

Kim - Here's
the summarized
| antitrust paper |
FYI - Bob Berenson
is a practicing MD
+ ~~director~~ medical
director of a PPO

If you have ?s,
Jm @ X2315.

| Lynn
Margheris |

Recovery week 1794

**MEETING WITH HILLARY RODHAM CLINTON ON
NATIVE AMERICAN HEALTH CARE ISSUES**

United States Senate
485 Russell Senate Office Building
March 17, 1993

AGENDA

3:30 p.m. **WELCOMING REMARKS, INTRODUCTIONS, & MEETING
OVERVIEW**

Richard Trudell, *Executive Director*, American Indian Resources
Institute

Honorable Daniel K. Inouye, *Chairman*, Committee on Indian Affairs,
United States Senate

3:40 p.m. **PERSPECTIVES ON HEALTH CARE REFORM**

Hillary Rodham Clinton

3:45 p.m. **NATIVE AMERICAN HEALTH CARE PERSPECTIVES**

Eddie Tullis, *Chairman*, Poarch Creek Band, "The Law and Policy
Foundation for the Delivery of Indian Health Care"

Gerald L. Hill, *M.D., President-Elect*, Association of American Indian
Physicians, "Health Care Delivery Systems"

James R. Floyd, *Director*, Portland Area Office, Indian Health Service,
"Financing Mechanisms, Cost Containment, and Health Data Systems"

James Crouch, *M.P.H., Executive Director*, CA Rural Indian Health
Board, "Coverage, Eligibility, and Access to Quality Care"

David Baldrige, *Executive Director*, National Indian Council on Aging,
"Special Indian Health Care Needs and Issues"

4:05 p.m. **OPEN DIALOGUE**

4:30 p.m. **CONCLUDING REMARKS**

INDIAN HEALTH SERVICE

The Indian Health Service (IHS), an agency of the Public Health Service within the Department of Health and Human Services, provides a comprehensive health services delivery system for American Indians and Alaska Natives (AI/AN) with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs. The goal of IHS is to raise the health status of the AI/AN people to the highest level possible.

The IHS, tribal governments, and urban Indian organizations, within the limits of annual appropriations, provide an unprecedented, comprehensive scope of preventive, clinical, and environmental health services, augmented by community and human resources development programs.

ISSUES

o Federal Responsibility for Providing Health Services to Members of Sovereign Tribal Governments

The Federal responsibility has its bases in transfer of vast expanses of land, repeatedly affirmed through treaties, legislation, and court decisions. Tribal governments expect this responsibility to be met through a special government to government relationship.

o Self-Determination and Self-Governance in Indian Health Programs

The Indian Self-Determination and Education Assistance Act gave tribal organizations the authority to contract with the Federal government to operate programs serving their members. Amendments were made to simplify the self-determination contracting process. The Departments of Health and Human Services (HHS) and the Interior (DOI) consulted extensively with Indian tribes to develop joint regulations to implement the amendments. A Notice of Proposed Rule Making is awaiting clearance by the new Administration. In 1992, legislation provided authority for demonstration grants for more extensive tribal self-governance of health programs.

o Alcoholism Prevention and Treatment Strategy

Alcoholism is the number one health and social problem for AI/AN people. The IHS is developing a national plan to identify state-of-the-art services, to pilot new approaches to prevention and care specific to AI/AN, and to highlight efforts to evaluate effectiveness of services. Essential to the success of the plan is coordination of services with the DOI and Indian communities.

o **Health Professions Recruitment and Retention**

Recruitment and retention of primary care health professionals is a major concern. For 15 health professions, the composite vacancy rate over the past five years is over 15 percent. The IHS attempts to be competitive with the private sector through a complicated system of special pay, bonuses, allowances, and loan repayment.

o **Coordinating Federal Health Care**

The IHS, Department of Defense, Department of Veterans Affairs operate direct health care delivery programs serving more than 36 million people. Since the late 1970s, these programs have improved access, quality, and cost effectiveness by sharing technology, facilities, and services. This is politically sensitive; each constituency seeks assurance that its primary goal of access to quality care will not be jeopardized by coordination. A conference, "Coordinating Federal Health Care", is scheduled May 19-21 at the Uniformed Services University of the Health Sciences.

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AMERICAN INDIAN RESOURCES INSTITUTE

A PROJECT OF THE AMERICAN INDIAN LAWYER TRAINING PROGRAM, INC. (AILTP)
A NON-PROFIT CORPORATION

Richard Trudell
Executive Director

March 4, 1993

See for 3pm
17m
will call

Need
work

Mrs. Hillary Rodham Clinton
Office of the First Lady
Old Executive Office Building
Room 100
Washington, DC 20500

Dear Hillary:

As you requested, enclosed are brief bio sketches and resumes of American Indians and others who should be considered for appointments to first or second tier positions in the Clinton/Gore Administration. I hope the information is helpful and I apologize for not getting it to you faster. Please don't hesitate to call on me if I can do additional spade work regarding appointments.

I also want to take this opportunity to discuss two other items — the Indian Health Summit and the need for a meeting between President Clinton and Indian leaders.

With regard to the Indian Health Summit, in my letter to you of February 12, 1993, I described the Summit and indicated that it would be held March 16-17, 1993. Due to meeting space considerations in the U.S. Senate, the Summit dates have been changed to March 15-16, 1993. For your information, I have enclosed a copy of the Summit announcement. It would be extremely helpful to our efforts in the Indian health area if you would address the Summit. If your participation is possible, we will modify the Summit schedule to fit your scheduling requirements. In the alternative, a meeting at the White House between you and a small delegation of Indian people active in the health area might provide the ideal opportunity to discuss the health needs and concerns of Indian Country.

Moving on to the next item, as you know, every President since Richard Nixon has issued a formal statement recognizing the government-to-government relationship between American Indian tribes and the United States. However, despite such formal recognition, not every President has opened the doors of the White House to tribal government leaders in the same fashion as they have to foreign leaders or to state, or even municipal, leaders. Yet, within Indian Country, tribal governments are responsible for providing the full panoply of government services to Indian communities, safeguarding reservation resources, building and promoting reservation economies, and generally performing all other governmental functions.

If the government-to-government relationship is to be meaningful and productive, I think it is critical that President Clinton meet with tribal leaders at his earliest convenience and I am requesting that you encourage him to do so. Such a meeting would

Mrs. Hillary Rodham Clinton
March 4, 1993
Page 2 of 2

provide Indian leaders with the opportunity to brief the President on the importance of the government-to-government relationship, to discuss the economic concerns of Indian Country, and to share other governmental concerns. Since many tribal leaders will be in Washington, D.C. the week of March 15, 1993, it would be particularly timely if a meeting could occur during that period. I would be more than happy to help plan and develop the meeting.

I realize I have asked much of you in this letter and I certainly don't want to wear out my welcome. However, as you know, I have devoted my life to advocating on behalf of American Indian tribes and people and I'm committed to continuing my efforts. I want to thank you for your consideration of my requests and I look forward to your reply.

With best personal regards.

Sincerely,

A handwritten signature in dark ink, appearing to read "Rich", written in a cursive style.

Richard Trudell

RT:DM
Enclosures

*Announcing
A National Summit On*

INDIAN HEALTH CARE REFORM

Dates:

March 15-16, 1993

Location:

Hart Senate Office Building — Room 216
United States Senate
Washington, DC

Convened By:

SENATE COMMITTEE ON INDIAN AFFAIRS
HOUSE SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS

In Cooperation With

AMERICAN INDIAN RESOURCES INSTITUTE
NATIONAL INDIAN HEALTH BOARD
AMERICAN INDIAN HEALTH CARE ASSOCIATION
ASSOCIATION OF AMERICAN INDIAN PHYSICIANS
NATIONAL CONGRESS OF AMERICAN INDIANS
NATIONAL INDIAN POLICY CENTER
ALASKA FEDERATION OF NATIVES
NATIVE AMERICAN RIGHTS FUND

HHealth care reform has been identified by President Clinton as the highest priority in reducing the nation's deficit. The work of the President's Task Force on Health Care Reform is under way and final recommendations are to be submitted to President Clinton in May 1993. Many of the reform proposals currently being discussed hold the potential to have significant impact on the Indian health care system that is administered by tribes, urban Indian health care programs, and the Indian Health Service.

To insure that the concerns of Indian Country are addressed adequately in the President's health care reform package, tribal leaders, along with Indian health care professionals and providers, must formulate recommendations which should be submitted to the President's Task Force on Health Care Reform. To facilitate this effort, the National Summit on Indian Health Care Reform is being convened in Washington, DC to provide the opportunity for Indian Country to reach consensus and determine how key Indian health issues should be addressed by the Clinton Administration. During the two-day summit, participants will meet in plenary and concurrent work group sessions to develop specific Indian health care reform recommendations which will be set forth in a report to be submitted to the Administration and Congress, as well as distributed throughout Indian Country.

SCHEDULE

MONDAY, March 15, 1993

- 8:00 a.m. **REGISTRATION** (*Hart Senate Office Building — Room 216*)
- 9:00 a.m. **INVOCATION**
WELCOMING REMARKS AND SUMMIT OVERVIEW
- 9:30 a.m. **OPENING ADDRESSES** (*Speakers from the Administration and the Congress have been invited to address the Summit.*)
- 10:30 a.m. **INDIAN PERSPECTIVES ON HEALTH CARE REFORM**
- 11:45 a.m. **LOGISTICAL INFORMATION ON CONCURRENT WORK GROUPS**
- 12:00 noon **LUNCH BREAK**
- 1:30 to
5:00 p.m. **CONCURRENT WORK GROUP SESSIONS**

Work group topics will include: treaty-derived moral and legal obligations to provide health care; financing mechanisms; structural concerns regarding health care delivery; access to quality health care; cultural appropriateness of services; community health care models; cost containment; use and development of uniform health data; innovation in health care delivery; self-governance and 638 responsibilities; and adequacy of coverage and eligibility.
- 6:00 to
8:30 p.m. **RECEPTION**

Location:

Washington Vista Hotel
1400 M Street, NW — *Vista Ballroom*
Washington, DC

TUESDAY, March 16, 1993

- 9:00 a.m. **CONCURRENT WORK GROUP SESSIONS** (*continued*)
- 12:00 noon **LUNCH BREAK**
- 1:30 p.m. **OPENING REMARKS**
- 2:00 p.m. **REPORTS FROM CONCURRENT WORK GROUPS**
- 3:00 p.m. **DISCUSSION OF WORK GROUP REPORTS AND NEXT STEPS**
- 4:30 p.m. **CONCLUDING REMARKS**

END OF SUMMIT

GENERAL INFORMATION

REGISTRATION FEE: Registration is limited. The registration fee, which includes Summit materials and a reception, is \$50 per participant. Registration may be phoned in, FAXed, or mailed in advance. To facilitate planning for the Summit, please register as soon as possible.

LOCATION & LODGING ACCOMMODATIONS: The Summit will be held in the Hart Senate Office Building (HSOB), Room 216, U.S. Senate. Participants are responsible for making arrangements for their lodging accommodations; however, the American Indian Resources Institute will provide, upon request, a list of hotels in the Washington, DC area. Participants are encouraged to make their hotel reservations as soon as possible.

FURTHER INFORMATION: For further information, please contact the American Indian Resources Institute by phone, at (510) 834-9333, or by FAX, at (510) 834-3836.

REGISTRATION FORM — HEALTH SUMMIT

Name(s) _____ Position _____

Tribe/Organization _____

Address _____

City _____ State _____ Zip _____

Telephone _____ FAX _____

REGISTRATION FEE: \$50/person Number of Persons _____

Payment Enclosed \$ _____

(Make check payable to: AILTP—Health Summit.)

Mail To: AILTP/American Indian Resources Institute, 319 MacArthur Blvd., Oakland, CA 94610.

3/16

Chris
WQM

Jamie May

STAFF/JP

225-~~9710~~

from Eugene
Chris

3625

want to

as enlvs contentious they be
consulted

Boaty has repeatedly stated his inclination to
supp. Rep's proposal & to date has
not pushed

As you know &
aware,

Health Subc Chair

in contrast Rep. Stark is much wants to
be at the table & does feel shut out of the
process. Despite your visit, we have chosen
to stay out of the contrasting approach.
we're going w/ Boaty.

you and and

Int aft Chairman fo that ten memb were
being based ^{by Ina} on substa

Fitzell - Dem members - ARC

they indicates they want this mtg - Significant
bec it may be losing in getting members
more involved.

Deborah Collins / Janice Mays

1. recs whether HRC shld recog Start, etc,
for particular H.C. involvement

2. Particular issues / Hot spots

10:15
spoke w/
Janet

3. Seq

Janice spoke w/ Tina this a.m.

Concerned - Start + Mc Dermott met w/ HRC
said she never asked them her opinion.
Never solicited their opinion.

Encourage to ^{as she can be}

- substantive;
- ask their advice;

made my question
w/ themselves &
others

Those not on subc, more docile - it
as invested

because sense is he
wants to be on the
team, my in-
coming consideration
in Board

Rusty view: ^R Short intro

rdg came up from HHS → Pam

HRC offering & they accepted

subs → talk policy w/ them; any recs to Pres;

T. Papers all believe everyone knows
more than they know; feel nt being
consulted

Replace Jenkins

UC: Full Rector
to see interaction

2

anything taken off the table

Pete +
McDermott

Then solicit their thoughts

Stark needs more striking. HCL + Cha
too afraid - not as fast as he appears;
puts together pkgs that work

He's worried about \$50b Medicare cuts in
Reconciliation - have to go after providers;
taking them on in Rec'n & then
again in HC Reform. Ruler straight
across the board

Kelly
Advance

Hearing beginning at 10:00. She can
arrange it any time - tell chairman

(Library (Hearing - Budget Proposals)

Hearing

HVEMO

will
Chairman Moderator

David Abernathy, Staff Dir. Health
in w/

Chuck Brain, Asst Staff Dir -

Deborah Colton, Sp Asst Chairman

Jane Fitzgerald, Tax Staff - co-ord Rev aspects

This is what you've heard

~~Solicit~~ hope you won't hesitate to be
frank w/me now

TAKE ^{one} it step **beyond**

**Toll Gate 2:
Benefit and Structural Options**

**Cluster Group IV:
Integrating Government Programs**



**Task Group 16A:
Other Government Programs
(Indian Health)**

March 7, 1993

OFFICIAL INTERNAL USE ONLY

BACKGROUND

The Indian Health Service (IHS), an agency of the U.S. Public Health Service (PHS) in the Department of Health and Human Services (DHHS), is responsible for providing Federal health services to American Indians and Alaska Natives. The IHS provides comprehensive preventive, curative, rehabilitative, and environmental health services for approximately 1.3 million eligible beneficiaries. It does this while maintaining a government to government relationship with approximately 500 sovereign tribal governments to which these beneficiaries belong. This responsibility is carried out in the most remote and harsh environment existing in the United States as well as in modern metropolitan locations.

The provision of Federal health services to Indians is based on a special relationship between Indian tribes and the U.S. Government that has its bases in the transfer of vast expanses of land, repeatedly affirmed through treaties, legislation, and court decisions. First set forth in the 1830's by the U.S. Supreme Court, this unique relationship has been reconfirmed by numerous treaties, statutes, constitutional provisions, and international law and theory. Principle among these is the Snyder Act (25 U.S.C.) of 1921 which provided basic authority for federal health services to American Indians and Alaska Natives.

MISSION

The IHS provides a comprehensive health services delivery system for American Indians and Alaska Natives (AI/ANs) with the opportunity for maximum tribal involvement in developing and managing programs to meet their health needs.

GOAL

The goal of IHS is to raise the health status of the AI/AN people to the highest level possible.

SERVICE POPULATION

The IHS is responsible for providing Federal health services to 1.3 million AI/AN members of approximately 500 sovereign tribal governments residing in 33 "reservation" States. In addition, approximately 700,000 AI/ANs are not served by IHS/Tribal/Urban programs. The median age of the IHS population is 22.6 years as compared to 30 years for the general U.S. population. AI/ANs are diverse in their characteristics and health needs but generally lag behind the U.S. general population in income, health, and other socio-economic indicators.

SCOPE OF SERVICES

The IHS, tribal governments, and urban Indian organizations, within limits of annual appropriations, provide a comprehensive scope of preventive, clinical, rehabilitative, and environmental health services, augmented by community and human resources development programs. IHS is not an entitlement program and does not offer guaranteed and uniform benefits.

OPERATIONS

Services are provided directly at IHS and tribal hospitals and clinics and urban clinics; and are purchased from other public and private providers, including sharing agreements with DOD and VA.

More than 500 health facilities are operated in the remotest and harshest environments in the U.S., on isolated Indian reservations, in Alaska villages, in other rural areas, and in cities.

The IHS appropriations were \$621 million in 1980, \$1.58 billion in 1991, and \$1.86 billion in 1993.

PREVENTIVE HEALTH SERVICES

Promotion of wellness and prevention of disease are achieved in Indian communities by surveillance, early screening and detection, education, and active intervention before onset of serious illness and dysfunction. Services include public health nursing, outreach, education, nutrition, and immunizations. These are integrated with clinical services, environmental health and safety monitoring, community based injury prevention, and construction of safe water supply and sanitation facilities.

CLINICAL SERVICES

Clinical services integrate health promotion, disease prevention, diagnostic, therapeutic, and rehabilitative activities in accredited hospitals and ambulatory facilities. Direct services emphasize community oriented primary care, blending traditional AI/AN approaches to wellness and healing with western medical science. In 1991, over 441,000 inpatient days, over 5 million outpatient visits and 2.3 million dental services were provided.

Cross cutting programs focus on high priority problems in maternal and child health, alcohol and substance abuse, communicable disease control, and family violence, among others.

COMMUNITY BASED PROGRAMS

In addition to IHS/Tribal programs, a number of AI/AN communities have developed 501c3 clinics with community boards of directors. Some of these

clinics are federally-funded Community Health Centers (section 330, PHS Act) and others are funded by private funding sources.

PURCHASED SERVICES

In locations where IHS facilities or services are unavailable, eligible AI/ANs are referred to other public and private facilities and providers. Payment depends upon prior authorization, consideration of medical priorities, availability of funds, and availability of alternate payment sources.

URBAN HEALTH

IHS funds 34 Indian urban health organizations which operate 41 clinics in cities throughout the U.S.

SELF-DETERMINATION AND SELF GOVERNANCE

Tribal governments express self-determination by contracting to assume management of IHS programs or by having the IHS operate the programs. Self-determination contracts are negotiated non-competitively at tribal government initiative. When fully implemented, self-governance legislation will allow tribes discretion to redirect Federal health funds to local health priorities.

TRIBAL MANAGMENT

IHS maintains a self-determination assistance program for capacity building for tribal governments who wish to manage their own programs.

INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

The scholarships program augments health professional staffing recruitment especially to address chronic shortages of physicians, nurses and other professions in remote facilities, and removes barriers to AI/ANs entrance into the health professions.

INDIAN HEALTH FACILITIES

The IHS funds construction and maintenance of health facilities and staff quarters, and construction of safe water supply, sewage disposal, and solid waste facilities for AI/AN communities and homes. From 1980 to FY 1992, IHS constructed 11 hospitals, 11 ambulatory health centers, 315 staff quarters. First time water and sewer connections were provided to 73,500 Indian homes. IHS owns and operates nearly 2,600 buildings and structures for the benefit of AI/ANs.

ACCREDITATION STATUS

In 1992, 100 percent of IHS and tribal hospitals were accredited by JCAHO. The most recent numerical "grid" scores, which reflect relative degrees of

achievement considering the hundreds of factors examined in JCAHO surveys, was 79.6, which is not statistically different from the U.S. average of 80. Ninety-five percent of health centers are accredited. Overall proficiency rating for IHS laboratories was 97 percent which exceeds the 80 percent requirements of the Clinical Laboratory Improvement Amendments of 1988.

ACCOMPLISHMENTS

Indian health has improved significantly since the establishment of the IHS. For example, the maternal mortality rate for AI/ANs residing in reservation states dropped from 82.6 (rate per 100,000 live births) in 1958 to 7.1 in 1987, a decrease of 91 percent. The infant mortality rate for AI/ANs residing in reservation states dropped from 62.7 per 1,000 live births in 1955 to 9.7 in 1987, a decrease of 85 percent. By comparison, the U.S. infant mortality rate for all races for 1987 was 10.1. The birth rate for AI/ANs residing in reservations states was 28.0 per 1,000 population in 1987, 78 percent greater than the U.S. birth rate for all races.

NEW CHALLENGES

While IHS health care services have made noteworthy strides in improving the health of AI/ANs, much work remains to be done. For example, in 1988, the Indian age-adjusted mortality rates for the following causes were considerably higher than those for the general U.S. population.

1.	Tuberculosis -	480 percent greater
2.	Alcoholism -	388 percent greater
3.	Accidents -	185 percent greater
4.	Diabetes mellitus -	169 percent greater
5.	Homicide -	91 percent greater
6.	Suicide -	52 percent greater
7.	Pneumonia and Influenza-	42 percent greater

STRUCTURAL OPTIONS

I. MAINTAIN SEPARATE PROGRAM - No integration with HIPC

Under this option, the IHS/Tribal program would continue to operate outside of the HIPC framework. The IHS appropriation would continue to flow through the program to the Indian population. IHS funds would not be available to help subsidize coverage obtained through the HIPC.

AI/AN could either be exempted from the general system and rely solely on IHS coverage, or AI/AN could be included in the general population coverage and with dual eligibility, choose whether to receive services from the IHS/Tribal program or another provider.

A. Maintain separate program without adding a managed care option or adopting managed care features.

Interface with the new system would need to be established. As currently exists, services not available through the IHS/Tribal program would need to be coordinated with outside health plans. A combination of direct Federal provision of care, self-determination contracts with tribes and tribal organizations for service delivery, and contracts with private entities would continue to be the mode of service delivery. In addition, an AI/AN could continue to choose another health plan and not utilize IHS/Tribal services, since their dual eligibility would continue to exist. There would be no guarantee of the benchmark plan through IHS.

A variation of this would be to fund the IHS/Tribal programs at a level that would guarantee, at a minimum, the benchmark benefits that are available to the general population through the IHS/Tribal program.

IHS/Tribal program would continue to bill third party insurers for services provided where beneficiary has non-IHS coverage.

B. Provide managed care option within program.

IHS/Tribal program would provide a managed care option for its target population. This managed care option would be a comprehensive health plan operated by a private entity. Individual AI/AN would choose to be served by the plan, or receive services directly from IHS/Tribal programs. IHS/Tribal program would either pay the plan or retain the funds depending on the AI/AN choice. In rural and isolated areas, IHS may be the only provider.

Other services such as public health nursing, environmental services and community outreach, and other services currently authorized to be provided to AI/AN would continue to be provided directly by IHS.

C. Strengthen managed care features in current program.

IHS would strengthen existing managed care/cost control features. These include managed care practices, case management, networking with VA, DOD, utilization review, and an emphasis on health promotion and disease prevention efforts and programs. Through the Community Health Representative Program, IHS has a mechanism for close patient follow-up, patient education and limited home-based care.

II. RETAIN CURRENT PROGRAM AS AN OPTION WITHIN HIPC.

Under this option, IHS/Tribal programs would be offered as an enrollment based option for the target population available through the appropriate HIPC. Any U.S. citizen could choose to enroll in the IHS AHP, not just AI/AN. In rural and isolated areas, this is likely.

Both IHS/Tribal programs would be re-configured as a stand-alone comprehensive health plan offering a full range of acute care services. An IHS AHP could be structured as a quasi-public national plan where local service units and facilities decide whether to affiliate with the national IHS/Tribal/Urban AHP or not. Tribes could still decide to establish and operate separately, their own health programs, offered as a separate AHP.

A variation on the individual choice would be for the tribe to make the choice of provider for all tribal members. Individual AI/AN would not exercise an individual choice of health coverage, but would accept the tribal determination.

Eligible members of the target population would be required to make an enrollment choice between the re-configured IHS/Tribal/Urban programs and other AHPs offered through the HIPC. IHS would compete with other AHPs for enrollment and funds. For the benchmark plan, IHS annual appropriation for services would no longer be provided. Instead, IHS/Tribal/Urban programs would rely on payments like other AHPs.

Other services not provided through the competing plan in the HIPC would continue to be provided directly by IHS/Tribal/Urban programs. These services would include public health nursing, environmental health services and community health outreach, and other non-medical programs such as the IHS scholarship program.

III. INTEGRATE PROGRAM FULLY WITHIN HIPC.

Under this option, the IHS program would be eliminated as a distinct program, except for those public health and other services not included in the national benchmark plan. Financing would be provided directly to AI/AN individuals to cover the cost of coverage of a plan offered by an AHP through the HIPC.

Concerns about culturally-sensitive health care could be addressed through training and education of health workers.

BENEFITS OPTIONS

This section addresses current health care benefits and services available to AI/AN people and the possible benefit package options that might be provided under the national reform package. The benefits options are generally discussed independently from structural options. In the case of certain public health services and in the case of isolated areas in which existing IHS and tribal facilities are the only providers, the benefit options are related to likely structural alternatives.

I. NO CHANGE IN EXISTING BENEFITS

A diverse and comprehensive array of health care benefits are currently authorized and available to many, but not all AI/ANs. These benefits include curative, rehabilitative, prevention, environmental, public health, and social services. These benefits are not guaranteed to the individual AI/AN person. The availability and financing for these services is limited by the fixed annual IHS appropriation and other alternate resources. Historically, the IHS/Tribal/urban delivery system has not been funded sufficiently to guarantee it services to AI/ANs. ***It is significant that IHS health services are provided to the individual AI/AN persons at no cost, no deductibles, or co-pays .***

The exact scope and definition of the national benefit package is not yet known. Existing AI/AN benefits can not be precisely compared to the hypothetical national package. We can make instructive broad comparisons however.

A: Core Medical Benefits

A full range of medical inpatient and ambulatory services, routine and emergency medical services are available to many AI/ANs. These are not guaranteed to individual AI/ANs currently and are limited in depth, especially for tertiary level care. Many services are often relatively inaccessible to AI/ANs residing in the most remote environments (e.g., Alaska villages where IHS must transport patients thousands of miles to Anchorage or even to the continental U.S. for highly specialized care). All the existing core medical benefits are likely to be covered in the proposed reform package, presumably with greater depth than presently available to most AI/ANs through IHS.

B: Supplemental Medical Services

Many, but not all, AI/ANs obtain supplemental medical services such as contract health services, dialysis, dental services, eye care and eye glasses, chronic and rehabilitative services, prescription

medications, and specialized alcoholism and substance abuse programs. Some of these services could be included in a core package. Some services could be included in a generic supplemental medical services package targeted to sub-populations, such as the poor, or presumably to the AI/AN population.

Besides supplemental services, supplemental benefits to AI/ANs could take the form of lower or no co-payments and deductibles not only for the poor, but also specifically for AI/AN based on the special government-to-government relationship.

C: Public Health and Other Services

A third category of services provided to AI/ANs is not likely to be included in any standard benefits package. Some of these services are similar in function to those carried out by state and county public health departments. Others are unique to AI/ANs. IHS currently provides public health nursing, community education and outreach programs, environmental services, specialized programs for traditional AI/AN cultures, construction for safe water, sewer, and solid waste disposal. Many of these "collective" community and environmental benefits are difficult to relate to individual entitlements as contemplated under national health care reform. In addition, IHS currently provides grants to build tribal health management capacity, and scholarships to AI/ANs for health related professions. Research is also carried out on epidemiological characteristics of AI/AN people in order to monitor changing health status.

Comparison of Existing Benefits with Reform Proposals

- Health care services available through IHS/Tribal/Urban programs are broader and more comprehensive, if less deep, than is anticipated under reform proposals. Some of those services relate to the specific needs and circumstances in AI/AN communities. Some of those services, particularly those in the public health and environmental arena, are not likely to be available from participating HIPC plans.
- Contrasted with reform proposals, existing benefits are not guaranteed to individual AI/AN persons and are not portable outside the IHS/Tribal/Urban delivery system. Guaranteed full scope medical benefits would represent an improvement for many AI/AN people. An option would be to augment the IHS/Tribal/Urban program in order to guarantee benefits. If benefits under an IHS/Tribal/Urban delivery system continued unguaranteed, questions of equity for AI/ANs would certainly arise. This is particularly true in remote isolated areas (e.g., rural Alaska) where it

is difficult, economically at least, to guarantee services and access equivalent to those contemplated for more urban areas.

- AI/ANs must currently meet additional qualifying criteria for some IHS/Tribal/Urban benefits, especially for tertiary and elective services, for some supplemental services such as contract health services, dental and eye care, and for certain public health services. These criteria impose a rationing of services to levels less than the natural demand. It is yet unclear whether such services would be guaranteed, limited by additional qualifying criteria, or excluded from the reform core package.
- Many AI/ANs now have dual eligibility. In addition to IHS, many have private insurance through employers, Medicare and Medicaid, VA, and DOD.
- AI/ANs are not charged co-pays or deductibles for IHS services.

II. PROVIDE STANDARD PACKAGE FOR NEW BENEFICIARIES ONLY

Because AI/AN beneficiaries maintain standing eligibility based upon ancestry and affiliation with Tribes, whether actively enrolled and utilizing services or not, this option is not applicable. The existing IHS/Tribal benefits represent a kind of "collective" and limited entitlement to tribes and to AI/AN people generally without endowing any individual entitlement rights to a fixed and unvarying package of services.

III. PROVIDE STANDARD PACKAGE TO AI/AN SUBGROUPS CONTINGENT UPON ADDITIONAL QUALIFYING CRITERIA

This option contemplates provision of the basic core package of medical benefits to eligible AI/ANs contingent upon meeting some additional criteria. In some respects, this option is similar to the certain practices within the existing IHS/Tribal delivery system. Because individuals are not guaranteed health benefits, services are further restricted by various kinds of qualifying criteria. For example, full IHS financing for AI/ANs referred to private sector sources is limited to AI/ANs that reside on or near reservations, excluding many AI/ANs who reside in urban areas. Less urgent care is often limited by the application of other program-based criteria. Finally, in a very fundamental way, access to direct IHS/Tribal benefits is limited by the locations of their facilities. Typically, IHS/Tribal facilities are located away from major urban areas where many AI/ANs reside. The practical result is that a large subgroup of the 2 million AI/ANs have very limited access to benefits for which they are otherwise technically eligible. Moreover, service availability differs geographically, depending on financial, administrative, and local needs. For example, dialysis is readily available in some areas, but not in others. Possible options include:

- A. Guarantee core medical benefits only to AI/ANs who qualify under some additional program criteria (as yet undeveloped).
- Means tests - AI/ANs have traditionally opposed tests based on income because the basis for their health benefits derive from treaties and obligations from the U.S. that are unrelated to current means and ability to pay.
 - Residency tests - IHS/Tribes currently apply residency tests for services purchased from the private sector. Indirectly, the geographic locations of IHS/Tribal facilities generally have the effect of a residency test. Such tests could be maintained and refined.
 - Needs tests - certain programs and services are not provided generally to all AI/ANs but are targeted to specific individuals, sub-groups, or communities based upon program criteria.
 - Blood quantum is sometimes proposed a method to limit eligibility. Tribes have generally opposed fixed limits determined by the IHS on grounds that determining who is a tribal member is the sovereign right of the tribe and not the U.S.
 - Any deductibles or co-pays could be reduced or eliminated for AI/ANs who qualify under the additional criteria.
- B. Provide supplemental medical services only to AI/ANs who qualify under some additional program criteria (as yet undeveloped).
- The scope of supplemental health benefits could be varied to reflect a scale of need as determined by application of the various qualifying criteria.
 - Alternatively, deductibles and co-pays could be reduced or eliminated for AI/ANs who qualify under the additional criteria
- C. Provide the public health and other services only to AI/ANs who qualify under some additional program criteria.
- This option is similar to existing IHS/Tribal practices. Public health services, especially construction of water, sewer, and waste facilities, are provided to AI/AN communities based upon priorities and other qualifying criteria and are limited in extent by a fixed discretionary appropriation.
 - Some aspects of IHS' public health package are not "individual" benefits that only benefit individual AI/AN persons. Rather, they are services that benefit AI/AN communities collectively and, in turn, benefit individual AI/ANs indirectly. Establishing individual eligibility limitations or entitlement provisions becomes very murky with community and environmental oriented programs.
 - Other programs such as health scholarships for AI/ANs have existing qualifying criteria in place.

IV. PROVIDE STANDARD PACKAGE FOR AI/ANS WHO CHOOSE AN AHP OPTION UNDER HIPC

The proposed standard core package of medical services is likely to be somewhat more narrow, but more complete in its depth and coverage, than is currently enjoyed by many AI/AN people. In addition, the supplemental and public health services exceed those contemplated under the reform package. The options for extending the coverage based upon consumer choice is limited, in most practical respects, to only the medical core package and supplemental medical services and only in those areas where competing plans exist. Few, if any, alternative sources will be available in isolated rural areas. We foresee no alternative choices under national health care reform for public health services and environmental services such as water/sewer systems.

A. Provide full core medical benefits to those AI/ANS who elect to enroll in an accepted plan under HIPC supervision.

- Multiple alternatives, possibly including existing IHS/Tribal/Urban programs, are likely to be available in urban and some rural areas.
- Few real options are expected in isolated localities. In these circumstances, either the existing IHS/tribal programs would need to be strengthened to offer the core benefits package if it is guaranteed and portable.
- Alternatively, IHS/Tribal programs in remote regions could be maintained at existing discretionary levels without guaranteeing benefits to residents residing in isolated regions on grounds of economics. This creates the potential of a two-tiered benefits package to AI/ANS with possible overtones of second class status for those AI/ANS not guaranteed benefits.

B. Provide supplemental medical benefits to those AI/ANS who elect to enroll in an accepted plan under HIPC supervision.

- Multiple alternatives, possibly including existing IHS/Tribal/Urban programs, may be available in urban and some rural areas.
- Few alternatives, other than in IHS and tribal facilities, are likely to be available in remote areas.

V. PROVIDE STANDARD BENEFIT PACKAGE TO ALL AI/ANS

A. All AI/ANS would be provided the standard core medical package on the same basis as all other U.S. citizens. Those with multiple plans to choose from could do so.

B. Continue current supplemental medical benefits in excess of the standard package.

- Supplemental medical services might be part of a national supplemental package that is provided to special groups and

individuals based upon additional qualifying criteria. The qualifying tests could be waived for all AI/ANs because of the special legal relationship with tribal governments.

- Public health services would continue on a non-entitlement basis with collective benefits accruing to AI/AN communities based upon program criteria.

C. Eliminate current benefits in excess of the standard package.

- The public health and environmental services are currently authorized in legislation and their elimination would be opposed by AI/AN people. These programs have substantially contributed to the improved health of AI/ANs that has been achieved thus far.

EVALUATION CRITERIA

1. Effects on Tribal Sovereignty.

The United States has a legal and moral obligation to provide adequate health care and services to Indian tribes and their members. The Trust Responsibility for the provision of health care to Indian people was established in numerous treaties and has been further delineated and defined by numerous statutes, court decisions and administrative regulations. The tribal governments and Alaska Native villages strongly hold the belief that in exchange for over 50 million acres of native land that they have paid a premium on a health insurance program which entitles their members to continued health care benefits. It is this legal relationship which distinguishes American Indians and Alaska Natives from other minority populations.

The American Indian and Alaska Native population is diverse, encompassing approximately 500 tribal governments and Alaska Native villages, each with its own traditions and cultural heritage. Virtually all of these separate entities exercise a government-to-government relationship with the United States. In carrying out its trust obligation, the United States government provides health care services utilizing three systems of care: a) through the Indian Health Service (IHS) which provides direct care to native patients, b) through P.L.93-638 (Indian Self-Determination Act) contracts in which the tribes contract to provide services normally provided by the IHS, and c) within urban Indian health programs. In addition to direct care services, the IHS and the tribal health care delivery systems provide federal financing for the purchasing of contract health services. Nearly 35 percent of the IHS program consists of Self-Determination contracts whereby tribal governments and Alaska Native villages provide for health care services. The urban Indian health care delivery system includes 34 programs nationwide.

This criterion will be applied to all options since the obligation of the United States to provide health care services to American Indians and Alaska Natives is based on sovereign principles well defined in treaties and statutes. Self-determination must remain as the foundation for tribal delivery systems under a national system. Tribes must retain the option to administer directly health care services for their population. Further, Indian programs must be able to monitor and maintain their special legal status as state citizens

and tribal members to preclude exclusion of service eligibility under state programs.

2. Effectiveness for Raising Health Status; Quality and Comprehensiveness of Services.

The degree to which options demonstrate continued progress toward improved health status and evidence of systems to define, collect and analyze data for surveillance, monitoring, tracking of both quality of care to individuals and also their effectiveness on the health of the AI/AN people will be examined.

The Indian Health Service has as it's goal to raise the health status of American Indian/Alaska Native people to the highest possible level. While the health of Indian people has improved remarkably as a result of IHS/Tribal/Urban programs, a disparity still exists for many disease categories. For example, in Alaska, suicide is nearly 20 times the national average and in the Northern Plains states, Indian infants die at twice the U.S. rate. The IHS Trends in Indian Health for 1992 reports that the age-adjusted mortality rates were considerably higher among Indian than those for U.S. all races.

In applying this criteria in the development of new systems of care, the disparity between Indian populations and the general population in health status will require ongoing evaluation and monitoring. The health care reform proposals address only a part of the total Indian community health model. IHS and other Indian delivery systems have a broader and more comprehensive view of Indian health.

3. Cultural Specificity, Sensitivity, Acceptability.

Consideration will be given to the unique differences between the variety of 550 tribal governments and Alaska Native village communities. Cultural variation related to language differences, belief systems and geographic location will need to be taken into account. Cultural sensitivity is a consideration in any delivery system targeting Indian communities to ensure the staff, facilities and services are appropriate, sensitive, and integrated with the community. Assessment of Indian community requirements should precede changes in the system. Individual Indian patients desire a choice in selecting their health care provider based on quality and culturally sensitive health care. Native traditional healing practices are also an important element in an Indian delivery system. The "quality of caring" in addition to the quality of care is important. Finally, Indian preference in contracting and employment of health care providers is important to AI/ANs in considering the acceptability of an Indian delivery system.

4. Resources, Budget, Efficiency and Cost Containment.

The question of "primary vs. residual provider" status of the IHS and other government delivery systems once a national health coverage plan is implemented will require further review. It will be necessary to estimate the funds needed to elevate the Indian health delivery system (IHS/Tribal/Urban) to a competitive benchmark standard. This is particularly important since the historically fixed budgets of IHS/Tribal/Urban health systems have resulted in rationing of services. Medicaid and Medicare revenue represent a significant portion of Indian health revenue. Pharmaceutical and Medical supplies purchased by the IHS should also fall under cost containment efforts under a new system of care. The creation of infrastructure changes to streamline insurance and financing reimbursements could potentially improve the efficiency. Enhanced economies and buying power will be examined in the broader context of cost containment envisioned under health reform.

5. Economic Impacts on American Indian and Alaska Native Communities.

Employment provided to Indian communities by IHS, tribal and urban Indian delivery systems have a positive impact on the Indian economy and community empowerment. This is particularly important as the unemployment rate averages 45 to 85 percent in Indian communities. Moreover, the operation of local programs, including the health programs, is an important business function that builds and supports vitality of tribal governments.

6. Implementation Feasibility.

Defined as any special difficulties with each option, i.e., 1) Rural: IHS is the only provider, 2) other health services, social services. Is there evidence that the option will really work? Will the option produce the goals of health care reform, i.e., access and cost controls.

ATTACHMENTS

Comparison Of Programs By **PLAN LEVEL** Features

INDIAN HEALTH SERVICE

Plan-Level Feature	COMPARABLE PLAN FEATURE	COMMENT (Not all AI/ANs are served by IHS & some IHS beneficiaries are under-served.)
Enrollment Based	Eligibility is based on AI/AN ancestry and affiliation.	AI/AN persons are eligible by presenting proof of ancestry or tribal affiliation without enrolling.
Individual Choice of Multiple Competing Health Plans	NA	Otherwise eligible AI/ANs may obtain care from other sources if they have insurance or other personal means.
Level Contribution by Employer/Gov't Based on Lowest Cost Plan in Area	None	
Standardized Benefit Package	Package limited discretionary fixed budget. The services rendered vary somewhat by location. Individual AI/ANs are not guaranteed services.	
Detailed Comparative Information at Plan Selection	N/A	
Coordinated Open Enrollment by Program Sponsor	N/A	
Risk Adjustment of Contributions	N/A	AI/AN population has health characteristics that are elevated relative to US. Risks vary tribe by tribe and area to area.
Income Related Financing/Subsidies for Low Income	Not a means tested program.	AI/AN people feel strongly that federal health benefits derive from the special legal relationship with the U.S. and not based on means.
Global Budgets	Yes through fixed annual budgets	

Comparison Of Programs By **SERVICE LEVEL** Features

INDIAN HEALTH SERVICE

SERVICE LEVEL FEATURE	COMPARABLE PLAN FEATURE	COMMENT (Not all AI/ANs are served by IHS & some IHS beneficiaries are under-served.)
Physician Payment	Salaried for directly provided services. Some purchased services are paid for under contract or as fee for service.	
Hospital Payment	NA for IHS hospitals. Some purchased inpatient services are paid for under contracts with private hospitals.	
Cost Sharing	No co-pays or deductibles are charged to AI/ANs who get IHS services.	IHS pays co-pays, deductibles, & bill balances for AI/ANs it refers to outside source. IHS is payer of last resort for AI/ANs with 3rd party benefits.
Balance Billing	IHS bills reimbursements for AI/ANs treated in IHS facilities who are also eligible for Medicare and Medicaid benefits. (\$120 million in 1992)	
Provider Choice	N/A	
Basis for Provider Selection	N/A	
Case Management	YES. IHS operates much like an HMO. It has strong gate keeper practices for advanced care whether inside or referred outside	
Utilization Review	YES. Inside QA and utilization reviews. Employs Utilization Review for commonly used outside sources to which referrals are sent.	
Inpatient Care	YES. Basic primary and some secondary level care is provided where economical or is otherwise purchased. Essential tertiary care is purchased under strict priority lists. When demand exceeds funding available, referrals are limited to urgent and emergent care only.	IHS hospitals are not accessible to many AI/ANs. Scope of inpatient services is not as deep with respect to frequency of use for advanced tertiary and chronic care.
Ambulatory Care	Yes. Most basic primary ambulatory care is provided in IHS facilities. Some advance and specialty services are also available in some locations. Advanced diagnostic and therapeutic care is usually purchased.	Total ambulatory services and demand continues to grow while hospital admissions are declining. This pattern has mirrored the national trends in this regard.

	OPTION 1 Maintain separate program for AI/ANs with no integration with HIPC, but with enhanced managed care practices.			OPTION 2 Current program would be offered as an enrollment based option for AI/ANs.			OPTION 3 Eliminate IHS programs as a distinct delivery organization for AI/ANs except for other authorized services not normally planned for under a HIPC		
TRAITS ↓	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [[Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]

STRUCTURE	- IHS programs and delivery system provides core package to AI/ANs - Modify to meet core standards - Optional sharing arrangements with DOD & VA	Provide to AI/ANs through IHS system or arranged under contract	- Provide to AI/ANs through existing IHS system. - Few alternative plans are likely to cover these.	- IHS competes with other Plans in market areas for AI/ANs and others under the HIPC - Few if any competitors in rural & isolated areas	- IHS competes with other Plans in market areas for AI/ANs and others under the HIPC - Some plans may not offer these - Few if any competitors in rural & isolated areas	- Provide through existing IHS system. - Few alternative plans are likely to cover these.	- Eliminate IHS medical delivery system - AI/AN core medical services provided on same basis as other citizens - Few alternatives in rural & isolated areas	- May eliminate IHS delivery system except in limited respects - Plans would have supplemental \$ to provide to AI/ANs - Few alternatives in rural & isolated areas	- Provide through IHS system similar to existing. - Few alternative plans are likely to cover these.
BENEFITS	- IHS medical benefits are not currently standard or guaranteed to AI/AN individuals (broad, not deep) - Expand primary through tertiary to benchmark - Guarantee benchmark package to each AI/AN person	- Services (e.g., ESRD, Alcoholism & Sub. Abuse, chronic, dental, eye, long term care) are authorized but not guaranteed. (Options) - Provide to AI/ANs at limits of discretionary \$ - Guarantee (entitlement) to AI/AN persons	- Public health nursing, environmental svcs., water/sewer/waste facilities., community outreach - Maintain at authorized levels under discretionary \$	National Benchmark Medical Package	- Services (e.g., ESRD, chronic, dental, eye, long term care) are authorized but not guaranteed. (Options) - Provide to AI/ANs at limits of discretionary \$ - Guarantee (entitlement) to AI/AN persons	- Public health nursing, environmental svcs., water/sewer/waste facilities., community outreach - Maintain at authorized levels under discretionary \$	National Benchmark Medical Package	- Services (e.g., ESRD, chronic, dental, eye, long term care) are authorized but not guaranteed. (Options) - Provide to AI/ANs at limits of discretionary \$ - Guarantee (entitlement) to AI/AN persons	- Public health nursing, environmental svcs., water/sewer/waste facilities., community outreach - Maintain at authorized levels under discretionary \$

	OPT ON 1			OPTION 2			OPTION 3		
	Maintain separate program for AI/ANs with no integration with HIPC, but with enhanced managed care practices.			Current program would be offered as an enrollment based option for AI/ANs.			Eliminate IHS programs as a distinct delivery organization for AI/ANs except for other authorized services not normally planned for under a HIPC		
← TRAITS	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [[Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]

PROVIDER	• Combination of direct Federal provision, Tribal program provision and private sources. • Individual tribes retain option of operating their programs non-competitively	• Combination of direct Federal provision, Tribal program provision and private sources. • Individual tribes retain option of operating programs non-competitively	• Combination of direct Federal provision, Tribal program provision. • Individual tribes retain option of operating their programs non-competitively	• Mix of Federal, Tribal, and regular HIPC providers under HIPC depending on results of competition • Federal and Tribal programs are the predominant modes in rural and isolated areas.	• Mix of Federal, Tribal, and regular HIPC providers under HIPC depending on results of competition • Federal and Tribal programs are the predominant modes in rural and isolated areas. • Non-competitive tribal option???	• Combination of direct Federal provision, Tribal programs. • Individual tribes retain option of operating their programs non-competitively	• Plans under the normal HIPC concept • IHS or tribal facilities are the only options in some rural and isolated areas. • Would private plans find rural isolated low volume programs economical?	• Mix of Plans under HIPC and some federal or tribal programs in areas with no other alternatives • Individual tribes retain option of operating their programs non-competitively	• Combination of direct Federal provision, Tribal programs. • Individual tribes retain option of operating their programs non-competitively
ELIGIBILITY	• AI/ANs retain current eligibility except all core benefits are guaranteed and therefore are portable to other IHS or tribal providers [options] • Extend to non-AI/ANs in isolated areas and to DOD/VA eligibles as appropriate	• AI/ANs retain current eligibility. [options] • continue additional qualifying standards based on medical priorities • extend guaranteed coverage to all AI/ANs	• AI/ANs retain current eligibility. • continue additional qualifying standards based upon community and environmental characteristics	• No special eligibility standards for AI/ANs • Plans could offer culturally sensitive features to recruit AI/ANs	• AI/ANs retain current eligibility. [options] • continue additional qualifying standards based on medical priorities • extend guaranteed coverage to all AI/ANs	• AI/ANs retain current eligibility. • continue additional qualifying standards based upon community and environmental characteristics	• No special eligibility standards for AI/ANs • Plans could offer culturally sensitive features to recruit AI/ANs	• AI/ANs retain current eligibility. [options] • continue additional qualifying standards based on medical priorities • extend guaranteed coverage to all AI/ANs	• AI/ANs retain current eligibility. • continue additional qualifying standards based upon community and environmental characteristics

	OPTION 1			OPTION 2			OPTION 3		
	Maintain separate program for AI/ANs with no integration with HIPC, but with enhanced managed care practices.			Current program would be offered as an enrollment based option for AI/ANs.			Eliminate IHS programs as a distinct delivery organization for AI/ANs except for other authorized services not normally planned for under a HIPC		
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COVERAGE	• Some Service overlap (duplicate eligibility) • No competition with private plans • Possible sharing arrangements with DOD/VA	• Some Service overlap (duplicate eligibility) • No competition with private plans • Possible sharing arrangements with DOD/VA	• Little, if any, overlap	• No overlapping benefits since individual chooses exclusive use of one source. • Under-utilization is a cost each plan would minimize	• No overlapping benefits since individual chooses exclusive use of one source. • Under-utilization is a cost each plan would minimize	• Little, if any, overlap	• No overlapping benefits since individual chooses exclusive use of one source. • Under-utilization is a cost each plan would minimize	• No overlapping benefits since individual chooses exclusive use of one source. • Under-utilization is a cost each plan would minimize	• Little, if any, overlap
CHOICE	• AI/ANs have no PORTABLE benefits. May choose non-IHS source if they have personal means or insurance. • No real choices in rural and isolated areas.	• AI/ANs have no PORTABLE benefits. May choose non-IHS source if they have personal means or insurance. • No real choices in rural and isolated areas.	• AI/ANs have no PORTABLE benefits. Public health benefits also depend on additional qualifying factors • No real choices in rural and isolated areas.	• AI/AN chooses source of care • Individual choice eliminates tribal option to be sole provider	• AI/AN chooses source of care • Individual choice eliminates tribal option to be sole provider	• AI/ANs have no PORTABLE benefits. Public health benefits also depend on additional qualifying factors • Tribes retain option to operate programs	• AI/AN chooses source of care • Individual choice eliminates tribal option to be sole provider	• AI/AN chooses source of care • Individual choice eliminates tribal option to be sole provider	• AI/ANs have no PORTABLE benefits. Public health benefits also depend on additional qualifying factors • Tribes retain option to operate programs

	OPTION 1 Maintain separate program for AI/ANs with no integration with HIPC, but with enhanced managed care practices.			OPTION 2 Current program would be offered as an enrollment based option for AI/ANs.			OPTION 3 Eliminate IHS programs as a distinct delivery organization for AI/ANs except for other authorized services not normally planned for under a HIPC		
TRAITS	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]	(A) Benchmark Package [Typical medical services defined in National Plan]	(B) Supplemental Medical Services [Other authorized medical services, above benchmark, currently provided, but not guaranteed to all AI/ANs]	(C) Public Health Package [Other authorized public health services currently provided to AI/ANs that are not typically available from health plans]

FINANCING	- Discretionary appropriation to IHS / tribal programs - Guaranteed benchmark benefits will require \$ above current levels in some cases - Still payer of last resort and bill 3rd parties when AI/ANs duplicate eligibility	- Discretionary appropriation to IHS / tribal programs - If Guaranteed benchmark benefits will require \$ above current levels in some cases - Still payer of last resort and bill 3rd parties when AI/ANs duplicate eligibility	Discretionary appropriation to IHS / tribal programs	- Entitlement (voucher?) to AI/AN individuals - Amount determined through HIPC competition - Rural isolation is factor for sole sources.	- Could be entitlement or discretionary to AI/AN individuals - Amount determined through HIPC if entitlement or discretionary appropriations - Rural isolation is factor for sole sources.	Discretionary appropriation to IHS / tribal programs	- Entitlement (voucher?) to AI/AN individuals - Amount determined through HIPC competition - Rural isolation is factor for sole sources.	- Could be entitlement or discretionary to AI/AN individuals - Amount determined through HIPC if entitlement or discretionary appropriations - Rural isolation is factor for sole sources.	Discretionary appropriation to IHS / tribal programs
COST CONTROLS	- Salaried staff (need flexibility) - Global budget/ fixed appropriation - Payer of last resort - Networking with DOD/VA - Managed Care Practices strengthened - HP/DP model - Co-pays & deductables not currently applied, but could be proposed	- Salaried staff (need flexibility) - Global budget/ fixed appropriation - Networking with DOD/VA - Managed Care Practices strengthened - HP/DP model - Rationing and Needs Qualifying Criteria - Co-pays & deductables not currently applied, might be proposed	- Salaried staff - Global budget/ fixed appropriation - HP/DP model - Rationing and Needs Qualifying Criteria	- Salaried staff - Capitated funding - Competitive bids - Global budget - Managed Care Practices & Utilization Review - Co-pays & deductables may be part of HIPC package - Waivers for AI/ANs ?	- Salaried staff - Global budget - Managed care and Util. Rv. - Competitive Bids? - Rationing and Needs Qualifying Criteria if not guaranteed. - HP/DP model - Co-pays & deductables may be part of HIPC package - Waivers for AI/ANs ?	- Salaried staff - Global budget/ fixed appropriation - HP/DP model - Rationing and Needs Qualifying Criteria	- Salaried staff - Capitated funding - Competitive bids - Global budget - Managed Care Practices & Utilization Review - Co-pays & deductables may be part of HIPC package - Waivers for AI/ANs ?	- Salaried staff - Global budget - Managed care and Util. Rv. - Competitive Bids - Rationing and Needs Qualifying Criteria if not guaranteed. - HP/DP model - Co-pays & deductables may be part of HIPC package - Waivers for AI/ANs ?	- Salaried staff - Global budget/ fixed appropriation - HP/DP model - Rationing and Needs Qualifying Criteria

Issue 7: Antitrust Issues

Just as antitrust law has so far been crucial for the development of alternative delivery arrangements in the health care sector, so is it likely to prove necessary to the future of reform based on managed competition principles. A managed competition reform would tend to stimulate conduct by providers that might raise suspicions under Section 1 of the Sherman Antitrust Act as currently interpreted and enforced. At the same time, managed competition cannot work without antitrust enforcement to ensure that competition is not stifled.

As part of the health reform debate, providers often argue for an antitrust exemption to improve their bargaining position with large insurers and other managed care entities who they fear will dominate the market. Similarly, hospital representatives argue that at times there is an inherent conflict between antitrust laws and collaborative forms of cost containment, i.e., mergers and joint ventures. [Recently, the pharmaceutical manufacturers have expressed an interest in voluntarily controlling drug prices, and have requested immunity from the antitrust laws to carry out their effort.]

Subissue 7a: Do hospitals need a special antitrust exemption to allow them to enter efficiency-enhancing joint ventures or mergers?

Under the new health system, hospitals are going to face increasing pressure to lower costs, and reduce capacity. In some circumstances, hospitals could increase their efficiency by entering into joint ventures or mergers with other hospitals in their community. Hospital trade associations have advocated that a special antitrust exemption needs to be given to hospitals, especially hospitals in rural areas, to allow them to enter into mergers and joint ventures, e.g. to own and operate an MRI scanner. Basically, they argue that hospitals are prevented or at least deterred from entering these types of transactions out of fear of challenges by federal or state antitrust authorities. The trade associations say this is especially true in rural areas where few hospitals exist and mergers and joint ventures are likely to draw the attention of antitrust authorities. Advocates for an exemption argue cost-containing mergers and joint ventures are inhibited because of perceived uncertainty about possible antitrust action by the Federal antitrust enforcement agencies.

In general, however, hospital competition has an important role to play under the new system. It forces hospitals to operate more efficiently and better serve the needs of consumers. Therefore, in evaluating a proposed merger or joint venture between competing hospitals, using a "rule of reason" analysis, the enforcement agencies could evaluate the harm to competition and the efficiencies to be achieved by the transaction and determine what is in the best interest of consumers. Existing antitrust laws allows for this balancing.

Over the years, only a small number of the hundreds of hospital mergers that have occurred have been investigated by the Federal Trade Commission and the Antitrust Division of the Justice Department. Few have been challenged, and many have been cleared by the agencies quickly. In general, challenges have not occurred in small or rural communities. No hospital joint ventures have been challenged by the agencies.

Options:

1. Enact a limited antitrust exemption for hospital joint ventures and mergers.

Pros: Hospitals will proceed with more hospital joint ventures.

Cons: Some of the mergers and joint ventures may be anti-competitive.

2. Enact an antitrust exemption for hospitals in certain, small rural areas.

Pros: Small hospitals will be able to merge or enter joint ventures without fear of violating the antitrust laws.

Con: Some mergers or joint ventures will occur that limit competition yet do not create any efficiencies that benefit consumers. Exemption is unnecessary since few antitrust investigations or enforcement actions are occurring in rural areas.

3. No changes to existing antitrust laws.

Pro: Most efficiency-enhancing mergers and joint ventures will continue to be allowed and competition will be enhanced. The findings of

the HIPC in the area as to the desirability of the proposed merger or joint venture could inform the enforcement agency review and likely be given substantial weight.

Con: Hospitals will proceed in this area with uncertainty. Some mergers and joint ventures will probably not take place because of perceptions of antitrust problems.

Subissue 7b: Should HIPCs play a role in reviewing hospital mergers and joint ventures?

Because of their role as the managers of competition in their areas, HIPCs may have unique perspectives on both the competitive and efficiency-enhancing potential of proposed mergers and joint ventures. Therefore, it has been suggested that they be allowed to review these transactions either in addition to or instead of the federal antitrust authorities.

Currently there is substantial healthcare expertise in the FTC and Antitrust Division. In reviewing proposed transactions these agencies seek the views of major purchasers in the area where the hospitals are located as well as state and local healthcare officials. Under the new system, HIPCs would likely be consulted on all hospital mergers and joint ventures in their area.

Options:

1. Grant HIPCs sole authority to review mergers.

Pros: Hospitals may feel that HIPCs are more sympathetic to their problems and more familiar with the local area. Their uncertainty would be decreased because of the local decision-making.

Cons: HIPCs may not have the expertise and resources to do appropriate reviews and may not be sensitive to the anticompetitive aspects of certain proposed actions. If the effects of the proposed merger or joint venture extend beyond the HIPCs jurisdiction, it is unclear that the HIPC should have jurisdiction.

2. Retain current enforcement system.

Pros: In general, the current system is working well-- few proposals have been rejected. HIPCs will participate in review but would not be required to invest substantial resources in the process. Ultimate authority would remain with the antitrust enforcement agencies.

Con: Arguably, the HIPC may be in a position to understand local health care market better than the federal antitrust authorities.

Subissue 7c: Should physicians be given a limited antitrust exemption to undertake joint activities?

Physicians have expressed an interest in being allowed to engage in more joint activities including being allowed to bargain collectively with large payers and being allowed to market their services jointly without partially integrating their practices. Many physicians feel that they are small entities dealing with large managed-care plans that are able to exercise substantial market power as purchasers and thus able to force physicians reimbursement below competitive levels. There is concern that under the new systems HIPCs will be able to exercise even more power than current large purchasers. Physicians have also express concern that their lack of knowledge and limited experience negotiating with payers puts them at an additional disadvantage.

Agreements between independent physicians to fix prices or collectively refuse to deal with either a HIPC or a managed care system would be per se violations of the antitrust laws. Such agreements are per se because they are unlikely to benefit consumers and could significantly increase the prices that health plans would have to pay for physician services. Groups of physicians could, however, collectively negotiate with health plans if they were joined in an integrated joint venture and were not so overinclusive as to be able to exercise market power. Such joint ventures would allow physicians to share information and work together to provide quality services in an efficient manner.

Options:

1. Allow self-designated group of physicians to deal collectively with health plans.

Pro: Meets physicians' claim of need for countervailing power. Appears to promote symmetrical fairness in negotiating power.

Con: In general, there is not empiric support for the idea that payers exercise monopsony power. An antitrust exemption here would likely lead, effectively, to physician boycotts of managed care entities. Antitrust laws are designed to protect competition, not competitors.

2. Continue to apply antitrust laws to prevent agreements that would restrain competition.

Pro: Physicians would compete on the basis of price, quality and service. The kinds of integrated delivery systems that we seek would be allowed to negotiate aggressively with payers under existing antitrust law and interpretation.

Con: Physicians will continue to feel that they are at a competitive disadvantage in their negotiations.

Subissue 7d: Should price discussions among pharmaceutical companies be allowed to encourage voluntary price controls?

In response to recent criticisms of the rapid rise in prescription drug prices, the Pharmaceutical Manufacturers Association has indicated that the industry collectively would like to voluntarily hold down future price increases. In order to do so, they would like to meet and agree on the maximum price increase that can occur each year. Such conduct would violate the antitrust laws.

Agreements between competitors on maximum price schedules have been held to be per se illegal. This is because courts have not found any procompetitive benefits from such agreements, and such agreements interfere with the functioning of the free market. Such agreements could in fact be price-fixing agreements as the maximum increase becomes the actual increase instituted by each company. It is for the government, not private competitors, to decide the necessity of price controls and the appropriate method of instituting and enforcing such controls.

If under the new health system pharmaceuticals are included in the standard benefits package, health plans will be looking at strategies to control prescription drug costs, including negotiating with manufacturers. This will increase the pressure on the pharmaceutical industry to control costs and price competitively.

Options:

1. Grant the pharmaceutical companies an antitrust exemption.

Pro: Might lead to small price increases in first year as manufacturers try to convince Congress that they can be trusted to regulate themselves.

Con: Will allow pharmaceutical companies to collusively agree on price increases and will result in limiting the impact of competition under the new system.

2. Leave the antitrust laws unchanged. The pharmaceutical industry will not be able to meet and agree on price increases.

Pro: Pharmaceutical manufacturers will be able to unilaterally decide on the price that is best to make their drugs attractive to enrollees and providers in integrated health systems. Should reduce price in the long run.

Con: Pharmaceutical companies will claim that under managed competition prices will be too low to allow them to fund research and development and that methods used by managed care systems lead to substandard care.

Subissue 7e: Under the new health system, will collusive conduct by health plans be exempt from antitrust enforcement by the McCarran-Ferguson Act?

The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, grants an antitrust exemption to the business of insurance to the extent that such business is regulated by state law. It does not, however, exempt "any agreement to boycott, coerce, or intimidate, or any act of boycott, coercion, or intimidation." Not all acts of insurers are exempt under the act, but only those that go to the relationship between the insurer and the insured, including the premium rate. Thus agreements between health plans as to premiums could not be challenged if there is state legislation regulating the plans.

Under the new health system, this exemption may immunize anticompetitive conduct by health plans, such as agreements as to the premium levels to be offered to HIPC's. This would only be true if there were existing state legislation that would satisfy the "regulated by state law" requirement of McCarran-Ferguson that was not repealed or overridden. If HIPC's are state agencies, their actions may also be deemed to be regulation by the state. If premiums are set or premium increases established by HIPC's, there is no need to take any action.

Options:

1. Repeal McCarran-Ferguson.
2. Pass legislation that excludes price agreements between health plans on premiums from McCarran-Ferguson.
3. Leave law unchanged.

It is difficult to evaluate these options since it is unclear whether this will in fact be a problem under the new system and how many states will be affected.

MEETING WITH HILARY RODHAM CLINTON
ON AMERICAN INDIAN HEALTH CARE ISSUES

March 17, 1993

AMERICAN INDIAN & ALASKA NATIVE PARTICIPANTS

<u>Name</u>	<u>Position & Organization</u>
1. The Honorable Peterson Zah	<i>President</i> Navajo Nation
2. The Honorable Larry EchoHawk	<i>Attorney General</i> State of Idaho
3. The Honorable Richard A. Hayward	<i>Chairman</i> Mashantucket Pequot Tribe
4. The Honorable Wilma Mankiller	<i>Principal Chief</i> Cherokee Nation of Oklahoma
5. Dr. Johanna Clevenger, M.D.	<i>President</i> Association of American Indian Physicians
6. Ms. Julie E. Kitka	<i>President</i> Alaska Federation of Natives
7. Mr. Richard Trudell	<i>Executive Director</i> American Indian Resources Institute
8. Ms. Patricia M. Zell	<i>Staff Director/Chief Counsel</i> Senate Committee on Indian Affairs
9. Mr. John E. Echohawk	<i>Executive Director</i> Native American Rights Fund
10. Dr. Gerald Hill, M.D.	<i>Director</i> Center of American Indian & Minority Health

American Indian Delegation-Cont'd
Page 2 of 4

- | | |
|-------------------------------------|--|
| 11. Mr. Michael E. Lincoln | <i>Acting Director</i>
Indian Health Service |
| 12. Ms. Norine Smith | <i>President</i>
American Indian Health
Care Association |
| 13. Ms. Jennie R. Joe, Ph.D. M.P.H. | <i>Associate Professor & Director</i>
Native American Research
& Training Center |
| 14. Mr. James R. Floyd | <i>Director</i>
Portland Area Office
Indian Health Service |
| 15. Ms. Anne Walker | <i>Executive Director</i>
Alaska Native Health Board |
| 16. Mr. Gordon Belcourt | <i>Executive Director</i>
National Indian Health
Board |
| 17. Mr. Andrew Lorentine | <i>Chairman</i>
National Indian Health
Board |
| 19. Ms. Carol Marquez-Baines | <i>Interim Executive Director</i>
American Indian Health
Care Association |
| 20. Ms. Phyllis Moore | <i>Director</i>
Health & Human Services
Mashantucket Pequot Tribe |
| 21. Ms. Deanna L. Bauman | <i>Interim General Manager</i>
Governmental Services
Oneida Tribe of Indians of
Wisconsin |
| 22. Ms. Jo Ann Kauffman | <i>President</i>
Kauffman & Associates, Inc. |

American Indian Delegation-Cont'd
Page 3 of 4

23. Ms. Deanna Martinez

Deputy Director
American Indian Resources
Institute

24. Mr. W. Ron Allen

Chairman/Executive Director
Jamestown S'Klallam Tribe

25. Mr. Eddie Tullis

Tribal Chairman
Poarch Creek Band

26. Ms. Ethel Lund

Southeastern Alaska Regional
Health Corporation

27. Ms. Carmelita Skeeter

Executive Director
Indian Health Care
Resource Center Tulsa, Inc.

28. Mr. David Baldrige

Executive Director
National Indian Council on
Aging

29. Mr. Gerald J. Ignace

Executive Board Member
Association of American
Indian Physicians

30. Mr. James Crouch

Executive Director
CA Rural Indian Health
Board

31. Ms. Pam Iron

Executive Director
Cherokee Nation

32. Ms. Donna Vandall

Executive Director
Aberdeen Tribal Chairmens'
Health Board

33. Mr. Buford Rollin

Secretary
National Indian Health
Board

American Indian Delegation-Cont'd
Page 4 of 4

34. Ms. Mary Thomas

Lieutenant Governor
Gila River Indian
Community

35. Ms. Doni Wilder

Executive Director
Northwest Portland Area
Indian Health Board

36. Mr. Gregory Yawakia

Chairman
Pueblo of Zuni

37. Mr. Bill Fife

Principal Chief
Creek Tribe/Muscogee

38. Ms. Julia Davis

Vice-Chair
National Indian Health
Board

39. Mr. Robert J. Clark

Bristol Bay Area Health
Corporation

A SUMMARY OF INDIAN HEALTH STATUS

o Demographics

There are approximately 2.2 million American Indians and Alaska Natives residing in the U.S. The Indian Health Service (IHS) provides health services to about 1.3 million Indians (60 percent of U.S. Indians), primarily those residing on or near reservations. The Indian population is less educated than the general population, i.e., 65.5 percent are high school graduates or higher compared to 75.2 for the general population. The Indian population is also poorer because of high unemployment rates and low wages. In 1989, the Indian median household income was only two-thirds that for the general population (\$20,025 versus \$30,056).

o Accomplishments

The health status of the IHS service population has improved significantly under the IHS. For example since 1973,

- gastrointestinal diseases death rates decreased 77 percent
- tuberculosis death rates decreased 76 percent
- maternal death rates decreased 69 percent
- alcoholism death rates decreased 63 percent
- pneumonia and influenza death rates decreased 59 percent
- accident death rates decreased 54 percent
- infant mortality rates decreased 50 percent

o Remaining Problems

The Indian population fares poorly compared to the general population for a number of conditions/problems. Following is a comparison of Indian age-adjusted death rates to U.S. rates.

- tuberculosis - 520 percent greater
- alcoholism - 476 percent greater
- diabetes mellitus - 188 percent greater
- accidents - 167 percent greater
- homicide - 71 percent greater
- suicide - 54 percent greater

o Demand for Services

Since 1955 (the inception of IHS), the volume of IHS services has greatly increased.

- inpatient admissions increased 86 percent to 93,180
- outpatient visits increased 1045 percent to 5,211,351
- dental services increased 1216 percent to 2,369,484

o Unmet Need for Services

The IHS service population receives health services at lower rates than the general population as illustrated below.

	<u>IHS</u>	<u>U.S.</u>
- hospital discharges/1,000 population	87	124
- hospital days/1,000 population	399	792
- physician visits/person	3.1	4.6

INDIAN HEALTH SERVICE

The Indian Health Service (IHS), an agency of the Public Health Service within the Department of Health and Human Services, provides a comprehensive health services delivery system for American Indians and Alaska Natives (AI/AN) with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs. The goal of IHS is to raise the health status of the AI/AN people to the highest level possible.

The IHS, tribal governments, and urban Indian organizations, within the limits of annual appropriations, provide an unprecedented, comprehensive scope of preventive, clinical, and environmental health services, augmented by community and human resources development programs.

ISSUES

o Federal Responsibility for Providing Health Services to Members of Sovereign Tribal Governments

The Federal responsibility has its bases in transfer of vast expanses of land, repeatedly affirmed through treaties, legislation, and court decisions. Tribal governments expect this responsibility to be met through a special government to government relationship.

o Self-Determination and Self-Governance in Indian Health Programs

The Indian Self-Determination and Education Assistance Act gave tribal organizations the authority to contract with the Federal government to operate programs serving their members. Amendments were made to simplify the self-determination contracting process. The Departments of Health and Human Services (HHS) and the Interior (DOI) consulted extensively with Indian tribes to develop joint regulations to implement the amendments. A Notice of Proposed Rule Making is awaiting clearance by the new Administration. In 1992, legislation provided authority for demonstration grants for more extensive tribal self-governance of health programs.

o Alcoholism Prevention and Treatment Strategy

Alcoholism is the number one health and social problem for AI/AN people. The IHS is developing a national plan to identify state-of-the-art services, to pilot new approaches to prevention and care specific to AI/AN, and to highlight efforts to evaluate effectiveness of services. Essential to the success of the plan is coordination of services with the DOI and Indian communities.

o **Health Professions Recruitment and Retention**

Recruitment and retention of primary care health professionals is a major concern. For 15 health professions, the composite vacancy rate over the past five years is over 15 percent. The IHS attempts to be competitive with the private sector through a complicated system of special pay, bonuses, allowances, and loan repayment.

o **Coordinating Federal Health Care**

The IHS, Department of Defense, Department of Veterans Affairs operate direct health care delivery programs serving more than 36 million people. Since the late 1970s, these programs have improved access, quality, and cost effectiveness by sharing technology, facilities, and services. This is politically sensitive: each constituency seeks assurance that its primary goal of access to quality care will not be jeopardized by coordination. A conference, "Coordinating Federal Health Care", is scheduled May 19-21 at the Uniformed Services University of the Health Sciences.

A National Summit On

INDIAN HEALTH CARE REFORM

Convened By:

SENATE COMMITTEE ON INDIAN AFFAIRS
HOUSE SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS
HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

In Cooperation With

AMERICAN INDIAN RESOURCES INSTITUTE
AMERICAN INDIAN HEALTH CARE ASSOCIATION
ASSOCIATION OF AMERICAN INDIAN PHYSICIANS
NATIONAL CONGRESS OF AMERICAN INDIANS
NATIONAL INDIAN POLICY CENTER
NATIONAL INDIAN HEALTH BOARD
ALASKA FEDERATION OF NATIVES
NATIVE AMERICAN RIGHTS FUND

SUMMIT SCHEDULE

MONDAY, March 15, 1993

8:00 a.m. REGISTRATION (*Hart Senate Office Building (HSOB) - Room 216*)

9:00 a.m. PLENARY SESSION
CALL MEETING TO ORDER
INVOCATION

WELCOMING REMARKS AND SUMMIT OVERVIEW

Richard Trudell, *Executive Director*, American Indian Resources Institute
John E. Echohawk, *Executive Director*, Native American Rights Fund

9:15 a.m. CONGRESSIONAL PERSPECTIVES

Hon. Daniel K. Inouye, *Chairman*, Committee on Indian Affairs, U.S. Senate
Hon. John McCain, *Vice Chairman*, Committee on Indian Affairs, U.S. Senate
Hon. Paul D. Wellstone, *Member*, Committee on Indian Affairs, U.S. Senate
Hon. Ben Nighthorse Campbell, *Member*, Committee on Indian Affairs,
U.S. Senate
Hon. Henry Waxman, *Chairman*, Subcommittee on Health and the Environment,
U.S. House of Representatives

10:00 a.m. INDIAN HEALTH CARE PERSPECTIVES

Gerald L. Hill, M.D., *President-Elect*, Association of American Indian Physicians;
Gerald L. Ignace, M.D., *Past President*, Association of American Indian
Physicians — "*Meeting the Challenge to Improve Indian Health Care and Build
Healthier Communities*"

Andrew Lorentine, *Chairman*, National Indian Health Board and Gordon
Belcourt, *Executive Director*, National Indian Health Board — "*Indian Health
Care Reform and Tribal Governmental Responsibility*"

Norine Smith, *President*, American Indian Health Care Association and Carol
Marquez-Balnes, *Interim Executive Director*, American Indian Health Care
Association — "*Indian Health Care Reform and Off-Reservation Delivery
Systems*"

WORKING GROUP
CHAIR ★

Michael E. Lincoln, *Acting Director*, Indian Health Service, Rockville, MD —
"*Indian Health Service: What Has Been, What Is, and What Can Be*"

11:00 a.m. AN OVERVIEW OF THE POSSIBLE ELEMENTS OF A
HEALTH CARE REFORM PACKAGE

Denise Dougherty, *Senior Associate*, Office of Technology Assessment
James R. Floyd, *Director*, Portland Area Office, Indian Health Service

11:15 a.m. OPEN DIALOGUE: INDIAN HEALTH CARE NEEDS AND ISSUES

11:45 a.m. CONCURRENT WORK GROUPS: LOGISTICAL
AND GENERAL INFORMATION

JoAnn Kauffman, *President*, Kauffman and Associates, Inc., Washington, DC

12:00 noon LUNCH BREAK

1:30 p.m. **CONCURRENT WORK GROUP SESSIONS**

Focus & Location:

Work Group "A" "Health Care Delivery Systems" (HSOB — Room 216)

Work Group "B" "Financing Mechanisms, Cost Containment, and Health Data Systems" (HSOB — Room 216)

Work Group "C" "Coverage, Eligibility, and Access to Quality Care"
(Russell Senate Office Building (RSOB) — Room 465)

Work Group "D" "Special Indian Health Care Needs and Issues"
(Offices of United Methodist Ministries, 100 Maryland Ave., NE,
Washington, DC)

Work Group "E" "The Law and Policy Foundation for the Delivery of Indian Health Care" (Offices of Patton, Boggs & Blow, 2550 M St., NW, Washington, DC)

6:00 to

8:30 p.m. **SUMMIT RECEPTION**

Location:

Washington Vista Hotel
1400 M Street, NW — Vista Ballroom
Washington, DC

Hosted By:

ALASKA FEDERATION OF NATIVES, INC.
DUCHENEAUX, GERARD & ASSOCIATES, INC.
AMERICAN INDIAN HEALTH CARE ASSOCIATION
ASSOCIATION OF AMERICAN INDIAN PHYSICIANS
SONOSKY, CHAMBERS, SACHSE & ENDRESON
NATIONAL CONGRESS OF AMERICAN INDIANS

AMERICAN INDIAN RESOURCES INSTITUTE
NATIVE AMERICAN RIGHTS FUND
PATTON, BOGGS & BLOW
ONEIDA TRIBE OF WISCONSIN
PEQUOT PHARMACEUTICAL NETWORK
NATIONAL INDIAN HEALTH BOARD

TUESDAY, March 16, 1993

9:00 a.m. **CONCURRENT WORK GROUP SESSIONS** (*continued*)

12:00 noon **LUNCH BREAK**

1:30 p.m. **PLENARY SESSION**
INVOCATION
CALL MEETING TO ORDER
OPENING REMARKS
Richard Trudell & John Echohawk

1:45 p.m. **CONGRESSIONAL PERSPECTIVE**
Hon. Edward M. Kennedy, *Chairman, Committee on Labor and Human Resources, U.S. Senate*

2:00 p.m. **REPORTS FROM CONCURRENT WORK GROUPS**

3:15 p.m. **OPEN DIALOGUE: DISCUSSION OF WORK GROUP REPORTS AND NEXT STEPS**

4:45 p.m. **CONCLUDING REMARKS**
END OF SUMMIT

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: WEDNESDAY, MARCH 17, 1993
DRAFT #1

Call Paula T.

PREV RON

The White House

HAPPY ST. PATRICK'S DAY!!!

7:45 am

DEPART The White House South Portico
EN ROUTE Capitol Hill
Travelling Staff:
Kelly Craighead
Melanne Verveer
Lisa Caputo???

7:55 am

ARRIVE Longworth Bldg

8:00 am -
10:00 am

1,

MTG W/Dan Rostenkowski & Dem. Members of
The Ways & Means Committee
Room 1100, Longworth Bldg (Library in back)
~~OPEN/CLOSED ???~~

Format:

spray

Participants: Approx. 24 Members Attending
(See briefing for more info)

Staff Contact: Melanne Verveer (456-2538)
Contact: Virginia Fletcher
225-4061

10:05 am

DEPART Capitol Hill
EN ROUTE The White House

10:15 am

ARRIVE The White House South Portico

11:00 am -
11:30 am

2,

PVT MTG W/Mrs. Rabin
Green Room (Residence)

Contact: Will Itoh
456-6536

12:00 pm

LUNCH

12:30 pm

3,

HEALTH VIDEO
Location:???

Contact: Jason Soloman
456-7151

1:00 pm -
1:15 pm

PVT MTG W/Maggie & Patti
HRC's Office

1:15 pm -

PVT MTG W/Maggie

1:30 pm HRC's Office

1:30 pm - PVT MTG W/Ira & Carol
1:45 pm HRC's Office

2:15 pm DEPART The White House South Portico
EN ROUTE Capitol Hill

Travelling Staff:
Kelly Craighead
Melanne Verveer

2:25 pm ARRIVE Rayburn Bldg

2:30 pm - PVT MTG W/Cong. Jack Brooks (D-TX)
3:15 pm A, Rayburn Bldg - Room 2449
CLOSED PRESS

Format: Informal discussion

Contact: Pamela
225-6565

3:30 pm - 6, INDIAN HEALTH SUMMIT
4:30 pm Room 485 - Russell Bldg
PRESS PLAN

Format: Richard Trudell - Exec. Dir. American
Indian Resources Inst. intros HRC, HRC
remarks

Participants: Approx. 30 attending
(See briefing book for further info)

Staff Contact: Melanne Verveer (456-2538)
Contact: Patricia
224-2251

5:00 pm - HEALTH CARE MTG W/THE PRESIDENT
7:00 pm Oval Office

Participants:

Contact: Maggie Williams
456-1660

NOTE: HAPPY BIRTHDAY!! To James Ramsey - Butler



OFFICE OF THE DIRECTOR

To: Kim Tilley

Facsimile Number

202-456-2239

From: Joe Deffenbaugh

Our Facsimile Number

301 443 4794

Our Telephone Number

301 443 1011

Note:

The
Date

3/16/93

How Many Pages

4

Indian Health Service
5600 Fishers Lane
Rockville, Maryland 20857



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

MAR 16 1993

NOTE TO KIM TILLEY

Subject: Your Request for Indian Health Service Information

Attached are fact sheets on Indian Health Status and Indian Health Service Issues.

I forwarded your request for a Political Analysis to Mr. Lincoln's Health Reform staff person, as he was leaving for Senator Inouye's Summit, who will provide the analysis by 9 a.m., Wednesday, March 17.

If I can be of further assistance, please call me on (301) 443-1083.

Joseph H. Deffenbaugh, Jr.
Director, Policy Review and
Coordination Staff

Attachments

DANIEL K. INOUE, HAWAII, CHAIRMAN
JOHN MCCAIN, ARIZONA, VICE CHAIRMAN

DENNIS DECONCINI, ARIZONA
THOMAS A. DASCHLE, SOUTH DAKOTA
KENT CONRAD, NORTH DAKOTA
HARRY REID, NEVADA
PAUL SIMON, ILLINOIS
DANIEL K. AKAKA, HAWAII
PAUL WELLSTONE, MINNESOTA
BYRON L. DORGAN, NORTH DAKOTA
BEN NIGHTHORSE CAMPBELL, COLORADO

FRANK H. MURKOWSKI, ALASKA
THAD COCHRAN, MISSISSIPPI
BLADE GORTON, WASHINGTON
PETE V. DOMENICI, NEW MEXICO
NANCY LONDON KASSIRBAUM, KANSAS
DON NICKLES, OKLAHOMA
MARK O. HATFIELD, OREGON

PATRICIA M. ZELL
STAFF DIRECTOR/CHIEF COUNSEL
DANIEL N. LEWIS, MINORITY STAFF DIRECTOR

United States Senate

SELECT COMMITTEE ON INDIAN AFFAIRS

WASHINGTON, DC 20510-6460

March 16, 1993

MEMORANDUM

TO: JULIE HOPPER, SARAH GROTT

FROM: PATRICIA ZELL

RE: CONSIDERATIONS FOR TOMORROW'S MEETING

You had asked whether there were any particular points, issues or subjects of which Mrs. Clinton would want to be aware prior to meeting with tribal government leaders and Indian health care professionals tomorrow. Outlined below are some general considerations and the fundamental context in which the tribal representatives will be sharing their concerns and recommendations.

Historical Background

The First Pre-Paid Health Care Plan: Indian people have long viewed the provision of health care services by the federal government as the first pre-paid health care plan -- pre-paid with the cession of 500 million acres of Indian lands to the United States.

Many of the treaties that provided for the relinquishment of Indian lands contained commitments of the part of the United States that health care and educational services would be provided to the Indians in perpetuity (as long as the sun rises in the east...).

The Supreme Court has consistently construed these treaty commitments to be the basis for the legal and political relationship that Indian tribal governments have with the United States, thereby distinguishing Indians from being accorded the status of a racial or ethnic group.

Continental Congress Debates and the Constitution: From the time of the earliest debates in the Continental Congress and the contemporaneous writings of the framers of the Constitution, we know that Indian tribes have been viewed as sovereign

nations. These same documents make clear that the framers viewed the relationships between states and Indian nations as potentially hostile, and thus provided that the primary relationship with the Indian nations would be a government-to-government relationship between the United States and Indian tribes.

Given this historical background, and the subsequent course of dealings between state and tribal governments which have in fact proved to be as problematic as the framers of the Constitution forecast them to be, many of the participants at the National Tribal Summit on Health Care Reform (held in the Senate over the last two days), have expressed their concerns that any new health care system not require the tribal governments to work through the state governments.

Legal and Policy Background

Notwithstanding which political party may have been in the White House or in control of either house of the Congress at any particular time in American history, it has generally been the case that all three branches of the federal government have acknowledged and supported the notion that the United States has a trust responsibility for Indian lands and resources. This legal responsibility has been interpreted by the Supreme Court to have arisen out of the treaty commitments and the course of dealings with Indian nations as "domestic, dependent sovereigns".

Within this context, the second concern expressed by tribal summit participants is that the United States' trust responsibility and the treaty commitments require that there must be more than a "minimum benefits package" when it comes to the provision of health care to Indian people. On this same basis, summit participants are also strongly opposed to any effort that might be part of a nationwide health care reform initiative that would result in the elimination of the Indian Health Service.

Practical Considerations

Urban vs. Reservation Indian Health Care: Several federal policies have had a dramatic effect on the distribution of the Indian population across the United States. The federal policies of removal, termination, and urban relocation have resulted in a relocation of over 50 percent of all Indian people to urban areas.

While the federal responsibility for health care was originally focused on the reservation-based portion of the Indian patient population, it later became clear that Indians who had relocated to urban areas were not receiving health care services through the traditional health care providers. Urban Indian health care programs designed to provide outreach and referral services to urban Indians began to be established, and when it later became apparent that urban Indians still did not have adequate access to health care services, the urban programs began to provide direct health care services.

When the Congress subsequently authorized and funded urban Indian health care programs, in addition to those operated at the reservation-level, both urban and reservation-based Indians developed the perception that they were competing against one another for what has always been a scarcity of health care funds.

Summit participants have expressed the concern that any new health care system should not pit urban Indians against reservation Indians when it comes to the allocation of health care services or health care funds.

Self-Determination Contracting: Pursuant to the provisions of the 1975 Indian Self-Determination and Education Assistance Act, tribal governments have been contracting with the Indian Health Service to provide for direct tribal operation of health care programs, Indian hospitals and clinics for the past 18 years. Alaska Native regional health corporations also contract to perform formerly-federal functions in the health care service delivery area.

Summit participants want to assure that the ability of tribal governments to contract for the provision of health care services is kept intact under any new health care system.

Community Health: It is widely acknowledged that improvements in the health status of Indian people have come about as a function of: (1) tribal governments assuming increasingly greater responsibility for the health care services provided to reservation residents; and (2) the community health approach to improving health status. Community Health Representatives on reservations and Community Health Aides in Alaska provide a vital link between Indian communities and health care providers, and have helped to assuage the effect of the meaning of the term "hospital" in most Indian languages as "a place to go to die."

Summit participants have expressed the concern that a new health care system which might be based on a narrowly-interpreted medical model approach would replace the community health approach to Indian health care and the critical links between Indian communities and health care providers.

we
Thurs

submit to
Cong & TEL-ORCE

Budget Resolution

afternoon may be cancelled

Tribal sovereignty

- Focus on well-being & health prevention
- Health facilities - some ~~health~~ - care
focus on ability to get new hospital
serve well-being

Universal access & Comprehensive
pkg. / Even a question of
Should there be an Indian
Health

File analysis

see Dufferbaugh
words w/ Michael Lincoln
301/446-1083

Mike Sweeney
Mike ~~Linton~~

1. 8:00 / ¹¹⁰⁰ Longworth # OB

24 attending

2. Mrs. Rabin - Will I toh

3. Health Video Filming
Jason !!!

4. Jack Brooks

MEMORANDUM
OF CALL

Previous editions usable

TO: *FX*

☒ YOU WERE CALLED BY

☐ YOU WERE VISITED BY

Jean Per

OF (Organization)

☐ PLEASE PHONE

☐ FTS

☐ AUTOVON

☐ WILL CALL AGAIN

☐ IS WAITING TO SEE YOU

☒ RETURNED YOUR CALL

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Michael Lincoln's phone #

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*Sharon Hoppman, ass**

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SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: WEDNESDAY, MARCH 17, 1993
DRAFT #1

PREV RON

The White House

HAPPY ST. PATRICK'S DAY!!!

7:45 am -

DEPART The White House South Portico
EN ROUTE Capitol Hill

7:55 am

ARRIVE Bldg

8:00 am -
10:00 am

MTG W/Dan Rostenkowski^{Si} & Dem. Members of
The Ways & Means Comm.
Room

Chris / Caspe

Staff Contact: Melanne Verveer (456-2538)
Contact: Virginia
225-4061

10:05 am

DEPART Capitol Hill
EN ROUTE The White House

10:15 am

ARRIVE The White House

11:00 am -
11:30 am

2.

PVT MTG W/Mrs. Rabin
Room

NSC will I for

12:00 pm

LUNCH

1:00 pm -
1:15 pm

PVT MTG W/Maggie & Patti
HRC's Office

1:15 pm -
1:30 pm

PVT MTG W/Maggie
HRC's Office

1:30 pm -
1:45 pm

PVT MTG W/Ira & Carol
HRC's Office

2:30 pm -
3:15 pm

3.

PVT MTG W/Cong. Jack Brooks (D-TX)
Room

Chris

Contact: Pamela
225-6565

3:30 pm -
4:30 pm

4.

INDIAN HEALTH SUMMIT
Location: ???

Staff Contact: Melanne Verveer (456-2538)
Contact: Dick Trudell

*Chris / let him know
collecting
remarks*

(510) 834-9333

5:00 pm -
7:00 pm

HEALTH CARE MTG W/THE PRESIDENT
Location:

Participants:

Contact: Maggie Williams
456-1660

RON

The White House

Interiors

Tom Collier 208-7351

Stephanie Salen

3

Tatton Boggs + Blaw
457-6000
6th Fl
Conf Rm

~~Dick Muddell~~

3:00 p.m.

- List of attendees
- agenda

Info

Boyer
Wilma Markkula
coming in spec for
w/ HPE

Seq. / For / Remarks
will provide a brief stmt

- agenda for summit
- Roster of participants - 30 approx.
-

Hot Spots - are some

Comp. look at health / child & fam
alcohol & drugs abuse

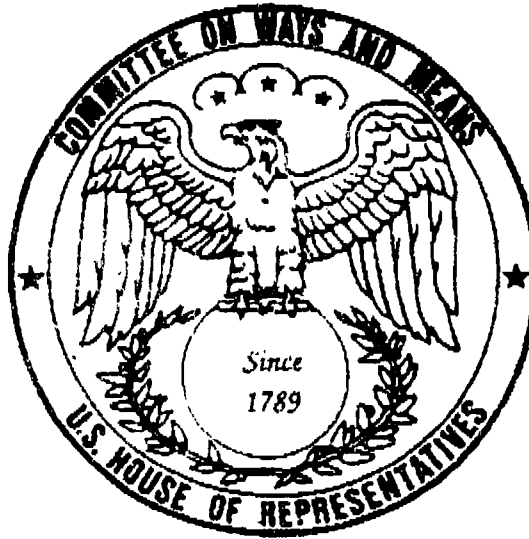
Dr. Gessels Hill

work

local
contact

Patricia (Bell) 22 4-2257

FACSIMILE TRANSMITTAL COVER SHEET



Date: March 15, 1993

To: Julie

From: Tanica Mays, Committee on Ways and Means

Telephone No.: (202) 225-³⁶²⁵~~1721~~

Cover Sheet Plus 24 Page(s) To Follow

Enclosed are the materials you requested for Mrs. Clinton's meeting with our Committee Democrats on Wednesday, March 17 at 8⁰⁰ a.m.

ONE HUNDRED THIRD CONGRESS
DAN ROSTENKOWSKI, ILLINOIS, CHAIRMAN

SAM M. GIBBONS, FLORIDA
J.J. PICKLE, TEXAS
CHARLES B. RANGEL, NEW YORK
FORTNEY PETE STARK, CALIFORNIA
ANDY JACOBS, JR., INDIANA
HAROLD E. FORD, TENNESSEE
ROBERT T. MATSUI, CALIFORNIA
BARBARA B. KENNELLY, CONNECTICUT
WILLIAM J. COYNE, PENNSYLVANIA
MICHAEL A. ANDREWS, TEXAS
FANDER M. LEVIN, MICHIGAN
BENJAMIN L. CARDIN, MARYLAND
JIM McDERMOTT, WASHINGTON
GERALD D. KLECZKA, WISCONSIN
JOHN LEWIS, GEORGIA
J. F. PAYNE, VIRGINIA
RICHARD E. NEAL, MASSACHUSETTS
PETER HOAGLAND, NEBRASKA
MICHAEL R. McNULTY, NEW YORK
MIKE KOPETSKI, OREGON
WILLIAM J. JEFFERSON, LOUISIANA
BILL K. BREWSTER, OKLAHOMA
MEL REYNOLDS, ILLINOIS

BILL ARCHER, TEXAS
PHILIP M. CRANE, ILLINOIS
BILL THOMAS, CALIFORNIA
E. CLAY BRAWN, JR., FLORIDA
DON SUNDQUIST, TENNESSEE
NANCY L. JOHNSON, CONNECTICUT
JIM BUNNING, KENTUCKY
FRED BRANDY, IOWA
AMO HOUGHTON, NEW YORK
WALLY HERBER, CALIFORNIA
JIM McCLERTY, LOUISIANA
MEL HANCOCK, MISSOURI
RICK SANTORUM, PENNSYLVANIA
DAVE CAMP, MICHIGAN

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, DC 20515-8348

March 15, 1993

JANICE MAYS, CHIEF COUNSEL AND STAFF DIRECTOR
CHARLES M. BRAIN, ASSISTANT STAFF DIRECTOR

PHILLIP D. MOSELEY, MINORITY CHIEF OF STAFF

The following is a list of the Democratic Members of the Committee on Ways and Means. The members of the Subcommittee on Health are marked with an asterisk.

Mr. Gibbons
Mr. Pickle
Mr. Rangel
Mr. Stark*
Mr. Jacobs
Mr. Ford
Mr. Matsui
Mrs. Kennelly
Mr. Coyne
Mr. Andrews*
Mr. Levin*
Mr. Cardin*
Mr. McDermott*
Mr. Kleczka*
Mr. Lewis*
Mr. Payne
Mr. Neal
Mr. Hoagland
Mr. McNulty
Mr. Kopetski
Mr. Jefferson
Mr. Brewster
Mr. Reynolds
Mr. Rostenkowski

. . .

SEVENTH DISTRICT

SAM GIBBONS, Democrat, of Tampa, FL; born in Tampa, January 20, 1920, son of Gunby Gibbons and Jessie Kirk Craile Gibbons; educated in public schools of Tampa; received J.D. degree from the University of Florida; named to the University's Hall of Fame and to its honor society, Florida Blue Key; member of Alpha Tau Omega Fraternity; married to the former Martha Hanley; they have three sons—Clifford, born 1950; Mark, born 1952; and Timothy, born 1958; three grandchildren; elected to the Florida House of Representatives in 1952 and served for 6 years; elected to the Florida Senate in 1958 and served for 4 years; named 1 of the top 10 members of each body; named Tampa's Outstanding Young Man of the Year in 1954; received Chamber of Commerce president's sward; Distinguished Alumnus Award, University of Florida in 1973; deacon, First Presbyterian Church of Tampa; first president and member of University of South Florida Foundation; served in U.S. Army 5 years during World War II with 301st Parachute Infantry, 101st Airborne Division; awarded Bronze Star; was in initial assault force landing before D-Day in Europe; took part in other major combat actions, including operations at Bastogne; released from active duty as major; elected to the 88th Congress, November 6, 1962; reelected to each succeeding Congress; member and vice chairman of Ways and Means Committee and chairman of Subcommittee on Trade; member, Joint Committee on Taxation; official U.S. advisor to the General Agreement on Tariffs and Trade.

Office Listings

2204 Rayburn House Office Building, Washington, DC 20515-0907 225-3376
 Chief of Staff.—Janice F. Stoorza.
 Scheduler/Chief Legislative Assistant.—Flora Sullivan.
 Suite 1425, 101 East Kennedy Boulevard, Tampa, FL 33602 (813) 228-2101
 Office Manager.—Gregory F. Wonders.
 201 South Kings Avenue, Brandon, FL 33511 (813) 689-2047
 Staff Assistant.—Lana Luelro.

Hillsborough County: That part not contained in the Ninth District. Population (1980), 512,905.

ZIP Codes: 33303, 33511, 33527 (part), 33530, 33534, 33547, 33550, 33561 (part), 33566 (part), 33569-71, 33584 (part), 33586, 33594 (part), 33598, 33600-04, 33603 (part), 33606-18, 33617 (part), 33618 (part), 33619-23, 33629-31, 33634-35, 33647, 33660-61, 33672-75, 33677, 33679-82, 33684-86, 33688, 33690, 33695, 33697, 33834 (part), 34299

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TENTH DISTRICT

J.J. PICKLE, Democrat, of Austin, TX; born October 11, 1913, Roscoe, Nolan County, TX, son of J.B. and Mary Pickle; educated in public schools of Big Spring, TX; graduate of the University of Texas, B.A. degree; area director, National Youth Administration, 1938-41, resigning to enter Navy during World War II, serving 3½ years in Pacific; after discharge from Navy entered radio business as one of coorganizers of Radio Station KVET, Austin, TX; later entered public relations and advertising business; director of Texas State Democratic Executive Committee, 1957-60; appointed member Texas Employment Commission in 1961, resigning September 27, 1963, to be candidate for the Congress; elected in special election December 17, 1963, to the 88th Congress; reelected to each succeeding Congress; married the former Beryl Bolton McCarroll; three children: Peggy Pickle, Dick McCarroll, and Graham McCarroll.

Office Listings

242 Cannon House Office Building, Washington, DC 20515-4310..... 225-4865
 Administrative Assistant.—Barbara A. Pate.
 Executive Secretary.—Molly S. Mitchell.
 Press Secretary.—Dave Mason.
 762 Federal Building, Austin, TX 78701 (512) 482-5921
 District Administrator.—Paul E. Hilgers.

Counties: Bastrop, Blanco, Caldwell, Hays, and Travis. BURNET COUNTY: The southern half of the county, including the cities of Burnet, Marble Falls, and Granite Shoals. Population (1980), 526,943.

ZIP Codes 73301, 73344, 78600, 78602, 78603 (part), 78606, 78610-12, 78616-17, 78619-20, 78621 (part), 78622, 78632, 78636 (part), 78640, 78641 (part), 78644, 78648 (part), 78650-51, 78654 (part), 78655 (part), 78656, 78659 (part), 78660-63, 78665, 78666 (part), 78667, 78669, 78676, 78700-05, 78710-13, 78716-39, 78741-69, 78771-74, 78776, 78778-79, 78941 (part), 78943 (part), 78953, 78957 (part), 78959 (part)

SIXTEENTH DISTRICT

CHARLES B. RANGEL, Democrat-Liberal-Republican, of New York, NY; born in Harlem, New York, NY, June 11, 1930; attended the public schools in Harlem, P.S. 89 (now P.S. 175), Junior High School 139, and DeWitt Clinton High School; enlisted in the U.S. Army and served from 1948 to 1952; awarded the Purple Heart, Bronze Star for Valor, U.S. and Korean Presidential Citations and three battle stars while serving in combat with the Second Infantry Division in Korea; honorably discharged with rank of staff sergeant; after military duty, completed high school, 1953; graduated from New York University School of Commerce, as dean's list student under the G.I. bill, 1957; graduated from St. John's University School of Law, dean's list student under a full 3-year scholarship, 1960; lawyer; admitted to practice in the courts of the State of New York, U.S. Federal Court, Southern District of New York, and the U.S. Customs Court; appointed assistant U.S. attorney, Southern District of New York, 1961; legal counsel, New York City Housing and Redevelopment Board, Neighborhood Conservation Bureau; general counsel, National Advisory Commission on Selective Service, 1966; served 2 terms in the New York State Assembly, 1966-70; active in 369th Veterans Association, Community Education Program, and Martin Luther King Democrats; married Alma Carter; one son, Steven; one daughter, Alicia; elected to 92d Congress, November 3, 1970; reelected to each succeeding Congress.

Office Listings

2252 Rayburn House Office Building 20510-3216.....	225-4365
Executive Assistant.—Patricia O. Bradley	
Tax Counsel.—Jon Sheiner	
163 West 125th Street, New York, NY 10027.....	(212) 663-3900
District Administrator.—Vivian E. Jones	
601 West 181st Street, New York, NY 10031.....	(212) 927-5333
2110 First Avenue, New York, NY 10029.....	(212) 348-9630

New York County: that part of Manhattan Island north of East 96th Street and West 90th Street, including Central Park, Randall's Island, Roosevelt Island, and Wards Island. Population (1980): 518,033.

ZIP Codes: 10017 (part), 10024 (part), 10025 (part), 10026, 10027 (part), 10028 (part), 10029 (part), 10030, 10031 (part), 10032 (part), 10033 (part), 10034 (part), 10035, 10037, 10039, 10040 (part), 10044-45, 10090, 10128, 10463 (part)

* * *

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NINTH DISTRICT

PORTNEY PETE STARK, Democrat, of Oakland, CA, born in Milwaukee, WI, November 11, 1931; graduated from Wauwatosa, WI, High School, 1949; Massachusetts Institute of Technology, B.S., 1953; University of California, Berkeley, M.B.A., 1960; East Bay Skills Center, Oakland, G.E.D. (honorary), 1972; served in U.S. Air Force, 1955-57, captain; banker, founder, and president, Security National Bank, Walnut Creek, CA, 1963-72; trustee, California Democratic Council; chairman, board of trustees, Starr King School for the Ministry, Berkeley; trustee, Graduate Theological Union, Berkeley; sponsor, Northern California American Civil Liberties Union; director, Common Cause, 1971-72; four children: Jeffrey Peter, Beatrice Ann, Thekla Brumder, and Sarah Gallun; married to Carolyn Wentz; elected to the 93d Congress, November 7, 1972; reelected to each succeeding Congress.

Office Listings

135 Cannon House Office Building, Washington, DC 20515-0509 225-5065
 Administrative Assistant.--William K. Vaughan.
 Personal Assistant.--Ella M. Mumford.
 Press Assistant.--Perry R. Plumart.
 Suite 500, 22320 Foothill Boulevard, Hayward, CA 94541 (415) 635-1092
 District Administrator.--Debbie Lyons.

Alameda County: Communities of Alameda, Castro Valley, Dublin, Hayward, Livermore, Pleasanton, San Leandro, San Lorenzo, Union City, cities of Oakland (part) and Union City (part). Population (1990), 1,214,961.

TENTH DISTRICT

ANDREW JACOBS, JR., Democrat, of Indianapolis, IN; born in Indianapolis, IN, February 24, 1932; graduated from Shortridge High School, 1949; duty, U.S. Marine Corps, combat infantry in Korea in 1951; Indiana University, B.S. 1955; L.L.B., 1958; practiced law 1958-65, 1973-74; married to Kim Hood Jacobs; one son, H.B. James Andrew (Andy) born August 31, 1989; member: Indiana House of Representatives, 1959-60; elected to the 89th Congress; reelected to each succeeding Congress; reelected to each succeeding Congress.

Office Listings

2313 Rayburn House Office Building, Washington, DC 20515-1410 225-4011
 Administrative/Legislative Assistant.—David Seyre Wildes.
 Appointment Secretary.—Deborah McGinn.
 Staff Assistants.—Patricia Roberson; Marjorie Guggenheims.
 Office Manager/Personal Secretary.—Phyllis E. Coelho.
 Room 441-A, 46 East Ohio Street, Indianapolis, IN 46204 (317) 226-7331
 District Office Manager.—Loretta Raikes.

Marion County: City of Indianapolis (part), townships of Center and Decatur, parts of the townships of Lawrence, Perry, Pike, Warren, Washington, and Wayne, included in the towns of Speedway and the cities of Beech Grove (part) and Lawrence (part). Population (1980), 341,332.

ZIP Codes: 46107 (part), 46113 (part), 46183, 46200-02, 46203 (part), 46204, 46205 (part), 46206, 46208, 46214 (part), 46216, 46217 (part), 46218, 46219 (part), 46220 (part), 46221-23, 46224 (part), 46225, 46226 (part), 46227 (part), 46231 (part), 46233 (part), 46236 (part), 46237 (part), 46239 (part), 46241, 46244, 46251, 46254 (part), 46255, 46260 (part), 46266, 46268 (part), 46277, 46278 (part), 46283, 46285, 46291.

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Congressional Directory

TENNESSEE

NINTH DISTRICT

HAROLD E. FORD, Democrat, of Memphis, TN; born in Memphis, May 20, 1945; son of Newton J. and Vera Ford; received M.B.A., business administration, Howard University; B.S., business administration, Tennessee State University, Nashville, 1967; graduate work, Tennessee State University, Nashville, 1968; John Gupton Mortuary, 1969; member of Tennessee House of Representatives: 87th Congress, ways and means committee; majority whip for house secretary of rules committee, 88th Congress; chairman, special legislative committee to investigate rates and practices of utilities across the State; married Dorothy Bowles Ford, 1969; three children: Harold, Jr., Newton, and Sir Isaac; Baptist, member of Mount Moriah Baptist Church; member, St. Jude Children's Research Hospital; National Advisory Board and metropolitan board of directors, YMCA of Memphis; trustee, Rust College; trustee, Pisk University; elected to 94th Congress, November 5, 1974; reelected to each succeeding Congress; member of Ways and Means and Select Committee on Aging; chairman, Ways and Means Subcommittee on Human Resources.

Office Listings

2305 Rayburn House Office Building, Washington, DC 20515-4209..... 225-3265
 Senior Legislative Assistant.—David Warr. FAX: 225-9215
 Legislative Director.—Seth Berger
 Office Manager.—Bernadette Connor.
 Press Secretary.—Gayla Kirksey.
 Federal Office Building, Suite 369, 167 North Main Street, Memphis, TN
 38103..... (901) 544-4131
 District Office Administrator.—Mildred Horne.
 193 West Mitchell Road, Memphis, TN 38109..... (901) 544-4141

Shelby County: That part not contained in the Seventh and Eighth Districts. Population (1980), 504,846.

ZIP Codes: 38100-01, 38103, 38104 (part), 38105-06, 38107 (part), 38109, 38111-14, 38116 (part), 38117, 38119 (part), 38122, 38124, 38126, 38128 (part), 38131-32, 38133, 38173-74, 38182, 38186

* * *

THIRD DISTRICT

ROBERT T. MATSUI, Democrat, of Sacramento, CA; born in Sacramento, CA, September 17, 1941; attended the public schools; graduated, C.K. McClatchy High School, 1959; A.B., University of California, Berkeley, 1963; J.D., Hastings College of Law, University of California, 1966; admitted to the California Bar in 1967 and commenced practice in Sacramento; Sacramento City Council, District 8, 1971-75; reelected, 1975-78; chairman, budget-finance committee, 1976-78; vice mayor, 1977; chairman, law and legislative committee, 1978; chairman, U.S. Congressman John E. Moss reelection campaign committee; member, California Democratic Central Committee, 1973-78; president, Active 20-30 Club, 1972; vice president, Sacramento Safety Council; board member, United Crusade and Sacramento Rotary Club; officer and director, Sacramento Metropolitan Chamber of Commerce; Jaycee Young Man of the Year, 1973; married to the former Doris K. Okada, 1966; one child, Brian Robert; elected to the 96th Congress, November 7, 1978; reelected to each succeeding Congress; member, Ways and Means Committee.

Office Listings

2353 Rayburn House Office Building, Washington, DC 20515-0503 225-7163
 Administrative Assistant.—Neil Dhillon. FAX: 225-0566
 Press Secretary.—Tom Keaney.
 Executive Assistant.—Shirley Queja.
 8058 Federal Building, 630 Capitol Mall, Sacramento, CA 95814 (916) 551-2846
 District Director.—Collette Johnson/Skulke.

City of Sacramento, Sacramento County: That part not contained in the Fourth District. Population (1980), 525,784.

ZIP Codes: 95223 (part), 95608-09, 95610 (part), 95621 (part), 95624 (part), 95628, 95630 (part), 95655, 95662 (part), 95670, 95683, 95693 (part), 95800 (part), 95801-12, 95814, 95816-20, 95821 (part), 95822-24, 95825 (part), 95826-32, 95838 (part), 95841 (part), 95842, 95860, 95864-66

REPRESENTATIVES

FIRST DISTRICT

BARBARA B. KENNELLY, Democrat, of Hartford, CT; born in Hartford, July 10, 1936; daughter of John M. and Barbara Leary Bailey; graduated, Mount St. Joseph Academy, West Hartford, CT; B.A., economics, Trinity College, Washington, DC; certificate

of completion, Harvard-Radcliffe Program in Business Administration, Harvard Business School, Cambridge, MA; masters degree in government, Trinity College, Hartford; honorary doctorates: Sacred Heart University, Bridgeport, CT, 1981; Mount Holyoke College, South Hadley, MA, 1984; University of Hartford, West Hartford, CT, 1985; St. Mary's College, Notre Dame, IN, 1986; served: Secretary of the State of Connecticut, 1979-82; Hartford Court of Common Council, 1975-79; member: board of trustees, Trinity College, Hartford, CT; member: House Ways and Means Committee and its Subcommittees on Select Revenue Measures and Human Services; House Permanent Select Committee on Intelligence; married James J. Kennelly; four children: Eleanor Bride, Barbara Leary, Louise Moran, and John Bailey; elected to the 97th Congress, January 12, 1982; reelected to each succeeding Congress.

Office Listings

204 Cannon House Office Building, Washington, DC 20515-0701..... 225-2255
 Administrative Assistant.—Michael Prucker. FAX: 225-1031
 Appointment/Personal Secretary.—Emma Lee Harrell.
 One Corporate Center, Hartford, CT 06103..... (203) 278-8488
 District Director.—Robert Croce.
 District Caseworker.—Gerald Martin.

Hartford County: Towns of Berlin, Bloomfield, East Hartford, East Windsor, Glastonbury, Hartford, Manchester, Marlborough, Newington, Rocky Hill, South Windsor, West Hartford, Wethersfield, and Windsor. MIDDLESEX COUNTY: Towns of Cromwell, East Hampton, and Portland. TOLLAND COUNTY: Town of Hebron. Population (1980), 514,237.

FOURTEENTH DISTRICT

WILLIAM J. COYNE, Democrat, of Pittsburgh, PA; born in Pittsburgh, PA, August 24, 1936; graduated, Central Catholic High School, Pittsburgh, 1954; graduated, Robert Morris College, Pittsburgh, PA; served in U.S. Army, 1955-57, Korea; member: Pennsylvania State Legislature, 1970-72; Pittsburgh City Council, 1974-80, Pittsburgh Housing Authority, and Governor's Justice Commission; chairman, public works committee; board member: OIC [Opportunities Industrialization Center]; elected to the 97th Congress, November 4, 1980; reelected to each succeeding Congress; member, House Ways and Means Committee (Health Subcommittee, Subcommittee on Select Revenue Measures); Democratic Study Group, Congressional Steel Caucus, Environmental and Energy Study Conference, and serves on the Steering Committee for the Northeast-Midwest Congressional Coalition; he is also a member of the Congressional Human Rights Caucus.

Office Listings

2455 Rayburn House Office Building, Washington, DC 20515-3814 225-2301
 Administrative Assistant.—Coleman J. Conroy. FAX: 225-1844
 3009 Federal Building, 1009 Liberty Avenue, Pittsburgh, PA 15222 (412) 644-2870
 District Administrator.—James P. Rooney.

Allegheny County: City of Pittsburgh: townships of Baldwin, Kennedy, Neville, Reserve, and Stowe; boroughs of Castle Shannon, Coraopolis, Ingram, McKees Rocks, Millvale, Mt. Oliver, Sharpsburg, and Wilkinsburg. Population (1980): 516,611.

ZIP Codes: 15106 (part), 15108 (part), 15136 (part), 15201, 15203-04, 15205 (part), 15206-09, 15210 (part), 15211-15, 15216 (part), 15217, 15218 (part), 15219, 15220 (part), 15221 (part), 15222, 15224-25, 15226 (part), 15230, 15232-33, 15240, 15242 (part), 15245, 15290, 15299

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TWENTY-FIFTH DISTRICT

MICHAEL A. ANDREWS, Democrat, of Houston, TX; born in Houston, TX, February 7, 1944; attended the public schools of Fort Worth, TX; graduated from Arlington Heights High School, 1962; B.A., University of Texas, Austin, TX, 1967; J.D., Southern Methodist University School of Law, Dallas, TX, 1970; admitted to the Texas Bar, 1971; law clerk for U.S. district judge for the Southern District of Texas, 1971-72; assistant district attorney, Harris County, TX, 1972-76; commenced private practice in Houston, 1976; member: State Bar of Texas, Houston and American Bar Associations; member: St. John's Episcopal Church; married to former Ann Bowman of Houston, TX; two daughters: Caroline and Emily; elected to the 98th Congress, November 2, 1982; reelected to each succeeding Congress; serves on Ways and Means Committee; member, Congressional Caucus on Competitiveness, the Congressional Hispanic Caucus, Congressional Caucus for Women's Issues, Congressional Caucus on Soviet Jewry, and the Congressional Space Caucus; serves on Subcommittee on Select Revenue Measures and Subcommittee on Human Resources.

Office Listings

303 Cannon House Office Building, Washington, DC 20515-4325 225-7506
 Chief of Staff.—Ann Rowan. FAX: 225-4210
 Administrative Assistant.—Andrea LaRue.
 Press Secretary.—Jeff Patterson.
 Executive Assistant.—Lori Huffman.
 Federal Building, Suite 12102, 515 Rusk Street, Houston, TX 77002 (713) 229-2244
 Suite 810, 1001 East Southmore, Pasadena, TX 77504 (713) 473-4334

Harris County: That part not contained in the Seventh, Eighth, Ninth, Eighteenth, or Twenty-Second Districts.
 Population (1990), 526,801.

ZIP Codes: 77004 (part), 77005 (part), 77012 (part), 77017 (part), 77021 (part), 77025, 77030, 77033, 77034 (part),
 77035 (part), 77045 (part), 77047-48, 77051, 77053 (part), 77054 (part), 77058 (part), 77059, 77061, 77062 (part),
 77075 (part), 77083 (part), 77087 (part), 77096 (part), 77209, 77217, 77225, 77231, 77233-35, 77243, 77254, 77265,
 77279, 77282, 77289, 77501-04, 77536, 77571, 77586-87

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SEVENTEENTH DISTRICT

SANDER M. LEVIN, Democrat, of Southfield, MI; born in Detroit, MI on September 6, 1931, attended Roosevelt Elementary School and Durfee Intermediate School, Detroit, MI; graduated, Central High School, Detroit, 1949; B.A., University of Chicago, 1952; M.A., Columbia University, New York, NY, 1954; LL.B., Harvard University, Cambridge, MA, 1957; attorney, admitted to the Michigan Bar in 1955 and commenced practice in Detroit, MI; member, Oakland Board of Supervisors, 1961-64; elected to Michigan Senate, 1965-70; Democratic floor leader in State senate; served on the Advisory Committee on the Education of Handicapped Children in the Department of Health, Education, and Welfare, 1965-68; chairman, Michigan Democratic Party, 1968-69; Democratic candidate for Governor, 1970 and 1974; fellow, Kennedy School of Government, Institute of Politics, Harvard University, 1973; assistant administrator, Agency for International Development, 1977-81; married to the former Victoria Schläfer, 1957; four children: Jennifer, Andrew, Madeleine, and Matthew; elected on November 2, 1982 to the 98th Congress; reelected to each succeeding Congress.

Office Listings

323 Cannon House Office Building, Washington, DC 20515-2217..... 225-4961
 Administrative Assistant.—Kitty Higgins
 Legislative Director.—John Griffin
 Press Secretary.—Cynthia Mann
 North Park Plaza Office Building, Suite 1120, 17117 West Nine Mile Road, Southfield, MI 48075 (313) 559-4444
 District Administrator.—Susan Miller

Oakland County: Cities of Berkley, Clawson, Ferndale, Huntington Woods, Lathrup Village, Oak Park, Pleasant Ridge, Royal Oak, and Southfield; Madison Heights City, that part beginning at the north city limits and I-75.

thence south on I-75 to 12 Mile, east to Alger, south to Dicing, east to John R., south to Katherine, west to Brush, south to Brown, east to John R., south to Gardenia, west to Brush, south to Royal Park, west to Palmer, south to Forest, west to Barrington, south to Farnum, west to Brittenwood, north to Forest, west to Hampden, south to 11 Mile, west to city limits, north, west, north, and east along city limits to the point of beginning; township of Royal Oak, WAYNE COUNTY: City of Inkster; Dearborn Heights City, that part beginning at the southern Dearborn City limits and Dearborn Heights City limits and Dudley, thence south on Dudley to Elton, east to William, south to Powers, west to Katherine, south to Hanover, west to Monroe, south on Monroe to Dearborn Heights southern city limits, beginning going west along city limits to the point of beginning; Detroit City, that part beginning at the north city limits and Evergreen, thence south on Evergreen to Santa Clara, east to Edinborough, north to Curtis, east to Huntington, south to Santa Clara, east to Grandville, south to Outer Drive, east to Warvel, south to McNichols, east to Southfield, south to Jeffries Freeway, west to Evergreen, south to Joy Road, west to city limits, beginning going north along city limits to the point of beginning; Redford Township, Population (1980), 514,560.

ZIP Codes: 48017, 48034, 48037, 48067-70, 48071 (part), 48072-73, 48075-76, 48080, 48127, 48128 (part), 48141, 48219 (part), 48220, 48221 (part), 48223, 48228 (part), 48237, 48239 (part), 48240

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THIRD DISTRICT

BENJAMIN L. CARDIN, Democrat, of Baltimore, MD, born in Baltimore, October 5, 1943; attended Baltimore public schools; graduated Baltimore City College, 1961; B.A., University of Pittsburgh, PA, 1964 (cum laude); LL.B., University of Maryland, Baltimore, 1967 (1st in class); attorney; admitted to Maryland Bar November 1967 and began practice in Baltimore; member of the Maryland House of Delegates, 1966-86; Speaker of House of Delegates, 1979-86; chairman, Ways and Means Committee, 1975-78; vice-chairman, Ways and Means Committee, 1971-73; member, Presidential Advisory Committee on Federalism; chairman, State Federal Assembly, National Council of State Legislators, 1980-81; member, National Council of State Legislators, Executive Committee; member, Council of State Governments, Executive Committee, 1979-86; co-chairman, Legislative Policy Committee, Maryland General Assembly, 1979-86; trustee, Baltimore Museum of Art; member, Baltimore Jewish Community Relations Council; trustee, Baltimore Council on Foreign Affairs; member, Associated Jewish Charities Welfare Fund; board of trustees, University of Maryland Alumni Association-International; trustee, St. Mary's College; chairman, Maryland Legal Services Corporation; Maryland Psychiatric Society's Friend of Psychiatry Award, 1988; Common Cause of Maryland Ann Hogan Memorial Award, 1987; Waterfront Workers of Baltimore, Public Service Achievement Award, 1987; MACO Legislator of the Year Award, 1984; Hadassah Award, 1981; Dr. Herman Seidel Humanitarian Award, Histradut, 1980; B'nai B'rith Menorah Lodge Award, Save-a-Heart Humanitarian Award, 1975; William Strobe Thomas Award for the Highest Academic Achievement at the University of Maryland School of Law; Order of the Coif, a National Honor Society Award; Omicron Delta Epsilon Economic Honorary Award; married to the former Myrna Edelman, 1966; two children, Michael and Deborah; elected to the 100th Congress, November 4, 1986; reelected November 8, 1988.

Office Listings

117 Cannon House Office Building, Washington, DC 20515-2003..... 225-4016
 Administrative Assistant.—David Koshgarian.
 Scheduler/Office Manager.—Marli Helmann.
 Press Secretary.—Dawana McVitt.
 Suite 201, 340 East Belvidere Avenue, Baltimore, MD 21212..... (301) 431-8886
 District Office Director.—Balley Fine.

City of Baltimore: Wards 1-3 and 21-26; ward 4, precinct 1; ward 6, precincts 6-7; ward 8, precincts 1-3; ward 9, precincts 7; ward 27, precincts 2-40, 59-62, 65-91, and 102-108; ward 28, precinct 1. BALTIMORE COUNTY: Election district 13; election district 1, precincts 7-16; election district 2, precincts 9-10, 13 and 14; election district 3, precincts 2-12; election district 9, precincts 1, 3, 4, and 12-16. HOWARD COUNTY: Election district 1; election district 5, precincts 2-4 and 7-10; election district 6, precincts 3, 4, and 6-14. Population (1980), 527,804.

ZIP Codes: 21021, 21043 (part), 21045 (part), 21046 (part), 21055, 21076 (part), 21117 (part), 21133 (part), 21200 (part), 21204 (part), 21206 (part), 21207 (part), 21208 (part), 21209 (part), 21210 (part), 21211 (part), 21212 (part), 21213 (part), 21214, 21215 (part), 21218 (part), 21220 (part), 21222 (part), 21223 (part), 21224 (part), 21225 (part), 21226 (part), 21227, 21228 (part), 21229 (part), 21230-31, 21234 (part), 21236 (part), 21237 (part), 21239 (part)

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SEVENTH DISTRICT

JIM McDERMOTT, Democrat, of Seattle, WA; born in Chicago, Cook County, IL, on December 28, 1936; attended public schools in Downers Grove, IL; B.S., Wheaton College, Wheaton, IL, 1958; M.D., University of Illinois Medical School, Chicago, 1963; residency in adult psychiatry, University of Illinois Hospitals, 1964-66; residency in child psychiatry, University of Washington Hospitals, Seattle, 1966-68; served, U.S. Navy

Medical Corps, lieutenant commander, 1968-70; psychiatrist; elected to Washington State House of Representatives, 1970-72; elected to Washington State Senate, 1974-87; Democratic nominee for Governor, 1980; regional medical officer, U.S. Foreign Service, 1987-88; practicing psychiatrist and assistant clinical professor of psychiatry, University of Washington, Seattle, 1970-83; member: Washington State Arts Commission; Washington Council for Prevention of Child Abuse and Neglect; Executive Committee and Education Committee of the National Conference of State Legislatures; Washington State Medical Association; King County Medical Society; American Psychiatric Association; St. Mark's Episcopal Church, Seattle; two grown children: Katherine and James; elected on November 8, 1988, to the 101st Congress; reelected to the 102d Congress, November 6, 1990; member: Committee on Ways and Means; Committee on District of Columbia.

Office Listings

1707 Longworth House Office Building, Washington, DC 20515-4707 225-3106
 Administrative Assistant.—Charles M. Williams.
 Executive Assistant.—Wilda E. Chisolm.
 Legislative Assistant.—Dick Van Wageningen.
 Tower Building, 1809 7th Avenue, Seattle, WA 98101-1313 (206) 353-7170
 District Manager.—Nancy F. James.

King County (part): This part beginning by proceeding south on Lake Washington, counterclockwise around Mercer Island to May Creek (north Renton); east, southeast and east on May Creek to extension of 132d Avenue SE; south on extension of 132d Avenue SE to Union Avenue NE; south on Union Avenue NE to Northeast 4th Street; east on Northeast 4th Street to Southeast 12th Street; east on Southeast 12th Street to 154th Avenue SE; south on 154th Avenue SE to Southeast 142d Place; southwest on Southeast 142d Place to 154th Place SE (Orting Road); southwest on 154th Place SE (Orting Road) to Southeast Jones Road; northwest on Southeast Jones Road to 149th Avenue SE; south on 149th Avenue SE to Southeast Renton-Maple Valley Highway (SR 169); west on Southeast Renton-Maple Valley Highway to 140th Place SE; southeast and southwest on 140th Place SE to 140th Avenue SE; south on 140th Avenue SE to Pipeline R/O/W (eastward extension of Southeast 144th Street, just south and parallel to Southeast Fairwood Boulevard), northwest on pipeline to 116th Avenue SE; south on 116th Avenue SE to Southeast 196th Street; east on Southeast 196th Street to 122d Avenue SE; south on 122d Avenue SE to Southeast 198th Place; east on Southeast 198th Place to Southeast 199th Street; east on Southeast 199th Street to 124th Avenue SE; south on 124th Avenue SE to Southeast 208th Street; west on Southeast 208th Street to 100th Avenue SE; south on 100th Avenue SE to Southeast 140th Street; west on Southeast 140th Street to 94th Avenue South; south on 94th Avenue South to Kent-Kingley Road (Canyon Drive SE); southeast on Kent-Kingley Road to 97th Place South (Crow Road); southeast on 97th Place South (Crow Road) to Southeast 164th Street; east on Southeast 164th Street to 108th Avenue SE; south on 108th Avenue SE to Southwest 28th Street; east on Southeast 28th Street to 112th Avenue SE; south on 112th Avenue SE to unnamed creek (north line of tracts 30-34 and 37 of the plat of "Crestview Tract" and tracts 27-29 of the plat of "Crestview Tract Division No. 27"); west on unnamed creek to Green River; north on Green River to northeast extension of 52d Street NE; southwest on extension and west on 52d Street NE to South 277th Street; west on South 277th Street to Star Lake Road; west on Star Lake Road to 42d Avenue South; north on 42d Avenue South to South 272d Street; west on South 272d Street to 1-3; north on 1-3 to South 188th Street; west on South 188th Street to 12th Place South; northwest on 12th Place South to Des Moines Way South; northwest and north on Des Moines Way South to South 176th Street; east on South 176th Street to 12th Avenue South; north on 12th Avenue South to South 160th Street; west on South 160th Street to 1st Avenue South (State Highway 309); north on 1st Avenue South to Southwest 146th Street; west on Southwest 146th Street to 14th Avenue SW; north on 14th Avenue SW to Southwest 144th Place; southwest on Southwest 144th Place to Southwest 146th Street; west on Southwest 146th Street to 21st Avenue SW; south on 21st Avenue SW to Southwest 132d Street; west on Southwest 132d Street to Maplewild Avenue SW; southwest and south on Maplewild Avenue SW to Southwest 156th Street; northwest on Southwest 156th Street to Maplewild Avenue SW; south on Maplewild Avenue SW to Southwest 163d Place; northwest on Southwest 163d Place to Puget Sound; north through Puget Sound to King/Kitsap county line; north on King/Kitsap county line to a point west of Elliott Bay; east into Elliott Bay to extension of West Roy Street; northeast on extension and West Roy Street to West Mercer Place; southeast on West Mercer Place to 6th Avenue West; north on 6th Avenue West to West Olympic Place; northwest on West Olympic Place to 9th Avenue West; north on 9th Avenue West to Olympic Way West; northwest on Olympic Way West to 10th Avenue West; north on 10th Avenue West to West Galer Street; west on West Galer Street to 11th Avenue West; north on 11th Avenue West to West Blaine Street; west on West Blaine Street to 12th Avenue West; north on 12th Avenue West to West Howe Street; east on West Howe Street to 11th Avenue West; north on 11th Avenue West to Olman Avenue West; northwest on Olman Avenue West to 14th Avenue West; north on 14th Avenue West to West Nickerson Street; southwest on West Nickerson Street to Ballard Bridge (15th Avenue NW); north on Ballard Bridge to Salmon Bay Waterway; northwest through Salmon Bay Waterway to 24th Avenue NW; north on 24th Avenue NW to Northwest 70th Street; east on Northwest 70th Street to 21st Avenue NW; north on 21st Avenue NW to Northwest Canoe Place; east on Northwest Canoe Place to 20th Avenue NW; north on 20th Avenue NW to Northwest 25th Street; east on Northwest 25th Street to 14th Avenue NW; north on 14th Avenue NW to Holmes Road North; northeast on Holmes Road North to North 105th Street; east on North 105th Street to Fremont Avenue North; north on Fremont Avenue North to North 107th Street; east on North 107th Street to Meridian Avenue North; south on Meridian Avenue North and extension to Northeast 100th Street; east on Northeast 100th Street to 1st Avenue NE; north on 1st Avenue NE to Northeast 103d Street; east on Northeast 103d Street to 5th Avenue NE; south on 5th Avenue NE to Northeast 100th Street; east on Northeast 100th Street to Lake City Way NE; southwest on Lake City Way NE to Northeast 85th Street; east on Northeast 85th Street to 20th Avenue NE; south on 20th Avenue NE to Northeast 79th Street; east on Northeast 79th Street to 35th Avenue NE; south on 35th Avenue NE to Northeast 65th Street; west on Northeast 65th Street to 29th Avenue NE; south on 29th Avenue NE to Northeast 55th Street; east on Northeast 55th Street to 30th Avenue NE; south on 30th Avenue NE to Union Bay Place NE; southeast on Union Bay Place NE to Northeast 41st Street; east on Northeast 41st Street to extension of 38th Avenue NE; south on 38th Avenue NE, extended to Union Bay; south and east through Union Bay to Lake Washington, the point of beginning. Population (1980) 513,793.

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FOURTH DISTRICT

GERALD D. KLECZKA, Democrat, of Milwaukee, WI; born in Milwaukee, WI, November 26, 1943; graduated Don Bosco High School, Milwaukee, 1961; attended University of Wisconsin, Milwaukee; served in the Wisconsin Air National Guard, 1963-69; served in Wisconsin Assembly, 1969-74; Wisconsin Senate, 1975-84; member: Environmental and Energy Study Conference, Congressional Caucus for Women's Issues, Congressional Arts Caucus, Congressional Hispanic Caucus, Arms Control and Foreign Policy caucus, Northeast-Midwest Congressional Coalition, Democratic Study Group.

LaFarge Lifelong Learning Institute, Thomas More Foundation, Polish National Alliance-Milwaukee Society, Polish American Congress, 19th Assembly District Democratic Party Unit, State and Milwaukee County Democratic Party; married to the former Bonnie L. Scott, 1978; elected by special election, April 3, 1984, to the 98th Congress; reelected to each succeeding Congress.

Office Listings

126 Cannon House Office Building, Washington, DC 20515-4904..... 225-4572
 Administrative Assistant.—Brian M. Doherty.
 Legislative Director.—Ron Bookbinder.
 Press Secretary.—Pamela S. Moen.
 5032 West Forest Home Avenue, Milwaukee, WI 53219..... (414) 297-1140
 Wisconsin Director.—Kathryn Hein.
 617 Clinton Street, Waukesha, WI 53186..... (414) 549-6360

Milwaukee County: Cities of Cudahy, Franklin, Greendale, Oak Creek, St. Francis, South Milwaukee, West Allis, and Milwaukee, that part lying south of a line commencing where the East-West Freeway (highway I-94) intersects the western city limits; thence easterly on Highway I-94, downriver along the Menomonee River, upriver along the Milwaukee River, east on East Juncus Avenue, south on North Van Buren Street, east on East State Street, south on North Cass Street, and easterly on East Kilbourn Avenue and East Kilbourn Avenue extended to Lake Michigan; villages of Greendale, Hales Corners, and West Milwaukee. WAUKESHA COUNTY: Cities of Muskego, New Berlin, and Waukesha, that part lying south of a line commencing where the right-of-way of the M.S.P. & S.S.M. R.R. intersects the northern city limits; thence southerly along the right-of-way of the M.S.P. & S.S.M. R.R., easterly on Morland Boulevard, north on Murray Avenue, east on Catherine Street, north on Highland Avenue, easterly on Josephine Street, northerly on Cardinal Drive, east on Atlanta Drive, and northeasterly on Empire Drive and Wolf Road to the northern city limits; towns of Vernon and Waukesha; village of Big Bend. Population (1980), 522,880.

ZIP Codes: 53072 (part), 53103, 53110, 53129, 53130 (part), 53132, 53146, 53149 (part), 53150-51, 53154, 53172, 53186 (part), 53187-88, 53193, 53202 (part), 53204, 53207, 53214 (part), 53215, 53219-21, 53227-28, 53233

FIFTH DISTRICT

JOHN LEWIS, Democrat, from Atlanta, GA; born in Pike County, AL on February 21, 1940; attended Dunn's Chapel Elementary School, Troy, AL; graduated Banks Junior High School and Pike County Training School, Brundidge, AL, 1957; B.A., American Baptist Theological Seminary, Nashville, TN, 1961; B.A., Fisk University, Nashville, TN, 1963; civil rights leader; elected to the Atlanta City Council, 1982-86; member: Martin Luther King Center for Social Change, African American Institute, Robert F. Kennedy Memorial; married to the former Lillian Miles in 1968; one child: John Miles Lewis; elected to the 100th Congress on November 4, 1986; reelected to each succeeding Congress.

Office Listings

329 Cannon House Office Building, Washington, DC 20515-1005..... 225-3801
 Administrative Assistant:—Linda Earley Chastang..... FAX: 225-0351
 Legislative Assistants: Kim Caskin, John Franklin.
 The Equitable Building, Suite 750, 100 Peachtree Street SW., Atlanta, GA
 30303..... (404) 659-0116
 District Manager:—Michael Oerman.

De Kalb County: City of Atlanta (that part within the county), also the southwest quarter of unincorporated De Kalb County. **Fulton County**: City of Atlanta (all except a portion of Northeast Atlanta), East Point, Palmetto, Roswell, Sandy Springs, (western half), Union City (eastern half), and the southwest part of unincorporated Fulton County. Population (1980), 550,070.

ZIP Codes: 30049 (part), 30075 (part), 30213 (part), 30268 (part), 30272, 30286 (part), 30291 (part), 30301-03, 30305 (part), 30306 (part), 30307 (part), 30308-10, 30311 (part), 30312-15, 30316 (part), 30317-18, 30319 (part), 30321, 30326 (part), 30327, 30328 (part), 30330-32, 30334, 30336, 30337 (part), 30338 (part), 30343-44, 30350 (part), 30354 (part), 30355, 30357, 30361, 30364, 30377, 30379.

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FIFTH DISTRICT

LEWIS F. PAYNE, Jr., Democrat, of Nellysford, VA; born in Amherst, Amherst County, VA, on July 9, 1945; attended Amherst Elementary School, VA; graduated, Amherst High School, 1963; B.S., Virginia Military Institute, Lexington, 1967; M.B.A., University of Virginia, Charlottesville, 1973; served, U.S. Army, 1st Lt., 1969-70; served, U.S. Army Reserve, 1st Lt., 1971-73; businessman; president, Wintergreen Development, Inc., 1976-83; chairman of the board, Wintergreen Development, Inc., 1983-88; member, Urban Land Institute; Nelson County Community Development Foundation; Young President Organization; Economic Development Commission; board of directors: Piedmont Virginia Community College Foundation; University of Virginia Real Estate Foundation; Nelson County Chamber of Commerce; Greater Charlottesville Area Development Corporation; married to the former Susan King, 1980; four children: Graham F., Hunter E., Sara V., and Anne E.; elected to the 100th Congress by special election, June 14, 1988, to fill the vacancy caused by the death of Dan Daniel; reelected on November 8, 1988 to the 101st Congress; reelected to the 102d Congress, November 6, 1990.

Office Listings

1118 Longworth House Office Building, Washington, DC 20513-4603 225-4711
 Administrative Assistant.—Jim Johnson. FAX: 226-1147
 Legislative Director.—Terry C. Hoye
 Communications Director.—Ellis Woodward.
 Scheduler.—Dunna Watson.
 301 Post Office Building, Danville, VA 24541 (804) 792-1280
 103 South Main Street, Farmville, VA 23901 (804) 392-8331
 Highway 664-W, P.O. Box 256, Nellysford, VA 22938 (804) 363-1558

Cities: Appomattox, Bedford, Buckingham, Campbell, Carroll, Charlotte, Cumberland, Fluvanna, Franklin, Halifax, Henry, Lunenburg, Mecklenburg, Nelson, Patrick, Pulaski, and Prince Edward. CITIES: Bedford, Danville, Martinsville, and South Boston. CITY OF LYNCHBURG: That part not contained in the Sixth District. Population (1980), 330,988.

ZIP Codes: 22920 (part), 22921 (part), 22928 (part), 22942 (part), 22949, 22951 (part), 22952 (part), 22954, 22958, 22963-64, 22967 (part), 22969 (part), 22971, 22974 (part), 22976, 23004, 23012, 23017, 23038 (part), 23040, 23055, 23081 (part), 23084, 23121, 23122, 23801, 23811, 23819, 23816 (part), 23817, 23819 (part), 23820 (part), 23821, 23912-24, 23927, 23934-44, 23947, 23950, 23952, 23954, 23957-60, 23962-64, 23966-68, 23970, 23973-74, 23976, 24053-55, 24059 (part), 24068, 24067, 24069, 24076-78, 24079 (part), 24082, 24088-89, 24092, 24095, 24101 (part), 24102, 24104, 24105 (part), 24112-15, 24120 (part), 24121-22, 24133, 24137, 24139, 24146, 24148, 24151, 24161, 24165, 24168, 24171, 24174, 24176 (part), 24177-78, 24179 (part), 24184-85, 24312 (part), 24317, 24325, 24328, 24333 (part), 24343, 24348 (part), 24351-52, 24380 (part), 24381, 24464, 24501 (part), 24502 (part), 24503 (part), 24517, 24520, 24521 (part), 24522-23, 24526-31, 24534-36, 24538-41, 24549-51, 24553 (part), 24554, 24556-58, 24563-66, 24568-71, 24576-77, 24580-81, 24583-86, 24588-89, 24590 (part), 24597-94, 24596-99

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SECOND DISTRICT

RICHARD E. NEAL, Democrat, of Springfield, MA; born in Springfield, on February 14, 1949; attended public school system, Springfield; graduated, Springfield Technical High School, 1968; B.A., American International College, Springfield, 1972; M.A., University of Hartford Barney School of Business and Public Administration, CT, 1976; instructor and lecturer; assistant to mayor of city of Springfield, 1973-78; elected member of Springfield City Council, 1978-84; elected mayor, city of Springfield, 1984-88; member: Massachusetts Mayors' Association; Adult Education Council; American International College Alumni Association; Boys' Club Alumni Association; Emily Bill Athletic Association; Cancer Crusade; John Boyle O'Reilly Club; United States Conference of Mayors; Valley Press Club; Solid Waste Advisory Committee for the State of Massachusetts; Committee on Leadership and Government; Mass Jobs Council; trustee: Springfield Libraries and Museums Association; Springfield Red Cross, Springfield YMCA; married to the former Maureen Conway; four children: Rory Christopher, Brendan Conway, Mauru Katherine, and Sean Richard; elected on November 8, 1988, to the 101st Congress; reelected to the 102d Congress, November 6, 1990.

Office Listings

437 Cannon House Office Building, Washington, DC 20515-2102..... 225-5601
 Administrative Assistant.—Morgan Broman. FAX: 225-8112
 Executive Assistant.—Ann Brozek.
 Press Secretary.—Bill Tringese.
 Federal Building, Room 309, 1530 Main Street, Springfield, MA 01103-1422... (413) 785-0325
 District Manager.—James Leydon.
 881 Main Street, Fitchburg, MA 01420-1000..... (508) 342-8722

Hampden County: Cities of Chicopee and Springfield. Towns of Brimfield, East Longmeadow, Hampden, Holland, Longmeadow, Ludlow, Monson, Palmer, Wales, and Wilbraham. WORCESTER COUNTY: Cities of Fitchburg, Gardner, and Leominster. Towns of Bayville, Brookfield, Charlton, Dudley, East Brookfield, Hardwick, Holden, Hubbardston, New Braintree, North Brookfield, Oakham, Oxford, Paxton, Princeton, Rutland, Southbridge, Spencer, Sterling, Sturbridge, Warren, Webster, West Brookfield, and Westminster. Population (1980), 320,479.

ZIP Codes: 01005, 01009-10, 01013-14, 01020-21, 01022 (part), 01028, 01031, 01036-37, 01056-57, 01068-69, 01074, 01080-81, 01082 (part), 01083, 01089, 01095, 01100-01, 01102-09, 01115-16, 01118-19, 01128-29, 01138-39, 01151, 01420 (part), 01440 (part), 01452-53, 01473, 01506-09, 01515, 01517-18, 01520, 01522, 01531, 01532 (part), 01535, 01537, 01540-41, 01543, 01550, 01562, 01564, 01566, 01570, 01585, 01602 (part), 01612

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SECOND DISTRICT

PETER HOAGLAND, Democrat, from Omaha, NE; born on November 17, 1941; attended Harrison and Dunder elementary schools, Omaha; graduated, Omaha Central High School; graduated, Stanford University, International relations, 1963; Yale University Law School, 1968; lieutenant, U.S. Army, 1964-65; clerked for a Federal judge upon graduation from law school; returned to Omaha to practice law; elected to the Nebraska legislature, 1978-86; married to Barbara Hoagland; children: Elizabeth, Katie, David, Christopher, and Nicholas; member: Committee on Banking, Finance, and Urban Affairs; Committee on Interior and Insular Affairs, and Committee on the Judiciary; elected to the 101st Congress on November 8, 1988; reelected to the 102d Congress, November 6, 1990.

Office Listings

1710 Longworth House Office Building, Washington, DC 20515-2702 225-4155
 Administrative Assistant.—Kathleen Ambrose.
 Executive Assistant.—Susan Carey.
 Legislative Director.—Glenda Booth.
 8424 Zorinsky Federal Building, Omaha NE 68102 (402) 344-8701

Counties: Butte, Douglas, Sarpy, and Washington. CASS COUNTY: That part not included in the First District.
 Population (1980), 375,765.

ZIP Codes: 68002, 68005, 68007-08, 68010, 68014, 68019-20, 68022-25, 68028-29, 68031 (part), 68034, 68037-38, 68044 (part), 68045 (part), 68046, 68048, 68054, 68056, 68059, 68061, 68064 (part), 68068-69, 68100-02, 68104-10, 68111 (part), 68112-14, 68116-17, 68119-20, 68122-24, 68127-28, 68131-35, 68137-38, 68142, 68144, 68147, 68152, 68154-55, 68157, 68164, 68307 (part), 68349 (part), 68403, 68407 (part), 68409, 68413 (part), 68455 (part), 68463, 68490 (part), 68773 (part)

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TWENTY-THIRD DISTRICT

MICHAEL R. McNULTY, Democrat, of NY, born in Troy, Rensselaer County, NY, September 16, 1947; graduated from St. Joseph's Grammar School, Green Island, NY, 1961; attended LaSalle Institute, Troy, NY, 1961-64; graduated St. Joseph's Institute, Barrytown, NY, 1965; attended, Loyola University, Rome Center, Rome, Italy, 1967-68; B.A., Holy Cross College, Worcester, MA, 1969; attended Hill School of Insurance, New York City, 1970; insurance broker; elected: town supervisor, Town of Green Island, NY, 1969-77; mayor, Village of Green Island, 1977-83; New York State Assembly, 1983-88; member: Albany County Democratic Executive Committee, Green Island Democratic Committee, New York State Democratic Committee; board of directors, Capital Region Technology Development Council; delegate, Democratic National Convention, 1972; married to the former Nancy Ann Lazzaro, 1971; four children: Michele M., Angela E., Nancy T., and Maria L.; elected on November 8, 1988 to the 101st Congress; reelected to the 102d Congress in November 6, 1990.

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Office Listings

414 Cannon House Office Building, Washington, DC 20515-3223.....	225-5076
Chief of Staff.—Lana R. Helfrich.....	FAX: 225-5077
Press Secretary.—Charles Segal.....	
Systems Manager/Legislative Assistant.—Jim Glenn.....	
Leo W. O'Brien Federal Building, Albany, NY 12207.....	(518) 465-0700
U.S. Office, Schenectady, NY 12305.....	(518) 374-4547
33 Second Street, Troy, NY 12180.....	(518) 271-0822
9 Market Street, Amsterdam, NY 12010.....	(518) 543-3400

Albany County: Towns of Berne, Bethlehem, Coeymans, Colonie, Green Island, Quakerland, Knox, New Scotland, Rensselaerville, and Westerlo; cities of Albany, Cohoes, and Watervliet. MONTGOMERY COUNTY: Town of Florida; city of Amsterdam. RENSSELAER COUNTY: City of Troy. SCHENECTADY COUNTY: Towns of Duanesburg, Glenville, Niskayuna, Princeton, and Rotterdam; city of Schenectady. Population (1980), 516,943.

ZIP Codes (12007-09, 12010 (part), 12019 (part), 12023 (part), 12027 (part), 12041, 12045, 12046 (part), 12047, 12053 (part), 12054-56, 12059, 12066 (part), 12067, 12049, 12077, 12084-85, 12087 (part), 12107, 12110-11, 12120 (part), 12127-28, 12137, 12141, 12143, 12147, 12148 (part), 12150, 12158-59, 12161, 12179, 12180 (part), 12181, 12182 (part), 12183, 12186, 12189, 12193, 12194 (part), 12200-02, 12220, 12224-25, 12300-01, 12370 (part), 12301-09, 12469 (part))

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FIFTH DISTRICT

MIKE KOPETSKI, Democrat, of Keizer, OR; born in Pendleton, OR, October 27, 1949; graduated, Pendleton High School, 1967; B.A., The American University, Washington, DC, 1971; J.D., Northwestern School of Law at Lewis and Clark College, 1978; congressional aide to Senate Watergate Committee, 1973-74; committee administrator, Oregon State Legislature, 1977-79, 1981; labor, management, and education consultant, 1981-84; community organizer for Oregon Law Education Project, 1986; vice president, Currier-McCormick Communications, 1989-90; page at the Democratic National Convention, 1968; delegate to Democratic National Convention, 1976; State representative, Oregon State Legislature (representing portions of Marion and Polk Counties), 1984-88; married to the former Linda Zuckerman, 1982; one son: Matthew; elected to the 102d Congress on November 6, 1990; member: Committee on Agriculture, 1991; Committee on Science, Space, and Technology, 1991; vice president, Congressional Freshman Class, 1991.

Office Listings

1520 Longworth House Office Building, Washington, DC 20515-3705 225-5711
 Administrative Assistant.—Phil Rotondi.
 Press Secretary.—Maureen Driscoll.
 Executive Assistant.—Penny Gross.
 Suite 340, 530 Center Street NE, Salem, OR 97301 (503) 588-9100
 District Director.—Ted Coran.

Benton County (part). CLATSOP COUNTY (part). LINN COUNTY (part). MARION COUNTY (part). POLK COUNTY (part). Population (1980), 326,120.

ZIP Codes: 97002, 97004, 97009 (part), 97011, 97013, 97015, 97017, 97019 (part), 97020, 97022-23, 97026-28, 97030 (part), 97032, 97034 (part), 97036, 97038, 97042, 97043, 97049, 97055, 97062 (part), 97067, 97068 (part), 97070-71, 97080 (part), 97132 (part), 97137, 97140 (part), 97166 (part), 97267 (part), 97268 (part), 97301-03, 97304 (part), 97305-06, 97308-09, 97321 (part), 97323 (part), 97330 (part), 97335, 97338 (part), 97339, 97342, 97343 (part), 97346-48, 97350 (part), 97351 (part), 97352, 97357, 97358 (part), 97359-60, 97361 (part), 97362, 97371 (part), 97373, 97374 (part), 97375, 97377 (part), 97381, 97383 (part), 97384-85, 97389, 97392, 97396, 97446

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SECOND DISTRICT

WILLIAM J. JEFFERSON, Democrat, of New Orleans, LA; born in Lake Providence, LA, March 14, 1947; attended East Carroll Davish Training School, Lake Providence, LA; graduated, G.W. Griffin High School in Lake Providence, LA, 1965; B.A., political science, Southern University and A&M College, Baton Rouge, LA, 1969; J.D., Harvard Law School, Cambridge, MA, 1972; admitted to the bar, New Orleans, LA, 1972; attorney, Jefferson, Bryan, Jupiter, Lewis & Blanson, New Orleans, LA; first lieutenant, U.S. Army, J.A.G. Corps, 1975; member, board of trustees, Greater St. Stephen Baptist Church; Urban League of Greater New Orleans; Southern University Foundation Board; elected to the Louisiana State Senate, March, 1990-January 2, 1991; married to the former Andrea Green in 1970; five children: Jamila E., 1972; Jalila E., 1975; Jelani F., 1979; Nailah A., 1981; and Akilaha, 1984; elected to the 102d Congress, November 6, 1990.

Office Listings

300 Cannon House Office Building, Washington, DC 20515-1802 225-6636
 Administrative Assistant.—Weldon J. Rousseau. FAX: 225-1988
 Executive Secretary/Scheduler.—Annette L. Crumbley.
 Press Secretary.—Jean LaPlace.
 1012 Boggs Federal Building, 501 Magazine Street, New Orleans, LA 70120 ... (504) 589-2274
 District Office Manager.—Stephenie Edwards.

Orleans Parish: That part not contained in the First District. Population (1980), 326,605.

ZIP Codes: 70012, 70046, 70050, 70058 (part), 70062 (part), 70081, 70085, 70112-17, 70118 (part), 70119 (part), 70122 (part), 70123, 70124 (part), 70125-31, 70140, 70150-53, 70156-58, 70160-62, 70172, 70174-76, 70178-79, 70182, 70184-86, 70189-90, 70438 (part)

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THIRD DISTRICT

BILL K. BREWSTER, Democrat, of Marietta, OK; born in Ardmore, OK, November 8, 1941; graduated, Petrosia, TX, high school, 1959; B.S. in pharmacy, Southwestern Oklahoma State University, 1964; owner-operator, Colleyville Drug, Inc., Colleyville, TX, 1964-77; cattleman, Brewster Angus Farms, 1968-; U.S. Army Reserve, 1968-71; Oklahoma House of Representatives, 1982-89; chairman, Economic Development Committee, 1983-86; chairman, Business and Commerce Committee, 1987-88; chairman, Tourism and Recreation Committee, 1988-89; vice chairman, Education Appropriations Committee; member, Appropriations Committee; member, Oklahoma Legislature's Special Joint Committee on International Development; South/West Energy Council, vice-chairman, 1987-88; chairman, 1988-89; Executive Committee, 1982-; National Conference of State Legislators, Oklahoma delegate, 1983-; chairman, Energy Committee, 1989-90; Oil Marketers Association, "Legislator of Year"; Southwestern Oklahoma State University, "Distinguished Alumni"; INCA Board for Community Action; Recreational Vehicle Industry's Golden Telephone Award; married to the former Mary Sue (Suzie) Nelson, in 1963; three children: daughter, Balynda Karel; another daughter, Betsy Kecia, and a son, Bradley Kent, lost their lives in a tragic accident in early 1990; elected to 102d Congress, November 6, 1990; member: Committee on Public Works and Transportation, Committee on Veteran Affairs.

Office Listings

2848 Longworth House Office Building, Washington, DC 20515-3603	225-4365
Administrative Assistant.—Phyllis Krcin.	FAX: 225-9029
Press Secretary.—Jim Pata.	
Executive Assistant.—Jeff Rabon.	
Legislative Assistant.—Jeff Murray.	
Suite B, 900 North Mississippi, Ada, OK 74820	(405) 436-1980
116 Federal Building, McAlester, OK 74501	(918) 423-5951
Suite 206, 123 West 7th Avenue, Stillwater, OK 74074	(405) 743-1400

Coalition Atoka, Bryan, Carter, Choctaw, Coal, Hughes, Johnston, Latimer, LeFlore, Lincoln, Love, McCurtain, Marshall, Murray, Payne, Pittsburg, Pontotoc, Pushmataha, and Seminole. POTTAWATOMIE COUNTY: That portion not contained in the Fourth District. Population (1980), 304,248.



Melvin Reynolds

**2nd District
Illinois**

Melvin Reynolds, 40, replaces Rep. Gus Savage, whom Reynolds defeated in the Democratic primary. Reynolds, an educator and community activist, won the general election with 85% of the vote. He and his wife Marisol have a daughter, Corean.

Reynolds recently served as an Assistant Professor at Roosevelt University, Executive Director of the Community Economic Development and Education Foundation, and as a radio talk show host. He has also worked with the NAACP and with community-based organizations and churches.

Reynolds studied at the Chicago City Colleges and the University of Illinois at Champaign before being selected as a Rhodes Scholar. He received his law degree while studying at Oxford and is completing a masters degree in public administration at Harvard's Kennedy School of Government.

During his career, Reynolds has led opposition to toxic waste and landfills, promoted strong action to combat drugs and gangs, and worked for solutions to world hunger.

DEMOCRATIC MEMBERS OF THE HOUSE WAYS AND MEANS COMMITTEE 103rd CONGRESS

◆ Chairman Dan Rostenkowski (IL)

As you know, Congressman Rostenkowski serves as Chairman of both the House Committee on Ways and Means and the Joint Committee on Taxation. He is extremely interested in holding a Forum similar to the Dingell Forum and was intrigued by the Senators' desire to hold briefings with Ira. This has further raised his enthusiasm for sponsoring a Forum with members of the House.

◆ Rep. Sam Gibbons (FL)

As you know from your trip to Florida with the Congressman, Gibbons serves as Chairman of the Trade Subcommittee. He is the second ranking member on the Committee behind Chairman Rostenkowski. He also sits on the Joint Committee on Taxation. Although the Congressman does not have a national reputation on health care issues, he does strongly support comprehensive reform.

◆ Rep. J. J. Pickle (TX)

Congressman Pickle serves as Chairman of the Oversight Subcommittee and sits on the Social Security Subcommittee as the 2nd of 5 Democrats. Formerly, he served as Chair of this Subcommittee, in which capacity he was involved in the 1983 reform efforts. Pickle has been an advocate of support for rural hospitals in past tax reform debates. It is expected that Pickle will be sympathetic to health care providers, in particular the AMA. Pickle also serves on the Joint Committee on Taxation.

◆ Rep. Charles Rangel (NY)

Congressman Rangel serves as Chairman of the Select Revenue Measures Subcommittee. He is a strong advocate of including coverage for drug treatment in the Administration's benefits package. Rangel is traditionally a single payer advocate, but we believe he will be open to alternative options. He also supports enterprise zones and residential treatment programs for substance abusers. Rangel sponsored a bill to establish the Select Committee on Narcotics Abuse and Control. As you know, it is unlikely that the Select Committees will be approved for reauthorization. Rangel is a member of the Congressional Black Caucus.

◆ Rep. Pete Stark (CA)

Congressman Stark serves as Chairman of the Subcommittee on Health and as Chairman of the House Committee on the District of Columbia. He also sits on the Joint Economic Committee. His Subcommittee has announced hearings on budget issues for the coming weeks. Stark has introduced several Health Care legislative initiatives including the Health Care Cost Containment and Reform Act of 1993 (H.R. 200); the Comprehensive Physician Ownership and Referral Act of 1993 (H.R. 345); the Prescription Drug Prices Review Board Act of 1993 (H.R. 916); the National Health Care Anti-Fraud Act of 1993 (H.R. 1255); and an Amendment to the Constitution of the United States concerning access to medical care (H.J.Res. 114).

◆ **Rep. Andrew Jacobs (IN)**

Congressman Jacobs serves as the Chairman of the Social Security Subcommittee; a position he took over from Rep. Pickle in 1987. Although unpredictable, Jacobs is typically very liberal. He has traditionally been frugal on fiscal matters and is an enthusiastic supporter of the balanced budget amendment. Jacobs is a big non-smoker advocate and supporter of Veterans benefits. He has, however, long opposed U.S. involvement abroad.

◆ **Rep. Harold Ford (TN)**

Congressman Ford serves as Chairman of the Human Resources Subcommittee and sits on the Oversight Subcommittee. Congressman Ford is not expected to attend the meeting.

◆ **Rep. Robert Matsui (CA)**

Congressman Matsui serves on the Human Resources and Trade Subcommittees. He has introduced the Children and Pregnant Women Health Insurance Act of 1993 (H.R. 727) and has expressed repeatedly that if a system of phasing in coverage is adopted, children should receive priority. Matsui also sponsored the Social Security and SSS "AIDS" Disability Act of 1993 (H.R. 728). He is most proud of his 1988 Japanese American redress that gave recognition and compensation to Japanese Americans interred during World War II. He has also championed the cause of migrant workers, has worked to reform the foster care system and may be sensitive to health care provider interests.

◆ **Rep. Barbara Kennelly (CT)**

In addition to the House Committee On Ways And Means, Congresswoman Kennelly serves on the Budget and House Administration Committees. Kennelly has introduced a bill to clarify tax treatment of certain disabilities benefits provided to police officers and fire fighters (H.R. 225). Representing Hartford, Kennelly is obviously concerned with the insurance industry and how it will be affected by health reform. In the past, however, she has encouraged private insurance companies to support long-term care initiatives. Kennelly serves as a Chief Deputy Whip for the House Democrats.

◆ **Rep. William Coyne (PA)**

In addition to the Ways and Means Committee, Congressman Coyne serves on the Budget Committee. In the past, he has sponsored legislation to fund home dialysis demonstration projects and increase medicare reimbursements.

◆ **Rep. Michael Andrews (TX)**

Congressman Andrews serves on the Health Subcommittee as well as on the House Committee On The Budget and the Joint Economic Committee. In 1988, Andrews served, at Rostenkowski's request, as the point person in resisting Claude Pepper's expensive long-term health care bill. He is a co-sponsor of the CDF proposal and has introduced the Tobacco Health Tax Act (H.R. 1246) which would tax cigarettes at the rate of one dollar per pack.

◆ **Rep. Sander Levin (MI)**

Congressman Levin serves on the Health and the Human Resources Subcommittees. Congressman Levin is upset at the level of Senator Riegle's involvement in the Michigan Forum and believes that he has not been consulted sufficiently. He views himself as an influential player on health care and is next in line to Stark on the Health Subcommittee. Levin has worked extensively in the past to increase mental health coverage under medicare. He also introduced legislation to require health care providers receiving medicare and medicaid funding to provide information concerning living wills and other options for incapacitated patients. Levin is a union advocate and is especially concerned with retired health issues. He also wants strong cost-containment measures.

◆ **Rep. Ben Cardin (MD)**

In addition to serving the Health and Human Resources Subcommittees, Congressman Cardin serves on the Committee On House Administration, and the Committee On Standards Of Official Conduct. Congressman Cardin has introduced the Medicare EKG Payment Restoration Act of 1993 (H.R 942). He is a single payer advocate and is a strong proponent of maintaining state flexibility in order to maintain Maryland's all-payer reimbursement system.

◆ **Rep. Jim McDermott (WA)**

As you know from your meeting with Congressman McDermott on March 9, he is a chief sponsor of the single payer model. He has, however, repeated his intentions to work with the Administration in developing a health reform proposal. In addition to serving on the Health Subcommittee, McDermott is Chairman of the House Committee on Standards Of Official Conduct and serves the House Committee on the District of Columbia and as Chair of its Fiscal Affairs and Health Subcommittee.

◆ **Rep. Gerald Kleczka (WI)**

Congressman Kleczka serves on the Health Subcommittee, as well as on the Committee on House Administration and the Joint Committee on Printing. It has been difficult to confirm his support for the President's economic plan.

◆ **Rep. John Lewis (GA)**

In addition to serving on the Health Subcommittee, Congressman Lewis sits on the House Committee on the District of Columbia. Lewis supports a single payer model but is open to compromise. He is, however, not willing to support a plan that does not require universal coverage or appears to be a two-tier system. As you know, Lewis is a member of the Congressional Black Caucus and represents Atlanta, which the President will visit on Friday. Lewis also serves as a Chief Deputy Whip for the House Democrats.

◆ **Rep. L. F. Payne (VA)**

Congressman Payne serves on the Select Revenue Measures and Trade Subcommittees. Payne is a co-sponsor of the CDF plan in the House. As you may know, Payne met last month with the President and five other members of Congress concerning the Balanced Budget Amendment. The members expressed their support for the President yet reiterated the importance of keeping on track with the balanced budget initiative. They have asked that attention turn to the amendment after the reconciliation is completed.

◆ **Rep. Richard Neal (MA)**

Congressman Neal serves on the Select Revenue Measures and Trade Subcommittees. He has a liberal voting record.

◆ **Rep. Peter Hoagland (NE)**

Congressman Hoagland serves on the Select Revenue Measures and Trade Subcommittees. Hoagland has sponsored several health related initiatives including the Health Services Cost Control Act (H.R. 73); the Health Payor Forms Simplification Act of 1993 (H.R. 74); the Children's Vaccine Initiative Amendments Act (H.R. 78); and three Amendments to the Social Security Act. These amendments would require that new parents receive information on immunizations and would provide extended coverage for home health services and preventative examinations. Hoagland is also interested in drug control policy and has introduced proposals for drug-offenders' boot camps.

◆ **Rep. Michael McNulty (NY)**

Congressman McNulty serves on the Select Revenue Measures and Trade Subcommittee. McNulty has not sponsored any legislation regarding health care and has had no significant involvement with the Health Care Task Force.

◆ **Rep. Michael Kopetski (OR)**

Congressman Kopetski serves on the Human Resources and Select Revenue Measures Subcommittees. Kopetski has introduced legislation to include mental health benefits in a health reform package (H.Con.Res. 52) as well as the Medicare Diabetes Outpatient Self-Management Training Services Coverage Act of 1993 (H.R. 1194). As you may know, he also sponsored a bill designating a "Future Farmers of America" week, which the President signed into law in a ceremony on February 25 here at the White House.

◆ **Rep. William Jefferson (LA)**

As you know from your flight to New Orleans with the Congressman, Jefferson has not sponsored any legislation regarding health care and has had no significant involvement with the Health Care Task Force. In addition to serving on Ways and Means and its Social Security Subcommittee, Jefferson sits on the Committee on the District of Columbia and its Fiscal Affairs and Health Subcommittee. He is also a member of the Congressional Black Caucus.

◆ **Rep. Bill Brewster (OK)**

Brewster serves on the Oversight and Social Security Subcommittees. A former Pharmacist and owner of Collyville Drug Inc., Brewster has a knowledge of the health industry. He is a strong advocate of rural health care and the advancement of rural hospitals. He will be concerned, however, with any proposal that shifts costs from the public to the private sector. We have heard that Brewster is distraught that we have not contacted him concerning health reform. Chairman Rostenkowski, however, has asked that we allow him to work with the members of his Committee. We hope that this meeting will help to bridge some of these gaps between the members and help to make them feel included in the process. Brewster has also expressed some reservations about the President's economic plan.

◆ **Rep. Mel Reynolds (IL)**

Congressman Reynolds serves on the Human Resources and Social Security Subcommittees. A new member of Congress, he campaigned on relieving the violence in our cities and is supportive of taxes on fire arms and ammunition. A member of the Congressional Black Caucus, Reynolds is also the first African-American Rhodes Scholar from the state of Illinois.

VIDEO SCRIPT -- FINAL DRAFT

Hello, this is Hillary Clinton.

I want to thank you for letting me speak with you about an issue that is central to our children's future and critical in our fight to restore this nation's economy: solving our nation's health care crisis. Our message to you is simple: It's time to bring about fundamental change, control our nation's soaring health care costs and provide security for American families.

Since we first came to Washington, I've been chairing the President's Task Force on Health Care, and every day I have been lucky to hear from people all over the country. But I think the person who best summed up the situation we face was a doctor I met recently at St. Agnes Hospital in Philadelphia. He said to me: "You know the saying, 'If it ain't broke, don't fix it.' Well, Mrs. Clinton, the system's broke, and it's time to fix it."

Since January, people from all over the government and experts from around the country have been working round-the-clock to come up with a comprehensive health care reform package. We've met with groups from all over the country representing different perspectives on health care. From nurses to hospital administrators, from doctors to businesspeople, we have reached out in an effort to get the best advice we can.

The President also asked people to write and tell us their concerns and opinions about health care, and the response has been just incredible. Let me read you part of a letter from a woman in Warren, Michigan: "I am a middle class American with a husband and three children," she wrote. "My family ran upon rough times 2 years ago when my husband lost his job [after] 7 years with the same company...We aren't eligible for State funded programs and can't afford the price of the insurance premiums, so as a result, we do without. I hope and pray that a solution to this problem will come about soon."

As we develop our plan, we're thinking about that woman from Michigan -- and the points of view of every American and every group involved in making health care reform work. The small businessperson who wants to cover his employees but struggles with premiums that rise at thirty percent each year. The older American caught between a fixed income and prescription drug prices that are out of reach. And the parents of four who can't switch jobs because they're afraid of losing coverage.

For those people and the groups who have been fighting for health reform for years, this is not the time for yet another study or report. As President Clinton said in his February address to the joint session of Congress, it is time for action.

But let me say up front: we are going to preserve American medical care at its best -- the superior technology our doctors need and the flexibility that our nation demands. We will

maintain the highest quality medical care in the world and the individual's right to choose a doctor.

But there's also a lot you won't see in our new system. You won't see the patchwork of forms that frustrate patients and make doctors spend more time with paper than people. You won't see prescription drugs that cost three times more than they do in other countries. You won't see the phrase "pre-existing condition" on any insurance form. And you won't hear of people who lose their jobs and can't find coverage.

These kinds of fundamental changes won't be easy. Believe me, I've learned since I started working on this issue -- there are powerful special interests who profit from the status quo. And high-priced lobbyists who get paid to keep everything the same. They're already lining up to block the change.

But with your help, we can break the gridlock. People need a health care system that controls costs and provides security to families. And I know the American people share the urgency that I feel -- the sense that we must act now.

We face a historic opportunity -- and we must seize the moment. I ask you to join me in working for fundamental change in America's health care system: to lead this nation toward quality, affordable care for all Americans.

Thank you all very much.

Briefing on Malpractice Reform Options
prepared by Bob Berenson

Goals of a malpractice system:

1. promote health care quality
2. provide remedies for negligently injured patients
3. provide prompt resolution of disputes
4. adequately and equitably compensate injured patients
5. operate efficiently and economically

Many find that the current tort-based system does not satisfy these goals:

- o Two studies a decade apart find that roughly 1 percent of hospitalizations result in medically induced adverse outcomes. Yet, only a small fraction of these ever enter the tort system and only about a half of claimants receive any compensation.

- o Only 30-40% of costs of the tort system actually goes to claimants. The rest supports legal fees, court costs, etc.

- o There is little evidence that the tort system deters poor medical care.

- o In some states, e.g., Florida, that have not enacted some limits on damages and other tort reforms, malpractice premiums are such that certain high risk specialties, such as obstetricians, go bare.

Despite these manifest problems, there has been no consensus on reform. Physicians seek limits on damages, which do limit premium increases but do nothing to increase patient access to remedies for negligence. Others recommend removing disputes from the tort system altogether, but numerous state demonstrations with various forms of alternative dispute resolution mechanisms have been inconclusive. Practice guidelines offer promise for a subset of malpractice claims (estimated to be about 30%), but they have not yet been developed broadly or adequately tested.

The managed competition model offers some new possibilities for reform. Responsibility for injury resolution could be integrated with responsibility for quality assurance and monitoring under the umbrella of health plans or other responsible entity, e.g., hospitals. Even more important, responsibility could go well beyond the small share of cases found by the current liability system. This would provide appropriate incentives for monitoring injuries and taking cost-effective steps to reduce the risk of injury during medical care.

The workgroup is looking at a range of options, some of which could be adopted in the short term, whereas others need further demonstration and would be more appropriate in a reformed health care system. For the long term, either legislative or monitored private contracts could lodge responsibility for quality

assurance and redress of injuries with plans rather than individual providers. Formal approaches to do so include proposals for "enterprise liability," "quasi-no-fault compensation" and "monitored private alternatives" offered by health plans during the open enrollment process. The workgroup is examining these options.

The short term options include:

1. Statutory reform of tort litigation rules. The federal government would require states to meet a set of minimum reforms. The most prominent ones are capping liability for non-pecuniary losses such as pain and suffering, collateral source offsets, modifying contingency fees, periodic payment of awards. These come from the California-model of tort reform enacted in 1975.

Pros

- o Limits provider exposure, reduces size of awards, may have a marginal positive effect on "defensive medicine."

Cons

- o Decreases access for injured patients, does nothing to promote quality, prompt resolution of disputes or efficiency of the tort system.

2. ADR methods. ADRs change the process by which disputes are solved, not the substantive rules of fault, causation, or damages. ADR can involve a full-blown system that formally weighs all evidence and comes to conclusions on all issues, as arbitration does. Or it can involve less formal facilitation techniques, such as mediation or pre-trial screening.

Pros

- o Potentially faster, less expensive, less adversarial than traditional litigation.

Cons

- o Their promise has not been realized in the medical malpractice arena. Some "voluntary" approaches create duplicative layers of discovery and delay. Yet "mandatory" techniques are relatively untested and may take away rights.

3. Inducement of voluntary "early offers" of settlement. To bring more negligent injuries to light and provide faster compensation, medical providers would be encouraged to make voluntary offers to settle out of court for objectively determined reasonable amounts. In exchange, any person rejecting such an offer could not sue for non-pecuniary losses. Offers would be made within a short period of time, e.g., 120 days from an adverse event or reasonable discovery of the event.

Pros

- o Potentially many more patients would be compensated, faster and with more predictable outcomes. The tort system "lottery" would be replaced. Transaction costs may be less.

Cons

- o Virtually untested. May shift too much power to providers. (But HIPC's or other program oversight could monitor that offers were being made when they should.)

4. Practice Guidelines. They are systematic, scientifically derived statements of appropriate measures to be taken by health professionals in the diagnosis and treatment of disease. Guidelines will be of forensic use only in those cases in which the physician allegedly chose the wrong course of treatment or should have gone further to diagnose or treat. However, most malpractice claims involve errors of performance. While perhaps not directly applicable in many particular cases, practice guidelines, have the potential of alleviating the perception of physicians that their practice will be retrospectively judged according to arbitrary and ill-founded standards determined by a lay jury.

Briefing on Antitrust Issues and Options

Various aspects of managed competition raise concern under Section 1 of the Sherman Antitrust Act as currently interpreted and enforced. At the same time, however, managed competition cannot work without antitrust enforcement to ensure that competition is not stifled.

Antitrust issues have been considered by the working group as they relate to HIPCs, providers, and price negotiations between pharmaceutical companies.

I. **HIPCs:** Will the structure and function of the HIPC work to limit competition instead of promoting competition? How will the structure and function of the HIPC effect its potential exposure to antitrust suits?

II. **Providers:** Should physicians be given a limited antitrust exemption to undertake joint activities? Should hospitals be granted a special antitrust exemption to allow them to enter efficiency-enhancing joint ventures or mergers?

III. **Pharmaceutical Companies:** Should pharmaceutical companies be allowed to agree on maximum price increases?

I. HIPCs

Will the structure and function of the HIPC work to limit competition instead of promoting competition?

Background

If the HIPC has the discretion to limit the number of plans offered, plans may be forced from the market, leaving fewer plans available from which to choose.

Options

- Require the HIPC to contract with all bidders which meet the national standards within a price band
- Allow the HIPC discretion to limit contracts

How will the structure and function of the HIPC effect its potential exposure to antitrust suits?

Background

If the HIPC is a private entity, it may be subject to challenges by health plans or providers who do not receive

contracts from the HIPC.

Options

- Grant the HIPCs antitrust immunity
- Limit the likelihood of antitrust suits by restricting the HIPC's power to set premiums and restrict the number of plans it offers

II Providers

Should physicians be given a limited antitrust exemption to undertake joint activities?

Background:

As part of the health reform debate, providers often argue for an antitrust exemption to improve their bargaining position with large insurers and other managed care entities who they fear will dominate the market. Similarly, hospital representatives argue that at times there is an inherent conflict between antitrust laws and collaborative forms of cost containment.

Options:

- Allow self-designated groups of physicians to deal collectively with health plans.
- Continue to apply antitrust laws to prevent agreements that would restrain competition.

Should hospitals be granted a special antitrust exemption to allow them to enter efficiency-enhancing joint ventures or mergers?

Background:

Under the new health system, hospitals will face increasing pressure to lower costs and reduce capacity. In some circumstances, hospitals could increase their efficiency by entering into joint ventures or mergers with other hospitals in their community. Hospital trade associations have advocated that a special antitrust exemption needs to be given to hospitals, especially to hospitals in rural areas, to allow them to enter into mergers and joint ventures.

Only a small number of hospital mergers have been investigated by federal enforcement agencies. Few have been challenged, and many have been cleared by the agencies quickly. No hospital joint ventures have been challenged by the agencies.

Options:

- Enact a limited antitrust exemption for hospital joint ventures and mergers.
- Enact an antitrust exemption for hospitals in certain, small rural areas.
- No changes to existing antitrust laws.

Should HIPC's play a role in reviewing hospital mergers and joint ventures?

Background:

Currently, the FTC and the Antitrust Division at DOJ review hospital mergers and joint ventures. These agencies seek the views of major purchasers in the area in which the hospitals are located, and would likely seek the views of the HIPC's, regardless of reform.

Options:

- Grant HIPC's sole authority to review mergers.
- Retain current enforcement system.

III. Pharmaceutical Companies

Should pharmaceutical companies be allowed to agree on maximum price increases?

Background:

In order to voluntarily hold down future price increases, pharmaceutical companies might meet and agree on the maximum price increase that can occur each year. Under current antitrust law, agreements between competitors on maximum price schedules have been held to be per se illegal.

Options:

- Grant the pharmaceutical companies an antitrust exemption.
- Leave the antitrust laws unchanged.

MEETING WITH HILARY RODHAM CLINTON
ON AMERICAN INDIAN HEALTH CARE ISSUES

March 17, 1993

AMERICAN INDIAN & ALASKA NATIVE PARTICIPANTS

<u>Name</u>	<u>Position & Organization</u>
1. The Honorable Peterson Zah	<i>President</i> Navajo Nation
2. The Honorable Larry EchoHawk	<i>Attorney General</i> State of Idaho
3. The Honorable Richard A. Hayward	<i>Chairman</i> Mashantucket Pequot Tribe
4. The Honorable Wilma Mankiller	<i>Principal Chief</i> Cherokee Nation of Oklahoma
5. Dr. Johanna Clevenger, M.D.	<i>President</i> Association of American Indian Physicians
6. Ms. Julie E. Kitka	<i>President</i> Alaska Federation of Natives
7. Mr. Richard Trudell	<i>Executive Director</i> American Indian Resources Institute
8. Ms. Patricia M. Zell	<i>Staff Director/Chief Counsel</i> Senate Committee on Indian Affairs
9. Mr. John E. Echohawk	<i>Executive Director</i> Native American Rights Fund
10. Dr. Gerald Hill, M.D.	<i>Director</i> Center of American Indian & Minority Health

- | | |
|-------------------------------------|--|
| 11. Mr. Michael E. Lincoln | <i>Acting Director</i>
Indian Health Service |
| 12. Ms. Norine Smith | <i>President</i>
American Indian Health
Care Association |
| 13. Ms. Jennie R. Joe, Ph.D. M.P.H. | <i>Associate Professor & Director</i>
Native American Research
& Training Center |
| 14. Mr. James R. Floyd | <i>Director</i>
Portland Area Office
Indian Health Service |
| 15. Ms. Anne Walker | <i>Executive Director</i>
Alaska Native Health Board |
| 16. Mr. Gordon Belcourt | <i>Executive Director</i>
National Indian Health
Board |
| 17. Mr. Andrew Lorentine | <i>Chairman</i>
National Indian Health
Board |
| 19. Ms. Carol Marquez-Baines | <i>Interim Executive Director</i>
American Indian Health
Care Association |
| 20. Ms. Phyllis Moore | <i>Director</i>
Health & Human Services
Mashantucket Pequot Tribe |
| 21. Ms. Deanna L. Bauman | <i>Interim General Manager</i>
Governmental Services
Oneida Tribe of Indians of
Wisconsin |
| 22. Ms. Jo Ann Kauffman | <i>President</i>
Kauffman & Associates, Inc. |

American Indian Delegation-Cont'd
Page 3 of 4

23. Ms. Deanna Martinez

Deputy Director
American Indian Resources
Institute

24. Mr. W. Ron Allen

Chairman/Executive Director
Jamestown S'Klallam Tribe

25. Mr. Eddie Tullis

Tribal Chairman
Poarch Creek Band

26. Ms. Ethel Lund

Southeastern Alaska Regional
Health Corporation

27. Ms. Carmelita Skeeter

Executive Director
Indian Health Care
Resource Center Tulsa, Inc.

28. Mr. David Baldrige

Executive Director
National Indian Council on
Aging

29. Mr. Gerald J. Ignace

Executive Board Member
Association of American
Indian Physicians

30. Mr. James Crouch

Executive Director
CA Rural Indian Health
Board

31. Ms. Pam Iron

Executive Director
Cherokee Nation

32. Ms. Donna Vandall

Executive Director
Aberdeen Tribal Chairmens'
Health Board

33. Mr. Buford Rollin

Secretary
National Indian Health
Board

American Indian Delegation-Cont'd
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34. Ms. Mary Thomas

Lieutenant Governor
Gila River Indian
Community

35. Ms. Doni Wilder

Executive Director
Northwest Portland Area
Indian Health Board

36. Mr. Gregory Yawakia

Chairman
Pueblo of Zuni

37. Mr. Bill Fife

Principal Chief
Creek Tribe/Muscogee

38. Ms. Julia Davis

Vice-Chair
National Indian Health
Board

39. Mr. Robert J. Clark

Bristol Bay Area Health
Corporation

MEMORANDUM TO THE FIRST LADY

DATE: March 16, 1993

FROM: Charlotte Hayes, Shelly Crow, Yvette Jospeh-Fox, June Tracy

SUBJECT: Meeting with Indian Tribal Government Leaders

BACKGROUND

[Note: Tribal chair men and women are addressed as the Honorable. When you refer to tribes you should say "tribal governments."]

The tribal governments have expressed much concern that they hear there are no people who actually give health care and understand giving health care to American Indians, which is why three of the non-Indian Health Service working group members are with you at this meeting.

The premier Indian Health Services program is the Public Law 93-638 Indian Self Determination Act program which enables the tribal governments to contract for services normally provided by IHS. American Indians favor the 638 program, which jibes with the Administration's view that health care should be shaped by the communities it must serve.

(35% of the IHS programs consist of 638 contracts, American Indians support more.)

NOTE: IHS is one of the only federal systems providing rationed health care today. This is due to limited resources, e.g., there are few hospitals, 90% of facilities in Indian country is ambulatory care. This type of facility cannot address cardiac heart arrest, infant deliveries and operates within a total global budget of approximately \$1.9 billion which addresses only 40% of the population's needs.

Tribal governments rely heavily on Congress to address their concerns, this affects 26 states, principally in the West.

What they will say about health reform

They will affirm that United States government has a trust obligation to Indian Tribal governments; that this is a legal and moral obligation to provide adequate health care and services to tribal governments and their members. They believe that in working on a health care reform plan the United States government must work government-to-government with the tribal governments to set a new system.

They believe that in exchange for over 50 million acres of land, they have already paid a premium for a health insurance program which entitles their members to continued health care benefits. It is this legal relationship which distinguishes American

Indian and Alaska Native from other minority populations.

There are over 500 tribal governments and Alaska native villages, each with their own tradition and cultural heritage. They believe that culture affects how you heal and how you consider health care professionals and will recommend culturally sensitive care, i.e., traditional healing and acknowledgement of tribal differences.

In carrying out its trust obligation the United States government provides health care using three systems of care:

1. Through the Indian Health Service, which provides direct care to native patients
2. Through Public Law 93-638 Indian Self Determination Act contracts in which the tribal government contract to provide services normally provided by IHS; and
3. Through the Urban Indian Health Programs.

They are working toward a tribal health task force to offer recommendations to the First Lady and her Task Force.

They will ask for Indian representation on the National Health Board which will be part of the new system.

They will say that IHS does not have enough money as it addresses only 40% of the Indian population's health care needs. They may say the United States has shirked its obligation to tribal governments. They may also say they want to provide for their own care under the new system and will want more resources to do so.

They may raise the fact that IHS is not only driven by medical benefits cost. NOTE: Indian health care also includes public health services also, like sanitation facilities, mental health counseling, community health activities, and public health nursing. They fear everything is so driven by finances, that the Administration may forget that 40% of expenditures for Indian health is attributed to public health services delivery.

What else they may say

They are concerned about quality and are hearing that Indian health will be cut in the FY 94 budget. HHS gets \$800 billion and IHS gets about \$2 billion (about 0.9% of federal health care budget)

In addition, they want to meet with Secretary Shalala, because they believe that most of the Indian Health Services decisions are made by her.

A SUMMARY OF INDIAN HEALTH STATUS

o Demographics

There are approximately 2.2 million American Indians and Alaska Natives residing in the U.S. The Indian Health Service (IHS) provides health services to about 1.3 million Indians (60 percent of U.S. Indians), primarily those residing on or near reservations. The Indian population is less educated than the general population, i.e., 65.5 percent are high school graduates or higher compared to 75.2 for the general population. The Indian population is also poorer because of high unemployment rates and low wages. In 1989, the Indian median household income was only two-thirds that for the general population (\$20,025 versus \$30,056).

o Accomplishments

The health status of the IHS service population has improved significantly under the IHS. For example since 1973,

- gastrointestinal diseases death rates decreased 77 percent
- tuberculosis death rates decreased 76 percent
- maternal death rates decreased 69 percent
- alcoholism death rates decreased 63 percent
- pneumonia and influenza death rates decreased 59 percent
- accident death rates decreased 54 percent
- infant mortality rates decreased 50 percent

o Remaining Problems

The Indian population fares poorly compared to the general population for a number of conditions/problems. Following is a comparison of Indian age-adjusted death rates to U.S. rates.

- tuberculosis - 520 percent greater
- alcoholism - 476 percent greater
- diabetes mellitus - 188 percent greater
- accidents - 167 percent greater
- homicide - 71 percent greater
- suicide - 54 percent greater

o Demand for Services

Since 1955 (the inception of IHS), the volume of IHS services has greatly increased.

- inpatient admissions increased 86 percent to 93,180
- outpatient visits increased 1045 percent to 5,211,351
- dental services increased 1216 percent to 2,369,484

o Unmet Need for Services

The IHS service population receives health services at lower rates than the general population as illustrated below.

	<u>IHS</u>	<u>U.S.</u>
- hospital discharges/1,000 population	87	124
- hospital days/1,000 population	399	792
- physician visits/person	3.1	4.6

BACKGROUND

The Indian Health Service (IHS), an agency of the U.S. Public Health Service (PHS) in the Department of Health and Human Services (DHHS), is responsible for providing Federal health services to American Indians and Alaska Natives. The IHS provides comprehensive preventive, curative, rehabilitative, and environmental health services for approximately 1.3 million eligible beneficiaries. It does this while maintaining a government to government relationship with approximately 500 sovereign tribal governments to which these beneficiaries belong. This responsibility is carried out in the most remote and harsh environment existing in the United States as well as in modern metropolitan locations.

The provision of Federal health services to Indians is based on a special relationship between Indian tribes and the U.S. Government that has its bases in the transfer of vast expanses of land, repeatedly affirmed through treaties, legislation, and court decisions. First set forth in the 1830's by the U.S. Supreme Court, this unique relationship has been reconfirmed by numerous treaties, statutes, constitutional provisions, and international law and theory. Principle among these is the Snyder Act (25 U.S.C.) of 1921 which provided basic authority for federal health services to American Indians and Alaska Natives.

MISSION

The IHS provides a comprehensive health services delivery system for American Indians and Alaska Natives (AI/ANs) with the opportunity for maximum tribal involvement in developing and managing programs to meet their health needs.

GOAL

The goal of IHS is to raise the health status of the AI/AN people to the highest level possible.

SERVICE POPULATION

The IHS is responsible for providing Federal health services to 1.3 million AI/AN members of approximately 500 sovereign tribal governments residing in 33 "reservation" States. In addition, approximately 700,000 AI/ANs are not served by IHS/Tribal/Urban programs. The median age of the IHS population is 22.6 years as compared to 30 years for the general U.S. population. AI/ANs are diverse in their characteristics and health needs but generally lag behind the U.S. general population in income, health, and other socio-economic indicators.

SCOPE OF SERVICES

The IHS, tribal governments, and urban Indian organizations, within limits of annual appropriations, provide a comprehensive scope of preventive, clinical, rehabilitative, and environmental health services, augmented by community and human resources development programs. IHS is not an entitlement program and does not offer guaranteed and uniform benefits.

OPERATIONS

Services are provided directly at IHS and tribal hospitals and clinics and urban clinics; and are purchased from other public and private providers, including sharing agreements with DOD and VA.

More than 500 health facilities are operated in the remotest and harshest environments in the U.S., on isolated Indian reservations, in Alaska villages, in other rural areas, and in cities.

The IHS appropriations were \$621 million in 1980, \$1.58 billion in 1991, and \$1.86 billion in 1993.

PREVENTIVE HEALTH SERVICES

Promotion of wellness and prevention of disease are achieved in Indian communities by surveillance, early screening and detection, education, and active intervention before onset of serious illness and dysfunction. Services include public health nursing, outreach, education, nutrition, and immunizations. These are integrated with clinical services, environmental health and safety monitoring, community based injury prevention, and construction of safe water supply and sanitation facilities.

CLINICAL SERVICES

Clinical services integrate health promotion, disease prevention, diagnostic, therapeutic, and rehabilitative activities in accredited hospitals and ambulatory facilities. Direct services emphasize community oriented primary care, blending traditional AI/AN approaches to wellness and healing with western medical science. In 1991, over 441,000 inpatient days, over 5 million outpatient visits and 2.3 million dental services were provided.

Cross cutting programs focus on high priority problems in maternal and child health, alcohol and substance abuse, communicable disease control, and family violence, among others.

COMMUNITY BASED PROGRAMS

In addition to IHS/Tribal programs, a number of AI/AN communities have developed 501c3 clinics with community boards of directors. Some of these

clinics are federally-funded Community Health Centers (section 330, PHS Act) and others are funded by private funding sources.

PURCHASED SERVICES

In locations where IHS facilities or services are unavailable, eligible AI/ANs are referred to other public and private facilities and providers. Payment depends upon prior authorization, consideration of medical priorities, availability of funds, and availability of alternate payment sources.

URBAN HEALTH

IHS funds 34 Indian urban health organizations which operate 41 clinics in cities throughout the U.S.

SELF-DETERMINATION AND SELF GOVERNANCE

Tribal governments express self-determination by contracting to assume management of IHS programs or by having the IHS operate the programs. Self-determination contracts are negotiated non-competitively at tribal government initiative. When fully implemented, self-governance legislation will allow tribes discretion to redirect Federal health funds to local health priorities.

TRIBAL MANAGEMENT

IHS maintains a self-determination assistance program for capacity building for tribal governments who wish to manage their own programs.

INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

The scholarships program augments health professional staffing recruitment especially to address chronic shortages of physicians, nurses and other professions in remote facilities, and removes barriers to AI/ANs entrance into the health professions.

INDIAN HEALTH FACILITIES

The IHS funds construction and maintenance of health facilities and staff quarters, and construction of safe water supply, sewage disposal, and solid waste facilities for AI/AN communities and homes. From 1980 to FY 1992, IHS constructed 11 hospitals, 11 ambulatory health centers, 315 staff quarters. First time water and sewer connections were provided to 73,500 Indian homes. IHS owns and operates nearly 2,600 buildings and structures for the benefit of AI/ANs.

ACCREDITATION STATUS

In 1992, 100 percent of IHS and tribal hospitals were accredited by JCAHO. The most recent numerical "grid" scores, which reflect relative degrees of

achievement considering the hundreds of factors examined in JCAHO surveys, was 79.6, which is not statistically different from the U.S. average of 80. Ninety-five percent of health centers are accredited. Overall proficiency rating for IHS laboratories was 97 percent which exceeds the 80 percent requirements of the Clinical Laboratory Improvement Amendments of 1988.

ACCOMPLISHMENTS

Indian health has improved significantly since the establishment of the IHS. For example, the maternal mortality rate for AI/ANs residing in reservation states dropped from 82.6 (rate per 100,000 live births) in 1958 to 7.1 in 1987, a decrease of 91 percent. The infant mortality rate for AI/ANs residing in reservation states dropped from 62.7 per 1,000 live births in 1955 to 9.7 in 1987, a decrease of 85 percent. By comparison, the U.S. infant mortality rate for all races for 1987 was 10.1. The birth rate for AI/ANs residing in reservations states was 28.0 per 1,000 population in 1987, 78 percent greater than the U.S. birth rate for all races.

NEW CHALLENGES

While IHS health care services have made noteworthy strides in improving the health of AI/ANs, much work remains to be done. For example, in 1988, the Indian age-adjusted mortality rates for the following causes were considerably higher than those for the general U.S. population.

- | | | |
|----|--------------------------|---------------------|
| 1. | Tuberculosis - | 480 percent greater |
| 2. | Alcoholism - | 388 percent greater |
| 3. | Accidents - | 185 percent greater |
| 4. | Diabetes mellitus - | 169 percent greater |
| 5. | Homicide - | 91 percent greater |
| 6. | Suicide - | 52 percent greater |
| 7. | Pneumonia and Influenza- | 42 percent greater |

March 16, 1993

MEMORANDUM

TO: Kim Tilley

FROM: Mike Sweeney

RE: Department of the Interior: Key Indian Issues

Indian Gaming. Recent interest in Indian gaming has been widespread and intense, involving State Governors and Congress. Tribes view gaming as a legitimate opportunity for economic development on Indian reservations, generating dollars that by statute must be used for health, schools, social services, and infrastructure development unless otherwise approved by the Department. Tribal gaming activities fall primarily into two categories: Class II, consisting of games of chance similar to bingo, and Class III, including other forms of gaming typically associated with casino-type operations. Generally, Class III gaming cannot occur on reservations without an agreement (compact) with the State involved. Tribes in 18 States have successfully negotiated such agreements. Some States view as overly broad the definition of Class III activities, often interpreted by courts as allowing Tribes casino-type activities not otherwise operating in those States. Legislation is expected to be introduced in Congress to amend the Indian Gaming Regulatory Act (IGRA). Tribes in general oppose amendments primarily because they fear the States will seek to repeal the IGRA entirely or otherwise erode Tribal sovereignty, to the advantage of State interests. Western governors generally support the enactment of amendments restricting Tribal gaming.

Federal Acknowledgement of the Lumbees. President Clinton was asked recently about Federal recognition of the Lumbees, a group who have variously petitioned the Department and Congress for Federal recognition as an Indian Tribe. In response, the President stated that he would have staff look into the issue. Tribes acquire Federal recognition by meeting certain criteria related to group membership rolls, governance, membership requirements, historical continuity and community and political autonomy. Federal recognition allows Tribes and their members to be eligible to receive benefits from Federal Indian programs and has long-term Federal budget implications. At the President's request, the Secretary is studying this matter.

Education. Indian education is a Federal responsibility, but schools' operating budgets have suffered and facilities have degenerated in recent years. Education and training are important economic development factors in Indian Country. This connection is recognized in the President's Economic Stimulus Package in which over \$58 million is directed to Indian school facilities and school operations during the FY 1993/1994 school year. A concerted effort will be made in the President's FY 1994 Budget to remedy this situation and improve Indian schools.

Economic Development on the Reservations. The Federal Government must maintain a positive posture in assisting and facilitating Tribal Economic Development initiatives. Economic stimulus and development on reservations has the direct positive effect of improving the lives of Native American peoples while reducing the need for direct funding for health, education, social services, and infrastructure on the reservations, and waste disposal sites, if well-engineered and environmentally conscientious, provide both a needed public service and an economic development opportunity for Tribes.

September 12, 1992

To President Zah and Native American Leaders:

I'm sorry that my schedule will not allow me to be with you on this glorious day. The 46th Annual Navajo Nation Fair is a thrilling testament to the rich traditions of the Navajo people and the other tribes represented here today. It is a day of celebration for you and for all of us who cherish the diversity of the American people.

I believe that one of the greatest aspects of America is this diversity. No nation on earth can boast the broad citizenship that America has, and no group represents the greatness of that citizenship more than Native Americans.

Native Americans in general and Navajo people in particular, have made great contributions to the United States. From the World War II service of Navajo soldiers, who devised the only code not broken by the Japanese, to the lifelong accomplishments of Dr. Annie Dodge Wauneka, the legendary Navajo mother who won the Presidential Medal of Freedom over twenty-five ago, Native Americans have enriched this great nation immeasurably throughout its history.

As President, I will support the sovereignty and self-determination of Native American tribal governments and will protect the religious freedom of the Native American people. I will also work to encourage economic development by helping small businesses prosper, guard our precious environment, expand the health care system so that it serves all Americans, and improve education from pre-school to college for every American child. I believe that this great nation cannot afford to waste the talents of any of our citizens; everyone should have access to the opportunities this nation offers.

In my presidency, every year, not just 1992, will be the year of the Native American. And we will show it not just with proclamations but with real programs and a deep commitment to extend the American dream to every American citizen.

I look forward to working with you over the next four years to put the American people first again.

My warmest regards on this great day,

Bill Clinton