June 22, 1995

MEMORANDUM TO LEON PANETTA

FROM: MARILYN YAGER

RE: BUDGET MEETING WITH SENIORS GROUPS

DATE/TIME: FRIDAY, JUNE 23
2:00PM (a quick drop-by only)

LOCATION: Room 180, OEOB

PURPOSE: To clarify the support of the senior groups for the President's budget proposal, and to keep them focused on a joint strategy to defeat the GOP budget proposals.

BACKGROUND: The senior groups have been muted in their response to the President's plan for several reasons: they disagreed with our strategy to announce an alternative before the public clearly understood how bad the GOP proposals were; they feel caught between the Hill Democrats and the White House on how to react to proposal; and they are concerned about the Medicare cuts to hospitals.

The purpose of this face to face meeting is to clarify that our budget strategies are the same (to defeat the GOP budget proposals), and to help them put our proposal into perspective against the GOP proposals.

FORMAT:

Opening Comments	Alexis Herman
Brief Comments	Leon Panetta
Overview of Our Budget Approach	Gene Sperling
Discussion	Joe Minarik Gene Sperling Chris Jennings Jennifer Klein

ATTENDEES:

John Rother, AARP
Lloyd Duxbury, Nat. Comm. to Preserve SS and Medicare
Larry Smedley, NCSC
Dianna Porter, Older Women's League
Samuel Simmons, Nat. Caucus and Ctr on Black Aged
Joel Packer, NEA
Bruce Yarwood, Am. Health Care Assn.
Michael Rodgers, Barbara Gay, Am. Assn. of Homes for the Aging

TALKING POINTS:

- Describe to these folks why the President felt it was important to provide an alternative, and why now (they fail to understand why we felt the timing had to be now).

- If possible, you should try to allay their concerns about the Hill Democrats, perhaps reminding them that there can be honest disagreements about timing on strategy.

May 30, 1995

MEMORANDUM FOR CAROL RASCO, DOUG SOSNIK, JENNIFER KLEIN, GENE SPERLING AND BOB LITAN

FROM: Debbie Fine and Marilyn Yager

SUBJECT: Budget Briefing for Disability Organizations

DATE: Wednesday, May 31, 1995
TIME: 1:00 to 2:00PM
LOCATION: Room 180, OEOB

I. PURPOSE

As most of you know, this is one in a series of meetings we have organized for this week with key groups and allies on the budget. The purposes of these meetings are:

- to reassure participants that the President is committed to fighting the proposed Republican budget cuts to Medicare, Medicaid, Education and EITC;
- to try to coordinate the focus of efforts to oppose these cuts;
- to energize and mobilize participants for this fight;
- to hear feedback and plans for fighting these cuts from participating groups.

II. BACKGROUND

Political Background

Although the disability community tends to be bi-partisan in that its agenda is more important than any political alignment, they lean Democratic and have been very loyal to this administration. In general, the leaders in the community feel that they have been at the table for policy decisions more than during any other administration. As a result they have mobilized their memberships to fight on behalf of priority initiatives, such as health care reform.

In terms of the current political climate: on one hand they are more supportive now that we are clearly on the right side of most of their issues in contrast to the Republicans, and on the other hand they feel some of the distrust that many of our allies feel because of a perception that we are not taking a strong enough stand on some issues (i.e. entitlements.) But the bottom line on the budget is that they are very supportive of our opposition to the Republican proposals.

On the Budget

The disability organizations present have all been actively lobbying on the Hill in opposition to the proposed budget resolutions and educating their memberships about their implications for people with disabilities. Some of these groups are currently working with other organizations in the field to coordinate opposition efforts; for example, the Long Term Care Campaign, AARP, AFL-CIO and others.

The issues they are currently most focused on with the budget are for the most part consistent with our message:

- **Medicaid Cuts:** They are opposed to elimination of the entitlement; block granting; and the cap on federal payments to the states.

  (Medicaid currently provides health and long term services and supports for people with disabilities. Without this funding, many children and adults with disabilities would be forced into nursing homes or on the streets.)

- **Medicare Cuts**

- **Education Cuts**

- **SSI Reform** (included in the House budget proposal)

Attached are some examples of information some of the organizations present have been sending out.

III. FORMAT

- Carol Rasco will open the meeting.
- Gene Sperling will do a brief overview on the negative impact of the budget.
- Doug Sosnik will make brief comments on the political importance of the budget fight.
- Jennifer Klein will do a brief overview on Medicare/Medicaid.
- Bob Litan will do a brief overview of the HUD/DOT/DOJ cuts in the Republican proposals as they pertain to people with disabilities.
- We will open discussion for feedback and for questions and answers.

IV. PARTICIPANTS

Cornelius Baker:	National Association of People with AIDS
Amy Berenson:	AIDS Action Council
Alan Dinsmore:	American Foundation for the Blind
David Fields:	American Rehabilitation Association
Roger Kingsley:	American Speech-Language-Hearing Association
Paul Marchand:	CCD and the Arc

Kathy McGinley:	The Arc
Celane McWhorter:	United Cerebral Palsey Association
Christina Metzler:	American Occupational Therapy Association
Katy Beh Neas:	National Easter Seal Society
Becky Ogle:	National Association for Medical Equipment Suppliers; Co-Chair of Justice For All Network; National Council on Independent Living; and Co-Chair of CCD Rights Task Force
Len Rubenstein:	Bazelon Center for Mental Health Law
Bob Sevigny:	Democratic National Committee
Patty Smith:	National Parent Network on Disability
Kimberly Turner:	Howard University
Julie Ward:	Epilepsy Foundation
Tony Young:	American Rehabilitation Association

NOTE: Many of these groups are members of the Consortium of Citizens with Disabilities, an umbrella organization of approximately 125 national disability organizations.

May 23, 1995

MEMORANDUM TO LAURA TYSON

FROM: MARILYN YAGER
OFFICE OF PUBLIC LIAISON

RE: BUDGET BRIEFING FOR WOMEN'S GROUPS

DATE/TIME: Wednesday, May 24
4:00pm

LOCATION: Room 211, OEOB

PURPOSE: One in a series of meetings we are doing this week to bring key groups and allies in before the Memorial Day recess to make sure: we are all on the same page regarding our focus on the budget cuts; to reassure them of the President's commitment to fight the GOP Budget cuts in Medicare/Medicaid/Education/EITC; and to hear from them what they are doing over the recess to fight these cuts.

You will be making the opening remarks, speaking on behalf of the President to reiterate the President's commitment to fight these cuts, and to make sure they are aware of the magnitude of what the GOP budget bills are proposing. Gene Sperling, Jennifer Klein, and others will provide the specifics.

This particular list of women's groups are organizations that we have been meeting regularly with on a range of Presidential priorities, and we view as generally supportive and most definitely friends of this Administration.

ATTENDEES: List Attached.

FORMAT:

Opening Remarks — Laura Tyson
(talking points attached)
(you may leave following your remarks)

Impact of GOP Budget Proposals — Gene Sperling

Discussion — Jennifer Klein
Nancy Ann Min

LAURA TYSON - TALKING POINTS

- Thank you for coming, and especially on such short notice. These are such critical issues to you and your membership we felt it was important to talk with you before this congressional recess, when I know many of your members will be talking with their members of Congress about issues before the Congress.

- Although the process seems to be moving fast, with the House having passed their Budget Resolution last week and the Senate poised to pass theirs this week, we have a great deal of work to do both short term and long term.

- Short term -- we all need to continue to send the message to the Senate about the real threat these cuts pose for working families, women and their children. We all have to continue to try to drive down the total number on the cuts they are proposing as the House and Senate prepare for their conference committee after the Recess.

- Longer term -- the Budget Resolution fight is just the beginning of what will be the reconciliation fight where Americans find out what approximately $250 billion in Medicaid and approximately $280 billion in Medicare really means when programs are targeted to reach those numbers.

- I can't empahisize enough the President's commitment to fight these cuts, which disproportionately affect women and their children. What we can not do, but you can, is to put a human face on these cuts. We need your help in telling what happens to the elderly women who depends on Medicaid for the nursing home care she could not live without, or the child whose future without head start would be that much more of a struggle. Only your members can put together the real people behind the lives that these programs help improve.

- The best endeavor is that which we all do together. We wanted to do this meeting today to share with you some of the data and talking points we are using, and hope you will share with us your strategy over the next couple of weeks to reach your membership on these critical budget issues. And with that I am going turn the meeting over to Gene Sperling and some of our budget staff to talk more specifically about these budget cuts.

BUDGET -- MEDICARE AND MEDICAID BRIEFING
May 24, 1995
Room 211, OEOB

REPRESENTATIVES FROM WOMEN ORGANIZATION'S

Debra Briceland Betts, Older Women's League
Christine Bneao, Association of Junior Leagues
Nancy Zirkin, American Association of University Women
Elizabeth Lawson, League of Women Voters
Diane Burke, AFSCME
Joyce Agunbiade, National Council of Negro Women
Chrystl Bridgeforth, Coalition of Labor Union Women
Deena Margolis, National Council of Jewish Women
Aileen Cooper, B'Nai B'rith Women
Joan Entmacher, Women's Legal Defense Fund
Janne Hustead, Women's Legal Defense Fund
Eileen McGrath, American Medical Women's Association
Rose Gonzalez, American Nurses Association
Sheila McCarron, National Council of Catholic Women
Ned McCulloch, SEIU
Beverly Waiser Stripling, YWCA
Michelle Healy, Nine to Five
Laurie Cooper, General Federation of Women's Clubs
Suzanne Stokes, Business and Professional Women

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

16-May-1995 02:10pm

TO: (See Below)

FROM: Marilyn Yager
Office of Public Liaison

SUBJECT: Medicare Budget Meeting with Groups.

This is to confirm our conversation earlier regarding a meeting with seniors and hospital groups on Medicare. We can confirm that meeting for tomorrow (Wednesday) at 3:00pm in the Roosevelt Room.

The format will include:

Opening Comments	Leon Panetta (he can then depart)
Substantive Discussion	Gene Sperling, Jennifer Klein, and Chris Jennings

Per your earlier memo, I have notified George and Doug's offices to let them know we are convening a meeting, and I have asked them to let me know if they wish a role in the meeting so that I can arrange the format accordingly.

The ground to be covered in the meeting:

- Follow up on what they have done since our meeting with these groups two weeks ago, specifically with regard to their political strategy and amendment strategy.
- Make sure they have the state by state impact numbers document released last week.

Distribution:

TO: Jennifer N. Palmieri

CC: Gene B. Sperling
CC: Jennifer L. Klein
CC: Christopher C. Jennings

Medicaid State by state ?

Groups for Outreach meetings:

Original Medicare/Medicare Meeting:

CDF
Assn. of Maternal and Child Health
Am. Assn. of Pediatrics
NACHRI
Consortium for Citizens with Disabilities
AHA
CHA
NAPH
Protestants
AARP
NCSC
Labor Retirees
Nat. Committee to Preserve
Older Women's League

Other Groups which need to be added for Medicare and Medicaid:

Nat. Assn. for Home Care
Other Disability Groups
Nat. Homes for the Aged
Am . Health care Assn
ANA
Nat. Black Nurses Assn.
NASW

Rural Health Groups:

AHA - Small and Rural Hospital Section
Am. Academy of Physician Assistants
Nat. Assn. of Counties
Nat. Assn. of Rural Health Clinics
ANA
Nat. Black Nurses
NASW
NCEC
Nat. League of Cities
CHA
Protestants
NAPH

May 9, 1995

MEMORANDUM TO NANCY-ANN MIN, CHRIS JENNINGS, AND JENNIFER KLEIN

FROM: MARILYN YAGER

RE: TODAY'S MEETING WITH PRIMARY CARE GROUPS ON FEE SCHEDULE UPDATE.

DATE/TIME: Tuesday, May 9
8:30 am

LOCATION: Room 180, OEOB

PURPOSE: To provide primary care physician groups with prior notification of the HHS letter of transmittal regarding the primary care update, and to clarify our support for seeking equity for primary care physicians.

FORMAT:

Welcome — Marilyn Yager

Opening Comments — Helen Smits
- o Purpose for Meeting
- o Contents of Transmittal (handout copies)
- o Timing of Transmittal

Discussion

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Note: If there is time, I will proceed into a discussion about the Budget, seeking their comments about their strategies around the Medicare and Medicaid cuts.

ATTENDEES:
Eileen Mcgrath, Am. Medical Womens' Assn.
Rich Deem, Am. Medical Assn.
Graham Newson, Am. Academy of Pediatrics
Howard Shapiro, Am. College of Physicians
Jack Ginsburg, Am. College of Physicians
Robert Doherty, Am. Society of Internal Medicine
Susan Prokop, Am. Society of Internal Medicine
Betsy Beckwith, Am. Osteopathic assn.
Tracy Walton, Nat. Medical Assn.
Carol Vargo, Am. College of OB/GYN
Rosie Sweeney, Am. Assn. of Family Physicians
Charlie Huntington, Am. Assn. of Family Physicians
Laura Edwards, Am. Assn. of Family Physicians
Yvette Rooks, Am. Assn. of Family Physicians

ADMINSITRATION STAFF:

Dr. Helen Smits, HCFA
Kathy Buto, HCFA
Nancy-Ann Min, OMB
Chris Jennings, DPC
Jennifer Klein, DPC
Marilyn Yager, OPL

Jennifer Klein

April 28, 1995

MEMORANDUM TO LEON PANETTA

FROM: MARILYN YAGER
OFFICE OF PUBLIC LIAISON

WHAT: Meeting with elderly, children's, and hospital groups to hear their concerns, strategies, and options with regard to likely Budget Resolution Medicare and Medicaid cuts.

DATE/TIME: Friday, April 28
5:00pm

LOCATION: Roosevelt Room

FORMAT: Opening Remarks — Leon Panetta

Open Discussion

ATTENDEES:

Families USA, Ron Pollack
Assn. of Maternal and Child Health Programs, Cathi Hess
Am. Nurses Assn., Rose Gonzalez
AARP, John Rother
Nat. Assn. of Children's Hospitals, Ann Langley
Catholic Health Assn., Bill Cox
Am. Hospital Assn., Herb Kuhn
Children's Defense Fund, Gregg Haifley
Am. Academy of Pediatrics, Graham Newson
Nat. Council of Senior Citizens, Larry Smedley, Dan Schulder
Older Women's League, Dianna Porter
National Council on Aging, Victoria Wagman
AFL-CIO Retirees, Steve Portulis, Carol Eickert
Nat. Assn. of Public Hospitals, Chris Burch
Consortium of Citizens with Disabilities, Becky Ogle, and Kathy McGinley

WH STAFF:

Leon Panetta
Alice Rivlin
Laura Tyson
George Stephanopoulos
Steve Ricchetti
Jennifer Klein
Chris Jennings
Gene Sperling
Nancy-Ann Min

DRAFT

MEDICARE 2000 CONFERENCE
Des Moines, Iowa

Purpose: To host a day-long conference to highlight the status of the Medicare program. The day will begin with an expert speaker who will present an overview of the Medicare program, what it does, how it is paid for and the impact of changes in Medicare financing and delivery. Various perspectives will be presented by concerned providers, payers and consumers who will focus on the future of Medicare. Each panel will be followed by an open forum moderated by prominent members of Congress. It is expected that various scenarios for change will emerge from bringing together interested parties.

Honorary Co-Chairs:	Senator John D. Rockefeller IV Senator Nancy Kassebaum
Co-Chairs:	Governor Robert D. Ray Dr. Steve Gleason
Invited Speakers:	Senior White House Official and GOP Presidential candidates (in separate forums)
Participants:	Prominent members of Congress Providers (hospitals, physicians, nurses) Payers Consumers (AARP, etc.)
Moderators:	Senators Grassley, Harkin, Rockefeller, Kassebaum
Panelists:	Governors Branstad (R-IA) and Dean (D-VT) Provider, payer, consumer representatives
Coverage:	CNN/C-SPAN "Road to the White House" local TV, radio, newspaper
Sponsors:	BC/BS of Iowa National Health Policy Council
Date:	April 28, 1995 (Congressional recess)

MEDICARE 2000

Des Moines, Iowa
April ____, 1995
8:30a.m. - 5:00p.m.

Program

DRAFT

Welcome

Governor Bob Ray
Dr. Steve Gleason

Introduction

"Medicare Under Siege: A Status Report on Medicare"
* Stu Altman or John Eglehart - Expert Speaker
☆ Overview (history, the way it works, what it costs)
☆ Myths vs. Reality (public perception; trends that threaten viability)

Panels/Forums

☆ **State Perspectives on Medicare**
Governor Terry Branstad
Governor Howard Dean
NCSL
Moderators: Sen. Grassley & Harkin

★ **GOP Candidate A**

☆ **Consumer Perspectives on Medicare**
AARP
Labor
Willis Goady, Iowa state demographer
Moderators: Sen. Rockefeller & Kassebaum

★ **GOP Candidate B**

☆ **Provider Perspectives on Medicare**
Physician
Hospital
Nurse
Moderators: Sen. Grassley and Rockefeller

★ **GOP Candidate C**

☆ **Business/Insurer Perspective on Medicare**
Insurer
Fiscal Intermediary
Employer Purchasing Group
Moderators: Sen. Harkin and Kassebaum

★ Administration Perspective

Closing Remarks

Note: the schedule will allow flexibility to accommodate candidate/Administration participation.

February 1, 1995

MEMORANDUM TO CAROL RASCO

FROM: BARBARA WOOLLEY AND MARILYN YAGER

MEETING: Meeting with Dr. Steve Gleason, Bob Waters, and Liz Shannahan -- all representing the National Health Policy Council (NHPC)

DATE/TIME: Thursday, February 2
1:00pm

LOCATION: Your West Wing Office

PURPOSE: They wish to share their views regarding: protecting Medicare in the budget debate; a potential Medicare Conference in Iowa; regulatory relief for providers; and the importance of appointing supportive providers to federal boards and commissions.

BACKGROUND: Dr. Steve Gleason is the founder and Chair of the National Health Policy Council, a group which grew out of an effort began in 1987 to get health providers involved in the President Democratic primaries. You may recall Steve's group sponsoring the health policy forums in the 1991-1992 Presidential campaign cycle in Iowa, New Hampshire, and Florida.

The NHPC Board includes Sen. Jay Rockefeller, Lynn Cutler, Jack Bresch, adn Pat Ford-Roegner (pretty heavily Democratic). The NHPC represents about 3000 providers (mostly physicians) who supported the Health Security Act and actively promoted it. The NHPC was the official speakers bureau for the HSA and the Health War Room forwarded hundreds of speaking engagements to them. These folks travelled all over the country, at their own expense, to speak on behalf of the HSA.

Steve, personally, was an early and active Clinton supporter, later serving as the Chairman of the Health Professions Review Group, and more recently as a senior consultant at HHS.

An old bone of contention has been that none of their physicians have ever been appointed to a board or commission at HHS, despite their active support, and Steve is likely to touch on this tomorrow.

Issue wise, Steve plans to share their concern about Medicare cuts to reduce the deficit and their desire to work with us to ensure the President gets all the credit he deserves for stating that we would not cut Medicare. They are thinking about doing a Medicare Conference in Iowa and will probably raise the fact that they would want the President to come.

On the regulatory front, they want to raise ideas they have about things the Administration could be doing to ease burdens on providers while still achieving our health priorities. Steve Gleason and Bob Waters met with the First Lady last November and she asked them to put together a list of ideas, which they forwarded to Jennifer Klein and Chris Jennings in December. You might want to comment that we are looking very aggressively at regulatory relief and their memo was helpful.

★
National Health
Policy Council
★

National Health Policy Council

"The National Health Policy Council is our nation's health reform consensus builder. Academics and activists, providers and purchasers have all commended NHPC's fairness and balance. NHPC's patient-centered credo causes each of us to focus on the real purpose of this debate on health care."
Senator Jay Rockefeller, *Honorary Chair*

Through various forums during 1991-1992, the National Health Policy Council has garnered the attention of some of the country's most notable health policy experts and government leaders. The NHPC's presidential candidate forums in Iowa, New Hampshire and Florida brought the health care reform discussion to millions of Americans through television and print media. Policy education presentations offered a wide-range of perspectives on how to solve the health care crisis and Town Meetings revealed the audience's appreciation and frustration with our health care system. The NHPC was on the forefront of the policy debate that introduced policy makers and politicians to everyday examples of a health care system in need of reform.

1601 NW 114th Street
Suite 130
Des Moines, IA 50325

Phone 515/222-7270
FAX 515/222-7257

Do nothing
per. Carol Rasco

Carol,
Bruce Fried
asked me to
forward this to
you. I have also
forwarded it to
Chris Jennings.
Marilyn Y.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: KLEIN

Draft response for POTUS and forward to CHR by:

Draft response for CHR by: Health Care

Please reply directly to the writer (copy to CHR) by: Info Center

Please advise by: Emily Curtis

Let's discuss: 435-6060

For your information: letter?

Reply using form code: if not we will do

File: x6

Send copy to (original to CHR): Office of records management correspondence

Schedule ?: ☐ Accept ☐ Pending ☐ Regret

Designee to attend: History # 202883347

Remarks: HAS THIS COME TO YOUR ATTENTION ALREADY FOR RESPONSE? IF NOT - LOOKS LIKE WE NEED ONE! 1/31 - TICKLER - ?

cc: ROB

(circled: [illegible] 1-27-95 [illegible])

Klein

THE WHITE HOUSE

WASHINGTON

FEB 13 1995

January 31, 1995

Mr. Nick Franklin
Senior Vice President
Public Affairs
FHP International Corporation
9900 Talbert Avenue
Fountain Valley, California 92708

Dear Nick:

Thank you for writing to me about FHP's Medicare program. I enjoyed meeting you at the recent breakfast at the White House, and I appreciate your following up on our discussion. I've asked Carol Rasco to look into the issues you raised and have passed along your invitation to my scheduler for consideration.

As we continue working to improve our health care system, I am grateful for your support. I hope you'll stay involved.

Sincerely,

Bill Clinton

Your letter was great

Thanks—

cc: Carol Rasco
Billy Webster

ck his letter to HRC, Ericka, Leon

BJ

FHP
HEALTH CARE

FHP International Corporation
Public Affairs Department
9900 Talbert Avenue
Fountain Valley, CA 92708
714.378.5767

January 12, 1995

William Jefferson Clinton
President of the United States
The White House
Washington, DC

Dear Mr. President:

I enjoyed the opportunity to meet you at the breakfast you hosted for members of the Democratic Leadership Councils at the White House on December 7, 1994.

You asked me to write to you and let you know how FHP is able to save Medicare beneficiaries and the federal government money under FHP's Medicare risk contract with the Health Care Financing Administration (HCFA), while providing beneficiaries with a broader range of benefits, including prescription drug coverage. I trust the following provides the information you requested.

I should begin with a brief background of the Company and its Medicare business. FHP International Corporation is a federally qualified health maintenance organization which began 33 years ago in Long Beach, California. Over the years, the Company has expanded and now serves people in 11 states and the Pacific Islands of Guam and Saipan. Over 1.7 million individuals today receive all of their health care from FHP. Our customers, or members, include the employees of over 5,000 small, medium, and large corporations; Medicaid recipients; military dependents; federal, state, county, and city employees; and nearly 350,000 Medicare beneficiaries.

FHP receives a capitated payment, a fixed amount of money every month, for each of its members and in return contracts to provide all of that member's health care needs irrespective of the cost or intensity of care. Approximately 20% of our members receive their care through our staff-model network of over 60 company-operated medical centers and five hospitals. The balance of our members receive their care through private physicians and hospitals with whom FHP has contracted.

Under our Medicare contract with the federal government, HCFA pays FHP an amount equal to 95% of what HCFA would otherwise pay to the fee-for-service physicians and hospitals in that geographical area. FHP in turn provides all of the benefits required under Medicare.

In addition, FHP provides outpatient prescription drugs and other benefits not covered by Medicare, including covering hospital and physician deductibles. For this FHP charges $5 for a prescription, $5 for an office visit, and charges no premium. The results are impressive. For example, the 5% savings to the federal government for our 350,000 Medicare members amounts to more than $60 million per year. Because FHP charges no premium and adds benefits over and above the standard Medicare benefits, we save each of our 350,000 Medicare members an average of more than $1,200 a year. These direct savings to our Medicare members total more than $348 million a year.

Through these efficiencies, FHP is removing over $400 million a year of unnecessary and wasteful health care costs from the health care system for our Medicare members alone. As evidence of the senior population's acceptance of this program, our Medicare membership grew on average 21% each year over the last five years.

We are able to accomplish these results by applying a series of basic principles which we have learned over the years, and which are readily applicable to the nation as a whole as we seek to provide health care to all Americans in a cost-effective way:

I. We remove the financial barriers to seeking early care. We know that if there are limited benefits, pre-existing condition exclusions or deductibles, many people will defer seeing the doctor until the disease or problem becomes unbearable. By the time they see the doctor, it is likely that more expensive procedures and possible hospitalization will be required. We know that if we remove the financial barriers to seeking early care we are often able to stabilize or correct the problem before it gets out of hand, and thereby avoid more expensive treatment later on. Not only does this save money, but it is a higher quality of medical care since no one wants to be sick or in the hospital if he or she can avoid it. The use of a hospital is the most expensive part of medical care, and FHP's use of hospital bed days is one of the lowest in the country.

II. Access to an individual's primary care physician on weekends and in the evenings is very important to the control of health care costs. If their doctor is not available, then typically, the patient will wind up in the emergency room of a hospital. Emergency room care is very expensive and is used by hospitals as a major source of admissions. Many of FHP's medical centers are open in the evenings and on the weekends. The centers are full-service medical centers which include both primary care doctors and specialists, a pharmacy, minor surgery, laboratory, x-ray, physical therapy, and even child care while the patient is receiving medical care.

III. Under the HMO Act, every federally qualified health maintenance organization must provide a minimum level of benefits as prescribed in the act. Except for outpatient drugs, this benefit level is all inclusive; but FHP adds prescription drugs to every one

of its benefit packages. This is particularly important for Medicare beneficiaries since many do not have the funds to fill a prescription. Without a drug benefit, the prescription would likely either not be filled or would be filled and spread over a longer period of time than is therapeutically required to cure the illness. From experience we know that the additional cost of a drug benefit is more than offset by lower hospital use and lower utilization of health care.

IV. The incentive for the physicians must be aligned with the HMO's and the nation's incentives to reduce costs while simultaneously improving quality. Under the fee-for-service system, providers are paid based on services performed. This incentive has lead to abuses and over utilization. At FHP, our staff and contract physicians have incentives to provide members with rapid access and to deliver high quality care. These incentives not only control costs, but also enhance quality—to do otherwise would result in lawsuits and loss of members. Holding back on appropriate utilization would also, as discussed earlier, actually result in eventual higher health care costs.

Our efforts to control costs while delivering high-quality care have had impressive results. Over the past months, our efforts to assure the highest standards of quality have been recognized by a number of organizations. The National Committee for Quality Assurance has awarded our plans in Arizona, New Mexico, Southern California, and Utah with unqualified certifications of quality care. The American College of Surgeons recognized FHP's exceptional quality of care in treating our members who have cancer.

V. FHP's Medicare program is community rated. This is an essential part of the program's success. Under a community rating system, HCFA pays FHP the same monthly amount, adjusted for age, for each member in each geographical area served by FHP, irrespective of the Medicare member's health. At any time, some of our Medicare members will be sick and some will be well. The key is that we have enrolled a large number of Medicare beneficiaries so that the cost of caring for the ill members can be spread over our entire 350,000 Medicare population, making health care on average affordable for any one individual.

VI. Physician choice is important, but not in the way most people think of it. Having the absolute, unchecked freedom to seek the services of any doctor, including expensive specialists, at any time and at any frequency, is not a prerequisite to receiving quality health care. One of the reasons FHP is so popular with its Medicare members is that we have carefully screened, credentialed, and regularly recredential each of our in-house and contracted physicians. We inquire into their malpractice history, their technical competence, where they went to school, where they trained, the amount of their training and experience, and the status of their licensure. When an FHP member selects one of our physicians, the member can have confidence in the level of care they will receive. This is not necessarily the case in the unmanaged, fee-for-service system.

Mr. President, my colleagues at FHP and I are convinced that HMOs offer the best solution to controlling the growing cost of health care, generally, and Medicare, in particular, while assuring coordinated high-quality care. The number of Americans in HMOs has grown steadily in recent years with more than 25 percent of Americans receiving health care through a managed care plan. The savings to the private sector have been significant, with health costs growing at the lowest level in years (indeed, for many employers, costs have actually declined with no loss in quality). Yet only some ten percent of Medicare beneficiaries receive their care through HMOs.

FHP is convinced that the Medicare program and beneficiaries can realize similar cost savings while assuring coordinated quality of care. We have been excited by the recognition managed care has been receiving from Members of the Congress as a way to address the Medicare programs problems. The biggest challenge will be to encourage beneficiaries to try something which for many of them will be new.

Our surveys, like those of the other Medicare HMOs, demonstrate enormous satisfaction by our Medicare patients with the quality, cost and additional benefits they receive. We are sure, given the chance, other beneficiaries would be similarly satisfied.

We would be pleased to work with you and others in your Administration to bring the beneficial cost and quality results of managed care to a greater number of Medicare beneficiaries. Also, we would be delighted for you to visit our medical and corporate headquarters campus in Southern California the next time your travels bring you to the West Coast. I think you will be very impressed with what you see.

Thank you for asking me to provide you with this information and for your leadership on health care issues. If you have any questions or if I can be of any further assistance, please do not hesitate to call me directly at: 714-378-5631.

Sincerely,

Nick Franklin
Senior Vice President,
Public Affairs

cc: Carol H. Rasco, Assistant to the President for Domestic Policy

g:\klein\whitehse.bf

FHP
HEALTH CARE

FHP International Corporation
Public Affairs Department
9900 Talbert Avenue
Fountain Valley, CA 92708
714.378.5767

January 12, 1995

JAN 18 1995

William Jefferson Clinton
President of the United States
The White House
Washington, DC

Dear Mr. President:

I enjoyed the opportunity to meet you at the breakfast you hosted for members of the Democratic Leadership Councils at the White House on December 7, 1994.

You asked me to write to you and let you know how FHP is able to save Medicare beneficiaries and the federal government money under FHP's Medicare risk contract with the Health Care Financing Administration (HCFA), while providing beneficiaries with a broader range of benefits, including prescription drug coverage. I trust the following provides the information you requested.

I should begin with a brief background of the Company and its Medicare business. FHP International Corporation is a federally qualified health maintenance organization which began 33 years ago in Long Beach, California. Over the years, the Company has expanded and now serves people in 11 states and the Pacific Islands of Guam and Saipan. Over 1.7 million individuals today receive all of their health care from FHP. Our customers, or members, include the employees of over 5,000 small, medium, and large corporations; Medicaid recipients; military dependents; federal, state, county, and city employees; and nearly 350,000 Medicare beneficiaries.

FHP receives a capitated payment, a fixed amount of money every month, for each of its members and in return contracts to provide all of that member's health care needs irrespective of the cost or intensity of care. Approximately 20% of our members receive their care through our staff-model network of over 60 company-operated medical centers and five hospitals. The balance of our members receive their care through private physicians and hospitals with whom FHP has contracted.

Under our Medicare contract with the federal government, HCFA pays FHP an amount equal to 95% of what HCFA would otherwise pay to the fee-for-service physicians and hospitals in that geographical area. FHP in turn provides all of the benefits required under Medicare.

In addition, FHP provides outpatient prescription drugs and other benefits not covered by Medicare, including covering hospital and physician deductibles. For this FHP charges $5 for a prescription, $5 for an office visit, and charges no premium. The results are impressive. For example, the 5% savings to the federal government for our 350,000 Medicare members amounts to more than $60 million per year. Because FHP charges no premium and adds benefits over and above the standard Medicare benefits, we save each of our 350,000 Medicare members an average of more than $1,200 a year. These direct savings to our Medicare members total more than $348 million a year.

Through these efficiencies, FHP is removing over $400 million a year of unnecessary and wasteful health care costs from the health care system for our Medicare members alone. As evidence of the senior population's acceptance of this program, our Medicare membership grew on average 21% each year over the last five years.

We are able to accomplish these results by applying a series of basic principles which we have learned over the years, and which are readily applicable to the nation as a whole as we seek to provide health care to all Americans in a cost-effective way:

I. We remove the financial barriers to seeking early care. We know that if there are limited benefits, pre-existing condition exclusions or deductibles, many people will defer seeing the doctor until the disease or problem becomes unbearable. By the time they see the doctor, it is likely that more expensive procedures and possible hospitalization will be required. We know that if we remove the financial barriers to seeking early care we are often able to stabilize or correct the problem before it gets out of hand, and thereby avoid more expensive treatment later on. Not only does this save money, but it is a higher quality of medical care since no one wants to be sick or in the hospital if he or she can avoid it. The use of a hospital is the most expensive part of medical care, and FHP's use of hospital bed days is one of the lowest in the country.

II. Access to an individual's primary care physician on weekends and in the evenings is very important to the control of health care costs. If their doctor is not available, then typically, the patient will wind up in the emergency room of a hospital. Emergency room care is very expensive and is used by hospitals as a major source of admissions. Many of FHP's medical centers are open in the evenings and on the weekends. The centers are full-service medical centers which include both primary care doctors and specialists, a pharmacy, minor surgery, laboratory, x-ray, physical therapy, and even child care while the patient is receiving medical care.

III. Under the HMO Act, every federally qualified health maintenance organization must provide a minimum level of benefits as prescribed in the act. Except for outpatient drugs, this benefit level is all inclusive; but FHP adds prescription drugs to every one

of its benefit packages. This is particularly important for Medicare beneficiaries since many do not have the funds to fill a prescription. Without a drug benefit, the prescription would likely either not be filled or would be filled and spread over a longer period of time than is therapeutically required to cure the illness. From experience we know that the additional cost of a drug benefit is more than offset by lower hospital use and lower utilization of health care.

IV. The incentive for the physicians must be aligned with the HMO's and the nation's incentives to reduce costs while simultaneously improving quality. Under the fee-for-service system, providers are paid based on services performed. This incentive has lead to abuses and over utilization. At FHP, our staff and contract physicians have incentives to provide members with rapid access and to deliver high quality care. These incentives not only control costs, but also enhance quality—to do otherwise would result in lawsuits and loss of members. Holding back on appropriate utilization would also, as discussed earlier, actually result in eventual higher health care costs.

Our efforts to control costs while delivering high-quality care have had impressive results. Over the past months, our efforts to assure the highest standards of quality have been recognized by a number of organizations. The National Committee for Quality Assurance has awarded our plans in Arizona, New Mexico, Southern California, and Utah with unqualified certifications of quality care. The American College of Surgeons recognized FHP's exceptional quality of care in treating our members who have cancer.

V. FHP's Medicare program is community rated. This is an essential part of the program's success. Under a community rating system, HCFA pays FHP the same monthly amount, adjusted for age, for each member in each geographical area served by FHP, irrespective of the Medicare member's health. At any time, some of our Medicare members will be sick and some will be well. The key is that we have enrolled a large number of Medicare beneficiaries so that the cost of caring for the ill members can be spread over our entire 350,000 Medicare population, making health care on average affordable for any one individual.

VI. Physician choice is important, but not in the way most people think of it. Having the absolute, unchecked freedom to seek the services of any doctor, including expensive specialists, at any time and at any frequency, is not a prerequisite to receiving quality health care. One of the reasons FHP is so popular with its Medicare members is that we have carefully screened, credentialed, and regularly recredential each of our in-house and contracted physicians. We inquire into their malpractice history, their technical competence, where they went to school, where they trained, the amount of their training and experience, and the status of their licensure. When an FHP member selects one of our physicians, the member can have confidence in the level of care they will receive. This is not necessarily the case in the unmanaged, fee-for-service system.

Mr. President, my colleagues at FHP and I are convinced that HMOs offer the best solution to controlling the growing cost of health care, generally, and Medicare, in particular, while assuring coordinated high-quality care. The number of Americans in HMOs has grown steadily in recent years with more than 25 percent of Americans receiving health care through a managed care plan. The savings to the private sector have been significant, with health costs growing at the lowest level in years (indeed, for many employers, costs have actually declined with no loss in quality). Yet only some ten percent of Medicare beneficiaries receive their care through HMOs.

FHP is convinced that the Medicare program and beneficiaries can realize similar cost savings while assuring coordinated quality of care. We have been excited by the recognition managed care has been receiving from Members of the Congress as a way to address the Medicare programs problems. The biggest challenge will be to encourage beneficiaries to try something which for many of them will be new.

Our surveys, like those of the other Medicare HMOs, demonstrate enormous satisfaction by our Medicare patients with the quality, cost and additional benefits they receive. We are sure, given the chance, other beneficiaries would be similarly satisfied.

We would be pleased to work with you and others in your Administration to bring the beneficial cost and quality results of managed care to a greater number of Medicare beneficiaries. Also, we would be delighted for you to visit our medical and corporate headquarters campus in Southern California the next time your travels bring you to the West Coast. I think you will be very impressed with what you see.

Thank you for asking me to provide you with this information and for your leadership on health care issues. If you have any questions or if I can be of any further assistance, please do not hesitate to call me directly at: 714-378-5631.

Sincerely,

Nick Franklin
Senior Vice President,
Public Affairs

cc: Carol H. Rasco, Assistant to the President for Domestic Policy

g:\klein\whitehse.bf

Returned to Roz

NOV 10 1994

EXECUTIVE OFFICE OF THE PRESIDENT

10-Nov-1994 10:54am

TO: Carol H. Rasco
TO: Rosalyn A. Miller

FROM: Marilyn Yager
Office of Public Liaison

CC: Christopher C. Jennings

SUBJECT: FHP and Bruce fried

Regarding the meeting request from Bruce Fried on behalf of FHP, I have already had a conversation with Bruce. I have indicated that there weren't many working days left in November with Thanksgiving and all, but that we would be happy to try to schedule something as soon as possible in December.

I will keep their request in my pending folder and will encourage Roz to schedule when appropriate in December. However, ~~Roz~~ Julie should acknowledge receipt of letter.

(Budget)

FHP
HEALTH CARE

FHP International Corp.
1401 Eye Street, N.W., Suite 210
Washington, D.C. 20005
202.408.7620 Fax 202.408.7628

November 8, 1994

Carol Rasco
Assistant to the President
for Domestic Policy
The White House
Washington, DC 20500

Dear Ms. Rasco:

We were pleased to learn that you and Robert Rubin will be leading the process to develop the Administration's health care policy proposals.

In that context, I would appreciate an opportunity for FHP's senior executives to meet with you in the near future to discuss FHP's health care policy ideas and concerns.

As you may know, FHP operates the nation's third largest HMO, serving almost two million members in eleven states and Guam. Also, FHP is the largest Medicare risk contractor, serving 350,000 Medicare beneficiaries. I have enclosed a fact sheet and our most recent annual report for your review.

I will be in touch with your office shortly to schedule a mutually convenient time to meet.

Thank you for your consideration and willingness to consider our views.

Sincerely yours

Bruce Merlin Fried
Vice President, Federal Affairs

cc: Chris Jennings
Marilyn Yeager
Nick Franklin

FACT SHEET

FHP International Corp.
9900 Talbert Avenue
Fountain Valley, CA 92708
(714) 963-7233

Washington Office
1401 I Street, NW, Ste. 210
Washington, DC 20005
(202) 408-7620

BACKGROUND:

- FHP International Corporation was founded in 1961; it is a federally qualified health maintenance organization based in Fountain Valley, California. With its subsidiaries, FHP serves more than 1.7 million members in Arizona, California, Colorado, Illinois, Indiana, Kentucky, Nevada, New Mexico, Ohio, Texas, Utah and Guam. FHP is the third largest HMO in the nation, and one of the largest providers of prepaid Medicare services.

- FHP is both a staff model and individual practice association model (IPA) HMO; it provides health care services through salaried physicians and allied professionals in 64 medical and dental centers throughout its regions.

- FHP operates two acute-care hospitals and two skilled nursing facilities in Southern California. FHP also operates a hospital in Salt Lake City, Utah. The company employs more than 14,000 full- and part-time employees, including 800 physicians, 6,000 nurses, and 200 dentists. In addition, FHP has outside contracts with 41,000 physicians and 500 hospitals.

- FHP was the first Medicare risk contractor on the West Coast and is now the largest Medicare risk contractor in the United States. FHP provides health care services to nearly 350,000 Medicare beneficiaries in Arizona, California, Colorado, Nevada, New Mexico and Utah.

- FHP's Senior Plan provides more comprehensive benefits to Medicare beneficiaries than traditional fee-for-service Medicare. This includes routine physicals, dental care, vision care, and prescription drugs.

- In addition to furnishing health care services to commercial employer groups and Medicare beneficiaries, FHP provides health care services to federal employees, retirees and their dependents.

- FHP also operates a health and life indemnity insurer and a workers' compensation insurer.

Returned to Roz

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EXECUTIVE OFFICE OF THE PRESIDENT

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(Budget)

NOV - 9 1994

FHP HEALTH CARE

FHP International Corp.
1401 Eye Street, N.W., Suite 210
Washington, D.C. 20005
202.408.7620 Fax 202.408.7628

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Assistant to the President
for Domestic Policy
The White House
Washington, DC 20500

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Vice President, Federal Affairs

cc: Chris Jennings
Marilyn Yeager
Nick Franklin

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- FHP also operates a health and life indemnity insurer and a workers' compensation insurer.

FAX

FEB - 7 1995

KLEIN

American Hospital Association
325 - Seventh Street, N.W.
Suite 700
Washington, D. C. 20004-2802
202-638-1100

TO: Carol Rasco
FROM: Rick Pollack
DATE: February 7, 95
FAX #: 456-2878
PAGES: 2

NOTES:

American Hospital Association

AHA

Richard J. Davidson
President

February 6, 1995

The Honorable Bill Clinton
President
The United States
Washington, D.C. 20550

Dear Mr. President:

The nation's hospitals are heartened that you kept your promise to protect the Medicare program in your fiscal year 1996 budget.

Your budget wisely rejects the "business-as-usual" budgeting of old...further ratcheting down of payments to caregivers to achieve some arbitrary target for savings from the Medicare program. Medicare, like Social Security, is a contract with our nation's seniors that determines their financial and health care piece of mind. By rejecting further spending reductions in Medicare's Part A trust fund, you have reinforced your administration's strong commitment to this important program.

America's hospitals and health systems understand the need for change. In fact, they are at the forefront of change in communities all across the country. Medicare's viability for future generations must be maintained. To achieve that, the types of structural changes taking place in the private sector that are providing innovative, coordinated care must be made available to the millions of Americans who must rely on Medicare. We strongly believe these changes will lead to better care for our nation's seniors and to reduced costs for all consumers.

As we mark the 30th anniversary of Medicare's creation, we should work together to renew our contract with America's seniors to provide them with the high quality health care they deserve. Your budget blueprint is a very good beginning.

Sincerely,

Dick Davidson

Liberty Place
325 Seventh Street, N.W.
Washington, D.C. 20004-2802
202.638.1100

One North Franklin
Chicago, Illinois 60606
312.422.3000

Roz -

Any ideas ~~what~~ this is or what I'm supposed to do about it?

Thanks -
Jen

FYI -

Sorry [redacted] Roz

Coalition on Smoking OR Health

1150 Connecticut Avenue, NW, Suite 820, Washington, DC 20036
Telephone: (202) 452-1184 Facsimile: (202) 452-1417

January 17, 1995

JAN 19 1995

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

Dear Mr. President:

Today we are delivering to you approximately 300,000 signatures on a petition calling for the protection of our children from tobacco. Americans across this country are demanding change. They are concerned about the dangers of secondhand smoke. They are concerned about the addictive nature of tobacco, and they are concerned about the tobacco industry's attempts to market and promote tobacco products directly to children. They are demanding that the Food and Drug Administration provide oversight and protection for the public in the way that tobacco products are manufactured, sold, labeled, advertised and promoted.

For more than thirty years politicians in both Congress and the Executive Branch have allowed the tobacco industry to control the tobacco and health agenda. In spite of 23 Surgeon General's Reports on Smoking and Health and 60,000 scientific studies finding tobacco use is a cause of disease, Congress allowed the tobacco industry to freely manufacture and market its addictive, dangerous products. We believe new opportunities for change are at hand.

Last November, the American voters sent a strong message to our federal policy makers that it is high time they put the public's interests above the special interests. There is no better example of where the public's interest has been sacrificed than in the area of tobacco. There is no other issue where the scientific evidence is so overwhelming as to justify speedy remedial action. A Gallup survey conducted for our health organizations in 1993 found that nearly 70 percent of the public felt that the FDA should regulate tobacco products in a manner similar to the way drugs are regulated. In fact it is in the health and safety area where the public expects the federal government to be responsive and responsible.

The undersigned organizations represent millions of Americans from all walks of life and all political persuasions. We are united in presenting these petitions to you to call for long overdue responsible action to protect the health of the American public by better controlling the manufacture and marketing of tobacco products.

The tobacco industry is spending millions of dollars to convince policymakers that tobacco products are already subjected to health and safety oversight and controls. The tobacco industry spends millions more in advertising to convince policymakers and the public that our organizations are advocating a ban on tobacco products. These tobacco industry claims are false in all respects.

AMERICAN CANCER SOCIETY®

AMERICAN LUNG ASSOCIATION®

American Heart Association℠
Fighting Heart Disease and Stroke

Through this petition, the American people are speaking out against the tobacco industry's campaigns to sell a product that addicts children. They are speaking out against the tobacco industry's aggressive use of images of sexual attraction, sophistication, success and athletics to convince our nation's youth that smoking is desirable and acceptable.

The signatures being submitted to you today were gathered by volunteers throughout the country --in homes, schools, workplaces and churches. In this campaign, unlike the tobacco industry's "counter-petition" drive, no one was paid to gather these signatures. The volunteers were concerned about the health of the American public, the right of the American public to be told the truth about the tobacco industry, and assurances for protection of our children from the seductive advertising and promotional practices of the tobacco industry.

The public health community in this country is unanimous in its support for having the FDA oversee tobacco products. Tobacco use is this nation's leading cause of preventable death. It is time for our policy makers to put health first.

We look forward to working with you on this important issue.

Sincerely,

Scott D. Ballin
Chairman, Coalition on Smoking OR Health
Vice President for Public Affairs
American Heart Association

Fran Du Melle
Deputy Managing Director
American Lung Association

Michael F. Heron
National Vice President for Public Affairs
American Cancer Society

cc: Donna E. Shalala, Secretary, Department of Health and Human Services
Philip R. Lee, M.D., Assistant Secretary for Health
William Corr, Deputy Assistant Secretary for Health
David Kessler, M.D., Commissioner of FDA
bcc: Carol H. Rasco

Coalition on Smoking OR Health
Public Policy Advisory Council

Patrick B. Harr, M.D.
Chairman of the Board
American Academy of Family Physicians

Alan R. Nelson, M.D.
Executive Vice President
American Society of Internal Medicine

George D. Comerci, M.D.
President
American Academy of Pediatrics

Cheryl A. Beversdorf, RN, MHS, CAE
Executive Vice President
Association of State and Territorial Health Officials

Trudy J. Watson, RRT
President
American Association for Respiratory Care

Roy Branson
Co-Chair
Interreligious Coalition on Smoking OR Health

James B.D. Mark, M.D., FCCP
President
American College of Chest Physicians

Jane Delgado
President and CEO
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)

Fernando Trevino, Ph.D., MPH
Executive Director
American Public Health Association

Gary S. Dorfman, M.D.
President
Society of Cardiovascular & Interventional Radiology

Coalition on Smoking OR Health
Sponsoring and Supporting Organizations

Alliance for a Smoke-Free South Carolina
American Academy of Otolaryngology-Head and Neck Surgery
American Association for Cancer Research
American College of Cardiology
American College of Nurse-Midwives
American College of Physicians
American Council on Science and Health
American Dental Association
American Dental Hygienists' Association
American Diabetes Association
American Medical Association
American Medical Student Association
American Medical Women's Association
American Muslim Council
American Nurses Association
American Psychological Association
American Radiological Nurses Association
American Speech-Language-Hearing Association
American Society of Addiction Medicine
American Society of Hematology
American Veterans Committee
Appalachian Health Educational Campaign
Associated Medical Schools of New York
Association for the Advancement of Health Education
Association for Nonsmokers-Minnesota
Association of American Cancer Institutes
Association of Maternal & Child Health Programs
Association of Minority Health Professions Schools
Association of Pediatric Oncology Nurses
Association of Professional Flight Attendants
Association of Schools of Public Health
Association of State & Territorial Dental Directors
Association of State & Territorial Directors of Health Promotion and Public Health Education
Boston Women's Health Book Collective
Center for Science in Public Interest
Church of the Brethren
Coalition for Smoke Free Maryland
Commission for a Healthy New York
Commission on Cancer of the American College of Surgeons
Committee for Children
Congress of National Black Churches, Inc.
Doctors and Lawyers for a Drug Free Youth
Erie County Department of Health (PA)
Evangelicals for Social Action
Families Against Cancer Terror
GASP of Massachusetts
General Board of Church & Society, The United Methodist Church
General Conference of Seventh-day Adventists
Group to Alleviate Smoking Pollution (GASP) of Colorado
Houston GASP
Illinois Caucus for Adolescent Health
Illinois Coalition Against Tobacco
INFACT
Interfaith Center on Corporate Responsibility, Tobacco Program (NY)
Interfaith Center on Corporate Responsibility, Tobacco Program (WI)
Joint Council of Allergy and Immunology
March of Dimes Birth Defects Foundation
Medical and Chirurgical Faculty of Maryland
Minnesota Coalition for a Smoke-Free Society 2000

National Association of Medical Directors of Respiratory Care
National Association of Pediatric Nurse Associates & Practitioners
National Coalition for Cancer Research
National Coalition for Cancer Survivorship
National Council for International Health
National Perinatal Association
National School Health Education Coalition
National Women's Law Center
New Jersey Group Against Smoking Pollution (GASP)
NETWORK: A National Catholic Social Justice Lobby
Nonsmokers, Inc.
Oncology Nursing Society
Physicians Committee for Responsible Medicine
Public Citizens' Health Research Group
Roswell Park Cancer Institute
Scenic America
Smokefree Class of 2000
Smokefree Educational Services, Inc.
Society for Public Health Education (SOPHE)
STAT (Stop Teenage Addiction to Tobacco)
Student Coalition Against Tobacco (SCAT)
Texas Department of Health, Office of Smoking and Health
Tobacco Control Resource Center
Tobacco Free Clark County Coalition
Tobacco-free Education and Action Coalition for Health (TEACH)
Tobacco Free North Dakota
Tobacco Products Liability Project
U.S. Public Interest Research Group (PIRG)
Washington Doctors Ought to Care (DOC)
The Washington Institute
West Virginia Tobacco Control Coalition
Women and Girls Against Tobacco

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: YAGER

Draft response for POTUS and forward to CHR by: cc: KLEIN

Draft response for CHR by: _____

Please reply directly to the writer (copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: No Conflict Yet

Please handle

NATIONAL EMPLOYEE BENEFITS INSTITUTE

601 Pennsylvania Avenue, N.W., Suite 750 North, Washington, D.C. 20004-2612 • (800) 558-7258 • (202) 737-9656 • Fax: (202) 393-0796

NEBI

January 16, 1995

JAN 19 1995

Ms. Carol Rasco
Assistant to the President
Domestic Policy Council
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Ms. Rasco: **Re: NEBI Spring Conference April 6-7, 1995**

I invite you to address members and guests of the National Employee Benefits Institute ("NEBI") at NEBI's spring legislative conference to be held April 6-7, 1995. The conference will take place in Washington, D.C., at the Washington Vista Hotel located at 1400 M Street, N.W.

Our members would especially be interested in hearing your comments on the Administration's health care reform strategy during the next two years.

NEBI represents Fortune 1,000-size companies on key legislative and regulatory issues which impact employee benefit plans. NEBI promotes the interests of its members by analyzing and developing positions on legislative and regulatory developments related to health plans, pension plans, and other benefit issues. An information sheet on NEBI and our membership is enclosed for your reference.

NEBI members sponsor both health and pension benefit plans for employees throughout the entire nation, in most cases, in all fifty states. These plans represent uniform benefits coverage for millions of American workers. NEBI members are committed to providing quality health and pension benefits for the employees of America's largest corporations.

NEBI holds legislative meetings to provide a forum for members and guests to hear and participate in discussions on significant legislative and regulatory issues of the day. You will be speaking to a group of employee benefit plan managers, human resource department managers, corporate policy makers, and others who follow legislative and regulatory developments. By meeting with our members, you will have the opportunity to help the group understand the problems and alternatives we face in solving challenges to the employee benefits system.

NEBI has an excellent reputation in holding timely and informative conferences Our speakers include members of the Administration, Congress, and the federal agencies.

Many of your colleagues have spoken at our conferences, including: Evelyn Petschek, Director, Employee Plans Technical and Actuarial Division, Internal Revenue Service; Olena Berg, Assistant Secretary for Labor, Pension and Welfare Benefits Administration; Judith Feder, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; and Bruce Vladeck, Administrator, Health Care Financing Administration.

Other recent speakers include: Former Senator Dave Durenberger (R-MN), Senators Don Nickles (R-OK) and James Jeffords (R-VT); former Representative Dan Rostenkowski (D-IL), Representatives Bill Archer (R-TX), Marge Roukema (R-NJ), Nancy Johnson (R-CT), Roy Rowland (D-GA), and Jim McDermott (D-WA).

I hope that you will be able to join us on Thursday, April 6, or Friday, April 7, 1995. I will work with you to determine an appropriate time to speak as well as to develop a specific topic. I will contact you in the next week to check on your availability. In the meantime, feel free to contact me at (202) 737-9656.

Sincerely,

Laura L. Tomarchio

Laura L. Tomarchio,
Director of Legislation

Enc.

NATIONAL EMPLOYEE BENEFITS INSTITUTE

601 Pennsylvania Avenue, N.W., Suite 750 North, Washington, D.C. 20004-2612 • (800) 558-7258 • (202) 737-9656 • Fax: (202) 393-0796

NATIONAL EMPLOYEE BENEFITS INSTITUTE

NEBI

In 1977, the National Employee Benefits Institute ("NEBI") was founded to represent the employee benefit interests of large corporations. Today, NEBI continues to represent a large corporate membership on issues that impact both health benefit plans and pension plans.

NEBI Member Profile. As a non-profit organization, NEBI represents Fortune 1,000 size companies on legislative and regulatory developments that impact employee benefit plans, both health benefit and pension plans.

NEBI members represent diverse interests in the business community: our companies sponsor pension plans for millions of workers and manage billions of dollars in pension assets; our members also provide uniform health benefit plans for employees throughout the nation. NEBI companies are dedicated to preserving and enhancing the employer-provided benefits system.

NEBI Representation of Its Members. NEBI works on and off Capitol Hill to represent its members' interests. We track benefits legislation and regulations, analyze the issues as they relate to our membership, and provide our members with a recommendation on how to react to such developments. On issues of significant concern to our companies, NEBI develops a position statement and communicates with Congress our support or opposition to the proposal in question.

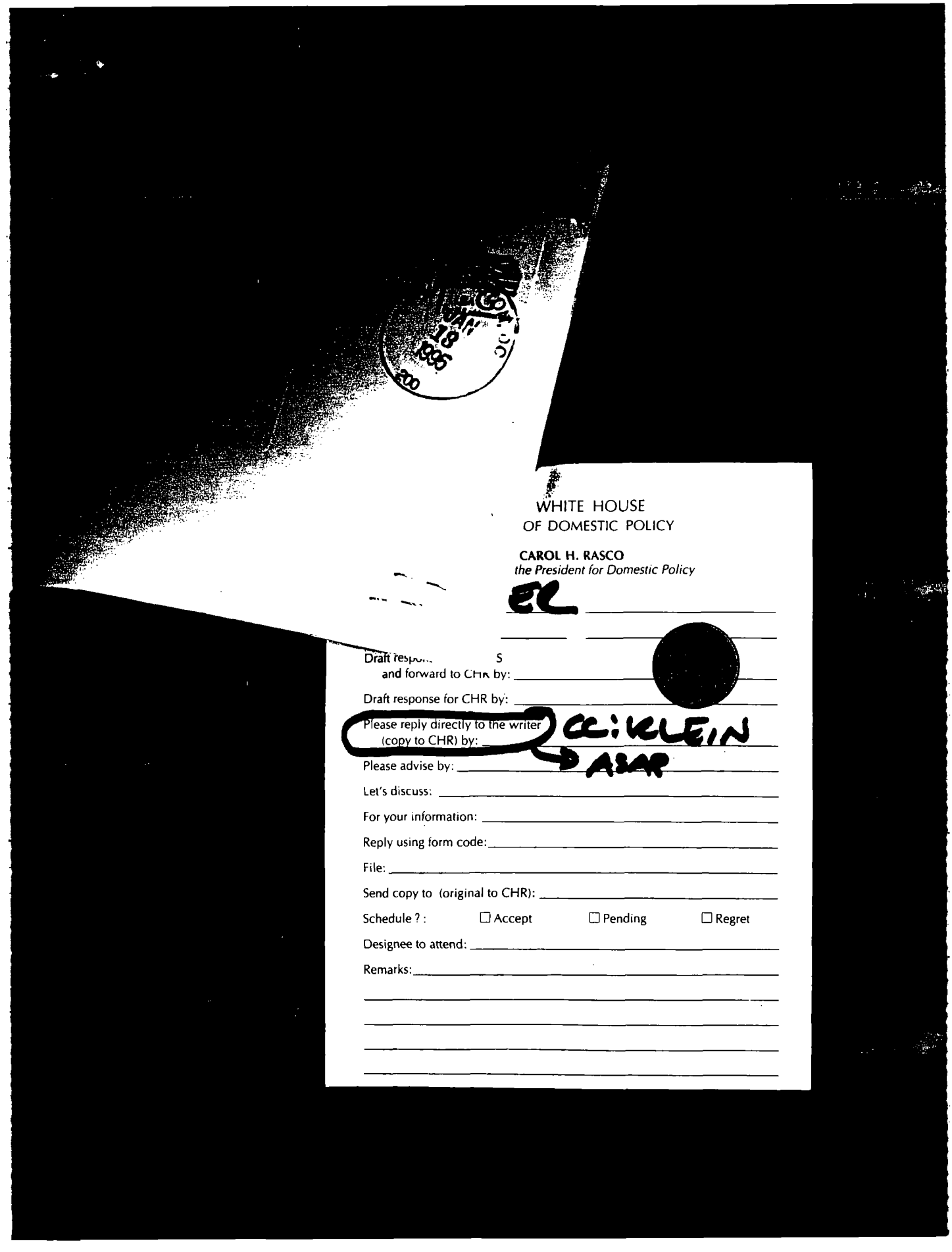
NEBI Relationship with Congress and Federal Agencies. NEBI has developed a working relationship with members of Congress, the Administration and the regulatory agencies (i.e., Department of Labor, Department of Treasury, Department of Health and Human Services, Internal Revenue Service, and the Pension Benefit Guaranty Corporation). We communicate with our contacts to exchange recommendations on significant pieces of legislation. NEBI submits written comments to the federal agencies and Congress on priority issues.

NEBI Legislative Conferences. NEBI holds annual legislative conferences in Washington, D.C. These conferences allow our membership to meet with and discuss benefit issues with the nation's leaders, including members of Congress, the Administration, and the federal agencies.

NEBI Lobbying Priorities. The NEBI Policy Board is composed of member companies who, together with NEBI executive staff, determine our lobbying priorities, develop position statements, and design an annual calendar.

During the past year, NEBI has been campaigning on behalf of its members to address several concerns under proposed health and pension reform legislation. Our foremost concern has been to preserve the federal framework created under the Employee Retirement Income Security Act ("ERISA") for the administration of employee health benefit plans.

656LT:LT 12/01/94



WHITE HOUSE
OF DOMESTIC POLICY

CAROL H. RASCO
the President for Domestic Policy

EL

Draft respo... S
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____ cc: KLEIN
ASAP

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: _____

FORUM ON CONSENSUS:

A New Look at State and Federal Roles in Health Care Reform

January 9, 1995

Ms. Carol Rasco
Assistant to the President for Domestic Policy
The White House
Washington, DC 20500

Dear Ms. Rasco:

When the 104th Congress recommences work on health care reform, we must be prepared to resume the debate with a new energy and a new approach. As state governments continue their experimental efforts to solve the health care dilemma and the private sector pursues innovative ways to deal with increasing costs, health care reform remains a feasible objective for next year.

The challenge lies in the capability of state and federal government and the private sector to craft an approach to health care reform that will lead to bipartisan consensus on the issues, and ultimately to sustainable solutions. We believe that if an agreement can be reached on the process by which to arrive at such a consensus, the outlook for achieving health care reform is promising. To explore the obtainable objectives for the new health care agenda, we will co-chair a roundtable meeting in Washington, D.C. on Wednesday, February 1, 1995.

The meeting will provide an opportunity for you to contribute to this working discussion with many of the nation's other top policy-makers and experts. As a whole, the group will work toward the common goal of charting a fresh route to sustainable reform.

The Columbia Institute will organize the meeting on a bipartisan basis and will include several of our colleagues from Washington and from the States. Kathy Prendergast of the Institute will contact you soon to provide further details. If you have questions in the meantime, please call her at (202) 547-2470.

We must explore new avenues for solutions to this complex problem. We hope that you will take the time to contribute to this worthwhile effort, and we look forward to seeing you on February 1st.

Sincerely,

Bill Thomas

BILL THOMAS
Member of Congress

John Kitzhaber

JOHN KITZHABER, M.D.
Governor of Oregon

8 E Street, S.E., Washington, D.C. 20003 ◦ Telephone: (202) 547-2470 ◦ Facsimile: (202) 547-1893

FORUM ON CONSENSUS:

A Direct Exchange Between State & Federal Public Officials on the Next Possible Steps for Health Care Reform

Wednesday, February 1, 1995
902 Hart Senate Office Bldg. - Washington, DC

PROGRAM OUTLINE
1/10/95 (To Date)

==========

A. MEETING CONCEPT

The meeting will provide a forum for state and federal elected officials to work together charting the future of health care reform. Each of the three sessions will address questions which will lead to the ultimate objective of achieving a consensus on the steps by which the nation should move sequentially towards a more economical and efficient health care system. Invited elected officials include several Governors, U.S. Representatives, Senators, and members of the Administration. Interaction with policy experts may also occur at the conclusion of each session.

B. MEETING STRUCTURE

To ensure tangible results, each session will observe the following format:

1) **Assumption(s)** - At the outset of each session, one or more assumptions will be made to create a common ground from which public officials will be able to contribute and respond.

2) **Proposal(s)** - Based on the assumptions, brief prepared statements will be given in order to open debate and discussion for the session.

3) **Response(s)** - Comments will be made on the topics raised in the proposals and an attempt will be made for reconciliation on minor issues.

4) **Roundtable Discussion** - An all inclusive discussion time will follow the formal proposal/response times of each session.

5) **Question(s) & Conclusion(s)** - The session leader will ask the public officials to respond to questions dealing with the topics raised in order to analyze and evaluate their consensus on the issue and will draw conclusions based on the their answers.

C. DRAFT AGENDA

8:00 a.m. WELCOME

8:15 a.m. OPENING ADDRESS: New Opportunities for a State & Federal Partnership on Health Care Reform

Senator Robert Dole (R-KS)
Majority Leader
U.S. Senate (invited)

SESSION I: IDENTIFYING THE ACHIEVABLE OBJECTIVES

9:00 a.m. A. Session Leader:

Uwe Reinhardt, Ph.D.
James Madison Professor of Political Economy
Princeton University

B. Content & Format:

Beginning with the assumption that the broad goal of health care reform is to move sequentially towards universal coverage, the session leader will lay out an overview of the commonalities of the proposals offered during the 103rd Congress and set the stage for a discussion to define the next feasible steps for health care reform. *Topics will include: insurance reform, medical malpractice and tort reform, portability, the issue of party unity, the experience of a bipartisan consensus, and the role of the private sector.*

C. Public Officials:

The Honorable Nancy Johnson* (R-CT)
The Honorable Jim McDermott (D-WA)
The Honorable J. Roy Rowland, MD* (Retired, D-GA)
The Honorable Bill Thomas* (R-CA)
Governor Jim Edgar* (R-IL)
Governor John Kitzhaber, MD* (D-OR)
Governor Pete Wilson (R-CA)
Carol Rasco (Assistant to the President for Domestic Policy)

D. Questions to Address:

- **What is feasible in 1995-1996?**
- **Is there another unique approach that was not attempted in 1994?**
- **Is health care reform a goal of both state & federal governments?**

SESSION II: DEFINING THE RULES & EXAMINING THE ROLES OF THE STATES AND FEDERAL GOVERNMENT

10:30 a.m. A. Session Leader:

David Helms, Ph.D.
Executive Director
The Alpha Center

B. Content & Format:

This session will examine the roles of the state and federal government. *Topics will include the following: Medicaid, ERISA, Medicare, and the Marketplace.*

C. Public Officials:

Senator Phil Gramm (R-TX)
Senator Paul Wellstone (D-MN)
The Honorable Harris Fawell (R-IL)
The Honorable Dennis Hastert* (R-IL)
The Honorable Marge Roukema* (R-NJ)
The Honorable J. Roy Rowland, MD* (Retired, D-GA)
Governor Jim Edgar* (R-IL)
Governor John Kitzhaber, MD* (D-OR)
Bruce Vladeck (Administrator, Health Care Financing Administration)

D. Questions to Address:

- **How will the States and the federal government resolve the conflicts could potentially prevent health care reform in 1995-1996?**

SESSION III: REVISING THE PROCESS AS A MEANS TO CONSENSUS

12:15 p.m. A. Session Leader:

Deborah Steelman
Attorney-at-Law
The Law Offices of Deborah Steelman

B. Content & Format:

Assuming that a consensus is attainable on certain issues, a timeline for action will need to be drafted that will not interfere with the '96 elections. *This discussion will cover federal and state blueprints for reform and the timetables needed for action.*

C. Public Officials:

Senator Jim Jeffords (R-VT)
Senator Nancy Kassebaum (R-KS)
The Honorable David Bonior (D-MI)
The Honorable Nancy Johnson* (R-CT)
The Honorable Jim McDermott (D-WA)
The Honorable Charlie Norwood (R-GA)
The Honorable John Porter* (R-IL)
The Honorable Bill Thomas* (R-CA)
The Honorable J. Roy Rowland* (Retired, D-GA)
Governor Jim Edgar* (R-IL)
Governor John Kitzhaber, MD* (D-OR)

D. Questions to Address:

- **Is this goal realistic? How much time will it require?**
- **After what time will election year politics take over?**

1:30 p.m. LUNCH BREAK

An informal lunch with the public officials will be served in the meeting room.

2:15 p.m. CLOSING ADDRESS

The Honorable Newt Gingrich
Speaker of the House
(invited)

ADJOURNMENT OF FORMAL PROCEEDINGS

INFORMAL AD HOC SESSIONS

* Confirmed

W/ Barbara W.

DEC 23 1994

Council for
Affordable Health
Insurance

December 21, 1994

Carol Rasco
Assistant to the President for Domestic Policy,
Executive Office of the President
Washington, DC 20500

Dear Ms. Rasco,

I saw some of your presentation at the NCSL meeting last week, and was struck especially by the last question from the legislator from Idaho about Medical Savings Accounts.

You expressed concern about the adequacy of patient education and requested more information about the concept.

I was delighted that you were receptive to the idea and would love to have an opportunity to sit down with you to share our perspective and answer any questions you might have. In anticipation of that, I am enclosing copies of some of the research we've done over the past three years.

Most of this does not address your specific question, so let me try to do that now. You are very right to be concerned about this. Under today's system patients are often not equipped with the information they need to make intelligent decisions about their choice of provider and treatment alternatives. I think in part that is because we have evolved into an increasingly paternalistic health care system in which most of the treatment decisions are the result of negotiations between provider and payer. The patient has become almost a passive bystander.

I believe this situation has serious clinical implications. To the extent patients are removed from these decisions, they are less likely to feel knowledgeable about, or invested in, the course of treatment. That means they are less likely to show up for follow-up appointments, take the prescribed medications on schedule, or do the necessary home treatments and therapies.

The Linda Polin Foundation has done some interesting work in the area of the need for psycho-social intervention with patients facing or recovering from major procedures. The greater their ignorance, the more likely they are to suffer depression or a sense of hopelessness about their medical condition.

112 S. West Street, Suite 400, Alexandria, VA 22314 703-836-6200 Fax 703-836-6550

I believe that MSAs will have an immeasurably beneficial effect on all this. The whole field of patient education, oucomes research, treatment assessment, etc. is in its infancy, and not growing fast enough. I would argue that is partly because there is little need or demand for that information outside of academia.

Because patients are passive recipients of services, they have little demand for that kind of information -- even if they made the effort to get and study it, it wouldn't much affect the ultimate decision. But if patients had more control over the health care dollar, they would be much more involved in every aspect of selecting the right provider and the best course of treatment, they would want to study the choices, and suddenly, there would be a huge demand for information. A brand new industry would develop to fulfill that demand.

Now, obviously, not each and every American wants to be put in that situation. Many people are incapable of or uninterested in understanding these choices. For those folks HMOs are a splendid alternative. One-stop shopping for health care. Walk through the door and the admissions coordinator tells you what room to go into. Perfect.

But not perfect for everyone. To the extent we can encourage a greater awareness and a higher level of intelligence of health care decisions, the health care system and the country will be better served.

Sincerely,

Greg Scandlen

Greg Scandlen
Executive Director

Julie –

THE WEXLER GROUP

1317 F Street, N.W.
Suite 600
Washington D.C. 20004
202-638-2121
202-638-7045 Telecopy

MEMORANDUM

Regretted for these times said to call again if Doris comes back 1/24/95

TO: Julie Demeo

FROM: Betsey Wright

RE: **Request for Meeting**

DATE: January 19, 1995

TRANSMITTED BY FACSIMILE

I am writing to request a meeting with Carol H. Rasco for the newly elected national leader of the American Dietetic Association, Doris Derelian. As ADA President, Ms. Derelian represents over 65,000 highly trained nutrition professionals who work in health care settings, school systems, and community based programs. The purpose of this meeting is to introduce ADA's new leadership and to discuss ADA's position on health care reform and other initiatives affecting nutrition.

Ms. Derelian will be Washington, DC the week of January 30th. She is available to meet Tuesday morning, Wednesday and Thursday afternoons, and all day Friday. I hope that you will be able to schedule a meeting of 30 minutes or less during one of these times.

Please call Sena Fitzmaurice at 202-662-3758 in my office to make meeting arrangements. If you have any questions, please feel free to call me at 202-662-3723.

Tell Ken I'm very sorry but due to my NGA participation, previous obligations on Wed/Thurs & travel on Fri. I can't do it this time. Hope to meet Doris another trip

December 8, 1994

Jennifer Klein
Senior Policy Analyst
Office of The First Lady
Second Floor, West Wing
The White House
Washington, DC 20500

American
Social
Health
Association

311 Massachusetts Avenue, NE
Washington, DC 20002
(202) 543-9129
Fax (202) 543-5327

Dear Ms. Klein:

I am writing on behalf of the Coalition to Fight Sexually Transmitted Disease (STD Coalition) in order to request a meeting with you. Members of the STD Coalition would like to express concerns about the underfunding of critical STD prevention, treatment, and research programs. The STD Coalition is composed of over 100 organizations with a common interest in preventing all STDs. We are troubled by the fact that public health prevention efforts have not been able to keep pace with the exploding STD epidemic that has taken a particular toll on women, adolescents, and minorities.

Every year, **12 million** new STD infections occur in the United States, producing severe medical conditions with lifelong consequences. It is a national disgrace that the United States has the highest incidence of STDs in the industrialized world. Women, minorities, and adolescents are the most at risk. We hope that this administration's interest in improving the health of women, adolescents and minorities will extend to addressing the public health emergency caused by STDs.

Preventing STDs has important consequences for:

- **Women's Health:**

  Most STDs are asymptomatic in women. A woman may be unaware that she has a reproductive tract infection until irreparable damage has occurred. **Untreated STDs can lead to life-threatening pelvic inflammatory disease (PID), ectopic pregnancy, infertility, infants mortality, a heightened risk of contracting HIV/AIDS and cervical cancer.**

  Cervical cancer accounts for nearly 5,000 deaths a year. Worldwide, cervical cancer is the second most common cause of cancer mortality among women. Sexual behavior is the most consistently identified risk factor for cervical cancer. The STD most strongly implicated is human papillomavirus (HPV). Studies have shown that as many as 46% of the women on college campuses are infected with HPV.

- **Adolescents:**

  Two-thirds of all STDs occur in people under the age of 25. The CDC has found that 20-30% of sexually active teenage women may have chlamydia. Gonorrhea rates are highest among women age 15-19. The risk of PID in sexually active 15-year-olds has been found to be approximately 10 times greater than in sexually active 25-year-olds. Unfortunately, teenagers are also the population least knowledgeable about the threat of STDs.

  Numerous studies have shown that the more a young person knows about sex and STDs, the longer that person will wait to initiate sexual activity. We must provide our young people with the information they need to protect themselves and the services needed to stop the spread of infection.

- **AIDS**

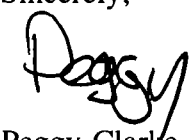
  Persons with an STD have a three-to-five-fold increased risk of HIV transmission. STDs are believed to facilitate the spread of HIV by causing damage to the reproductive tract, leaving it vulnerable to infection. **In the absence of an AIDS vaccine or cure, STD prevention is one of our best strategies for the control of AIDS.**

  STD prevention, and its effect on AIDS transmission, would especially benefit adolescents and minorities - populations that are disproportionatly affected by HIV/AIDS. In 1993, the rate of increase in reported AIDS cases was greatest for women, minorities, and adolescents.

Members of the STD Coalition would appreciate the opportunity to discuss these issues with you. Ms. Erin Bush of the Washington office of the American Social Health Association will contact your office to determine whether your schedule will allow for a brief meeting. Ms. Bush may be reached at 202/543-9129.

Thank you for your consideration.

Sincerely,

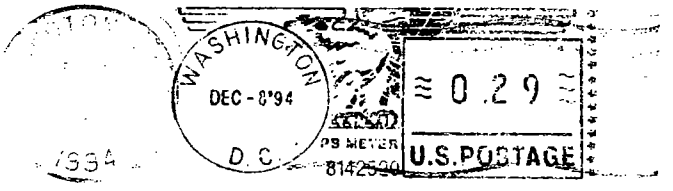


Peggy Clarke
President

asha

American
Social
Health
Association

311 Massachusetts Avenue, NE
Washington, DC 20002



Ms. Jennifer Klein
Senior Policy Analyst
Office of the First Lady
Second Floor, West Wing
The White House
Washington, DC 20500

January 9, 1995

MEMORANDUM TO CAROL RASCO

FROM: MARILYN YAGER

CC: JENNIFER KLEIN

MEETING: AMERICAN MEDICAL ASSOCIATION
Dr. Robert McAfee, President, AMA
Dr. Jim Todd, Executive Vice President, AMA
Rich Deem, Director, Federal Affairs, AMA

DATE/TIME: Tuesday, January 10, 1995
11:00 am - 12:00noon

LOCATION: Room 211, OEOB

AGENDA/TALKING POINTS:

- Open the meeting, thanking them for their flexibility on scheduling (this meeting was cancelled in December).
- Provide overview of the health care reform process, i.e., no decisions have been made, etc.
- Comment on our current focus on the Budget (they are likely to ask whether the President's "no new Medicare cuts" comment is reliable).
- When you open it up for discussion, you might want to remind them that this is a listening session for us.

BACKGROUND:

I know you don't need background information on the AMA, and I know you are aware that they opposed us more often than they supported us last year on various provisions of our health care reform efforts. They believe they are on very friendly ground with the new Congressional leadership, and as you know their Board recently decided to remove universal coverage from their legislative priorities.

Beyond these reminders let me review for you their priorities for the 104th Congress (listed in their order of priority):

THE WHITE HOUSE

WASHINGTON

- Advancing incremental health care reform that focuses on the AMA's Patient Protection Act (any willing provider), insurance and liability reform, medical savings accounts, and antitrust reform.

- Expanding patient choice of physician through the Patient Protection Act.

- Medical Savings Accounts.

- Professional liability reform that includes $250,000 cap on non-economic damages.

- No Medicare Part B (outpatient) cuts.

I have attached a more detailed summary of their position.

THE WHITE HOUSE

WASHINGTON

REPORT 36 OF THE BOARD OF TRUSTEES (I-94)
Health System Reform: Setting New Directions for 1995 and Beyond
(Reference Committee A)

EXECUTIVE SUMMARY

This report includes a summary of AMA health reform activities in 1994 and describes the policy and strategy modifications the Board believes are necessary to accomplish our objectives in 1995. The report recommends that the AMA pursue an incremental approach to health system reform focused on increasing patient protection and choice, maintaining diversity in medical care delivery, liability reform, insurance reform and an enhanced role for physicians individually and the profession as a whole in the rapidly changing market.

The November 8 election will have a profound effect in shaping the environment next year and beyond. There is deep sentiment against any comprehensive federal legislative action in the health system reform arena, with many preferring to wait and see what happens in the marketplace and at the state level. The Board's approach to advancing AMA's health system reform agenda is based on pursuing a more targeted strategy that takes into account the realities of the new political, legislative and marketplace environment. The AMA is committed to strengthening the U.S. health care system by advocating policies that put patients, and physician and patient responsibility, at the forefront. Because patients and physicians have a strong community of interest in assuring that cost and quality are balanced on the basis of the profession's standards, the AMA's focus in future health system reform advocacy will be on patient and physician empowerment.

A campaign built around patient power and choice, focusing on the AMA's *Patient Protection Act*, insurance and liability reform and Medical Savings Accounts will be the centerpiece of this effort. Antitrust reforms and physician network support are necessary to expand choice for patients. AMA will also promote the positive aspects of our system in general and of Medicare and medical research spending in particular, but AMA will support substantial Medicare reform and focused efforts to reduce care at the margins. The Board also recommends the reaffirmation of the profession's historic commitment to public health, public service and to providing care to those in need and suggests that AMA councils search for ways to expand access to care with an incremental reform approach.

Finally, the Board recommends that the AMA continue to fight for adequate funding for federal health care programs, in particular Medicare and Medicaid, for long term reform of those programs which insures their effectiveness and fiscal soundness, and against reimbursement reductions that promote cost shifting, diminish access and reduce the quality of care for beneficiaries.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 36 - I-94

Subject: *Health System Reform: Setting New Directions for 1995 and Beyond*

Presented by: P. John Seward, MD, Chair

Referred to: Reference Committee A
(Donavin A. Baumgartner, Jr., MD, Chair)

This report presents an update on the Association's (AMA) efforts to advance our health system reform policy and goals. It includes a summary of AMA health reform activities in 1994 and describes the policy and strategy modifications the Board believes are necessary to accomplish our objectives in 1995. The report recommends that the AMA pursue an incremental approach to health system reform focused on increasing patient protection and choice, maintaining diversity in medical care delivery, liability reform, insurance reform and an enhanced role for physicians individually and the profession as a whole in the rapidly changing marketplace.

I. THE AMA'S HEALTH SYSTEM REFORM LEGISLATIVE EFFORTS IN 1994

No health system reform passed in the 103rd Congress in large part because the public and most physicians came to fear that the kind of comprehensive reform advanced to support universal coverage would do more harm than good. Although the AMA opposed significant aspects of the President's plan -- most notably in a detailed analysis mailed to members of Congress and to each of the nation's 750,000 physicians -- AMA remained an advocate of reform throughout the legislative session.

In September the AMA publicly endorsed, and provided substantial grassroots support for, a specific reform bill -- the House Bipartisan Healthcare Reform Act of 1994 (the Rowland/Bipartisan bill). Although imperfect, the bill contained the best mix of the health system reform principles which formed the heart of Health Access America: physician voice, patient choice and improved coverage. The bill included insurance reforms guaranteeing portability and limiting pre-existing conditions, the Model Injury Compensation Reform Act (MICRA) reforms with a $250,000 cap on noneconomic damages; optional health medical savings accounts (MSAs); a required point-of-service or fee-for-service option in any health benefits package; some initial steps toward physician antitrust relief; and positive incentives for physicians to enter primary care training.

At the same time, the Rowland bill did not contain many of the unwise provisions included in other congressional bills, such as the creation of a large new federal program known as Medicare Part C, mandatory alliances, new government bureaucracies or price controls. By committing to a specific reform bill at a critical time, the AMA helped to insure that the fundamental strengths of America's healthcare system would not be damaged in the reform process.

Because of this action and a great variety of other activities throughout 1994, the medical profession played a widely acknowledged and essential role in shaping the reform debate. Fundamental principles which cut across specialty and geographic lines which the AMA led in championing – patient and physician protections in managed care, expanded choice of plan and physician, and liability reform – were contained in all of the competing Congressional bills at the time of adjournment. In addition, AMA made gains with both the Justice Department and Congress in anti-trust reform.

AMA's public advocacy efforts included the distribution of several million brochures to patients about reform, the campaign proposing "10 Questions Patients Should Ask About the Clinton Plan" featured in the Wall Street Journal, the national print advertising campaign "Would You Rather Trust Your Life to an MBA or an MD," the first AMA-paid television advertising – the "Dr. Bob" spots on CNN, profession-wide unity letters on reform principles involving virtually all of organized medicine, and the involvement of an unprecedented number of physicians and Alliance members in Congressional contacts. Over 58,000 contacts by members of AMA's P.O.W.E.R. Network (Physicians Organized to Work for Effective Reform), 40,000 personalized letters from physicians and spouses to Congress, and 880 presentations, speeches and appearances on health system reform were initiated by the AMA in 1994.[1]

II. UNRESOLVED PROBLEMS IN THE HEALTH CARE SYSTEM

The issues that brought health system reform to the forefront are still with us, however. For example:

- Large for-profit systems are growing at an accelerating pace. Physicians and patients are sometimes treated like commodities, to be acquired or jettisoned in the rush to build the toughest, most price-competitive system. The massive amounts of capital at these corporations' disposal can distort the marketplace and have a deleterious effect on quality and professionalism.

- Federal spending on health care continues to rise. Medicare cutbacks are likely in the next Congress, with pressure to push program "savings" toward deficit reduction rather than access expansion.

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[1] The AMA also placed over 40 advertisements in weekly magazines and newspapers, reaching approximately 84% of physicians an average of 12 times. According to a joint study by Times Mirror and the Kaiser Family Foundation, almost as many people recalled AMA advertising as advertising from the Health Insurance Association of America (HIAA) of "Harry and Louise" fame, with HIAA outspending the AMA tenfold. According to a report by the Annenberg Public Policy Center, AMA was more than four times likely to be mentioned than the AARP on television news broadcasts, and the AMA was by far the most dominant organization in print coverage, outdistancing business groups, AARP, NFIB or the Democratic or Republican parties. Several polls showed that the public continues to have more confidence in AMA reform ideas and proposals than virtually all other significant groups.

- Although private sector spending trends have moderated substantially (7.7% increase in 1993, down from 9.5% in 1990), spending continued to increase above the overall rate of inflation. Significantly, however, spending on physician services showed the smallest increase of any segment of health care spending.

- Patients are increasingly insulated from the economic consequences of their health care treatment decisions.

- Many people remain uninsured; portability and preexisting conditions remain significant problems.

Other factors that are also likely to cause increasing pressure on the system include:

- Unabated health conditions associated with increasing societal problems — violence, tobacco and substance abuse, teenage parents, HIV infections, tuberculosis and unsafe work conditions contributing further to rising health care spending;

- Growing payer demand for accountability without the tools or professional involvement to accurately measure quality;

- Advancing technology — that while promoting new and often lifesaving technologies — increasingly raises societal and payer concerns about the value of such care provided "at the margins;"

- Continued modest growth of the U.S. economy;

- Increasing size and aging of the population.

These facts present several overarching strategic challenges for the AMA next year:

- Strengthening of the traditional patient/physician relationship, professionalism, and more reliable standards for delivering good health care in an era when choice of physician and type of plan is increasingly controlled by employers and insurers, and health care delivery decisions are made from a corporate perspective.

- Pursuit of "incremental" changes of the current health care system that neither undermine system strengths nor create new problems.

- Medicare and Medicaid reform which does not involve depriving the poor and the elderly of needed care or physicians of adequate reimbursement.

- Representing all physicians at a time when divisiveness among specialties and modes of practice is increasing.

III. LEGISLATIVE ISSUES

The November 8 election will have a profound effect in shaping the environment next year and beyond. Congressional Republicans, having been in the minority for 40 years in the House and

eight in the Senate, can be expected to make significant adjustments in the way Congress addresses issues, as well as in committee structure, jurisdiction and staffing. Major changes will occur in the Congressional leadership as well. There is deep sentiment against any comprehensive federal legislative action in the health system reform arena, with many preferring to wait and see what happens in the marketplace and at the state level.

A. General Reform Theme

The Board's approach to advancing AMA's health system reform agenda is based on the realities of the new political, legislative and marketplace environment. Although AMA's basic reform goals, which are reflected in the Association's *Health Access America* policy base, remain the same, a more targeted approach is required today. The AMA is committed to strengthening the U.S. health care system by advocating policies that put patients, and physician and patient responsibility, at the forefront. Because patients and physicians have a strong community of interest in assuring that cost and quality are balanced on the basis of the profession's standards, the AMA's focus in future health system reform advocacy will be on patient and physician empowerment.

The nation needs to take stock of the health care delivery domination by large for-profit enterprises, employers and insurers. A campaign built around patient power and choice, focusing on the AMA's Patient Protection Act, insurance and liability reform, and Medical Savings Accounts, will be the centerpiece of this effort. Antitrust reforms and physician network support are necessary to expand choice for patients. AMA will also promote the positive aspects of our system in general and of Medicare and medical research spending in particular, but AMA will support substantial Medicare reform and focused efforts to reduce care at the margins. At the same time, the AMA will remain flexible enough in its approach to reform to ensure that future needs of patients and the profession can be effectively advocated. Set forth below is a more specific description of central aspects of our reform agenda:

B. Choice and the Patient Protection Act

The Patient Protection Act (PPA) focuses on six central needs of patients in the private sector:

- full disclosure of the plan's incentives and coverage;
- choice of physician and plans (HMO/PPO, traditional insurance, or benefit payment schedule);
- fairness in physician selection and deselection;
- protection of the patient physician relationship in general;
- standards for utilization review activities;
- a defined structure for advocacy and influence by physicians within plans

The Act will be made compatible with any kind or size of medical care delivery, from independent fee-for-service to large groups to HMOs. It cannot be viewed as an obstacle to a pluralistic health care system in which patients have a choice of any kind of delivery system. The Act provides the minimum standards of professionalism and fairness that the marketplace must observe in the delivery of medical care.

C. Medical Savings Accounts

As an additional option for patients, the Board believes that the Medical Savings Account (MSA) can significantly increase patients' freedom of choice, cost consciousness, and ultimately the number of people covered by health insurance. The MSA is a tax-deferred bank or savings account set up for individuals and families to pay for their health care expenses and medical insurance and to allow them to accumulate savings to pay for future medical expenses and for more general uses after retirement. Anyone should be able to choose an MSA as an alternative to current ways of funding medical care. For an employee choosing an MSA, the employer would purchase a high-deductible (catastrophic) insurance policy for the employee and deposit cash into an MSA each year in lieu of providing the employee low-deductible insurance or enrollment in an HMO. The price of the catastrophic policy plus the cash deposit must equal the cost of the alternative coverage. The employee then would use the cash in the MSA to pay for ordinary health expenses until the deductible of the catastrophic policy is met. Unspent balances accumulate at compound interest.

The Board supports MSAs as an additional option for individuals to fund healthcare for a number of reasons:

- The MSA is an important way to effectuate the concept of individually-owned insurance and achieve portability of insurance for employees who may switch employers.

- The AMA is opposed to regulatory cost containment through global budgets, price controls and arbitrary restrictions on technology. Rather, we believe it is better to let individuals, through their personal responsibility for choosing and purchasing care, make the choices of what health care should be produced and how much health care is worth.

- MSAs are the best approach to strengthening the market for medical care by giving patients the opportunity to be directly involved in their medical care choices and decisions. For those who choose MSAs for their medical coverage, price will become a more important consideration in their choices, a consideration that is lacking in the market at the present time.

- MSAs have the potential for substantially improving the physician-patient relationship, which has been significantly eroded by the increasing intrusion of third parties.

D. Professional Liability

In the new Congress there is genuine opportunity for professional liability reform. The AMA's liability reform agenda will continue to stress patient safety and cost containment. Patient safety will be promoted through private sector injury prevention initiatives and by increasing the resources of state licensing/disciplinary boards. California's 1975 Medical Injury Compensation Reform Act (MICRA) demonstrates that liability reform can be enacted that awards fair compensation to patients injured by medical malpractice and yet stabilizes costs. It continues to serve as the best model for baseline federal liability reform. AMA policy must also ensure that corporate policies which deny needed care are not rewarded through liability

reform, and we must search for additional ways to reduce the transaction costs of the liability system.

Working on its own and through coalitions such as the Health Care Liability Alliance (HCLA), the AMA/Specialty Society Medical Liability Project (AMA/SSMLP) and the American Tort Reform Association (ATRA), the AMA will pursue liability initiatives on three fronts: (1) the U.S. Congress; (2) State legislatures, and (3) the private managed care sector. At the federal level, the November 1994 elections are most encouraging to proponents of meaningful liability reform. Responding to a pre-election survey, at least 49 new members of Congress indicated strong support for California type reform provisions. The Republican party's *Contract with America* incorporates a limited product liability reform platform, and the Republican leadership has stated that liability reform should be a key component in health system reform.

E. Medicare

Entitlement reductions will be a major focus of the next Congressional budget cycle with Medicare providing a prominent target for budget savings. If Medicare cuts proposed in health system reform legislation introduced in the 103rd Congress are any indication, cuts considered by the 104th will far exceed the size of historical cuts. The Board believes, however, that further cuts in Part B physician payment cannot be justified:

- Part B payment updates have lagged far behind increases in the Medicare Economic Index, which was specifically designed to measure physicians' cost increases that should be compensated by Medicare.

- It has been clearly documented that Part B payment levels have fallen far below private sector payment levels.

- There is also evidence that Part B expenditure level cuts have been more than necessary to achieve budget targets because Congressional Budget Office (CBO) spending projections, which establish the projected baseline for such cuts, have been systematically higher than actual increases. In contrast, Part A (Hospital Insurance) baseline projections have been systematically lower than actual increases.

Continued Congressional cutting of physician payment – without regard for the cost of providing services, for the disadvantages that underpayment places on beneficiaries seeking physician services, and for the accuracy of forecasts used to calculate cuts – will be fought.

At the same time, it is widely recognized that much of the underlying growth in Part B expenditures is due to unconstrained beneficiary demand. The high prevalence of supplementary (e.g., "medigap") insurance defeats the intended cost-sharing requirements of Part B and imposes a substantial financial burden on the Medicare program which is not offset by additional revenue. Consequently, the Board believes that measures should be taken to strengthen Medicare Part B cost sharing on beneficiaries to restore appropriate levels of restraint on their demand for services. A number of approaches will be proposed, such as restructuring Part B to include the premium in the deductible, increasing the deductible, taxing supplementary plans, and income-testing Part B premiums.

F. Compassion, public service and expanded coverage

The increased emphasis on individual responsibility in AMA's health reform advocacy is sound economic and social policy. It is also consistent with the mood of the country, as reflected in attitudes toward welfare and other poorly designed government programs (at least those of which the majority is not a direct beneficiary). Historically, the United States has been unique in its reliance on individual freedom, incentives and responsibility as a public policy foundation, and that reliance has on balance been a great strength.

Americans and American physicians in particular have also been a people of compassion

> "It often happens among the most civilized nations of the globe, that a poor soul is as friendless in the midst of a crowd as the savage in his wilds: this is hardly ever the case in the United States. The Americans . . . seldom show insensibility; and if they do not proffer services eagerly, yet they do not refuse to render them."

If, as seems likely, the public and our government are not going to undertake or mandate expanded entitlement programs in healthcare or other areas, the profession must vigorously reaffirm its compassion for the needy and its commitment to public service. And we must do this without regard to the citizenship, race or the physical condition of those in need. As the Council on Ethical and Judicial Affairs (CEJA) states: "Each physician has an obligation to share in providing care to the indigent."

At the same time, AMA will press the government -- both federal and state -- not to abandon the responsibilities it has undertaken or to arbitrarily restrict the safety net for those who cannot accept responsibility for whatever reason. And AMA will continue to fight in Congress for the insurance reforms which guarantee portability and protection against limitations on pre-existing conditions.

Finally, the Board will ask the Councils on Legislation and Medical Service to immediately explore avenues within and beyond AMA's existing policy base to expand access and coverage for the uninsured in ways consistent with AMA's overall incremental approach to reform. As the CEJA opinion further states: "In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor."

G. Other significant AMA reform issues for 1995

- The expansion of voluntary purchasing groups can improve the choices available to employers and employees. Employers and voluntary health purchasing groups will be asked to offer a variety of plans, including a benefit payment schedule, prepayment arrangements, Medical Savings Accounts, and a point-of-service option. As another incentive for enhancing market forces, an employer who chooses to contribute to the cost of its employees' health insurance, should make a standard dollar contribution for all eligible employees.

- Physician-directed and medical society sponsored network plans should be allowed and encouraged to present competing products to employers and voluntary purchasing groups.

- Adequate public spending on medical research and education is essential to maintain the overall superiority of the American healthcare system. It is also cost/beneficial at a time when the nation is on the verge of so many scientific breakthroughs that could affect the health of millions of Americans. AMA will be the leading advocate for support of biomedical research.

- Deregulation of the government healthcare bureaucracy and delegation to the private sector of expanded standard setting roles and responsibilities -- in particular by the professional associations and the accreditation bodies they have created. AMA will ask for a partnership with the government on necessary standard setting activities and open up the profession's self regulatory efforts to enhanced public participation and accountability.

- A focused public health legislation agenda designed to bring the best science to bear on the problems of violence, AIDS, adolescent neglect, care for the elderly and substance abuse, including tobacco use.

- Recognition of the need for more effective and better supported continuing medical education -- through computer based interactive and distance learning technologies directed in partnership with the profession -- as a means by which the profession improves the quality of care and maintains professional standards of care in the face of competing commercially developed standards which may be focused primarily on cost or profit.

H. State Outlook and Strategy

It is likely that states will continue to vary in their approach to reform. Some states will continue comprehensive reform plans as funds can be found; others encourage the formation of voluntary alliances to offer improved choice and access to affordable insurance; many others will request Medicaid waivers to address specific population needs; and others will pursue legislation to address some of the problems identified by the AMA with managed care. Like the U.S. Congress, many state legislatures are now controlled by Republicans and there are now more Republican governors (31). A major battle may be fought in Congress between the states and the large employers over ERISA reform. The Republican governors at their recent meeting also took a strong position against Congressional imposed unfunded mandates on the states.

The AMA, through the SHRAG and other means, has worked in more than 40 states on system reform issues and will continue to work even more closely with the Federation on issues such as Medicaid waivers, patient protection legislation, antitrust issues, and liability reform. In addition, the AMA will continue to join with states in identifying areas for possible litigation, managed care strategy and product development, and in identifying managed care abuses. Through our private sector/managed care initiatives we will attempt to form a true partnership with the states in aiding the physicians in their states. The AMA will also continue its

alliance/outreach with the National Governors Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners in their development of the "Uniform Health Plan Licensing Act."

IV. ADVOCACY PROCESS AND STYLE

The AMA is undertaking some basic changes in the operations of the association which should significantly improve our ability to advocate on behalf of the profession in 1995 and beyond. These changes are designed to increase both the intensity and base of physician support for AMA's efforts:

- All of the units of advocacy - policy, Washington office, legislation, Office of the General Counsel and Communications have been consolidated into one team, and the legislative staff (as well as the Council on Legislation) has been moved to Washington where legislation is made. The consolidation has also provided substantial savings and a streamlining from the elimination of some 35 positions.

- All of AMA communications to physicians will be inventoried to assess their effectiveness in total. The goal will be to decrease the amount while improving the impact. Additional communications techniques - from television advertising to interactive computer systems - will be employed.

- A massive outreach effort will soon begin aimed at bringing AMA leadership, including the House of Delegates, face to face with the thousands of physicians who have never been personally or directly contacted by an AMA representative. Staff will become fanatic in insuring responsiveness and personal contact with members.

- While maintaining a strong emotional and policy connection with those physicians in traditional practices, the AMA will eradicate any perceived barriers with ethical physicians in any setting. Research shows that at least 80% of all physicians would like the AMA to be their common voice in defining good health care, and that, indeed, is AMA's mission. Special efforts will be made to insure AMA is seen as representing all physicians, including physicians in HMOs, academic settings and large group practices where AMA membership, though significant, should be much higher. AMA has long carried the profession's banner in accreditation, ethics, public policy and other fundamental issues of common bond with all physicians. As the health system reform agenda narrows and private sector concerns with commercial enterprises increase, true unity can, and needs to be, achieved.

- The Board will ask the House of Delegates to look carefully at its own representative nature and to adopt voluntary guidelines aimed at making the House of Delegates unequivocally the House of Medicine. The House can more closely reflect the characteristics of the entire physician community in age, gender, and mode of practice.

V. RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and that the remainder of this report be filed.

1. That the AMA continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationship, at the forefront.

2. → NEW #2: See page titled "Repot of REFERENCE COMMITTEE A"

3. That the central focus of AMA's reform campaigns in 1995 be the Patient Protection Act, professional liability reform, insurance reform, Medical Savings Accounts, regulatory reform, and physician network/anti-trust relief as the most immediate ways to expand patient choice, improve quality and enhance professionalism.

4. That the AMA further increase choice and cost consciousness by advocating the development of voluntary purchasing groups, a wide variety of choice of plans and, where an employer contributes to health plan costs, a standard dollar contribution toward an employee's insurance irrespective of the plan chosen.

5. That the AMA reaffirm the profession's historic commitment to public health, public service and to providing care to those in need, and that AMA Councils search for ways to expand access to care consistent with an incremental reform approach.

6. That the AMA fight for adequate funding for federal health care programs, in particular, Medicare and Medicaid; that AMA further advocate for long term reform of those programs which insures their effectiveness and fiscal soundness and against reimbursement reductions which promote cost shifting, diminish access and reduce the quality of care for beneficiaries.

7. See additions on sheet labeled "Report of Reference Committee A"

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-94)

Report of REFERENCE COMMITTEE A

Presented by: Donavin A. Baumgartner, Jr., MD, Chair

Mr. Speaker and Members of the House of Delegates:

Reference Committee A gave careful consideration to the several items referred to it and submits the following report:

(1) BOARD OF TRUSTEES REPORT 36 - HEALTH SYSTEM REFORM: SETTING NEW DIRECTIONS FOR 1995 AND BEYOND
RESOLUTION 117 - INCREMENTAL HEALTH CARE SYSTEM REFORM
RESOLUTION 120 - POLICY ON HEALTH SYSTEM REFORM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Report 36 of the Board of Trustees be amended by addition of a new Recommendation 2 (with other recommendations renumbered) as follows:

2. That the AMA seek an incremental approach to health system reform, targeted by patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patent Protection Act.

New #2

medical savings accounts,

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Report 36 of the Board of Trustees be amended by addition of a new Recommendation 7 as follows:

7. That the AMA reaffirm Policy 165.941 (1), which calls on the AMA to continue to develop and implement the [State] [Health] System Reform Action Group (SHRAG) initiative to provide meaningful assistance on [state] [health] system reform matters upon their request to [state] medical societies.

New #7

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations contained in Report 36 of the Board of Trustees be adopted as amended in lieu of Resolutions 117 and 120, and the remainder of the report be filed.

Board of Trustees Report 36 presents an update on AMA efforts to advance our health system reform policy and goals. It includes a summary of AMA health reform activities in 1994 and describes the policy and strategy modifications the Board believes are necessary to accomplish our objectives in 1995. The report recommends that the AMA pursue an incremental and more targeted approach to health system reform focused on increasing patient empowerment, protection, and choice, maintaining diversity in medical care delivery, liability reform, insurance reform, and an enhanced role for physicians individually and the profession as a whole in the rapidly changing marketplace. The AMA is committed to strengthening the U.S. health care system by advocating policies that put patients, and physician and patient responsibility, at the forefront.

A campaign focusing on the AMA's *Patient Protection Act*, insurance and liability reform, and Medical Savings Accounts will be the centerpiece of this effort. Antitrust reforms and physician network support are necessary to expand choice for patients. The Board also recommends the reaffirmation of the profession's historic commitment to public health, public service, and to providing care to those in need and suggests that AMA councils search for ways to expand access to care with an incremental reform approach. Finally, the Board recommends that the AMA continue to fight for adequate funding for federal health care programs, in particular Medicare and Medicaid, for long term reform of those programs which insures their effectiveness and fiscal soundness, and against reimbursement reductions which promote cost shifting, diminish access and reduce the quality of care for beneficiaries.

Resolution 117 calls on the AMA to recognize the need for incremental improvements in the American health system and to refocus toward achieving attainable improvements that increase choice and fairness for patients and physicians and a stable legislative and regulatory environment for patients, the business community, and physicians. Resolution 120 calls on the AMA to refocus Health Access America from a comprehensive approach to an incremental approach to health system reform based on a defined set of AMA priorities and to advocate that any proposals for health system reform must address economic, demographic, and regional differences in the health care needs of the states. This resolution also calls on the AMA to seek an incremental approach to health system reform, divided by patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patient Protection Act.

Your Reference Committee heard extremely positive testimony on this excellent and visionary report of the Board of Trustees. Based on testimony received on the need to emphasize the incremental nature of future AMA advocacy efforts, as well as on the need for continued AMA support of state medical associations as they grapple with state reform efforts, your committee recommends adoption with the additional two recommendations.