephanopolous	Cheryl Mills
Political Aff.	Joan Baggett	Vicki Divoll
Pres. Personnel	Veronica Biggins	Vicki Divoll
Public Liaison	Alexis Herman	Vicki Divoll
Scheduling/Adv.	Ricki Seidman	Chris Cerf
Social Secretary	Ann Stock	Marvin Krislov
Staff Secretary	John Podesta	Chris Cerf

THE WHITE HOUSE

WASHINGTON

March 7, 1994

MEMORANDUM FOR ALL WHITE HOUSE OFFICE STAFF

FROM: JOEL I. KLEIN
DEPUTY COUNSEL TO THE PRESIDENT

RE: GRAND JURY SUBPOENA FOR DOCUMENTS

As my memorandum of March 4 explained, the White House has received a grand jury subpoena requesting the production of documents. Attached please find a copy of that memorandum detailing the subpoena's requirements, which you should study carefully and refer to when reviewing all your documents and communications.

The subpoena calls for the documents to be produced no later than 10 a.m. Thursday, March 10, 1994. To respond to this deadline, absolutely all members of the White House Office staff immediately must search their files and all applicable documents and records (as defined in the subpoena and set forth in the March 4 memorandum at Paragraphs A and B and the accompanying Definitions section).

To coordinate compliance, we have designated a representative from all White House departments to be responsible for ensuring that all his or her employees have complied fully with the subpoena. These department representatives must collect a signed statement from each staff member certifying compliance with the subpoena, as well as provide any and all possibly responsive documents and communications from all staff members. Staff members should provide department representatives with all responsive documents in appropriate envelopes or folders with their signature clearly visible. These materials should be given by department representatives to the designated liaison from the Counsel's Office no later than 8 p.m. today. A complete list of White House department representatives, as well as a list of the liaisons from the Counsel's Office by White House department, is attached to the Chief of Staff's memorandum.

Each staff member must take personal responsibility for complying with this subpoena in full. If a staff member has questions about the scope of the request or any other matters, he or she should contact his or her liaison from the Counsel's Office.

I. PROCEDURES FOR REVIEWING FILES

In order to ensure that each staff member conducts a complete search of his or her files, the following procedures are established:

1. Trash Containers and Wastebaskets. Each staff member must search his or her office wastebasket or trash containers and retrieve any applicable documents, files or records no later than 2 p.m. today. Each agency or department representative must confirm that each staff member has searched his or her trash containers no later than 4 p.m. today. If a staff member is absent from the office today for any reason, the agency or department representative must confirm that the absent staff member's trash has been searched and any potentially responsive documents removed and preserved. The time found and the location, including room number, of any such documents should be noted and the documents should be provided to the appropriate liaison from the Counsel's Office no later than 8 p.m. today.

2. Burn Bags. All burn bags in White House offices must be searched no later than 2 p.m. today, and any potentially responsive documents must be removed and preserved. Each agency or department representative is responsible for ensuring that all burn bags in his or her department are searched and that all possibly responsive documents are removed and preserved. Any such responsive document(s) should be provided to the author and/or recipient, if apparent, who in turn should note the location of any such document(s) and provide them to the Counsel's Office as discussed below. If it is unclear as to the identity of the author and/or recipient, the staff member locating the document(s) should note the time found and location of any such documents. These documents should be provided to the appropriate liaison from the Counsel's Office no later than 8 p.m. today.

3. Electronic Mail. Each White House staff member should search his or her electronic mail files by 2:00 p.m. today to determine if there are any communications possibly responsive to the subpoena that were either received, sent by, or forwarded to the staff member. Any such communications, including any attachments, should be printed out immediately, and provided to the appropriate liaison from the Counsel's Office no later than 8 p.m. today.

4. Records and Files. Each White House staff member must ascertain whether his or her records and documents contain any possibly responsive documents (as defined in the subpoena and set forth in the March 4 memorandum at paragraphs A and B and in the Definitions section). Please consult the Definitions Section carefully. Note that the Definitions of documents includes, among other types of documents or communications, diaries,

calendars, notes, summaries or records of conversations, meetings, interviews or conversations, as well as documents that may refer only in part to the subjects set forth in Paragraphs A and B, or may refer to the preparation of other documents relevant to the subjects set forth in Paragraphs A and B. The definition of documents also includes earlier, preliminary drafts of documents. **Also note that any original documents in a staff member's file should be provided, as well as any copies.** Should a staff member wish to make an additional copy of a document for current use, he or she may do so but should notify the appropriate liaison from the Counsel's Office. See further instructions, below.

If, for any reason, you object to providing a possibly responsive document or communication, you must notify your liaison from the Counsel's Office of the type of document or communication no later than 8 p.m. today.

II. RESPONSIVE DOCUMENTS

If your search reveals possibly responsive documents or communications, please note that the subpoena specifies the following instructions:

1. If any original document cannot be produced in full, you must produce such document to the extent possible and indicate specifically the reason for your inability to produce the remainder.

2. Documents shall be produced as they are kept in the usual course of business, as organized in the files.

3. File folders, labels and indices identifying documents called for shall be produced intact with such documents. Documents attached to each other should not be separated.

4. The originals of all documents and communications must be produced, as well as copies within your possession, custody or control.

5. In the event that any document called for by this subpoena has been lost, destroyed, deleted, altered or otherwise disposed of, you should identify that document in writing as follows: a) author; b) position and title of the author; c) addressee; d) the position or title of the addressee; e) indicated or blind copies; f) date; g) brief description of the subject matter of the document; h) number of pages; i) attachments or appendices; j) all persons to whom the document, its contents, or any portion thereof, had been disclosed, distributed, shown or explained; k) the date of the loss, destruction, deletion, alteration or disposal and the circumstances thereof; l) the reasons, if any, for the loss,

destruction, deletion, alteration or disposal and the person or persons responsible.

6. If any information or data is withheld because such information or data is stored electronically, it is to be identified by the subject matter of the information or data and the place or places where such information is maintained.

III. COMPLIANCE RESPONSIBILITIES AND SIGNED STATEMENTS

If you have any doubts whatsoever about the responsiveness of any document or record, it is your obligation to notify your liaison from the Counsel's Office.

Each department representative must determine if any staff member's absence from the office will not enable that staff member to comply with these deadlines. In such instances, each department representative should notify your liaison from the Counsel's Office to discuss appropriate procedures.

In addition to providing the original(s) and any copies of any and all possibly responsive documents, each White House staff member must return to your designated agency or department representative a signed original of the statement found on the next page no later than 8 p.m. today. This signed statement should accompany any possibly responsive documents or communications that you have identified.

Additionally, those department representatives must also provide a signed statement certifying that they have canvassed their staff members and ensured compliance.

Please note that we assume that this subpoena imposes a continuing obligation to provide responsive documents to the grand jury. Should you create, receive, or discover any possibly responsive documents at any time in the future, you should notify your Counsel liaison immediately.

Statement for All White House Staff Members

I hereby certify that, to the best of my knowledge and ability, I have provided all responsive documents from the following sources within my possession, custody or control:

1. My trash container(s) or wastebasket(s) None

2. My burn bag(s) None

3. My electronic files None

4. My files, records and other documents (as set forth in the Definitions Section of the grand jury subpoena) None

I am not aware of the existence of any electronic mail communications or attachments that have not been produced or identified and are responsive to the grand jury subpoena. I further certify that I have provided all documents or communications responsive to the grand jury subpoena for White House documents (as set forth in Paragraphs A and B) for compliance as requested by the White House Counsel's Office.

Signed: [signature]

Dated: March 7, 1994

Statement for All White House Department Representatives

I hereby certify that I have canvassed all staff members in my agency/department (choose one) and have provided their signed statements as requested by the White House Counsel's Office. I further certify that I have received and provided any possibly responsive documents and communications (as defined in Paragraphs A and B of the subpoena, and the accompanying Definitions Section), including, but not limited to, those documents found in trash bags, burn bags, electronic files, and staff files and records.

Signed: Kristine McLaughlin

Dated: March 7, 1994

March 4, 1994

MEMORANDUM FOR THE WHITE HOUSE STAFF

FROM: JOEL I. KLEIN
DEPUTY COUNSEL TO THE PRESIDENT

RE: GRAND JURY SUBPOENA FOR DOCUMENTS

The White House has received a grand jury subpoena calling for the production of documents. The description of the documents called for reads as follows:

A. Any and all documents and/or communications referring or relating to any contacts, meetings or conversations about or regarding Madison Guaranty Savings & Loan, its subsidiaries or affiliates, held between or among (1) any member of the White House staff and (2) any official or employee of the Department of the Treasury or the Resolution Trust Corporation. This includes, but is not limited to any documents and/or communications:

1. referring or relating to the arrangement, existence, substance or circumstances of any such meetings or conversations;

2. discussed or referred to in any such meetings or conversations;

3. exchanged between any member of the White House staff and any official or employee of the Department of Treasury or the Resolution Trust Corporation at or in connection with any such meetings or conversations;

4. constituting notes taken at or referring to any such meetings or conversations;

5. summarizing, documenting or referring to all or any part of any such meetings or conversations.

B. Any and all documents and/or communications referring or relating to any criminal referrals made by the Resolution Trust Corporation about or regarding Madison Guaranty Savings & Loan, its subsidiaries or affiliates.

Definitions and Instructions

1. Definitions

a. The term "document" or "documents" as used in this subpoena means all records of any nature whatsoever within your possession, custody or control or the possession, custody or control of any agent, employee, representative, or other person acting or purporting to act for or on your behalf or in concert with you, including but not limited to memoranda, records, reports, notes, books, files, summaries or records of conversations, meetings or interviews, summaries or records of telephone conversations, diaries, calendars, datebooks, telegrams, facsimiles, telexes, telefaxes, electronic mail, computerized records stored in the form of magnetic or electronic coding on computer media or on media capable of being read by computer or with the aid of computer related equipment, including but not limited to floppy disks or diskettes, disks, diskettes, disk packs, fixed hard drives, removable hard disk cartridges, mainframe computers, Bernoulli boxes, optical disks, WORM disks, magneto/optical disks, floptical disks, magnetic tape, tapes, laser disks, video cassettes, CD-ROMs and any other media capable of storing magnetic coding, microfilm, microfiche and other storage devices, voicemail recordings, and all other written, printed or recorded or photographic matter or sound reproductions, however produced or reproduced.

The term "document" or "documents" also includes any earlier, preliminary, preparatory or tentative version of all or part of a document, whether or not such draft was superseded by a later draft and whether or not the terms of the draft are the same as or different from the terms of the final document.

b. The term "communication" or "communications" is used herein in its broadest sense to encompass any transmission or exchange of information, ideas, facts, data, proposals, or any other matter, whether between individuals or between or among the members of a group, whether face-to-face, by telephone or by means of electronic or other medium.

c. "Possession, custody or control" means in your physical possession and/or if you have the right to secure or compel the production of the document or a copy from another person or entity having physical possession.

d. The term "referring or relating" to any given subject means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject including, but not limited to, documents concerning the preparation of other documents.

Anyone who has any documents that fall within the foregoing description must retain those documents. You must also retrieve and retain any responsive documents in your wastepaper basket and your burn bag.

If you have any doubt about whether a particular document is called for by the above description, you must save it.

We will be back in touch with you next week to organize procedures for the collection of all relevant documents.

The destruction of documents after receipt of this subpoena may constitute obstruction of justice.

If you have any questions about this memorandum and what is expected of you, please contact Deputy Counsel to the President, Joel I. Klein (6-6611).

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release March 4, 1994

At approximately 7:00 p.m. today, the FBI on behalf of the Special Counsel served a grand jury subpoena on the White House for the production of documents concerning conversations between the White House and the Department of Treasury or Resolution Trust Corporation with regard to the Madison Guaranty matter. In addition, several individuals in the White House received subpoenas requiring testimony. The White House will comply fully and promptly with the subpoena. The Deputy Counsel has tonight issued a memorandum to all employees requiring the preservation of all documents. Because these subpoenas concern a pending investigation, the White House will have no further comment at this time.

THE WHITE HOUSE

WASHINGTON

March 7, 1994

MEMORANDUM FOR ALL WHITE HOUSE OFFICE AND
EXECUTIVE OFFICE OF THE PRESIDENT STAFF

FROM: JOEL I. KLEIN JIK
Deputy Counsel to the President

SUBJECT: Retention of Documents and Communications

Today we have requested that White House Office employees produce any documents or communications related to contacts between White House staff members and officials of the Department of the Treasury and the Resolution Trust Corporation.

We are aware that staff may have other documents or communications relating to Madison Guaranty, Whitewater Development Corporation, and any related matters. While any such documents or communications need not be produced at this time, staff members should take all necessary measures to preserve and maintain any such documents. Such documents should not, under any circumstances, be discarded, altered or destroyed. Additionally, all staff members should not remove or transport documents or communications related to any of these matters from their offices in the EOP or White House complex.

Should any staff member have questions about these procedures, please contact one of the following liaisons in the Office of White House Counsel:

Chris Cerf	6-7180	190 OEOB
Vicki Divoll	6-7181	190 OEOB
Marvin Krislov	6-7903	126 OEOB
Cheryl Mills	6-7900	128 OEOB

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Region II

Memorandum

Date: March 8, 1994

To: PHS Staff

From: Regional Health Administrator

Subject: Staff Reassignment - Regional AIDS Coordinator

Consistent with the restructuring of the National AIDS Policy Office, the Public Health Service is centralizing it's AIDS policy formulation and coordination function. As a result, Mr. Barry Gordon was reassigned to the Family and Child Health Services Branch in the Division of Health Resource Development on March 1st..

Over the past 5 years, Barry, as the Regional AIDS Coordinator, worked closely with State and local health officials and community groups to build a strong professional partnership. He was also one of the architects of the recently funded New York/Puerto Rico "Air Bridge" HIV migration project, and indeed successfully promoted collaboration among and between various HIV/AIDS program constituencies.

I am proud of his commitment and accomplishments in facilitating and coordinating programs for those infected with and affected by HIV disease. He worked to make a difference.

Please join me in wishing Barry well in his new assignment.

Raymond L. Porfilio

cc; T. Fitzpatrick - OIA
C. Gebbie, NAPO
W. Forbush, OM

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Christine Gebbie	From Darren Britton
Co.	Co.
Dept.	Phone # 212-727-9579
Fax # 202-632-1096	Fax # 212-807-0347

(212) 727.9579
121 W. 20th St. #3C
NY, NY 10011-3600

March 8th, 1994

David A. Kessler, M.D., Commissioner
Food and Drug Administration
5600 Fishers Lane
Rockville, Maryland 20857

Re: FDA's Denial of Treatment of Microsporidiosis in PWAs

Dear Dr. Kessler:

I am writing you in my capacity as a state AIDS public health administrator, as a treatment activist since 1985, and as one of the people who has had to access albendazole (Zentel, SmithKline Beecham) for acute microsporidiosis, *from the PWA Health Group in New York.*

First, let me give you an idea of what I was experiencing up to the point of finally receiving albendazole. For three months, I experienced an increasing number of bouts of watery, explosive diarrhea. By the time I received the albendazole, I was having about 6 watery bowel movements per day, which, at times, were entirely uncontrollable. I lost 13% of my total body weight in just the two weeks prior to initiation of treatment with albendazole. Upon starting 400mg b.i.d., my weight stabilized by day 3 of treatment, and continued to increase gradually over the next 10 weeks. I have still not regained my original weight before microsporidiosis, but I do know that initiation of treatment with albendazole stopped the diarrhea almost immediately and, more importantly, stopped further weight loss. After 4 weeks of treatment and dietary changes recommended by my GI doctor, my appetite was back to normal, and I added a few pounds.

I can not begin to impart to you the impact of attaining an increased quality of life through controlling my bowel movements, returning to work, and gaining back weight I wasn't sure if I would ever gain back. I had regained control over my life and my body, and that was only possible because of the PWA Health Group. As you know, there is no approved treatment for microsporidiosis in the United States. Furthermore it is the PWA Health Group that is helping people like myself remain relatively healthy, not the FDA. For this reason, it is all the more appalling that the FDA is trapping itself once again into a no win situation.

Since you should already be familiar with this situation and the roles of Bill Sedgewick and Ron Smith in the Cincinatti regulatory affairs office, I will cut to the quick: I demand you put an end to this unfortunate controversy immediately. You personally can, you have in the past, and you must do it again now. You know these issues have been visited, revisited, and revisited. The end has always been the same, and given the particulars of this specific case, there is no way that anything will change even if the FDA decides to persecute those involved in obtaining albendazole for the treatment of microsporidiosis in people with HIV. However, Mr. Sedgewick and Mr. Smith have already taken it upon themselves to harass and threaten

AIDS primary care physicians, including my own. This is absolutely unconscionable, and I will work with all physicians harassed by your staff to pursue any and all legal recourse available to them against Mr. Sedgewick and Mr. Smith, as well as their direct supervisors, who, given the sequence of events, had time to intervene to stop the campaign of terror that Mrs. Sedgewick and Smith pursued beginning Friday, March 4, 1994.

Given the seriousness of this situation, and the unethical behavior undertaken by your staff in the Cincinatti office, you must immediately clarify this specific issue with your staff AND **IMMEDIATELY RELEASE ALL ALBENDAZOLE YOU ARE YOU HAVE TAKEN FROM US.** Furthermore, the Mr. Sedgewick and Mr. Smith must be immediately removed from their duties regarding any and all agents pursued by groups like the PWA Health Group.

In conclusion, you know as well as the rest of us that the PWA Health Group in New York is the outstanding example of such buyers clubs, and have voluntarily instituted thorough quality assurance and testing mechanisms that rival those of the government and private pharmaceuticals. And I think you are quite aware of the possible political fallout from you trying to stop the rest of us from doing the job that you and other federal agencies should be doing, but are not.

I look forward to your swift and favorable action toward reinstating the import of albendazole, and fully expect that you will take it upon yourself to see to it that formal apologies are given to the physicians who suffered the extraordinary harassment campaign waged by Mr. Smith and Mr. Sedgewick, and that these two incompetents will be reassigned or terminated.

I will be awaiting your written response.

Darren J. Britton (212)727-9579

cc: Donna Shalala, HHS Secretary
Christine Gebbie, Ntl. AIDS Policy Coordinator
Nilsa Gutierrez, M.D., Director, NYS AIDS Institute
Sally Cooper, E.D., PWA Health Group/NY
Michael Isbel, Esq., Dir. of Policy, GMHC
Randy Wykoff, AIDS & Spec. Affairs Office, FDA
Ronald Chesemore, Regulatory Affiars, FDA
Bill Sedgewick, FDA
Ron Smith, FDA
Catherine Woodard/Laurie Garrett, New York Newsday
Nancy Loo, New York One News
The New York Times
ABC News
NBC News
CBS News
Gay Cable News
ACT UP/NY

Microsporidia is a devastating, life threatening infection in people with AIDS. It can cause disease in almost any part of the body -- although it most often causes severe diarrhea. Actually, severe diarrhea is a rather polite euphemism. Here's how the medical abstracts, not really known for being graphic, characterize what it is like to have microsporidiosis:

TI - **Clinical manifestations and course of intestinal Enterocytozoon bieneusi microsporidiosis.**
SO - Int Conf AIDS. 1993 Jun 6-11;9(1):57 (abstract no. WS-B14-5).
AU - Weber R, Bryan RT, Vugia DJ, Kaiser L, Sauer B, Luthy R
AB - To assess clinical and epidemiologic data on HIV-associated enteric infections, HIV-seropositive patients (pts) with and without diarrhea were prospectively followed at HIV outpatient clinics in Switzerland and Atlanta. E. bieneusi was found in 27 pts (23 m, 3 f, 1 child) using a coprodiagnostic technique [NEJM 1992;326:161]. Of those pts with chronic diarrhea, 7% (Switzerland) and 12% (Atlanta) had microsporidiosis. The pts presented with **chronic** (23/27) or **intermittent diarrhea** (3/27), **weight loss** (18/27), **fatigue** (18/27), **nonspecific abdominal pain** (13/27), **nausea, vomiting** (8/27). At time of diagnosis, **mean duration of diarrhea was 5 months** (0.5-23). **The average number of bowel movements/day was 4.4 (range: 1-12), the highest number ranged from 2-20. Mean weight loss was 9 kg** (0-27). One pt had no diarrhea. When microsporidiosis was diagnosed, 22/27 had AIDS, 3 ARC, 2 asymptomatic HIV-infection. CD4 cells were < or = 0.05 x 10(9)/L in 17/27, < or = 0.2 in 25/27. **Physical findings were nonspecific. Wasting syndrome was present in 17/27.** Alk. phosphatase and LDH were above normal values in 7/27 and 15/27 pts. Concomitant intestinal parasitosis was found in 9/27. Extraintestinal manifestations of E. bieneusi were: acalculous cholecystitis (1), pulmonary involvement (1 pt). **8/27 pts died 1-22 months (mean: 5) after diagnosis of microsporidiosis.** Autopsy was performed in 2; clinical assessment suggests that **cachexia substantially contributed to death in 6/8.** Mean follow-up of survivors was 4 months (1-16). **E. bieneusi is an important cause of chronic diarrhea and severe morbidity** in pts with low CD4 cells. The parasitosis itself may not be immediately life-threatening but **death is associated with severe wasting syndrome.**

TI - **Intestinal microsporidiosis in patients with HIV-infection.**
SO - Int Conf AIDS. 1993 Jun 6-11;9(1):383 (abstract no. PO-B10-1490).
AU - Sandfort J, Hannemann A, Gelderblom H, Schneider T, Ruf B
AB - OBJECTIVE: To determine the prevalence and clinical symptoms of microsporidiosis in HIV infected patients. METHODS: 65 HIV-infected patients with (n = 41) and without diarrhea (n = 24) were prospectively evaluated. A total of 151 stool specimens were evaluated for presence of microsporidia using a modified

trichrome stain. In patients with microsporidia urine, duodenal biopsies and fluid were also evaluated. Electron microscopy was performed from fecal samples and biopsies. **RESULTS:** Microsporidia were detected in 9 patients (22% of patients with diarrhea, 8 males, 1 female, 30-67 years, median 34). Previous HIV status was ARC in 2 patients and AIDS in 7 patients. **All patients suffered from chronic diarrhea lasting for 3 to 84 weeks (median 12 weeks).** Symptoms included **increased number of bowel movements (median = 9), watery stools** (n = 9), **nausea** (n = 4), **abdominal pain** (n = 2), **weight loss** (median = **0.4 kg/week**) and **loss of appetite** (n = 2). **Three patients** had a foreign travel history. Other pathogens isolated were cryptosporidia (n = 2) and mycobacteria (n = 2). **All patients with microsporidia (median CD4-count 50, range 1-110) showed evidence of malabsorption.** The alkaline phosphatase was normal in all patients with MI. Urine was negative in all 7 patients evaluated. Duodenal biopsy were positive in 6/6 cases and duodenal fluid in 4/5 cases evaluated. Until now diagnosis was confirmed by electron microscopy in 3 patients (Enterocytozoon bieneusi). CONCLUSIONS: **Microsporidia appear to be an important pathogen in immunosuppressed HIV-infected patients with chronic diarrhea and malabsorption** in Germany. There is evidence that the importance of this pathogen may be underestimated at present.

TI - **Intestinal Enterocytozoon bieneusi microsporidiosis in an HIV-infected patient: diagnosis by ileo-colonoscopic biopsies and long-term follow up.**
SO - Clin Investig. 1992 Nov;70(11):1019-23.
AU - Weber R, Muller A, Spycher MA, Opravil M, Ammann R, Briner J
AB - A 39-year-old patient with acquired immunodeficiency syndrome was diagnosed as having intestinal Enterocytozoon bieneusi microsporidiosis after **persistent watery diarrhea for 30 months** and a **16-kg weight** loss. Microsporidian parasites were found by light and electron microscopy in tissue specimens of the duodenum, jejunum, and terminal ileum, and by light microscopic examination of stool specimens. When duodenal tissue sections obtained 16 months previously were reviewed retrospectively, E. bieneusi was also found. Until now, diagnosis of intestinal microsporidiosis has been based on examination of bioptic specimens of the upper small intestine because the sensitivity of new coprodiagnostic techniques has not been determined. Our findings of ileal microsporidiosis show that examination of the terminal ileum and ileal biopsy collection in tandem with colonoscopy is indicated for patients infected with human immunodeficiency virus and suffering from unexplained chronic diarrhea. The long-term course of our patient demonstrates that E. bieneusi, although not necessarily life threatening, can cause protracted **debilitating diarrhea and wasting** in severely immunodeficient patients.

TI - **Asymptomatic intestinal microsporidiosis in 2 AIDS patients.**
SO - Int Conf AIDS. 1993 Jun 6-11;9(1):444 (abstract no. PO-B19-1855).
AU - Ouellet L, MacLean JD, Svenson J, Kokoskin-Nelson E, Szabo J, Lough J
AB - OBJECTIVE: To describe 2 cases of asymptomatic intestinal microsporidiosis and compare their clinical and pathologic features to microsporidiosis patients with diarrhea. METHODS: Seventy-nine AIDS patients with diarrhea (> or = 3 liquid

movements/day) of greater than 2 weeks' duration were examined for intestinal parasites with a battery of stool tests including a modified trichrome stain. Ten (12%) were found to have microsporidia. Five of seven who submitted to small intestinal biopsies had Enterocytozoon bienusi confirmed by electron microscopy (EM). All ten underwent a complete clinical and laboratory investigation. RESULTS: Eight cases had **chronic diarrhea with a duration of 2-24 months, a frequency of 2-20 (bowel movements) per day** and a CD4 count of 5-140 mean (37). Two cases had diarrhea of 12 and 6 weeks which resolved spontaneously and remained diarrhea-free for 5 and 2.5 months. Both continued to have microsporidium in stool specimens while diarrhea-free; one case was EM positive, the other negative. Their CD4 counts were 55 and 140. Clinical intestinal biopsy and laboratory features were compared to 8 symptomatic cases. CONCLUSION: Asymptomatic AIDS patients may be carriers of Enterocytozoon bienusi.

TI - **Albendazole treatment of two species of microsporidial enteritis.**
SO - Int Conf AIDS. 1992 Jul 19-24;8(2):B142 (abstract no. PoB 3333).
AU - Dieterich D, Kotler D, Lafleur F, Lew E, Orenstein J
AB - OBJECTIVE: To determine the efficacy of albendazole treatment of intestinal microsporidiosis in people with HIV. METHODS: Thirteen HIV-infected patients were studied. All had **severe diarrhea greater than 6 BM's/day, weight loss greater than 10 lbs**, and evidence of **malabsorption**. All patients had the diagnosis of microsporidiosis made on small bowel biopsy which was confirmed by electron microscopy (E.M.). Twelve out of thirteen patients had Enterocytozoon bieneusi, whereas one patient had a newly described species that was found in the urine and small bowel biopsy. Patients were treated with albendazole 400 mg po bid for one month. They underwent repeat small bowel biopsy and had diarrhea evaluated. RESULTS: Thirteen patients in all were treated. Median age was 40. All had T cells less than 200. As of this writing, seven are evaluable. One patient died of bacterial sepsis after 1 week of therapy. Two other patients also died (after 6 months and 1 month of therapy). The one patient with the new species cleared microsporidia from the small bowel biopsy, but had only a minor decrease in diarrhea. Five of the six remaining patients (83%) all had dramatic reductions in diarrhea while still showing some evidence of infection on E.M. of small bowel biopsy. **Diarrhea appeared to have returned when treatment was stopped.** Evaluation with repeat biopsies during continued treatment is ongoing. A method to quantitate biopsy results is under development. **There were no adverse events associated with albendazole.** CONCLUSIONS: **Albendazole appears to be a safe and effective treatment for 2 species of microsporidiosis in HIV patients.** A double-blind placebo controlled study with pharmacokinetics is presently underway. Stool tests for microsporidia and E.M. quantitative methods are under development.

TI - **Intestinal microsporidiosis in a Chilean patient with acquired immunodeficiency syndrome (AIDS).**
SO - Pathol Res Pract. 1993 Mar;189(2):209-13; discussion 213-6.
AU - Oddo D, Chuaqui R, Hoffmann E, Garcia M

movements/day) of greater than 2 weeks' duration were examined for intestinal parasites with a battery of stool tests including a modified trichrome stain. Ten (12%) were found to have microsporidia. Five of seven who submitted to small intestinal biopsies had Enterocytozoon bienusi confirmed by electron microscopy (EM). All ten underwent a complete clinical and laboratory investigation. RESULTS: Eight cases had **chronic diarrhea with a duration of 2-24 months, a frequency of 2-20 (bowel movements) per day** and a CD4 count of 5-140 mean (37). Two cases had diarrhea of 12 and 6 weeks which resolved spontaneously and remained diarrhea-free for 5 and 2.5 months. Both continued to have microsporidium in stool specimens while diarrhea-free; one case was EM positive, the other negative. Their CD4 counts were 55 and 140. Clinical intestinal biopsy and laboratory features were compared to 8 symptomatic cases. CONCLUSION: Asymptomatic AIDS patients may be carriers of Enterocytozoon bienusi.

TI - **Albendazole treatment of two species of microsporidial enteritis.**
SO - Int Conf AIDS. 1992 Jul 19-24;8(2):B142 (abstract no. PoB 3333).
AU - Dieterich D, Kotler D, Lafleur F, Lew E, Orenstein J
AB - OBJECTIVE: To determine the efficacy of albendazole treatment of intestinal microsporidiosis in people with HIV. METHODS: Thirteen HIV-infected patients were studied. All had **severe diarrhea greater than 6 BM's/day, weight loss greater than 10 lbs,** and evidence of **malabsorption.** All patients had the diagnosis of microsporidiosis made on small bowel biopsy which was confirmed by electron microscopy (E.M.). Twelve out of thirteen patients had Enterocytozoon bieneusi, whereas one patient had a newly described species that was found in the urine and small bowel biopsy. Patients were treated with albendazole 400 mg po bid for one month. They underwent repeat small bowel biopsy and had diarrhea evaluated. RESULTS: Thirteen patients in all were treated. Median age was 40. All had T cells less than 200. As of this writing, seven are evaluable. One patient died of bacterial sepsis after 1 week of therapy. Two other patients also died (after 6 months and 1 month of therapy). The one patient with the new species cleared microsporidia from the small bowel biopsy, but had only a minor decrease in diarrhea. Five of the six remaining patients (83%) all had dramatic reductions in diarrhea while still showing some evidence of infection on E.M. of small bowel biopsy. **Diarrhea appeared to have returned when treatment was stopped.** Evaluation with repeat biopsies during continued treatment is ongoing. A method to quantitate biopsy results is under development. **There were no adverse events associated with albendazole.** CONCLUSIONS: **Albendazole appears to be a safe and effective treatment for 2 species of microsporidiosis in HIV patients.** A double-blind placebo controlled study with pharmacokinetics is presently underway. Stool tests for microsporidia and E.M. quantitative methods are under development.

TI - **Intestinal microsporidiosis in a Chilean patient with acquired immunodeficiency syndrome (AIDS).**
SO - Pathol Res Pract. 1993 Mar;189(2):209-13; discussion 213-6.
AU - Oddo D, Chuaqui R, Hoffmann E, Garcia M

AB - A 24-year-old male patient with AIDS diagnosed in 1989, and with several episodes of pneumocystosis, was admitted because of a chronic diarrheic syndrome and severe epigastric pain. Endoscopy showed a granular duodenal mucosa. Light microscopy showed a moderate villous atrophy with round-cell inflammatory infiltration of the chorion. Giemsa, Ziehl-Neelsen, and Gram stains showed microsporidial spores measuring between 1.5 and 2 microns in the supranuclear cytoplasm of some enterocytes. (TRUNCATED)

There are many more abstracts. Most of them simply note that microsporidiosis can cause severe diarrhea. But again, this doesn't come close to describing the suffering it can cause. Here's how one PWA describes his experiences with severe diarrhea:

...No definition can do justice to the discomfort of this condition with the very large quantities of very liquid feces, flatulence, muscular pain and discomfort that are involved.
...My first experience with diarrhea meant that I went through agony. Not only physically as I tried to control my bowels which seemed to be developing a rebellious mind of their own, but mentally as I struggled with the feelings of shame, fear, pain, degradation, humiliation, total panic and fatigue. To be very blunt, smelling of shit is socially unacceptable and having no control over your bowels can be very degrading. "express deliveries" in your underwear are very depressing and distressing. Even more for those people whose state of health means that they have to rely on other people to clean them up.
(reprinted from Body Positive, Number 161, Nov. 29, 1993, pg. 5)

There is no known treatment for the microsporidiosis. However, a number of uncontrolled studies show that albendazole may offer some benefit to patients. In the absence of any alternative therapies PWAs MUST BE ALLOWED ACCESS TO THIS DRUG.

AIDS Action council

March 9, 1994

RECEIVED
MAR 11 1994

Kristine Gebbie, R.N., M.N.
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, NW
Suite 1060
Washington, DC 20503

Dear Ms. Gebbie:

I am writing in response to Andrew Barrer's letter of March 3, which attempted to address our concerns regarding your presentation of the President's FY 1995 AIDS-related programs budget. Unfortunately, the responses Mr. Barrer provided to my letter of February 17 lead us to conclude that our concerns are not clearly understood by you and your staff and therefore have not been sufficiently addressed.

First, I want to make it very clear that I did not, and it should not be represented, that I gave "approval" for any funding chart you presented in your press conference. I made a very clear plea that domestic discretionary spending and entitlement spending be clearly separated in your presentation and in charts used for the press conference. Nevertheless, several of the charts at the press conference (see attached) and your press statement continued to reflect no clear distinction between proposed increases in discretionary programs and rising entitlement costs. Your press statement which claims that "the president's continued commitment to HIV/AIDS is shown in a budget increase of nearly ten percent" is the crux of our objection.

1875
Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300

Second, we are mystified by your failure to explain the HUD FY 95 budget numbers. Your letter refers to **FY 94** funding for programs such as Shelter Plus Care and Supportive Housing, which are critical sources of funding for housing for people living with HIV/AIDS. You specifically reference a project for people living with HIV/AIDS in St. Louis, MO that is receiving FY 94 Supportive Housing funding; yet you fail to recognize the fact that HUD's FY 95 budget proposes **eliminating** funding for these very programs.

HUD's FY 95 budget very clearly calls for defunding McKinney Act programs (including Shelter Plus Care and the Supportive Housing program) to allow HUD to fund a new "Homeless Assistance Grants" program. There are no statutory or regulatory provisions governing who is eligible for the new grants, what activities may be funded, how grants will be applied for or administered, or how HUD will oversee and implement the new program. Moreover, even if this new program were to prove to be of enormous value to people living with HIV/AIDS (an extremely optimistic prediction), HUD's own budget clearly states HUD will spend only $152.4 million on these new grants in FY 95.

The reality is, HUD is asking Congress to defund programs you tout as valuable for people living with HIV/AIDS, to put funds into a program that does not exist and which may not serve people living with HIV/AIDS well. In addition, it will provide only $53 million more for all the homeless activities currently provided under the McKinney Act rather than the additional "$101 million" you state HUD is spending in FY 94 on AIDS housing alone. Moreover, the President's FY 95 budget for HUD proposes flat-funding for Section 811 housing for the disabled and the AIDS Housing Opportunities Act, even though as many as 10 new jurisdictions may qualify for formula grants in FY 95. Level funding for AHOA quite clearly translates into grant reductions for qualifying jurisdictions. We are enclosing the relevant excerpts from HUD's FY 95 budget document to assist in clarifying this situation.

Third, we are terribly concerned about the figures you cite for SAMHSA AIDS programs. Moreover, your claim that the $10 million cut from this program "has been reprogrammed for HIV and AIDS services within the new hard core substance abuser treatment program" is inaccurate. The HIV and AIDS services program you are referring to is a formula set-aside within the substance abuse block grant and bears little relation to the outreach demonstration program. The HIV set-aside is triggered only in states with AIDS cases of 10 or more per 100,000 individuals (about 22 states). These states would allocate between 2% and 5% of their block grant funds for one or more projects that would provide HIV early intervention services at substance abuse treatment sites. Therefore, a $10 million increase in the block grant which you identify as a transfer from the outreach program translates into far fewer than $10 million in additional HIV services under the terms of the block grant. You made an additional mistake in your budget calculation when you claimed that the $310 billion increase in the substance abuse block grant would translate into $25 million for AIDS programming. Here again, you are speaking of the set-aside which remains unchanged in its formula and would amount to far less than 5 percent of $310 million.

We are not only concerned with your presentation of the substance abuse/HIV budget, but we also take exception to the policy analysis you offer. The HIV outreach demonstration program is the only federal program which funds outreach to drug users and their sexual partners. As such, it serves a unique and important purpose in reaching a critically underserved population at high risk for HIV/AIDS. There is certainly precedent in the federal government for the continuation of valuable demonstration programs. The AIDS Pediatric Demonstration Project at HRSA is a case in point. We remain committed to advocacy for federal initiatives to respond to populations at risk for or living with HIV/AIDS who are not currently being addressed by other federal programs. The SAMHSA outreach demonstration is such a program.

I hope that this letter serves to further elucidate our concerns about the press briefing you hosted to educate the media and the HIV community about the President's FY 1995 budget recommendations for HIV/AIDS programs. Let me make it clear that we understand that you serve at the pleasure of the President and are obliged to serve as an advocate for the Administration's budget. However, it is imperative that the budgetary information that you offer is clear and accurate and not subject to the distortions that the inclusion of AIDS entitlement funding generates. Further, your attempts to rationalize the Administration's proposed reductions in key AIDS housing programs and in the SAMHSA HIV outreach program are not supported by the facts and contribute to undermining the credibility of your office. Both you and the AIDS community would have been better served by a accurate, straight-forward presentation of the details of the President's proposed budget for AIDS programs. As AIDS advocates, we are fully capable of drawing our own conclusions from such a presentation.

Please know that these comments are offered in a spirit of cooperation and in recognition of our responsibility as advocates for people living with HIV/AIDS.

Sincerely,

Daniel T. Bross
Executive Director

cc: William Jefferson Clinton, President of the United States
Carol Rasco, Assistant to the President for Domestic Policy
Leon Panetta, Director, Office of Management and Budget
Donna Shalala, Secretary, Department of Health and Human Services
Henry Cisneros, Secretary, Department of Housing and Urban Development

Attachments

Clinton Presidential Records
Digital Records Marker

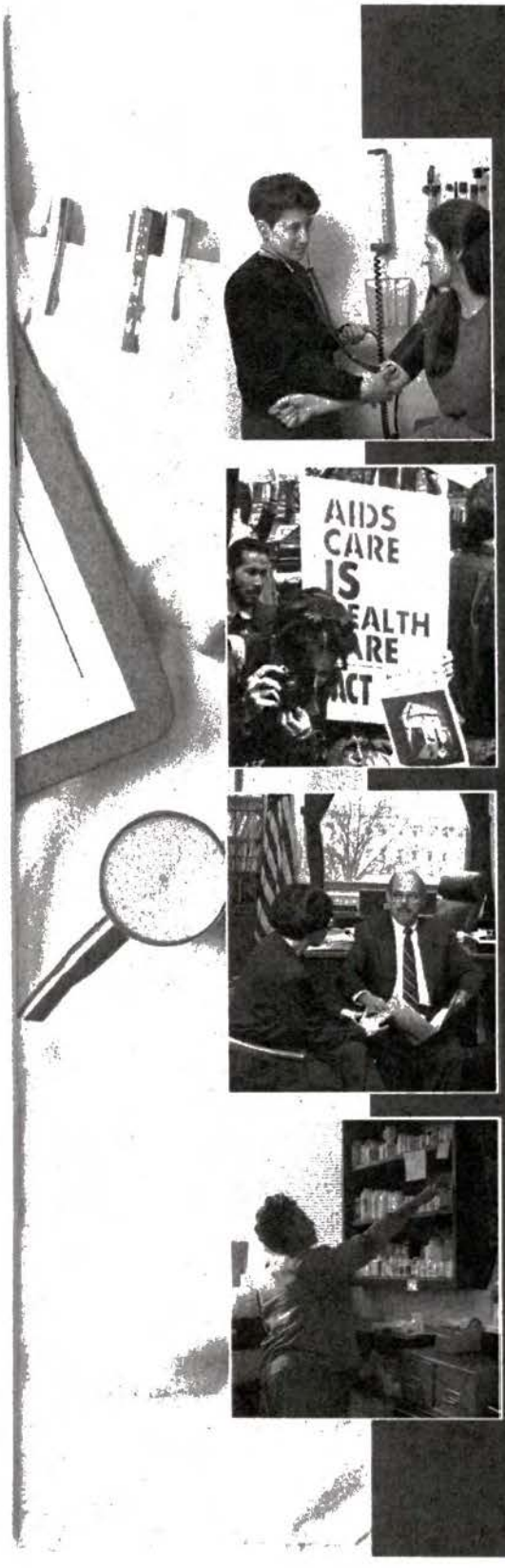
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

"AIDS Care is Health Care"
An AIDS Action Guide to
Health Care Reform

32 pgs



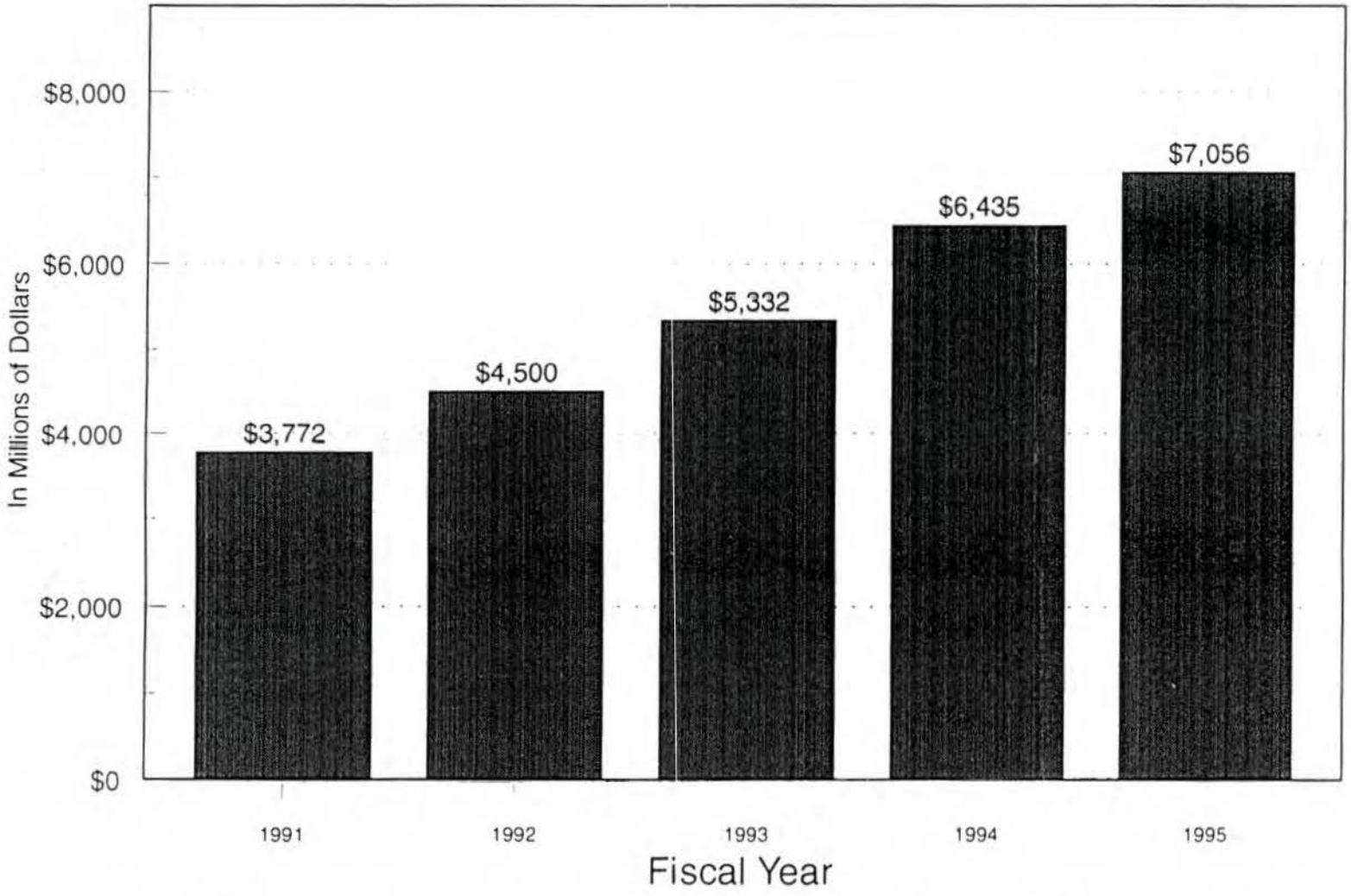
AIDS Care is Health Care

An AIDS Action Guide to Health Care Reform

AIDS Action council

Office of National AIDS Policy

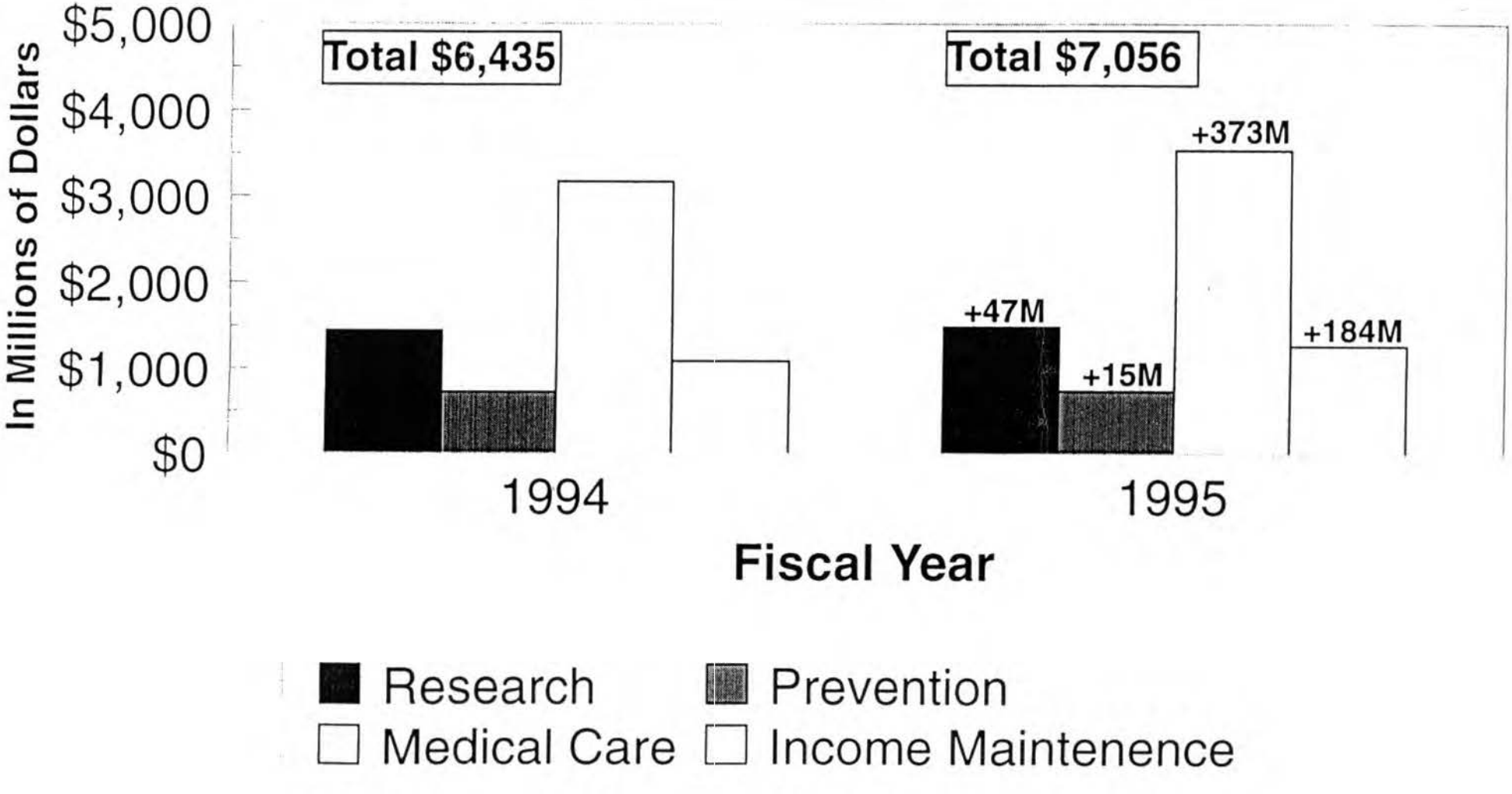
Total Federal Spending for HIV/AIDS
1991 THRU 1995



FY95 includes an estimated $15.5 million in HIV/AIDS prevention services in the Hard Core DrugTreatment Initiative, an increase of approximately $6 million above previous HIV/AIDS programming in SAMSHA.

Office of National AIDS Policy

Federal HIV Funding



SUPPORTIVE HOUSING PROGRAM

	CUMULATIVE 9/30/92	ACTUAL 1993	ESTIMATE 1994	ESTIMATE 1995
	(Dollars in Thousands)			
Program Level:				
Obligations	$515,818	$192,260	$484,333	...
Appropriation (Budget Authority):				
Enacted or proposed	656,073 a/	150,000	334,000	...
Transferred from SAFAH	...	443	...	...
Total	656,073	150,443	334,000	...
Budget Outlays	191,089	91,361	107,200	$158,827

a/ Reflects transfer of $750 thousand to the Interagency Council on the Homeless in 1988.

Budget Program. The Budget does not include an appropriation request for the Supportive Housing Program in 1995. Instead, the Administration proposes to provide funding for homeless assistance within a new program--the Homeless Assistance Grants program which is described separately in this volume.

Program Description. The Supportive Housing Program is authorized by Title IV, Subtitle C of the Stewart B. McKinney Homeless Assistance Act, as amended. The Supportive Housing program is designed to provide supportive housing and services especially to deinstitutionalized homeless individuals, homeless families with children, homeless individuals with mental disabilities and other persons including those with AIDS. Participants must match the acquisition/rehabilitation/new construction costs of a project and provide a percentage of operating costs. The Federal assistance is provided through grants for acquisition/rehabilitation/new construction, and annual payments for operating costs and supportive services, and through contracts for technical assistance. No more than 5 percent of a grant may be used for administrative purposes.

For the 1993 appropriation, over 1,300 applications were received. The Department renewed 199 prior-year grants and awarded 43 new grants. These new grants are expected to support the provision of 3,697 new beds.

SHELTER PLUS CARE

	CUMULATIVE 9/30/92	ACTUAL 1993	ESTIMATE 1994	ESTIMATE 1995
		(Dollars in Thousands)		
Program Level:				
Obligations	$3,047	$59,585	$438,198	...
Appropriation (Budget Authority):				
Enacted	110,533 a/	266,550	123,747	...
Budget Outlays	...	974	15,000	$50,000

a/ In 1992, separate appropriations were enacted for two of this program's components: $37,200 thousand for the Section 202 Sponsor-Based component and $73,333 thousand for the Section 8 SRO component.

Budget Program. The Budget does not include an appropriation request for the Shelter Plus Care program in 1995. Instead, the Administration proposes to provide funding for homeless assistance within a new program--the Homeless Assistance Grants program which is described separately in this volume.

Program Description. The Shelter Plus Care program is authorized by Title IV, Subtitle F of the Stewart B. McKinney Homeless Assistance Act, as amended. Under the Shelter Plus Care program, HUD provides rental assistance to homeless persons with disabilities. Supportive services at least equal in value to the aggregate rental assistance must also be provided by grant recipients, using other Federal, State, local and private resources. Eligible recipients include States, units of general local government, Public Housing Agencies and Indian tribes. Grants are awarded on a competitive basis.

The 1993 appropriation, combined with prior year unobligated balances, allowed conditional funding of 129 grants ranging from $173 thousand to $9.9 million. It is estimated that these funds will provide for 3,196 beds.

HOMELESS ASSISTANCE GRANTS

	ACTUAL 1993	ESTIMATE 1994	ESTIMATE 1995
		(Dollars in Thousands)	
Program Level:			
Obligations	NA	NA	$1,250,000
Appropriation (Budget Authority):			
Enacted or proposed	NA	NA	1,250,000
Budget Outlays	NA	NA	152,400

1995 Budget Program. The Budget proposes a total appropriation of $1,250 million for this new account in 1995. Of this amount, $1,120 million would be for a Homeless Assistance Grants program which would be authorized under a proposed amendment to Title IV of the Stewart B. McKinney Homeless Assistance Act. The remaining $130 million would be for the Emergency Food and Shelter program currently administered by the Federal Emergency Management Agency (FEMA).

Program Description. The new grant program would provide assistance to States, local governments, nonprofit organizations, and Indian tribes. Funds would support a wide range of activities which are components of an innovative approach to providing a "continuum of care" system to assist homeless persons and prevent future homelessness.

Grant funds would be initially allocated to communities that can demonstrate that they have an effective plan to comprehensively address homelessness, to forge partnerships with local, private, and nonprofit providers, and to improve access by homeless persons to mainstream services and income support programs. At the discretion of the Secretary, a portion of the funds could be used for the Secretary's Innovative Homeless Initiative, which also promotes comprehensive homeless systems through local partnership.

The Homeless Assistance Grants program would supersede separate funding for the following four existing programs assisting the homeless under Title IV of the McKinney Act: Emergency Shelter Grants, Supportive Housing, Shelter Plus Care, and Section 8 Moderate Rehabilitation (SRO). It would also include activities eligible under the currently authorized Safe Havens and Rural Homelessness Grant programs authorized under Title IV. In addition, the new program would support the types of activities eligible under the Innovative Homeless Initiatives Demonstration program authorized by Section 2 of the HUD Demonstration Act of 1993.

Legislation is proposed to transfer the Emergency Food and Shelter program to HUD from FEMA in 1995. Of the $1,250 million total request, $130 million is proposed to fund this Emergency Food and Shelter program in 1995. The Budget proposes to transfer the program to HUD in order to improve coordination of the delivery of resources to assist the homeless, consistent with HUD's lead responsibility in this area.

The 1995 Budget also includes $514 million for 15,000 incremental rental assistance units under the Annual Contributions for Assisted Housing account to assist previously homeless families obtain permanent rental housing in the private market. HUD's total homeless budget will increase to $1.76 billion in 1995, which is $811 million over the 1994 enacted level for the HUD and FEMA homeless programs.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS

	CUMULATIVE 9/30/92	ACTUAL 1993	ESTIMATE 1994	ESTIMATE 1995
		(Dollars in Thousands)		
Program Level (Reservations)	$3,602	$134,104	$166,001	$156,000
Appropriation (Budget Authority):				
Enacted or proposed	47,707	100,000	156,000	156,000
Budget Outlays	...	3,253	35,096	67,891

Budget Program. The Budget proposes a 1995 appropriation of $156 million for this program within the Annual Contributions for Assisted Housing account.

Program Description. The Housing Opportunities for Persons with AIDS program is authorized by Title VIII, Subtitle D, of the Cranston-Gonzalez National Affordable Housing Act (P.L. 101-625), as amended. Eligible recipients include States, units of local government, and under limited circumstances, nonprofit organizations. To be eligible for funding, recipients must have a HUD-approved Comprehensive Housing Affordability Strategy (CHAS).

Funds are allocated to grantees based on the incidence of AIDS and grants are available to provide housing and services for persons with AIDS. Such activities include: housing information and coordination services; short-term supported housing and services; short-term rental assistance; single room occupancy dwellings; and community residences and services. Of each appropriation, 90 percent is distributed on a formula allocation basis and 10 percent through a competitive process.

In 1993, 43 grantees received formula funding, with approximately 40 percent of the formula funds being used for rental assistance at an average cost of $5,000 per unit. In 1994, an estimated 54 grantees will receive formula funding.

HOUSING FOR THE ELDERLY OR DISABLED
(Capital Grants and Rental Assistance)

	CUMULATIVE 9/30/92	ACTUAL 1993	ESTIMATE 1994	ESTIMATE 1995
		(Dollars in Thousands)		
PROGRAM LEVEL:				
Budget Authority (Use):				
Capital Grants and Rental Assistance for the Elderly	$914,942	$1,294,783	$1,158,000	$150,000
Capital Grants and Rental Assistance for the Disabled	1,031,626	346,174	387,000	387,000
Service Coordinators	10,715	2,539	22,000	16,300
Total, Use	1,957,283	1,643,496	1,567,000	553,300
Unit Reservations				
Elderly	12,379	9,170	9,000	1,156
Disabled	3,234	2,535	3,000	2,915
Total, Reservations	15,613	11,705	12,000	4,071

1995 Budget Program. A total of $553.3 million is requested within the Annual Contributions account for Housing for the Elderly and for Persons with Disabilities. Of this amount, $150 million will support 1,156 units of new construction/substantial rehabilitation capital grants and rental assistance for the elderly and $387 million will support 2,915 units of new construction/substantial rehabilitation capital grants and rental assistance for the disabled. The Budget also requests $16.3 million for Service Coordinators to provide services to elderly and disabled tenants in Sections 202, 8, 221(d)(3) and 236 project-based housing.

PROGRAM DESCRIPTION

The Supportive Housing for the Elderly Program. The Capital Grants and Rental Assistance program was authorized by Section 801 of the Cranston-Gonzalez National Affordable Housing Act to provide housing for very low-income elderly individuals. The capital grants will be used to finance the acquisition, acquisition with moderate rehabilitation, construction, reconstruction, or rehabilitation of housing intended for use as supportive housing for elderly persons. Supportive housing meets the special physical needs of elderly individuals and accommodates the provision of supportive services for such persons.

The Supportive Housing Program for Persons with Disabilities. The Capital Grants and Rental Assistance program was authorized by Section 811 of the Cranston-Gonzalez National Affordable Housing Act to provide housing for very low-income persons with disabilities. The capital grants will be used to finance the acquisition, acquisition with moderate rehabilitation, construction, reconstruction, or rehabilitation of housing intended for use as supportive housing for persons with disabilities. Supportive housing meets the special physical needs of persons with disabilities and accommodates the provision of supportive services for such persons.

150 W. 26 STREET, SUITE 201
NEW YORK, N.Y. 10001

PWA HEALTH GROUP

(212) 255-0520
Fax: (212) 255-2080

9 March 1994

MAR 14 1994

David Kessler, MD
Commissioner, Food and Drug Administration
5600 Fishers Lane
Rockville, Maryland

Dear Dr. Kessler:

I am writing because it has suddenly become very difficult to import albendazole, a drug which significantly improves the quality of life of people with AIDS suffering from chronic unrelenting diarrhea. The unprecedented level of harassment of the People With AIDS Health Group and respected HIV/AIDS doctors emanating out of your Cincinnati field office does not serve public health.

Since February 22, a shipment of albendazole (©Zentel) has been held in Cincinnati by FDA enforcement officers, Ron Smith and Bill Sedgewick. On March 3, Randy Wykoff told me that the shipment was being "released with comment " re: SmithKline Beecham's compassionate use program. Apparently this abruptly changed Friday after a meeting with Regulatory Affairs, as his staff called on the following Monday to say we should deal directly with Cinncinnati. Easier said than done as they refuse to return our calls. Yesterday, after a second meeting we were told that with updated prescriptions, the shipment would be released.

Bravo.

The most egregious aspect of this ruckus has been the behavior of Ron Smith, who took it upon himself on Friday 3/4 to call physicians who had written albendazole prescriptions and threaten their licenses. His language included: "a secret drug smuggling ring" and "possible criminal charges." (Now, one thing we have never been accused of is being secret). We learned of his outrageous abuse of taxpayer dollars from a Boston clinician who had been harassed by him.

Why is a field officer from Cincinnati calling respected AIDS doctors and threatening their licenses? Exactly what aspect of public health is being served by this harassment? As every physician that Smith and Sedgewick have called will readily tell you, such high handed enforcement by an overzealous officer hot on the trail of a secret drug smuggling ring makes the FDA look ridiculous. **Is this the way the FDA plans to stop "AIDS fraud"?**

It is the responsibility of those responsible for public health that there is an under-utilized SmithKline Beecham compassionate use program (that we notify all buyers about). An excellent use of tax payer dollars might be: 1) a pro-active FDA investigation of why SmithKline's program has failed to meet the needs of clinicians, 2) a pro-active FDA inquiry as to why SmithKline Beecham has done nothing to pursue licensing, and 3) the development of a timetable and plan for drug approval.

Perhaps prematurely, I have viewed my role as working *with* the FDA, clinicians and PWAs to better the range of HIV/AIDS treatment options and education. As such, I have been one of a handful to argue for increased regulation of alternative therapies, (along with the development of an infrastructure by which to intelligently do so). The buyers' clubs serve as an invaluable link to an extremely vulnerable community for the FDA, and I would like to continue working together. Next time, perhaps, FDA enforcement officers might call us first (or at least second) to find out if they've uncovered a secret drug smuggling ring.

The PWA Health Group has operated responsibly with care and integrity quite openly since 1987. When we require prescriptions for products, there are no exceptions. When we require monitoring forms from doctors, there are no exceptions. Sometimes we even require prescriptions for unregulated products, because the pathogenesis of HIV is still unknown. **As PWAs, we are keenly aware of the dangers inherent in experimental therapies. Our lives depend upon it. We are also keenly aware that it is still not legal to survive AIDS in this country.**

In a painful era of research uncertainty and failure, it is unconscionable that the FDA would be party to restricting access to a well-known therapy that is **the sole recourse** of PWAs suffering from microsporidiosis, a horribly debilitating illness. Wasteful enforcement actions as such as these make both your work and mine much harder, and worse, unnecessarily risk the lives of people trying to survive AIDS. I appreciate your concern and attention to these matters, and look forward to hearing from you.

Sincerely,

Sally Cooper
Executive Director

cc: Donna Shalala
Kristine Gebbie
Ronald Chesemore
Gary Dykstra
Randy Wykoff
Bill Sedgewick
Lewin Usilton
Moises Agosto
Terry McGovern
Walter Rieman

UNITED STATES INFORMATION AGENCY
WASHINGTON, D.C. 20547

OFFICE OF THE DIRECTOR

March 9, 1994

Ms. Kristine M. Gebbie
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of the President
Washington, D.C. 20500

Dear Kristine:

It was delightful to meet you at the Chief of Staff breakfast. You are the person I have been looking for since the inauguration.

As I mentioned, Jaime is a terrific young woman. She worked for me during the transition and inauguration. She is smart, hardworking, creative and, as you can see by her resume, dedicated to working with AIDS related organizations. She would love to intern for you this summer and I feel sure you would not be disappointed.

I would be happy to answer any questions you might have and I know Jaime would be grateful for the opportunity to talk to you as well.

Hope to see you soon.

Warm regards,

Iris J. Burnett
Chief of Staff

Jaime A. Wild

Present
Rutgers University
RPO 7002 PO Box 5063
New Brunswick, NJ
(908)247-9843

Permanent
16 Clover Lane
Lincoln Park, NJ
07035
(201)696-0723

OBJECTIVE A summer internship or job to gain the opportunity to learn more about the political aspect of the AIDS epidemic.

EDUCATION Rutgers College, New Brunswick, NJ
B.A., Political Science, B.A. Mass Media and Journalism, expected May 1996
Major G.P.A.: 3.8

HONORS Phi Eta Sigma (National Honor Fraternity)
Top 100 students academically at Rutgers College 1993
Dean's List, Fall 1992, Spring 1993, Fall 1993

RELEVANT COURSEWORK

- Politics and Culture
- Urban Politics
- HIV and Public Policy
- Nature of Politics
- American Party Politics
- AIDS in the Media
- AIDS in Literature
- AIDS in Communication
- Biology, Society and Biomedical Issues: HIV/AIDS

EXPERIENCE

Central NJ Pediatrics AIDS Program (CNJPAP)
Robert Wood Johnson University Hospital, New Brunswick, NJ
Pediatric HIV Volunteer, September 1992-Present
-Assist Director of CNJPAP with paper work and filing. Work with HIV infected children on both the pediatrics floor and in the One-Day-Stay Unit.
-Co-Coordinate support group for HIV infected mothers. Coordinate activities for children as their mothers receive therapeutic support.

Children's AIDS Network, New Brunswick, NJ
Rutgers College Chapter, Vice-President, September 1992-Present
-Head Committees that organize holiday parties and dinner gatherings for the children of CNJPAP and their families. Help organize weekly tutoring programs.
-Conduct AIDS awareness programs for the Rutgers community.

Presidential Inauguration Committee, Washington, DC
Office of the First Family, Winter 1993
Assistant to scheduling managers of the Rodham family, Virginia Kelley and Chelsea Clinton
-Made arrangements and reservations for members and friends of the First Family.
-Assisted Chelsea Clinton on various occassions as her traveling director.

Very Special Arts of NJ, New Brunswick, NJ
Volunteer at workshop, September 1992-December 1992
-Worked with autistic children with various media of art to help them concentrate on creating and expressing themselves through their projects.

ACTIVITIES

- Vice-President, Children's AIDS Network
- Member, United States Student Association
- Member, Rutgers HIV/AIDS Task Force

AID POLICY
750 17th St

Andrew ff

THE WHITE HOUSE

WASHINGTON

RECEIVED

MAR 14 1994

March 11, 1994

MEMORANDUM FOR ALL WHITE HOUSE STAFF

FROM: JACK QUINN
ASSISTANT TO THE PRESIDENT AND
CHIEF OF STAFF TO THE VICE PRESIDENT

JOEL I. KLEIN
DEPUTY COUNSEL TO THE PRESIDENT

RE: Prohibited Contacts on Rulemaking Matters

By memorandum dated May 4, 1993, we reiterated our policies governing communications by members of White House staff with independent agencies, executive branch agencies, and their components. We also noted that the President was considering certain changes to the regulatory review process and that further guidance regarding communications on regulatory and rulemaking matters would be forthcoming.

In the Fall, the President issued Executive Order No. 12866, "Regulatory Planning and Review." Consistent with the intent of that Order, White House staff members are directed to adhere to the following guidelines with respect to communications with executive branch agencies regarding rulemaking matters:

I. Contacts with Agencies

A. Members of the White House staff may contact executive branch agencies with respect to pending rulemaking matters if the purpose of the communication is not to influence the outcome of the pending proceeding (including, specifically, contacts regarding the status of the matter or general policy, budgetary, or administrative issues).

B. When the purpose of the contact is to influence the outcome of a pending rulemaking proceeding, the staff member should, prior to making the contact:

1. obtain approval from his or her principal or departmental supervisor; and

2. coordinate the contact with the Administrator of OIRA, who will advise the staff member on the appropriateness of the contact.

II. Contacts with Members of the Public

A. Members of the public (that is, persons not employed by the executive, legislative, an judicial branches of the federal government) often approach members of the White House staff and ask to have a position or information considered in a rulemaking proceeding at an executive branch agency. When this occurs, White House staff should inform the person that positions or information provided by members of the public must be submitted in writing if they are to be incorporated into the rulemaking process. All such written communications received from members of the public are to be forwarded by the recipient to the affected agency(ies) for inclusion in the public docket.

Please be reminded that under Executive Order No. 12866, this provision applies to contacts with the public regarding pending rulemaking proceedings under review by the President, Vice President, or any regulatory policy advisor.

B. Consistent with the policies reflected in Executive Order No. 12866, White House staff members should not communicate non-written comments from members of the public on pending rulemaking matters to agencies, OIRA, or anyone else involved in the rulemaking or the review process.

* * *

Please cooperate in observing the guidelines discussed above and continue to refer to prior memoranda issued by the White House Counsel's Office on contacts regarding investigative and adjudicative matters and, more generally, contacts with independent agencies. If you have any questions regarding any of these procedures, please contact the White House Counsel's Office.

Thank you for your continuing assistance and cooperation in this area.

J.m.q.
JIK