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003. letter	personal letters re: medical issues (43 pages)	ca. 1993	b(6)

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FOLDER TITLE:
Congressional Member Question and Answer [Binder] [4]

2013-0534-S
rc1531

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]
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LEGISLATIVE INTERESTS

103rd: Cong. Thomas has cosponsored legislation to improve the administration of the Medicare program (Pickle, H.R. 22), and to establish provisions in the Food Drugs & Cosmetics Act regarding the composition and labeling of dietary supplements (Gallegly, H.R. 509). Thomas is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill. He also sponsored H.R. 2261 to contain health care costs through improved consumer information, and H.R. 2851 to reform medical malpractice laws.

CONGRESSMAN CLAY SHAW JR. (R-FL): Congressman Shaw voted to repeal Medicare Catastrophic Act in 1989 and he has been an ally of Congressman Stenholm. The Democrats are trying to recruit Anthony Shriver to run against Shaw in 1994.

While Shaw's specific health care views are not known, he has voted against abortion funding.

POLITICAL PROFILE

Cong. Clay Shaw, is a former mayor of Ft. Lauderdale. Although he voted for the Medicare catastrophic bill in 1988, the retirees in his district quickly voiced their displeasure over the surtax and put Shaw into the position of being one of the Republican members leading the efforts to repeal the bill. A former member of the Judiciary and Select Narcotics Committees, Shaw has been active in anti-drug legislation designed to address the narcotics problems in South Florida. In the 99th Congress, the Minority Leader appointed Shaw to the GOP drug task force and he is now its chairman. Shaw introduced the 1988 anti-drug bill, which included the death penalty for drug kingpins, creation of the drug czar, and use of the military for drug interdiction. He is also an advocate for drug testing of employees in the transportation industry and other industries where consumer safety is at stake.

In his position on the Subcommittee on Human Resources, he has opposed expansion of unemployment benefits and has successfully countered many of the Social Security amendments offered by former Chairman Downey. Cong. Shaw's legislative interests lie in drug abuse intervention, penalties for drug smuggling and the impact of public policy on senior citizens.

LEGISLATIVE INTERESTS

103rd: Cong. Shaw has sponsored H.R. 741 which would provide welfare families with education, training, job search and other services to prepare them to leave welfare within 2 years and to authorize states to conduct demonstration projects to help people leave welfare. He also sponsored H.R. 953, a Medicare provision helping small rural hospitals dependent on Medicare. Shaw has cosponsored a bill to improve the efficiency and accountability of the administration of Medicare (Pickle, H.R. 22). He is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN DON SUNDQUIST (R-TN): Congressman Sundquist chairs the Republican Study Group and may run for Governor of Tennessee. He has one of the most conservative voting records in the House.

Recent Developments: Following the President's speech, Sundquist told the AP: "I approach the health care debate with an open mind, though as a rule, the greater the government's role in running health care, the less comfortable I am."

POLITICAL PROFILE

Cong. Don Sundquist is known as a savvy and sure-footed politician. However, he over-reached his popularity in his failed attempt in the 101st Congress to unseat Guy Vander Jagt as chairman of the House GOP campaign committee. Many of his colleagues thought that he went too far in his criticisms of the committee's operations. His personal style is non-confrontational and he is a strong believer in party building. He is loyal to the Republican agenda and he supported the republican position on issues even when the political price was steep.

On the Ways and Means Committee, Sundquist has become interested in trade issues, especially those affecting the shoe industry and other industries in his district. Sundquist is a firm believer that many things the federal government does can be done better by local government or the private sector. Sundquist's legislative interests are in government downsizing, trade, and matters affecting rural areas.

HEALTH REFORM ISSUES/PRIORITIES

Sundquist's general health care views are not known. He believes in government downsizing and is concerned about matters affecting rural areas. In this Congress, he is a cosponsor of Michel's Health Care Reform Act and of legislation to improve the efficiency and accountability of Medicare. He has voted against reproductive rights.

LEGISLATIVE INTERESTS

103rd: Cong. Sundquist cosponsored legislation to improve the efficiency and accountability of Medicare (Pickle, H.R. 22), the Action Now Health Care Reform Act of 1993 (Michel, H.R. 101), and an amendment allowing separate Medicare billing for EKGs (Torricelli, H.R. 421). He is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSWOMAN NANCY JOHNSON (R-CT) - Congresswoman Johnson has used her seat on the Health Subcommittee to focus on Medicare, health, and child care.

Recent Developments: Congresswoman Johnson was one of the three Republicans responding to the President's speech. There has been some backlash among Republicans about the negativity of that response.

POLITICAL PROFILE

Cong. Nancy Johnson is sometimes seen on the periphery of the GOP for often voting with the Democrats, but she can also be partisan. Her tendency to vote independently, both in committee and on the floor, has made it difficult for her to get the committee posts she has sought. But in the 101st Congress, she became the first Republican woman ever to serve on Ways and Means, and she has earned praise for her efforts to craft a comprehensive package of child care initiatives. Her priority issues have been Medicare, health, child care, and trade. She was the author of the Republican alternative to the Family Preservation Act in the 102nd Congress.

She has been an active member of the '92 Group, a coalition of moderate Republicans, who worked on ways to set budget priorities and reduce the deficit. Johnson served as the co-chairman of the `92 group in the 100th Congress. In 1988, she joined Lowell Weicker in an effort to moderate the GOP's opposition to abortion rights and restore support for the Equal Rights Amendment in the party's platform.

HEALTH REFORM ISSUES/PRIORITIES

Congresswoman Johnson is well known for her concern about and advocacy for the insurance industry. She wants to be a player in the health care debate, but she is a high maintenance member with many priorities. More importantly, large commitments of time with her do not assure support.

In addition to her insurance industry sensitivities, she is a strong supporter of outcomes research. She seems to be leaning toward requiring the individual to obtain health care coverage, rather than requiring all small business to do so. Most recently, she suggested that we should all consider a mandate on companies with 50 employees and above and rely on an individual mandage for firms with fewer employees. Her husband is an oncologist, and she has said repeatedly that doctors are not the cause of the country's health care ills. As such, and because of her insurance industry impact concerns, she is adamantly opposed to insurance premium caps -- that will also guarantee savings from the provider community.

LEGISLATIVE INTERESTS

103rd: Cong. Johnson has cosponsored legislation to reauthorize the National Institutes of Health (Waxman, H.R. 4); to improve access to health insurance and contain health care costs (Michel, H.R. 101); to require State Medicaid plans to provide coverage of screening mammography (Vucanovich, H.R. 425); to expand research on breast cancer (Lloyd, H.R. 615); and to provide welfare families with the education, training, job search, and work experience needed to prepare them to leave welfare within 2 years (Shaw, H.R. 741). Johnson sponsored H.R. 2317 to amend the Internal Revenue Code with respect to treatment of long-term care insurance policies. She is a cosponsor of H.R. 3080, the House Republican leadership health care reform legislation.

CONGRESSMAN JIM BUNNING (R-KY): Congressman Bunning, a former professional baseball pitcher, is now part of Rep. Gingrich's hard-hitting conservative team. Bunning is a member of both Ways and Means and Budget.

While Bunning's health care views are not known, he is a strong protector of Social Security recipients and is anti-abortion.

POLITICAL PROFILE

People who watched Cong. Jim Bunning as a major league pitcher generally described him as a tough, stubborn competitor who hated to lose and never yielded an inch to an opposing batter. Those who have watched him in politics have observed the same characteristics.

As ranking member of the Ways and Means Social Security Subcommittee, Bunning has been a supporter of eliminating the Social Security earnings limit and of making the Social Security Administration independent of the Department of Health and Human Services.

He is anti-abortion.

LEGISLATIVE INTERESTS

103rd: Cong. Bunning has cosponsored bills to eliminate the Social Security earnings limit (Hastert, H.R. 300); increase access to mammography screening under Medicaid (Vuncanovich, H.R. 425 and H.R. 427); prevent misleading Social Security mailings (Jacobs, H.R. 978); and add AIDS as a communicable disease for immigration purposes (McCollum, H.R. 985). Bunning is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN FRED GRANDY (R-IA): Congressman Grandy calls himself a "knee-jerk moderate." Many believe he will run for the Senate at some point. Although Grandy voted against Family and Medical Leave, he remains a White House target on health care. Grandy left the Education and Labor Committee to serve on Ways and Means. Grandy is a member of the Health Subcommittee. He is regularly allied with business and against labor interests.

Recent Developments: After the President's speech, Grandy told the AP: "I think he did a very good job of outlining the opening bid. I think ... that everything is on the table as long as we don't shortchange universal access and cost containment. If there's going to be any philosophical debate, the Democrats are going to emphasize security while the Republicans are going to emphasize choice."

POLITICAL PROFILE

His primary focus was on the Agriculture Committee his first two terms; he joined Ways and Means in the third. He has worked hard to earn a reputation for intelligence, incisiveness and homework. His work on the House ethics committee has demonstrated his willingness to perform unpleasant duty for GOP leaders. Grandy votes with his party more often than the average Republican; he usually is allied with the Education and Labor Committee's more conservative Republicans opposing labor initiatives such as parental leave. Grandy also is an opponent of abortion.

HEALTH REFORM ISSUES/PRIORITIES

Congressman Grandy is someone most people like, respect, and frequently hold out hope that he will join cross over to a high priority Democratic issue. Generally, he brings himself to the edge of the cliff, but does not jump. Most recently, like Nancy Johnson, he has hinted that an employer-mandate bridge could be built. The trade-off might be the Administration laying off on insurance premium caps.

Other health issues of interest: Grandy believes too much money is spent in the last months of life and is concerned about coverage for self-employed individuals. He is an abortion opponent. In this Congress he has sponsored a bill to provide basic group health care benefits, and cosponsored Rep. Michel's health care reform bill and Rostenkowski's Medicare improvement program. He attended the February Republican meeting with the First Lady and has been attending Ira's breakfast meetings.

LEGISLATIVE INTERESTS

103rd: Cong. Grandy introduced a bill to provide universal access to basic group health coverage and provide incentives to make coverage affordable (H.R. 30). He cosponsored the health care reform bill by the Minority Leader's task force (Michel, H.R. 101); a "microenterprise" bill removing barriers in AFDC that prevent recipients from moving toward self sufficiency (Hall, H.R. 455); and legislation to provide welfare families with the education, training, job search, and work experience needed to prepare them to leave welfare within 2 years (Shaw, H.R. 741). Grandy is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN AMO HOUGHTON (R-NY): Congressman Houghton is a new member of the Ways and Means Committee. In this Congress he has introduced HR 196 -- a tax credit based health care reform bill. With support from his wife and sister, he has voted pro-choice. Houghton attended the Republic breakfasts with Ira and is considered a priority target by Congressman Bonior.

POLITICAL PROFILE

Cong. Houghton, a new member of Ways and Means, is a former CEO of Corning Glass Works and scion of one of the nation's wealthiest families, brings with him the conviction that government's fiscal affairs should be run like those of a corporation. Congressman Houghton stands to the left of the GOP Party line on a number of issues. He was one of 17 Republicans opposing a constitutional amendment to ban flag desecration and voted against repeal of Medicare Catastrophic. He opposes a balanced-budget amendment stating that it is Congress' responsibility to control spending. Congressman Houghton has been an active participant in the House Budget Committee's budget and deficit deliberations.

LEGISLATIVE INTERESTS

103rd: Cong. Houghton has introduced the Health Equity and Access Improvement Act (H.R. 196) which would provide tax incentives to improve health care access, expand rural health programs, create a new public health program for the near poor, preempt State anti-managed care laws and reform the small group health insurance market. Also, he has cosponsored the Republican Action Now Health Care Reform Act of 1993 (Michel, H.R. 101). Houghton is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN WALLY HERGER (R-CA): A new member of the Ways and Means Committee, Congressman Herger adds another solidly conservative voice. His health care views are not known but he has voted against abortion funding.

POLITICAL PROFILE

Cong. Wally Herger is a Northern California rancher who easily won election to the House in 1986 and held his Democratic district due to his friendly style, despite being a conservative. Herger was in his third term in the State Assembly when he first won his House seat, defying predictions of tough Democratic competition for the open seat.

He has served his constituents on the Agriculture Committee by protecting his district's fruit and nut growers, and loggers. This is his first session as a member of the Ways and Means Committee.

He opposes government funding of abortions.

LEGISLATIVE INTERESTS

103rd: Cong. Herger has cosponsored a health care reform bill (Hastert, H.R. 150) and a bill to revise the way of regulating diet supplements (Gallegly, H.R. 509). Herger is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN JIM MCCRERY (R-LA): Congressman McCrery is a member of the Republican Task Force on Health and the Wednesday Group. He is said to be supportive of the Heritage Foundation's tax credit proposal for health care. McCrery opposes abortion except to save the life of the woman.

POLITICAL PROFILE

Cong. Jim McCrery is a conservative Republican with a low-key approach. Although this is his first term serving on Ways and Means, he has been a member of the Budget Committee since his arrival in the House.

McCrery was first elected to the House as a Democrat in 1988, taking over the seat of his former boss, Cong. Buddy Roemer. He switched to the Republican Party in 1991; in 1992, he defeated former Cong. Jerry Huckaby in a reapportioned seat.

LEGISLATIVE INTERESTS

103rd: Cong McCrery cosponsored the Republican Leader's health care reform bill (H.R. 101), but as yet, he has not cosponsored H.R. 3080, the recent House Republican leadership health care reform bill.

CONGRESSMAN MEL HANCOCK (R-MO): Congressman Hancock represents southwest Missouri -- a solidly conservative area matched by his voting record. His health care views are not known but he has voted against abortion funding.

POLITICAL PROFILE

Cong. Mel Hancock, the oldest freshman member of the 101st Congress, favors privatization of all government activities. His district includes the region's industrial and commercial center with Kraft, Litton, 3M, Rockwell and Zenith as major employers. In the 102nd Congress Hancock pushed his bill creating tax-free savings accounts for parents and grandparents who are saving for college for their children and grandchildren.

He opposes government funding of abortions.

LEGISLATIVE INTERESTS

103rd: Cong. Hancock has cosponsored Health Freedom Act, which would establish provisions regarding the regulation of dietary supplements (Gallegly, H.R. 509); Action Now Health Care Reform Act, the Michel bill (H.R. 101); and Social Security Domestic Employment Tax Simplification Act, which would simplify the payment of employment taxes (Klug, H.R. 899). He is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN RICK SANTORUM (R-PA): Serving his second term, Congressman Santorum has already built a reputation as a bomb-thrower, and one who may get bored with the House. If so, he could run against Sen. Wofford in 1994.

Regarding health care, Santorum has said he believes companies should give employees $3,000 cash for deductibles and let insurance cover the rest. If health care reform is not enacted in this Congress, Santorum would use that issue against Wofford.

POLITICAL PROFILE

Cong. Rick Santorum arrived in the House in 1990 after a upset victory over seven- term incumbent Democrat Doug Walgren. Against the odds and with little support from the national Republican Party, Cong. Santorum assembled a volunteer organization of anti-abortion activists and young Republicans. Santorum focused attention on repeal of the Congressional pay raise, institution of the line-item veto, and limits on political action committee contributions.

Cong. Santorum's father was an Italian immigrant who was a clinical psychologist for the Veterans' Administration. He has long been involved in politics: working on campaigns while at Penn State; working for a state senator while getting his law degree at Dickinson; joining the Pittsburgh law firm that included former U.S. Attorney General Dick Thornburgh; staying active in Pittsburgh Republican politics; and then taking on Congressman Doug Walgren in 1990.

LEGISLATIVE INTERESTS

103rd: Cong. Santorum has cosponsored two health related bills of interest: the Action Now Health Care Reform Act of 1993 (Michel, H.R. 101) and the Responsibility and Empowerment Support Program Providing Employment, Child Care and Training Act which would authorize States to conduct demonstration projects to test welfare reform policies (Shaw, H.R. 741). Santorum is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

CONGRESSMAN DAVE CAMP (R-MI): Congressman Camp is a conservative member of the Ways and Means Committee and is on the Human Resources Subcommittee. Camp's health care views are not known but he has voted against abortion funding.

POLITICAL PROFILE

Cong. Dave Camp is considered a moderate who has also been known to take a hard line against tax increases and abortion. Dow Chemical's international headquarters and a Dow Corning plant dominate his district's economy and set the tone for its Republican politics. The city is surrounded by small, rural communities and farmland. Cong. Camp has made a commitment to focus on agricultural issues, as well as improving his district's roads and bridges. He also is on record as supporting a school voucher program.

He opposes Federal funding of abortions.

LEGISLATIVE INTERESTS

103rd: Cong. Camp is a cosponsor of H.R. 3080, the House Republican leadership health care reform bill.

DETAILED QUESTIONS AND ANSWERS

BASED ON DOCUMENT SUBMITTED BY

PETE STARK,

CHAIRMAN OF HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

SKEPTICAL ABOUT ADEQUACY OF FINANCING

QUESTION:

I am very skeptical about the adequacy of the proposed financing. The success of the entire package rides on the ability to achieve the very ambitious budget savings you have proposed for the public and private sectors. (Stark)

ANSWER:

- Mr. Chairman, let me assure you, the numbers add up. We can debate the policy underlying the numbers, but our arithmetic is solid.

- On the achievability of the health care savings we have budgeted for, I would point out that our bill gradually phases health care spending growth down to a level that approximates the growth in GDP -- as do bills that you and Cong. McDermott and other health care leaders have introduced. Our phase in schedule, I believe is one year faster than the Stark bill and one year slower than the McDermott bill.

- The President is very firm in his commitment to achieving health care savings. We are the only country on Earth that has not achieved affordability in health care. We owe it to the American people to make every effort to make our health care system as efficient as possible.

THE ROLE OF STATE GOVERNMENTS

QUESTION:

There is a great deal of concern about the fact that you plan to rely on State governments, rather than the Federal Government to implement health care reform. The Health Care Financing Administration has done a creditable job with Medicare. States' track record in the Medicaid program and with private health insurance is certainly not reassuring. Also private interest groups have greater influence at the State level than at the federal level. As a Congressman I am concerned about the impact that this may have on our accountability to our constituents for actions that 50 governors and legislatures are taking. How do you plan to address this? (Stark)

ANSWER:

- We recognize that State governments have struggled at times in many areas of governing, but we also think that in many cases they have experience and knowledge of their residents unique problems in areas where we do not.

- In our plan, we attempt to strike a balance between allowing for local flexibility, but at the same time providing for federal oversight protections.

- We will be establishing a Federal framework for budgets, quality standards, insurance reform and employer and individual requirements to purchase health insurance. We will be monitoring these to insure that we achieve what we are all most concerned about -- that all Americans receive quality, affordable health care.

NATIONAL VS. STATE-BASED PLAN

QUESTION:

Shouldn't reform be based on a national uniform plan, with Federal enforcement and opportunities for state-based alternatives -- rather than state-based plan with Federal oversight? (Stark)

ANSWER:

- I believe that our two approaches have much in common. We both would have national goals of universal coverage and cost containment. However, we believe that states should be allowed to meet these goals in ways that reflect their unique markets and demographic characteristics. Our plan assures that these goals are met through strong federal oversight.

- The many states that have already developed, and continue to develop, plans that reflect their unique characteristics and circumstances (such as Hawaii, Vermont and Washington) is indicative of the strong support and preference for state based programs.

SUSPICIOUS OF "MANAGED COMPETITION"

QUESTION:

I am suspicious of, and concerned about, the credibility of those urging reliance on untested theories of "managed competition." The structure of the plan relies on the creation of completely new bureaucratic entities (health alliances) with which there has been no experience. Can you comment on this? (Stark)

ANSWER:

- What we are proposing is not managed competition.
- It is a blended system which focuses on restructuring the existing health care market.
- We do have some experience with alliance type structures at the federal level in Federal Employees Health Benefits Plan and at the state level with CalPERS.

RISK ADJUSTMENT

QUESTION:

Everyone recognizes that our capacity to adjust premiums for risk is currently inadequate. How can you promise risk adjustments that will assure fair payment to health plans and adequate service to people at risk?

ANSWER:

- First, we can adjust for age, sex, and other demographic characteristics, and will do so. Furthermore, we expect to draw on surveys of plans' enrollees about their self-reported health status to make broad adjustments to reflect differences in overall health status across plans. Experts inside and outside the Administration believe these adjustments are doable in the short term.

- Second, we will require mandatory reinsurance for health plans to protect against high cost claims and cases. Reinsurance will be structured to provide plans protection, while retaining incentives for efficiency.

- We believe these measures will give plans adequate protection in the early years of the system -- reducing incentives to avoid high-risk patients and providing sufficient resources to care for these patients. But more is needed.

- Research over the last several years has demonstrated an improved capacity to adjust for risk, based on individuals' prior use of services. These efforts have been hampered by the lack of data on enrollee health status. Our quality assurance program will provide the data necessary to make these better adjustments to plan payments.

NATIONAL HEALTH [redacted] BOARD

QUESTION:

I question the need for, and utility of, an entirely new Federal bureaucracy under the aegis of the proposed National Health Board. The Department of Health and Human Services, and its Health Care Financing Administration, are not without flaws, yet you cannot find a private health insurance company which performs the functions of HCFA <u>with respect to Medicare</u> with lower overhead or fewer problems.

The Secretary and staff of HHS, perhaps with input from an advisory board of experts, are eminently capable of taking on the responsibilities of running a national health care system. Would you comment, please? (Stark)

ANSWER:

- I fully agree that HHS deserves much of the credit for the smooth operation of the Medicare program. As you point out, overhead costs are low and there are few problems in the system.

- Let me emphasize that I expect HHS to draw on that experience and play a significant role in implementing the President's plan. HHS will have the responsibility of handling a variety of important administrative functions which are key to making the program operate smoothly.

- The Board is key, as well, especially in its function of insulating controversial decisions from the political process.

SINGLE PAYER ADMINISTRATIVE COSTS LOWER?

QUESTION:

In pursuing this multi-payer approach, haven't you assured administrative costs will be higher than if you had chosen a single-payer reform?

ANSWER:

- Our plan does a great deal to reduce administrative costs in the health system. We require all plans to use a common billing and data collection system. We end the expensive and counterproductive practice of medical underwriting. We standardize health plan benefits. And we provide for a more streamlined process of purchasing coverage through Alliances. In short, we eliminate administrative costs that are duplicative and wasteful.

- Having said this, if the only function of health insurance was to pay claims, I would concede that the economies of a scale in a single payer are hard to beat.

- However, we are talking about a new generation of health plans that will not only assure coverage but improve the health care delivery system. Under reform, plans will not only pay bills, they will be held accountable for the cost and quality of care provided. This means plans must contract with providers, organize networks, and set up systems that monitor and continuously improve the quality and efficiency of services provided by their doctors and hospitals.

- These activitiies require personalized interaction between health plan and medical personnel at the community level, and as such, involve administrative costs beyond those required for merely processing claims. But they produce health care that is more coordinated, more appropriate, and more affordable. This is an investment worth making.

PREMIUMS CHARGED BY PLANS FOR MEDICARE BENEFICIARIES

QUESTION:

How will premiums charged by health plans to Medicare beneficiaries be determined? Will they be capped as a percent of the blended premium otherwise applicable to plan enrollees? (Stark)

ANSWER:

- We are still reviewing how these premiums will be determined.

- In doing so, we are looking at capping the premiums.

STATE WAIVERS

QUESTION:

What criteria would be used by the Secretary of HHS to evaluate whether States should receive the waiver to absorb all Medicare beneficiaries? How will the Secretary assure that Medicare beneficiaries are adequately protected under the State plan? (Stark)

ANSWER:

- HHS will be developing adequate protections, just as we do now, to ensure that Medicare beneficiaries are adequately protected.

- We have a lot of experience reviewing state plans and managing the Medicare program which we will utilize. We will also have the ability, under our plan, to collect new data, which we will evaluate carefully and incorporate into our protections.

MEDICARE UNDER GLOBAL BUDGETS

QUESTION:

Clarify the treatment of Medicare beneficiaries within alliance budgets. (Stark)

ANSWER:

- To the extent that Medicare beneficiaries choose to enroll in plans under regional alliances rather than under Medicare, we would expect that premiums for Medicare beneficiaries would fall within premium limitations of the alliance.

- We recognize that there are technical questions regarding the methodology for including premiums of Medicare beneficiaries within alliance premium limitations, and we are working on those technical questions.

- We would be happy to work with you in developing that methodology.

IMPLEMENTATION TIMELINE IS UNREALISTIC

QUESTION:

I believe that the time table for implementing this plan is absurdly optimistic. The Administration routinely takes 18 months to issue regulations for relatively simple changes in policy. This reform will not be simple. (Stark)

ANSWER:

- As we have learned from the thousands and thousands of letters received from people across the nation, families are desperately struggling to survive the status quo. We must move forward to address their concerns and provide real relief through reform as expeditiously as possible.

- That is why we have provided the opportunity for states who have been working on reform programs to come into our new system early. We also will provide for expedited review of state reform programs so that they can be up and running as soon as possible.

- In addition, we have provided for funding so that start up administrative duties and technical assistance can be available.

- Although we anticipate that some states will be ready sooner than others, no state must have their system ready before 1997.

- Clearly, the Congress will debate this aspect of our plan along with all the others. We want to express again our willingness to work closely with you. And we want to restate our own, and the Nation's sense of urgency that real access and affordability be achieved at the earliest possible date.

COST CONTAINMENT

QUESTION:

How are the cost containment approaches for Medicare spending and private health spending linked? Shouldn't a single, uniform, approach to cost containment be used? (Stark)

ANSWER:

- We agree that cost containment approaches must be linked -- we need to apply similar pressure on costs in both private and public sectors and avoid the excesses of cost shifting we have seen in the past.

- Under health reform, growth in Medicare and in private health spending will be linked since both will be budgeted at similar growth rates. We believe that, although the two sectors may use different approaches to cost containment, the critical linkage is that both are held to similar rates of growth.

  + Medicare's rate of growth will be slightly higher, primarily to reflect the fact that its population is growing faster.

- In fact, the payment methods used to achieve these rates of growth share certain similarities:

  + In its fee-for-service component, Medicare relies primarily on fee schedules and rate setting to achieve its reduced rate of growth. In its managed care program, Medicare makes capitated payments to plans and plans generally are responsible for providing benefits within that payment amount.

  + Similarly, the private sector will also use fee schedules in its fee for service plans, and capitated payments for its managed care plans.

COST-SHIFTING

QUESTION:

Won't the President's plan permit a significant differential to exist between Medicare and private plan payments to hospitals and physicians? Won't this differential blunt Alliances' ability to meet premium targets and shouldn't we assure that the current differentials be exacerbated?

ANSWER:

- An important principle in the design of the plan is that for the first time comparable standards for affordability and cost containment will be exerted in the public and private sector precisely to address the cost shifting problems that have arisen in the past.

- In fact, the plan uses the same phase-in schedule for cost containment for both Medicare and the private sector to assure that cost shifting is constrained.

LONG-TERM CARE PREMIUM UNFAIR

QUESTION:

If the long-term care home and community based initiative is an entitlement to States, rather than individuals, then isn't proposed $10/month premium imposed on Medicare beneficiaries unfair? (Stark)

ANSWER:

- We had considered charging a premium for the long-term care program.
- As you know, an important principle of our reform proposal is responsibility, and we are asking all Americans to contribute something toward their health plan coverage.
- Having said this, we realize that the structure of the long-term care benefit program is not the same as the other health benefits (e.g., it is not an insured program nor an entitlement to individuals) consequently the issue of a premium is still being reviewed.

INTERIM INSURANCE REFORMS

QUESTION:

What are the interim insurance reforms?

ANSWER:

- The interim insurance reforms which we would have in place pending full implementation include:
  - Prohibitions on insurers from terminating or failing to renew health insurance coverage for any insured person, except for non-payment of premiums or other strictly defined cause;
  - Restrictions on premium increases.
  - Minimizing preexisting condition limitations: insurers and self-insured employers plans are prevented from applying exclusions to new employees and their dependents who were insured within the 90-day period immediately prior to joining the employer.

    New employees not currently insured may have exclusions imposed for only six months.
  - Prohibitions on employers and insurers from reducing existing coverage for any medical condition or course of treatment if the anticipated cost is expected to exceed $5,000 in a year.
- To assure that health insurance is available during the transition for those who become unemployed or are otherwise unable to obtain coverage, HHS may organize a national risk pool.

MEDICARE "NOTCH"

QUESTION:

Your plan imposes a variety of changes on people when they turn sixty-five: their premium contributions will change, and their benefits will change. This creates, in effect, a "notch" that will be an enormous political headache for years to come.

I strongly recommend that the plan be amended to make the transitions at age 65 much less dramatic. This could be done either through a long-range policy to equalize benefits, or through policies that would encourage employers to continue their wrap-around coverage for their retirees. (Stark)

ANSWER:

- We agree that the plan would create a "notch" for people when they turn 65.

- We are looking at ways to minimize this problem, and we would be willing to work with you on ways to address that issue.

ELIGIBILITY FOR SUBSIDIES

QUESTION:

Should not the method for determining eligibility for low income subsidies be uniform across alliances, as these subsidies are funded using Federal funds? Similarly, should not the method for retroactive adjustment of payments to individuals be applied consistently? (Stark)

ANSWER:

- **Yes, the <u>methods</u> used by alliances for determining eligibility for subsidies will be the same across the country.**
- **Of course, the subsidy <u>amounts</u> will vary by family income and by the average premium for that family type in the alliance, which will differ to reflect differences in medical care costs across alliances.**

SCOPE OF BENEFITS UNDER THE GLOBAL BUDGETS

QUESTION:

The current plan may create an incentive to move individuals into the high cost-sharing plans since these plans would have lower premiums and thus be more likely to be below the premium target. This incentive could be substantially reduced by including the cost-sharing for covered services within the budgeted amounts. The current formulation also presumes that it will be possible to estimate the initial premium targets net of cost-sharing. This problem could be avoided by including cost-sharing within the initial budget targets. (Stark)

ANSWER:

- We do not agree with the assumption that the fee-for-service plan will always be the lower cost plan. Nor do we anticipate it will always be the high cost plan. Fee-for-service plans will need to adopt provider fee schedules that are consistent with the overall Alliance budget.

- We are intending for individuals to have some responsibility, through their cost sharing, for making decisions about their own health care and thus creating competition by the plans to not only provide reduced premiums, but also reduced cost-sharing.

SHIFT BETWEEN MEDICARE AND ALLIANCES

QUESTION:

Are beneficiaries allowed to switch back and forth between the alliance and Medicare, and if so, couldn't they be dumped back into Medicare as they go older and sicker and the plans increase their premium rate? (Ways and Means staff)

ANSWER:

- Measures are needed to assure beneficiary choice, while still protecting Medicare against adverse selection. There are a number of options under consideration, including limiting the number of times a beneficiary can elect into and out of Medicare.

- We welcome your views and suggestions.

COMMUNITY AND MIGRANT HEALTH CENTERS

QUESTION:

What does your health reform plan do for Community and Migrant Health Centers (C/MHCs)?

ANSWER:

- The President's health care reform plan affirms that C/MHCs are a successful model for providing primary care in underserved areas of urban and rural America.
- HHS has requested expanded funding for C/MHCs by $100 per year in FY 1995 - 1998 for new C/MHC delivery sites.
- Our plan continues direct project funding through categorical authorities (Section 330 and 329).
- The plan will offer designation to C/MHCs as "essential community providers." This designation will give special payment protections and access to capital to providers serving vulnerable populations. Under this provision, health plans will be required to contract with C/MHCs for at least 5 years and pay a rate no less than their Medicare rate.
- In addition, it provides new authorities to the Public Health Service to increase access in underserved urban and rural areas ($700 million in FY 1996). C/MHCs could apply for these funds, but it is also envisioned the funds could be used to build networks around other entities, including small rural hospitals, public hospitals, and individual providers.
- Expands the National Health Service Corps (NHSC) significantly ($75 million in FY 1996 and 5,000 new scholarships) and enacts a new set of strategies to redirect physician training to primary care specialties. C/MHCs often rely on the Corps for their primary care workforce.
- We anticipate that CHCs and MHCs will be likely partners in telemedicine networks with Academic Health Centers.

KEY INFORMATION:

The Community Health Center and the Migrant Health Center Programs (Sections 330 and 329, respectively) are funded through categorical grants to community-based organizations. C/MHCs provide comprehensive primary care services to vulnerable populations living in rural and urban medically underserved areas. Services are provided at 1,465 sites serving an estimated 6 million people in 1993. In FY 1991, 64 percent of those served by CHCs were non-white, including 31 percent black.

CHC funding in 1993 was $558.8 million, with an additional nearly $4 million for MHCs. In 1994, the CHC appropriation rose to $617.3 million, while the MHC funding remained consistent.

PRIMARY CARE TRAINING

QUESTION:

Is your plan to increase the number of primary care physicians and decrease the number of specialists, so as to achieve a 50-50 mix of training slots by the year 2000, excessive government regulation?

ANSWER:

- Any decisions made by the Secretary of HHS will be based on the recommendations of a non-governmental National Medical Education Advisory Board composed of private citizens, including practicing physicians, medical educators and consumers.

- Accreditation of training programs and the recruitment and selection of students will remain a totally private sector responsibility.

- We believe the benefits to consumers of a better balanced workforce far outweigh this minimal amount of decision-making on the part of DHHS.

OB/GYNS AS PRIMARY CARE PHYSICIANS

QUESTION:

Will OB/GYNs be included in the definition of primary care physicians?

Answer:

- Yes. Since OB/GYNs provide a significant amount of primary care in their care of women, we have decided to include them as primary care providers.

- We recognize that a portion of OB/GYN's services are specialty services, therefore it may be necessary to adjust our year 2000 goals on primary care-specialty mix (to 57 % primary care and 43 % specialists to compensate for the specialty component in OB/GYN).

BLOCK GRANTING OF PHS PROGRAMS?

QUESTION:

Does your health reform program expand block granting of PHS programs?

ANSWER:

- **No expansion of current block grants or new block grants are contemplated.**
- **All new public health spending is through project grants.**

COST OF NEW PUBLIC HEALTH INITIATIVE

QUESTION:

How much new net spending in public health will there be?

ANSWER:

- **The preliminary estimates released in mid-September call for new spending in FY 1996 of $3.0 billion and savings from new third-party payments to our grantees of $2.0 billion. We are further refining the estimates and evaluating the need for new spending.**

PREVENTION SCHEDULE IN BENEFITS PACKAGE

QUESTION:

How did we arrive at the prevention schedule in the benefits description of the plan?

ANSWER:

- The content and frequency of the clinical preventive services included in the core benefit package are supported by an extensive science base and are the recommendations of the US Preventive Services Task Force.

- This Task Force is a non-governmental expert body which uses scientific evidence to develop its recommendations. Their work is highly respected by clinical professionals and widely published in scientific journals.

- We recognize that there is not always universal agreement in medicine about the optimal time or frequency to screen for certain conditions. The plan addresses this by incorporating targeted screening provisions for those tests which must be left up to the clinical judgment of the physician and discussions with the patient.

- Therefore, as science advances, the National Health Board can update these recommendations to reflect the most effective way to prolong life and reduce disease.

SPENDING CONSTRAINTS ON MEDICARE/MEDICAID TOO TIGHT

QUESTION:

The spending constraints on Medicare are not politically feasible. (Stark)

ANSWER:

- The savings targets result from applying a limit on spending increases to the entire health care system. That limit approximates the growth in spending of GDP. This type and level of budget target has already been proposed in legislation authored by Cong. Stark, Cong. McDermott, and other health leaders in the Congress.

- We are applying a slightly higher budget target to Medicare than to the private sector, reflecting the fact that population growth in the Medicare population is higher.

- We have recommended a series of specific policy changes to achieve these spending levels. As you will see, a significant portion of the savings comes from extending the kinds of reconciliation changes that the Congress recently passed. Our savings proposals in these areas would begin as the effects of the recently enacted reconciliation bill are wearing off.

- Another category of savings is derived from retargeting and reducing special payments to offset graduate medical education and uncompensated care expenses.

- Finally, we are talking about applying these spending limits in the context of overall reform. As you know, projected Medicare spending in the absence of reform suggests $1.4 trillion in Medicare expenditures over the period we are discussing. Permitting such unchecked growth will be hard to defend, politically, and the burden on the federal treasury and the taxpayer will be problematic, as well.

WAYS & MEANS

Medicare Savings

How is it possible to accomplish $124 billion in Medicare savings without reducing the benefits of Medicare beneficiaries?

Medicare savings must be viewed in the context of overall health reform.

Without overall health policy reform we would oppose savings of this magnitude, because there would be no way to protect Medicare beneficiaries from serious risks of benefit reductions.

During the budget debate the Administration opposed an "entitlement cap" for this very reason. The cap would have forced reductions in the Medicare program -- whether or not we accomplish overall health care reform controlling private sector health care costs -- and whether or not beneficiaries could be protected.

In the context of health reform Medicare beneficiaries can be protected.

Health care reform will protect against two factors which now make it difficult to contain Medicare costs without hurting beneficiaries: cost shifting that results from uncompensated care and price pressures arising from the difference between private and public reimbursement rates.

Universal coverage will make it unnecessary for providers to look for ways to shift costs for uncompensated care to paying customers -- which includes Medicare as well as private insurance.

Controlling private sector health costs will bring public and private reimbursement rates closer together. By restraining the growth in spending on the private side, it is possible to restrain the growth on the public side while at the same time reducing the risk that providers will elect not to treat Medicare patients in favor of patients with private insurance.

The health plan will not reduce Medicare spending. It will only slow the rate of growth from three times inflation to twice inflation. In the context of universal coverage and corresponding private sector cost restraint, there is no reason why this reduction in the rate of growth should harm beneficiaries.

In contrast to other proposals, the Administration only supports Medicare savings of this magnitude in the context of health reform.

43 Senators voted for the entitlement cap without a corresponding cap in private health care costs, and without any assurances about the impact on Medicare beneficiaries.

Other health care proposals call for Medicare savings comparable to or greater than ours, but fail to meet the critical test of protecting beneficiaries because they fail to provide universal coverage (and therefore put an end to uncompensated care) or to

control private health care spending (and therefore reduce the differential between private and public reimbursement).

The Clinton Administration only supports Medicare savings of this magnitude in the context of health reform that removes these risks that beneficiaries will be hurt. The Chafee/Dole plan, in contrast, would result in comparable Medicare savings [$111 billion]. However, the Chafee/Dole plan would not guarantee cost controls in the private health care system and it would not guarantee universal coverage or expanded Medicare benefits.

Reform and Competition will reduce Medicare costs.

Competitive forces will reduce the cost of health care for people over 65 as well as for people under 65. With cost differentials of 300 percent between Miami and Wisconsin, there is much room for savings from competition.

Streamlined administrative procedures will reduce the costs to providers of caring for Medicare patients.

Health reform plan will specify detailed policies to achieve Medicare savings.

Unlike proposed "entitlement caps" which leave the difficult task of finding specific savings to be determined in the future, the health reform plan will propose specific policies to achieve $124 billion in savings over five years.

If Congress believes that other specific measures are more appropriate, we will work with Congress on designing alternative savings measures.

The Administration is firm on the amount of Medicare savings that are necessary. If the specific measures that are enacted fail to meet the projected spending levels, we are prepared to work with Congress on streamlined procedures to ensure that policies are put in place to achieve the spending targets.

Medicare savings will be used to provide new Medicare benefits.

Savings from Medicare will be used to finance prescription drug benefits and long-term care benefits for Medicare recipients.

Third Party Administrators

At your meeting with the Ways and Means Committee last week Congressman Jake Pickle asked you a question about the impact of health care reform on third party administrators (TPA's).

If he asks a similar question at the hearing, we would propose the following response:

Third party administrators will continue to play an important role under our health reform plan.

Business alliances will offer opportunities for third party administrators to play a creative role in developing a new market.

Providers who join together to form plans will often turn to third party administrators as well.

While the opportunities for third party administrators will change, they will continue to have a role under health reform.

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ENERGY AND COMMERCE COMMITTEE

Profiles of Members

9/23/93

CHAIRMAN JOHN DINGELL (D-MI)

Comprehensive health care reform would fufill a dream of Chairman Dingell, which his father championed before him. At some point in the hearing it would be a good idea to reflect on the possibility that his father's dream will become a reality.

In meetings he has expressed his view that the plan should guarantee universal coverage for acute care services with state flexibility to develop their own plans. He thinks the plan should also include cost containment, malpractice reform and coverage for preventive services including family planning.

After the President's speech, Dingell told the Washington Post: "It's the most enormous piece of legislation I've seen in my career."

His primary goal is passage of health care reform in this Congress. He is very attentive to jurisdictional challenges from other Committees and will be attentive to the relative roles of the Departments of HHS and Labor.

Cong. Dingell has not sponsored or cosponsored any health reform legislation in the 103rd Congress.

CONGRESSMAN HENRY WAXMAN (D-CA)

As Health subcommittee chairman since 1979 and the single most significant Congressman on health issues, he has initiated numerous bills to expand Medicaid coverage, and is responsible for virtually all key PHS legislation since 1980. Cong. Waxman is pro choice, strongly supports Public Health Service programs, but opposes block grants to achieve goals.

He is deeply concerned over the low-income subsidies, the choice of plans and providers, and suspicious of managed care for the poor.

Waxman led the fight in the House for the President's immunization initiative even though he was disturbed by financing the vaccine benefits through savings and was displeased, overall, by the final reconciliation measure. His impression of the Administration from reconciliation is that supporters are not treated as well as squeaky wheels. Over the past weeks we have been working closely with Waxman to address his concerns. While several important issues remain open -- particularly his concern that low income people should be enabled to participate in fee for service plans -- he has been increasingly supportive in his recent statements.

Recent Developments: On Sept. 3 Waxman told USA Today he did not feel health care could be enacted by the end of 1993. In identical comments to the Wall Street Journal and the Washington Post on September 8 and 9, he stated : "Some of the savings figures floated around may be unrealistic and politically unacceptable." In a Washington Times article on the First Lady, he said she had single handedly wooed and won the support of several members of his committee. He was also quoted as "concerned and a little skeptical" that Clinton can squeeze $238 billion from projected spending in Medicare and Medicaid.

Following the President's speech, Waxman told USA Today: "Most members are going to see that the framework...really does make a lot of sense." He also told them: "The plan is not perfect...Perhaps it's no one's first choice. But the President has skillfully woven a compromise that provides the blueprint we need to move forward." He also told The L.A. Times, "when all is said and done, some time next year, the alternatives are going to be pretty much the Clinton proposal and the goals it presents, or the status quo. . . . I can't believe those of us who say they'd prefer single payer will say they would rather see no reform" than the Clinton plan. He also said the President's greatest challenge in the days ahead "will be to resist efforts to abandon" the basic principles.

CONGRESSMAN PHIL SHARP (D-IN)

Congressman Sharp is a careful legislator with a doctorate from Georgetown and a moderate to liberal record in the Congress. In addition to the Energy and Commerce Committee, Sharp is a member of the Rural Health Care Coalition and the Mainstream Forum.

While he has not been particularly active on health care in the past, he has expressed an interest in being helpful to the Administration. He expects a tough reelection race next year. Sharp has voted pro-choice.

Recent Developments: Following the President's address, Sharp told the AP the plan "is profoundly important to Hoosiers and represents a most ambitious undertaking in terms of domestic reform." He wants to talk with constituents before his final decision on the package." He also told The Indianapolis Star, "All of us have to have coverage, and all of us have to contribute. In Indiana every month, we have 4,400 people who lose their medical insurance. . . . This debate is central to people's lives."

CONGRESSMAN EDWARD MARKEY (D-MA)

Congressman Markey has matured as a legislator and and is now known as a consensus builder, well-liked for consulting members of both parties on pending legislation.

As Chairman of the Subcommittee on Telecommunications, Markey's interest in health care relates to the role of telecommunications. He outlined that potential contribution in an extensive letter to the First Lady following her meeting with the Committee in March.

Rep. Markey has supported the single-payer approach to health care reform during the 102nd (Russo, H.R. 1300) and the 103rd (McDermott, H.R. 1200) Congresses.

CONGRESSMAN AL SWIFT (D-WA)

Congressman Swift recently announced he would not run for re-election -- a promise made during the term limit campaign in Washington State.

Swift's views on health care are not known, but he has been a supporter of reproductive rights.

CONGRESSWOMAN CARDISS COLLINS (D-IL)

Representative Collins chairs the Subcommittee on Commerce, Consumer Protection and Competitiveness, which will have jurisdiction over the insurance reform provisions of the health care package.

Collins introduced the Women's Basic Health Coverage Act of 1993, the Long-Term Care Insurance Standards and Consumer Protection Act, and the National Institute on Minority Health Act.

Recent Developments: At the July House Focus Group meeting, Collins raised concern about limiting malpractice awards to victims, the impact of the reconciliation bill on our ability to finance reform, specifically the use of Medicare and Medicaid savings for deficit reduction.

Rep. Collins has been a consistent supporter of the single-payor approach to health care reform during the 102nd (Russo, H.R. 1300) and the 103rd (McDermott, H.R. 1200) Congresses.

CONGRESSMAN MIKE SYNAR (D-OK)

Congressman Synar wants reform and to be helpful to the Administration. He is fiercely anti-smoking. He co-founded the Rural Health Care Coalition and co-sponsored bills to improve rural health services as well as access to basic health care services for needy children. He worked with Congressman Wyden to create the Stark-Gephardt compromise on health reform in the last Congress.

Synar wanted the plan to be marketed before release in order to garner public support. He is close to Gephardt, and will be influential in bridging the gap between liberals and the Conservative Democratic Forum.

Recent Developments: Synar told Congressional Quarterly on 9/4: "What this is all about is how we market the future to the American people... every generation has its opportunity to leave a lasting mark. This is it, folks."

In USA Today after the President's address, Synar said: "I think congressmen who don't get ahead of this debate are going to get run over." The Tulsa World said he had already traveled through his district to sell the plan. He said, "I am particularly committed to ensuring the rural needs of my district are served by this reform package."

CONGRESSMAN W.J. "BILLY" TAUZIN (D-LA)

Congressman Tauzin is known as a coalition builder on the Energy and Commerce Committee, most notably forging a compromise that facilitated the passage of the Clean Air Act. On issues not related to gas and oil, he is often a key swing vote, reluctant to take sides early on and eager to negotiate.

On health care issues, the Congressman is very concerned about the cost of prescription drugs for Medicare and Social Security beneficiaries. He notes that estimates indicate 30-35% of Louisianans are uninsured, and is concerned about rationing. Tauzin is protective of small business employees, and will likely oppose an employer mandate. He is anti-choice. He also favors tort reform.

Although known to oppose global budgets, Rep. Tauzin has not sponsored or cosponsored any health reform legislation in the 103rd Congress.

CONGRESSMAN RON WYDEN (D-OR)

The former executive director of Oregon's Gray Panthers, Congressman Wyden is an ardent advocate for the interests of the elderly. He serves on both Small Business and Energy and Commerce where he is a close ally of Chairman Dingell. A team player, Wyden is also close to Congressman Waxman and may be willing to serve as a broker a between liberals and conservatives.

Congressman Wyden is an enthusiastic supporter of Oregon's health care reform demonstration program. He is a strong proponent of abortion rights Wyden was a major sponsor of legislation to constrain the costs of drugs sold to Medicaid patients, and recently backed a bill to establish a process to provide reasonable prices for drugs, devices and other products receiving NIH funding. In the 103rd Congress, he reintroduced a bill to establish Federal standards for long-term care insurance policies.

Recent Developments: In September Wyden told the New York Times that he welcomed cuts in Medicare and Medicaid but that they should not be used to pay for new programs. Discussing the multiple committees involved, Wyden told USA Today on September 22: "This has got to stop virtually everywhere on the legislative gauntlet."

After the President's speech he said, "There is no question that health care costs are rising too quickly, and too many Americans are uninsured. But I find it very hard to believe that increasing government's role will make health care, or for that matter anything, cheaper and more accessible. Good speechmaking does not make good policy."

Rep. Wyden has not sponsored or cosponsored any health reform legislation in the 103rd Congress. In the last Congress he sponsored a bill to certify fertility clinics (PL# 102-493). He has sponsored a bill to establish a process to provide for reasonable prices for drugs, devices and other tangible products developed with NIH funding. He also reintroduced his bill to establish Federal standards for long-term care insurance policies and cosponsored the President's immunization initiative.

CONGRESSMAN RALPH HALL (D-TX)

Congressman Hall's voting record reflects the rural conservative area he represents. Fiscally conservative, he often votes with the Republicans, as he has done this year in voting against the Administration on all three economic policy votes, particularly on fiscal issues or on controversial matters such as funding for AIDS .

He is a member of the Rural Health Care Coalition and is opposed to employer mandates and cost controls on providers. He is also anti-choice. Hall is sympathetic to physician concerns and supports improvements in organ transplantation. He is close to Chairman Dingell. While it is highly unlikely that Hall will vote for the final package, he might be persuaded to vote for it in committee to get it to the floor.

In the event cost controls are included in health care reform he would urge that other incentives be included to attract providers. While he isn't one of the committee's more active health members, when he decides to weigh in on an issue his political insight and relationship with Chairman John Dingell give him considerable influence.

Rep. Hall has not sponsored or cosponsored health care reform legislation in the 103rd.

CONGRESSMAN BILL RICHARDSON (D-NM)

While considered a liberal Democrat, on the Energy and Commerce Committee Congressman Richardson is seen as a centrist, business-oriented vote. Given his leadership position, Richardson will probably be supportive on health care reform, but he also has a reputation for unpredictability so he will need continuing attention.

Richardson served on the Select Committee on Aging and brings those concerns to the health care debate. He is a strong advocate of Indian, as well as Hispanic, health care interests. Other health related issues with which he is identified are women's health, alternative therapies (which are popular in his district), malpractice reform, and rural access. A Roman Catholic, he has voted pro-choice.

Richardson wanted the plan to be announced after Labor Day and was a supporter of the Health Care University.

Richardson sponsored amendments to the FY94 budget reconciliation bill to expand Medicare payments to occupational and physical therapists, psychologists, rural nurse practitioners and physician assistants.

Recent Developments: Richardson told the AP after the President's speech that he was concerned whether New Mexico's rural areas would be able to operate in a managed competition system. He also said, "The plan has enough incentives to give small business a realistic opportunity to participate, but maybe we can improve on it."

CONGRESSMAN JIM SLATTERY (D-KS)

Congressman Slattery is a moderate to conservative Democrat who has been willing to buck the leadership in order to reduce the budget deficit. In addition to Energy and Commerce, Slattery is a member of the Veterans' Affairs and Banking Committees, the Rural Health Care Coalition and the Mainstream Forum. In the 100th Congress, he was part of the committee's "group of nine" which tried to work with all sides on the Clean Air Act. Moderate conservatives look to him for leadership.

Health care is one issue on which Slattery has indicated a willingness to spend more federal dollars. He has sponsored or cosponsored bills to expand Medicaid coverage to poor children, to improve rural access to health care, and to improve the availability and affordability of health insurance for small businesses.

In the current health care reform debate, Congressman Slattery is concerned about states and state flexibility, especially with respect to cost containment. He is also very concerned about a payroll tax, and wants coverage for pregnant women, children, and rural areas. Slattery has suggested limiting the deduction for tobacco advertising.

While he wants to support the Administration on health care reform, he is strongly anti-choice and might oppose the final package if reproductive rights are included.

Recent Developments: Slattery announced on September 8 that he will not run for re-election. It is rumored that he is considering a race for the governorship.

Slattery told the AP following the President's speech: "I want to give the President a lot of credit for tackling what I consider the most complex domestic problem we have faced in 50 years."

The Wichita Eagle described Slattery's role: "Slattery will wear two big hats during the health-care debate. First, he belongs to two pivotal committees: the House Energy and Commerce health subcommittee, which will write the bulk of the reform package, and the Veterans' Affairs Committee, which oversees veterans' health-care concerns. Second, he is running for governor of Kansas, and health-care reform will put new burdens and responsibilities on the states.

He also told that paper after the speech: "There may be some kind of mandate necessary on small business, but I can't go along with the kind of mandates that are being recommended. . . . That's really excessive for some small businesses."

Slattery has not sponsored or cosponsored health care reform legislation in the 103rd.

CONGRESSMAN JOHN BRYANT (D-TX)

Congressman Bryant is a loyal Democrat and populist who believes strongly in the need for health care reform. While he will be concerned about costs, his number one priority will be access. Bryant is close to Congressmen Dingell and Waxman.

Rep. John Bryant can be considered one of Texas' most loyal Democrats. In fact, only one other member of the State's delegation voted against President Bush more often in 1990. However, he is not a liberal, instead a strong-willed populist with political ambition.

Access is his number one priority in health and although he is concerned about costs, he is more concerned about universal coverage. He has made it known that he is poised to do whatever it takes to assist President Clinton is passing his health reform package.

Bryant sponsored legislation to direct the Secretary of HHS to make grants for the Federal share of the cost of community outreach services and services for children of substance abusers, including comprehensive services for the entire family (H.R. 3796). Rep. Bryant cosponsored the Family Planning Amendments of 1991 (Waxman, H.R. 2343); the Drug Testing Quality Act (Dingell, H.R. 33); the Medicaid Infant Mortality Amendments of 1991 (Collins, H.R. 290).

Rep. Bryant has not sponsored or cosponsored health care reform legislation in the 103rd.

CONGRESSMAN RICK BOUCHER (D-VA)

Congressman Boucher is a lawyer and former McGovern advance man with one of the most liberal voting records in the Virginia delegation. On the Energy and Commerce Committee, Boucher played an important role as a member of the "group of nine" in the 100th Congress -- a caucus of moderate-to-conservative Democrats who tried to end a Clean Air stalemate between pro-industry and environmental factions. Boucher also serves on the Judiciary Committee and is a member of the Rural Health Care Coalition and the Mainstream Forum.

On health care matters, Boucher will be concerned about black lung disease. He will be opposed to a tobacco tax as shown by his co-signing the March 10 letter regarding tobacco excise taxes. He has voted pro-choice. Tobacco politics is likely to determine whether or not Boucher will be a supporter.

Rep. Boucher has not sponsored or cosponsored any principal health reform legislation in the 102nd or 103rd Congresses.

JIM COOPER (D-TN)

As you are well aware, Rep. Cooper plans to introduce his own bill next week. This is consistent with his history as a Member who has been instrumental in forging compromises on the Energy and Commerce Committee.

Last term he was chosen to be the lead spokesman for the Conservative Democratic Forum's health care bill which was based Jackson Hole Group model. He advocates reform without significant government intrusion, opposing price controls or the extension of Medicare rates to private insurance. He questions whether Congress has the courage to pass a global budget restricting private sector growth and believes that even if passed, it would not be enforced. He is concerned about employer mandates and prefers a voluntary approach to expanding coverage.

On June 2nd, Congressman Cooper sent a memo to his constituents interested in health care reform. It was notable more for its negative tone than its substance. At meetings he has praised the White House for the attention given to Tennessee and its new health care reform proposal, but expressed his concern that the White House is disavowing managed competition.

He believes that the health care reform package should phase in the parts people agree on but hold off on employer mandates and enforceable budgets. He also does not believe abortion should be in the package.

Recent Developments: On September 3, Cooper told USA Today that months of hearings would be needed on health care reform. Since then, Cooper has been publicly critical of the administration plan, noting in particular his opposition to employer mandates and global budgets. He told the Wall Street Journal on September 12 that the plan "makes both conservatives and liberals unhappy...You can't have a sausage product when it comes to health care."

Cooper told USA Today after the President's address: "The public's going to keep us on a short leash on this one." A September 24 wire service story quotes him as calling the employer mandate a "clumsy and expensive" way to get universal coverage.

Cooper told the AP: "President Clinton took managed competition and went to the left. The Republicans took it and went to the right. We're still squarely in the middle." He said his plan does not include any new taxes and that they aren't necessary. "We don't have to raise new taxes. We can get the money from savings in the current plan." On cigarette taxes he said: "We've got to find a way to deal with the No. 1 cause of preventable death in America. But we couldn't put (a cigarette tax) in our bill and attract regional support...but I think it will be added by others." He also said "I'm against employer

mandates, global budgets, bureaucratic price controls and unfunded new entitlement programs. He applauded Clinton's courage and looks forward to working with the White House "to gain the backing of moderates in both parties."

CONGRESSMAN ROY ROWLAND (D-GA)

Congressman Rowland is a key player on health care reform not only because he is a physician and respected southern Democrat, but because he will be a point person for veterans, rural areas, and small business. He one of only two physicians in the House. Dingell and Waxman rely heavily on Rowland's credibility as a physician and as a go-between for committee moderates and liberals. He is an astute, knowledgeable politician and a key Southern ally for the Democratic leadership. He has served on the National Commission to Prevent Infant Mortality. Rowland is also close to Rep. John Lewis.

Rowland has sponsored three health care related bills this year: (HR 862) the "Long-Term Care Insurance for the Elderly Act" to benefit individuals earning less than $45,000 annually by providing for tax-free withdrawals from IRAs to purchase health insurance; (HR 1770) the "Rural Physicians' Incentives Act" to provide qualified medical education loans to physicians for underserved rural areas and to extend deferments of Federal student loans for rural physicians; and (HR 1771) the "Rural Access to Obstetrical Care Act" to start state demonstration projects to improve access in rural areas. He is a strong supporter of preventive health care for children and high-risk mothers.

Rowland is opposed to mandates. In past legislation, he has authored "anti-hassle" bill to reduce Medicare red tape.

Recent Developments: After the President's speech he told The Atlanta Constitution, "[The President] talked about a lot of things that I agree with. But I'm uneasy about creating another large federal program when we don't have a way to pay for it and it could be worse than what we have now."

Rep. Rowland was a key broker behind the scenes on the Clean Air bill and Chairman Dingell named him to the conference committee on the bill. Most of his legislative interest, however, lies in health care issues. He has a special interest in reducing infant mortality, drug addiction, AIDS, community health centers, and in issues that affect physicians.

Rowland has supported legislation to provide relief to physicians from burdensome Medicare regulations (H.R. 2695). He has also cosponsored the Medicare Physicians Payment Reform Amendments (Stark, H.R. 3070).

Rep. Rowland has not sponsored or cosponsored health care reform legislation in the 103rd.

CONGRESSMAN THOMAS MANTON (D-NY)

Congressman Manton is considered a "leadership loyalist" and obtained his seat on Energy and Commerce by carefully courting Chairman Dingell. Manton served on the Select Committee on Aging. Manton is a lawyer and former policeman. He is Roman Catholic and votes anti-choice.

Rep. Manton has been a consistent supporter of the single-payer approach to health care reform during the 102nd (Russo, H.R. 1300) and the 103rd (McDermott, H.R. 1200) Congresses.
Recent Developments: At an August focus group meeting, Manton voiced his support for a comprehensive benefits package.

At an August focus group meeting, Manton voiced his support for a comprehensive benefits package.

CONGRESSMAN ED TOWNS (D-NY)

Congressman Towns is a liberal who is loyal to the leadership of his committee. In the past, Towns has co-sponsored a number of bills dealing with women's health interests, including research, Medicaid benefits for breast and cervical cancer, and mammography. He is a McDermott co-sponsor in this Congress. He believes in the need for a uniform record-keeping process.

Cong. Towns is the immediate past chairman of the Congressional Black Caucus.

LEGISLATIVE INTERESTS

102nd: Rep. Towns sponsored a bill in the last Congress to expand Medicaid to cover alcoholism and drug dependency residential treatment (H.R. 2489) and one to expand Medicaid coverage for substances abuse treatment for pregnant women and caretaker parents (H.R. 6132). Rep. Towns cosponsored bills to revitalize NIH (Waxman, H.R. 4); the "gag rule" from family planning grantees (Porter, H.R. 392) and the Family Planning Amendments Act (H.R. 2343). Rep. Towns also cosponsored several women's health bills.

103rd: Rep. Towns is a cosponsor of the House "single-payer" bill to provide health care for every American and to control the costs of the health care system (McDermott, H.R. 1200).

Immunization: Rep. Towns cosponsored the Comprehensive Childhood Immunization Now Act of 1993 (Waxman, H.R. 940) but on some issues supported the position of the vaccine manufacturers.

CONGRESSMAN GERRY STUDDS (D-MA)

While Congressman Studds has not been particularly active on health issues, he has cosponsored legislation to revitalize NIH, revise orphan drug provisions, improve Federal funding for women's health research, increase Medicaid coverage for HIV-related services, and improve Medicare's basic health care services for children. Studds is a cosponsor of Congressman McDermott's single-payer bill. While Studds recognizes that compromise will be required to get health care reform passed, his support should not be taken for granted.

LEGISLATIVE INTERESTS

102nd: Rep. Studds cosponsored single-payor reform legislation (Russo, H.R. 1300). He introduced legislation to revise the orphan drug exclusivity provisions of the FD&C Act (H.R. 3930 and H.R. 4959).
Studds also cosponsored bills to revitalize NIH; (Waxman, H.R. 4); to improve Federal funding for women's health research (Schroeder, H.R. 1161); to give States the option of providing coverage for HIV-related services for individuals diagnosed as HIV-positive (Scheuer, H.R. 1394); improve access to basic health care services for needy children (Slattery, H.R. 1392); and to permit separate payments for EKG interpretations (McMillan, T., H.R. 3373).

103rd: Rep. Studds has cosponsored single-payor reform legislation (McDermott, H.R. 1200).

CONGRESSMAN RICHARD LEHMAN (D-CA)

Congressman Lehman will have a very tough fight in 1994. He voted against the Administration on deficit reduction and the budget.

In February, Lehman wrote to the First Lady explaining the health care problems of the rural areas of his district, specifically underserved farmworkers. Other issues included: malpractice reform; fair reimbursement for urban and rural areas; health care as an undue burden on small business; duplication of services; local health networks providing preventive and primary care; and concern that managed competition would not work in rural areas.

Recent Developments: After the President's speech he told The Fresno Bee, "It's better than a good start -- an awful lot of thought has gone into it (but) it's going to be substantially changed just by the way we do business here."

Congressman Lehman has not sponsored or cosponsored any significant health reform legislation in the 102nd or 103rd Congresses.

CONGRESSMAN FRANK PALLONE, JR. (D-NJ)

Representing a Republican district Congressman Pallone is generally a fiscal conservative and a supporter of the Conservative Coalition in Congress. A recent Energy and Commerce appointee, Pallone has not developed much of a record on health care issues. Pallone voted against the Deficit Reduction Bill.

While Pallone was a single payer co-sponsor in the past, he has not done so this year. Pallone wants prescription drugs covered by reform, and believes that cost containment is essential. He did, however, cosponsor Porter's Title X Pregnancy Counseling Act, and Regula's Comprehensive Preventive Health Program for Medicare Beneficiaries. A longtime opponent of abortion, he changed his stance in the wake of Webster.

Rep. Pallone was one of those who felt strongly about having a health care university.

CONGRESSMAN CRAIG WASHINGTON (D-TX)

A new member of the Energy and Commerce Subcommittee on Health, Congressman Washington is an outspoken liberal who can be unpredictable, as when he voted against the compromise civil rights bill in the last Congress.

While his general health care views are not known, as a state senator he was responsible for passage of the first legislation in Texas to provide funding for the education and treatment of AIDS. He will probably center his concerns on children, minority and urban health matters. Washington attended the First Lady's March meeting with the CBC. His significant other is a general practitioner.

Recent Developments: On Sept. 6, Washington told the Washington Times that he felt the plan was flawed because: "He is talking more to doctors, hospitals, and insurance companies. That's where the problem is."

Rep. Washington has cosponsored the single-payor approach to health care reform (McDermott, H.R. 1200) and the Comprehensive Child Immunization Act of 1993 (H.R. 1640).

CONGRESSWOMAN LYNN SCHENK (D-CA)

Freshman Congresswoman Schenk campaigned hard to win with 51% in a Republican leaning district.

Schenk's health care concerns include: women and children; mental health coverage; and protecting choice of provider. Her district includes a number of biotech industries and she wants to see them protected. A strong pro-choice supporter, Schenk signed the May 13 letter regarding the importance of including abortion coverage in the health care package.

Rep. Schenk has not sponsored or cosponsored any health reform legislation in the 103rd Congress.
103rd Congress.

CONGRESSMAN SHERROD BROWN (D-OH)

Freshman Congressman Brown lobbied hard for a seat on Energy and Commerce in order to pursue his interest in health care reform. He has pledged to pay for his own health care, rather than use the Congressional coverage, until a national health care program is in place. He has indicated his desire to be helpful to the Administration on health care reform.

As a follow-up to a March meeting with the First Lady, Brown wrote to her about his concern that the health reform proposal "emphasize preventive and cost-effective health services," investing in immunization, pre-natal and well-baby programs in particular. Brown campaigned for abortion rights. He is a supporter of home-based long-term care services as a cost-effective alternative to institutionalization.

As a freshman member Brown has not sponsored health care reform legislation in the 103rd.

He cosponsored the Comprehensive Child Immunization Act of 1993 (Waxman, H.R. 1640)

Recent Developments: In a Sept. 1 AP Wire story, Brown praised the President for tackling the health care issue but stated he felt "the task force is headed in the wrong direction... regulating the economy and eliminating people's freedom to choose is not an effective way to tackle the health care crisis."

CONGRESSMAN MIKE KREIDLER (D-WA)

Freshman Congressman Kreidler comes to Congress with a strong background in health care both in the state legislature and as a practicing optometrist who worked for 20 years in a managed care system. Kreidler holds a Masters Degree in Public Health. He would like to see a bold system which moves toward a single-payer approach.

In March, he wrote to the First Lady recommending that the Task Force include universal coverage, expenditure limits, and state flexibility. He also stated his desire to be helpful in whatever way appropriate. Kreidler serves on the Veterans' Affairs Committee and was in the Army Reserve for 20 years.

He has not cosponsored any health reform legislation but he did cosponsor the Comprehensive Childhood Immunization Act of 1993 (H.R. 1640).

Recent Developments: On August 4, Kreidler commented to the AP on health care reform "it is time for the Federal government to lead or get out of the way."

CONGRESSWOMAN MARJORIE MARGOLIES-MEZVINSKY (D-PA)

Congresswoman Margolies-Mezvinsky is finding that her courageous vote on final passage of the budget has brought her more respect and less criticism than anticipated in her district.

On health care, the Congresswoman's particular concerns are children and child welfare, education, and issues related to families. She was the first unmarried American to adopt a foreign child and at one time or another she has had 11 children growing up in her household. She has said she wants to be involved with the Administration on health care, but given her budget vote, we may not be able to push her very hard.

Rep. Margolies-Mezvinsky has not sponsored or cosponsored any health reform legislation in the 103rd Congress.

Recent Developments: In her reaction to AP following the President's address. Margolies-Mezvinsky said that improvements were needed in women's health services, such as the availability of mammograms and that small employers could be "socked in a way they wouldn't be able to handle."

CONGRESSWOMAN BLANCHE LAMBERT (D-AR)

Congresswoman Lambert advocates greater access to affordable health care, especially in rural areas. In meetings with the First Lady and Ira, Lambert has voiced concern about waste in the system, the chronically ill, reducing overall health costs, and educating the public about those costs.

Congresswoman Lambert has not sponsored or cosponsored any health reform legislation in the 103rd Congress.

Recent Developments: Lambert told the AP after the President's address that "everyone realizes there has got to be health-care reform in the nation...(lawmakers) want to work hard to craft a package that's affordable and allows people a choice for health care...They (the Administration) were blatantly honest that this was not the end-all and be-all. This was the beginning." She said she would push a way "to give doctors incentive to come into rural settings. We have to look at ways to put incentives into preventive care. It's cheaper."

CONGRESSMAN CARLOS MOORHEAD (R-CA)

Moorhead is the ranking Republican on the Committee and is one of the most conservative members of the House. Despite that, he does cooperate with Democrats, most notably on energy policy. He also serves on the Judiciary Committee.

Moorhead is a member of the Republican Task Force on Health. In a February meeting with the First Lady he discussed the need to cover part-time and temporary workers. He did not believe employers should be taxed on health care benefits. Moorhead has a pro-business philosophy and votes against reproductive rights. His low key style may mean he will not play a major role in opposing the Administration on health care.

Congressman Moorhead is a cosponsor of the Republican leadership health care reform bill (Michel, H.R. 3080).

CONGRESSMAN THOMAS BLILEY JR. (R-VA)

A soft-spoken former mortician, Congressman Bliley serves on the Republican Task Force on Health and is the most active Republican on Energy and Commerce health issues. He is the ranking Republican on the Health Subcommittee where he and Rep. Waxman have clashed often on tobacco-related legislation. Bliley is known as the tobacco industry's "sentry" on the subcommittee.

As a senior member of the Committee, he will likely be the first member to raise the issue of the tobacco tax.

On health care, Bliley is interested in preventive medicine and maternal and child health care. He supports cost controls on hospitals and procedures. He occasionally votes with the Democrats to increase health services for African Americans, especially maternal and child health care. He has not sponsored or cosponsored any health care reform legislation in this Congress. Bliley attended the February Republican meeting with the First Lady and has attended Ira's breakfast meetings.

Rep. Bliley cosponsored bills on FDA debarment (Dingell, H.R. 2454); drug testing (Dingell, H.R. 33); to require physicians to disclose their HIV status to their patients (Dannemeyer, H.R. 2788); family planning parental notification (Dannemeyer, H.R. 1397).

Rep. Bliley is a cosponsor of the Republican leadership health care reform legislation (Michel, H.R. 3080).

Recent Developments: Bliley reacted to the AP after the President's speech as follows: "Clearly reforms are necessary, but I am unsure if his plan provides all the answers or if it will work. How does the President pay for his plan? How will government mandates on employee coverage affect workers and their jobs in a weak economy...President Clinton's cost estimates for his plans are questionable at best."

CONGRESSMAN JACK FIELDS (R-TX)

Congressman Fields is an activist conservative who has concentrated his efforts on Energy and Commerce in the areas of oil and natural gas.

Fields supports protections for physicians and hospitals, funding for teaching hospitals and medical school research. In addition, he has a record of voting against reproductive rights.

Congressman Fields is a cosponsor of the Republican leadership, health care reform bill (Michel, H.R. 3080).

CONGRESSMAN MIKE OXLEY (R-OH)

Congressman Oxley is a conservative and regular opponent of regulation and control on the Energy and Commerce Committee.

He has voted against reproductive rights.

Rep. Oxley is a cosponsor of the Republican leadership health care reform bill (Michel, H.R. 3080).

CONGRESSMAN MICHAEL BILIRAKIS (R-FL)

Congressman Bilirakis has had some tough re-election fights and has said he will retire in 1994 if he has no major legislation pending. He serves on both Energy and Commerce and the Veterans' Affairs Committees as well as the Republican Task Force on Health.

He has cast key votes on health in the past -- against catastrophic in 1988, for increased federal elderly home care funds, and for drug discounts for the VA and other federal purchasers. He is opposed to abortion.

Bilirakis was a registered Democrat until 1970. He was active in local campaigns but did not run for public office until 1982. He generally votes along party lines but places his highest priority on constituents' needs. He is particularly concerned about elderly issues. More than a third of the people in his district are over 65.

Rep. Bilirakis introduced a health care reform bill which included tax credits, risk pools for the uninsured, administrative reforms, and malpractice reforms (H.R. 3951). He cosponsored bills to: provide special payments to hospitals with large Medicare caseloads (Shaw, H.R. 827); relieve physicians of Medicare's paperwork burdens (Rowland, H.R. 2695); and to regulate mammography screening facilities (Dingell, H.R. 5938). Rep. Bilirakis has cosponsored both versions of the Republican leadership health care reform bill (Michel, H.R. 101, H.R. 3080).

Rep. Bilirakis has cosponsored both versions of the Republican leadership health care reform bill (Michel, H.R. 101, H.R. 3080).

CONGRESSMAN DAN SCHAEFER (R-CO)

Congressman Schaefer is a former state legislator who reflects the conservatism of his suburban Denver district.

Rep. Schaefer is a cosponsor of the Republican leadership health care reform bill (Michel, H.R. 3080). He has voted against abortion rights.

Recent Developments: On August 30, Schaefer stated publicly that he wanted to be heavily involved in health care reform and did not want to reduce the overall quality of the present system.

CONGRESSMAN JOE BARTON (R-TX)

A conservative with a heavily Republican Ft. Worth and Dallas suburban district, Congressman Barton's major goal is continuation of the Supercollider. He serves on both Energy and Commerce and the Science Committees.

Cong. Barton is a cosponsor of the Republican leadership, health care reform bill (Michel, H.R. 3080). He has voted against abortion.

CONGRESSMAN ALEX McMILLAN (R-NC)

Conservative but pragmatic, Congressman McMillan has become a key ally of the House Republican leadership.

McMillan has been a leader on the House Republican Task Force on Health studying health care reform. He co-sponsored the House Republican health care reform bill, which has been reintroduced in the 103rd. He led the subgroup examining administrative reforms in health care and cosponsored a separate health care administrative reform bill. He also has introduced malpractice reform legislation. There are a substantial number of insurance companies headquartered in his district. A former businessman, he consistently opposes Federal mandates on business.

He voted against an increase in the minimum wage and against the family leave bill. McMillan has a 90-95 percent voting record in support of the Conservative Coalition in the Congress.

In the last Congress, Rep. McMillan cosponsored the House Republican health care reform bill, (Michel, H.R. 5323). He has also introduced malpractice reform legislation (H.R. 3857).

Rep. McMillan is concerned that the the Administration health reform plan approach will lead to monopoly plans and providers. He has cosponsored both versions of the Republican leadership health reform legislation (Michel, H.R. 101; H.R. 3080).

CONGRESSMAN J. DENNIS HASTERT (R-IL)

Congressman Hastert was selected by House Minority Leader Michel to be his point person on health care reform. Hastert's appointment was a surprise, considering that he is only in his fourth term in the House and his second term on the Energy and Commerce Committee.

While Hastert, an evangelical Christian, is a staunch conservative, he is willing to offer proposals and be a part of the process. Since his election in 1986, Hastert has easily won reelection each time.

Congressman Hastert has sponsored his own "Health Care Choice and Access Improvement Act" (HR 150), which would reform the small group insurance market, increase the tax deductibility for the self-employed, and allow employers to establish tax-free Medi-Save accounts. He is also a cosponsor of the Republican leadership, health care reform bill (Michel, H.R. 3080)

Congressman Hastert has been pleased and appreciative of the weekly briefings by Ira and other members of the working groups to Republican members. He has spoken about the need to hold costs down and to open up access. He has indicated a desire to be helpful.

CONGRESSMAN FRED UPTON (R-MI)

Serving his fourth term in the House, Congressman Upton is a protege of former Budget Director Stockman. Upton is a member of the Energy and Commerce Committee and the Wednesday Group. He is known to listen closely to local groups.

Congressman Bonior considers him a priority target. Upton supported the Administration's national service bill. Upton supports abortion to save the life of the mother and in cases of rape or incest.

Upton is a conservative and an independent thinker who, at times, has broken ranks with his party. The most notable instance of this is when he stood fast in his opposition to the 1990 bipartisan budget agreement.

Upton supported a bill in the last Congress to ease Medicare's paper-work burden on physicians (Rowland, H.R. 2695). He also supported a bill to have Medicaid cover certain medically underserved populations (Machtley, H.R. 1002).

Rep. Upton is a cosponsor of the Republican leadership, health care reform bill (Michel, H.R. 3080). He also has cosponsored the bill to revitalize NIH (Waxman, H.R. 4), and a bill that would establish provisions regarding the composition and labeling of dietary supplements (Gaggely, H.R. 509).

CONGRESSMAN CLIFF STEARNS (R-FL)

Congressman Stearns is a conservative representing a strong Republican central Florida district. Stearns grew up in Washington and serves on both Energy and Commerce and Veterans' Affairs.

Rep. Stearns has not sponsored or cosponsored any significant health reform legislation in the 103rd Congress. He has been against abortion rights.

CONGRESSMAN BILL PAXON (R-NY)

The Chairman of the National Republican Congressional Committee, Congressman Paxon was a volunteer in Jack Kemp's first campaign for the House and now holds that seat. Paxon recently became engaged to Rep. Molinari.

He is considered a conservative and serves as one of Whip Newt Gingrich's assistant deputy whips.

Paxon has voted against abortion. In the last Congress Paxon cosponsored the Republican leadership health care reform bill (Michel, H.R. 5325). He has cosponsored legislation to: require State Medicaid plans to include mammography screening (Vucanovich, H.R. 1311); to expand Medicare to include annual mammograms for women 65 and older (Vucanovich, H.R. 1312); and to have prevent Federal assistance for research on the drug RU-486 and regulated the interstate transportation of human fetal tissue.

Paxon is a cosponsor of the Republican leadership health care reform bill (Michel, H.R. 3080).

CONGRESSMAN PAUL GILLMOR (R-OH)

Congressman Paul Gillmor is a conservative member but does not favor the confrontational style of others in his party. As a the former leader of the Ohio State Senate, Gillmor was the State's highest ranking Republican and sacrificed some political power to come to Congress. Rep. Gillmor was unopposed in 1992.
His health care views are unknown but he has voted against abortion funding.

Rep. Gillmor is a cosponsor of the Republican leadership, health care reform bill (Michel, H.R. 3080)

CONGRESSMAN SCOTT KLUG (R-WI)

Congressman Klug is a new member of the Energy and Commerce Committee, part of the Wednesday Group, and previously served on the Select Committee on Children and Education and Labor. He is both a White House and a Bonior target.

While Klug's health care views are not known, he has called for early intervention programs for at-risk children.

Rep. Scott Klug won an upset victory over Democratic incumbent Rep. Bob Kastenmeier by stressing his vote against Desert Storm and by painting him as a career politician. Klug, a former TV reporter, did not even join the GOP until a few days before announcing his candidacy. He is a leading spokesman in Congress in promoting congressional term limits of 12 years. A fiscal conservative, he favors both a balanced budget amendment and the line-item veto.

In the last Congress, Klug was the only Republican member of the Energy and Commerce Committee to cosponsor the managed competition approach to health care reform (Cooper, H.R. 5936). He has not taken a position on health care reform during the 103rd.

Recent Developments: In comments to AP after the President's speech Klug had two concerns: small business and the National Health Board.

CONGRESSMAN GARY FRANKS (R-CT)

The first Republican to join the Congressional Black Caucus, Congressman Franks is a self-made millionaire who opposes most of the CBC's bills.

Franks is pro-choice. He is a co-sponsor of the Republican leadership's health care reform bill. His mother was a dietary aide in a city hospital. He is one of Bonior's Republican targets.

In the last Congress, Franks cosponsored a bill to lift the "gag rule" in family planning clinics (Porter, H.R. 392); "Family Unity and Parental Notification Act" (C. Smith, H.R. 1490); a major physician payment reform bill (Stark, H.R. 3070).

Rep. Franks is a cosponsor of both versions of the Republican leadership health care reform bill (Michel, H.R. 101, H.R. 3080).

CONGRESSMAN JIM GREENWOOD (R-PA)

Greenwood is a former social worker who dealt with children. He is a freshman who campaigned for creating a health care system and has been considered a possible target.

Greenwood defeated 16-year incumbent Peter Kostmayer (D). He served six years in the state House and six in the Senate.

Mr. Greenwood is a fiscal conservative who supports a constitutional balanced budget amendment, (Pennsylvania is required to have a balanced budget); but he is pro-choice.

Rep. Greenwood is a cosponsor of the Republican leadership health care reform bill (Michel, H.R. 3080).

CONGRESSMAN MICHAEL CRAPO (R-ID)

(pronounced CRAY-poe) Freshman Congressman Crapo quickly aligned himself this year with the freshman reformers and now sits on the Energy and Commerce Committee. He is a fiscal conservative.

While Crapo's health care views are not known, he will be sensitive to the needs of his district's farmers.

Rep. Crapo has not sponsored or cosponsored any significant health reform legislation in the 103rd Congress.

Energy and Commerce Committee
Responses to Written Comments

The Energy and Commerce Committee written comments were prepared by Henry Waxman's staff. These issues raised in these comments have all been discussed at meetings with Waxman and/or his staff. The discussion below indicates how we have responded to these issues in the course of these meetings.

Medicare

Rather than respond to inquiries regarding individual Medicare cuts, we would recommend using the more general talking points on Medicare savings.

How is it possible to accomplish $124 billion in Medicare savings without reducing the benefits of Medicare beneficiaries?

Medicare savings must be viewed in the context of overall health reform.

Without overall health policy reform we would oppose savings of this magnitude, because there would be no way to protect Medicare beneficiaries from serious risks of benefit reductions.

During the budget debate the Administration opposed an "entitlement cap" for this very reason. The cap would have forced reductions in the Medicare program -- whether or not we accomplish overall health care reform controlling private sector health care costs -- and whether or not beneficiaries could be protected.

In the context of health reform Medicare beneficiaries can be protected.

Health care reform will protect against two factors which now make it difficult to contain Medicare costs without hurting beneficiaries: cost shifting that results from uncompensated care and price pressures arising from the difference between private and public reimbursement rates.

Universal coverage will make it unnecessary for providers to look for ways to shift costs for uncompensated care to paying customers -- which includes Medicare as well as private insurance.

Controlling private sector health costs will bring public and private reimbursement rates closer together. By restraining the growth in spending on the private side, it is possible to restrain the growth on the public side while at the same time reducing the risk that providers will elect not to treat Medicare patients in favor of patients with private insurance.

The health plan will not reduce Medicare spending. It will only slow the rate of growth from three times inflation to twice inflation. In the context of universal coverage and corresponding private sector cost restraint, there is no reason why this reduction in the rate of growth should harm beneficiaries.

In contrast to other proposals, the Administration only supports Medicare savings of this magnitude in the context of health reform.

43 Senators voted for the entitlement cap without a corresponding cap in private health care costs, and without any assurances about the impact on Medicare beneficiaries.

Other health care proposals call for Medicare savings comparable to or greater than ours, but fail to meet the critical test of protecting beneficiaries because they fail to provide universal coverage (and therefore put an end to uncompensated care) or to control private health care spending (and therefore reduce the differential between private and public reimbursement).

The Clinton Administration only supports Medicare savings of this magnitude in the context of health reform that removes these risks that beneficiaries will be hurt.

Reform and Competition will reduce Medicare costs.

Competitive forces will reduce the cost of health care for people over 65 as well as for people under 65. With cost differentials of 300 percent between Miami and Wisconsin, there is much room for savings from competition.

Streamlined administrative procedures will reduce the costs to providers of caring for Medicare patients.

Health reform plan will specify detailed policies to achieve Medicare savings.

Unlike proposed "entitlement caps" which leave the difficult task of finding specific savings to be determined in the future, the health reform plan will propose specific policies to achieve $124 billion in savings over five years.

If Congress believes that other specific measures are more appropriate, we will work with Congress on designing alternative savings measures.

The Administration is firm on the amount of Medicare savings that are necessary. If the specific measures that are enacted fail to meet the projected spending levels, we are prepared to work with Congress on streamlined procedures to ensure that policies are put in place to achieve the spending targets.

The Chafee/Dole plan, in contrast, would result in comparable Medicare savings [$111 billion]. However, the Chafee/Dole plan would not guarantee cost controls in the private health care system and it would not guarantee universal coverage or expanded Medicare benefits.

Medicare savings will be used to provide new Medicare benefits.

Savings from Medicare will be used to finance prescription drug benefits and long-term care benefits for Medicare recipients.

Medicaid and Low-income Issues

1. **Premium and cost sharing subsidies**

We understand the Committee's concern that low income participants should have as much choice as possible, and that they should be assured of access to a plan that will meet their needs.

The plan is designed to *improve* the quality of care available to low income participants. Medicaid patients today have limited choices -- their choices are limited to providers who agree to accept Medicaid reimbursement. I think we would agree that in many cases, the choices today are not what we would like them to be.

Under the health plan, all Medicaid participants will be guaranteed comprehensive coverage through plans in their regional alliance. However, low income participants will no longer bear the stigma of being in a separate health care system. Simply integrating low income people into the broader health care system will provide many with better choices than they have today.

We are exploring the suggestion that broader premium subsidies and cost sharing subsidies be provided. We are concerned about the cost of expanding these subsidies, but will continue to work with the Committee to explore options.

If the concern is that low income participants should not face "redlining" which would force them into plans that cover only low income people, we are prepared to explore either strengthening provisions which assure that boundaries not be drawn in a discriminatory manner and that plans be open to a broad range of participants.

2. Entitlement nature of subsidies

We agree that discounts which are provided must be a matter of right. The plan calls for reserve funds to be established to help finance extra costs at times when more individuals and families are eligible for discounts than expected. In general, the funding of these reserves would be through the alliances. In the event that the alliances are unable to finance these discounts at a given time, there must a fallback of federal funding to ensure that individuals eligible for discounts can receive their discounts. We will work with the Committee to design an appropriate mechanism.

3. Bona Fide DSH

During the transition period when the new plan is being phased in, it will be necessary to continue to provide assistance to hospitals that are disproportionately serving the poor.

A portion of the Medicare DSH payments will continue, but they will be targeted to institutions that truly merit these extra payments. In the past, DSH has been taken advantage of and that practice must not be permitted to occur again.

We will work with the Committee on a transitional provision that addresses this concern.

4. Medicaid Long Term Care

We agree that existing long term care community service benefits which are individual entitlements under current law should remain so.

5. Supplemental Services

The plan proposes to continue to provide supplemental services to cash beneficiaries as under current law. Supplemental services for non-AFDC and SSI medicaid recipients could be converted into a block grant through the states. We are considering extending the current law treatment to the non-cash population (which includes many pregnant women who are not yet eligible for AFDC). [The states reacted very negatively when they heard that we were discussing this change with Waxman.]

6. Illegal Aliens

The plan would target federal assistance to providers who serve illegal aliens. We are exploring mechanisms to guarantee funding to providers in areas where service is provided to illegal aliens.

Public Health Initiatives and Savings

1. **Public Health Offsets/Savings**

Savings in this area will develop as presently uninsured patients become covered. We are exploring ways to reinvest these savings, as well as additional new dollars to support this system.

2. **Formula Grants for Access**

We have agreed that these funds will continue to flow through existing programs rather than a block grant.

3. **Core Public Health Functions**

We have agreed that a new infrastructure grant program should be proposed instead of a formula grant program.

4. **Priority Health Problems Initiative**

We have agreed that increased funding should flow through existing programs, rather than through a consolidated program, with administrative simplification and expanded demonstration authority.

5. **Essential community providers**

We understand the Committee's concern with the five year limit on the essential provider provisions and we are reviewing the recommendation that the period be extended beyond five years. The essential provider provisions are intended to ease the transition for these providers to be integrated into plans or to form new community based plans. We will work with the Committee to make certain that essential services are available in traditionally underserved areas.

6. **Amount of Public Health Investment**

The plan was designed to provide a significant increase in funding for traditional public health programs -- such as TB control. We believe that the proposed funding levels are adequate, but will continue to discuss concerned raised by the Committee and review the policy in this area.

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Clinton Presidential Records
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Melanne Verveer
OA/Box Number: 6198

FOLDER TITLE:
Congressional Member Question and Answer [Binder] [4]

2013-0534-S
rc1531

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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WASHINGTON (Rep. McDermott)

- Price gouging (Seattle), (b)(6)

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SUMMARIES OF LETTERS

CALIFORNIA (Reps. Stark, Moorhead, Waxman, Lehman)

[002]

* Prescription drugs: pre-existing condition (Santa Rosa)

(b)(6) has diabetes, high blood pressure, and asthma, and is currently on SSI and PERS disability after working for 30 years. She buys COBRA insurance, which does not cover prescription drugs. She has stopped taking her medications because she cannot afford the $150/mo. Two insurance companies told her that she could qualify for their plans if she went on county aid (which still would not pay for the medications). (NOTE: Consent has not yet been obtained for public use of her letter.)

* Long term care insurance premiums (Salinas)

(b)(6) and wife are in their 80s and in good health. They pay long term care insurance premiuns ($7,026/yr.), uninsured dental care costs, and supplemental insurance ($1,476/yr.) for a total of $9,938 in out-of-pocket insurance and health costs in 1992.

* Pre-existing condition; loss of coverage (Livermore)

(b)(6) 24 year-old son, (b)(6) -- born with cystic fibrosis -- is hospitalized once a year for about $50,000/yr, and requires approx. $1,300 in prescription drugs each month. The family is covered by the father's insurance, which has covered 80% of these expenses until now. As (b)(6) recently graduated from college, he is only covered on his parents' insurance if he remains a dependent. He is otherwise uninsurable. The husband is 66 years old, has worked for over 40 years, and cannot retire for fear that his family will lose health coverage.

CONNECTICUT (Rep. Johnson)

* Pre-existing condition (Milford)

(b)(6) 36, had an ileostomy (most of her intestines removed) at age 12. Her supplies are termed "maintenance" and coverage for them may be dropped under her insurance plan. If so, she will be forced to quit her job and go on public aid.

* Self-employed; pre-existing condition (Danbury)

(b)(6) and husband were laid off from good jobs, but paid own COBRA insurance of $400/mo. Daughter required surgery to repair ear drums (which cost $12,000 for a 24-hour hospital stay). After this, Paula took a job paying just over 1/3 her former salary, and her husband opened a small business. The best policy they can get is a $400/mo. premium with a $3,000/yr. deductible, but this will exclude her husband's pre-existing heart condition (he had a heart attack five years ago) and her daughter's ear problems. The only way they can get care is to sell everything and go on welfare.

GEORGIA (Rep. Rowland)

* Self-employed, excessive medical costs (Cedartown)

(b)(6) insurance cost $80/mo. for a $500 deductible in 1983 and now costs $403/mo. for a $1,000 deductible. Her husband's medical bills last year were $2,960, and their insurance premiums were $5,650 ($8,610 total), on an income of $26,100. They are in their 50s and don't know how to continue paying these expenses. Quote on phone: "I work to pay insurance. It's about all we can do to hang on."

* Lost job; pre-existing condition (Roswell)

(b)(6) husband lost his job in 1991 when the company reorganized. Months later, her 17 year-old daughter had kidney failure, went on dialysis and received a kidney transplant (father donated kidney). The family bought COBRA insurance, which ran out after 18 months, leaving the daughter on Medicare, which cut off all coverage in Dec. 1992. Medicare covered Patsy (who had cancer) and her daughter (except for her $550/mo. of prescription drugs) for one year before ceasing. Mr. (b)(6) is uninsurable in his new job because he had donated the kidney.

* Overcharged medical costs (Newnan)

(b)(6) went to the emergency room with a dislocated shoulder, and was charged $686, including erroneous fees ($183) for four x-rays when only three were taken. His bill was corrected upon his complaint, though he is unsure if Medicare will receive the corrected bill. Quote: "If every hospital patient is over-charged $183 it is no wonder the U.S. is going broke paying medical expenses."

* Lost job; pre-existing condition (Atlanta)

(b)(6) 36, lost his job and health coverage because of ongoing health problems (multiple knee and ankle operations). When COBRA runs out, he worries that he'll have no insurance; currently, most of his money goes to medical bills. Quote: "It's not my fault that I have these problems. I would certainly prefer to be healthy."

ILLINOIS (Reps. Rostenkowski, Hastert)

* Pre-existing condition (Arlington Heights)

(b)(6) 24, was a juvenile diabetic, and is now being denied coverage for a pre-existing condition despite the fact that she has been in good health for 12 years and had only one 2-week stay in the hospital when she was an adolescent. She currently carries COBRA insurance that will expire on October 8, 1994, and feels that she will have trouble getting coverage after this time.

* Excessive costs (East Peoria)

(b)(6) 55, is a quadraplegic after a car accident that was not her fault. She cannot change her insurance, which costs her a $4,000 premium with a $2,500 deductible; she did not work enough to get Social Security disability since she was

raising her family; and is not eligible for SSI or Medicaid. Her husband takes care of her, and as a result, can no longer attend to his business.

* Simplicity - excessive paperwork (Mascoutah)
(b)(6) needs to file over 51 claim forms to be reimbursed for his prescription medications (five times as many as he had to file for the same prescriptions in 1992.) He is in Blue Cross/Blue Shield under the Service Benefits Plan of the Federal Employee Program.

* Excessive medical costs (Glenview)
(b)(6) husband underwent a 20 minute outpatient cataract operation (they were at the hospital for three hours), and received a bill for about $3,000. The doctor's bill will be about $1,500. The charges are partly covered by Medicare, but (b)(6) wonders why the charges are not more in line with what Medicare pays.

KENTUCKY (Rep. Bunning)

* High premiums (Brandenburg)
(b)(6) eight year old daughter has tonsilitis, but the Embrys cannot afford health insurace as they are self-employed. In the meantime, she takes her daughter for weekly shots to combat the infections that would likely end with tonsil surgery.

* Pre-existing condition (Hopkinsville)
(b)(6), her husband, and their four children were denied medical assistance (Medicaid) because the husband earned $300-$400/mo. doing odd jobs. He was turned away from the hospital with pneumonia (feverish and hallucinating). The (b)(6) borrowed money from their parents to buy his medication. He was recently hired at a local factory which offers health insurance. The (b)(6) will pay, but (b)(6) worries about being refused because she has been treated for depression in the past.

LOUISIANA (Rep. Tauzin)

* Excessive costs (Ville Platte)
(b)(6) was charged over $11,000 for a seven-day hospitalization with pneumonia. He feels overcharged for services and medications (i.e. $3.50 per Advil).

* Job lock (New Iberia)
(b)(6) 58, has worked as a legal secretary for 40 years with good health insurance. Her husband, 61, is insured under her plan and recently had a heart attack. She cannot retire because her husband is uninsurable and will not be covered by Medicare until age 65.

* High costs (Kenner)
(b)(6) does not work outside the home so she can raise her children (ages 4 and 9 mos.); her husband's work does not provide insurance. They pay $261.50 per

month for insurance with a $500 deductable, receive no maternity coverage, no well baby care, etc. on an income of $30,000.

* Social Security technicality; high costs (Madisonville)

(b)(6) has a chronic heart ailment, but was denied Social Security Disability on a technicality (denial may have been related to wife's income - $20,000). His medical costs are $300/mo., insurance; $378/mo., medications; $1,000/mo., payments on deductables. His heart condition precludes his returning to work. He feels that he is an economic burden on his wife (whose premiums, incidentally, are rising 40% this year).

MICHIGAN (Rep. Dingell)

* Excessive costs, prescription drugs (Livonia)

(b)(6) paid 270% more for his wife's medication in February 1993 than in October 1992 ($19 to $53). His wife will require the medication for the rest of her life; further increases will drain their resources.

* Medicaid (Pontiac)

(b)(6) 65, is angry because an OB/GYN refused to treat her pregnant daugther because of fears she wasn't covered by Medicaid (card takes 45 days to process). Her daughter and son-in-law have no insurance, and their first child was premature after receiving no pre-natal care. She pays for the children's shots. She feels that "little babies suffer because of a group of greedy doctors."

* Prescription drug prices vary (Southgate)

(b)(6) 76, notes that drug prices vary from pharmacy to pharmacy, and feels that she cannot drive miles in Michigan winters at her age to pay less for her medications.

PENNSYLVANIA (Rep. Santorum)

* Small business (Sellersville)

(b)(6) recently joined the Chamber of Commerce to obtain group medical insurance for himself and his four employees. They were denied coverage from the HMO they chose because one employee had a heart attack five years ago as a result of smoking (after the surgery, he stopped smoking, takes no medications, and has no heart troubles). The letter from the HMO cited their business as one with fewer than 25 employees, yet they joined the Chamber of Commerce specifically to be considered as part of a 2,500 person group.

TENNESSEE (Reps. Sundquist, Cooper)

* Prescription drugs, home health care (Tullahoma)
Louise Ewell is a home health nurse; one couple among her clients must pay $475/mo. for medications on a fixed income of $675/mo. "They must a decision on whether to eat, buy clothes, or buy medicines."

TEXAS (Rep. Archer)

* Small business, fraud and abuse (Richardson)
Drake Bunday owns a small business with three employees. Their group health insurance premiums have increased 1100% since 1981 after one employee developed a heart condition. The person would be uninsurable if Drake dropped his company's policy. "This burden is bankrupting our little firm."

* Elderly, high premiums (Kingwood)
(b)(6) [NOTE: Consent to use story, but not name], 59, had polio 40 years ago, and uses a leg brace and canes. She falls frequently and has sufficient pain that she cannot work. She does not qualify for any benefits, and has no insurance. She has decided not to seek medical care should she need it so that she will not lose her house in attempting to pay for her treatment.

* Prescription drugs (Winnie)
(b)(6) receives Social Security disability benefits after his leg became paralyzed in 1988. Several months ago, he had a severe heart attack which almost killed him. Medicare paid for the surgery, but does not pay for his medication. "What good is it for Medicare to spend a huge sum of money for the surgery to keep a person alive if the person cannot buy the medicine he needs to maintain that life."

VIRGINIA (Reps. Payne, Bliley, Boucher)

* Job lock, no preventive care (Virginia Beach)
(b)(6) mother of three, received notice of second increase/year in premium. She will have to drop coverage soon because of the cost. Her high premium discourages her from getting preventive care for her children. She is not on the family plan because of a mild heart condition, so she keeps jobs she would rather quit to keep insurance. Quote: "I am holding my two year old while I am writing this letter. He is running a fever and sounds congested. Now, do I take him to a doctor or wait and see how bad he gets?"

* Home health care, Medicaid (Norfolk)
(b)(6) 69 year-old mother receives $715/mo. in Social Security benefits, but her home care costs over $1,200/mo. She does not qualify for Medicaid unless she gives up and goes into a nursing home, which would cost about 2/3 more than her current home care. She is spending down her savings.

WASHINGTON (Rep. McDermott)

* Price gouging (Seattle)

(b)(6) visited doctor for an AIDS test, was told $126 as a fixed price, and found AIDS tests for $35 and $25 at local clinics. She was "livid" and wrote him an angry letter, which she "cc'd" to you.
(NOTE: Consent has not yet been obtained for public use of her letter.)

EWELL

Tullahoma, Tenn
Jan 12, 1993

Dear Governor [illegible]:

I am a Registered Nurse, and I'm proud of it - But I really see a lot now that bothers & hurts me -

I am a Home Health Nurse [illegible] see many pitaful cases - The most problem now is people who only live on fixed Incomes - and spend most of their money on medicine -

I visited a home yesterday - They get an income of $675.00 & their meds are $475.00 Combined - They must make a decision on whether to eat, buy clothes or buy meds - [illegible] first Please work on [illegible] trouble - because so many people are in trouble -

I have been a nurse for 30 yrs and a Home Health nurse for 14 yrs -

I'm so proud of you + [illegible] More -

I know you will help the little people - someway - I want them to have as good as anyone else - I pray God will guide you + your lovely family -

[illegible]

Louise Ewell R.N.
Box 4122 Rt 4
Tullahoma, Tennessee
37388

Drake S. Bunday
911 Warren Way
Richardson, Texas 75080

February 18, 1993

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

Re: HEALTH INSURANCE

Dear Mrs. Clinton:

Our American health care / health insurance system is broken, and is desperately in need of an overhaul. I would like to point out some BIG problems.

It has become commonplace for many health insurance companies to cancel the policies of those who get sick, or to raise the premium rates to the point that the insured might almost as well just pay his own medical expenses outright. (I am one in the later group.) This sleezy way of doing business completely defeats the very concept of insurance, which should be to spread the risk. Instead, these insurance companies are in the business of avoiding risk. I think this should be regarded as a form of fraud. These companies are selling insurance that really is not insurance. They collect the premiums but find a way to avoid standing behind the promise, explicit or implied, to protect the insured in time of need. It's a cruel shell game; "now you see it, now you don't."

Our government has "truth in lending" laws, "truth in advertising" laws, and a host of other consumer protection statutes. Why isn't there a "TRUTH IN INSURANCE" law? Why does our government allow these deceitful, crooked and financially devistating practices to go on? Why can't the insurance companies be required to provide what they say they do ... real protection against risk. Why shouldn't the law require that premium rates be averaged among all people, and prohibit segregating policies between sick and well persons? Apparantly the law now allows an insurance agent to promise (or imply) wonderful coverage in his sales presentation, but the policy sold has some fine print loopholes that allow the company to renege on ultimately assuming the risk. Why is this not illegal? And this is not a penney-ante shell game; we are talking about fraud that frequently amounts to tens and even hundreds of thousands of dollars on just a single policy.

Another shady practice of many insurance companies is the "conversion clause" found in most group policies. This clause in the contract appears to gurantee that an individual insured through the group can have personal insurance coverage, regardless of health conditions, should he leave the group by changing jobs, etc. Provision of a policy for the person may be guranteed, but the terms and coverage of said individual policy are nothing like those of the group. Often the monthly premiums are double, and coverage is so limited as to make the policy almost worthless. Do you think this is disclosed when the insurance agent makes his sales presentation? Not likely. The agent just lets the succer buying the policy assume that the coverage and terms would be equal. Some agents absolutely refuse to let a prospective customer read the fine print of the proposed insurance policy contract until the customer signs to purchase the policy and makes the innitial payment. Why are such business practices legal?

I am the owner of a small business with three (3) employees. Our group health insurance premiums are now eleven (11) times as high as when we purchased the innitial policy in 1981, and we are insuring fewer persons now at higher deductibles. That's an 1100% increase! That's not just adjustment for inflation; not even health care costs have inflated anything like that! What happened is that one person in our

group developed a chronic health condition and submitted a lot of claims. Right after that, our insurance premiums escalated right through the roof. We are now paying $765 per month per person. This burden is bankrupting our little firm. To drop the policy would leave the sick employee without insurance protection for years. He is considered uninsurable through the private sector under present insurance practices, and to my knowledge there is NO GOVERNMENT SAFETY NET, except for medicare, for which this person will not qualify for 12 more years.

I can't stomach to hear any more partizan rhetoric about how wonderful the present American health care system is. The system is a mess! It is full of inequality, fraud, greed, waste and inefficiency! Who is going to fix it? Who else but the government has the power and resources to tackle such a large problem? The American people need, want, and expect to see something done. I believe that the HEALTH CARE CRISIS is the NUMBER ONE ISSUE facing our nation.

We need to find a way to:

(1) Equalize medical insurance premiums,
(2) Stop the greed and fraud by insurance companies,
(3) Control health care costs, and
(4) Assure that all Americans have access to coverage.

I would appreciate hearing from you about your ideas on how to achieve these goals, and how quickly you believe we can reach them.

Awaiting your solution,

Drake S. Bunday

Drake S. Bunday

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