MEMORANDUM

TO: HILLARY RODHAM CLINTON
IRA MAGAZINER

FROM: JOHN HART

DATE: FEBRUARY 5, 1993

RE: OFFICE OF INTERGOVERNMENTAL AFFAIRS PLAN FOR HEALTH CARE REFORM

The successful integration of state and local concerns during the health care policy formulation process is critical to building the strong base of state and local support so important to the passage and implementation of health reform legislation. The Office of Intergovernmental Affairs will build upon the work of campaign and transition efforts to solicit and incorporate state and local concerns into the policy formulation process, and to prepare health care reform legislation reflecting state and local views. Our goal is to have the President's health care package reflect policy that state and local officials will not only support, but will actively endorse.

In order to achieve that goal, IGA will ensure timely and constructive input from appropriate state and local elected officials who face the issues being addressed by the task force and who are on the front lines of the issues.

Role of Intergovernmental Affairs to Achieve Task Force Goals

Intergovernmental Affairs will play an important role in ensuring the success not only of the task force, but also in the implementation of the President's plan. For example, it may be that the Administration will set the overall standard for what proper health care and health insurance should cost, leaving to the states the responsibility for making sure everyone receives adequate coverage. Thus, it is critical that state and local officials feel ownership to the President's plan.

Intergovernmental Affairs will approach this effort through a four-pronged strategy:

1. Identify health care issues of concern to state and local officials.

2. Identify key state and local players and staff in the area of health care reform.

3. Establish mechanism for managing information flow between the policy task groups and state and local officials.

4. React to final policy formation with state and local interests/viewpoints in mind, develop strategy of response for state and local officials.

It is critical that the outreach working group speak with one voice as the process proceeds and the plan unfolds. To that end, the Intergovernmental team plans to work closely with the legislative affairs, communications, and public liaison working groups to ensure a cohesive, consistent approach.

1. Identify health care issues of concern to state and local officials.

During the transition and in the weeks following the inauguration, IGA has conducted a series of meetings with state and local officials to identify the health care issues that most concern states and localities. These issues center upon the nature of federal-state involvement in the implementation of these programs, the degree of flexibility in state and local administration, and the level of state and federal funding and the role of the current Medicaid program in a restructured health care system. For example, in the area of Budgets and Caps, states differ with respect to their ability to cost-effectively deliver health care. The task force budgeting system proposal must address this differential.

As a result of these discussions, we have identified a preliminary list of state and local health concerns as we enter Tollgate 1. The issue areas are framed in terms defined by the preliminary list of working groups:

- **Budgets and Caps**
- **HIPC Organization**
- **Organization of Boards and Oversight Bodies**
- **Structure of Employer Participation**
- **Coverage of Low-Income Population**
- **Short-Term Cost Controls**
- **Public Financing**
- **Long Term Care**
- **Insurance Reform** (Workers compensation issues)

2. Identify key state and local officials and staff in the area of health care reform.

As with the identification of issues, supplemented by activity of the transition team, we have made significant progress toward identifying and beginning to work with the various state and local groups.

Over the next week we will continue to meet with state and local officials and representatives of state and local organizations to create a matrix of issues and relative players.

IGA will also be responsive to speaking requests at association meetings and other gatherings, and, in the absence of the First Lady, will try to arrange a senior member of the Task Force.

Our plan supposes participation by officials at all levels, but recognizes that Governors are a unique constituency and plans to treat them accordingly. (See Exhibit 1).

State Level

The principal players on the state level will be Governors and their staffs. Our most important task will be to maintain and build upon the bipartisan coalition around the issue of health care reform. To that end we will work with the four Governors designated by the NGA.

1) Each of the 56 state or territorial Governors will have a person from their office designated to work with the Task Force and the IGA. The contact will be an expert in the area of health care reform and be on call 24 hours a day over the next one hundred days.

2) An additional 3-4 state people will come to Washington, D.C., to work with NGA staff and be available for advice and consultation.

3) Ray Sheppach will coordinate the task of assigning one National Governors Association staff person and one state person to be liaisons to each policy group.

4) Establish a Briefing Process for Governors and their staffs:

- o Weekly five-minute conference calls.
- o Bi-weekly half-hour briefings.
- o Every 2-3 weeks hold Governors briefings.

A summary of the gubernatorial outreach strategy is contained in Exhibit 2. A briefing schedule for Governors and their staff is attached as Exhibit 3.

Other State and Local Officials:

NCSL	National Council of State Legislatures
NACO	National Association of Counties
NAIC	National Association of Insurance Commissioners
NASBO	National Association of State Budget Officers
APWA	American Public Welfare Association
Mayors	The U.S. Conference of Mayors has designated Mayor Mike White of Cleveland to be its liaison to the Task Force. We will continue outreach with the League of Cities and City Managers.

1) A senior member from the Task Force will initially brief the broad gathering of each level of state or local representatives.

2) Each of the state and local officials representatives will have a person from their organization designated to work with the Task Force and the IGA. The contact will be an expert in the area of health care reform and be on call 24 hours a day over the next one hundred days.

3) The preliminary list of issues will be floated by each level of officials for reaction and initial input.

4) Each level of officials will draft an issue paper on each issue of concern, stating their initial areas of interest and policy preferences.

A schedule of briefings modeled on the gubernatorial schedule will be constructed in the week ahead.

3. Establish mechanism for managing information flow between the policy task groups and state and local officials.

Establish a mechanism for information management that accomplishes two things:

1) Ensures that players and constituencies are involved and that their input is being heard and incorporated;

2) Allows the policy team to receive input from state and local officials and their staffs in a manageable and useful way

As policy working groups identify needed data and analysis that would be likely sought from Intergovernmental sources, IGA will serve as the liaison between the policy groups and these agencies or officials. Though seemingly cumbersome, it is important that all these requests be coordinated with IGA in order to ensure timely and consistent contacts.

As the actual policy options take shape, IGA will manage the input from state and local level; this will be accomplished on a multi-tiered approach and IGA will interface with the policy team as necessary to accomplish this: whether with a form letter response to an interested legislator or a senior level response to an important speaking request.

4. React to final policy formation with state and local interests/viewpoints in mind, develop strategy of response for state and local officials.

As the options narrow and the Task Force begins to put together a specific plan, the Intergovernmental team must be advised of decisions being made on specific areas of interest to the state and local constituencies. Those areas of interest, as identified during the input process and refined through the continuous input lent to the effort from these officials and their staffs, will be voiced to the policy group by the intergovernmental team. The intergovernmental team will need the opportunity to "plead the case" of states and localities on specific policy approaches, and to voice the likely political consequences of the choices being made.

When it is clear what the plan will entail, and what state and local participation in terms of legislation, financing and implementation will be, the intergovernmental team will put together an outreach, consensus and education effort in conjunction with the legislative, public liaison, and communications group. This will entail:

1) Identifying key Governors, Mayors and others who can be counted on to speak on behalf of the Presidents plan;

2) Identifying officials in geographic areas of special concern; and,

3) Identifying legislators who are opposed or on the fence and marshalling state and local forces to speak out in support of the plan.

Conclusion

Just as supportive state and local officials will be able to bolster the outreach effort with people and in areas where support is flagging, so, too, the Intergovernmental team will rely on health care constituency groups, members of Congress, and targeted media outreach to pull in state and local groups outside the tent. Recognizing the existing alliances between health care constituency groups, members of Congress, and state and local officials, the four outreach groups will work closely to coordinate these efforts.

cc: Regina Montoya

III.

A. **Targeted Outreach Strategy**

In addition to the centralized intake warroom, surrogate speaking, and the public hearings or summit we do, we need to have a very strategic approach to organizational outreach.

We could end up wasting a huge amount of staff time "receiving input" that would not accomplish very much toward actually building the coalition that will help us pass health care reform. With literally hundreds and hundreds of groups wanting to give us input, we could assign ten full-time staff people to do nothing but be in meetings all day everyday for four months, and we would still have groups we didn't have time to meet. And I don't believe that all that input would necessarily bring us much closer to our goal.

I think of a two-prong strategy. First is the very traditional public liaison strategy of setting up consultation meetings for small groups of organizational representatives that come from the same sector. These kinds of meetings should be done for:

- the major insurance companies
- small and medium sized insurance companies
- insurance agents
- the AMA
- other groups of doctors
- for-profit hospitals
- non-profit and church-run organizations
- health care workers
- labor unions in general
- small business owners
- CEOs of big businesses
- single payer advocates
- groups concerned with rural health care
- women's health advocates
- children's health advocates
- low income health advocates
- minority groups

Although the transition met with all of these kinds of groups, it is different being invited to a White House briefing, and we should take advantage of that aura to build on the transition work.

Secondly, I think we should put together interdepartmental teams with assignments to focus on five key sectors in the health debate. Each team will have a different primary goal, depending on the nature of the sector they deal with:

1. A team of people assigned to work with the major industry players on health care - AMA, Hospital Association, Insurance Association and the biggest insurance companies. Their goals

would be to gather intelligence on what these groups would be most upset about, and try to keep at least some of them from being opposed to the final package.

2. A team assigned to working with small business: they could end up being our toughest opponents. Again, intelligence gathering on their attitudes is a central goal, as well as trying to figure out a package that will be creative about meeting some of their needs.

3. A team assigned to working with big business and the major business associations. Big business could end up being an ally, so we need to pay their key ideas a lot of attention.

4. A team assigned to working with the single payer advocates, both the organizations and Congressional supporters. This team's top goal should be finding the one or two key concessions that we can live with that would bring them completely into the fold.

5. A political research team assigned to finding out what are the seemingly smaller groups or issues that could end up causing us a big problem. For example, maybe there is a small industry group that has no clout with anyone except John Dingell: we need to know about things like that, or we will find ourselves blindsided.

If we have these five projects well-coordinated, we will go into this fight well prepared to take on the interest groups we need to take on, and it will be very tough to stop us.

SENIORS

B. **The Data Base**

Building on the work of the transition health team, we are developing a data base which will include the following:

1. Name of organization

2. Membership information:

   - numbers of members
   - regional or Congressional district strength
   - demographic characteristics

3. Summary of positions in each major issue area:

   - whether they have their own plan
   - how strongly they feel about different positions

4. History of our relationship with them:

   - did they endorse campaign plan?
   - did we meet with them in campaign?
   - did we meet with them in transition?
   - have they been included in a WH briefing?
   - did they support us in the election?

5. Information about leadership:

   - home and business phone numbers, fax numbers, and addresses
   - biographies
   - analysis of credibility in the media
   - known relationships with Congresspeople

C. **The DNC Role**

The DNC clearly has a critically important role to play in the campaign. I would suggest the following roles:

1. The DNC should formally launch a pro-Clinton health reform initiative so that our base of organizations and grassroots supporters have a place to channel their activity. This coalition should have at least two distinct functions:

a. Enlisting the formal support of national, regional, state, and local organizations in the Clinton health care reform proposal.

b. Providing an organized structure, state by state and in targeted Congressional districts, for grassroots activist to help us generate local support: phone calls , letters, faxes, and mailgrams to Congress people; supportive letters-to-the-editor and talk show chatter; local speakers bureau; attendance at Congressional town hall meetings.

2. A closely related role for the DNC is that they need to be very active in general to help keep the Democratic base groups pumped up and excited. It's easy in this town for the nay-sayers to get to people, and we need to counter that cynicism.

3. The DNC can be instrumental for us in intelligence gathering and opposition research. Their staff will hear talk about things that may never reach us inside these walls.

4. David Wilhelm, as I mentioned before, should be a very active surrogate on the health care issue. He can help us whip up enthusiasm at J.J. dinners, party meetings, and union conventions all over this country.

D. **Surrogates**

In addition to the public appearances by Mrs. Clinton, Mrs. Gore, the President, and the Vice-President, we need to have a large and diverse group of "inside" and "outside" surrogates to help us get our message out. The entire surrogate scheduling operation should be centrally coordinated out of the health reform war room.

Inside Surrogates

For the purposes of this memo, by inside surrogates I mean every speaker directly affiliated to this administration. I would include in this list:

1. Every cabinet member who is a health care task force member, and their deputies. The heaviest load will clearly need to be carried by Secretary Shalala and her deputy. Other assistant secretaries at HHS should also be part of the list.

2. White House staff including Ira Magaziner, Carol Rasco, Maggie Williams, Melanne Verveer, Regina Montoya, John Hart, Alexis Herman, and Mike Lux.

3. David Wilhelm and Celia Fisher should be available for speeches to Democratic activists on health reform, and should include a paragraph on health reform in every speech where it is appropriate.

Outside Surrogates

We should also aggressively encourage our friends outside the administration to speak for our health reform. This includes the friendly Governors and other state and local officials; friendly providers and other health experts; and leaders of supportive organizations. Although we won't have as much control over the message with these allies, we should do everything we can to educate them on our message, and encourage them to adhere to it.

Realistically, we won't be able to coordinate the schedules of most outside surrogates. But we can certainly be very active in asking for help and training people how to be most helpful.

Overall Surrogate Scheduling Considerations

We need to be cognizant of the following things as we are putting together our surrogate schedule:

1. No one organizational sector (consumers, business, health industry, etc.) should get too much attention: everyone else would notice and get nervous.

2. We should make sure that we're getting all of the country's top tier media markets covered on a regular basis, but not do top tier markets exclusively.

3. Most of our speaking opportunities that we schedule, if not all, should have a format that allows for questions and comments. We need to be seen as listening.

4. Surrogate scheduling, like much of what we do, should be driven in great part by Congressional considerations.

II. **Options on Health Care Hearings/Summit**

There are two viable options for doing mass public education on health care via public participation events. Those options, which will be described in more detail below, are to do one major health reform "summit" or to do a series of regional hearings. Though there are advantages and disadvantages to both ideas, because of our tight overall timeline, we are recommending the summit option.

OPTION A: Health Reform Summit

For this option to work best, we would recommend the following:

1. The summit would be a two day event structured similarly to the economic summit except with Mrs. Clinton running it. The President should come by to open or close the event, but should not be there most of the time.

2. It should be held outside of Washington, D.C.

3. This should be an event where the average people dealing with the health crisis get their chance to speak up. Although individual health care providers should be invited to speak, no one who is head of or lobbyist for a trade association or other interest group should be asked to speak.

4. There should be at least two or three people with specific horror stories, but there should also be several middle class people with decent benefits who are feeling squeezed and worried.

5. Small business people should be prominently featured. There should also be at least one Fortune 500 CEO.

6. Senior citizens should be there, and should be encouraged to talk openly about their insecurities about potential changes in medicare and their choice of doctors. If these fears are expressed, and we deal with them head on, we will gain immeasurably.

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