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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. bio	re: C. Duane Dauner [partial] (1 page)	10/12/1993	b(6)

COLLECTION:
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FOLDER TITLE:
Hospitals

2013-0534-S
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RESTRICTION CODES

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

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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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HOSPITALS

PHOTOCOPY
PRESERVATION

PHOTOCOPY
PRESERVATION

HOSPITALS

file

TIMELINE FOR OPENING OF SAVIOR'S HOSPITAL FOR PEACE AND CHARITY BIRTHHOUSE
1/17/95

Hospitals yes (Health care files)

Approved by: **Dr. Alexander Goldberg**
Chief Physician, Savior's Hospital for Peace and Charity

Irma Goertzen
President and CEO, Magee-Womens Hospital

DATE	RESPONSIBLE PERSON	ACTIVITY
January 9, 1995	H. Ayres	• Shipment of supplies and equipment leave Magee for Moscow.
January 9, 1995	Dr. Goldberg	• All engineering systems completed.
January 31, 1995	T. Kotys	• While in Russia, Tanya investigates donation or purchasing of drugs for project.
January 31, 1995	Dr. Goldberg	• Heating system completed. • Administrative wing completed.
February 3, 1995	C. Grimes K. Waleko S. Jackson G. Maurer E. Kitchen G. Davis T. Kotys J. Butler	• C. Grimes updates list of equipment and supplies. • T. Kotys determines how much money is available to purchase supplies. • Determine what supplies/equipment must be purchased.
February 7, 1995	K. Waleko	• Call meeting of committee to check progress. a. Update from Tanya's visit b. Review status of supplies c. Review Education Plan
March 1, 1995	T. Kotys C. Feiler	• Have all H.R. materials needed--contract, policy, competency lists.

DATE	RESPONSIBLE PERSON	ACTIVITY
March 31, 1995	D. English J. Butler T. Kotys	• Identify tapes that can be purchased, donated, or made for teaching purposes--physicians and midwives. • Tanya to coordinate taping and translation.
March 31, 1995	Dr. Goldberg	• Second and third floor renovation completed.
April 1, 1995	T. Kotys	• All H.R. materials are translated.
April 1, 1995	Dr. Goldberg	• Hires fifty additional key managers for the Birthhouse.
April 2 - 6, 1995	K. Waleko	• AIHA Nursing Leadership Conference in Moscow.
April 7 - 30, 1995	I. Goertzen T. Kotys	• Indepth Quality Assurance and Management Seminar for managers of Birthhouse.
April 15, 1995	T. Kotys	• All clinical education materials translated and assembled.
April 15, 1995	Dr. Goldberg	• Fourth floor renovation completed.
May 1 - 31, 1995	Dr. Goldberg	• Interview and hire remaining staff for Birthhouse.
May 7, 1995	Dr. Goldberg	• First floor renovation completed.
May 15, 1995	K. Waleko	• Unpack supplies, clean Birthhouse and set up inventory system. Oversee process of sterilization.
May 31, 1995	Dr. Goldberg	• Painting of outside of Birthhouse completed.
June 1 - June 30, 1995	K. Waleko	• Clinical education of staff.
July 1, 1995	Dr. Goldberg	• Opening of Birthhouse to patients.

The Health Security Plan

HOSPITALS

In so many ways, America's hospitals represent the best of American health care: they are the centers where the finest well-trained health care providers cooperate to provide high quality care to patients from every walk of life. But too often our hospitals also demonstrate what's wrong with our health care system. More and more, America's hospitals must struggle against tremendous odds.

- *Hospitals provide care to millions of uninsured Americans who seek treatment in emergency rooms. These unpaid bills -- so-called uncompensated care -- drain billions of dollars from American hospitals each year and force hospitals to inflate bills for their patients who are insured.*

- *Hospitals are buried in a crush of paperwork generated by the more than 1500 private insurance companies and various government health programs. Faced with requirements from peer review organizations, government inspectors, industry regulators, billers, coders and fiscal middlemen, hospitals treat more paper than patients. They hire four new administrators for every new doctor; in some hospitals, nurses fill out 19 separate forms per patient.*

- *Hospitals deal daily with the tensions caused by "defensive medicine" -- performing countless tests and procedures not out of medical necessity but out of fear of malpractice lawsuits.*

The Health Security plan will end today's vicious cycle of mounting paperwork, declining service and cost-shifting and reinforce efforts by hospitals to provide high-quality patient care.

Universal Coverage Ends Uncompensated Care

- Universal coverage will guarantee hospitals that they will get paid for services delivered to all the patients they treat.

- Hospitals will no longer be forced to charge inflated prices to some patients in order to make up for free care they now deliver for others.

Administrative Simplification

- Streamlined paperwork requirements and regulations will significantly reduce the costs of hospital administration. These measures will increase the time that physicians and nurses can devote to patient care.

- Standard claims forms and electronic data systems will save hospitals time and money.

Antitrust and Collaborative Reforms

- The Health Security plan will relax antitrust barriers that hospitals confront today and encourage collaboration in purchasing equipment and other investments. It will encourage hospitals to share technology, and help slow the growth in health care spending. It will also allow small hospitals to merge so that they can be competitive and save consumers money.

- Hospitals may contract with as many health plans as they choose working out their own arrangements with competing health plans or organizing plans themselves.

Malpractice Reform

- Medical malpractice reform -- including limits on lawyers fees and alternative dispute resolution measures -- will give hospitals increased protection against frivolous lawsuits and reduce defensive medicine.

Protections for Specialty Hospitals and Academic Health Centers

- Recognizing that not all hospitals are alike, the Health Security plan will provide flexible support for hospitals that perform the most specialized types of care, conduct research or training, or serve poor patients in rural communities and inner cities.

- The Health Security plan will dedicate special funds to teaching hospitals in order to recognize and reinforce the unique role they play in advancing clinical research and treating complex illnesses.

Melanne

October 12, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Kim Tilley, Amanda Crumley
SUBJECT: Briefings for Wednesday, October 13th

California Association of Hospitals and Health Systems

- American Hospital Association analysis of Health Care plan
- Initial letter of invitation
- Bio of Duane Dauner
- CAHHS letter of endorsement for President's plan
- Description of California Legislature's Conference Committee
- Draft op-ed "Will Clinton's Health Care Cost Control Plan Work?" Stephen Zuckeman, The Urban Institute, and Jack Halley, Georgetown University (This defense of the plan contains California and hospital specific numbers towards the end of the piece.)

Hispanic Proclamation Reception

- Participants list

Speech Text

- To be provided by Christine Heenan

October 12, 1993

SATELLITE FEED WITH CALIFORNIA
ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

DATE:	October 13, 1993
LOCATION:	Room 459 OEOB
TIME:	5:00 p.m.
FROM:	Kim Tilley, Amanda Crumley

I. PURPOSE

To address the Annual Meeting of the California Association of Hospitals and Health Systems (CAHHS) by satellite.

I. BACKGROUND

The California Association of Hospitals and Health Systems, commonly referred to as CAHHS (pronounced "cause"), was founded in 1935. It is the largest hospital association in the country representing 500 -- or 80% -- of the 596 hospitals and health systems in California. (More than 400,000 people are employed by the 596 hospitals operating in California.)

CAHHS has substantial influence with the American Hospital Association. They are generally enthusiastic about the President's plan. (NOTE: letter of endorsement is attached.)

The theme of this year's Annual Meeting is "Partners in Change: Building Strategic Alliances. "Fifty percent of the expected audience will be hospital administrators and associate administrators. The rest will include hospital physicians, volunteers, board and trustee members, and medical equipment vendors. All audience members, except the vendors, are members of CAHHS.

<u>Issues of Concern</u>

(Michael Stafford and John Garamendi provided the following information.)

- Obviously, due to the large number of administrators, the audience wants to know the impact of the President's plan on hospitals, especially rural and county hospitals. They are also more interested in how the proposal affects them as health care providers than as employers.

- As California hospitals obtain nearly 50% of their revenue from Medicare and

Medicaid, CAHHS is concerned about the rate of reduction for Medicare and Medicaid while the plan is phased in.

- The group want information on the provisions for long term care and mental health benefits in the benefits package. They also want to know how many and how powerful the health alliances will be.

- As you know, California has the highest market penetration for HMO and HMO type providers in the country because the concept of managed care is accepted there as something that works. The people attending feel that HMO services should not be viewed as sacrifices and that California should be an example in explaining this to people.

- A large concern in California is the commitment at a federal level to addressing health care for illegal immigrants.

III. PARTICIPANTS

Duane Dauner , President, CAHHS. (NOTE: You met briefly with Mr. Dauner at a VIP reception for the presidents of individual state associations following the American Hospital Association conference in Florida. You asked him about Mark Lowman. Mr. Dauner was at the White House on September 29th to meet with people from Public Liason, Political Affairs, and Congressional Affairs regarding CAHHS support of the President's plan.)

Charles Mason, Jr., President and CEO, Mills-Peninsula Health System, and Chairman of Board of Trustees, CAHHS.

Mark Lowman, Director of Federal Relations, CAHHS. (NOTE: As you know, an Arkansan, and former Chief of Staff for Beryl Anthony.)

Michael Stafford, GRQ, Inc.

Approximately 1,000-1,200 to attend.

IV. PRESS PLAN

Open press at San Diego Convention Center.

V. SEQUENCE OF EVENTS

- Duane Dauner, the President of CAHHS, introduces HRC from site.
- HRC gives remarks/No Q&A (20 minutes) (NOTE: Despite repeated "no's" from our office, CAHHS has pushed hard for you to do Q&A's. Because they felt there was difficulty in scheduling the event, the organizers believe the Q&A would have helped soothe ruffled feathers as well as demonstrate the White House's seriousness in addressing their concerns. We, however, have addressed those concerns in the following remarks.)
- Duane Dauner wraps up program.

IV. REMARKS

Follow.

John Garamendi suggested that you mention the California Legislative Conference Committee that has been created to implement the plan in California.

INITIAL SUMMARY AND ANALYSIS OF PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL

Prepared by American Hospital Association
September 16, 1993

On September 22, President Clinton will present his proposal for health care reform to a joint session of Congress. This short summary and analysis is based on information provided by the White House to AHA prior to that time. Since things can change all the way up to the last minute, watch for subsequent information. This summary focuses on the big picture to provide you with quickly consumable information in the event you are asked to comment on the proposal. In it we cover the basic elements of the Clinton package, how it stacks up to what we believe makes sense, and our overall reaction. After the plan's announcement, more complete and detailed summaries should be available covering these and a host of other issues addressed in the proposal, such as antitrust, medical liability reform, and financing for graduate medical education.

As you review it and form your own reactions, keep in mind that the introduction of President Clinton's proposal is just the first step down a long path. His proposal will be joined by many others that Congress will consider before it acts. Among the major plans that are expected to receive attention are the Conservative Democratic Forum's plan (also based on managed competition), single payer plans such as those supported by Congressmen Stark and McDermott, and Senate and House Republican alternatives.

BASIC ELEMENTS OF THE CLINTON PLAN

ACCESS – Overall, universal access by Jan. 1997 to a federally defined guaranteed standard benefit accomplished predominantly by an employer mandate. Specifics:	
❑ Guaranteed benefit package initially defined by statute but subject to interpretation and expansion by National Health Board. ❑ Limits on mental health and substance abuse services, adult dental care, and long term care with expansions phased in (by year 2000).	❑ Access expansions phased in by each state as ready, but no later than 1997. ❑ Undocumented aliens excluded from program, but federal $$ to providers for required emergency care.

ACCESS (cont'd.)

- Employers contribute at least 80% of *average* premium capped at 7.9% payroll. Employees contribute remainder based on plan selected.
- Federal subsidies for small (<50 workers), low-wage (<$24,000/yr avg.) employers; low-income employees; and unemployed.
- Medicaid program limited to AFDC and SSI recipients. Then split into two: acute and long-term care.
- Medicaid acute program to purchase coverage through alliances. Long-term care program kept separate.
- Medicare left as separate program unless state chooses to integrate, but benefit expands in 1996 to include outpatient Rx drugs.
- Medical care under workers' compensation and automobile insurance paid separately but delivered through health plan.

RESTRUCTURING – Overall, implements reform of insurance market and adapts managed competition framework except in those states that obtain waivers for other approaches (e.g., single payer). Specifics:

- National Health Board does annual report evaluating program, updates benefit package, sets global budget and per capita premium targets, specifies quality information standards, and establishes risk adjustment methods.
- States establish one or more regional health alliances, which can be not-for-profit corporations or state agencies. State agencies determine plan solvency requirements (minimum $500,000 capitalization) and establish and enforce certification requirements for accountable health plans.
- Health alliances enforce global budget and handle enrollment for all employees of firms with <5,000 employees, self-employed, Medicaid recipients, and unemployed.
- Large employers (>5,000) choose whether in or out of alliance. If out, have to meet same requirements as alliances.
- Alliances required to offer at least 3 plans, one of which is fee-for-service. Plans must adhere to one of three standard levels of cost-sharing: high, mixed high/low (PPO), and low cost share. Alliances must offer all plans that meet quality and certification standards.
- Insurance reforms: eliminate pre-existing condition limits and ability to terminate coverage; require use of community rating for premiums (but plans receive risk-adjusted per capita payments); and require open enrollment up to plan capacity. All but fee-for-service plans can limit subscribers to specific providers.

ECONOMIC DISCIPLINE – Overall, based on competition between accountable health plans within a national health budget applied on a per capita premium basis by health alliances. Specifics:

- National Health Board determines first-year national *baseline* per capita premium for the standard benefit package based on current expenditures data, with adjustments for regional variations.
- Year-to-year increases in spending for the standard benefit package are gradually reduced to inflation (based on the CPI) and population changes.
- National Health Board sets a per capita premium target for each health alliance, adjusted for alliance's population relative to national average.
- Alliance limits average, weighted plan price increases to per capita budget.
- When average plan premium within an alliance exceeds the target, the alliance could freeze enrollment in high-cost plans (>120% of avg.) or assess high-cost plans an amount equal to excess. Plans could pass assessments on to providers in the form of payment reductions.
- Unless state obtains a federal waiver to set all provider prices, alliance rate setting for providers is limited to setting a *maximum* fee schedule for fee-for-service plans.

FINANCING – Overall, based on increased employer obligations, Medicaid cuts of $114 billion (1996-2000), Medicare cuts of $124 billion (1996-2000), and increased cigarette and alcohol (except beer) taxes.

- Medicare cuts designed to slow Medicare growth to CPI plus population growth by year 2000.
- Medicare cuts drawn from reductions in hospital market basket, indirect teaching adjustment, capital payments, disproportionate share payments, RBRVS updates, as well as other actions, including income-related Part B premiums.
- Medicaid converted to per capita payment to alliance, with limit on annual increases.
- Medicaid cuts reflect shift of employed recipients to employer-sponsored coverage under mandate. Also reflect converting acute care program to capitated approach equal to 95% of average annual per capita Medicaid expenditures.

HOW THE CLINTON PLAN STACKS UP

The Clinton proposal makes a credible start on many of the issues AHA and member hospitals have sought to address under reform, chiefly the creation of universal access to health care coverage and delivery system restructuring. It also would implement several sorely needed reforms in the health insurance market that enable retaining a pluralistic system, such as the elimination of pre-existing condition clauses and the ability to terminate insurance policies as soon as someone becomes ill.

At the same time, the Clinton plan includes several provisions that are problematic. Chief among them are these:

- **The plan requires the new health alliances to be a success from day one.** This places too much dependence on organizations that don't even exist yet. Moreover, any failure on the part of alliances is likely to lead to even more regulation.
- **The lack of incentives to integrate Medicare** into the new system, coupled with the practical effects of even deeper cuts, will impede progress in implementing health care delivery reform. Providers will have to straddle between different incentive systems, and those serving significant Medicare populations are likely to be financially disadvantaged.
- **Deep cuts in Medicare** play a major role in the financing of the Clinton plan. Cuts of this magnitude threaten the viability of the program and run a large risk of destabilizing the entire system.
- **The method for creating a global budget and per capita premium targets calls for** stringent and rapid cutbacks in the rate of increase in health care expenditures beginning in 1996. It is a highly formulistic and simple approach to a complex issue.
- **The definition of accountable health plans** would be left predominantly to each state to set, providing too much opportunity for business as usual. While some flexibility is desirable, consistency is also desirable, particularly in the need to ensure that plans are held accountable to the communities they serve.
- The ability of states to obtain **waivers to implement alternative programs** (e.g., single-payer programs) does not guarantee enough opportunity for local level input into the decision--for example, the input that would come from a state legislative process.

THE BOTTOM LINE

Overall, the Clinton plan presents significant common ground we can build on and some battlegrounds where improvement is needed. There is much work to be done in reshaping several of its pieces. It is acceptable as a starting point for the debate, but not as a final destination. Hospitals have a dual objective: to make sure that the debate stays on track and that health reform happens.

CAHHS
CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

August 2, 1993

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

Dear Mrs. Clinton:

I am writing you on behalf of the California Association of Hospitals and Health Systems (CAHHS) to invite you to be the keynote speaker at the Opening General Session of our 1993 Annual Meeting. Our meeting will be held in San Diego on October 13-14, and the keynote address is scheduled for 3:00 p.m. on October 13, in the San Diego Convention Center.

The theme of the Annual Meeting is *Partners in Change: Building Strategic Alliances.* The meeting will attract a wide cross section of California's hospital leadership including executive management, financial officers, physicians, trustees and volunteers. We anticipate an attendance in excess of 700.

CAHHS was established in 1935 and is the largest state hospital association in the nation with over 460 hospital members and 240 affiliate and personal members. Of the 596 hospitals operating in California, approximately 80 percent are CAHHS members. California hospitals currently employ over 400,000 people, and in many communities the local hospital is the largest employer. The hospitals are governed by boards of trustees that represent a cross section of community leaders from a wide variety of business, socioeconomic and cultural areas.

CAHHS feels that hospitals must assume the responsibility to forge visionary, workable solutions to the critical problems facing our nation and we take pride in the role we have historically played in improving our state and our nation's health care delivery system. We look forward to working with your office and the Clinton Administration in the critically important effort to achieve health care reform.

As you know, California has long been viewed as a "bell weather" state with respect to health care reform. In view of this, our Annual Meeting, *Partners in Change: Building Strategic Alliances,* will offer a unique forum for you to discuss health care reform. We look forward to an opportunity for you to appear as the Keynote Speaker before the California Association of

Hospitals and Health Systems, and we will be happy to provide whatever assistance is necessary to accommodate your busy schedule.

I will be in contact with your office within the next few days to discuss this matter. In the meantime, if you or your staff have any questions, or I can be of any assistance please call our office at (916) 443-7401.

Sincerely,

C. Duane Dauner
President

CDD:dlv

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CAHHS
CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

Biographical Summary
of
C. DUANE DAUNER

C. Duane Dauner was appointed President and Chief Executive Officer of the California Association of Hospitals and Health Systems (CAHHS) in November 1985. CAHHS is one of the nation's largest state hospital associations, representing 500 hospitals and health systems.

Mr. Dauner's association with hospitals began in 1966 when he became Director of Research at the Kansas Health Facilities Information Service. In 1968, he became Vice President of the Kansas Hospital Association where he served until his appointment as President and Chief Executive Officer of the Missouri Hospital Association (MHA) in 1975.

Mr. Dauner has been active in national hospital issues, serving on numerous American Hospital Association (AHA) and American College of Healthcare Executives (ACHE) committees. He is serving a four year term as a member of the American Hospital Association Board of Trustees. Mr. Dauner has also authored numerous articles and is a nationally known leader on health issues. [001]

Mr. Dauner was born in (b)(6) He attended Pepperdine University in Los Angeles and Wichita State University in Kansas, where he received bachelor's and master's degrees. He taught mathematics and logic at Wichita State University and following postgraduate study at the University of Nebraska became an Assistant Professor at Washburn University of Topeka, Kansas.

4/93
CDD:laa

CAHHS
CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

September 29, 1993

President Bill Clinton
The White House
Washington, D.C. 20500

Dear Mr. President:

On behalf of the 500 members of the California Association of Hospitals and Health Systems (CAHHS), congratulations on an outstanding speech on health reform last week. California hospitals applaud your leadership in health and support your efforts to reform the health care system.

Many of the concepts embodied in your proposal are consistent with the "California Hospitals' Vision, Values and Conditions for Health Care Reform." Your foundation building blocks of universal access to a standard benefit package, pluralistic financing structures with employer and employee participation, reliance upon community-based delivery networks which are locally accountable, economic discipline and predictability, relief from antiquated antitrust restrictions and malpractice reform are essential.

We concur with your sense of priority on health reform and look forward to working with you on issues of concern to California hospitals. We stand ready to assist in enacting responsible and responsive legislation.

Sincerely Yours,

C. Duane Dauner
President and Chief Executive Officer

MEMORANDUM FOR THE FIRST LADY

FROM: **John Hart, Deputy Assistant to the President for Intergovernmental Affairs**

DATE: **October 12, 1993**

SUBJECT: **California Legislature's Conference Committee**

The California Legislature's Conference Committee, is a bipartisan body established to direct California's efforts in implementing the Health Security Plan on a state level. Established in September of 1993, the bi-partisan Committee is comprised of ranking members of the California Senate and Assembly. These members are:

Assemblymen: Co-Chair Burt Margolin (D-Los Angeles)
Assemblyman Willie Brown (D)
Assemblyman Paul Woodruff (R-ranking Republican Assemblyman on CA's Health Care Committee)

Senators: Co-Chair Art Torres (D- Los Angeles)
Senator Nicholas Petris (D-Oakland)
Senator Ken Moddy (R- Fresno; Republican Leader in the CA Senate)

The legislature is on recess and the Committee has not met. Although will consider holding several exploratory meetings before Congress passes the health security act, they have not scheduled their first meeting.

Intergovernmental Affairs is working with the Committee to ensure that the Health Plan is adequately implemented in California.

THE WHITE HOUSE

WASHINGTON

October 12, 1993

RECEPTION CELEBRATING NATIONAL HISPANIC HERITAGE MONTH

DATE: October 13, 1993
LOCATION: State Floor
TIME: 5:30 PM
FROM: Alexis Herman
Suzanna Valdez

I. PURPOSE

To celebrate "National Hispanic Heritage Month" with those who supported you in the campaign.

II. BACKGROUND

Each year, the President signs a proclamation declaring "National Hispanic Heritage Month" from September 15 through October 15. In the past, a proclamation signing ceremony has taken place at the beginning of the month. However, this year, to launch "National Hispanic Heritage Month," you spoke at the Congressional Hispanic Caucus Institute Dinner on September 16th. To culminate this month's festivities, you are hosting this informal reception on October 13 in recognition of the contributions that Hispanics have made to this country, and to thank Hispanic supporters who have not yet visited the White House.

The invited guests are a select group of supporters representing the Hispanic community from states such as, Florida, Texas, California, Colorado, New Mexico, Arizona, Illinois, New York, New Jersey, and the District of Columbia. A criteria for the invitation list was to include those who have not been to the White House or did not attend a Presidential event during your travel. Also invited are DNC Trustees, contributors, and friends of members of the Congressional Hispanic Caucus. There will be a receiving line, but no remarks are required.

III. PARTICIPANTS

18 Members of the Congressional Hispanic Caucus
270 Guests (Adelante con Clinton, Hispanic DNC trustees and others)
Cabinet Members

IV. SEQUENCE OF EVENTS

To be provided by the Social Secretary.

V. PRESS PLAN

Closed press.

VI. REMARKS

None necessary.

RSVP (alphabe

HISPANIC PROCLAMATION CEREMO

ID NAME

56955 Apodaca, ~~Clara (Mrs.)~~
Jerry

55785 Aponte, Mari-Carmen (Ms.)
(202) 835-1555

55798 Aranda, Juan, Jr. (Mr.)
(915) 544-2266

58076 Archuleta, Katherine (Ms.)

56907 Aspin, Les (Hon.)
703/695-5261

55790 Atencio, Dolores (Ms.)
(303) 771-6200

55791 Aviles, Pedro (Mr.)
(202) 332-1053

55792 Ayala, Ruben (Mr.)
(916) 445-6868

56909 Babbitt, Bruce (Hon.)
208-7551 CAROL FLOREMAN

55818 Baca, Jim (Mr.)
(202) 208-3801

55813 Baca, Polly (Ms.)
(303) 620-4436

RSVP (alphabe

HISPANIC PROCLAMATION CEREMO
Contact Social Office X7787

THE PRESIDENT AND MRS. CLINT

ID NAME

53218 Acevedo, Henry (Mr.)
313-234-8225

55233 Agosto, Miguel (Mr.)

55235 Aguiar-Velez, Deborah (Ms.
609-921-3630

55241 Alatorre, Richard (Mr.)
213-485-3335

56926 Albright, Madeleine K. (Ho
736-7555

55247 Allen, Gary (Mr.)
510-451-1300

55252 Alvarez, Aida (Hon.)
202-708-9892

57033 Anastos, Peggy (Ms.)
201-278-4800

55255 Andrade, Juan (Mr.)
312-427-8683

55712 Apodaca, Clara (Ms.)
(505) 843-7313

RSVP (alphabeti

HISPANIC PROCLAMATION CEREMONY

ID	NAME
55113	Bonilla, Henry (Hon. (Rep.)) 225-4511 CHRISTINE
56919	Brown, Jesse (Hon.) 535-8623
56911	Brown, Ronald H. (Hon.) 482-5880
56921	Browner, Carol M. (Hon.) 260-4700
55861	Burgos, Tonio (Mr.)
55862	Burguillo, Luis (Mr.) 202/708-0030
57947	Cass, Jose Antonio (Mr.)
55863	Calderon, Charles (Sen.) 916/327-8315
57960	Califa, Antonio (Mr.)
55865	Callejo, Adelfa B. (Ms.) 214/741-6710
55864	Callejo, William (Mr.) 214/741-6710

RSVP (alpha

HISPANIC PROCLAMATION CERE

ID	NAME
55819	Barros, Roque (Mr.) (619) 661-6912
55820	Becerra, Manuel (Mr.) (202) 225-6235
55841	Becerra, Maria (Ms.) (202) 225-6235
55111	Becerra, Xavier (Hon. (R 225-6235 JEAN
55845	Belcher-Torres, Randy (M (202) 682-3000
56906	Bentsen, Lloyd (Hon. (Se
55853	Bermea, Jose M. (Mr.) (703) 684-5911
55856	Besteiro, Raul (Mr.)
56944	Betancourt, Annie (Ms.) 305-237-2369
55860	Bolanos, Jorge L. (Mr.) 305/326-0065
58069	Bonilla, Deborah (Mrs.)

RSVP (alphabetic

HISPANIC PROCLAMATION CEREMONY

ID	NAME
55875	Chavez, Patricia (Ms.) 202-482-4861
55876	Chavez-Thompson, Linda (Hon.
56905	Christopher, Warren M. (Hon. 647-9640 & 647-9574 CARLENE
55877	Cisneros, Henry (Hon.) 202/708-0810
55880	Coleman, Maria (Ms.) 202/223-3111
55161	Coleman, Ronald D. (Hon. (Re 225-4831
55919	Collado, Jose (Mr.) 305/220-7041
55921	Colon, Gil (Mr.) 202/482-1684
55925	Colon, Nidia (Ms.) 201/222-2828
55927	Colon-Jorge, Janette (Ms.) 201/733-6604
55939	Coronado, Elaine Marie (Ms.)

RSVP (alphab

HISPANIC PROCLAMATION CEREM

ID	NAME
58070	Campos, Santiago (Mr.)
55866	Cantu, Norma V. (Hon.) 202/205-5413
55867	Cantu, Santiago (Mr.) 512/884-4023
56965	Caraballo, Wilfredo (Mr.)
55868	Cardona, Alice (Ms.)
55869	Carlo, Gerardo (Mr.) 809/723-0113
55870	Cavazos, Oscar (Mr.) 210/548-8375
55871	Cejas, Paul (Mr.) 305/591-3311, X1951
55872	Cervantes, Maggie (Ms.) 213/484-1515
55873	Chapa, Art Pastor (Mr.) 602/745-8000
55874	Chavez, Diana (Ms.) 313/926-5531

RSVP (alphabet

HISPANIC PROCLAMATION CEREMON

ID NAME

56028 Diaz, Nelson A. (Mr.)
202/708-2244

56025 Diaz, Olga (Ms.)
212/675-0800

56034 Diaz, Romulo (Mr.)
202/586-6210

55131 Diaz-Balart, Lincoln (Hon.
225-4211 LIDIA

56811 Dias-Oliver, Remedios (Mr.)

55818 Durand, Anna (Ms.)
202/690-7741

56824 Echaveste, Maria (Ms.)
202/219-8305

56836 Eckstrom, Daniel (Mr.)
602/740-8126

56837 Elizondo, Rita (Ms.)
202/543-1771

57034 Erickson, Charles (Mr.)
202-234-0280

56841 Escheverria, John (Mr.)
202/208-4423

RSVP (alphabe

HISPANIC PROCLAMATION CEREMO

ID NAME

55968 Cortes, Yolanda (Ms.)
415/476-2155

56007 Crocker, Elvira (Ms.)
202/822-7208

57030 Cruz, Felix M. (Mr.)
201-733-6577

56016 Cruz, Miriam (Ms.)
202/387-3331

A

56013 Cruz, Rebecca (Ms.)
312/278-5130

56019 Cruz, Ruben (Mr.)
312/743-7451

55115 de la Garza, E "Kika" (Hon.
225-6872 RIKA SPANGLER

55126 De Lugo, Ron (Hon. (Rep.))
SPOUSE NAME - Mrs. Shei
(202) 225-1790

55126 De Lugo, Sheila (Mrs.)
Spouse of Ron De Lugo

56037 Diaz, Guarione (Mr.)
305/642-3484

56047 Diaz, Luis (Mr.)

RSVP (alphabeti

HISPANIC PROCLAMATION CEREMONY

ID	NAME
55130	Garcia, Pete (Mr.) 602-257-0700
55127	Garcia, Yolanda (Ms.)
56931	Gibbons, John M. (Hon.) 456-7116
55132	Gonzalez, Jr., Efrain (Mr.) 212-299-7905
55134	Gonzalez, Henry C. (Mr.) 213-402-1771
55319	Graziadio, Josie (Ms.)
57028	Griego, Linda (Ms.) 213-624-6996
58085	Grijalva, Raul (Mr.)
56137	Guardiana, Robert (Mr.) 310-215-0551
55166	Guerra, Gabriel (Mr.) 202/638-7030
55169	Guillemortti, Rafael (Mr.) (809) 724-7568

RSVP (alph

HISPANIC PROCLAMATION CER

ID	NAME
56844	Espinoza, Arnaldo (Mr.) 203/677-9333
56847	Estrada, Rudolph I. (Mr 818/441-8700
56854	Fanjul, Alfonso (Mr.) 407/659-6303
56858	Fernandez, Tony (Mr.) 908/272-4200
56860	Ferrer, Fernando (Mr.) 212/590-3557
56864	Flores, Don (Mr.) 202/662-7145
58074	Floresca, Felipe (Mr.)
56867	Floresca, Providence (I
57020	Fonnegra, D. Lolita (M 212-417-4631
55122	Fuentes, Jennice (Ms.) 202-225-8203
55123	Gallegos, Mario (Mr.) 713-223-9166

RSVP (alphabetic

HISPANIC PROCLAMATION CEREMONY

ID	NAME
55237	Icaza, Ricardo F. (Mr.) (213) 487-7070 X107
55245	Ithier, Luis (Mr.) (212) 815-1945
55249	Jaramillo, Rita (Ms.)
55251	Jimenez, Ralph (Mr.) (313) 926-5531
55256	Jordan, Roberto (Mr.) (212) 243-3365
56929	Kantor, Mickey (Hon. (Amb.)) X3204 MALIK KAHN
55269	Kimerling, Kannath (Mr.) (212) 305-6546
55271	Lacayo, Henry (Mr.) (805) 498-7679
56930	Lake, Anthony (Hon.) X2255
55273	Lantigua, Rafael (Dr.) (212) 305-6546
55277	Laracuente, Sonia (Ms.) (212) 265-7000 X331

RSVP (alpha

HISPANIC PROCLAMATION CERE

ID	NAME
55182	Gutierrez, Gloria (Ms.) 482-4951
55141	Gutierrez, Luis V. (Hon. 225-8203 MAGGIE
56937	Hall, Cindy Ybedra (Ms.) 305-854-0220
55189	Hernandez, Andy (Mr.) (512) 222-8014
55187	Hernandez, Antonia (Ms.) 213-629-2512
57021	Hernandez-Pinero, Sally (212-306-3434
55190	Hidalgo, Frank (Mr.) (602) 965-8889
55228	Hopwell, Lus (Ms.) 546-3803
55231	Huerta, Dolores (Ms.) (805) 822-5571
59086	Ibarra, Jose (Mr.) 602-740-8126
55236	Ibarra, Mickey (Mr.) 202/822-7348

RSVP (alphabet

HISPANIC PROCLAMATION CEREMON

ID	NAME
58077	Marks, Fae Morales (Ms.)
55342	Marquez, David (Mr.) (713) 622-3589
55340	Marquez, Karen (Ms.) (703) 671-9810
55348	Marrero, Victor (Hon.) (212) 415-4402
56813	Martin, Dilan (Mr.)
57031	Martinez, Henry (Mr.) 201-733-6577
55358	Martinez, Laudelina (Ms.) (512) 692-3805
55352	Martinez, Lawrence (Mr.) (303) 922-0509
55355	Martinez, Maria-Elena (Ms.) (703) 222-6414
55142	Martinez, Matthew (Hon. (Re 225-5464
56920	McLarty, Thomas F. "Mack" (456-6797 MARILYN

RSVP (alpha

HISPANIC PROCLAMATION CERE

ID	NAME
55279	Leon, Nancy (Ms.) (202) 466-6732
55287	Limon, Lavina (Ms.) (202) 401-9200
55290	Longacre, Henry (Mr.) (505) 877-0505
55292	Lopez, Osvaldo (Mr.)
55300	Lopez, Rick (Mr.) (202) 226-3430
55294	Lopez, Ronnie (Mr.) (602) 264-4791
55308	Lowry, Carmen (Ms.)
58071	Lucero, Richard (Mr.)
56952	Luna, Vilma (Ms.) 512-857-0233
55334	Machado, Richard (Dr.) 809/780-5319
55338	Madrid, Arturo (Dr.) (714) 625-6607

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HISPANIC PROCLAMATION CEREMO

ID	NAME
56985	Montes, Tony (Mr.) 202-783-5065
55379	Montoya, Alfredo C. (Mr.) (202) 347-4223
58083	Montoya, Liz (Ms.)
56950	Montoya, Regina (Ms.) 214-821-2411
55381	Morales, Tony (Mr.) (512)477-3222
56948	Morgado, Marcia (Ms.) 305-858-1503
55383	Moyano, Nellie (Ms.) (201)420-6036
56933	Muller, Jr., Elio E. (Mr 813-251-5991
55385	Munoz, George (Mr.) (202) 622-0410
55387	Newton, Frank (Mr.) (202) 736-2140
55388	Nino, Jose (Mr.) (202) 862-3939

RSVP (alphal

HISPANIC PROCLAMATION CERE

ID	NAME
57027	Medina, Coco (Ms.) 805-376-6640
55360	Mendelsohn, Jeff (Mr.) (202) 225-1640
55365	Mendez, Joseph (Mr.)
55363	Mendez, Olga (Hon.) (212) 860-0893
55367	Mendoza, A.G. (Mr.) (213) 385-7554
55366	Mendoza, Ray (Mr.) (714)637-8090
55143	Menendez, Robert (Hon. (R 225-7919
55368	Merino, S.Q. (Chano) (Mr. (512) 477-1811
5537:	Mesa, Choco (Ms.) (202) 708-0030
55373	Molina, Gloria (Ms.) (213) 974-4111
55377	Monserrate, Flores (Ms.)

ID	NAME
56922	Panetta, Leon E. (Hon.) X5883
55148	Pastor, Edward (Hon. (Rep.]
56960	Pena, Ada (Ms.) 202/833-2301
56959	Pena, Devon (Mr.) 408/554-4782
56958	Pena, Federico (Hon.) 366-6788
57029	Penelas, Alex (Mr.) 305-375-5071
56961	Perez, Demetrio (Mr.)
57024	Perez, Jorge (Mr.) 305/460-9900
55887	Perez, Yvonne (Ms.) 305-854-0220
55891	Perez-Pietri, Luis (Mr.) 785-3136
55895	Petrovich, Janice (Ms.) 202-835-3600

ID	NAME
55545	Nunez, Louis (Mr.) 202-223-3915
56883	Ocanas, Gilberto (Mr.) 512-832-6700
56885	Olivarez, Manuel (Mr.)
56946	Ortiz, Elvira (Ms.) Spouse of Juan Ortiz
56886	Ortiz, Hildamar (Mr.) 212/788-3308
56946	Ortiz, Juan (Mr.) SPOUSE NAME - Ms. Elvira Oı 800-822-2979
55144	Ortiz, Solomon P. (Hon. (Rep 225-7742
56949	Otero, Jack (Mr.) 202/219-6043
56951	Pachon, Harry (Mr.) 202/546-2536
56954	Padilla, Tony (Mr.) 202/783-3660
56938	Padron, Euardo (Mr.) 305237-3203

RSVP (alphabetic) LI

HISPANIC PROCLAMATION CEREMONY - Oc

ID	NAME	A/I
55926	Rangel-Hodges, Rose (Ms.) 213-680-9567	
56913	Reich, Robert B. (Hon.) 219-8271 DONNA	
55928	Reinoso, Cruz (Mr.) 376-7700	
56967	Rendon, Florencio (Mr.) 202-225-7742	
56969	Rendon, Mary (Ms.) 226-3430	
56908	Reno, Janet (Hon.) 514-4195 EVELYN LONG	A
55150	Richardson, William B. (Hon. 225-6190	
56918	Riley, Richard W. (Hon.) 401-3043 KAREN BURCHARD & JENNI	
56970	Rios, Elana (Ms.)	
56972	Rivera, Dennis (Mr.) 212/586-5216	
58073	Rivera, Jose Jaime (Mr.)	A

RSVP (al

HISPANIC PROCLAMATION C

ID	NAME
55900	Pla, George (Mr.) 213-895-0224
55901	Portalatin, Maria (Ms.
55902	Portes, Carlos (Mr.) 212-567-0001
55904	Prieto, Grace (Ms.)
56966	Prio, Maria Elena (Ms.
55914	Pulver, Edward B. (Mr. 201-435-9424
55920	Quintana, Luis (Mr.) 201-733-3686
55922	Ramirez, Aldaberto (Mr 619-344-6300
57022	Ramirez, Carlos D. (Mr 212-807-4600
55923	Ramon, Cipriano (Mr.) 713-449-1244
55924	Ramos, Frank (Mr.) 205-6411

RSVP (alphabetic) LI

HISPANIC PROCLAMATION CEREMONY - OC

ID	NAME	A/F
55151	Romero-Barcelo, Carlos A. (H 225-2615	A
56986	Roque, Margarita (Ms.) 366-4277	A
55139	Ros-Lehtinen, Ileana (Hon. (225-3931 - MARGIE	
56987	Rosado, John (Mr.) 201-675-3300	
56988	Roybal, Edward R. (Hon.)	
55152	Roybal-Allard, Lucille (Hon. 225-1766	A
56989	Ruano, Miguel (Mr.) 305-225-8767	
56928	Rubin, Robert E. (Hon.) 456-2174 LINDA	
56990	Saab, Lourdes (Mr.) 213-725-1657	
56939	Saborido, Belen (Mr.) 305-223-8916	
56991	Sanchez, Felix (Mr.) 467-5050	

RSVP (alphabet

HISPANIC PROCLAMATION CEREMON

ID	NAME
56973	Robb, Cristina (Ms.)
56974	Robles, Victor (Mr.)
56936	Rodham, Maria Arias (Ms.) 305-442-3334
56979	Rodriguez, Arturo (Mr.) 805-822-5571
56981	Rodriguez, Jose V. (Mr.) 213-483-6630
56978	Rodriguez, Lidia (Ms.)
56977	Rodriguez, Lula (Ms.) 514-1955
57019	Rodriguez Ramirez, Rose (M 212-417-2266
56975	Rodriguez, Sam (Mr.) 863-8060
56983	Rodriguez-Colon, Charlie (809-724-2030
56982	Rodriguez-Ramanski, Shirle

RSVP (alphabeti

HISPANIC PROCLAMATION CEREMONY

ID	NAME
56942	Soler, Ivonne (Ms.) 305-375-1641
57000	Sotomayor, Marta (Ms.) 265-1288
55156	Tejeda, Frank (Hon. (Rep.)) 225-1640
57023	Torano, Maria Elena (Ms.) 703/243-3608
57003	Torres, Art (Mr.) 213-620-2529
57001	Torres, Celestino P. (Mr.) 602-888-8440
57002	Torres, Eileen (Ms.)
55157	Torres, Esteban E. (Hon. (I 225-5256
57004	Torres, Gerald (Professor) 514-2701
57005	Torres-Gil, Fernando M. (H 401-4541
57006	Toscano, Ellen (Ms.) 225-4361

RSVP (al

HISPANIC PROCLAMATION C

ID	NAME
56994	Sanchez, Frank (Mr.) 213-727-0747
56993	Sanchez, Oscar (Mr.) 312-221-5727
56995	Sanchez, Tony (Mr.) 210-722-8092
56992	Sanchez, Yolanda (Ms.) 638-4282
56996	Sandez, Jose Luis (Mr. 225-4831
58075	Sandoval, Marcela (Ms.
56968	Santos, Miriam (Ms.) 312-744-3356
56997	Seda, Damaso (Mr.) 212-873-6000
56999	Sequeira, Luis (Mr.) 720-5923
55154	Serrano, Jose (Hon. (R 225-4361
56915	Shalala, Donna E. (Hon. 690-6610 CASSANDRA & 69

RSVP (alphabeti

HISPANIC PROCLAMATION CEREMONY

ID	NAME
57032	Vega, Sal (Mr.)
57014	Velasquez, Hector (Mr.) 212-685-2311
55159	Velazquez, Nydia (Hon. (Re 225-2361 JOYCE
57015	Vermillion, Stephen (Mr.) 686-3295
57016	Veve, Michael (Mr.) 663-9087
57017	Vigil-Ellerman, Beverly (M 835-0324
57018	Yzaguirre, Raul (Mr.) 202-289-1380
57025	Zamora, Anthony (Mr.) 213-857-8327

RSVP (alphabe

HISPANIC PROCLAMATION CEREMC

ID	NAME
58072	Underwood, Lorraine (Mrs.)
55146	Underwood, Robert A. (Hon. 226-1188
56964	Unzueta, Silvia (Ms.) 305-857-6883
57007	Urra, Marty (Mr.) 305-366-3265
57010	Valdez, Abelardo L. (Mr.) 626-6622
57009	Valdez, Roberto (Mr.) 212-563-7553
57011	Valencia, John (Mr.)
57012	Valenciana, Clifford (Mr.) 909-780-6203
56980	Vargas, Raul (Ms.) 213-740-4735
57013	Vas, Joseph (Mr.) 908-826-7121
57969	Vazquez, Adelino (Mr.)

TOTAL COUNTS

NUMBER OF ACCEPTS:	135
NUMBER OF REGRETS:	10
NUMBER OF NO RESPONSES:	147
NUMBER OF UNKNOWN GUESTS:	0
NUMBER OF EXPECTED ATTENDEES:	282

RSVP (alphab

HISPANIC PROCLAMATION CEREM

REGRETS

ID	NAME
55878	Cofino, Anita (Ms.) 305/633-7488
56910	Espy, Michael (Hon.) 720-5538 SHARON HARRIS
56932	Ferro, Simon (Mr.) 305/463-7920
55128	Garcia, Raul (Mr.) 201-863-3355
55140	Gonzalez, Henry B. (Hon. (225-3236 - CHRISTINE OCHOA
56917	O'Leary, Hazel R. (Hon.) 586-5534
56927	Rasco, Carol (Hon.) X2249 ROSALYN
56984	Romero, Ed (Mr.) 505/823-6801
56925	Tyson, Laura D'Andrea (Hon X5042
57026	Uribe, Charles (Mr.) 212-889-9100

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16 Pages

American Hospital Assoc.
News Volume 29, Number 30
July 26, 1993

AHA News®

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Association Focus

Mathis: AHA plays a significant role in shaping health reform

The following text constitutes the mid-year report of Larry L. Mathis, chairman of the AHA board of trustees and president and CEO of The Methodist Hospital, Houston.

In the first six months of 1993, health care reform dominated the agenda for the new administration, states and communities, and for the AHA.

In national health care reform (as in most public-policy issues), results will come only after a lengthy process. However, it is already clear that the AHA's and hospitals' activities will be a significant factor in shaping the eventual outcome. At the national level, the AHA is actively preparing for and aggressively pushing for national health care reform.

Mathis

On the local level, hospitals are beginning to prepare for and move toward a restructured health care-delivery system that best fits their communities.

Overall, I perceive a pervasive spirit of America's hospitals today—a deep and abiding determination to seize the opportunity to redesign the health care-financing and -delivery system in a way that makes sense for our patients and our communities. We have begun to realize that the time is now ... that for health care reform, later may be too late.

We cannot let the momentum for reform slip away, leaving a health care system facing increasing payment shortfalls from government programs, large numbers of uninsured people and spiraling costs. We cannot let the momentum stall, or the vision of community-responsive and provider-based delivery organizations could be replaced in the not-so-distant future by a micromanaged, single-payer, government-controlled approach to health care delivery.

Activities that stepped up the pressure for national health care reform be-

(continued on page 5)

Conferees look to split difference on Medicare

Budget conference chairmen Rep. Dan Rostenkowski (D-IL) and Sen. Daniel Patrick Moynihan (D-NY) last week sought to split at $54 billion the difference between the House and Senate numbers on Medicare savings. But Rep. Pete Stark (D-CA) attempted to keep House conferees behind the chamber's $50 billion figure for Medicare.

"I can think of no good reason" to go beyond the House position on Medicare-spending reductions, Stark said July 22 after a round of budget talks, in explaining his opposition to a compromise. He is the prime author of the House's two-year freeze on Medicare-provider payments, which is expected to be dropped in conference.

Meanwhile, as the budget conferees continued to wrangle over differences in House and Senate Medicare-spending levels, hospitals greeted with disappointment reports that the Clinton administration would be willing to accept the Senate's $58 billion in five-year Medicare savings.

In a July 22 letter to White House Office of Management and Budget Director Leon E. Panetta, AHA President Dick Davidson said the administration was abandoning its commitment to "shared sacrifice" in developing a $500 billion deficit-reduction package.

"Given our willingness to work in a responsible manner to achieve a fair and balanced response to the president's call for 'shared sacrifice,' it is disturbing that the administration appears ready to abandon its own budget," Davidson said.

He added: "This lack of commitment by the administration to its own position raises serious concerns about our ability to forge a reliable partnership to win health reform in the months ahead."

Stark

Davidson's letter was prompted by Panetta's remarks last week that the administration was moving toward the Senate's position on Medicare.

In a related development, the AHA July 22 joined a group of 50 health care and business organizations in calling on congressional budget conferees to limit the reconciliation measure's ban on physician self-referrals to Medicare and Medicaid services, and to exempt managed care programs.

The measure's physician self-referral restrictions would "interfere with the development of integrated delivery systems ... and also would seriously undermine other managed care organizations, which have strong incentives to control inappropriate utilization of services caused by self-referral and other factors," the groups stated.—*Gary Luggiero*

Davidson: Calls to members of Congress can't wait

The House/Senate conference committee is at this moment hammering out a budget compromise. Its timetable is tight: Negotiators are trying to finish before the summer recess begins Aug. 6.

What action conferees take on Medicare spending levels is important to every patient you serve and to the prospects for health reform down the road. The Senate version calls for $58 billion in Medicare savings—the House version calls for $50 billion.

If you have not yet acted on our earlier alert, pick up the phone, call the U.S. Capitol switchboard at (202) 224-3121 and ask to speak with your members of Congress. It is vital that you contact—today—your senators and representatives, ***even if they are not on the conference committee.***

Ken Heinen

Every member of Congress must know and let their colleagues on the committee know that the Senate version goes beyond shared sacrifice to the point of punishing providers that are trying to work responsibly with the government to reduce the deficit. The House savings—$50 billion—are in line with the president's call for shared sacrifice. The conference committee must be convinced to adopt the House version's savings.

The intensity of the budget debate grows daily. You cannot afford to wait. The AHA has only one advocacy tool that we know works with every member of Congress, regardless of party affiliation or position. That's you ... the voice from home telling them straight from the shoulder what effect their actions will have on their hospitals and their communities.

Last week, the AHA brought to Washington, DC, leaders from many of the hospitals that will be hardest hit by the additional Medicare reductions. They were extremely effective in opening the eyes of their members of Congress to how "savings" will affect patients, health care workers and communities. I am more convinced than ever before that your one-on-one advocacy can make a big difference in the budget-reconciliation outcome.

Please act today.

Dick Davidson

News Flash!

First lady Hillary Rodham Clinton has accepted the AHA's invitation to be the keynote speaker at the Aug. 9 opening session of the association's annual convention in Orlando, FL.

Clinton

Briefs

- Eight out-of-state physicians have filed suit challenging a 2 percent tax to be levied against them as part of the MinnesotaCare insurance program. They say the tax is unconstitutional and violates laws governing commerce between states. A similar suit is pending by out-of-state hospitals.
- Karen M. Ignagni, director of employee benefits for the Washington, DC-based AFL-CIO, last week was named president of the Group Health Association of America, Washington, DC. She will replace James F. Doherty, who will retire next year.
- The financially troubled Blue Cross and Blue Shield of the National Capital Area, Washington, DC, has received $60 million from a group of 37 independent Blues plans and BCS Financial Corp., Chicago. Also, the plan's CEO, Benjamin W. Giuliani, announced his resignation last week.
- The American Organization of Nurse Executives (AONE), an AHA subsidiary, named Cathy Holmgren, R.N., acting executive director, effective Aug. 1. Holmgren, the AONE's director of membership services, will replace Carol Boston, R.N., who has resigned to become a senior consultant in the Chicago office of the Hay Group.
- Twenty-six people were laid off recently at the Chicago-based Blue Cross and Blue Shield Association as part of a restructuring that narrowed the number of the group's divisions from 10 to six.
- HCFA recently proposed regulations that would allow federally qualified HMOs to offer point-of-service plans and to use the resources of parent organizations to meet fiscal-soundness requirements.

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release August 9, 1993

REMARKS BY THE FIRST LADY
TO AMERICAN HOSPITAL ASSOCIATION

Orlando, Florida

MRS. CLINTON: Thank you very much, Dick, George, for that very generous introduction. Thank you also for putting so many of my friends from Arkansas in the front row here. It makes me feel very welcomed and at home. It is indeed a special privilege for me to be here with this organization, although I would just contest one point that Dick made in his introduction. He said here we are in the magic kingdom. I feel like for the last six months I have been in the magic kingdom. And it's nice to be somewhere outside of that kingdom here in Orlando with all of you.

Because what we are embarked upon and what we are partners in is nothing less than trying to deliver on the promise that this organization and the President have made to deliver health care in a way that is affordable, maintain quality and providing it to every citizen of our country.

To that end, I'm particularly pleased to be joined here with Governor Chiles. Those of you from Florida must know how closely the rest of us have watched what you have achieved already in organizing a delivery system to provide quality health care. And I want to applaud not only the Governor, who is with us, but all of you from Florida, the hospitals and the medical community, who are going to make this program in Florida a model for the rest of the country.

I'm also pleased to be here with Congressman Bacchus. There was a very tough vote last week. It was a vote to try to move this economy forward. It was a vote that was controversial, but which he voted in the favor of ending gridlock and getting us a budget and an economic program that began to put our house in order in this country. And I hope that our constituents and this state know how difficult it sometimes is in the other magic kingdom to stand up to what you believe is right for the country at the time.

And I particularly want to thank this association because all during the very difficult days leading up to that vote

MORE

last week, the American Hospital Association played a very constructive and productive role. It is a role that I have come to expect from Dick Davidson and the people who represent you in Washington. It is a role that I have come to depend upon. They're always straight, they always tell us what your thinking and what's at stake, but they do it in a productive and constructive way. There's too little of that in Washington sometimes. And I'm very pleased that this association is represented so well by your board and by your staff that they can play that kind of positive role in reaching difficult decisions that this country faces.

If we are on the brink of health care reform, it is only because of the work of associations like yours and all of you represented here. It is only because for a number of years, you have been sounding the alarm about what is happening on the front lines of health care. It is only because you see every day what comes in the emergency room, what comes in the front door, what comes in the out-patient clinics that you run. It is only because you understand, being on the front lines, that we cannot continue doing what we do in health care in this country and fulfill either our human mission or meet our economic demands.

So let us move forward together in trying to fashion a health care system that represents the best about what each of you believe and do every day. It is not going to be easy, just as the budget reconciliation was not easy. It did not satisfy all the goals of the President. It did not satisfy all the goals of the American Hospital Association.

I know many of you are distressed about the level of the Medicare cuts that emerged from the House-Senate conference. But even so, you understood how imperative it was that the budget be passed not only to put our house in order and our country on the right track, but so that we could get to the second stage of the important business facing this country -- and that is health care reform.

When I joined the board of the Arkansas Children's Hospital, I thought I had something of a working knowledge of the challenges hospitals faced, the changing role of physicians, nurses, other health care professionals. I learned all about the dish payments and the DRGs, the utilization reviews. I figured out what PROs and PPOs and HMOs were. But I also learned a lot more. I learned about what you face every day. I have taken that knowledge with me into this assignment of the last six months.

I can't even pretend to understand the day-to-day complexities, but I fully understand how dedicated hospital administrators and medical personnel are to meeting those challenges.

If it has not been for the many hundreds and even thousands of you and your colleagues around the country who have participated in the efforts of the last six months, we would not be where we are today -- on the brink of having the President present a plan to the country and to the Congress.

But then the plan that the President is going to be presenting will very much resemble what this association has been saying all along. I was telling Dick as we were waiting to come in that I picked up the Conventional Daily, and the American Hospital Association and health care reform article which appears on the second page outlines what health care reform has to consist of. You know it better than I, but it is a message that comes from you to the American people and will be a part of what the President presents as he takes the concepts that you have worked on and are implementing and presents them to the entire nation.

Now, I do not want to be overly optimistic about the challenge that confronts us. Taking this article and going down point by point and looking at how access to health care must be universal, it must provide health services delivered by networks of providers, we must contain costs -- all of those things which you agreed on and that we agreed on will not come easily. There will continue to be opposition based on fear -- the fear of change, the fear of losing some advantage -- opposition based on ideological concerns about how we should or should not reform our system. But we have to take each of those fears or concerns and deal with them honestly. Because if we can present a plan that corresponds to what you know will work, we ought to be able to convince the Congress and the country, because there is so much at stake.

When we began this effort there wasn't any preconceived plan waiting in any closet for someone to pick up and present. The plan that is being developed has rested on the advice of people representing hospitals, of physicians, of businesspeople, of nurses, of everyone who has a stake in the health care system. We looked at every model that we could find anywhere in the world. We looked to see what worked and what didn't work. We looked to understand how we could draw from different approaches to create an American solution to an American problem.

We looked here within our own country. I know that earlier you honored Jack Lewin, who has been an integral part in helping us to think through and design a system that would work for the country based on Hawaii's experience. We visited hospitals all over the country that are doing creative and entrepreneurial ways of approaching specific issues, because we wanted to be sure that what we presented bore the mark of reality and experience.

And so, as we move forward, that has been our hallmark. We have wanted to be able to say to any American, we believe this will work and here is the evidence to back us up. We also wanted to start from the very simple premise that at the bottom, health care reform is about individual opportunity and responsibility. As the President has said all during the last six months, we must ground our country's course in our most enduring values. And that is the belief that America can extend all of us an opportunity if we assume responsibility for ourselves, our communities, and our country.

In other words, you have to eliminate the all too prevalent state of mind that there is a free lunch, that there can be a free ride, that there is something for nothing, and get back to what I was raised to believe and, I would venture, most of you, that the American Dream depended upon our willingness to work hard and to be responsible.

But we also have to be sure that that American Dream is out there to be seized. And one of the most corroding aspects of the last years has been the way our health care system has eaten away at our economic potential, at our human potential. So if we agree that we have to ground what we are doing in experience and reality, and if we believe we have to restore opportunity and responsibility, then the health care reform debate is something beyond just the specifics. And we may not agree on all of the specifics, but if we can agree on the direction we are going and how we should get there, we will make enormous progress together, because we are united by common concerns and common goals.

We've already made great strides in putting together a plan that will represent those common concerns and common goals. And I want to share some of those features with all of you today.

Let me start with your goal. We must achieve universal coverage. Every American should have the security of knowing that no matter where he or she works, whether he or she has ever been sick before, where he or she lives, because that person is an American, he or she will be entitled to a package of benefits that will give them health security. We cannot achieve cost containment in a system in which nearly 40 million of our citizens now do not have coverage for their health care needs.

We also need a delivery system that integrates the delivery of care along the lines that you have advocated. You were among the first to promote community care networks -- a concept that lies at the very heart of revitalizing our health care system. That, combined with the universal coverage, gives us the tools at the local level to be creative in providing services to meet the needs of local populations. You also have understood from the very beginning that

integrating delivery and providing networks of care is the surest and most efficient way to provide for contained costs because when providers are paid as a group, whether it's in a fee-for-service network, or a PPO, or a HMO, or some as yet unnamed form for delivery care, there is then a sentence built into the system to be careful about the allocation of resources; to look to other people to learn how better to deliver the care that we have to; to understand what the trade-offs are. It is very important that we organize our health care system so that it is better able to deliver health care to all of our citizens.

You have also understood how we have to cut the costs in the current system by simplifying administration and paperwork. You are living, breathing examples every day of what is wrong with our health care system. You know as hospital administrators, as directors of nursing, as people who are in the back offices that are filled with paperwork, that if we do not simplify the burdens on our health care system we can never provide health care to every American at an affordable cost.

In order to do that we need to move toward a single form system. We need to do all that we can to implement more efficient means of electronic and computerized billing. We need to understand clearly that it is no longer acceptable for the paperwork hospital to be growing at four times the rate of the care-giving hospital. When you have, as I have talked with hospital administrators all over this country, the difficult choices of having to hire more bookkeepers and clerical people while you are laying off nurses and technicians, that is an unacceptable choice for any hospital and needs to be eliminated as soon as possible. (Applause.)

Because what the current ratio is that hospitals must hire four new administrators for every new doctor -- four to one -- simply to handle the avalanche of insurance forms and paperwork. I will never forget talking to a nurse a few months ago who summed it up for me. She said she went into nursing to care for people. If she had wanted to be an accountant she would have gone through an accounting course and worked for an accounting firm. And yet she spent nearly 50 percent of her time filling out forms.

I want to see nurses like the ones who took care of my father in his last days in that hospital, St. Vincent's in Little Rock, taking care of people, not filling out unnecessary forms in a duplicative system that doesn't delivery one more ounce of compassion, care, and help. (Applause.) And if we have anything to do with it, in this reform effort, it is to free our doctors and our nurses from those kinds of burdens.

We also have to be aware of how the interaction between the legal system and the health care system have often interfered with your capacity to make good decisions. One of the issues that your association brought to me was one that I heard all over the country: How can we try to move forward to this new world that we're outlining if we cannot even collaborate among ourselves? How can we try to be more efficient in our communities if we're afraid that we might be sued for antitrust violations? You told us and we heard you, and is was something that I have never known before I got into this, that the kind of positive arrangements that you would want to pursue with your neighbors and even your competitors were being either chilled or in some way eliminated from consideration because of the fear of the antitrust laws. Hospitals such as yours have come to believe that expensive legal opinions would be required any time they wanted to merge or share high-technology equipment or form a purchasing cooperative or integrated network for delivering services.

You also told us that hospitals were frustrated over the last years because they couldn't get quick and reliable advise from the enforcers of the antitrust laws in the federal government. Well, we not only heard you, we're going to do something about that. (Applause.) At the request of the task force and the White House, the Justice Department right now is exploring guidelines for mergers, networks, joint ventures, purchasing cooperatives, and information exchanges so that hospitals do not have to file hundreds of more forms and wait years and years to share an MRI or pool advanced ultrasound equipment or do some of the other things you would like to do to give better service to your community. So we intend to move on that. It will part of the President's health care reform package. (Applause.)

We intend for that package to result in a health security card for every American that will be the key to a package of benefits that will, again, do something you have urged us to do: a package of benefits that will stress primary and preventive health care. Because we believe that if we have funding streams for primary and preventive health care we will save money, not just in the long run but in the medium run. That if you know that there is reimbursements standing in the wings for immunizing children, for providing mammograms for every woman, for providing well child care for young children, the services will be there. And all of us will benefit from those services.

We cannot have a healthy health care system without stressing primary and preventive health care. And we have to do that by changing the incentives that have grown up in our insurance industry that only pay for something once it was a problem. If you will stand with us on primary and preventive health care we will make a huge difference. (Applause.)

Even though universal coverage is one of our keys, and something we share in common with you, I want to make clear that health care reform is not any longer, from my view, driven just by the needs of those who are uninsured. It is driven by the fears and concerns of those who are already insured. Two million Americans a month lose their health insurance. Some may only lose it for a month, some may lose it for more than a year or two. But the fear of losing it, the increasing costs of acquiring it, the problems employers face in a market where they have so little purchasing power has made the fact of insurance, once taken for granted by many millions of Americans, no longer a source of personal security.

So in the community from which you come, the debate is not just about taking care of those who have no coverage, it is about taking care of all of us. And part of that debate has to be explained by you because you see it every day. Until all Americans are insured for health care we can never control costs because of the phenomenon you know so well, known as cost-shifting.

Many Americans in my conversations over the last month who do have insurance are desperate to hold on to it and want it to mean something again. They often don't make the link that you make every day between the people who do get care in our country -- because we do take care of people who come through those hospital doors, but it is often at the most expensive, latest point. And they come without any reimbursement stream, or an inadequate one. And that is what leads to the $25 Tylenols, the latex gloves that are so expensive, that Governor Chiles has tried to use to educate the people of Florida.

Because you know that the money has to come from somewhere. All those who are currently insured will be better off financially and in terms of the services they will have access to if everybody is insured, because you will then have the kind of compensation you deserve to have when you take care of everybody. That is a message local hospitals will have to help us deliver to educate Americans, so that the linkage between the benefits to be obtained from insuring those who are not insured and the security that all Americans, including those who are insured, will receive can be made clearly at the grass roots level.

Because until Americans fully appreciate what you go through every day they will not understand that right now those of us who have insurance are paying not only for ourselves, we're paying for the shortfalls in the public system and we're paying for the uncompensated care. We can do better than that if we get everybody in the system and make everybody responsible for some part of their

own care. That has to be a hallmark of the message that we send in the next several months.

Because when all Americans have a comprehensive package of benefits, then the hospitals that I have visited, like King Drew in Los Angeles or St. Agnes in Philadelphia, which treat large populations of indigent patients, will be able to serve the needy people in their own communities because they know they will be compensated for the care that they give. So that is a key issue that we have to have your help in explaining to our fellow citizens.

We also know that hospitals that reach out, like the one honored today from Cambridge, Massachusetts, to get into the community and provide services that are beyond what is traditionally thought of as conventional hospital services, will enable their communities to get ahead of the curve. Community care networks, like the ones that you've honored or the ones that are exemplary like in Wellsboro, Pennsylvania, or rural southwest Georgia, are examples of the approaches I'm talking about.

If you go to Georgia in that 10-county region where this network is operating, you will see people who have all of the problems that are exacerbated by poverty, often afflicted by chronic disease, often without the resources adequately to take care of themselves until they end up in your emergency rooms. But if we have an organized approach with a package of benefits that has a reimbursement stream behind it, then networks like that one in Georgia or ones that many of you are running will be able to provide primary care in underserved urban and rural areas. You'll be able to have mobile care going out into those communities. And the net result will be our costs will actually begin to decrease, because we will have reached out to people where they live to provide the services that they need.

Making it possible for you to do what you know needs to be done in your communities is one of the keys to a successful health care reform. We also have to change the mix of health care professionals. We have to provide incentives for the National Health Service Corps to encourage doctors and nurses to practice in remote and challenging parts of our country. We need to change the way Medicare has funded graduate medical education. That is the primary reason we have the mix of specialist to primary care physicians today -- a ratio that is 70 percent in favor of those who are specialists.

We need specialists. We have to have specialists. But the reason we have so many is not just because every young man and woman -- seven out of 10 going to medical school in the last 20 years has decided they would rather be a specialist, it's because we as taxpayers subsidize the subspecialties. We need to change those

incentives so that we can begin to give the pool of primary and preventive health care professionals back to the country. We cannot have universal coverage and health care reform unless we have more primary care physicians and nurses, and that starts at the top with the way the federal government funds the programs. (Applause.)

We also need to be sure that we make the very best possible use of our doctors and our nurses. We need to encourage physician assistants. We need to encourage advanced practice nurses, nurse midwives, and others who can provide the kinds of services that will be needed in a broad-based system that emphasized primary and preventive health care. And we need to be sure that where there is an underserved area, a network of care is there to provide those services.

You know, in Washington -- the other magic kingdom -- there is a hospital in the poorest ward of that city. That hospital is in a place called Ward 8. It has only six percent of the city's pediatricians and only one of 15 city-run clinics. But it has 25 percent of the city's children, the highest proportion of premature babies the city, the most children with AIDS, and the largest number of infants who die before their first birthday.

Now, the Greater Southeast Community Hospital is there in that community, and it could be wringing its hands, it could be trying to keep its head above water, it could be folding its doors and going elsewhere. But instead, it has taken the challenge that its community provides and risen to it. It couldn't afford to keep giving away the kind of care that it was giving as people were brought in like some warehouse receiving sick people at their emergency room dock. It had to break out of conventional thinking about health care and devise inventive ways of dealing with the problems that were destroying the hospital as well as the community.

So Greater Southeast opened a school-based clinic, launched ambulatory care program, organized volunteers to perform blood pressure screenings at Sunday church service, made judicious investments in the kind of technology that would serve the most people in their area -- opting, for example, for a state-of-the-art kidney dialysis machine rather than even pretending it could perform open-heart surgery.

The net result is that costs are beginning to be somewhat put into balance, because so many people are treated at an earlier stage. Yes, they still show up in great numbers at the emergency room, but many more are treated in the much more cost-effective way of providing primary care in the community.

Those are the kinds of unconventional thinking that we need to make conventional -- that all of you know so well. If we do, then we will not only provide health care for all Americans, we will begin to see results in terms of cost savings. We make a promise to you: Not only will we deal with the problems that you have brought to us, like antitrust, with the intrusive micromanagement that just boggles my mind.

I once met a hospital administrator who told me that two of the departments in their hospital were now under 100 percent utilization review without any noticeable increase in quality. We want to get back to doctors and nurses making sound judgments about their patients. We also intend to simplify the well-intentioned regulations that often burden you like CLIA, so that it can be a reasonable approach to a problem.

We will make these promises to you, because we believe we can deliver them. We believe we can change what is currently going on in the federal government when it comes to health care. We also will make promises to our citizens -- not only those who will be insured and those who will have security, but to older Americans, many of whom now come to seek treatment in your facilities. We will increase the options for home and community-based care services and greater protections for nursing home residents. There will be a new federal home care program for disabled citizens, regardless of income. We want to end the travesty of people spending themselves into poverty to qualify for meager government aid, which only paid for nursing home care. (Applause.)

We want people to be able to be treated with dignity and respect in their home and in their community. We want hospitals, like many of yours, to start getting reimbursement for adult day care or for Alzheimer patient care. We want you to be able to serve your communities in a creative, unconventional way that we want to become the standard of practice.

We also intend to provide a prescription drug benefits, because one of the things I learned in the many hours I've spent in St. Vincent's talking with my friends who were doctors and nurses and hospital administrators is that you know very often when someone is discharged with that prescription in hand, either they can't afford to refill it, or they self-medicate because they want the pills to go longer. So if it says take four a day for three weeks, they'll take one a day and try to stretch it out. And then all too often they end up back in your care.

We want to provide a prescription drug benefit that will save us money by keeping people out of your hospitals who don't need to be there because they can be treated well by medication. You

will have to help us with that because it is something that has to be done carefully and cannot be permitted to get out of control in terms of cost. But it is a need that we want to see included in the benefits package.

Now, there are several ways of paying for this system. And really, if you cut through all of the arguments that will come from all directions, there are really three general approaches that the President could have pursued. There is a publicly financed approach where we would substitute for all of the existing private sector funding -- federally mandated tax money to go into financing the health care system. That's often referred to as a single payor system, and many of the countries with whom we compete provide such a system and do it at far less of a cost than the system we have.

For a number of reasons, that will not be the approach that the President proposes, although there are many strong -- (applause) -- there are many strong advocates who believe it is the right way to go. The President, ever since he was a governor and studied this issue at the National Governors Association meetings and all through the campaign, has believed that the strength of that system, like cutting administrative costs and reaching universal coverage, could be achieved without some of the problems that would come with it.

A second approach that will be advocated strongly is putting the responsibility for being insured on the individual, much as what states do now with auto insurance. If you want to drive, you have to have auto insurance. I guess the analogy would be if you want to get sick, you have to have health care insurance. It's a very difficult -- for health care needs.

It would also be difficult to predict how many employers who now provide health insurance would cease doing so because of the existence of an individual mandate. But, again, it has some strengths that we want to be very aware of. The emphasis on individual responsibility is absolutely key. We have to make consumers better informed consumers as they make health care choices.

And the third approach, which is the one the President has always thought would be most promising, is to build on the system we currently have -- an employer-employee system that has given us the best quality of health care in the world, that has placed us at the head of the pack when it comes to research and development and technological breakthroughs, but which, unfortunately, hasn't fulfilled its promise because of the problems of cost-shifting and inability to actually organize the delivery of care.

But most employers in this country currently do provide some health insurance for their employees. They have been paying the price for the increases in Medicaid and Medicare and for those who are without insurance. And it is appropriate to ask that if some have borne all the burden, shouldn't all of us bear some of the burden? Why should any employer or employee who does not take on the responsibility for health insurance coverage any longer get what amounts to a free ride? Because you and I could go down the main street in Orlando or any street in America and we could point to a store that does provide insurance and a store that doesn't. But when the people who are employed by and work in the store that doesn't get sick, they go to your hospital, don't they? They're there. Maybe they have some coverage, maybe they have some savings they can use. But, by and large, they don't pay the full freight.

So the next year when it comes time to renew insurance, that first store that's trying to provide health care for its owners and its employees has to pay a higher premium to cover the costs of his neighbor's employee. At some point, America once again has to be willing to believe that all of us are in this together, because health care reform is not just about eliminating paperwork and bureaucracy or making the antitrust laws make sense, or reaching universal coverage on paper. Health care reform is about reinstituting a sense of compassion and caring into our society. It is about making common sense, practical judgments about our economic priorities. It is about putting our national house in order.

So we must establish new priorities, new incentives, and new partnerships. We must all take responsibility and we must all contribute. This will not be easy, but we don't have a choice.

Too many times in the past, individuals and interest groups and the government have marched to the edge of health care reform only to cower in fear and shrink away. And our problems have only gotten worse. Too many times we have held meetings and drafted brochures and plans and walked away. Too many times we have watched as one political party blamed the other for a system that had awry. And while they were all pointing fingers, the problems got worse, the pressures on you got harder, and yet we all walked away once again.

Now, after having walked away from this problem like so many others, how many more meetings do we need? How many more plans shall we draft? How many more dollars shall we pile up on the national debt, on more uncompensated care ledgers, on the backs of the people who are really paying the freight?

We need your help. We need you help at the Association. We need your help in your communities as the primary care givers. This is an opportunity that doesn't come often in the life of either

individuals and institutions or in country. This is an opportunity to make a bold stand, to fix a problem, to do it in a way that will work and to move our country forward.

If we are bold enough, and wise enough to meet this challenge now, we can join together not as Democrats or Republicans or liberals or conservatives, or any of those other categories that for too long have not only divided us, but have obscured the real debate about what is at stake. Let us come together as Americans -- as people committed to safeguarding our nation's future health and well-being. Let us join hands in knowing that if we move forward in the direction so many of you have urged for so long, we can be proud of the contributions we have made to fulfilling the American Dream of putting our nation back on the right course, of dealing with its human and economic challenges, and of once again, having a society that truly is a community.

That is what is at stake. That is our opportunity. That is our responsibility.

Thank you all very much.

END

Draft Outline for Senate Finance Committee Chairman's Mark

Health Security Act of 1994

I. Insurance Reforms

A. Guaranteed Issue: Require insurers to accept all applicants.

B. Guaranteed Renewal: Prohibit insurers from terminating or failing to renew coverage.

C. Pre-Existing Conditions: Prohibit insurers and employer plans from imposing any exclusions for pre-existing conditions.

D. Modified Community Rating

1. Permit variation for family size, geography, and age (with limits so that the highest age-adjusted premium for a given family size and geographic area would be no more than twice the lowest age-adjusted premium).

2. Require all firms with fewer than 500 employees to purchase community rated insurance and prohibit self-insuring below this level.

3. Treat existing Taft-Hartley and rural cooperative plans with 500 or more employees, and bona fide multiple employer plans (MEWAs) with 1000 or more employees, as large employers; however, prohibit MEWAs from self-insuring and limit each such plan to its present size.

E. Risk adjustment and reinsurance mechanisms: The Secretary of HHS would develop mechanisms for implementation by the States.

F. Antitrust Reform: Repeal health insurance immunity from antitrust suits under the McCarran-Ferguson Act.

II. Coverage: Employer and individual mandate with special rules for small business

A. All employers with more than 20 employees would be required to pay 80 percent of the average premium for a qualified standard health plan; employees would be required to pay 20 percent, or less if the employer elects to pay more. (Non-workers and workers in exempt firms would be responsible for the full cost of the standard plan.)

B. Small employers (20 employees or fewer) would have the option to be excluded from the 80 percent mandate; firms exercising the option would pay a payroll assessment of 1 percent if they have 1-10 employees and 2 percent if they have 11-20 employees.

C. Trigger: The employer mandate would be imposed on small employers

1. at the end of 1998 if 97% of all employees (and their dependents) are not receiving employer-provided health insurance or

2. at the end of the year 2000 if 98.5% of all employees (and their dependents) are not receiving employer-provided health insurance.

III. Subsidies: Payable to both individuals and employers (including firms with 20 or fewer workers that voluntarily provide coverage)

A. Individuals: Family payments for the 20 percent share would be capped at 5 percent of income up to $30,000. Families with incomes below 150 percent of poverty would pay less, based on a sliding scale. Workers in exempt firms who are responsible for paying the full premium would be eligible for income-based subsidies that cap total payments at 5 to 7 percent of income up to $30,000.

B. Employers: In general, employer contributions would be limited to no more than 12 percent of each worker's wage. For firms with 11-75 employees with average wages below $24,000, the cap on contributions would be as low as 5.5 percent. For low wage firms with 10 or fewer employees that elect to pay premiums, premiums would be capped at one-half the otherwise applicable rate, ranging from 2.8 to 6.0 percent of each worker's wage. Eligibility for a subsidy would be based on the individual worker's wage; however, the amount of the subsidy would be based on firm size and the average wage of the firm.

C. Independent contractor and S-corporation shareholder anti-abuse provisions would be included.

IV. Benefits

A. Mental illness services would have parity with services for other medical conditions. The Secretary of HHS would develop standards for the appropriate management of these benefits.

B The benefit package would have an actuarial value equivalent to the Blue Cross/Blue Shield Standard Option under the FEHB program.

C. Cost-sharing options described in statute would include co-payments, co-insurance, and deductible amounts for services other than clinical preventive services.

D. Plans would be required to offer a standardized set of covered services.

E. Categories of covered services specified in statute would include: hospital services; health professional services; emergency and ambulatory medical and surgical services; clinical preventive services; mental illness and substance abuse services; family planning and services for pregnant women; hospice care; home health care; extended care; ambulance services; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation; durable medical equipment, prosthetic and orthotic devices; vision and dental care for children; and investigational treatments.

F. National Health Benefits Board

1. A National Health Benefits Board would be established in the Department of HHS to clarify covered services and cost-sharing; define medical necessity and appropriateness; consult with expert groups for appropriate schedules for covered services; refine policies regarding coverage of investigational treatments; and propose modifications to the benefits package that would go into effect unless voted down by Congress under fast-track procedures.

2. The Board would have 7 members nominated by the President and confirmed by the Senate. They would serve 6 year, overlapping terms.

Draft Outline for Senate Finance Committee Chairman's Mark

V. Health Insurance Purchasing Cooperatives

A. Voluntary Participation: No employer or individual would be required to purchase through a cooperative. Individuals and employers eligible to purchase insurance through a cooperative could elect to purchase insurance at modified community rates through a broker or insurance company.

B. Eligibility: Firms with fewer than 500 employees (and their employees), self-employed individuals, and individuals not connected to the workforce, as well as dependents of those persons, would be eligible to purchase insurance through a cooperative.

C. Competing Cooperatives

1. Cooperatives would be permitted to contract selectively with certified health plans. If a cooperative negotiates a price lower than the community rate, that price becomes the plan's new community rate.
2. Nothing would prevent a cooperative from serving more than one area.
3. If a cooperative were not established in every area by 1996, the State would be required to sponsor or establish a cooperative. In such cases, the State would only be required to establish or sponsor one cooperative that could serve all unserved areas within the State.

D. Federal Employees Health Benefits (FEHB) program: Employers with 2-10 employees who contributed at least 50% of the cost of health insurance would be permitted to enroll their employees in a FEHB program at the same premium price (both employer and employee share) paid by federal employees, plus an administrative fee.

E. Rules for Cooperatives

1. Cooperatives would be required to accept all eligible individuals and employers within the area.
2. Individuals not connected to the workforce would enroll based on residence.
3. Cooperatives could require payroll deductions for employed individuals.
4. If employees ask their employers to make payroll deductions for a cooperative, employers would be required to comply.

F. Choice of Health Plans/Cooperatives

1. Enrollees, not employers, would choose a health plan within the cooperative. Employees of the same employer could choose different health plans.
2. Employers above the community rating threshold would be required to provide employees with a choice of at least three health plans, including a fee-for-service plan.
3. Employees of firms with 20 or fewer employees whose employer contributes at least 50% of the cost of health insurance could enroll in a cooperative chosen by the employer. Employees could purchase insurance at modified community rates elsewhere, but the employer would not be required to make the same contribution to insurance costs.
4. Employees of firms with 20 or fewer employees whose employers do not contribute at least 50% to the cost of health insurance could enroll based on either residence or worksite.

G. Governing Structure
   1. Cooperatives would be non-profit organizations governed by a board of directors elected by members of the cooperative.
   2. Insurers would be prohibited from forming a cooperative, but would be permitted to administer a cooperative.

H. Duties of Cooperatives
   1. Cooperatives would be required to enter into agreements with health plans, employers and individuals; collect and forward premiums to health plans; coordinate with other cooperatives; and provide a complaint process.
   2. Cooperatives would be expressly prohibited from approving or enforcing provider payment rates; performing any activity relating to premium payment rates; and bearing insurance risk.

VI. Cost Containment

A. Managed competition would help contain costs by encouraging consumers to make informed health care purchasing decisions based on the price and quality of a standardized benefit package, by banding consumers into large purchasing pools with lower administrative costs, and by encouraging providers to form more efficiently organized delivery systems.

B. Premium Targets
   1. Targets for changes in per-capita premiums would be set by law at CPI plus or minus an adjustment factor that would take into account increases in real per-capita income, changing demographics and health status indicators, and changes in medical technology and the use of services.
   2. An independent National Health Cost Commission would be established to monitor per-capita premiums. The Commission would have 7 members nominated by the President and confirmed by the Senate. They would serve 6 year, overlapping terms.
   3. If the Commission determines that the targets have been exceeded, it would recommend appropriate actions for consideration by the Congress under fast-track procedures.

C. Federal Deficit Control
   1. OMB would determine annually, through 2004, whether enactment of health care reform had caused an unprojected increase in the deficit.
   2. Any deficit increase would trigger automatic reductions in subsidies unless Congress enacts alternative budget reductions (considered by fast-track) or OMB determines that GDP growth has fallen below 0% for 2 consecutive quarters.

D. Malpractice Reforms
   1. Alternative dispute resolution (ADR) procedures would be established by health plans and malpractice claims could not be brought in court until they had gone through the plan's procedures.
   2. Contingency fees paid to attorneys would be limited to a sliding-scale schedule.
   3. Awards would be reduced by the amount of any payment for the same injury from another source.

4. Payments of over $100,000 could be made on a periodic schedule determined by the court.
5. Demonstration projects would be authorized for limiting liability to health plans rather than physicians.
6. Demonstration projects would be authorized for adopting medical practice guidelines as the standard of care in medical liability actions.
7. Federal law would preempt inconsistent State laws except to the extent such laws imposed greater restrictions on attorney fees or a person's liability, or permitted additional defenses to malpractice actions.
8. Federal law would govern actions in State courts and would not establish a basis for bringing malpractice actions in federal courts.

E. Administrative Simplification and Paperwork Reduction
1. Establish a process for setting health information standards for paper and electronic transactions.
2. Create a public/private health information network to facilitate cost effective administration and practice of health care including automated coordination of benefits and claims routing.
3. Issue health identification cards using the Social Security number.
4. Require all health providers and plans to use standard electronic transactions to conduct business after a grace period for implementation.
5. Fund demonstration projects in telemedicine and electronic medical record systems in primary care.
6. Certify organizations to produce aggregated data for quality assessment, public health, research, and planning.

F. Fraud
1. Federal sanctions would be applied to all health care fraud that affects federal subsidies or other federal outlays.
2. A health care anti-fraud trust fund would be established to fund federal enforcement activities; a portion of the fines and civil penalties collected from such activities would go to the trust fund and the remainder to the Treasury.

VII. Financing (unofficial estimates)

A. Revenue Raisers (over 5 years)
1. Increase tobacco excise tax to $2.00 per pack = $86 billion.
2. Increase handgun ammunition excise tax to 50% (except .22 caliber) = $140 million.
3. Impose a 1% employer payroll assessment on firms of 500 or more employees = $50 billion.
4. Extend HI tax to all State and local employees = $6 billion.
5. Recapture Medicare part B subsidies for individuals with incomes over $90,000 and couples with incomes over $115,000 = $4 billion.
6. Health benefits provided through a flexible spending arrangement would not be excludable = $2 billion.

7. Levy an assessment on health insurance premiums, phased up to 2.5% of premiums by 1999, for academic health centers and medical education and research = $40 billion.
8. Payroll assessments on small firms that do not provide coverage = $10 billion.

B. Revenue Losers (over 5 years)
1. Provide 80% self-employed health insurance deduction = ($5) billion.

C. Medicare Savings (over 5 years) = $33 billion.

VIII. Medicaid

A. Mainstreaming of AFDC and Non-Cash recipients: Both groups would be treated like other low-income individuals and families for purposes of community rating, enrollment in health plans and subsidies. States would pay a maintenance of effort based on current spending on these groups for services covered in the benefit package.
B. SSI recipients: Those not enrolled in Medicare could enroll in health plans. States could make premium payments based on negotiations with certified health plans.
C. Services not covered in the standard benefit package: Retain current Medicaid mandatory and optional eligibility groups for provision of services not otherwise provided by health plans. States could negotiate with health plans to provide supplemental services.
D. Federal matching payments: Enhance matching payments for Medicaid home and community based long term care services, and change overall federal Medicaid matching formula.

IX. Long-Term Care

A. Retain Medicaid long-term care program with improvements.
B. Establish federal long-term care insurance standards.
C. Include tax credit for cost of personal assistance services for working disabled.
D. Exclude certain accelerated death benefits from taxable income.

X. Medicare

A. Maintain Medicare as a separate program.
B. Individuals could maintain coverage through private health plans when they become eligible for Medicare.
C. Medicare Select would become a permanent option in all States.
D. Medicare risk contracts would be improved.
E. Improvements in hospital payment methodologies would include:
1. Medicare Dependent Hospital Extension,
2. EACH/RPCH program improvements and extension to all States,
3. making Medical Assistance Facilities permanent and available to all States,
4. extending the rural health transition grant program, and
5. rebasing PPS exempt hospitals.

XI. Academic Health Centers and Medical Education and Research

A. Academic Health Centers (AHCs) Trust Fund

1. A trust fund for AHCs would be established with contributions from the Medicare indirect medical education (IME) adjustment at current law levels, plus a portion of revenues from a 1.5% assessment on premiums and on premium equivalents for self-insured plans.
2. Payments would be made to all AHCs and teaching hospitals in a manner modeled after the current IME adjustment
3. Payments would total $6.28 billion in 1996, $7.25 billion in 1997, $8.22 billion in 1998, $9.4 billion in 1999, and $10.64 billion in 2000, increased annually thereafter by the change in the national premium targets.

B. Biomedical and Behavioral Research

1. A Health Research Trust Fund would be established to fund expanded biomedical and behavioral research through NIH.
2. The trust fund would be financed with an assessment on premiums and premium equivalents equal to 0.25% in 1996, 0.50% in 1997, 0.75% in 1998, and 1.0% in 1999 and subsequent years. Also, the tax code would be amended to authorize persons filing Federal tax returns to elect to make contributions to the trust fund or to donate tax overpayments to the trust fund.

C. Graduate Medical and Nursing Education Trust Fund

1. A trust fund for graduate medical and nursing education and for transitional costs would be established with contributions from Medicare direct medical education costs at current law levels, plus a portion of revenues from the 1.5% assessment on premiums and premium equivalents.
2. Graduate medical education payments would be made to qualified applicants operating approved residency programs or participating in voluntary consortia.
   a) Payments would be based on historical costs of individual programs.
   b) Payments would total $3.2 billion in 1996, $3.55 billion in 1997, and $5.8 billion in 1998, increased annually thereafter by the change in the national premium targets.
3. Graduate Nursing Education
   a) Payments would be made to qualified applicants operating graduate nurse training programs based on national average costs with a geographic adjustment factor.
   b) Payments would total $200 million in 1996, increased annually by the change in the national premium targets.
4. Medical School Account
   a) Payments would be made to medical schools to assist in meeting additional teaching and research costs associated with the transition to managed competition and expanded ambulatory teaching.
   b) Payments would total $200 million in 1996, $300 million in 1997, $400 million in 1998, $500 million in 1999, and $600 million in 2000, increased annually thereafter by the change in the national premium targets.

Draft Outline for Senate Finance Committee Chairman's Mark

XII. Access Issues in Urban and Rural Areas

A. A trust fund based on a portion of receipts from the tobacco tax (approximately $1.3 billion per year) would be established for infrastructure development. It would provide funding for the development of health plans and capital investment for hospitals and other facilities.

B. Provide tax incentives for practitioners that locate in designated urban and rural areas.

XIII. State Flexibility

A. States would have the option to establish a single-payer system.

B. States would have the option to implement other systems designed to increase coverage, control costs, or fund uncompensated care, but which do not have a significant adverse impact on the administration of plans maintained by multi-State employers.

XIV. Privacy and Confidentiality

A. Protect all health information which could be related to a specific individual, regardless of form or medium.

B. Specify appropriate and necessary uses and reasons for release of protected information.

C. Reduce the amount of information released to the minimum necessary to perform authorized tasks.

D. Other uses and release of protected information, without specific authorization by the individual concerned, would be subject to penalties.

E. Define individual rights to access, annotate, and limit release of protected information.

XV. Health Plan Standards

A. National standards for health plans would be set by the Secretary of HHS for:

1. Capital and solvency standards, including guaranty fund, capital requirements, and risk adjustment/reinsurance;
2. Quality standards for quality improvement and assurance, continuity of care, physician credentialing, utilization management, and medical recordkeeping;
3. Patient protection standards for advance directives, physician incentive plans, participation by physicians in policymaking, anti-discrimination, grievance procedure, confidentiality, marketing, and ethical business conduct; and
4. Access standards for specialized services and essential community providers.

B. Accreditation and Enforcement

1. States would certify that health plans meet the national standards using a State program or private accreditation organization.
2. Federal grants would be available to States to help fund their enforcement programs.

Draft Outline for Senate Finance Committee Chairman's Mark

XVI. Quality and Consumer Information

A. Provide Federal funding to support research on appropriateness and outcomes of medical treatments.

B. The Secretary of HHS would provide grants to quality improvement foundations to disseminate research findings to improve provider practice patterns.

C. States would be required to provide health care consumers with comparative value information on health plans. Federal grants would be available to States to help fund their programs.

D. States would be required to establish a standardized appeals process for benefit denial, reduction or termination.

E. Modify Federal remedies for benefit denials, reductions or terminations.

XVII. Tax Treatment of Health Care Organizations

A. Strengthen current law "community benefit" standard for tax exemption for non-profit hospitals.

B. Repeal cap on tax-exempt bonds for section 501(c)(3) organizations.

C. Repeal special deduction for Blue Cross/Blue Shield organizations.

D. Limit tax exemption for HMOs to "staff" or "dedicated group" model.

E. Impose certain penalty excise taxes ("intermediate sanctions") on tax-exempt health care organizations for transactions involving private inurement.