Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Indian Health Board of Billings [partial] (2 pages)	4/15/93	b(6)
002. fax	From: Cindy Dwyer, To: Patty Solis, Re: Meeting with Lancaster Co. Medical Society [partial] (1 page)	4/14/93	b(6)
003. fax	From: Cindy Dwyer, To: Patty Solis, Re: Meeting with Lancaster Co. Medical Society [partial] (1 page)	4/14/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Friday, April 16 [1993]

2014-0483-S
sb334

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

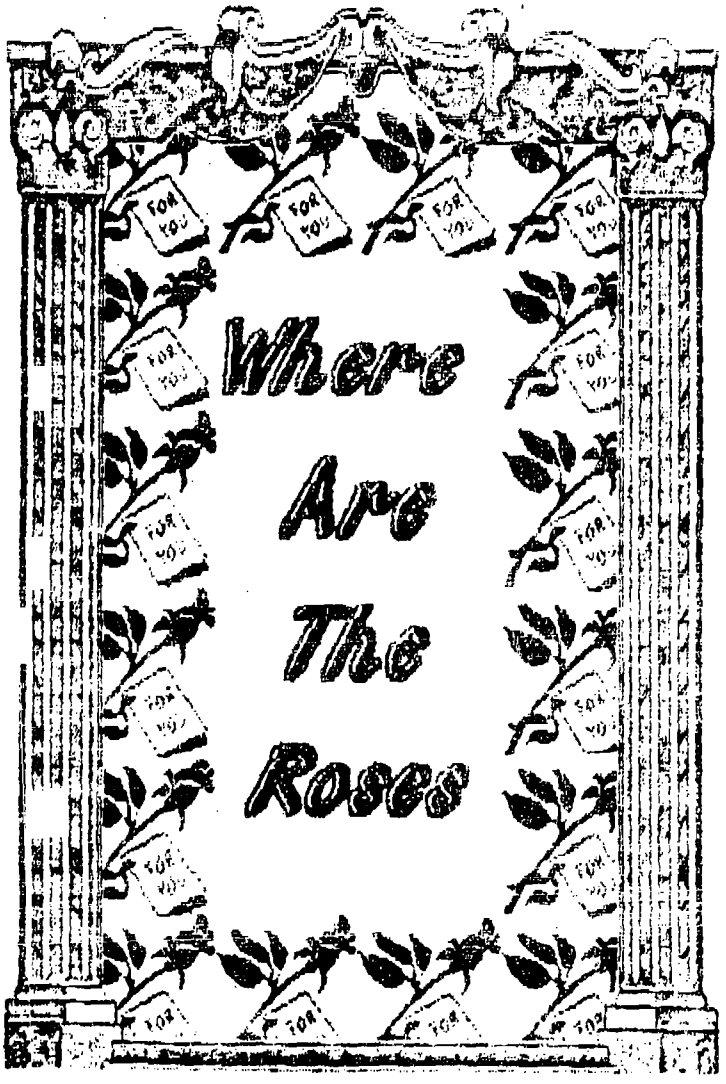
C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FRIDAY, APRIL 16th

A Tribute to Natalie Hertz and Runaway Teens



Sharon Swindler
Where Are The Roses
March 16,1993-April 16, 1993
Opening March 19
7:00-9:30
YWCA
Bridenbaugh Room
909 Wyoming Ave.
Billings, MT
Hours Open 8:00 A.M.-5:00 P.M.
Monday-Friday
8:00 A.M.-3:00 P.M.
Thursdays

THE NATIONAL HEALTH SERVICE CORPS

- Begun more than 20 years ago, the National Health Service Corps (NHSC) is a national service program which encourages doctors and nurses to serve in areas that have shortages of health providers in exchange for medical scholarships and loan repayment.

- The Corps, made popular by the television show "Northern Exposure," is one way we increase the number of health providers in rural communities.

  - **In 1986, 70% of the 3,127 health professionals serving under the NHSC program served in rural areas.** [Department of Health and Human Services]

  - State officials in 35 states rated the National Health Service Corps as effective in improving the availability of health services in rural areas. [Robert Wood Johnson Foundation]

Note: After 1986, NHSC field strength dipped sharply due to Reagan era budget cuts, but has rebounded since. Many rural Americans hope that this program will be reinvigorated to increase the numbers of health providers serving in rural areas.

Montana Indian Health Board of Billings, Inc.

Marjorie Bear Don't Walk, Director

Last Year -- 1992

4700 came through to see the doctor

21,000 came for consultations for substance abuse, immunization and mental health services.

Health educ, ~~transport~~ for other hlth care

FOR Tour 4/16 5:00 p.m. Billings, Montana

406 245 8872

Questions?
Diane Hill 225-3211

Ask about NEC briefing

N. Americans

- HRC asked them to do consensus building
- They did it & will prob ask for f-up meeting

per Lorrie

Latmos pissed off Ron Brown didn't meet w/

Audit Groups

HPR6 Public Cons HRC will be asked about these

Legal, Quan, Ana Admin, consultants Simplica

"What If" format at outset of structure

Ira orig said he wanted Legal, Financial A

Evaluation sheets subject to FOIA

HPR6 - Develop themes

HRRG – Names will be released

Maggie reg – meet w/ legal/Steve
pt by pt point

Consumer Panels not

HRRG - define the scope

no surprises

1) How selected

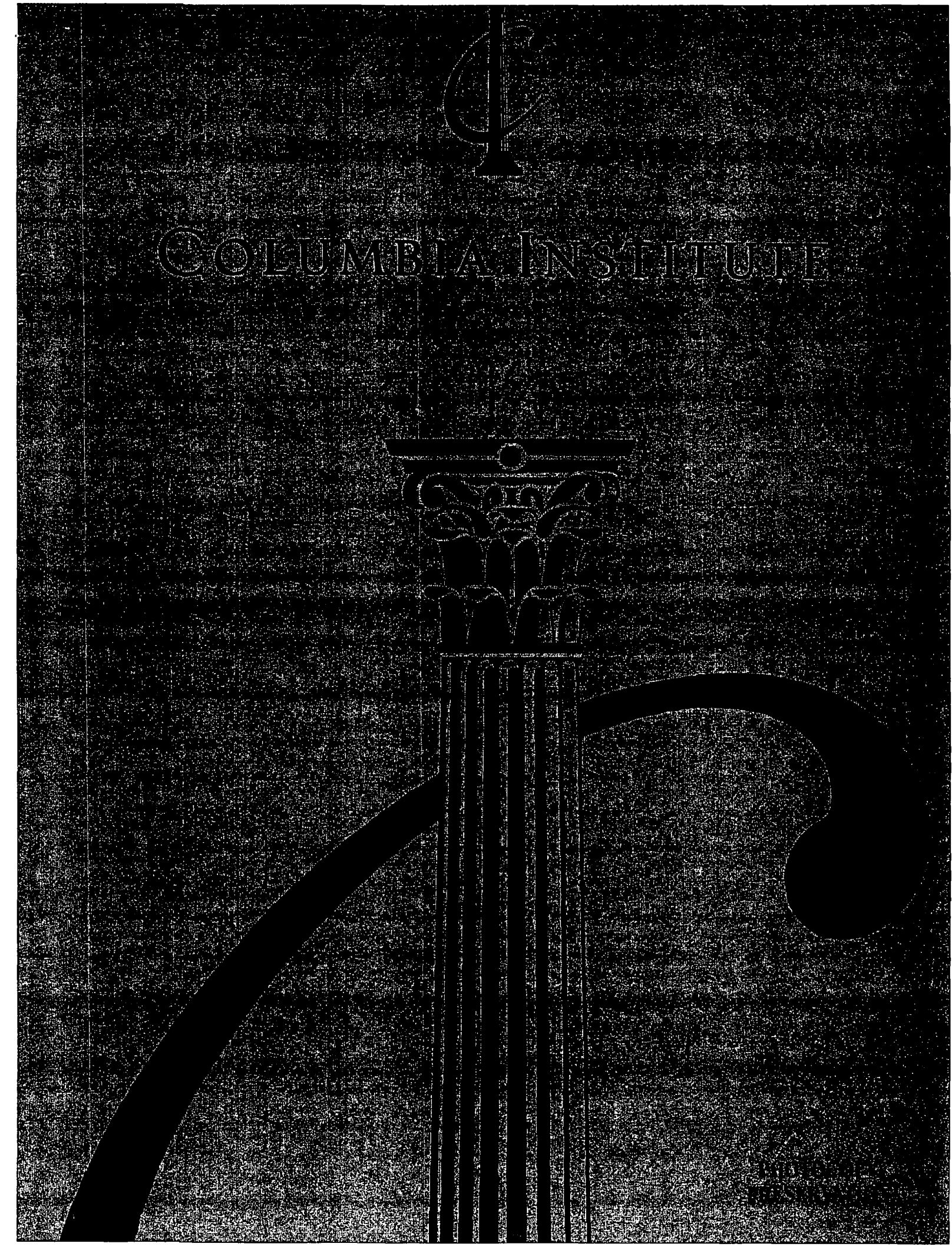
2) Why can't be discussed

CT Thursday 4:00 Rm 100 Trip Meeting

Billings

2398

overnight Great Falls (2) Lawrence Payne
H.C. Forum
(2) MT of Great


COLUMBIA INSTITUTE

Health Care in the 21st Century:
National Challenges, Nebraska Solutions

April 16-17, 1993
University of Nebraska - Lincoln, Nebraska

Senator J. Robert Kerrey, Chairman
Governor E. Benjamin Nelson, Co-Chair

DINNER ATTENDEES

Carol Aschenbrener, M.D.
University of Nebraska Medical Center

Jack Baker
Baker's Supermarkets, Inc.

Prem Bansal, Ph.D.
Governor's Policy Research Office
Governor E. Benjamin Nelson

Frank Barrett
Blue Ribbon Coalition

Robert Bartee
University of Nebraska Medical Center

Robert Bates
Guarantee Mutual Life Company

Bob Bell
Omaha Chamber of Commerce

Jim Botkin
Sandoz Pharmaceuticals

John Braasch, Ph.D.
Share Health Plan of Nebraska/United HealthCare

Gretchen Brown
Kaiser Family Foundation

E. Richard Brown, Ph.D.
President's Task Force on National Health Care Reform

Thomas Cinque, M.D.
Creighton University

Catherine Coleman
Office of Senator J. Robert Kerrey

Sister Norita Cooney
Mercy Midlands

Bernard Dana
Vetter Health Services, Inc.

Dick Davis
Northern Plains Natural Gas Co.

Paul Ellwood, M.D.
Jackson Hole Group

Allen Fredrickson
Accent Service Company, Inc.

James Geist
Lincoln Telecommunications Company

Elaine Guffey

Richard Guffey
Blue Cross and Blue Shield

Allen Hager
Clarkson Hospital

Terry Hager

Mark Hanley
Abbey Home Health Care

Mary Dean Harvey
Nebraska Department of Social Services

Jack Hogan
Physicians Mutual Insurance Co.

Randall Horn
Mutual of Omaha Companies

Karen Horn

Dave Hunt
Nebraska Citizen Action

Donna Hunt

William Kaizer
Central States Health and Life Company

Mrs. Kaizer

Matthew Kurs
AMI St. Joseph Hospital

Darroll Loschen, M.D.
Nebraska Medical Association

Lon Lowrey
Dorsey-Sandoz Pharmaceuticals

Kathy Mallatt
Share Health Plan of Nebraska\United HealthCare

Charles Marr
Immanuel Medical Center

Ken Mass
Nebraska AFL-CIO

Sheila Murphy
Office of Senator J. Robert Kerrey

Herman Myers, Jr.
Continental General Insurance Company

Betty Myers

Governor E. Benjamin Nelson

Diane Nelson

Charlie Nields
Physicians Mutual Insurance Co.

Joan O'Brien

Richard O'Brien
Creighton University

David Palm
Nebraska Department of Health

Kim Robak
Office of Governor E. Benjamin Nelson

Fred Runington
Northern Plains Natural Gas Co.

Gene Schellpeper
Continental General Insurance Co.

William Schellpeper
Nebraska Medical Association

Robert Shapiro, M.D.
Nebraska Medical Association

Janet Shikles

U.S. General Accounting Office

Tom Sick
Physicians Mutual Insurance Co.

Richard Spellman
Guarantee Mutual Life Company

Arlan Stromberg
Lincoln General Hospital

Jack Vetter
Vetter Health Services, Inc.

Lora Villarreal
First Data Resources

Larry Villarreal

Senator Don Wesely
Nebraska Legislature

Neal Westphal
Lincoln Telecommunications Company

Ross Wilcox
Union Bank & Trust Company

Bill Williams
Dorsey-Sandoz Pharmaceuticals

Ronald Wilwerding
Accent Service Company

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HEALTH CARE IN THE 21ST CENTURY: NATIONAL CHALLENGES, NEBRASKA SOLUTIONS

Friday, April 16, 1993
Saturday, April 17, 1993
University of Nebraska, Lincoln
Kimball Hall & Student Union

KEYNOTE PRESENTATION:
Hillary Rodham Clinton
First Lady of the United States of America

Senator J. Robert Kerrey, Chairman
Governor E. Benjamin Nelson, Co-Chair

A COLUMBIA INSTITUTE *Coordinated Event*

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COLUMBIA INSTITUTE

An independent public policy group specializing in conference management and research services.

NOTE: Mrs. Clinton's address will be held in Lied Center.

NOTE: The Senator wil introduce Mrs. Clinton, she will speak for 30 minutes. She will take questions after her remarks.

12:45p.m. LUNCHEON ADDRESS: A VIEW FROM WASHINGTON AND THE TASK FORCE

Hillary Rodham Clinton

Current:

Chair, President's Task Force on National Health Care Reform

First Lady of the United States of America

Previous:

Partner, Rose Law Firm

Founder, Arkansas Advocates for Children and Families

Education:

Wellesley College

Yale Law School

12:00 p.m. LUNCHEON

"...we will now break for lunch. The luncheon will be held in the Centennial Ballroom at the Student Union. Due to the size of our crowd, we will be providing box lunches instead of a buffet so please feel free to begin eating as soon as you receive your lunch and you are welcome to eat outside or in any part of the Union you wish. We do ask that you please go to the LIED CENTER NO LATER THAN 12:40 so that we may seat people for the keynote address by Hillary Clinton. TICKETS WILL COLLECTED AT THE DOOR. Enjoy your lunch PLEASE RECONVENE at 12:40 p.m."

NOTE: Make a brief announcement reminding the audience to turn in the surveys on health care as they proceed outside for the luncheon.

BOB KERREY

U.S. Senator for **Nebraska**

J. ROBERT KERREY OF NEBRASKA

In the four years since Bob Kerrey was elected to the U.S. Senate, he has impressed political observers with his independence, his candor, and his tireless determination to make government work. Bob Kerrey's devotion, hard work, and leadership has made him one of America's most exciting and effective political leaders.

Since his overwhelming electoral victory to the U.S. Senate in 1988, when he defeated an incumbent United States Senator, Bob Kerrey has demonstrated that his is a voice to be heard on the major issues of the day:

--ON HEALTH CARE: While the President and the Congress stalemated on health care reform, Bob Kerrey spent three years developing **Health USA**, the most comprehensive health care reform package in America. As a consequence of Senator Kerrey's tireless efforts, the debate over health care reform has finally begun in earnest on Capitol Hill.

--ON AGRICULTURE: As a member of the powerful Senate Agriculture Committee, Senator Kerrey was instrumental in writing the commodities section of the 1990 Farm Bill and has become a recognized leader on agriculture and rural development issues. As evidence of Senator Kerrey's leadership, Agriculture Committee Chairman Patrick Leahy in 1989 named Senator Kerrey to the 1990 Farm Bill Conference Committee even though Kerrey was the most junior member of the Committee. Congressional Quarterly's Almanac of American Politics notes, "Another reason Leahy may have valued Kerrey's presence in the conference was [Kerrey's] unflinching tenacity in the face of administration opposition."

--ON EDUCATION AND CHILDREN'S ISSUES: Bob Kerrey's compassion and understanding of the great needs facing our children have made him one of the Senate's most consistent voices for America's youth. In education, Senator Kerrey's belief that bureaucracies at all levels have become impediments to improving our schools culminated with his sponsorship of the Education Capital Fund Act which provides federal funds directly to local school districts to undertake systemic reform initiatives.

Senator Kerrey has also been a consistent voice for children's programs like Head Start, child care, and WIC; his Health USA legislation would guarantee that every American child has full access to high quality health care services.

--AS A SENATOR WHO STANDS FOR WHAT IS RIGHT: Bob Kerrey has demonstrated that his is a voice of reason in confronting the hottest and most politically charged issues of our day. Bob Kerrey has beco r cognized as a Senator who is willing to take on the vested interests, and who is willing to

qualities are perhaps best exemplified in Senator Kerrey's defense of the First Amendment during the flag burning controversy in 1989. Senator Kerrey's work to defeat the controversial legislation was heralded as one of Congress's most eloquent profiles in courage.

--AS AN EMERGING LEADER IN THE AREA OF FOREIGN AFFAIRS: In the four years that Senator Kerrey has served in the Senate, he has proved equally adept in understanding America's role in the World. During his Senate service he has had direct exposure to some of the most dramatic global political changes of the century:

U.S. Senate, Washington, D.C., 20510 ■ 7602 Pacific Street, Omaha, NE 68114
202-224-6551 402-391-3411

100 Centennial Mall North, Room 294, Federal Building, Lincoln, NE 68508
402-437-5246

STATE OF NEBRASKA

EXECUTIVE SUITE
P.O. Box 94848
Lincoln, Nebraska 68509-4848
Phone (402) 471-2244

E. Benjamin Nelson
Governor

BIOGRAPHICAL SKETCH OF NEBRASKA GOVERNOR

E. BENJAMIN NELSON

Elected in 1990, Governor Ben Nelson immediately began working for his initiatives in Education, the Environment and Economic Development.

During his first 16 months in office, Nelson initiated and guided to passage a solution to the state's personal property tax crisis. The tax problem had been building for 20 years and was threatening to strangle local government operations. Resolution of the problem restored confidence in, and stability to, the state's tax system.

At the same time, Nelson moved to restore fiscal responsibility to state spending. His tight reign led to a one year budget increase of less than one-half of one percent. The Governor also instituted a Strategic Budget Plan with the goal of making government more efficient and effective. Under the plan, every state agency is required to evaluate programs and priorities for possible reallocations, interagency coordination, and budget cuts.

Under Nelson's leadership, Nebraska has moved from 31st to 21st in Financial World magazine's "State of the States" financial health ranking. City and State magazine ranks Nebraska 2nd among all 50 states in terms of a solid financial condition.

Governor Nelson also led the way in enacting landmark environmental legislation for the state. The Governor's Environmental Trust Fund has been establish and will provide needed financing for worthy environmental projects. Monies for the Trust Fund will be provided from proceeds from a statewide lottery. The lottery, proposed by the Governor and passed by state lawmakers, received voter approval in November 1992.

Governor Nelson is currently serving as Chairman of the National Education Goals Panel. Nelson helped established, and served as Chairman of, the Governors' Ethanol Coalition, a 16-state ethanol promotion and policy group. Additionally, Nelson was selected as Vice Chair of the Midwestern Governors' Association and is past Vice Chair of the National Governors' Association's Agriculture Committee.

-- more --

In recognition of his work to build Nebraska's economy, the Nebraska Diplomats honored Nelson with the prestigious "Ambassador Plenipotentiary" award and title. He is one of only four Nebraskans to receive the award.

Nelson entered the practice of law in 1970, eventually being named General Counsel, President, and Chief Executive Officer for a national insurance group. He also served as Executive Vice President of the National Association of Insurance Commissioners. Nelson joined Kennedy, Holland, DeLacy & Svoboda, one of Nebraska's most prominent law firms, as Attorney-of-Counsel in 1985. He has also served as Nebraska's Director of Insurance.

Nelson earned degrees in logic, philosophy and law from the University of Nebraska. In May of 1992, he was awarded an Honorary Doctor of Law Degree from Creighton University for his accomplishments.

Nelson, who announced as a candidate for Nebraska governor in January 1990, won the Democratic nomination by 42 votes, one of the closest elections for a statewide race in modern U.S. history. He was elected as the 37th Governor of Nebraska on November 6, 1990, and inaugurated as Governor on January 9, 1991.

Nelson was born in McCook, Nebraska in 1941 to Benjamin E. and Birdella Nelson. He is a life-long Nebraskan. The Governor and his wife Diane have four children.

-- 30 --

PAPER Lincoln Star
DATE 4-14-93 PAGE 1

THIS IS CLIP PAGE 2
FROM CLIP PAGE
CONTINUED ON PAGE

BC

First lady to speak in Lincoln

Hillary Rodham Clinton expected at health reform conference Friday at UNL.

By JoAnne Young
of The Lincoln Star

First lady Hillary Rodham Clinton will join a list of national and state authorities to speak on health care reform at a conference scheduled for the University of Nebraska-Lincoln campus Friday and Saturday.


Clinton

Although few details were available Tuesday evening, Clinton is expected to be in Lincoln on Friday, said Phil Richmond, a spokesman for Gov. Ben Nelson. Clinton is scheduled to speak at 12:45 p.m. Friday during a luncheon at the conference on "Health Care for the 21st Century: National Challenges, Nebraska Solutions."

Her address is titled "A View from Washington." Clinton is the chairwoman of the President's Task Force on National Health Care Reform.

A spokeswoman in Clinton's press office said details of her visit would be released today.

The location for the Friday sessions of the conference was moved from the Nebraska Union Ballroom to UNL's Kimball Hall. But that location could change if officials decide a larger space is needed, said Phyllis Larsen, UNL associate director of university relations.

A WHITE HOUSE advance team and state fire marshal officials will meet Wednesday with Ron Bowlin, Kimball Hall director, to determine if the Kimball space is adequate, Larsen said.

The conference is being coordinated by the Columbia Institute, an independent, bipartisan organization based in Washington, D.C. Sen. Bob Kerrey is chairman and Gov. Ben Nelson is co-chairman of the conference. Kerrey has been recognized as a leader on health care reform and was one of the first to develop a comprehensive national health care plan.

The goal of the forum is to inform Nebraskans about health reform proposals from both national and state perspectives so they can make decisions about which plan to support. In addition to Clinton and local officials, other speakers are to include:

- Dr. Paul Ellwood of the Jackson Hole Group, the originator of the concept of managed competition. He is currently working with leaders to develop the "21st Century American Health System."
- Janet Shikles, director of health financing and policy in the U.S. General Accounting Office. She has studied national health care policies of four other countries and will speak on "Social Values vs. Economic Necessity."
- E. Richard Brown of the UCLA School of Public Health, who will speak on cost control.
- Gov. Howard Dean of Vermont, who will deliver the keynote address on Friday.
- Minnesota state Sen. Linda Berglin, who will deliver the keynote address on Saturday.

Kerrey's plan would make health care available to everyone

A comprehensive reform of the American health care system is vital for economic and medical reasons, according to Nebraska Sen. Bob Kerrey.

"Without true health reform, deficit reduction will remain a dream, our national economy will continue to stagnate, the number of Americans without adequate health coverage will grow and the uninsured will remain economically vulnerable and medically underserved," Kerrey said.

In response to this growing concern, Kerrey has designed *Health USA*, a proposal that he says would make health care affordable and available to all Americans. "*Health USA* is a uniquely American system that builds upon the strengths of our current system and directly addresses its shortfalls," Kerrey said.

More than $11 billion in health care spending would be saved during the program's first year, according to the plan's outline. Savings would total more than $150 billion over a five-year period.

Health USA reforms the way health care is financed, not delivered, Kerrey said. The program preserves Americans' right to choose among private physicians, hospitals, insurers and health plans, he added.

Under Kerrey's proposal, Americans would choose among competitive private and public health care plans for their coverage. All policies will be required to offer a basic package of benefits, including hospital, physician and other services.

"A system of regional purchasing cooperatives contracting with competing private plans will ensure that choice and quality remain characteristics of American health care," he said.

Insurers won't be allowed to reject anyone wishing to enroll in their plan. Those who don't enroll in a private plan will be enrolled in a state-operated program.

To ensure equity and access, all health plans must offer a uniform, comprehensive benefit package. "Insurers will not be able to attract young, healthy enrollees and avoid older, poorer clients by tailoring their benefit packages," Kerrey said.

"Long-term care benefits must be a part of this reform, either as part of the basic package or as a supplemental benefit available on a premium basis to all Americans," he continued.

UNDER HEALTH USA, individuals and employers would contribute to the program and their care, based on their ability to pay through payroll and income taxes. These taxes would replace the private insurance premiums now paid.

"We must commit to financing health services as fully and equitably as possible through private and public dollars," Kerrey said. "Individuals should also participate in cost-control measures.

"We must finance not only service delivery, but also clinical research, professional training, services for vulnerable groups and other needs," he added.

Health USA would be administered federally by an independent commission similar to the Federal Reserve Board. The commission would provide general guidelines to states, make recommendations on federally-prescribed benefit packages, encourage states to develop ways of providing quality health care, distribute funds, recommend malpractice reforms and work to standardize and simplify billing and other administrative procedures.

Kerrey's plan addresses the health care needs of persons living in rural and underserved areas. Payments to providers will be assured and adjusted according to health care costs in each state. A resource development fund will help states provide financial, educational or other incentives to health care professionals practicing in these areas.

TO ACCOMPLISH meaningful health care reforms, Americans must follow several principles, according to Kerrey.

"The first principle is that all Americans are eligible to receive health care. Not only is this the most equitable and compassionate approach, but universal eligibility is also the best means to control health care spending," he said.

"Only a system which guarantees universal access to health care services will address the problems of uncompensated care and cost shifting, job lock, differential access and escalating costs which plague our system," Kerrey continued.

Other cost-control and access-enhancing ideas must be considered, he said. "Appropriate cost-sharing measures have proven to reduce unnecessary utilization, and preventive care must be encouraged," he said.

Cost-control strategies should be determined on a local level to help address specific concerns, Kerrey said. "We want a system which provides financial incentives and rewards for private sector providers, payers and entrepreneurs who deliver high-quality, low-cost care."

The time to begin implementing health care reforms has come. "The United States prides itself on having the best health care in the world," Kerrey said. "We must act now to ensure that all Americans enjoy this care."

OWH CLIPS, AM X DATE 4/10/93
PM X PAGE 7

OMAHA WORLD HERALD

BK

'Health Plan Must Give Consumer Control'

BY DONALD F. ORTON, M.D.

All these national health care bills would mean: a crushing new tax burden on senior citizens and others; health care rationing, depriving seniors of care for life-threatening or terminal illness; a huge new government health care bureaucracy guaranteed to waste millions of tax dollars, and extra regulatory and tax burdens for employers.

The vast majority of health care costs, up to 95 percent in the case of hospital bills, are paid by someone other than the consumer.

In the case of President Clinton's plan or Bob Kerrey's "Health USA," the third-party effect would be predictably disastrous.

What is needed is a plan that would revamp tax treatment of health insurance for both employees and employers by giving health care consumers incentives to be aware of costs and allowing financial benefits to be derived from money saved on premiums. Most importantly it would give the consumer control over decisions made by health care providers at the time of treatment. (The Clinton and Kerrey plans would take control away from citizens.)

Such plans already exist: one is promoted by the Heritage Foundation, and another is the Medi-Save option sponsored by the National Center for Policy Analysis.

I have noticed ads for an April 16 and 17 meeting at the University of Nebraska-Lincoln with Bob Kerrey and Gov. Ben Nelson called "Health Care in the 21st Century." I am wary of this as more Hillary Clinton/Kerrey smoke and mirrors for socialized medicine. Knowledgeable individuals and organizations, such as the Heritage Foundation and Dr. Jane Orient, executive director of the Association American Physicians and Surgeons, have not, to my knowledge, been invited to speak at this symposium.

The last thing our nation needs now is another huge federal government program with control over every detail of health care, including life and death decisions made by politicians, bureaucrats and computers.

It is federal legislation, including Medicare/Medicaid and current federal tax treatment of private third-party group health plans, that in large part is responsible for ballooning health costs.

Results should be the final argument against socialized health care. Citizens of Canada, Mexico and the United Kingdom come here for their health care if they can, not the other way around.

NAME OF PAPER News
CITY, STATE Norfolk, NE
DATE 3/2/93
PAGE 1 OF 2

Kerrey shares health, farm opinions

By Diane Becker
News Correspondent

ALBION – Neither budget cuts nor tax increases by themselves will solve the federal budget deficit problem, U.S. Sen. Bob Kerrey told about 100 people gathered here Saturday at Gragert's Villa Inn.

"Taxes won't get the job done. The number one problem we've got is growth in health care costs. They grew by $30 billion last year, and they'll grow by $30 billion this year," Kerrey said.

Kerrey answered questions posed by numerous members of the audience, including Dr. Randy Kohl, who works at Boone County Health Center in Albion. He asked Kerrey about regulations burdening small hospitals.

Kerrey said the nation's existing health care strategy will result in depopulation of rural America. "Rural health is a losing battle until there's reform," he said.

Kerrey said there should be a simplified version of eligibility for medical benefits. He said Americans spend 9 percent of their income on food, which is the lowest rate in the world, and 14 percent on health care, which is the highest rate in the world.

When asked an abortion-related question, Kerrey said he accepts the Roe vs. Wade court ruling that established the right of a mother to choose to have an abortion in the first 20 weeks of pregnancy.

"After that, the government has the right to intervene," Kerrey said.

Keeping government out of matters concerning personal choice is not liberal, but conservative in philosophy, he said. Kerrey said he personally believes abortion is wrong.

Kerrey also said he felt some parents aren't providing children with values they need to live a useful life.

"We have to go away from the government. The government is not going to raise families. The incentives right now very often (encourage) people not to get a job or get married or they'll lose their welfare payments. It's up to the parents to provide the environment," Kerrey said.

On agricultural issues, Kerrey said it's important to remember that farm subsidies are the least costly of the top 10 entitlement programs that are part of the federal government.

"All the other (budgets) went up last year, but the farm program went down 10 percent. So, they can't say we aren't going to do our fair share," Kerrey said.

He emphasized the need for urban senators to understand that the farm program protects both consumers and producers.

Kerrey said he disagreed with much of President Clinton's economic proposal. The plan to raise taxes on energy is an example of a Clinton proposal that he opposes because of its negative impact on small business, Kerrey said.

He estimated the new tax would add $1 to $2 an acre in costs to farmers.

"Farms are too often seen as special interest groups rather than businesses. In Nebraska they brought $8.6 billion worth of revenue and $120 billion nationwide," Kerrey said.

He said he favors tax breaks for production of ETBE (ethyl tertiary butyl ether), a fuel derived from ethanol that can be added to gas to increase fuel efficiency.

"It's a win for the oil companies, a win for the corn producers and a win for the environmentalists," Kerrey said.

He estimated the program would create a demand for 4 million bushels of corn annually.

Marvin Fritz of Bartlett told Kerrey he had been farming for 20 years but was "losing motivation" knowing that the U.S. Environmental Protection Agency might find a legal infraction on his farm from 40 years ago that could put him out of business.

Kerrey agreed that the EPA's major problem is regulation that is too remote from agriculture. He also said personnel changes in federal agriculture agencies cause regulations to vary greatly.

"The Soil Conservation Service recently said that if you have ruts in your field from last fall, then you can't repair them without their permission. That's ridiculous," Kerrey said.

About the proposed dismantling of the Rural Electric Administration, Kerrey said the agency still provides a vital service and that the REA will be responsible for keeping rural communities current in telecommunications.

Kerrey said he is against a presidential line-item veto. He acknowledged, however, that a "substantial amount of waste, fraud, and abuse" exists in government, but it should be handled by review boards at a local level.

Coash of Albion sponsored Saturday's meeting.

OWH CLIPS, AM ____ DATE 3/19/93
PM X PAGE 145

THIS IS CLIP PAGE 1
CONTINUED FROM CLIP PAGE ____
CONTINUED ON CLIP PAGE ____

BK

Mrs. Clinton Hears Kerrey Health Plan

BY PAUL GOODSELL
WORLD-HERALD BUREAU

Washington — Sen. Bob Kerrey, D-Neb., used an hourlong meeting Thursday with Hillary Rodham Clinton to advocate his plan to place all health-care spending on a pay-as-you-go basis.

Mrs. Clinton was not particularly receptive to the plan, Kerrey said Friday.

"She politely considered it," he said. "It's a new idea; it takes time. I'm just beginning to lean into it."

The first lady, who heads a White House task force on health-care reform, met with Kerrey in his Senate office. Kerrey has proposed his own comprehensive health-care legislation, although he has expressed support for the administration's general proposals.

Kerrey said he told Mrs. Clinton that he was not enthusiastic about using short-term price controls as a way to restrain health costs. Clinton advisers recently said they were actively considering some kind of medical price controls.

"They're deadly serious about doing something to get health-care costs under control," Kerrey said. But he said he questions whether price controls would be effective or wise.

Instead, Kerrey said, he believes that it would be better to create a federal trust fund to cover all $250 billion to $300 billion in current federal spending for health care.

The trust fund would be fully funded through existing revenues, without the deficit financing. Kerrey said such an

Please turn to Page 5, Col. 5

Kerrey Pushes Health-Care Plan In Meeting With Mrs. Clinton

Continued from Page 1

accounting system would not save any money this year but would reduce next year's budget deficit.

Instead of borrowing money to cover an estimated $30 billion increase in health-care spending, he said, federal officials would have to cut spending or raise taxes to make ends meet.

"It creates an immediate fiscal discipline," Kerrey said.

Since health-care spending is a major and rapidly growing part of the budget, deficit-reduction efforts for health care would reduce the overall federal deficit, he said.

A pay-as-you-go system might force more managed-care requirements for Medicaid recipients or lead the federal government to prod private insurers to adopt Medicare reimbursement rates, he said.

Kerrey said he did not consider his plan to be a substitute for a more sweeping reform of the nation's health-care system, including both private and public spending. "I would prefer to have it as a first step toward comprehensive reform."

Kerrey said he agreed to help the administration in developing and enacting a health-care plan. Several Kerrey staff members are working with Mrs. Clinton's task force.

"It's a very important issue for the country," Kerrey said, "and I'm pleased that the first lady has asked me to help."

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PM X PAGE 9-A

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Wesely: States Key In Health Planning

BY MARY MCGRATH
WORLD-HERALD MEDICAL WRITER

Architects of President Clinton's health-care plan are fashioning a key role for state governments in carrying out reforms, Nebraska State Sen. Don Wesely said Saturday.

"They have come to the conclusion states need to have an important role in bringing employers and consumers together into health insurance purchasing cooperatives," Wesely said.

The cooperatives would bargain with insurers and the providers of health care to obtain higher-quality care at lower prices, Wesely said from Washington, D.C., where he took part in a health-care reform meeting Friday.

The Lincoln lawmaker was one of 13 representatives of the National Conference of State Legislatures who met with several members of the Clinton health-care reform task force and its director, Ira Magaziner.

"This was the first time that legislators themselves have had direct input," said Wesely, an officer of the National Conference of State Legislatures and chairman of the Nebraska Legislature's Health and Human Services Committee.

"I got very positive feelings out of the meeting," he said.

Wesely said it is good news for states that they apparently will be major players in carrying out health-care reforms.

That involvement should help ensure that the national plan can be adapted to the needs of different states, he said.

"The federal role will be to set the framework for reform, decide what will be included in a basic package of coverage and establish the basic mechanisms for financing," Wesely said.

Financing has not yet been spelled out.

Wesely said states apparently would determine how many health insurance cooperatives would be needed, oversee their development and monitor their operation.

Nelson to Get Progress Report

Gov. Nelson will be among the governors meeting with White House officials Monday for an update on the progress of proposals for health-care reform.

Nelson and other members of the National Governors Association will attend an all-day meeting.

Medicare, the nationwide program that covers the elderly and disabled, would remain outside the cooperatives, Wesely said. The federal-state Medicaid program for the poor probably would be included in the cooperatives, he said.

Wesely said the health-care reform planners "are looking toward global budgeting." The budget would target how much U.S. health-care costs should increase annually.

Each state likewise would have its own goal, he said. If costs exceeded a state's goal, the state would have to make up the excess, Wesely said.

"I felt they (task force members) were aware of the concerns of the state senators," Wesely said. "I don't know that they have all the solutions, but at least they are aware of the problems."

Wesely said the task force members were aware that programs that could work in cities would not work in rural areas and that many people on Medicaid have health-care needs that exceed basic coverage and no way to pay for those services.

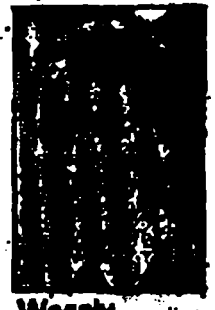
Wesely said that considering the time it could take to pass federal and state legislation, it might be January 1997 before a health-care reform plan could be in place in all states.

"Some states such as Oregon, Florida and Colorado are moving ahead very quickly," he said. "We talked about letting them move ahead and letting other states learn from their experience."

Wesely: Don't fear health care plan

By James Joyce
Lincoln Journal-Star

If you're worried about how President Clinton's reform proposal will affect your health care, you're worrying unnecessarily.


Wesely

At least that's the opinion of Sen. Don Wesely of Lincoln, who recently attended a White House briefing on the plan and came away satisfied with what he learned.

Furthermore, he said, for most Americans — those who get their health insurance through their employers — the changes proposed by Clinton will hardly be noticed.

"For the employee who already has health insurance, there's not going to be a lot of difference," Wesely said.

According to Wesely, who's chaired the Health and Human Services Committee for most of his 14 years in the Legislature, the most noticeable change for the average American will be in the way he or she gets health insurance.

IN THE current system, most people select from one or two group plans offered through their employers.

Under the Clinton plan, however, a person's choice of insurer won't be tied to where they work. Instead, it will be tied more to where they live.

This is because the Clinton plan calls for the creation of "local health purchasing alliances" within which a variety of health insurance plans will be offered to employers and employees.

The employers would have to offer insurance to their workers, but the workers would be able to choose between their employer's plan or another plan available within the alliance.

In other words, what plans would be available to the residents of a Lincoln purchasing alliance might be different from what might be offered by an Omaha or a Panhandle alliance.

Even then, though, there would be a minimum level of benefits that would have to be available in every plan regardless of where the purchasing alliance is located.

As with current employer-based plans, the cost — even for one not offered by the employer — would be shared between employer and employee.

FOR SOME, however, there might be another noticeable change.

Although the details are still being worked out, because of the President's strong advocacy of the concept of "managed health care," this is likely to be a strong element of the final proposal.

In other words, it's likely that many plans will require you to have a primary care physician who will "manage" your treatment and who will have a lot to say about whether you receive specialized treatment for your illness, such as a heart or liver transplant.

Although some might consider this a big deal — it has been suggested by some critics as a system that takes away a patient's freedom to choose his or her physician, an allegation the Clinton administration denies — Wesley is among those who think it's much ado about nothing.

Since 1979, Wesely has belonged to Health America-Lincoln, one of the first managed care health insurance programs in the state.

"I've been through managed care and I have no problem with it. I think it's great," he said.

There is another reason why he doesn't think managed care is such a big deal.

THE CONCEPT of managed care has caught on throughout the health insurance industry, and even if Clinton hadn't bought into it, sooner or later it will be part of every plan anyway, Wesely said.

The Clinton plan, which is currently scheduled to be submitted to Congress in late May, is aimed at extending coverage to the 37 million Americans, including 155,000 Nebraskans, who now lack health insurance and to bring the skyrocketing costs of health care, which now comprises about 14 percent of the nation's gross national product, under control.

One of Wesely's main concerns before his White House briefing was that the plan wouldn't take into account the differences, such as population densities and geography, that exist among the states.

However, he said, he was assured the plan will not only allow for differences among the states but differences within a state, such as exist between Omaha and the Panhandle.

HRC MEETING WITH GOVERNORS DEAN (VT) AND NELSON (NEB)
APRIL 16, 1993

I. GOVERNOR HOWARD DEAN, M.D. (D-VT)
(spouse = Judith Steinberg, M.D.)

A. Background

Governor Dean was born in New York City in 1948 and grew up in East Hampton, N.Y. He received a B.A. in political science from Yale in 1971 and a medical degree from the Albert Einstein College of Medicine in New York in 1978. He then completed his residency in Vermont and remained there as a general practitioner (internal medicine).

Governor Dean was a member of the Vermont House of Representatives from 1983 to 1986. He was elected lieutenant governor in 1986 and reelected in 1988 and 1990. He became Governor upon the death of Governor Richard Snelling in August 1991, and was elected to a full term in November 1992. His current term expires in January 1995.

B. Health Care

In 1992 Governor Dean signed into law a health care reform bill that won overwhelming support in both houses of the state legislature. The legislation commits Vermont to universal access, centralized health planning and a global budget. The Vermont Health Care Authority ("VHCA") is now preparing models for single-payer and multi-payer systems that would provide universal health care. Governor Dean wants to present the models to the legislature by November 1, 1993, after which he will conduct extensive public education. His goal is to provide universal access by October 1, 1994.

As you know, Governor Dean is a member of the National Governors Association's bipartisan health care committee, and you have met with him (as a member of this group) several times in the Roosevelt Room. As a former doctor (general practitioner/ internist) he will make an ideal surrogate for the Administration's health care reform legislation.

Last month he had dinner with Ira Magaziner and "expressed serious concerns about the proposals ... for achieving health care cost savings during the next two years [and] any attempt to impose strict controls on health care expenditures in the absence of universal access and health care delivery system reforms." Governor Dean followed up the meeting with two letters to Ira that set forth his own proposals for cost controls.

Attached are copies of Governor Dean's correspondence with Ira, as well as the Governor's February 16, 1993 letter to you expressing concern over proposed to "cut expenses in the Medicare program."

II. GOVERNOR E. BENJAMIN NELSON (D-NEB)

(spouse = Diane Nelson)

A. Background

Governor Nelson was born in rural southwestern Nebraska in 1941. He earned a B.A. in philosophy in 1963, a master's degree in philosophy in 1965, and a law degree in 1970 from the University of Nebraska. From 1965 to 1972 he worked for the Consumer Division of the Nebraska Department of Insurance, in 1975 he was named Director of Insurance, and in 1982 he became executive vice-president of the National Association of Insurance Commissioners. During much of the period from 1972 to 80 Governor Nelson worked for a major Omaha insurance provider, serving as general counsel, president and later CEO. In November 1990 Governor Nelson was elected to a four year term as Governor.

B. Health Care

Nebraska does not have any health care reform legislation, either enacted or pending, although the Nebraska Legislature is currently looking at plans to cut Medicaid spending because of a budget shortfall.

In January 1992 Governor Nelson formed the "Governor's Blue Ribbon Coalition to Study Health Care in Nebraska," to look at all of the health care issues in Nebraska and recommend "solutions" (not legislation) for the state's problems. The Coalition is a diverse group of 33-35 consumers, business leaders, doctors, insurance executives, etc. (There were no legislators or other electeds on the Coalition.)

In December 1992 the Coalition issued its preliminary report, stressing universal access, quality of care, cost containment, responsibility, flexibility/freedom of choice, innovation and financing. The report described a basic benefit package for all Nebraskans, having relied on its insurance industry to identify a package that reflected an average of what all Americans were currently receiving. The Coalition is now focused on how Nebraska can afford to pay for health care reform, and whether to have an employer mandate. They hope to have their work completed by summer.

Governor Nelson is viewed as a moderate, swing-vote among his fellow governors and is therefore potentially an important ally. He is concerned about rural health care issues, and has two primary reservations about the work of the Health Care Task Force:

1. cost containment - the ability to achieve real savings with such a comprehensive benefits package; and

2. state flexibility - not all states have the same constraints.

We suggest that you communicate to him that you are aware of his concerns and would like to speak to him about them at a later date.

Health Care in the 21st Century:
National Challenges, Nebraska Solutions

April 16-17, 1993
University of Nebraska - Lincoln, Nebraska

Senator J. Robert Kerrey, Chairman
Governor E. Benjamin Nelson, Co-Chair

PARTICIPANTS AND SPONSORS

Participants:

Carol Aschenbrener, M.D.
Chancellor, University of Nebraska Medical Center

Frank Barrett
Chair, Blue Ribbon Coalition

State Senator Linda Berglin
Chair, Health Care Committee
Minnesota State Senate

E. Richard Brown, Ph. D.
U.C.L.A. School of Public Health
Task Force on Health Care Reform

Sister Norita Cooney
President and Chief Executive Officer
Mercy Midlands Hospital

Howard Dean, M.D.
Governor, Sate of Vermont

Lynn Dierker
Health Policy Analyst
Office of Colorado Governor Roy Romer

Charles Dougherty, Ph.D.
Director, Center for Health Policy and Ethics
Creighton University

Paul Ellwood, M.D.
President and Chief Executive Officer
Jackson Hole Group

Bill Gradison
President
Health Insurance Association of America

Richard Guffey
Chairman and Chief Executive Officer
Blue Cross and Blue Shield of Nebraska

Randall Horn
Executive Vice President
Mutual of Omaha Companies

Mark Horton, M.D., M.S.P.H.
Director of Health
State of Nebraska

Dave Hunt
Consumer Advocate
Nebraska Citizen Action

Darroll Loschen, M.D.
President
Nebraska Medical Association

John Luehrs
Senior Coordinator of the Health Team of the
Public Policy Institute
American Association of Retired Persons

Ken Mass
Secretary and Treasurer
Nebraska AFL-CIO

Janet Shikles
Director of Health Financing and Policy
U.S. General Accounting Office

Senator Don Wesely
26th Legislative District
Nebraska State Senate

Neal Westphal
Personnel Director
Lincoln Telecommunications Company

Sponsors:

Mr. Mark Hanley
Abbey Home Health Care

Mr. Allen Fredrickson
Accent Service Company, Inc.

Mr. Matthew Kurs
AMI St. Joseph Hospital
AMI St. Joseph Center for Mental Health

Mr. Jack Baker
Baker's Supermarkets

Mr. Richard Guffey
Blue Cross and Blue Shield of Nebraska

Byerly & Company of Nebraska, Inc.

Mr. William Kaizer
Central States Health & Life Co.

Mr. Max Francis
Clarkson Hospital

Mr. Herman Myers
Continental General Insurance Company

Dr. Richard O'Brien
Creighton University

Ms. Lora Villarreal
First Data Resources

Mr. Rick Spellman
Guarantee Mutual Life Company

Bill Gradison
Health Insurance Association of America

Mr. Charles Marr
Immanuel Medical Center

Mr. James Geist
Lincoln Telecommunications Company

Medical Rehabilitation Education Foundation

Ms. Jane Huerter
Mutual of Omaha Companies

Mr. Bill Schellpepper
Nebraska Medical Association

Mr. Dick Davis
Northern Plains Natural Gas Company

Mr. Fred Petersen
Omaha Public Power District

Mr. Robert Reed
Physicians Mutual Insurance Company

Mr. Jim Botkin
Sandoz Pharmaceuticals Corporation

Dr. John Braasch
Share Health Plan of Nebraska/United HealthCare

Mr. Ross Wilcox
Union Bank & Trust Company

Mr. Robert Bartee
University of Nebraska Medical Center

Mr. Bernie Dana
Vetter Health Services, Inc.

LATORIA

from Janet Shikles office will call for you, if I am not here. Their number is 512-7119

THE WHITE HOUSE
WASHINGTON

Jeff

Janet Shikles, Director of Health Financing & Policy from the GAO is testifying before Hillary at tmorrow's event. Would you please call to find out if she has a prepared statement we can get our hands on? If not, please ask her (or an assistant) to walk through what she'll be saying. Thanks — Kim

275-5388

512-5388

7119

Being filed 2:30 p.m.

PHOTOCOPY
PRESERVATION

Kerry Speech

"Social Values Versus Economic Necessity"

(Sacrifices society must make in order to provide health care services to everyone while trying to reduce the deficit)

I. Introduction

Thank you. I really appreciate the opportunity to participate in this important conference that Senator Kerry and Governor Nelson have convened

As the Senator told you,the GAO is a congressional agency and I am responsible for the health studies that we do for both Senators and Congressmen, both Democrats and Republicans. Over the past several years we have reported on the considerable and increasing problems in our system and have urged the Congress to take some tough actions. And that is what I am really going to talk about this morning.

Areas are: Acess, Cost, and the Catch 22 we're in

How did we get in this mess

German Health Care Reforms provide an example of leadership
(will seem odd, but the problems will sound very familiar to you
as will some of the fixes--this is a study I am doing for the Senate
that we will issue next month)

Nine tough decision areas where Congress has to act
if we're going to begin to address our access and cost problems

II. Access, Cost and the Catch 22 We're In

A. Access

-The access problem is very serious and getting worse-it is estimated that about 100,000 individuals are losing their health insurance each month

-A recent study found that nearly half of families in america currently have a member who doesn't have insurance, will lose insurance this year or have insurance that fail to cover major medical costs

--Individuals who don't have insurance pay a big price: one in three did not go to a doctor during the year for financial reasons and we know they put off treatment to the point of endangering their health

B. Costs

-At the same time that the number of individuals without insurance are growing, so are our costs--in fact we have the most expensive health care system in the world.

--It is estimated that our costs will be $939 billion this year and more than a $trillion in 1994.

--The Commerce Dept. predicts that unless significant changes are made in the health delviery system costs could jump to more than $2 trillion by 1999--6 years from now

C. Catch 22

--This is a growing problem for workers, who are seeing lower wages, and business, state and federal government.

--But why is it a catch 22? The more we try to contain costs the more these efforts seem to backfire on us.

--For example, President Clinton can not reduce the federal deficit unless he makes significant cuts in the Medicare and Medicaid programs. (Together we're spending about $260 billion this year and these programs are expected to double by 1988)/ These two programs are the fastest growing in the federal buget; absent any change they will account for 60% of the increase in the deficit over the next several years.

--Currently Medicare pays about 90% of a providers costs and Medicaid about 80%. To make up the difference and to cover the costs of serving the uninsured, providers charge private insurers 128% of costs. If medicare and medicaid are cut further this will increase charges to private insurers who will pass these higher costs on to business.

As these costs to business continue to increase many are dropping their insurance (one estimate is 100,000 a month). Yet these individuals still will get sick, will show up at hospitals or will end up on Medicare and Medicaid thereby driving the costs up further.

II. How did we get in this mess?

--Factors driving health care costs include: an aging population, increasing availability of expensive technology, consumer demand for more services, a fee for service system that rewards more the more services are performed

--What's interesting is that every other industrialized nation is wrestling with these same issues and yet all have a level of health care spending significantly below ours, insure all of their citizens, manage to have health care outcomes about the same as ours

--We have been asked to look at these systems for the Congress to identify why they seem to be doing better than us--are they rationing, living off of our technology, what? Issued reports on Canada, France, Germany, Japan

--Lessons, back in the 1970s many of these countries were not covering all of their citizens, may have had cost increases as large as ours

--Instituted comprehensive (rather than piecemeal) reforms, have made adjustments to these systems constantly

III. Germany

a. In 1991 spent about 8.5% of GDP compared to 13.4% US. (Germany spends 63.4% of what the US does on health care each year

B. Germans covered at the workplace, standardized benefit package (dental and preventive, drugs, rehabilitation, eyeglasses, home health care, even spa visits as part of work therapy) and very minimal copayments

C. Payroll tax, average is 13.7% split equally between employee and employer/payment is the same regardless of health status, age or familiy size

d. GErmans choos their own docs and hospitals and docs are reimbured on a fee for service basis.

e. Quality seems to be high, no queuing, Germans see their doctors more often than Americans

f. Cost reforms

--aggressive cost containment strategies (Concerted Action in the 80s)

--global budgets to pay hospitals and doctors (reduced real physician spending by 17% between 77 and 87)

--problems in 92: cost or reunification
payroll rate jumped a point
sickness funds deficits
public angry over docs income
angry over high drug prices, high dental fees,
excessive testing by docs
inefficiencies in hospital sector

--passed most sweeping reform in 50 years (no one thot it could be done)

-what did they do?

tightened budgets on hospitals and doctors/can only increase at same rate as wages

;new budgets on dentists and drugs

reduce no. of specialists and no. of doctros

increased preventive services

(for 3 years until new system reforms passed/ 6% reduction in expected spending)

-(dentists threaten to strike / doctors challenging law)

IV What Do We Need to DO?

--Past piecemeal strategies won't work/ plan has to be comprehensive

--Can;'t duck the tough decisions

--What our work for congress, both from issued reports and those in progress show that there are a set of elements that have to be part of any comprehensive strategy:

1. coverage has to be universal and mandatory--can't be voluntary

if it is voluntary many people will not purchase insurance; yet they still may get sick and require care; you can't impose cost constraaints on physicians and hospitals and other health professionals at the same time you are asking them to continue to provide care to a large group that is uninsured

2. eliminate certain insurance practices

need to prohibit denials for preexisting conditions, guarantee coverage, portability, community rating (Rochester report)

3. change the mix of physicians

have 70% specialists;30% primary care physicians

this ratio is a major contributor to our rising health care costs

--a recent study found that doctor bills for older Americans varied dramatically across the country and are twice as high in some large cities as in others--average payment to a doctor in Miami was $1874 (in 1989) and in San Francisco $872

The differences were not due to health of elderly or in outcomes; charges were lowere in places with relatively more family doctors and fewer specialists.

--what do we need to do: subsidize the education of doctors who plan to become family physicians

4. reduce administrative burden

a recent study showed that Canadian hospitals are providing care at costs significantly lower than US hospitals without compromising patients treatment.

but it is not because US hospitals are delivering more clinical services per patient

Instead US hospitals incur higher overhead and are less efficient users of clinical equipment and personnel.

overhead at Can. hospitals is about half that of their US coutnerparts (if US hospitals exhibited same spending patterns as Can. hospitals the US could have saved $40 billion)

need one form, one card, standardized benefits package, savings from elimination of insurance practices (Toronto versus US hospitals)

5. insitute measures to reduce fraud and abuse

--self referral issue

6. revamp how we pay for technology to reduce excess supply; proliferaiton

--payment changes do not have to lead to the end of new drugs or technology or long waits

--change payment (MRI study in Florida and Michigan)/planning

7. address malpractice problem

--a successful reform plan must reduce doctors fear of malpractice suits--this could save the nation about $36 billion in five years according to some estimates from reduction in defensive medicine

8. institute measures of quallity

--this is especially important particularly in a cost containment environment

--now we assoicate high costs with high quality

--recent study in PA of bypass surgery and outcomes--one hospital charged 21,000 and had sig. fewer deaths than expected; another hospital charged 83,000 and had sig. more deaths than expected

9. public health; prevention stragies and ways to increase personal responsibility

--reinvest in our public health department, school nurses, health care support to rural areas, immunization screening, home visiting

10. identify strategies to pay for uninusred

--hard for public to understand why they need to be taxed to pay for the uninusred when we have a system that many feel already is too costly and has excess capacity

--difficulty is that whatever cost controls we put in place will take years to see benefits

--in meantime need to finance coverage for uninsured, need to increase medicaid payments so they are fair to providers, need to finance public health strategies

--no way to get around the fact that if we ultimately want to lower costs need to increase health care spending--estimates 30 plus billions

11. identify strategies to begin to slow spending

--I've left the most politically sensitive til last

--there are no good strategies to slowing rate increases

--managed care is offered as one model-- yet we and others looking at research find that only closed panel HMOS at least in the past produced savings and these are not the form of managed care that is growing most rapidly

--most countries have used global budget stragies--produce inefficiencies, or queing

GAO United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

Fax Transmittal Sheet

DATE: 4/15/93

TOTAL PAGES: Cover sheet plus 7 pages

TO: Kim Tilley

Telephone No. _____

Fax Machine No. 456-6244

FROM: Janet Shikles

U.S. GENERAL ACCOUNTING OFFICE
NGB/HEALTH FINANCING AND POLICY ISSUES
441 G Street, NW
Washington, DC 20548
Telephone No. (202) 512-7119

Fax Machine Telephone No. (202) 336-6642

REMARKS: _____

February 24, 1993

Mrs. Hillary Rodham Clinton
President's Task Force on
National Health Care Reform
The White House
Old Executive Office Building
Washington, D.C. 20500

Dear Mrs. Clinton:

As you know, the health care crisis has become a top priority in our domestic agenda. With nearly 37 million Americans lacking health insurance and health care costs contributing significantly to our national deficit, it is obvious that the need for reform is urgent. In constructing a new health care program we must consider three often conflicting aspects of health care: affordability, accessibility, and quality.

Our citizens must be informed about all of our health reform options so that they may make solid decisions about which proposal they support. With this in mind, I, along with Governor E. Benjamin Nelson, have decided to convene and chair a forum on Friday, April 16 and Saturday, April 17, 1993 entitled "Health Care in the 21st Century: National Challenges, Nebraska Solutions." The conference will be held at the University of Nebraska in Lincoln. We feel this forum will provide our constituents an unsurpassed opportunity to learn more about our national health care options. I would like to extend to you an invitation to participate as the keynote speaker at this conference.

Your insight would prove invaluable to the over 350 business leaders, policy makers, educators, health care professionals, and consumers who will be attending the forum. We believe that your experience and expertise will provide the audience the information it needs to make informed decisions.

The day's agenda will cover a range of topics including the future of our health care system, policy options facing Congress, and the challenges facing Nebraska including some difficult value decisions. We hope during the conference not only to promote a better understanding of these issues, but also to solicit responses from the audience on the variety of reform initiatives which have been proposed. The recommendations of my constituents will surely prove beneficial to me as the Congress faces increasingly controversial health reform proposals in the coming months.

Your participation will help to ensure the success of this project, and I sincerely hope that you will be able to join us. Randi Footlick of the Columbia Institute will be in touch with you within the next few days to discuss the logistics involved in your participation. As always, I encourage you to call my office at (202) 224-6551 or Randi at (202) 547-2470 should you have any questions or comments.

I look forward to seeing you soon.

Sincerely,

J. ROBERT KERREY
United States Senate

- Who does it serve?
- how funded?

a:\apr16cl1.

April 14, 1993

Pat's mom

INDIAN HEALTH CARE CLINIC: BILLINGS, MONTANA

(W) 406/245-8872
(H) 406 259-3026

DATE: April 16, 1993
LOCATION: Indian Health Care Clinic
TIME: 4:50 p.m
FROM: Kim Tilley

Pt NA from son - Rhodes Scholar
she was invited to partic in "Faces of Hope"

406/245-7318

I. PURPOSE

IHS

II. BACKGROUND

- Fed $
- Don't Charge anyone #5

III. PARTICIPANTS

- Clinic Director, Marjorie Bear Don't Walk — IHS.
- FACTS
- 65% of NA live off reservation
- Less than 1% of total IHS budget given to URBAN IND HLTH progs (34 across US.)
- At hdqtr there is 1 person for URBAN Health V. thousands overall.

IV. PRESS PLAN

Closed press

V. SEQUENCE OF EVENTS

o 10 minute tour

o Proceed to YWCA

IV. REMARKS

Family

shawl, necklace, headband

husband works in N.D.

immunized

Andrew Kline

Nightmare walk through

Indian Health Board of Billings, Inc.

The Indian Health Board of Billings, Inc. (IHBB) is a not-for-profit organization developed under Title V of the Indian Health Improvement Act of 1974. The intent of the act was to develop a plan to improve health care delivery for Native Americans living in urban areas. IHBB has provided health care and other services to 6,000 Indian residents of the Billings area for over 13 years, despite being woefully underfunded.

Although the Indian Health Service employs 409 persons at national headquarters in Rockville, MD, there is only one employee at the facility to represent the national urban Indian health programs across the country. Although the Indian Health Service employs over 1,000 persons in the Billings area alone, IHBB continues to struggle to support less than ten full time positions.

Despite the fact that 65% of Native American people in the area live OFF reservations, less than 1% of the Indian Health Service budget has been allocated for urban based services. Currently, IHBB offers health care clinics, allied health clinics, dental services, substance abuse counseling, AIDS education and alcohol awareness programs, among many others.

It is our hope that the result of health care reform for Native American people will include strong support for urban based programs. We welcome the opportunity to show Mrs. Clinton and task force members how we manage to provide badly needed services in an underfunded and inadequate setting.

Post-it™ brand
Fax Transmittal Memo 7672

To	Kim Tilley	From	Diane Hill
Company	Mrs. Clinton	Company	Cong. Pat Williams
Location		Location	Dept. Charge
Fax #	Telephone #	Fax #	Telephone # 202-225-3211
Comments		Original Disposition	☐ Destroy ☐ Return ☐ Call for pickup

Attach Document Airbill

Purpose of Indian Health Care Meeting:

* Give tribal leaders an opportunity to discuss health care with Mrs. Clinton without buffering or intervention from federal entities, e.g. IHS. Tribal leaders are elected by their respective tribes and have the best knowledge and information on the needs of their people.

* The federal government has a long-standing obligation to provide health care to Native American people. When national reform is enacted it is critical that health care coverage for the Native American people be carefully considered and incorporated into that reform.

* While Mrs. Clinton and the Health Care Reform Task Force have heard testimony from national organizations representing Native Americans, she has not met tribal leaders in their home states to discuss health care reform.

Purpose of Rural Health Care Meeting:

* Billings serves as a major regional center for health care. There are two major hospitals and a mental health care hospital. Eastern Montana is extremely rural in nature. Small rural hospitals and Medical Assistance Facilities rely on the Billings health care community for support and referral.

MAC to DEQ

* The meeting will include brief remarks on how Billings serves as a regional center (1), what it takes to recruit and retain employees in rural areas, and (3) what educational components of health care reform would best serve rural areas. That will set the tone for an open discussion of health care reform in a rural setting like Montana.

* Participants include hospital administrators, doctors, nurses, physician assistants, nurse practitioners, public health providers, and others who are directly involved in the provision of health care.

NOTE: The introduction of the speakers in the Lied Center as agreed upon by the participants and their respective representatives:

Jonathan Ortmans, Executive Director, Columbia Institute will introduce Senator J. Robert Kerrey.

Senator Kerrey will introduce both Governor E. Benjamin Nelson and Governor Howard Dean.

Senator Kerrey will introduce Hillary Rodham Clinton.

Ms. Clinton speaks.

Following her speach, Governor Nelson will then introduce Governor Dean.

Governor Dean speaks.

The audience then leaves Lieds and returns to Kimbal Hall for the continuation of the conference.

HEALTH CARE TALKING POINTS

Summary

- Americans are getting killed by skyrocketing health care costs. What you're charged for health care is rising four times faster than your wages. That doesn't make sense -- and it threatens your family's future and the future of every business, large and small.

- President Clinton is committed to fundamentally reforming our nation's health care system. The Clinton plan will control your health care costs and provide security to every American family. We will preserve what is best in the American system -- the highest quality medical care in the world and the individual's right to choose a doctor.

- Within days of taking office, President Clinton established the Task Force on National Health Care Reform, chaired by First Lady Hillary Rodham Clinton, to develop a comprehensive health care reform proposal. Hundreds of health care experts -- doctors, nurses, professors and businesspeople -- have been brought in from around the country to work with officials from government agencies and White House staff in a series of policy working groups that have been set up to advise the Task Force. In addition, diverse panels of consumers and health care professionals will be brought in regularly to advise the working groups as they develop their recommendations.

- Powerful lobbies and special interests are already lining up to defeat any plan we develop. They oppose change because they profit from the waste and inefficiency of today's system. But we are committed to breaking the gridlock.

- The American people demand and deserve change now. Washington can delay no longer. Interest groups can obstruct us no longer. Without immediate reform, the annual cost of health care for American families will more than double by the end of the decade -- to a whopping $14,000 per family -- while workers will lose an anticipated $650 increase in their incomes.

- It won't be easy and it won't happen overnight. But we will stand with you and take on the special interests. No American will feel secure again unless we bring health care costs under control now -- and make it possible for your family to get ahead again.

Goals

The Clinton health reform proposal will:

- Control the rapid spiralling of your health care costs.
- Provide security and peace of mind, so that you don't have to worry about losing your insurance when you change jobs or being denied coverage because you're sick.
- Root out fraud and overcharges.
- Simplify the system and reduce paperwork.
- Maintain the highest quality medical care in the world and preserve your health care choices.

TO: Kim Tilly

OFFICE: White House

CITY, STATE:

FROM: Marjorie Bear Don't Walk

INDIAN HEALTH BOARD OF BILLINGS
915 BROADWATER SQUARE
BILLINGS, MT 59102

PHONE (406) 245-7318
FAX (406) 245-8872

DATE: 4-15-93

MESSAGE...

For Hillary Rodham Clinton

RE: U.S Health Care Reform Task Force

NUMBER OF PAGES (including cover page): 1

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Indian Health Board of Billings [partial] (2 pages)	4/15/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Friday, April 16 [1993]

2014-0483-S
sb334

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

102

Indian Health Board of Billings

Marjorie Bear Don't Walk
Urban T. Bear Don't Walk
Scott Bear Don't Walk -
Helena Bear Don't Walk
Georgianna Old Elk
Anna Old Elk
Clayton F. Old Elk, Jr.
Rosemary Simon
Mary [illegible]
[illegible] Vallie
Robin Vallie
Joseph Vallie
Brian Vallie
Thomas Vallie
Shelle Lande -
Norma Jo Valley
Eugene [illegible]
Billy Hanson -
Harold Little Light
Mario [illegible] -
Mr. Schnider -
Mr. Stewart -
Rosemary Stewart -
John Potter -
Donna Brewer -
Caroline Horn [illegible]
Jason McCracken -
Dr. Barry Pitts -
Rose Harris -
James Baird -
Urban Bear Don't Walk
Mr. John Seff - (b)(6)
Bill Yellowtail -
Mr. Bruce Olsen -
John Old Elk -
Clayton Old Elk -
Duane Jeanotte -
Joe [illegible] (b)(6)
Mr. [illegible]

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Minnesota [illegible] Health Dir [illegible]

William [illegible] (b)(6)
W[illegible] (b)(6)
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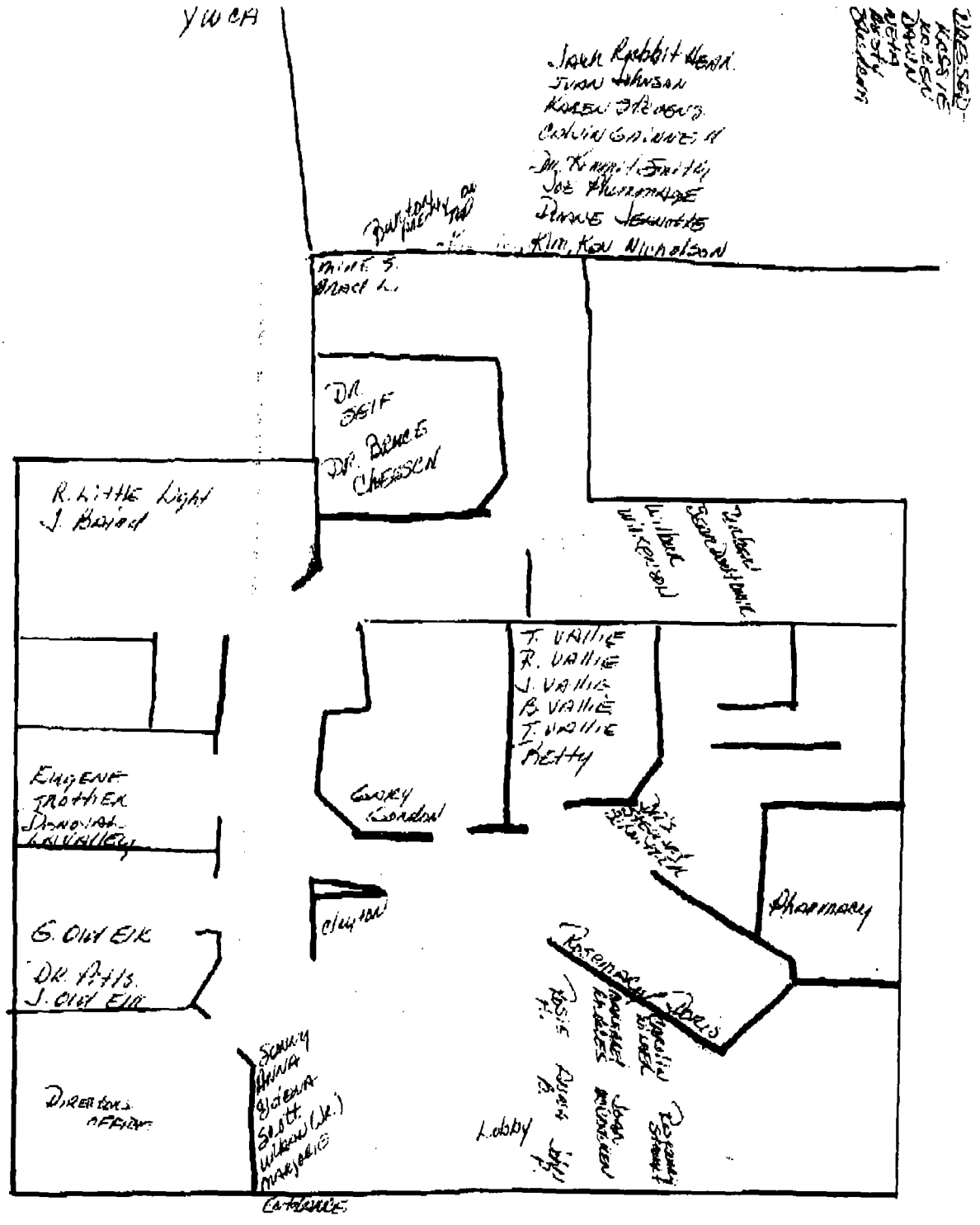
Ken Nickelson (b)(6) Child
✓ Kassie Marie Nickelson Emp. Taking
✓ Keon Nickelson Injur.
Linda Logg[illegible]
Margaret Rhodes 001

Karen Old Elk
Dawn Dwayne Old Elk
Reta Old Elk
Misty Old Elk
Sherra Old Elk
Calvin Grinnell (b)(6)
Karen Stevens
Ivan Johnson
Jack Rabbit Head
Mike Sherrod
Brad Hopping 001
Burton Pretty on Top. (b)(6) 001


YWCA
DR. SEIF
DR. BRUCE CHESSON
R. LITTLE LIGHT
J. BLACK
T. VALLIE
R. VALLIE
J. VALLIE
B. VALLIE
I. VALLIE
BETTY
EUGENE BROTHER
G. OLD ELK
DR. PHILLIPS
J. OLD ELK
Pharmacy
Lobby

224-6551

FROM THE DESK OF

Sheila M. Nix

Patti -

If you need any more information on the conference please call me on my direct line, 224-0295. Thank you for your help.

Sheila

MAKING MEDICAID WORK

How physician initiative solved the Medicaid problem in one U.S. community

story by WayneHearn

photo by John Nollendorfs

LINCOLN, Neb. — In early 1990, the leadership of the Lancaster County Medical Society was shaken when a survey revealed that virtually none of the community's primary care physicians accepted new Medicaid patients.

The society had commissioned the survey, suspecting a problem. Medicaid access had been inadequate for years in this community of 213,000 residents, of whom about 15,000 are Medicaid eligible. But the results confirmed the physicians' worst fears.

"There were a couple of things I was concerned about after it hit me," recalls Chris Caudill, MD, a Lincoln cardiologist who was chairman of the Nebraska Medical Assn.'s Medicaid Committee at the time.

"One was the absolute reality of the situation, with so many patients out there without physicians and without knowing what they were going to do for medical care." Many, he says, were seeking care in emergency departments at the county's three hospitals or at a county clinic for indigent patients. Physicians treated a handful as charity cases without filing for reimbursement. It was clear that quality of care was suffering.

Dr. Caudill's other concern was the public-relations dilemma posed by the finding.

"I wondered how long it would be before it became known to the public in general, and what the reaction might be. And I also was concerned about what the state legislature might do. I really felt that the medical community was in the best position to solve the problem."

In Lincoln, Neb. physician willingness to participate in Medicaid has been transformed, thanks to the local medical society.

This view may have seemed unrealistic, since physician dissatisfaction with Medicaid was at the root of the crisis. But Dr. Caudill was right, as it turned out.

The Lancaster County Medical Society formed an ad hoc Medicaid committee, chaired by Dr. Caudill. It joined with the Lincoln-Lancaster County Health Dept. and the Nebraska Dept. of Social Services to fashion a Medicaid referral system that remedied the access problem almost as soon as it was implemented in February 1991.

Since the program's inception, more than 90% of about 100 primary care physicians in the county have agreed to participate — a 180-degree shift in their level of commitment to serving Medicaid patients.

Because Medicaid varies from state to state, it's difficult to measure the degree of physician participation nationally. However, a recent survey of self-employed physicians by the AMA's Center for Health Policy Research found that 65.5% of 4,848 primary care physicians participated in Medicaid in 1991.

Last September, the Lancaster County Medical Society and the Lincoln-Lancaster County Health Dept. were honored by the U.S. Health Care Financing Administration with a Beneficiary Ser-

See INITIATIVE, next page

Initiative

Continued from preceding page

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The system is simple in concept: Any Medicaid-eligible patient who needs care but has no regular physician calls the referral line at the county health department. Within minutes, a public health nurse confirms the caller's eligibility via computer, assesses the patient's medical needs, screens for "access barriers" such as lack of transportation and assigns a primary care physician.

Assignments rotate among participating internists, pediatricians, family physicians and obstetrician-gynecologists. Each physician's name is kept in a card file. New patients are assigned to the doctor whose card is in front; the card is then moved to the back. Easy. Efficient. Equitable.

But best of all, it enables Medicaid patients to break the fragmented-care cycle that erodes quality and wastes health care resources.

By Jan. 31, nurses had assigned more than 5,655 patients to participating physicians, and had distributed 4,305 vouchers for free cab rides to and from appointments. Since the program began, the family physicians have accepted an average of 71 new patients each; pediatricians, 52 each; internists, 27; and obstetricians, 22.

The University of Nebraska Medical Center's family practice residency program also participates, exercising a "right of first refusal" to help it maintain an adequate case mix. If it declines, the intake nurse refers the patient to the next physician in line. The residency program, with 15 to 20 physicians, had accepted 809 referrals as of Jan. 31.

"When we started this, I think we really put together a new medical system," Dr. Caudill says. "Between the physicians and the patients and the participation of the public health nurses, it approaches some people's notion of an ideal situation. In terms of delivery of care, we have something that may not be available in the best private-pay coverage situations.

"It may not be that you can just take this plan and plunk it down anywhere and have it work, but I think the way it evolved could be useful in putting together a program that could work somewhere else."

The plans founders acknowledge that there are drawbacks, such as the lack of choice for patients, who must accept the assigned physicians unless both patient and physician agree they cannot work together.

Offsetting this restriction, however, is the access that Medicaid patients sometimes gain to practices closed to private-pay patients. Pat Lopez, RN, district public health supervisor and coordinator of the referral program, recalls asking a colleague to follow up on one of the Medicaid patients. "When she saw who the doctor was, she said, 'My god, I've been trying to get in to see him for two years!' "

Another drawback is that the program excludes non-primary care specialists, so consultations and referrals largely depend on the strength of the relationships between primary care physicians and the specialists with whom they regularly work.

"It's hoped that the support of the referrer would send a message to the physician being referred to that if they enjoy the patient flow, it would be appreciated if they would take care of this person," Dr. Caudill says. Subspecialists rarely have refused to accept Medicaid referrals.

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"We stress to the physicians the importance of the preventive services and tell them to make sure they bill for it," Lopez explains. "The physicians are getting the maximum benefit for billing purposes and at the same time, the patients are getting the maximum benefit from having continuous care. The kids are getting the well-child check-ups, and the women are getting their Pap smears when they should."

The system is successful because it was built on the problem-solving model, its proponents say. Through follow-up surveys, the committee learned why physicians did not want to treat Medicaid patients.

"That meant the basic components of the system were the solutions to the problems the doctors cited," Dr. Caudill says. "It also showed the physicians that we listened to what they had to say."

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Such problems are addressed by the state Social Services Dept. and the city-county Health Dept. Intake nurses stress the importance of compliance and keeping appointments. Under a contract between the Social Services Dept. and the Health Dept., federal money is earmarked for cab vouchers for patients without transportation and for other administrative case-management services.

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"All of us have leverage with our private patients," says family physician Dale Michels, MD, who was president of the county medical society when the program began. "If they continually fail to keep appointments, we can do something about it — we'll threaten to charge them for it. But with Medicaid you can't do that; it's considered fraud. So we didn't have a mechanism for [noncompliant] Medicaid patients, and now we do."

Says Dr. Caudill: "When we took this plan back to the physicians for their approval and explained why it was necessary and what the rules were, we were trying to extract from them an obligation to participate. In return, they wanted assurances from us that there would be accountability within the patient population and fairness within the rotational system."

The referral system also attempts to ease the hassles. Chris Wright, MD, the Social Services Dept. medical director, made it known her office was fully behind the system and encouraged physicians to call with complaints or reimbursement questions.

Dr. Wright adds that the new system also provided her department with a forum for updating physicians on Medicaid reforms they had missed because they weren't participating. For example, fees for primary care and obstetrics had been increased, and red tape had been reduced through the introduction of a universal billing form. "This helped us overcome a lot of the old history," she says.

The medical-society surveys helped prove that the Medicaid access problem was real, Dr. Michels says. It forced heads out of the sand. Many doctors "assumed someone else was taking care of things. Once we took care of that, we could start talking about fairness and making [patient distribution] equal — or at least close to equal — because things hadn't been very equal before."

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Eugene Schwenke, MD, was in a group family practice when the program began. "There were three in my group at the time, and I think we'd always done our fair share," he recalls, "but you'd open the door for one or two [Medicaid recipients], and pretty soon it would just be overwhelming."

Once the referral program was implemented, "everybody else started contributing and taking some of the load, and it did make things much smoother," says Dr. Schwenke, who now practices emergency medicine at a local hospital.

The program also offers flexibility to participating physicians, who may withdraw temporarily as needed, such as when a practice partner is sick or on maternity leave or the practice is at full capacity. Their cards are kept out of the rotation until they return. It's all based on good faith.

Peggy Barbee says the referral system has made it much easier to deal with Medicaid patients at Smith and Reed Clinic, the four-physician IM practice where she's the office manager.

"If the referral system calls, at least we know the patient is qualified for Medicaid coverage because the public health nurses have already screened for eligibility," she says. "Plus, people are much less likely to abuse the system when they know someone's keeping track on things."

The referral system has redefined the Medicaid problem for the community, Dr. Caudill says.

"What it boiled down to was that there was this access problem for a long time, and it looked like physicians simply wouldn't take Medicaid patients. But that really wasn't the issue. In the end there was a spirit of cooperation and a willingness to do their fair share. Once this system was in place, the good will of the physicians could manifest itself. It enabled them to do it."

The system is successful because it was built on the problem-solving model, supporters say. Through surveys, the committee learned directly from physicians why they did not want to treat Medicaid patients.

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TO: Kim Telly

OFFICE: White House

CITY, STATE: Washington D.C.

FROM: Majorie Bear Don't Walk

INDIAN HEALTH BOARD OF BILLINGS
915 BROADWATER SQUARE
BILLINGS, MT 59102

PHONE (406) 245-7318
FAX (406) 245-8872

DATE: 4-15-93

MESSAGE...

For: Hillary Rodham Clinton

NUMBER OF PAGES (including cover page): 2

Julie -
Keep copy for yourself & return.
I'll let you know if we do

TO: Patty Solis
FROM: Cindy Dwyer
Kerrey Scheduler
RE: Mrs. Clinton's visit to Lincoln, NE

Patty, as we talked yesterday, I am faxing you the article on the Lancaster County Medical Society.

It would be a tremendous favor to Senator Kerrey if Mrs. Clinton would meet briefly with a small group representing this effort for the purposes of presenting Mrs. Clinton with a copy of their report, brief introductions and a photograph.

There would be 7 people representing the group and I will give you their names and their social security numbers.

This is also a good news story for both Mrs. Clinton and Senator Kerrey and we'd like to have our Nebraska AP reporter attend--but not allow him to interrupt or ask questions--simply to cover the story.

I have spoken about this event with both Steve Graham and Pat Hally.

The time frame and location for this would be roughly 12:20-12:35 p.m. in the holding room after Mrs. Clinton and Bob have met privately.

Call me when you can, Patty.

Thanks,
Cindy
(202) 224-4425 (direct)
(202) 224-7645 (fax)

LANCASTER

MAKING

How physician initiative

MEDICAID

solved the Medicaid problem

WORK

in one U.S. community

story by Wayne Hearn

photo by John Hollendorf

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ADL

Initiative

Continued from preceding page

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Eugene Schwenke, MD, was in a group family practice when the program began. "There were three in my group at the time, and I think we'd always done our fair share," he recalls, "but you'd open the door for one or two [Medicaid recipients], and pretty soon it would just be overwhelming."

Once the referral program was implemented, "everybody else started contributing and taking some of the load, and it did make things much smoother," says Dr. Schwenke, who now practices emergency medicine at a local hospital.

The program also offers flexibility to participating physicians, who may withdraw temporarily as needed, such as when a practice partner is sick or on maternity leave or the practice is at full capacity. Their cards are kept out of the rotation until they return. It's all based on good faith.

Peggy Barbee says the referral system has made it much easier to deal with Medicaid patients at Smith and Reed Clinic, the four-physician IM practice where she's the office manager.

"If the referral system calls, at least we know the patient is qualified for Medicaid coverage because the public health nurses have already screened for eligibility," she says. "Plus, people are much less likely to abuse the system when they know someone's keeping track on things."

The referral system has redefined the Medicaid problem for the community, Dr. Caudill says.

"What it boiled down to was that there was this access problem for a long time, and it looked like physicians simply wouldn't take Medicaid patients. But that really wasn't the issue. In the end there was a spirit of cooperation and a willingness to do their fair share. Once this system was in place, the good will of the physicians could manifest itself. It enabled them to do it."

The system is successful because it was built on the problem-solving model, supporters say. Through surveys, the committee learned directly from physicians why they did not want to treat Medicaid patients.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. fax	From: Cindy Dwyer, To: Patty Solis, Re: Meeting with Lancaster Co. Medical Society [partial] (1 page)	4/14/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Friday, April 16 [1993]

2014-0483-S
sb334

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TO: Patty Solis
FROM: Cindy Dwyer
Kerrey Scheduler
RE: Meeting with Lancaster Co. Medical Society

Patty: This is a nearly complete list of the people Senator Kerrey would like Mrs. Clinton to meet on Friday in the Green Room at the Lied Center prior to Mrs. Clinton's speech.

Previously, I had sent the article on the Medical Society and their efforts to work on solving the medicaid problem in their community.

During the meeting, the Society would like to present Mrs. Clinton with a detailed report on how they proceeded and how it's working.

The attendees would include:

Natalie Clark, Lancaster County Medical Society
SS# (b)(6) 002

Jane Ford, Director, Lincoln/Lancaster County Health Dept.
SS# (b)(6) 002

Mary Dean Harvey, Director, Neb. Dept. of Health
SS# (b)(6) 002

Pat Lopez, Neb. Dept. of Public Health Nurse
SS# (b)(6) 002

Dr. Chris Caudill, Cardiologist
SS# (b)(6) 002

Dr. Chris Wright, Medical Director for Medicaid
SS# (still waiting for this one)

David Buntain, Attorney, Nat'l. Dem. Committeeman
SS# (b)(6) 002

Lucy Buntain, University of Neb. Foundation
SS# (b)(6) 002

*We also would like to include a medicaid patient who has benefitted from this effort. We have one identified and whose name I will forward to you shortly along with their social security number.

Thanks, please call.

Cindy
4/14/93
6:45 p.m.

Post-it™ brand
Fax Transmittal Memo 7672

To	Kim Tilley	No. of Pages	Today's Date / Time
Company	Mrs. Clinton	From	Diane Hill
Location		Company	Cong. Pat Williams
Fax #	Telephone #	Location	Dept. Charge
Comments		Fax #	Telephone # 202-225-3211
		Original Disposition:	☐ Destroy ☐ Return ☐ Call for pickup

Allsorts Document Airline

Purpose of Indian Health Care Meeting:

* Give tribal leaders an opportunity to discuss health care with Mrs. Clinton without buffering or intervention from federal entities, e.g. IHS. Tribal leaders are elected by their respective tribes and have the best knowledge and information on the needs of their people.

* The federal government has a long-standing obligation to provide health care to Native American people. When national reform is enacted it is critical that health care coverage for the Native American people be carefully considered and incorporated into that reform.

* While Mrs. Clinton and the Health Care Reform Task Force have heard testimony from national organizations representing Native Americans, she has not met tribal leaders in their home states to discuss health care reform.

Purpose of Rural Health Care Meeting:

* Billings serves as a major regional center for health care. There are two major hospitals and a mental health care hospital. Eastern Montana is extremely rural in nature. Small rural hospitals and Medical Assistance Facilities rely on the Billings health care community for support and referral.

* The meeting will include brief remarks on how Billings serves as a regional center, what it takes to recruit and retain employees in rural areas, and what educational components of health care reform would best serve rural areas. That will set the tone for an open discussion of health care reform in a rural setting like Montana.

* Participants include hospital administrators, doctors, nurses, physician assistants, nurse practitioners, public health providers, and others who are directly involved in the provision of health care.

Post-it™ brand Fax Transmittal Memo 7672

To Kim Tilley | No. of Pages 7 | Today's Date 4-15 | Time

Company | From Jim Foley

Location | Company

Fax # | Location | Dept. Charge

Telephone # | Fax # | Telephone #

Comments | Original Disposition: ☐ Destroy ☐ Return ☐ Call for pickup

Please call if you have question on this first round of info.

Attach Document At Line

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Montana Indian Health Board of Billings, Inc.

Marjorie Bear Don't Walk, Director

Last Year -- 1992

4700 came through to see the doctor

21,000 came for consultations for substance abuse, immunization and mental health services.

FOR Tour 4/16 5:00 p.m. Billings, Montana

Questions?
Diane Hill 225-3211

American Indian Health Care Assoc.

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Health Promotion Disease Prevention	395,000	500,000	395,000	413,991	500,000
Immunization	395,000	500,000	395,000	413,991	500,000
Child Abuse		500,000			2,000,000
Facility Improvement		500,000			1,000,000
Infant Mortality		2,000,000			2,000,000
Expand Capacity		2,400,000			2,400,000
Population Growth			91,500		91,500
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*Existing urban substance abuse funding transferred from Alcohol Program Branch to Urban Program Branch

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Continuing IHS funding is essential for the very existence of Urban Indian Health Programs.

URBAN INDIAN HEALTH PROGRAMS

State	Urban Indian Health Program Location
Arizona	Phoenix Tucson Flagstaff
California	Bakersfield Fresno Los Angeles Sacramento San Diego San Francisco/Oakland San Jose Santa Barbara
Colorado	Denver
Illinois	Chicago
Kansas	Wichita
Massachusetts	Boston
Michigan	Detroit
Minnesota	Minneapolis
Montana	Billings Butte Great Falls Helena Missoula
Nebraska	Lincoln/Omaha/Sioux City
Nevada	Reno/Carson City
New Mexico	Albuquerque
New York	New York City
Oregon	Portland
South Dakota	Pierre/Aberdeen/Sioux Falls/Vermillion
Texas	Dallas/Ft. Worth
Utah	Salt Lake City
Washington	Seattle Spokane
Wisconsin	Green Bay Milwaukee

Health Care Concerns Expressed by Montana Tribes

I. IHS is a payer of last resort. This causes several burdens for Native Americans.

A. Veterans

Veterans must use VA facilities -- IHS won't serve them. Often Native American veterans have to travel great distances (there are only 2 veterans hospitals in Montana) to get health care when IHS has facilities on their reservation. The Blackfeet have voiced this concern because their hospital is relatively new, finished in 1985 and could serve veterans.

B. Medicaid Eligibility

Medical bills for contract care often go unpaid for extended periods because IHS waits to see if individuals are eligible for other government programs, i.e. medicaid, before they will agree to consider making payment. Meanwhile, the individual who received the service is expected to make payment.

One Montana hospital turned $250,000 in payments due over to a credit bureau, damaging the credit of many tribal members.

C. Fundamental problem is that IHS operates on a discretionary basis, not as an entitlement. What IHS will cover fluctuates. Indian people are never sure what IHS will or will not cover.

II. Contract Care

A. Native Americans without access to IHS hospitals have to rely on IHS to pay for services from general hospitals, i.e. contract care. While Medicare and Medicaid set a payment schedule for services, IHS does not. What that means is that the cost shifting from Medicare and Medicaid is paid by IHS. This erodes the amount of money available for tribal members relying on IHS. For example, if you look at raw percentage of services a hospital provides to Native Americans, Indians consume 35% while 45% of revenues come from IHS. Hospitals that serve Native Americans often have only Medicare and Medicaid as their other usage. The result, IHS subsidizes Medicare and Medicaid.

III. Long Term Care

A. Montana's Native American community would like to have nursing homes operated by either the IHS or tribes. Right now they must put their elderly in nursing homes far away from the reservation. Last year in the Indian Health Care Amendments we included a demonstration program that would allow tribes to attach nursing homes to IHS facilities. It did not provide bricks and mortar funding. The clear sign from the Energy and Commerce Committee is that they will not support the building of nursing homes with government money.

FYI, the Blackfeet Tribe has a nursing home which is operated by the tribe. They need a new building.

National Perspective

Michael Anderson, Executive Director of the National Congress of American Indians testified before the White House Health Care Task Force on March 29. Following is an excerpt from his testimony.

"...the answer for American Indians is to permit them the option to participate in nationally provided health care options like insurance while retaining access to Indian health service/tribal services...IHS and tribally operated programs should be able to collect for American Indian/Alaska Native people who have other coverage who choose to use IHS or tribally operated programs."

Most Montana tribes participate in NCAI. The Crow do not.

Dick Truman

Phil Lee

WHAT IS COLUMBIA INSTITUTE?

Founded in 1977, Columbia Institute is an independent public policy group specializing in conference management and research services. ▪ Combining policy expertise with organizational skills, Columbia Institute plans conferences and workshops, provides public policy research and consulting services, and coordinates international business and political programs. ▪ Individually tailored projects advance the exchange of information and ideas and provide a basis for cooperation among leaders at all levels. When managing public policy initiatives, Columbia Institute maintains a non-partisan and independent position by ensuring balanced consideration of the issues at hand. ▪ Based in Washington, D.C., Columbia Institute has an affiliate office in Seattle and coordinates projects in all 50 states and many foreign countries.

CONFERENCE MANAGEMENT SERVICES

Columbia Institute plans and coordinates conferences, annual meetings, and conventions for private companies and trade associations. From developing an initial concept or goal, to on-site management and follow-up, Columbia Institute has established a reputation for both quality and results. Columbia Institute:

- develops an agenda and program
- identifies, recruits and confirms prominent business and government speakers
- evaluates, negotiates and manages conference sites, air travel, audio-visual including electronic polling and satellite links, printers and mail houses, and other subcontractors
- formulates, prepares and manages computerized registration databases
- designs, prints and distributes invitations and event programs
- generates and manages press and publicity, and conference promotion
- coordinates and prepares reports, transcripts, videotapes, evaluations, and other follow-up activity
- manages all finances, providing complete and timely reporting

PUBLIC POLICY FORUMS

Since 1981, more than 2,000 U.S. corporations have served as sponsors of Columbia Institute's extensive regional conference program. These forums, chaired by members of Congress from both parties, and convened in their states, address policy issues currently on the nation's agenda. Issue areas include:

- health care reform
- economic development
- international trade policy
- education
- the environment
- energy policy

In addition to appropriate public recognition, sponsorship provides organizations with the opportunity to: work closely with members of Congress and their staffs on program development; educate personnel on complex policy issues; promote cooperation with others on issues of common interest; and increase public awareness on special matters of concern.

Fax Transmittal Memo 7672

To Kim Tilley
Company
Location
Fax #
Comments

No. of Pages 7 Today's Date 4-15 Time
From Jim Foley
Company
Location Dept. Charge
Fax # Telephone #
Original Disposition: ☐ Destroy ☐ Return ☐ Call for pickup

Please call if you have question on this first round of info.

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Massachusetts	Boston
Michigan	Detroit
Minnesota	Minneapolis
Montana	Billings Butte Great Falls Helena Missoula
Nebraska	Lincoln/Omaha/Sioux City
Nevada	Reno/Carson City
New Mexico	Albuquerque
New York	New York City
Oregon	Portland
South Dakota	Pierre/Aberdeen/Sioux Falls/Vermillion
Texas	Dallas/Ft. Worth
Utah	Salt Lake City
Washington	Seattle Spokane
Wisconsin	Green Bay Milwaukee

4/12 Randy Footlik 317-2470

Kerney - Re: NE

- Heavily insurance based
- Gov Set up
  Blue Ribbon
  came out of his system

Reason for conf.
Kerney initiated it over a yr ago. Obviously agenda changes since

Hot Spots: Gov Rig thinking doing his own conf, but joined in. Pretty much supportive

Crowd: 900 /heavy insurance

$: Corporate community raised

Ellwood
Brown

HRC Remarks:
- want Q&A w/ audience
- she decides length

Re Cornhusker

Purpose: To allow N. the opp to learn as much as possible about Nat'l Healthcare Problem.

Columbia Inst:

Series of h. c. conf – Reps + Dems

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate
WASHINGTON DC 20510-4802

FROM THE OFFICE OF SENATOR JAY ROCKEFELLER

FAX COVER SHEET

TO: Melanne Verveer

OFFICE: First Lady

FROM: Tamera Stanton

DATE: _____

OF PAGES (INCLUDING COVER) 6

Problems with transmission call (202) 224-6472

*** Nothing changed. Kerrey's big thing is "financing" --- it sounded to me like he was searching for an issue related to health care reform to make himself "distinct" from others and decided financing was the issue (this was several years ago) . The words he uses alot are "deficit-financing" He argues that we shouldn't go down the path we have with Medicare, Medicaid, and others and finance health care through federal debt.

File item 2: HRC-KERR.BOB 3/11/93 2:25PM

a note from my staff in response to a question to be sure this memo is still current. It is

Melanne —

Kerrey voted for the Nunn cap on entitlements, and was carrying around his own health care andt to the budget resolution that he scrapped related to financing.

He has attended the Magaziner/Feder lunches with Dem senators, and was complimentary at the second one.

~~CONFIDENTIAL~~

Memorandum

To: HRC
From: JDR
Re: Senator Kerrey's Health Reform Plan
Date: March 11, 1993

I had originally drafted this memo to you because of Bob Kerrey's repeatedly stated concerns about President Clinton's approach to health care reform. I wanted to give you a sense of the health care bill that Bob introduced a couple of years ago, and to let you know that the similarities between the two plans are more striking than their differences.

But since we drafted this, Bob and I had an exchange -- during yesterday's health care briefing for Democratic Senators by Ira and Judy -- in which he said in a note that he "likes what he is hearing" from the White House on health care. With that more hopeful comment, I pass these thoughts on in order to assist you in forging a partnership with Bob on health reform that we all want.

Both President Clinton's approach and Bob Kerrey's plan rely on the private insurance market to provide insurance coverage through pooling arrangements. Kerrey's bill would require everyone to buy coverage through purchasing pools versus only businesses of a certain size (yet to be determined by your Task Force). Instead of quasi-public or private entities acting as purchasing agents (HIPCs), Kerrey's bill relies on the states to act as purchasing agents.

Very confidentially, my health staff has spoken with a former aide to Kerrey, and she agreed that the approaches are compatible. She thought the Clinton managed competition framework with a global budget and the Kerrey bill were amazingly consistent with each other. (She even acknowledged that she wished they would have added the HIPC as the purchasing agent instead of the state.)

While Senator Kerrey's bill explicitly "breaks" the job-based link for health insurance, he does go to the workplace for financing health care through an employer and employee payroll tax. Kerrey has specifically made financing a key issue -- to make himself distinct from others -- and it is also a point other "modified" single payers like Tom Daschle frequently make to point out that individual taxpayers are already footing the bill for our private health care system.

Under their modified single payer bills, they are only recapturing current health care spending by taxpayers and funneling it through the federal government. The net increase in taxpayer spending is only minimal. For some it may even be less. Daschle, as you have probably already heard, uses the term "fiscal clarity."

Other factors may explain Kerrey's discontent, and I am hopeful they can be overcome with the proper attention to his concerns and need for involvement.

** Summary of "Health USA"

In July 1991 Senator Kerrey introduced his "Health USA" plan (S.1446). The major provisions of the proposal are:

- A federal commission appointed by the President and confirmed by Congress would oversee the plan.

- The Federal Government would collect most health care funds, combining current federal health care spending (Medicare, Medicaid, Federal Employees Health Benefits Program, CHAMPUS), a new payroll tax of 4% on employers and 1% on employees, and a series of new taxes on liquor and cigarettes, taxes on Social Security benefits, higher top personal income tax rates, and a rise in the amount of income subject to taxation.

- These funds would be channeled to new state health agencies. Federal dollars could be supplemented with state dollars.

- States would certify private managed care and other private networks of insurers and providers who offer a mandated benefit package, including some mental health, substance abuse, prescription drug, preventive, hospice, and long-term care coverage. Residents would choose from among these certified plans. Plans could charge enrollees extra premiums for more generous benefits.

- Plans would receive from the state a capitated payment based on the number of enrollees in each plan.

- Plans would have to accept all who apply. Enrollees could only change plans during an annual "open enrollment" period.

- The plan would replace Medicare, Medicaid, the Federal Employees Health Benefits plan, and CHAMPUS. States would operate or contract for a separate plan which could be a fee-for-service plan. Physician fees would be state set using an RBRVS-like mechanism.

- Resource Development Accounts would be set up in each state to fund access in underserved areas.

- Outcomes research and practice guidelines would be funded by the federal commission.

- The VA Health Care System would be preserved, with arrangements for the Department of Veterans Administration to be reimbursed for care provided in VA facilities.

Under Kerrey's bill, costs would be controlled by states having a predetermined allocation of federal funds and the authority to set rates and capitation fees. As I said above, the concept is actually very similar to HIPCs, but instead of the state government, managed competition envisions state-designated agencies would be the purchasing pools. Access is provided through universal enrollment. Consumer choice of private plans is expected to maintain quality.

It is apparent that there are <u>many similarities</u> to the basic framework of managed competition within the discipline of a national health care budget: A federal commission overseeing the program; state-designated agencies negotiating with private health care systems; the possible use of a capitation (as opposed to a federal rate-setting) mechanism to control costs; elimination of current insurance practices such as exclusions for pre-existing conditions.

Again, one difference is that the Kerrey plan would be financed by federal revenue collections, primarily employer and employee payroll taxes, as opposed to employers and employees sharing in the payment of <u>premiums</u>. A payroll tax is viewed by Kerrey as a source of financing, rather than building on our job-based system.

Julie — Keep copy for yourself for return. I'll let you know if we do

TO: Patty Solis
FROM: Cindy Dwyer
Kerrey Scheduler
RE: Mrs. Clinton's visit to Lincoln, NE

Patty, as we talked yesterday, I am faxing you the article on the Lancaster County Medical Society.

It would be a tremendous favor to Senator Kerrey if Mrs. Clinton would meet briefly with a small group representing this effort for the purposes of presenting Mrs. Clinton with a copy of their report, brief introductions and a photograph.

There would be 7 people representing the group and I will give you their names and their social security numbers.

This is also a good news story for both Mrs. Clinton and Senator Kerrey and we'd like to have our Nebraska AP reporter attend--but not allow him to interrupt or ask questions--simply to cover the story.

I have spoken about this event with both Steve Graham and Pat Hally.

The time frame and location for this would be roughly 12:20-12:35 p.m. in the holding room after Mrs. Clinton and Bob have met privately.

Call me when you can, Patty.

Thanks,
Cindy
(202) 224-4425 (direct)
(202) 224-7645 (fax)

MAKING MEDICAID WORK

How physician initiative solved the Medicaid problem in one U.S. community

story by Wayne Hearn

LINCOLN, Neb. — In early 1990, the leadership of the Lancaster County Medical Society was shaken when a survey revealed that virtually none of the community's primary care physicians accepted new Medicaid patients.

The society had commissioned the survey, suspecting a problem. Medicaid access had been inadequate for years in this community of 213,000 residents of whom about 15,000 are Medicaid eligible. But the results confirmed the physicians' worst fears.

"There were a couple of things I was concerned about after it hit me," recalls Chris Caudill, MD, a Lincoln cardiologist who was chairman of the Nebraska Medical Assn.'s Medicaid Committee at the time.

"One was the absolute reality of the situation, with so many patients out there without physicians and without knowing what they were going to do for medical care. Many, he says, were seeking care in emergency departments at the county's three hospitals or at a county clinic for indigent patients. Physicians treated a handful as charity cases without filing for reimbursement. It was clear that quality of care was suffering.

Dr. Caudill's other concern was the public-relations dilemma posed by the finding.

"I wondered how long it would be before it became known to the public in general, and what the reaction might be. And I also was concerned about what the state legislature might do. I really felt that the medical community was in the best position to solve the problem."

photo by John Hollendor

This view may have seemed unrealistic, since physician dissatisfaction with Medicaid was at the root of the crisis. But Dr. Caudill was right, as it turned out.

The Lancaster County Medical Society formed an ad hoc Medicaid committee, chaired by Dr. Caudill. It joined with the Lincoln-Lancaster County Health Dept. and the Nebraska Dept. of Social Services to fashion a Medicaid referral system that remedied the access problem almost as soon as it was implemented in February 1991.

Since the program's inception, more than 90% of about 100 primary care physicians in the county have agreed to participate — a 180-degree shift in their level of commitment to serving Medicaid patients.

Because Medicaid varies from state to state, it's difficult to measure the degree of physician participation nationally. However, a recent survey of self-employed physicians by the AMA's Center for Health Policy Research found that 65.5% of 4,545 primary care physicians participated in Medicaid in 1991.

In Lincoln, Neb., physician willingness to participate in Medicaid has been transformed, thanks to the local medical society.

Last September, the Lancaster County Medical Society and the Lincoln-Lancaster County Health Dept. were selected by the U.S. Health Care Financing Administration with a Beneficiary Ser-

See INITIATIVE, next page

Initiative

Continued from preceding page

ices Certificate of Merit for improving health care delivery to Medicaid recipients. One of four local efforts honored, this was the only one targeted to Medicaid patients.

The system is simple in concept: Any Medicaid-eligible patient who needs care but has no regular physician calls the referral line at the county health department. Within minutes, a public health nurse confirms the caller's eligibility via computer, assesses the patient's medical needs, screens for "access barriers" such as lack of transportation and assigns a primary care physician.

Assignments rotate among participating internists, pediatricians, family physicians and obstetrician-gynecologists. Each physician's name is kept in a card file. New patients are assigned to the doctor whose card is in front; the card is then moved to the back. Easy. Efficient. Equitable.

But best of all, it enables Medicaid patients to break the fragmented-care cycle that erodes quality and wastes health care resources.

By Jan. 31, nurses had assigned more than 5,655 patients to participating physicians, and had distributed 4,505 vouchers for free cab rides to and from appointments. Since the program began, the family physicians have accepted an average of 71 new patients each; pediatricians, 52 each; internists, 27; and obstetricians, 22.

The University of Nebraska Medical Center's family practice residency program also participates, exercising a "right of first refusal" to help it maintain an adequate case mix. If it declines, the intake nurse refers the patient to the next physician in line. The residency program, with 15 to 20 physicians, had accepted 809 referrals as of Jan. 31.

"When we started this, I think we really put together a new medical system," Dr. Caudill says. "Between the physicians and the patients and the participation of the public health nurses, it approaches some people's notion of an ideal situation. In terms of delivery of care, we have something that may not be available in the best private-pay coverage situations.

"It may not be that you can just take this plan and plunk it down anywhere and have it work, but I think the way it evolved could be useful in putting together a program that could work somewhere else."

The plans founders acknowledge that there are drawbacks, such as the lack of choice for patients, who must accept the assigned physicians unless both patient and physician agree they cannot work together.

Offsetting this restriction, however, is the access that Medicaid patients sometimes gain to practices closed to private-pay patients. Pat Lopez, RN, district public health supervisor and coordinator of the referral program, recalls asking a colleague to follow up on one of the Medicaid patients. "When she saw who the doctor was, she said, 'My god, I've been trying to get in to see him for two years!'"

Another drawback is that the program excludes non-primary care specialists, so consultations and referrals largely depend on the strength of the relationships between primary care physicians and the specialists with whom they regularly work.

"It's hoped that the support of the referrer would send a message to the physician being referred to that if they enjoy the patient flow, it would be appreciated if they would take care of this person," Dr. Caudill says. Subspecialists rarely have refused to accept Medicaid referrals.

After two years, the organizers are analyzing hospital emergency department records for signs that the program has reduced unnecessary visits by Medicaid patients. Preliminary results show emergency visits increased 7% since 1989, while the number of Medicaid eligibles jumped by 6%, from 9,000 to 15,000. "That has to speak positively of the program somehow," Dr. Caudill says.

The involvement of public health nurses gives the program a strong preventive-medicine orientation that benefits both patients and physicians, the providers say.

"We stress to the physicians the importance of the preventive services and tell them to make sure they bill for it," Lopez explains. "The physicians are getting the maximum benefit for billing purposes and at the same time, the patients are getting the maximum benefit from having continuous care. The kids are getting the well-child check-ups, and the women are getting their Pap smears when they should."

The system is successful because it was built on the problem-solving model, its proponents say. Through follow-up surveys, the committee learned why physicians did not want to treat Medicaid patients.

"That meant the basic components of the system were the solutions to the problems the doctors cited," Dr. Caudill says. "It also showed the physicians that we listened to what they had to say."

The complaints were familiar: low reimbursement, too much paperwork, too many claims denied on technicalities and long delays in receiving payment. Physicians also criticized Medicaid patients for missing appointments and being noncompliant.

Such problems are addressed by the state Social Services Dept. and the city-county Health Dept. Intake nurses stress the importance of compliance and keeping appointments. Under a contract between the Social Services Dept. and the Health Dept., federal money is earmarked for cab vouchers for patients without transportation and for other administrative case-management services.

Physicians are encouraged to report patients who miss appointments, so that Health Dept. nurses can follow up — with home visits, if necessary. Occasionally, the nurses observe evidence of other problems, such as domestic violence or substance abuse, and communicate it to the appropriate agencies. Patients who repeatedly abuse the referral program are simply dropped; it's happened to about 35 over the first two years.

"All of us have leverage with our private patients," says family physician Dale Micnels, MD, who was president of the county medical society when the program began. "If they continually fail to keep appointments, we can do something about it — we'll threaten to charge them for it. But with Medicaid you can't do that, it's considered fraud. So we didn't have a mechanism for [noncompliant] Medicaid patients, and now we do."

Says Dr. Caudill: "When we took this plan back to the physicians for their approval and explained why it was necessary and what the rules were, we were trying to extract from them an obligation to participate. In return, they wanted assurances from us that there would be accountability within the patient population and fairness within the rotational system."

The referral system also attempts to ease the hassles. Chris Wright, MD, the Social Services Dept. medical director, made it known her office was fully behind the system and encouraged physicians to call with complaints or reimbursement questions.

Dr. Wright adds that the new system also provided her department with a forum for updating physicians on Medicaid reforms they had missed because they weren't participating. For example, fees for primary care and obstetrics had been increased, and red tape had been reduced through the introduction of a universal billing form. "This helped us overcome a lot of the old history," she says.

The medical-society surveys helped prove that the Medicaid access problem was real, Dr. Michels says. It forced heads out of the sand. Many doctors "assumed someone else was taking care of things. Once we took care of that, we could start talking about fairness and making [patient distribution] equal — or at least close to equal — because things hadn't been very equal before."

Previously, Lancaster physicians say, when word got out that a practice was accepting Medicaid patients, it created a deluge.

"Periodically, the medical society would go to a couple of groups and ask them to help us out and see some Medicaid patients, and they'd get inundated because they were the only group doing it," Dr. Caudill says.

Eugene Schwenke, MD, was in a group family practice when the program began. "There were three in my group at the time, and I think we'd always done our fair share," he recalls, "but you'd open the door for one or two [Medicaid recipients], and pretty soon it would just be overwhelming."

Once the referral program was implemented, "everybody else started contributing and taking some of the load, and it did make things much smoother," says Dr. Schwenke, who now practices emergency medicine at a local hospital.

The program also offers flexibility to participating physicians, who may withdraw temporarily as needed, such as when a practice partner is sick or on maternity leave or the practice is at full capacity. Their cards are kept out of the rotation until they return. It's all based on good faith.

Peggy Barbee says the referral system has made it much easier to deal with Medicaid patients at Smith and Reed Clinic, the four-physician IM practice where she's the office manager.

"If the referral system calls, at least we know the patient is qualified for Medicaid coverage because the public health nurses have already screened for eligibility," she says. Plus, people are much less likely to abuse the system when they know someone's keeping track on things."

The referral system has redefined the Medicaid problem for the community, Dr. Caudill says.

"What it boiled down to was that there was this access problem for a long time, and it looked like physicians simply wouldn't take Medicaid patients. But that really wasn't the issue. In the end there was a spirit of cooperation and a willingness to do their fair share. Once this system was in place, the good will of the physicians could manifest itself. It enabled them to do it."

The system is successful because it was built on the problem-solving model, supporters say. Through surveys, the committee learned directly from physicians why they did not want to treat Medicaid patients.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. fax	From: Cindy Dwyer, To: Patty Solis, Re: Meeting with Lancaster Co. Medical Society [partial] (1 page)	4/14/93	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 5432

FOLDER TITLE:
[HRC Daily File] Friday, April 16 [1993]

2014-0483-S
sb334

RESTRICTION CODES

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

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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TO: Patty Solis
FROM: Cindy Dwyer
Kerrey Scheduler
RE: Meeting with Lancaster Co. Medical Society

Patty: This is a nearly complete list of the people Senator Kerrey would like Mrs. Clinton to meet on Friday in the Green Room at the Lied Center prior to Mrs. Clinton's speech.

Previously, I had sent the article on the Medical Society and their efforts to work on solving the medicaid problem in their community.

During the meeting, the Society would like to present Mrs. Clinton with a detailed report on how they proceeded and how it's working.

The attendees would include:

Natalie Clark, Lancaster County Medical Society
SS# (b)(6) 003

Jane Ford, Director, Lincoln/Lancaster County Health Dept.
SS# (b)(6) 003

Mary Dean Harvey, Director, Neb. Dept. of Health
SS# (b)(6) 003

Pat Lopez, Neb. Dept. of Public Health Nurse
SS# (b)(6) 003

Dr. Chris Caudill, Cardiologist
SS# (b)(6) 003

Dr. Chris Wright, Medical Director for Medicaid
SS# (still waiting for this one)

David Buntain, Attorney, Nat'l. Dem. Committeeman
SS# (b)(6) 003

Lucy Buntain, University of Neb. Foundation
SS# (b)(6) 003

*We also would like to include a medicaid patient who has benefitted from this effort. We have one identified and whose name I will forward to you shortly along with their social security number.

Thanks, please call.

Cindy
4/14/93
6:45 p.m.

BETH M. GONZALES
Press Secretary

Senator J. Robert Kerrey
Nebraska

United States Senate
Washington, DC 20510
(202) 224-6551

PEGGY A. JOHANNSEN
Deputy Press Secretary

Senator J. Robert Kerrey
Nebraska

United States Senate
Washington, D. C. 20510
(202) 224-6551

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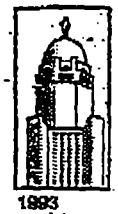
Senators Reject Effort to Alter Abortion Bill

BY JASON GERTZEN
WORLD-HERALD BUREAU



1993 Legislature

Lincoln — Lawmakers favoring a 24-hour waiting period for women seeking abortions in Nebraska held firm Tuesday against efforts to dismantle parts of Legislative Bill 110.

"We ought to move the bill as soon as possible" to second-round debate, said State Sen. John Lindsay of Omaha, the chief sponsor of LB 110.

In addition to imposing a 24-hour waiting period, LB 110 would require that a doctor or his assistant discuss with the woman such things as the medical risks of abortion and carrying a pregnancy to term.

■ State Sen. John Lindsay says women need more information about abortion; State Sen. Ernie Chambers plans to fight Lindsay's abortion bill. Page 5.

The bill also would require that women be given the opportunity to review written information that described and showed pictures or drawings of the fetus at the stage of development when the abortion would be performed.

Senators supporting a woman's right to an abortion renewed an effort Tuesday to remove from the bill a provision that would require the physician or

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Senators Reject Effort to Alter Abortion Bill

Continued from Page 1

assistant to tell women that medical assistance benefits may be available before and after the birth of the child. Another provision explains that the father is liable to help support the child even if he offered to pay for the abortion.

Senators last week rejected the amendment to remove the two provisions, but Sen. Ernie Chambers of Omaha asked his colleagues Tuesday to reconsider that decision.

Chambers said it didn't make sense to require physicians to provide information on child support because it was beyond their expertise as medical professionals.

Sen. Jessie Rasmussen of Omaha said the information is misleading because it doesn't help the women determine whether they are actually eligible for medical assistance benefits.

"I don't object to giving good information to a woman," Sen. Rasmussen said. "It should be honest, and it should be accurate. You may be eligible for these services, but you may not be."

Sen. Ardyce Bohlke of Hastings said she had similar objections to the child-support information requirement as it is worded in the bill.

Well over half of the child-support orders issued in the state are not followed, Sen. Bohlke said.

"To bring a woman in and indicate that child support from the father will be there to assist her is misleading and grossly unfair," Sen. Bohlke said.

Sen. Rasmussen said the way the two provisions were worded to provide only partial information led her to question the motives for including them in the bill.

"By only giving pieces of information, we are trying to persuade one way or the other," Sen. Rasmussen said. "That is not good policy."

Sen. M.L. "Cap" Dierks of Ewing spoke against Chambers' motion that the Legislature reconsider its action of last week in not removing the two provisions.

The Legislature rejected Chambers' motion Tuesday, 20-9.

Dierks said he thought it made good medical sense to make sure that doctors discuss the information with women seeking abortions.

Lindsay said the bill was needed because he questioned whether doctors performing abortions voluntarily provide the information.

"Once they are inside the clinic, there is a financial incentive to withhold information," Lindsay said.

Sen. DiAnna Schimek of Lincoln said she questioned the need for the bill.

"Any woman making such an awesome decision will have thought about it long and hard and have asked for as much information as she can get," Sen. Schimek said.

Day-Care Frustration Erupts Over Grant Procedure Leads Some Omahans to Write to Nelson

BY JAMES ALLEN FLANERY
WORLD-HERALD STAFF WRITER

Some Omaha day-care providers have complained to Gov. Nelson that the state has treated them inconsistently and unfairly in rejecting their applications for federal grants to expand day care.

Nelson has ordered a review of application procedures, and some changes already have been made. The governor wrote one critic that he tended to agree with the critic's complaints that instructions for obtaining grants were "ambiguous, repetitive and overlapping."

Nebraska is expected to award a total of $750,000 in fiscal years 1992-94 to day-care providers as part of a national push authorized by Congress to increase the quality and availability of day care.

"The grant selections that have been made so far in Nebraska were probably fair," Ed Schulenberg, the governor's adviser on children and family policy, said Monday. "But what was not was the process and the information they (providers) received. There was some ambiguity."

Questions about the grant process arose from these cases examined by The World-Herald:

■ Elizabeth Stiles scored 80 of a possible 100 points on her grant proposal last year to increase the size of the kitchen in her day-care home in the 6100 block of Florence Boulevard. She didn't get the money, but the state praised her for "a very good proposal" and urged her to tighten it and resubmit it. She did and scored 84. She is unsure whether she will apply a third time.

■ Robert Bock's corporation applied for a grant to transform an old house in Allen, Neb., into the town's only day-care facility. The corporation received $10,000 for what Bock describes as a major renovation and start-up costs. State rules say the federal grants may be

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Anger Heard Over Day Care

Continued from Page 9

used for "minor building modifications."

■ Helen Raikes, chairman of a subcommittee that decides on the day-care grants and co-director of a day-care facility in Lincoln, is eligible — along with other subcommittee members — to apply for the grants. Dr. Raikes, who has a Ph.D., said some committee members had applied. She said none had received a grant. If any came close to receiving one, she said, "procedures are there to avoid a conflict of interest."

Ms. Stiles and other Omaha day-care providers have appealed for help to State Sen. Dan Lynch of Omaha. They are scheduled to meet with him at 7 tonight at the Midwest Child Care Association office, 5015 Dodge St.

"My concern is we treat everybody in all areas even-handedly," Lynch said.

In 1991, Congress passed legislation to increase the quality and availability of day care. More than $2 billion was authorized over a three-year period. Most of the money is being spent to help low-income people afford day care.

More than $9 million has been received so far in Nebraska. The Legislature authorized $250,000 of that money to be spent each year for three years on grants to day-care providers to finance new programs and increase the capacity of existing operations.

The grants are supposed to help providers serving low-income areas. They also are supposed to increase day care for infants, disabled and ill youngsters and school-age children.

A special citizens advisory committee has been appointed by the governor to coordinate the effort. It is working with the State Department of Social Services and the Department of Education. Dr. Raikes directs one of five subcommittees involved in the effort. The Department of Social Services awards the grant money.

Pam Brown of Omaha, co-chairwoman of the citizens advisory committee, said about 500 Nebraska day-care providers applied for federal funds during the first round of grant applications early last year. More than 100 applied in the second round. So far, 79 providers have received grants for a total of $265,000.

Ms. Stiles said the grant program for day-care providers is confusing. She said that eligibility standards keep changing and that scoring is difficult to understand.

In a Feb. 26 letter to an Omahan who was critical of the program, Nelson said that he was asking for a review of the application process.

"We need to be clear regarding the purpose of the funding, so as not to cause confusion for those providing this very important service to our children and families," the governor said.

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Short-term health cost controls likely

LOS ANGELES TIMES
and Journal Writers

The White House on Monday sent its strongest signal yet that it intends to impose short-term price controls on doctors, hospitals and other private sector medical providers as part of national health care reform.

In the first public meeting of the White House Task Force on National Health Care Reform, Vice President Al Gore Jr., who chaired the meeting,

■ Doctors make how much?
Page 2.

said short-term cost controls are necessary to put a lid on the cost of insurance premiums, making it easier for businesses to furnish workers with health coverage under a government mandate.

Sen. Don Wesely of Lincoln, chairman of the Legislature's Health and Human Services Committee, said today price controls are something that need to be examined, but he would want to know how they would affect Nebraska before deciding whether to endorse them.

"Admittedly, they are extreme steps, but at the same time we have a crisis that in the short term we may need to put a brake on," he said.

Generally, health care costs are too high, but compared with other states Nebraska has lower average costs for some services, Wesely said. He said he would not want certain rates in Nebraska increased as a way to impose across-the-board price controls nationally.

Wesely said he will travel to Washington, D.C., on Friday to meet with the health care reform task force. Wesely said he will be one of about a dozen legislators from around the country invited to the meeting.

Anne Nation of Friend, a board member of a non-profit association

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that monitors legislation for 3,200 people enrolled in a health insurance pool for high-risk individuals, said she does not oppose short-term price controls, but added that "any health care reform has to be comprehensive."

"Rate limits and global budgets can be a key ingredient to making health care available and affordable," she said in a telephone interview this morning. "But unless you have other controls — such as an all-payer system, loss ratios for insurance companies and insurance coverage for all individuals — you are only dealing with one aspect of an entire system that needs to be reworked."

Nation said she believes price controls are a good idea because they begin to bring some of the health care costs under control by decreasing the rate of inflation. "But when you have fee-for-service and you limit the rate for procedures, you risk telling people simply to do more procedures," she said.

More than 60 interest groups and consumer representatives pleaded their case before the task force Monday. The only points of agreement were the need to cut down on insurance red tape and to place greater emphasis on preventive care.

Many who testified harshly criticized likely elements of the reform plan. Insurers argued against caps on premiums; doctors, hospitals and other providers resisted mandatory price controls; and small businesses opposed a government requirement that all employers pay a major portion of every worker's health insurance premiums.

Other elements of the proposed reform package disclosed Monday included plans to provide coverage for long-term care and to give nurses and physician-assistants greater roles in health care as a way to hold down costs. Senior administration officials also pledged to minimize disruptions in doctor-patient relationships.

In addition, to improve services to the underprivileged and others, the task force is exploring ways to eliminate Medicaid altogether, perhaps by gradually covering indigent persons under the same large health care coops being contemplated for much of the general population.

Judging from the questions posed by various administration officials, the task force apparently has not yet settled on some of the basic elements of the reform agenda — including how to finance coverage for the 37 million uninsured Americans and the extent of coverage for long-term care, mental health and prescription drugs, all of which are costly.

Gore presided over much of the meeting, sitting in for Hillary Rodham Clinton, who heads the task force. The first lady was still in Little Rock, Ark., with her father, who suffered a stroke nearly two weeks ago.

A number of small businesses vehemently argued against a government requirement that they pay for the health insurance of all workers, saying that would be a burden many small firms could not bear.

A government mandate to provide health coverage would cost small businesses at least $40 billion, according to Margaret Smith of National Small Business United.

As an alternative, Gary F. Petty of the Small Business Legislative Council urged the administration to institute a wage and price freeze on health care providers.

But G. Kirk Raab, president and CEO of Genentech Inc., a pioneering California-based high-tech firm, warned that such controls would "strangle investment" in the biotechnology industry.

Prices.
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BK

Clinton Health-Care Proposal Could Cut Benefits, Hike Taxes

BY PAUL GOODSELL
WORLD-HERALD BUREAU

Washington — President Clinton's health-care proposal could force the 700 employees at the Kellogg's plant in Omaha to pay more for their health benefits.

Instead of paying no deductibles or co-payments for doctor and hospital bills, Kellogg's employees — and other workers across America with relatively generous benefits — could wind up with new out-of-pocket medical costs or health-insurance premium increases.

And if the benefit package doesn't change, the Clinton plan could result in higher taxes for companies like Kellogg's — or possibly the employees.

"The whole notion of managed competition is that there will be a standard benefit package which will enjoy a tax subsidy, but anything above that will be paid with after-tax dollars," said Rep. Fred Grandy, R-Iowa. "Some benefit packages, either negotiated by unions or offered by employers, would have to be pared back."

'Managed competition carries with it a ticking time bomb. What you're probably going to have to do to get access to everybody is to provide fewer services for more money.'

— Rep. Fred Grandy

A White House task force headed by the president's wife, Hillary Rodham Clinton, is developing the administration's health-care proposal.

The administration wants to restrain health-care spending and provide benefits to an estimated 37 million Americans who lack coverage. Key decisions on taxing benefits have not been made, so it is difficult to determine how people will be affected.

But it is clear to Grandy and others, both in and out of Congress, that the Clinton plan eventually will prompt changes in some of the most generous benefit packages, including those negotiated in labor union contracts. As a result, the plan could face opposition from unions, which have been among the most vocal advocates of health-care re-

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BK

Clinton Health-Care Proposal Could Cut Benefits, Hike Taxes

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form.

"I don't believe that's a good move," Terry Moore, head of the Omaha Federation of Labor, said of reduced benefits. "I don't see us supporting something of that nature."

Tax Law

Although businesses have strained in recent years to absorb growing health-care costs, companies and workers have benefited from the way tax law treats health-care benefits. Employers can deduct all of the health-care benefits they provide, while workers do not pay taxes on the benefits they receive.

The Clinton plan, however, is based on the theory of managed competition, which relies on competitive market forces to restrain health-care costs. Insurers would compete to offer the best quality and lowest-cost version of a basic benefits package, which would be available to everyone.

As envisioned by Alain Enthoven, a Stanford University professor who is considered the father of managed competition, the federal government would impose tax penalties on packages that exceed the basic level.

The business's tax deduction for benefits might be limited to the cost of the basic benefits plan, encouraging companies to provide only the standard package.

Taxable Income

Another option would count excess benefits as taxable income for the employee, although Mrs. Clinton appeared to rule that out earlier this month by calling it an unfair tax increase on the middle class.

Enthoven, however, recently told the Washington Post that it is essential to use the tax code to deter unlimited health benefits. He said it is crucial that workers have a financial stake in choosing between health plans.

Without incentives for individuals to contain costs, Enthoven told the Post, the Clinton administration's efforts to control costs would be undermined.

Both Grandy and Sen. Bob Kerrey, D-Neb., agree that individuals should be more aware of the cost of health care.

"Everybody's going to have some contribution that they have to make," Kerrey said.

Similar Plan

Some people who have generous employer-paid benefits may have to pay something to obtain the same benefits under the Clinton plan, Kerrey said. But he said Clinton's basic benefits package will be a comprehensive plan similar to what many people have.

"The base package will not be a low-ball health-care package," Kerrey said.

But Grandy said the size of the benefits package will pose a major problem. If the plan is too generous, he said, it will be too costly for the federal government to subsidize it for the uninsured. If the basic package is too restrictive, however, it will leave many Americans dissatisfied with the change.

"Managed competition carries with it a ticking time bomb," Grandy said. "What you're probably going to have to do to get access to everybody is to provide fewer services for more money."

Average Plan

Grandy said the Congressional Budget Office told him that the average health-insurance package is worth $1,350 for individuals and $3,230 for families.

The typical plan offers comprehensive benefits with a $50 deductible for individuals, $250 for families and a 20 percent employee co-payment for medical bills up to $500 per person annually.

A tax cap based on that average would affect Kellogg's employees, said Joe Stewart, senior vice president for corporate affairs in Battle Creek, Mich.

"We're well above that," he said. "Our employees have a very excellent health care package — top of the line."

Stewart said hourly employees, including members of the American Federation of Grain Millers, pay no premiums, deductibles or co-payments. White-collar workers pay 1 percent of their salary up to a $600 maximum premium and a 10 percent co-payment.

It would be a mistake to tax benefits that exceed a basic level, Stewart said.

"We think that's absolutely the wrong direction," he said. "You cannot fix the health-care problem by penalizing those who are the 100 percent payers."

Such a tax change would be "enormously costly," Stewart said. He said he could not speculate on whether it would prompt the company to scale back benefits in its next labor negotiations.

But Moore said companies like Kellogg's would refuse union demands to continue generous benefits.

"I guarantee you it's a strike issue from the get-go," he said.

In Omaha, he said, limits on health-care benefits would affect unionized telephone workers, electricians and food processing employees, among others.

Gary Denier, a spokesman for the United Food and Commercial Workers International Union, said the union opposes taxation of individual health benefits and limits on corporate deductions.

Bargaining

"It undermines the collective bargaining process," he said.

But Kerrey said an advantage of Clinton's plan is that it will help break the link between employment and health care. He said he doubts that health-care benefits would be on the bargaining table in labor negotiations if Clinton's plan is enacted.

"You will not get health care through the negotiation process," he said.

"What will happen is, Americans will acquire a right to health care. They'll no longer fear they won't have coverage."

PAPER Lincoln Star
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Era of health care without limits is over

Now will come a wave of reaction against Oregon's unprecedented but also carefully crafted health care plan. It won the Clinton administration's conditional Medicaid waiver approval last week.

At the heart of the experimental program passed by Oregon's Legislature with broad, bipartisan support is this moral confrontation and revolutionary tradeoff:

Some high-cost medical procedures, or others with minimal long-term benefits, would no longer be available to Medicaid participants so that resources thus saved could be transferred and extended to the uninsured working poor.

With Washington's approval, an estimated 120,000 additional Oregonians now living in poverty would be newly entitled to Medicaid benefits. That isn't all.

A high-risk pool for the medically uninsurable would be established, something Nebraska did several years ago. Medical services would be delivered through a managed care protocol, something the Clinton administration is weighing for the entire nation. Small businesses which begin insuring workers would be eligible for state tax credits.

For the moment, let's suppose that Oregon can cough up the nearly $100 million in state matching funds required for the altered Medicaid program to be implemented. (This is nowhere near certain.) Alternatively, think about the plan's most celebrated feature, selective rationing.

Oregon's health care practitioners and vendors rated and ranked 688 procedures and conditions, factoring the severity of a condition and — here's the big departure — the likelihood of treatment improving the quality of a patient's life. The first 568 treatment regimes would be federally-state funded under Medicaid; the remaining 120 would not.

Typical of the criticism is that made by Joseph Tiang-Yau Liu, a senior health associate with the Children's Defense Fund. He laments that Oregon's "prioritization system would replace the individualized judgment of experienced physicians with a computer-generated list. . . . Only the poor would be subjected to this rationing process. The state did not include state employees in their prioritization scheme and the Legislature voted down a proposal to ration their own health care."

Historically, rationing of health care in America has been most based on the money of those wanting and needing services. Oregon moves in the direction of targeting public resources differently; the greatest good for the greatest number.

Yes, it's so that in Oregon, those who might be most victimized by the change are some Medicaid beneficiaries, those already poor or elderly. But none should be so blind as not to see the possibility of the same "outcomes and effectiveness" criteria later applied to the Medicare program nationwide, together with cost controls.

Oregon's senior senator, Bob Packwood, is right around the bull's-eye: "Sooner or later, the rest of America is going to come to what Oregon is trying. The era of health care with no limits" is over. If not yet, then very soon.

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Senators Face Health-Care Tax Issues

BY JASON GERTZEN
WORLD-HERALD BUREAU

Lincoln — Lawmakers this week will begin trying to assemble a budget-balancing package of new taxes that probably will total $20 million to $25 million, the chairman of the Nebraska Legislature's Revenue Committee said last week.

"It has been a revenue issue from day one," said the chairman, State Sen. Jerome Warner of Waverly. "We are looking for a combination that is feasible and reasonably acceptable tax policy."

Senators' turned their attention to taxes last week as the Legislature's Health and Human Services Committee killed most of the measures that had been proposed to ease the state's budget problems by cutting the services covered by Medicaid.

Medicaid is a cooperative program between the state and federal government. It helps pay for health-care services for the needy, aged, blind and disabled and for low-income families with children.

The state's expenses for the program have risen rapidly in recent years as more people have sought assistance and as more services have been covered. The state's cost increases for the next two years are expected to reach $72 million. The increases are largely responsible for a projected state budget shortfall of about $35 million over the next two years.

Warner and other state senators said the Legislature plans to heed the public's call to get the state budget under control by cutting spending.

But many specific cuts that have been proposed so far have met with opposition. The extent of the spending reductions that eventually are approved by the Legislature will depend on whether there will be new revenue and, if so, how much, Warner said.

"There is no point spending a lot of time arguing about a cut that isn't going to be made because there will be some revenue measures," he said. Warner served as chairman of the Legislature's budget-writing Appropriations Committee.

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Legislature Weighs Health-Care Taxes

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tee from 1977 to 1991.

Gov. Nelson's proposal in Legislative Bill 834, to raise an estimated $7 million a year by taxing the net income of hospitals and nursing homes, will be considered Wednesday at a public hearing.

The eight-member Revenue Committee then will begin trying to fashion a tax package to send to the full Legislature, Warner said. The committee will consider LB 834 and at least three other bills that would directly tax the health-care industry.

"I don't think the health-care industry can escape some type of contribution," said Lincoln lobbyist Walt Radcliffe, who represents some of the interests that would be affected by the taxes.

Revenue Transfers

Warner said he initially thought the health-care industry would face tax measures totaling about $12 million to $15 million. The proposals have attracted so much opposition, however, that he said he wasn't sure how realistic it was to assume that the health-care taxes would reach that level.

The Nebraska Hospital Association supports LB 815, which would raise an estimated $6.3 million a year by having local hospital authorities tax Douglas and Lancaster County hospitals. The hospital authorities, which are governmental bodies, would transfer the revenue to the state, which would use the money to leverage federal funding for the Medicaid program.

Hospital officials oppose taxing their industry in order to pay for problems for which they say all society should be responsible.

Taxing a hospital's gross receipts or repealing its sales tax exemption would be disastrous, said Roger Keetle, a lobbyist for the hospital association.

Hospital officials agreed early in the process to support LB 815 as a good-faith gesture that they were interested in helping find a solution to Nebraska's health-care financing problems, Keetle said.

"Unfortunately, it's kind of like, 'What have you done for me lately,'" he said. "Now they have come up with another approach to hit the hospitals again."

Options

Beside the health-care taxes, the Revenue Committee has other tax options, including raising general sales and income tax rates or reviving the sales tax on food.

Radcliffe said he considered general sales and income tax increases and repeal of the sales tax exemption on food to be among the proposals least likely to be adopted. "They face a certain veto," he said.

Warner said most of the tax increases before the committee would get his support only if they were limited to two years. This would recognize that changes affecting health-care financing are likely to be implemented, he said.

Two Views

Two other committee members indicated in interviews that the committee would not be starting the week with a clear consensus on which steps to take.

Sen. Ron Withem of Papillion said that if tax increases are necessary, he would prefer to see them targeted to avoid general increases in sales or income tax rates.

"Because so much of our problem is caused by problems within the medical cost arena, some of our budget cutting and some of our revenue increases need to be in that area," Withem said. "There are people within the medical community benefiting from the increase in expenditures in the medical arena, and they need to contribute to help solve the problem."

Sen. Doug Kristensen of Minden presented a nearly opposite view.

"The Medicaid issues are very broad-based issues," he said. "This appears to be a problem Nebraska as a whole has to shoulder."

Kristensen said he could support a slight increase in income or sales taxes. Another option, he said, would be to make everybody pay something by imposing a combination of taxes that could include higher levies on cigarettes and alcohol.

Doctors Board Calls for Change

BY JAMES ALLEN FLANERY
WORLD-HERALD BUREAU

Lincoln — The board that oversees Nebraska's doctors acknowledged Monday that the regulatory system it serves is "cumbersome, fragmented and hamstrung with a paucity of investigative and legal resources."

To better protect Nebraskans, the Board of Examiners in Medicine and Surgery said, it should be independent of the State Health Department and should have two or three additional members who have no ties to medicine.

At the same time, however, the board said a recent World-Herald series exaggerated shortcomings in Nebraska's system of regulating doctors.

Those who read "the exaggerated quotes and dramatic case histories and the speculation of the proper number of disciplinary actions might conclude that the situation was worse than it actually is," the board said in a three-page statement made public Monday.

"The articles could be construed to be a critical indictment of the efforts of the medical board and other components of the disciplinary mechanism," the board said. "On the contrary, Nebraska has been and continues to be served by dedicated individuals at all levels of this

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Doctors Board Issues a Call For Change

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endeavor."

The statement marked the board's first official reaction to The World-Herald articles, published Feb. 28 and March 1. The board, whose current members are six doctors and a retired pharmacist, makes recommendations on the licensing and investigation of doctors in the state.

Monday's statement follows action earlier this month by Gov. Nelson and other state officials to address possible changes in the system that licenses, investigates and disciplines 3,000 Nebraska physicians.

Nelson and the State Board of Health have appointed committees to recommend changes. A committee of the Legislature has embarked on a long-term study of additional reforms.

Nelson is expected to introduce a bill within the next few weeks that will incorporate some of the conclusions reached by his committee, the State Health Department and a variety of other interest groups.

In its statement Monday, the board said it desired a "more meaningful and comprehensive role in the whole disciplinary process."

It said it now is one of the six weakest medical boards in the country. Final decisions about disciplining doctors are made not by the board but by the state health director.

"We fear, however, that the public believes that we have far more authority and power" than the board has, the statement said.

At the same time, the board cautioned against too much government intervention.

The board said it favored the following changes in the regulatory system:

- Make the board independent of the State Health Department.
- Appoint two or three lay representatives to the board. A majority of similar boards in other states have more than one lay member. Nebraska's board has one.
- Give the board the power to regulate and define unprofessional conduct. A recent Nebraska Supreme Court decision overturned the discipline of a Nebraska doctor on the grounds that the doctor's reported action — prescribing drugs to undercover investigators — was not specifically prohibited by state law.
- Give the board power to subpoena doctors' records and demand that doctors appear before the board.
- Grant the board authority to require educational programs where necessary.
- Give the board power "to hire, train and direct its own investigators." Those who investigate doctors now work for the State Health Department. They investigate doctors and practitioners in 23 other health professions.
- Allow the board to hire its own attorney or obtain someone to represent it regularly from the Nebraska Attorney General's Office.

The board's statement came one day after the board met in Lincoln. At the Sunday meeting, Dr. James Dunlap of Norfolk, a former board chairman, urged it to take many of the actions it supports in Monday's statement.

The board decided to appoint Dr. Dunlap and another former board member, Dr. John Sage of Omaha, to assist Nelson's special committee.

Some board members were hesitant about hasty action.

"I'd hate to see us react to something written up in the newspapers and come out with a worse system than we have," said Dr. Robert Harry, a Lexington surgeon who has served on the board since January 1990. "As far as I can tell, there aren't too many things that slip by us."

Several board members said they were more concerned at the moment about the Nebraska Supreme Court decision March 5.

The court's ruling means that "we've got a major hole in the dike that's got to be plugged," said the board's vice chairman, Dr. Philip Metz, a Lincoln plastic surgeon. "The rest of these things (regulatory changes) can wait."

At its Sunday meeting, the board expressed little interest in changing the way it addresses the issue of doctors who are accused of medical malpractice.

Helen Meeks, director of the State Health Department's Bureau of Examining Boards, asked the medical board members whether they wanted to consider written criteria for when to investigate doctors accused of malpractice.

"It seems to me to be a redundancy," said Dr. William Shiffermiller of Omaha, a board member since 1986 and a past chairman.

The World-Herald series indicated that between Sept. 1, 1990, and Jan. 1, 1993, the board reviewed 82 Nebraska doctors who had made malpractice payments to patients. It chose not to investigate any of the 82 doctors.

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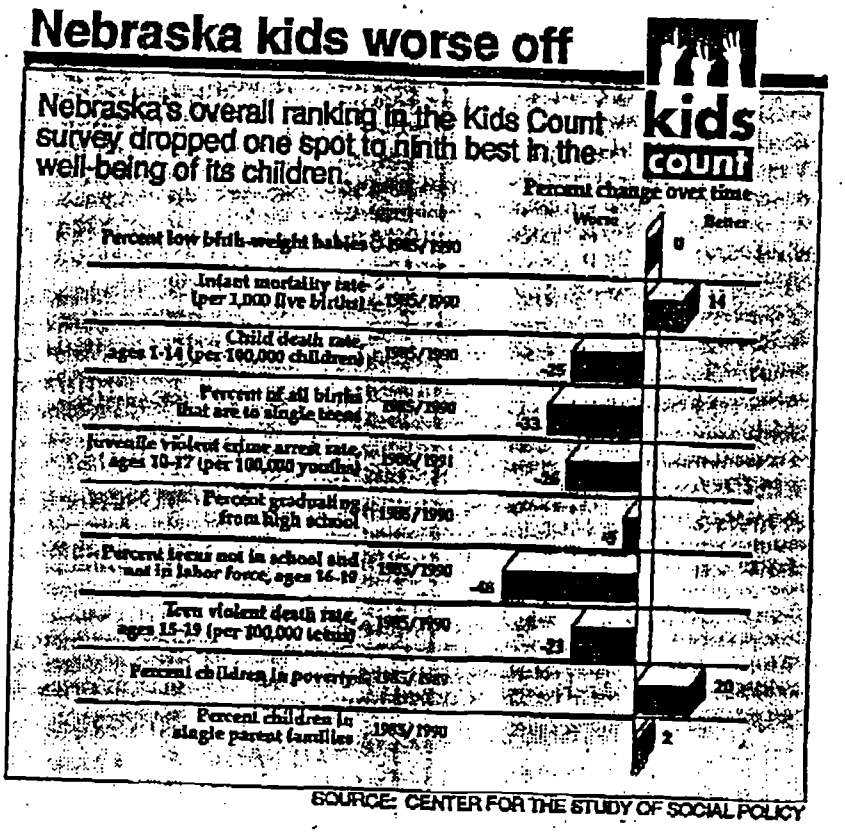
Nebraska kids worse off



SOURCE: CENTER FOR THE STUDY OF SOCIAL POLICY

State's high rank in child well-being also has signs of growing problems

BY MARTHA STODDARD
AND DAVID LYNCH
Lincoln Journal

Conditions have worsened on six of the 10 measures used in the report, including all of the five measures having to do with teen-agers. But even in two areas where the state improved — infant mortality rate and the percent of children in poverty — a closer look at the numbers shows a different story.

— Gail Flanery, Voices for Children of Nebraska

Nebraska's children rank among the best off in the nation but the state is slipping on several measures of child well-being, according to a state-by-state report card released today.

The fourth annual Kids Count Data Book, released by the Center for the Study of Social Policy and the Annie E. Casey Foundation, ranked Nebraska ninth best among the 50 states and the District of Columbia on child well-being.

Last year's report listed the state in eighth place.

New Hampshire was ranked as the best state for the well-being of children, and the District of Columbia was ranked the worst.

But the well-being of Nebraska children, especially those under 5 years old, is falling, said Gail Flanery, deputy director of Voices for Children of Nebraska.

Conditions have worsened on six of the 10 measures used in the report, including all of the five measures having to do with teen-agers.

But even in two areas where the state improved — infant mortality rate and the percent of children in poverty — a closer look at the numbers shows a different story, Flanery said.

The infant mortality rate dropped from 9.6 deaths per 1,000 live births in 1985 to 8.3 per 1,000 in 1990 for Nebraska as a whole. But the rate is "dramatically higher for minority race children," Flanery said.

Children in poverty dropped from 18.2 percent in 1985 to 14.5 percent in 1990, when looking at all ages. But the percent of children age 5 or younger in poverty increased 25 percent, according to federal census statistics, she said.

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Kids

Nebraska earned a ranking of 32nd, one of its lowest rankings on the measures used in the report, for its child death rate. The rate worsened by 25 percent between 1985 and 1990, increasing from 25.4 per 100,000 children age 1 to 14 to 31.6 per 100,000.

The state's lowest ranking came on the teen violent death rate — deaths from homicide, suicide and accidents for youths age 15 to 19. The rate worsened by 23 percent from 1985 to 1990, rising from 61.3 per 100,000 to 75.3. Nebraska ranks 33rd on this measure.

Dr. David Schor, director of Maternal and Child Health for the state, said year-to-year variations explain some of the worsening in death rates. But he also called for legislation that would set up child death review teams to look at whether deaths could have been prevented.

On other teen-age measures:

The proportion of teens age 16 to 19 who are not working or in school rose 48 percent from 1985 and 1990 in Nebraska. But nationally, the percentage of teens in this category decreased.

Births to teen-age mothers increased 33 percent over the same five years, rising from 5 percent of all births in 1985 to 7 percent in 1990. The percentage rose faster than the national average.

High school graduation rates, while fifth best in the country, slipped 5 percent. The number of teens graduating within four years dropped from 88 percent in 1985 to 84 percent in 1990.

The violent crime arrest rate for youths age 10 to 17 worsened by 26 percent in Nebraska from 1986 to 1991. But the state still fared better than the rest of the nation.

The report also showed that Nebraska had a sizable number of new families at risk, although the state did better than most other states.

"In 1990, almost one out of ten new families that began with the birth of a first baby — or 816 new families — were vulnerable right from the start because the mother lacked a high school education, was teen-ager, and was single when her first baby was born.

"Thirty-seven percent of new families — or 3,294 families had at least one of these strikes against them," the report said.

Forty-five percent of new families nationally started with at least one of those three risks, which Kids Count Coordinator Judith Weitz said increase the chances that "families will break up, be poor or be dependent on public assistance and that children will be neglected and fall behind in school."

"The alarming number of vulnerable new families is the tragic, but predictable, consequence of the deteriorating status of American teens," said Douglas W. Nelson, executive director of the Annie E. Casey Foundation.

The state has several projects under way to address problems identified in today's report, said Kathie Osterman, spokeswoman for the state Department of Social Services.

Among the efforts are a Commission for the Protection of Children, established in 1991 by Gov. Ben Nelson to improve the ways the state responds to and supports children and families.

One commission effort, called Good Beginnings, is still being developed but will focus on improving health, education and social services for children. Plans call for the program to include parent education, a family visitation program for parents of newborns and young children and early childhood education.

The Social Services Department has job support programs targeting teen parents, Osterman said. The Health Department is hiring an adolescent health coordinator, Schor said.

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Creighton Ethicist on Task Force

Professor Helping to Weigh Pros, Cons of Health-Care Provisions

BY ROBERT DORR
WORLD-HERALD STAFF WRITER

For an Omaha woman on Hillary Rodham Clinton's task force, helping to forge a national health-care reform plan means taking part in spirited small-group discussions that span 13-hour work days.

"It gets very intense," said Ruth Purtilo, whose national reputation as an expert in medical ethics won her a seat on the White House task force.

The Creighton University professor has been assigned to a working group that is weighing ethical pros and cons of provisions being considered for the health-care measure.

Her work on the task force encompasses many ideas, she said during an interview in Omaha last week after her first three days of meetings. She has returned to Washington this week and will every week until the health-care package is ready to go to Congress in May.

Some ideas come from stacks of mail sent by Americans who have their own suggestions about how to change the nation's health-care system. Vice President Al Gore said this week that 50,000 Americans have sent suggestions to the task force.

Dr. Purtilo said the stacks of letters seem unending.

The letters are directed to the ethics committee and to other small working groups within the Clinton task force. The groups mine the mail to find good ideas and to learn trends in the public's concerns about health care, she said.

"I haven't read the mail, but we're all taking our turns, and my turn will come," she said.

At Creighton University's Center for Health Policy and Ethics, Dr. Purtilo teaches and writes in her specialty of medical ethics, a relatively new field spawned by high-tech, high-expense medicine.

She also serves on St. Joseph Hospital's ethics committee.

An attending physician usually brings in members of the ethics committee — including a doctor, nurse, chaplain and ethicist — to help the family and the medical team deal with such questions as: When, if ever, should medical treatment be discontinued? And why?

> *'It gets very intense.'*
>
> — Ruth Purtilo
> Task force member

About 30 times last year she became involved in such discussions.

"That's high stress," said Dr. Purtilo, a friendly, smiling person who relaxes by reading T.S. Eliot's poetry, tending her garden and taking walks.

She seldom expresses her opinions about what should be done in medical cases, she said, preferring to ask questions that help focus the thinking of physicians, nurses and family members.

Those meetings should serve her well as one of 15 members of the Clinton task force's ethical considerations group.

Her group and 33 others, meeting separately in the Old Executive Office Building next to the White House, report once a week to a panel called Tollgate. Mrs. Clinton sits on that panel. To make it into the final health-care bill, an idea must be accepted by Tollgate, Dr. Purtilo said.

Sometimes an idea starts with the ethics group and goes to Tollgate. At other times, Tollgate sends an idea to the ethics panel for discussion.

Although the Clinton administration is committed to giving greater access to health care, Dr. Purtilo said, "there's no preconceived plan."

Dr. Purtilo, 50, daughter of a Methodist minister, grew up in Duluth and St. Paul, Minn., in a family that believed it should feed and take care of people who had no other place to go.

Her father once brought home a teenage boy who had completed a prison sentence for stealing. The youth lived with her family for several months until he got a job, Dr. Purtilo said.

Wanting to enter some helping profession, she picked physical therapy and graduated summa cum laude from the University of Minnesota.

Several years later she made a decision that became a career turning point, although she didn't know it then. Working at a Grand Forks, N.D., clinic, she gave therapy to a 19-year-old youth named David who was paralyzed from the neck down after breaking his neck in a diving accident.

Dr. Purtilo was present when David's former girlfriend and his older brother told David they were getting married. She groped for words and felt inadequate. She decided she needed something more than her physical therapy skills.

After earning a doctorate in ethics from Harvard University, she taught and worked as an ethicist at the University of Nebraska College of Medicine, at Massachusetts General Hospital, at the University of Massachusetts Medical School and as a visiting scholar at Karolinska Institute in Stockholm, Sweden.

She never returned to physical therapy.

Dr. Purtilo's marriage to Omaha lawyer Vard Johnson brought her back to Omaha. The two knew each other when she lived in Omaha. Johnson then was a state senator who worked with her on legislation affecting the N.U. Medical Center.

She moved from Omaha to Boston in 1987. When Johnson attended his Harvard Law School class reunion in 1989, they had dinner together. That began a yearlong, long-distance romance that led to marriage in 1990, the second marriage for both.

Ethicists typically are called in for the most difficult cases, she said. As an example, she recalled an infant girl who had a rare and complicated intestinal disease that kept her from digesting food.

Doctors at the N.U. Medical Center performed several surgeries in the first days after birth. The infant was fed through injections into blood vessels. Future medical care was estimated to cost $1 million a year, and success wasn't certain.

But the infant's family favored taking every lifesaving measure. Moreover, the baby was normal except for the intestinal disease.

Other factors that were considered: The family had enough insurance coverage to pay the cost for about a year, continued treatment wouldn't cause severe pain and without treatment death was certain.

The medical team and family ultimately decided to indefinitely continue the treatment, she said.

R=95%

Omahan: Health discussions intense

Creighton professor on small group weighing ethical issues

OMAHA (AP) — An Omaha woman on Hillary Rodham Clinton's task force trying to develop a national health-care plan says spirited small-group discussions are taking place as the issues and options are reviewed.

"It gets very intense," said Ruth Purtilo, who is known nationally as an expert in medical ethics.

The Creighton University professor has been assigned to a group weighing ethical pros and cons of provisions for the health-care measure.

She went to Washington this week and will every week until the package is ready to go to Congress in May.

Citizens have provided some suggestions about how to change the nation's health-care system, she said. Vice President Al Gore said this week that 50,000 Americans have sent suggestions to the task force.

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The ethics committee and other small working groups within the task force sift through the mail to find good ideas and to learn trends in the public's concerns about health care, she said.

At Creighton University's Center for Health Policy and Ethics, Purtilo teaches and writes in her specialty of medical ethics, a relatively new field spawned by high-tech, high-expense medicine.

She also serves on St. Joseph Hospital's ethics committee, which helps families and medical teams deal with such questions as: When, if ever, should medical treatment be discontinued? And why?

About 30 times last year she became involved in such discussions.

"That's high stress," Purtilo said.

She seldom expresses her opinions about what should be done in medical cases, she said, preferring to ask questions that help focus the thinking of physicians, nurses and family members.

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To make it into the final health-care bill, an idea must be accepted by Tollgate, Purtilo said.

Sometimes an idea starts with the ethics group and goes to Tollgate. At other times, Tollgate sends an idea to the ethics panel for discussion.

Although the Clinton administration is committed to giving greater access to health care, Purtilo said, "there's no preconceived plan."

She is one of several people with Nebraska connections helping the Clinton administration develop its health-care plan.

Others are Roger Blauwet, a former partner in the Kutak Rock law firm in Omaha who is tax counsel to Rep. Peter Hoagland, D-2nd District; Sheila Nix, a Creighton University graduate and former Washington lobbyist who works for Sen. Bob Kerrey, D-Neb.; Karen Davenport, 28, a federal government intern assigned to Kerrey's Senate staff; and Nicole Simmons, a former Omaha World-Herald reporter who now works for the federal Health Care Financing Administration.

More than 500 people serve on the task force.

BK

2 Link Kerrey to Health-Care Group

BY PAUL GOODSELL
WORLD-HERALD BUREAU

Washington — Sheila Nix was a college student at Creighton University when Bob Kerrey was governor of Nebraska.

Now a member of Kerrey's Senate staff, Ms. Nix and fellow aide Karen Davenport are his main links to the White House health-care task force.

"We bring Bob's viewpoint (to the task force)," Ms. Nix said. "He's concerned that there's a comprehensive package of benefits, and he's concerned about eligibility for all Americans."

A Chicago native, Ms. Nix graduated from Creighton in 1983 and worked in Omaha for Coopers & Lybrand accounting firm from 1983 to 1986. After earning a law degree at the University of Chicago in 1989, she became a lobbyist with a Washington law firm, Arnold & Porter.

Ms. Nix, 31, said she lobbied for both insurance companies and health-care providers.

'We bring Bob's viewpoint (to the task force). He's concerned that there's a comprehensive package of benefits, and he's concerned about eligibility for all Americans.'

—Sheila Nix
Senate staff member

She took a leave of absence from the law firm to serve as legal counsel for Kerrey's presidential campaign, which began in September 1991, returned to Arnold & Porter for a few months after Kerrey dropped out of the race in March 1992 and was hired for his Senate staff last November.

On the health-care task force, both women serve on the working groups handling the standard package of benefits and the plan for providing health care to low-income and nonworking families.

Ms. Nix is married to a Washington patent attorney. They are expecting their first child in three weeks.

Ms. Davenport, 26, is in Kerrey's office temporarily as part of the Presidential Management Internship program, a federal program that provides a two-year stint in government.

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RICH JANDA/THE WORLD-HERALD

CREIGHTON PROFESSOR: Task force member Ruth Purtilo is on the faculty of Creighton University's Center for Health Policy and Ethics.

THE ASSOCIATED PRESS

STAFF MEMBERS: Roger Blanwet, tax counsel for Rep. Peter Hoagland, D-Neb., and Sheila Nix, who works for Sen. Bob Kerrey, D-Neb., are among a number of congressional staffers and government agency employees on the health-care task force.

Midlands Voices Heard on Health

BY ROBERT DORR
and PAUL GOODSELL
WORLD-HERALD STAFF WRITERS

At least seven people with Nebraska or Iowa connections are helping to develop the Clinton administration's proposal for changing the nation's health-care system.

A task force headed by Hillary Rodham Clinton has a May 3 deadline to complete the proposal, which is intended to restrain health-care costs and guarantee insurance coverage.

More than 500 people serve on the task force. Nebraska and Iowa task force members include:

■ Ruth B. Purtilo of Omaha, professor of clinical ethics at Creighton University's Center for Health Policy and Ethics.

■ Roger Blauwet, a former partner in the Kutak Rock law firm in Omaha who is tax counsel to Rep. Peter Hoagland, D-Neb.

■ Sheila Nix, a Creighton University graduate and former Washington lobbyist who works for Sen. Bob Kerrey, D-Neb.

■ Karen Davenport, 26, a federal government intern assigned to Kerrey's Senate staff.

■ Peter Reinecke, legislative director for Sen. Tom Harkin, D-Iowa.

■ Dr. Stephen Gleason, a Des Moines physician.

■ Nicole Simmons, a former Omaha World-Herald reporter who now works for the federal Health Care Financing Administration.

For profiles of Nebraskans on the task force, see Page 11.

■ Market forces already are transforming the health insurance industry. Focus, Page 10.

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Omahan Caught Up in Health Project

BY PAUL GOODSELL
WORLD-HERALD BUREAU

Washington — Roger Blauwet, a member of the White House health-care reform task force, hasn't had much time to settle in since he moved here from Omaha in mid-January.

"I'm unpacking clothes out of the boxes as I need them," Blauwet said.

A former partner in the Kutak Rock law firm in Omaha, Blauwet moved to Washington to be tax counsel to Rep. Peter Hoagland, D-Neb. Hoagland recently won a seat on the tax-writing House Ways and Means Committee.

But Blauwet soon was asked to take on an unpaid second job as a member of the health-care task force headed by Hillary Rodham Clinton. He serves on a working group concentrating on insurance issues.

Blauwet, 46, is one of many congressional staffers working 10 to 12 hours a week on the task force. Unlike administration officials assigned from various federal agencies to develop details of the plan, the Capitol Hill aides have the added responsibility of screening the proposal for political and logistical land mines.

"The staffers are there, in a sense, to keep a political eye on the process," Blauwet said. Clinton officials "don't want to second-guess Congress on this issue."

Blauwet had relatively little direct experience in insurance operations or the theory of health-care reform before his assignment to the task force, although he had done legal work for Mutual of Omaha, Prudential Insurance Corp. and other insurers.

But Blauwet participated in meetings that Hoagland held this winter with Omaha insurance companies and area hospitals and said he has continued to meet with those groups. Hoagland said Blauwet is a quick study who has worked "seven days a week" to master health-care issues.

Blauwet said all the task force participants — but especially those working for members of Congress — are conscious of the debacle over catastrophic-illness health care four years ago.

> *'The staffers are there, in a sense, to keep a political eye on the process.'*
>
> —Roger Blauwet
> Member of health-care task force

Passed by Congress with near-unanimous support and signed into law in 1988 by then-President Ronald Reagan, the legislation was intended to provide additional Medicare coverage for catastrophic illnesses. The benefits were to be financed through higher premiums, based on income, of up to $600 per person for the most affluent retirees.

Although most retirees would have paid far less, the premium plan caused an uproar that led Congress to repeal the entire bill in 1989.

"If it could happen with a little thing, think of what could happen with comprehensive health-care reform," Blauwet said.

As a result, he said, it is important to consider how individuals will be affected by health-care changes.

Blauwet declined to discuss details of the task force's work or give his opinion about how the health-care system should be reformed. But he said a key challenge is to control costs without squeezing the system so much that doctors do not have enough incentive to deliver good services and individuals lose the ability to make their own health-care choices.

"You can't wring so much excess out of the system that you don't have innovation," he said.

At the same time, he said, most people realize that health-care costs are spiraling out of control and that some changes must be made.

The Clinton plan is expected to build on the theory of "managed competition" — establishing a better health-care marketplace where competition will restrain cost increases.

Insurers would compete to offer the best combination of service, choice and price for a standard health benefit package. They would have to provide coverage for anyone who selects their plan, regardless of current or potential health condition.

Individuals would choose between the competing plans and will not be limited, as many are now, to a single plan offered by their employer. But the Clinton plan is likely to increase the use of "managed-care" plans such as health maintenance organizations (HMOs), which place restrictions on individual choice of doctors.

Blauwet said the managed-competition approach must be modified in rural areas, however, where there are not enough health providers to generate competition. Rural areas have other problems that some task force members initially did not fully understand, he said.

Blauwet said he objected when some members spoke of rural residents perhaps having to drive 30 minutes to reach a hospital. He said he told the group that it takes more than an hour to get to a hospital in many rural areas.

"People who have lived in New York all their lives don't have a concept of what rural really means," he said.

The son of farmers who still live in Larchwood, Iowa, Blauwet graduated from Creighton University and Creighton School of Law. He served in the Army from 1969 to 1972, living in Washington, D.C.

Blauwet was a clerk for Associate Justice Lawrence M. Clinton of the Nebraska Supreme Court and worked at a law firm in Superior, Neb., before moving to Kutak Rock in 1980. He specialized in corporate finance and regulatory matters.

Blauwet, who is single, said he hopes to eventually have time to go sailing on the Chesapeake Bay. For a while, however, he expects to remain busy with long days and weekend task force meetings — a schedule that he said is not too different from his days at Kutak Rock.

"My office hours in Omaha tended to be 7 in the morning to 8 or 9 at night," he said.

Wesely to Weigh In On Health Proposal

BY JASON GERTZEN
WORLD-HERALD BUREAU

Lincoln — State Sen. Don Wesely of Lincoln is going to Washington Friday to advise the Clinton administration on what Nebraska legislators want in a national health-care plan.

"My focus is that they should listen to the states and not shut us out of the planning," said Wesely, chairman of the Legislature's Health and Human Services Committee.

"One size fits all is not going to work well for all 50 states," Wesely said. "Nebraska is not New York, Florida or California."

Wesely is one of about 25 legislative leaders on health-care issues from across the nation who have been invited to meet with members of the health-care task force headed by Hillary Rodham Clinton, said Susan Seladones, director of public affairs for the National Conference of State Legislatures.

The meeting will be conducted at the White House.

States are not sitting back and waiting for the federal government to bring a health-care reform plan to their doorsteps, Wesely said. But some states have been hindered in their efforts to make changes because a number of such initiatives require federal approval that is difficult to receive, he said.

"The federal government is part of the barrier," Wesely said.

Sen. Dennis Byars of Beatrice, a member of the health committee, said he believes that Nebraska should wait for the national health-care plan proposal to be made public next month before approving major changes to the state's system.

"It doesn't make sense to do a lot of things," Byars said. "I am going to be a foot dragger. How much time should we spend developing something that will become part of the junk heap before it's implemented?"

Byars said he questioned the value of pushing for significant Medicaid change in Nebraska until the federal plan is made public because "everything I hear is there won't be a Medicaid in the Clinton plan."

Medicaid is a state-federal cooperative program that helps pay for health-care for the needy, aged, blind and disabled, and for low-income families with children.

Wesely said there is a possibility that the plan will feature one basic package of benefits for all citizens instead of a separate package for the poor.

Sen. Jessie Rasmussen of Omaha, vice chairman of the health committee, said she was concerned that such a plan would not take into account the unique differences and needs of the poor, especially those with more serious medical needs.

"I hope they would not ignore the philosophical direction we have gone toward promoting independence rather than requiring them to live in institutions," Sen. Rasmussen said.

Byars said state legislators have tried to see that poor, disabled Nebraskans have access to personal aides and other services that allow them to live independently in their home, rather than being forced into a more expensive nursing home or other institution.

Although this approach is more cost effective, "we become portrayed as big spenders," Byars said.

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Cydney Janssen of Gordon, chairwoman of the Rural Health Task Force of the Nebraska Rural Development Commission, said Panhandle hospitals need to cooperate to keep prices down and give the best care.

Nebraska's per-capita health care cost was $2,452 in 1990 and is expected to be $5,578 by 2000, Janssen said. Those numbers mean Nebraskans have less disposable income, higher insurance premiums and rising prices in other sectors as employers pass on the cost of insuring their workers.

Phemister said a Panhandle cooperative might be like Wisconsin's.

"I think it could look a great deal like that," she said. Gordon and other small rural hospitals already have been discussing the idea for months.

The hospitals are looking at ways to share services, share an auditing firm and perhaps purchase supplies together, Phemister said.

Steve Hetzel, senior vice president of Regional Care Inc., an affiliate corporation of Regional West Medical Center, said his group has been talking with other hospitals about cooperation since last fall. The corporation was formed to develop a health plan for the Panhandle.

But for such informal efforts to develop into an organized cooperative, smaller hospitals and Regional West need to work together on an equal level, Ruff said.

"Come with the thought you're going to create something together, not buy into something that's structured already," she said.

The conference was sponsored by the University of Nebraska Panhandle Education Center. B.J. Peters, spokesman for the center, said it was a way to get the Panhandle hospitals together

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Area hospitals ponder ways to cooperate

By JAN TREFFER
Staff Reporter

SCOTTSBLUFF — Health care soon could look much different to Panhandle patients. Cooperative medicine is on the way.

Representatives of Panhandle hospitals say they're eager to form a consortium to keep care affordable and their hospitals open.

"I think there are enough of us in the Panhandle that think it's necessary for survival. It's a go," said Gladys Phemister, administrator of Gordon Memorial Hospital.

Sixty-six people came to Scottsbluff Friday for a rural health care conference featuring Patricia Ruff, who outlined the role of the Rural Wisconsin Hospital Cooperative.

> *"I think there are enough of us in the Panhandle that think it's necessary for survival. It's a go."*
>
> **Gladys Phemister, Gordon Memorial Hospital administrator**

Ruff, deputy director of the cooperative, said it was started in 1980 and offers services to 20 member hospitals. Members contract for only the services they need, such as purchasing and staff.

The cooperative also established HMO Wisconsin, a health maintenance organization that sells insurance to residents. The 30,000 subscribers pay into a pool, and the HMO pays physicians and hospitals at a contracted rate. If money is left over at year end, policy-holders get a refund.

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Health Plan to Allow Choice Of Doctor, Preventive Services

THE LOS ANGELES TIMES

Washington — President Clinton's health-reform plan will allow Americans the freedom to "follow their own doctors" into new provider networks, the administration's chief health-care adviser disclosed Friday. And the basic benefits package will include preventive services rarely covered by current insurance programs, he said.

"There should be a choice of physicians — you shouldn't herd people into one plan or another," Ira Magaziner, who is directing the administration's 500-member health-care task force, told a gathering of consumer groups.

Addressing an issue that many advisers consider critical to the success of the reform effort, he emphasized the president's desire to allow people to "be able to choose their own doctor."

The administration is eager to assure consumers who now have relatively good health-insurance coverage that they can continue their current relationships with their family doctors or specialists.

In a two-hour question-and-answer session, Magaziner provided other significant new details on the form of the health-reform package the administration will unveil next month. Among them:

— The government would create special incentives to get doctors and nurses to work in poor city neighborhoods and in rural areas, to "make it attractive to go there and stay there."

— Anti-trust laws would be eased to allow local groups of doctors and hospitals to join together in the creation of health-care networks.

— The popular Medicare program would be largely untouched by the reform package, other than the addition of some new benefits that will be part of the universal package. The administration is very "conscious of not wanting to break something most elderly people feel is working pretty well," Magaziner said.

The administration's package will have a basic set of health benefits guaranteed for all Americans. The coverage will be universal and portable, following each American, regardless of health status or employment, Magaziner said.

Care will be delivered under a "managed competition system," with residents of a geographic area choosing among several health plans meeting government standards. Local purchasing cooperatives would certify a variety of acceptable health networks.

The plans might include a health maintenance organization, with a restricted list of doctors and hospitals, a preferred provider organization with a somewhat broader list of doctors, or a traditional fee-for-service plan allowing the patient to choose any physician. The fee-for-service plan, which allows unrestricted selection of doctors, would be more expensive for those who choose to join.

All Americans "should be able to follow (their) own doctor" into the kind of plan the physician chooses to join, Magaziner said. "Americans don't want to be told they can't stay with their own doctors," Magaziner told the meeting, which was organized by Families, USA, an advocacy group active in the health-reform campaign. The audience included representatives from more than 200 organizations, including women's groups, labor organizations and health groups.

All the plans would have to offer at least the basic benefits package, providing hospital and doctors services, including mental health care and some prescription drug coverage.

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Hospitals

payers and advancements in treatment have contributed to the new ebb in inpatient numbers.

"What we didn't count on to the degree that it occurred were the changes in technology," said Arlan Stromberg, administrator at Lincoln General.

He cited a new technique for removing gallbladders as an example. With the new procedure, most gallbladders can be removed through small incisions instead of requiring major abdominal surgery. Patients can go home within a day or two instead of 10.

Bob Lanik, president and chief executive officer of St. Elizabeth, pointed to aggressive efforts by insurance companies and other payers to control health-care costs by managing care. Such efforts typically include requiring approval for patients to be admitted to the hospital and reviews during their stay to be sure hospital care is still needed.

Lincoln's hospitals have responded with their own measures to keep down costs by shortening stays where possible.

For example, Lincoln General has used the MEDIS system to make sure patients stay no longer than necessary. St. Elizabeth has turned to home health nurses to provide some of the pre- and post-admission care. All three hospitals have worked to compress the same amount of patient education, tests and care into shorter periods of time.

"As payers have changed the way they pay, it has changed practice patterns," Frye said.

As a result, average lengths of stay for acute care patients dropped at Bryan from a peak of 6.7 days in 1989 to 6.1 days last year, from 6.9 days in 1987 at Lincoln General to 4.5 days last year and from 5.2 days in 1988 at St. Elizabeth to 4.6 days last year.

With the increases in outpatient services, the shorter inpatient stays have not slowed the pace of activity.

"We're still seeing the same numbers of people throughout or even strengthening (the numbers)," Stromberg said.

At St. Elizabeth, for example, beds not used by inpatients often are filled by "extended outpatients." Those are patients who stay overnight but less than the 24 hours that would classify them as inpatients.

"We don't have that many empty beds because we've got them filled with these guys and gals," Lanik said.

Outpatient surgery has grown from less than a third of all surgery in 1984 to nearly half last year at Bryan and Lincoln General.

St. Elizabeth has seen the greatest change. People getting outpatient surgeries there accounted for 71 percent of all surgery patients last year, up from only 24 percent in 1984.

The shift to outpatient care has some health-care futurists pointing to a new type of hospital as a place where people go for treatment but not to stay.

"We're really going hospital without walls. Our focus here is patient services versus a lot of bricks and mortar," said Charlotte Liggett, vice president at St. Elizabeth.

But the decline in daily inpatient censuses has affected the hospitals' bottom lines.

Last year, St. Elizabeth responded to the drop in its inpatient numbers by asking all employees to take a 5 percent cut in hours or a 5 percent cut in salary. Lincoln General restructured its staff to eliminate several unfilled positions. Bryan has used a "considerable amount" of flex-staffing — calling in staff only when they are needed.

Lincoln General also dropped its licensed bed capacity from 307 in 1992 to 268 this year. Bryan plans to delicense 32 beds when its current expansion project is completed.

"We are delicensing beds because we know we will have plenty of beds left," Frye said.

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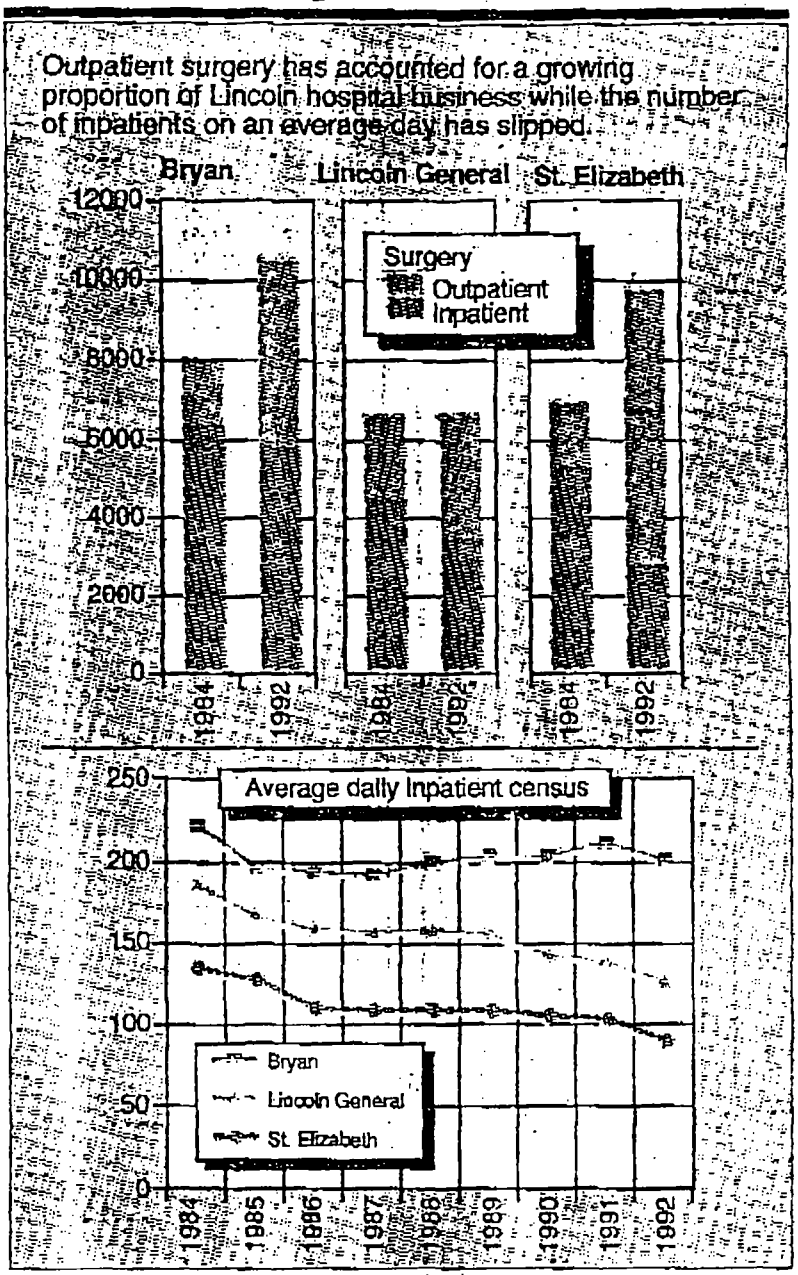
Hospital useage



SHEILA STORY KEYSER/LINCOLN JOURNAL-STAR SOURCE: NE DEPT. OF HEALTH

Hospitals (2 of 3)

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New services keep hospitals in black

Facilities shift to outpatient care

BY MARTHA STODDARD
Lincoln Journal-Star

SUNDAY SPECIAL

Mounting pressures to control costs, along with advancements in health care, emptied Lincoln hospital beds at a quickening pace last year.

Figures collected by the state Department of Health show sharp drops in the number of inpatients filling beds on an average day last year at all three general hospitals.

The decreases were the largest since Medicare shifted to a new hospital payment system in 1983.

"All of us in the industry have been working harder to get patients out of the system faster," explained Sue Frye, vice president at Bryan Memorial Hospital.

Having fewer inpatients has forced Lincoln General Hospital, Bryan Memorial Hospital and St. Elizabeth Community Health Center to take some cost-saving measures, but growth in outpatient and other services has kept them busy and in the black, officials said.

Statistical reports from the three since 1984 show that:

- Numbers of inpatients headed back down last year after increasing slightly during the late 1980s.
- The average acute care patient stayed an ever shorter time during the past few years.
- Outpatient operations continue to account for a growing proportion of all surgeries.

Traditional hospital utilization numbers — inpatient admissions and inpatient surgeries — took a dramatic dive in the mid-1980s after Medicare changed its payment system. Before 1983, Medicare paid hospitals based on their charges. After that date, the federal health-care program for the elderly and disabled paid hospitals a fixed amount for each diagnosis, no matter how long the patient stayed. Many private insurance companies followed suit.

While inpatient numbers plunged, outpatient services went through explosive growth.

A "new normal" pattern appeared to be emerging by the late 1980s. Outpatient services grew more slowly. Inpatient admissions stabilized or even grew, and the average patient stayed longer.

Hospital officials said the new pattern resulted from shifting almost all possible patients to the outpatient side and having only very sick people left as inpatients.

But after reaching a peak near the end of the 1980s, the average length of stay for inpatients started down in the 1990s. Hospital admissions also dropped at St. Elizabeth and Lincoln General.

Hospital officials said pressure from insurance companies and other

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Hospitals

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Optional services not Medicaid's problem

All the talk during the legislative session about cutting Medicaid services was mostly an educational exercise aimed at helping the rest of us understand how the Medicaid program works.

After all the sound and fury, the Health and Human Services Committee wisely dropped the bulk of the cutting proposals.

Medicaid, the federal-state partnership program that provides health care for some low-income Americans — very poor children and their parents, disabled adults and very poor seniors — is a definite financial headache for the states, which pay about half the costs.

But then, cost is a headache common to the entire health care issue.

The truth is, we can only eat around the edges of the state's Medicaid problem with cuts in programs, unless we are willing to tell very poor Nebraskans that they cannot get some of the basics of medical care.

The whole talk of optional services was mostly silliness. In fact, "optional" was sometimes synonymous with "least expensive."

These are optional only because the federal government puts them on a list called "optional." Some services states must provide to be part of the Medicaid program. Other services are listed as optional.

But many are not optional in the world of reality.

Let's just look at a few of them.

PODIATRISTS ARE an optional service. However, Medicaid reimburses for all physician services. So the folks who now use podiatrists for foot problems can simply go to a doctor with an MD title for the same problems and Medicaid will pay those bills, generally higher bills. No savings here.

Hiring aides to help people with physical handicaps eat, dress, cook, allows these people to live in their own home or apartment rather than in a nursing home. Usually it is far cheaper to pay for these aid services than to pay nursing home costs.

Nursing home costs are covered by Medicaid. Personal care services are on the optional list.

So what would happen if these optional services were cut? Folks would have to move into nursing homes and Medicaid would be paying more dollars.

Of course, eliminating some of the optionals really would save tax dollars.

The state could refuse to pay for dentures for poor older residents. Or for glasses. The state could stop buying hearing aids, pacemakers, or providing wheelchairs or oxygen.

The state could stop speech therapy for poor stroke victims.

These are all options, rather heartless options in a state where most families own several cars, many are able to buy personal computers for home use and take the family out to dinner once in a while.

It's very easy for those of us who have employee health benefits — often partially or completely subsidized by the company — to forget how vulnerable we would be, poor and sick.

The Health and Human Services Committee has dropped the cutting proposals that would save no money and the ones that would be heartless.

SOME VALID changes remain on the table.

- The state should make it very difficult for older residents to put their assets and money into trusts or give it outright to children, then turn to Medicaid to pay for nursing home care. The Legislature is seriously considering several bills that will make this paper impoverishment much more difficult. Medicaid's most expensive clients are the elderly. Taxpayers should be helping only those who are truly poor.
- The state should move into a managed care system if that kind of system will actually curb rising costs.
- The state also is looking at building co-payments and deductibles into the Medicaid system where feasible.

Hopefully, the Legislature put the useless "optional services" debate to bed.

That does not mean, however, that state leaders should not continue to examine the Medicaid system, looking for savings. Cost of services should be a factor in deciding what services are appropriate. The least expensive option, without greatly sacrificing quality, should be a guiding principle.

Costs of Health Care Run High on the Farm

Continued from Page 1

Union lobbyist.

The Donnellys make $12,000 a year from their family farming corporation and $6,500 from Mrs. Donnelly's part-time job.

Until last year, the Donnellys paid $160 a month for insurance that required them to pay the first $5,000 of medical costs for each family member. An increase to $180 a month was the final straw, Mrs. Donnelly said.

She quit as a classroom aide and took a $5.25-an-hour job in the Burt County Attorney's Office, largely because the county government would pay half the cost of group medical insurance for her family.

Mrs. Donnelly's half-share amounts to $2,760 a year for her family's health insurance, more than the family paid under the old policy. But the new policy carries a $100-a-person annual deductible, in contrast to the $5,000-a-person deductible in the old insurance plan.

Donnelly said what his family pays for medical insurance is "outrageous." But he is grateful his family is covered.

"I'm just lucky my wife has a job," he said.

Kathy Chatt, a nurse in the Tekamah-Herman Schools, said she sees children who need medical care but don't always get it.

"Health insurance is a luxury a lot of people can't afford," she said.

Ms. Danielson of the Farmers Union contends that managed competition, which is expected to become part of a new national health-care plan, isn't likely to work in rural areas.

Under managed competition, residents of a geographic area would choose among several health insurance plans that compete for their business. Those plans, including hospital and doctor care, would have to meet government standards.

But rural areas won't attract competition, Ms. Danielson said. Farming areas are thinly populated, and the residents tend to be middle-aged and elderly people, who are more likely to need health services.

The Farmers Union supports a single-payer system in which everyone chooses his or her own doctor and hospital, and all the bills go to the federal government. The cost would be paid by increased income taxes and employer-payroll taxes, she said.

Ms. Danielson said she worries that the Clinton task force on health care won't give enough attention to the problems of rural areas. Just one of the 34 working groups is assigned to rural health care, she said.

A health-care reform plan must deal with the problems that small communities have in keeping hospitals open and in attracting doctors, she said.

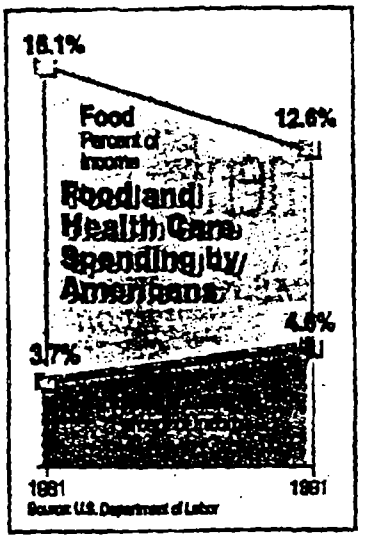
A recent study determined that the average rural physician is 60 years old, Ms. Danielson said. "This is even older than the average farmer."

Food, Health Care Spending by Americans

Year	Average Income	Food	Health Care
1991	$33,901	$4,271	$1,554
1990	31,889	4,296	1,460
1989	31,308	4,152	1,407
1988	28,540	3,748	1,298
1987	27,326	3,664	1,135
1986	26,481	3,363	1,062
1985	25,127	3,394	1,037
1984	24,578	3,391	899
1983	23,186	3,198	839
1982	22,702	3,137	822
1981	19,989	3,224	746

Source: U.S. Department of Labor

RISING COSTS: Health-care expenses doubled over 10 years for the average consumer spending unit — families and singles — while food costs increased one-third. Food costs include restaurant meals. Health-care charges exclude employer-paid insurance.



MIKE DRUMMY/THE WORLD-HERALD

Health Insurance Can Be Costly for Farm Families

BY ROBERT DORR
WORLD-HERALD STAFF WRITER

A Tekamah, Neb., farm wife changed jobs last year, mainly, she said, to get medical insurance that her family could afford.

"Basically, I work for insurance," said Terri Donnelly, 39, who lives with her husband, Dale, and their two children northeast of Tekamah.

Mrs. Donnelly is among a growing number of farm wives seeking work in town to put their families under an affordable medical insurance umbrella. Health-care experts contend that rural areas pose special problems for the Clinton administration task force that is studying national health-care reform.

Out-of-pocket health-care costs — medical and drug charges, plus health insurance — paid by the average American household doubled between 1981 and 1991, rising to $1,554 a year, U.S. Labor Department figures show. That excludes health insurance costs paid by employers.

For many farm families, the cost of health care runs much higher.

Health insurance takes 15 percent of the Donnellys' $18,500 before-tax income.

By comparison, the average U.S. household spent less than 5 percent of its income for medical insurance and other out-of-pocket health-care expenses in 1991, U.S. Labor Department figures show.

The lower national average partly reflects the fact that nearly two-thirds of Americans younger than 65 receive their health-care coverage through the workplace. For them, rising medical costs are partly or fully paid by their employers.

Self-employed people, such as farmers, must pay the entire cost themselves, said Keith Mueller, rural health specialist at the University of Nebraska Medical Center.

"They are out there trying to buy insurance as individuals," he said.

Farmers might pay as much as $4,000 a year for health insurance that carries a deductible of up to $5,000 per family member, Mueller said.

Farmers are at a disadvantage for another reason: Many large employers have joined insurance plans that bargain with groups of doctors and hospitals to reduce charges. That doesn't help self-employed farmers.

There is irony in farmers being among the primary victims of rising health-care costs, rural health specialists say.

The success of farmers is a large reason the average American household paid just 12.6 percent of its income for food in 1991 — compared with 43 percent in 1901, 35 percent in the mid-1930s, 27 percent in 1960 and 16 percent in 1981, federal figures show.

While the costs of health care paid by the average U.S. household doubled during the 10 years ending in 1991, food costs went up one-third.

"Perhaps the ultimate irony is the farm family that is forced to drop health insurance so that it can afford the crop insurance required by the bank for its operating loan," said Nancy Danielson, a National Farmers

Please turn to Page 2, Col. 1

Van to Carry Health Services Across State

A 34-foot motor home has been converted into a mobile nursing center to take diabetes education and services into Nebraska communities.

The mobile unit is a project of the University of Nebraska College of Nursing and the Cornbelt Federation of Cosmopolitan International.

The van's first trip was Tuesday, when it was taken to Southroads Mall to offer services to Health Hikers, a group of 300 men and women who walk at the mall.

Cosmopolitan provided $100,000 and volunteer services to provide the unit, said Jim Sauer, chairman of the West Omaha Cosmopolitan Club.

The mobile unit, staffed by nurses, offers services such as risk-factor appraisals, nutritional assessments, blood testing and screenings for high blood pressure, obesity, vision and foot abnormalities.

Catherine Todero, associate nursing dean and project coordinator, said the unit will concentrate on assisting underserved groups who are at high risk for diabetes: blacks, Hispanics, American Indians and the elderly.

Co-Payments Can Help Control Medicaid Costs

The Nebraska Legislature indicated it won't remove all the extra recipients it has allowed to go onto the Medicaid rolls or all the extra services it has added to Medicaid. But options for partially controlling costs remain.

One is Legislative Bill 808. It would require Medicaid patients to make a token payment for each prescription or visit to a doctor's office. The co-payments could raise $1.3 million a year for the state's Medicaid program.

More important, co-payments tend to make for more intelligent consumers. When an insurer provides first-dollar protection, some people see the benefits as free. They are more likely to go to a specialist, for example, for a cold. Even a token co-payment can cause them to take a second look. More than half the states require financial participation by Medicaid recipients.

Introduced by Sen. Tim Hall and others, LB 808 would require that Medicaid patients pay $3 for physician services or home health aides, $2 for a clinic visit and $1 for prescription drugs. The fee would be waived for the truly needy. Under federal law, children, pregnant women and some institutionalized persons would be excused from the payments.

The idea has opposition. There are people who view the attempt to control Medicaid spending as a cruel assault on the poor.

But no one has proposed denying basic care to people who have no other way to pay for it. The purpose is to raise revenue and discourage overuse.

Medicaid Cost Controls Proposed

BY JASON GERTZEN
WORLD-HERALD BUREAU

Lincoln — The Legislature's Health and Human Services Committee offered a counterproposal Wednesday in the bid to gain control over the state's rapidly increasing Medicaid costs.

"We are moving forward on significant changes to the system," said State Sen. Don Wesely of Lincoln, committee chairman. "When they are evaluated they will see these are significant cost-containment initiatives that will improve the system, reduce waste and minimize the harm to the truly needy."

The committee voted to send to the full Legislature bills that would require Medicaid recipients to pay a few dollars when they get services (LB 808), increase the licensing fees doctors pay (LB 805), make it more difficult for people to shift their assets so they are judged poor enough for Medicaid (LB 800), require prescreening for nursing home patients (LB 801) and require Medicaid recipients to go through a doctor who would serve as a gatekeeper for medical services (LB 816).

LB 805 was amended so that instead of $1,000 license fees, doctors would pay $150 a year. The money raised would be used to increase payments to primary care doctors who treat Medicaid patients.

The committee still is considering a bill, LB 804, that would allow the State Department of Social Services to reduce Medicaid costs by eliminating coverage for certain services.

On Tuesday, the Appropriations

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Committee agreed it would try to revive the proposal in LB 794 that would eliminate Medicaid coverage for 10 services. Committee members said they were angry and frustrated that the health committee had not made more of an effort to reduce spending on Medicaid, a health-care program for the poor that is expected to cost the state an additional $72 million over the next two years alone.

The health committee's cost-containment approach was more sensible than the "mean-spirited and hard-hearted" approach of LB 794, Wesely said.

LB 794 would eliminate coverage for 10 services the federal government gives states the option of providing with their Medicaid programs.

"The optional services have become a symbolic thing for making Medicaid recipients pay for the high cost of Medicaid," Wesely said. "I don't think it ultimately saves money."

When coverage for certain services is eliminated, Medicaid recipients will seek care from other, possibly more expensive, health-care service providers, he said.

Sen. Scott Moore of Seward, appropriations committee chairman, said he would consider pulling back on the drive to revive LB 794.

"We are just saying you have to curb the growth," Moore said. "If they have another way to do that, we will warm to that."

Wesely served notice Wednesday that he would push for health-care industry tax increases or other measures over deep cuts in Medicaid if the cost-containment proposals failed to satisfy other lawmakers.

Wesely filed a motion to revive bills killed in the Revenue Committee that would tax the gross revenue of hospitals and nursing homes, remove the sales tax exemptions given to hospitals and nursing homes and change a capital-gains deduction provision of the Employment and Investment Growth Act.

Gov. Nelson said Wednesday during a press conference that he thought legislators should rely more heavily on health-care industry temporary tax increases to help cope with the high Medicaid cost increases.

"It's appropriate to go back to the industry to get their help in solving the problem," Nelson said.

The Legislature's Revenue Committee is preparing a $27 million package that so far includes a beverage tax, a higher cigarette tax and a $6 million tax on health-care providers.

Nelson said he wanted the package to also include his Legislative Bill 834, which would raise $7 million in taxes on hospitals and nursing homes. Those taxes would be in addition to the $6 million in health-provider taxes that are part of the Revenue Committee's package.

"If you don't do that, tell me what incentive there is for health-care providers to be part of the long-term solution," Nelson said.

The governor said he opposed the beverage tax, was still considering the cigarette tax increase and was considering proposed spending cuts.

"If they go back to the budget we presented, there indeed is a balanced budget without increasing any of these taxes," Nelson said.

OUR VIEW

Scottsbluff Star Herald

WNCC turning good idea into affordable child care

Western Nebraska Community College has taken a significant step in showing what can be done with a good idea — in the process, demonstrating the value of forming partnerships.

The Child Development Center, now beginning construction, is a cooperative venture between the college, the city of Scottsbluff, the WNCC Foundation and Panhandle Community Services. The $680,000 facility should be completed by mid-August and will become operational shortly afterwards.

It will be owned by the foundation, built on college land, administered and operated by Panhandle Community Services and financed partly by a block grant administered through the city.

The day-care center will serve 125 children — mainly children of WNCC students and youngsters enrolled in Head Start.

At least half of the privately run day-care centers in the Twin Cities are at capacity and have a waiting list.

The center's goal is two-pronged. It will provide affordable day care for parents who are studying at WNCC. It also will serve as a training facility for students in the college's early childhood education program, allowing them to gain hands-on experience dealing with children.

Scottsbluff Star Herald

In our ever-changing, high-tech society, community colleges play a key role in retraining people for new careers. Not all students enrolled at WNCC are recent high-school graduates preparing for a four-year institution. A significant proportion are adults seeking fresh educational opportunities as they change the direction of their lives.

For this latter group, which includes many single parents, the lack of affordable and convenient child care often has held them back. Not so now.

Some have faulted WNCC for competing with the private sector when it comes to child care. But a quick survey of privately run day-care centers in the Twin Cities reveals that at least half are at capacity and have a waiting list.

In fact, WNCC and its partners would not have been able to secure funding for the new child-care facility if a need for such services had not been demonstrated.

This region will be well served by the day-care center and the training it provides.

Study Finds Lack of Health Insurance

BY ROBERT DORR
WORLD-HERALD STAFF WRITER

In 30 percent of Nebraska families and 27 percent of Iowa families, at least one person lacks health-care insurance or expects to lose it this year, according to a study released Thursday.

Nationally, 35 percent of American families have an immediate family member who has no health insurance or expects to lose it this year, according to the study by Families USA. The organization is a national consumer group that advocates health-care reform.

"Hard-working Americans are losing their health insurance because businesses, and especially small businesses, simply can't afford to protect their workers any more," Ron Pollack, executive director of Families USA, said in a statement in Washington, D.C.

He said the study shows the need for a national plan extending medical care to all Americans and for "getting health costs under control."

Earlier this week, a University of Nebraska Medical Center researcher reported that 10 percent of Nebraskans lacked medical insurance in 1991. That survey reported numbers of residents without insurance. The Families USA study counted families with at least one member lacking insurance coverage.

The N.U. Medical Center survey was based on a telephone survey of 1,500 adults. The Families USA study used data obtained in the U.S. Census Bureau's monthly surveys of 60,000 households.

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Views on Health, Medicine Proposals

The following are excerpts from recent essays submitted to The World-Herald concerning health care in the Midlands and in the nation. The writers are Omaha health professionals.

'Managed Competition Prescription for Failure'

BY FRANCES MENDENHALL, D.D.S.

It was terrible news when the Clinton task force appeared to slam the door on the one solution that has successfully addressed problems particular to America, the Canadian model.

Canada has done an end run around the bureaucracy and paperwork of multiple insurance companies by having a single payer, its federal government.

The Clinton administration is offering managed competition, an idea doomed to fail.

In Canada every resident is insured through the province. Canadians enjoy unrestricted choice of doctors. Their care is high quality, they live longer than we do, and fewer of their babies die. Their health plan is more popular than our Social Security.

Health care costs Canadian taxpayers 30 percent less per person than we now spend. The Canadian government collects the insurance premiums in the form of taxes and pays doctors and hospitals directly on a fee-for-service basis. Paperwork is simple, billing is easy. Most offices are able to collect fees within three weeks. Hospitals' billing departments need a tiny fraction of the payrolls and bureaucracy found in hospitals here.

Studies show that a billing system like Canada's would eliminate between $80 billion and $140 billion in waste on paperwork in the United States — enough to cover every insured American.

Most of us had never heard of managed competition until last December when the Jackson Hole Group, composed of business school professors and insurance industry CEO's, conceived of it. The plan would force Americans into cut-rate HMO's. These would offer a minimum care package that everyone would be encouraged to accept. Those desiring higher standards would be penalized by higher taxes. Insurance companies would practice "managed care," dictating what doctor a patient may see and what procedures he or she may perform. It is the worst of several worlds: some rationing, control taken from patients and doctors and put into the hands of the insurance industry, more paperwork for doctors and their staffs.

The architect of the plan, Alain Enthoven of the Jackson Hole Group, says it would eliminate small practices. Ironically, there is more "competition" — at least from the providers — in Canada where patients are free to choose their own doctor. How eliminating choice and forcing small practices to close could satisfy anyone's desire for freedom in the marketplace is beyond me.

Managed competition, furthermore, could never control costs. Just look at the last decade: While HMO's and other "managed care" programs have grown at an unprecedented rate, so have costs. A key problem has been and will continue to be administrative overhead, currently 24 cents of every health care dollar. Adding another layer of bureaucracy to the system will not lower this expense.

If the president's group won't change its mind, Congress must change it.

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'Cooperative Health Efforts Should Get Priority'

BY EDWARD J. TAYLOR, M.D.

Outpatient care is cheaper than hospitalization, but the shift of health care to the outpatient setting has not been without cost. Hospitals and physicians groups have invested large amounts of money in special new outpatient care facilities.

A less obvious cost is the decline in quality of care caused by an inadequate system for communication among care givers. In the old system, a patient in a hospital would have a complete chart with laboratory, radiology, nursing and physician inputs in one place almost immediately. Now, since patients undergo tests or treatments at different locations, it is difficult to assemble the information needed to care for them properly.

Most area hospitals have chosen individually to make investments in new facilities. Each project requires the approval of Nebraska's certificate of need board, and the board seems to be rubber-stamping most of the requests. This is an expensive way for us to proceed. Omaha would save on health costs if hospital systems worked together in these enterprises to share such facilities as:

- Expensive and underutilized equipment: MRI units, CT scanners, lithotripsy machines, etc.
- New operating rooms.
- Urgent care and emergency services.
- Rehabilitation and psychiatric units.
- Inpatient and outpatient dialysis.
- Outpatient care facilities.
- Medical information management systems (computers).

In order to foster a spirit of cooperation in Omaha medicine, I suggest the following:

- Do not place a moratorium on new project development. If outpatient care is to be safe and effective, we need new facilities that bring doctors, laboratories and radiology services together in the outpatient setting. Some degree of updating of inpatient services is also essential.
- Empower the state certificate of need board to consider only those projects proposed by cooperating networks of hospitals and physician organizations that provide unified and comprehensive health care.
- Lower the dollar limit above which a certificate of need is required.
- Encourage development of cooperative groups of Omaha businesses to negotiate directly for insurance contracts with comprehensive physician hospital organizations. In this model, physicians and hospitals organized together ARE the insurance company. The care institution would have a vested interest in operating efficiently and avoiding duplication. Costs would be driven down by eliminating the outside insurance company as the middle man.

With or without the Clinton health care reforms, these suggestions make sense.

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On panel with Hillary—

CSC dean speaks on health care

By LINDA STOTTS

The nation's health care problems are every bit as complex as might be suspected, according to the dean of the School of Science and Mathematics at Chadron State College after he had participated in a public forum on the situation in Des Moines, Iowa, this week.

Dr. Ted Davis

Dr. Ted Davis was one of two Nebraskans invited to participate on panels in the second in a series of public forums, "Conversations on Health: A Dialogue with the American People," held Monday.

Davis' invitation was initiated through Sen. Bob Kerrey's office.

The day-long meetings were sponsored by the Robert Wood Johnson Foundation. Dr. Steve Schroeder, president of the foundation, served as moderator.

Other panel members included the president's wife, Hillary Rodham Clinton, who heads a national task force working to produce a health-care reform plan, and Donna Shalala, secretary of health and human services.

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Health care panel—

(Continued from Page 1)

"I came away from the meetings with a deepened awareness of the complexity of our health care problem and the reform needed. Many concerns are, in fact, in conflict with one another," said Davis.

"I don't see an easy solution to the health care issue. The various needs must be addressed with different unique solutions making up the system with compatable components," he said.

Monday's meetings, targeting rural health, were divided into three sessions: controlling the costs of rural health, peace of mind and rural health needs.

Davis was on the panel concerned with rural health needs and spoke on the topic of distance and distribution of providers. He shared information about the Rural Health Opportunities Program at Chadron State, a cooperative program with the University of Nebraska Medical Center. He told the forum participants that the program is an "effort to allow rural people to help solve the health care shortage."

He explained the RHOP process, which recruits students from rural backgrounds and educates them in rural settings as much as possible, with the intent for them to return to work in rural areas.

"I observed a high level of energy among the 300 to 400 people in attendance. They were all concerned with sharing their needs and ideas for change in our rural health care systems," Davis said.

"We must not sit back and wait for a change. Hard work is needed to construct a system that will be successful," Davis concluded.

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UNIVERSAL Press Clipping Bureau

CSC professors attend Clinton briefing

Two Chadron State College professors, Dr. Margaret Crouse and Jim Stokey, attended a three-day briefing on the Clinton Administration's proposals for vocational education and job training in Washington, D.C., last week.

The event was sponsored by the American Vocational Association, representing some 40,000 vocational education leaders around the country. It was designed to provide information about vocational education issues.

Topics discussed during the briefing included the impact of trade agreements with foreign countries on local internship programs, charter schools and the role business and industry must take in education.

CROUSE and Stokey also met with legislative assistants of U.S. Senators James Exon and Bob Kerrey and U.S. Representatives Peter Hoagland and Bill Barrett to urge greater support for vocational education in the upcoming federal budget.

During the visit, the CSC professors were briefed by representatives and congressional staff currently engaged in reauthorizing the Elementary and Secondary Education Act and apprenticeship legislation.

Both Crouse and Stokey urged the Nebraska legislative assistants to look at the apprenticeship program carefully as it appears to fit within vocational education's existing infrastructure.

The Clinton Administration's plans for education and job training represent a major policy shift from the Reagan-Bush position, Crouse said.

The new administration will stress youth apprenticeships, in which high school students in their final two years or at graduation will be placed in workplace learning situations.

Vocational educators working with youth apprenticeship programs currently being tested around the country have found that the integration of classroom instruction and apprenticeships are effective in helping youth understand the relevance and necessity of academic skills as well as specific job skills, the CSC professors were told.

Several sessions also were offered to focus on how to more effectively administer "tech-prep" programs.

TECH-PREP is a program that coordinates curricula between community colleges, technical institutes and secondary schools so vocational students can enter a three- or four-year technical program while in the last two years of high school.

Crouse is Chadron State's vocational coordinator and is responsible for in-service and pre-service programs for vocational education teachers.

Stokey is an assistant professor of electronics and power. He is the instructor for Principles of Technology.

Chadron State offers graduate-level courses designed to prepare teachers for tech-prep settings. They include Principles of Technology, Applied Math and Administration of Vocational Education Programs.

Three major points on health care system

It would help, we think, while Hillary Clinton and her hundreds of panel advisors are trying to put together a new form of national health care, if someone would be bold enough to come out and say exactly what is bothering most Americans over the existing health care system. In plain words, those concerns are: (1) Most people think doctors' fees are too high; (2) Most people think hospitals charge too much; (3) Most people think the cost of prescription medicines is outrageous.

Come on, now, isn't that what it's all about?

And if it is, why doesn't someone come out and say that we may put together a thick book filled with new health care policy, but nothing will be accomplished until someone addresses those three major points.

We are not saying that doctors are overpaid, or hospitals are overcharging or prescription drugs are too expensive. We are not experts in that field and we would prefer to reserve such opinions for the experts. What we are saying is that most people think that those three points are the crux of the whole health care riddle, and until somebody addresses them, the rest of the rule book will be meaningless and hypocritical.

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What we read mostly is of the 30 million plus people who reportedly have no health insurance coverage. What we need to address directly is what the other millions of people think about a system under which they are fully or partially covered by insurance, but still feel the costs are too great. Employees and employers are caught up in this because a sizable portion of the paycheck is now going for health protection. Can they afford to continue this payment schedule? If not, who is going to pay it? And should the health care professionals help cut the costs so that we can get a handle on the overall problem? It's dirty work, but someone has to do it.

PAPER Lincoln Star
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Women leaders bring health to forefront

The increasing role of women in public life has had a tangible benefit. Women's health issues are getting the attention — read: research dollars — they deserve.

Women have been subservient to men when it comes to medical matters. Disease and drug studies rely heavily on male participants, even when the studies use animals. The assumption has been that sex was not a significant factor. But the facts are otherwise.

For example, Creighton University neurologist Nancy Futrell studied the appropriateness of using male mice to study aspirin as a stroke preventive. After noting that male and female mice age differently and respond differently to treatments, she argued that stroke research should recognize sex as a factor in humans. Most of the stroke studies done in the U.S. overwhelmingly use men, yet women outnumber men in the population most likely to suffer a stroke.

IN ANOTHER example, the New England Journal of Medicine reported a sex bias in heart treatment. Men were more likely to get aggressive treatment and to be counseled for heart disease. Heart disease was viewed as a man's disease, yet more women in the U.S. suffer from heart disease than do men.

In an editorial accompanying that article, Bernadine Healy, the outgoing director of the National Institutes of Health, warned that sex bias was leading doctors to underestimate the severity of coronary disease in women.

Healy, the first woman to lead the NIH, has done much to get women's health concerns into study and public policy.

Healy was appointed in 1991, and immediately the NIH under her leadership launched a massive study of women's health. In recent weeks, the NIH has announced another study targeting diseases that are major causes of death and disability in women.

MEANWHILE, THE Congressional Caucus for Women was instrumental in getting more research dollars to women's health issues and urging an FDA probe into the exclusion of women in studies performed by drug companies.

It was wrong to believe that women's presence would raise the nation's moral discourse (as argued when women fought for the vote), that women vote as one, or that women in power — in politics or business — will necessarily lead to a more humane social agenda.

But it is true that power held too closely by one generally homogenous group will distort the agenda. It's true of racial or ethnic groups, and it holds true for gender. The presence of women in Congress, in medical colleges and at the NIH has brought a serious health inequity to the forefront.

At the urging of Democrats in Congress, President Clinton asked for Healy's resignation. She was a Bush appointee, who supported many of Bush's health policies no longer in favor. Clinton would be wise to appoint someone — woman or man — who will continue in Healy's footsteps. The path to a better understanding of women's health is a journey just begun.

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First lady could attend UNL health meeting

Organizers have received no word yet whether first lady Hillary Rodham Clinton will join some of the leading national and Nebraska thinkers in health reform at a Friday and Saturday conference.

Sen. Bob Kerrey, D-Neb., and Gov. Ben Nelson will co-chair the conference, which was planned by the independent, bipartisan Columbia Institute. It will focus on state-level solutions to national health care problems.

Nearly 900 people have registered for the conference, according to a Columbia Institute spokeswoman. Others have been put on a waiting list.

The conference will be 8:30 a.m.-4:15 p.m. Friday and 8 a.m.-noon Saturday. Due to the larger than expected registration, the conference site was changed to Kimball Recital Hall, 11th and R streets on the University of Nebraska-Lincoln campus. Parking will be available at State Fair Park, one block north of Military Road on 14th Street.

Mrs. Clinton had said she would appear at the event, but that could not be confirmed this morning. She is scheduled to speak at 12:45 p.m. Friday, which could change to accommodate her. If she does not appear, another representative from the president's Task Force on National Health Care Reform will speak.

On the national side, the conference on Friday will feature Dr. Paul Ellwood, one of the chief architects of the managed competition model of health reform, and E. Richard Brown, a professor at the University of California at Los Angeles, who helped draft Kerrey's Health USA bill.

The managed competition model is expected to be part of President Clinton's health care proposals. Kerrey's proposal is a variation on a single-payer model of reform.

Other national speakers scheduled include Janet Shikles, director of health financing and policy for the U.S. General Accounting Office.

On the local level, the conference schedule for Saturday will feature reports from the governor's Blue Ribbon Coalition and a committee of state agency directors. The two groups have been studying Nebraska health problems and possible state-level solutions.

Representatives from Vermont, Minnesota and Colorado also will talk about their states' experiences in developing plans for health care reform. The states are at various points along the road to creating their own solutions.

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Mrs. Clinton, Health-Care Planner to Speak Friday in Lincoln

First Lady to Discuss Task Force's Work

BY ROBERT DORR
WORLD-HERALD STAFF WRITER

Hillary Rodham Clinton will come to Nebraska Friday for a health-care conference in Lincoln, the Governor's Office said Tuesday.

Mrs. Clinton heads the national task force on health-care reform. She will speak about the task force's work at 12:45 p.m. Friday at Kimball Hall on the University of Nebraska-Lincoln campus, said Karen Kilgarin, spokeswoman for Gov. Nelson.

Her appearance had been tentatively scheduled and was confirmed Tuesday afternoon.

"We are very excited that she is coming," Ms. Kilgarin said.

The task force Mrs. Clinton heads is expected to complete its work and issue a report next month. The task force's recommended national health-care plan will go to the president and then to Congress. Final action by Congress might not come until 1994.

The Lincoln trip will be Mrs. Clinton's second visit to the Midlands related to health care. Last month in Ankeny, Iowa, she listened and asked questions of health-care experts and consumers who have had experiences

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THE ASSOCIATED PRESS
HILLARY RODHAM CLINTON: She will speak Friday.

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with the health-care system.

About 880 people have registered to attend the Lincoln conference, which will last all day Friday and until noon Saturday. Ms. Kilgarin said she didn't know how much of the two-day event Mrs. Clinton would attend.

No room remains for members of the general public, said Jennifer Belles, a project associate for the conference coordinator, the Columbia Institute. Those attending will be business executives, civic leaders, health professionals and consumer advocates.

Some people were invited to attend, and others contacted the institute for reservations, Ms. Belles said. The institute is an independent, bipartisan organization based in Washington.

Some of those attending probably will have to stand. Kimball Hall seats 850.

Sen. Bob Kerrey, D-Neb., is chairman of the conference. Gov. Nelson is co-chairman.

Several national health-care experts will speak Friday and will appear as members of panels.

They include Dr. Paul Ellwood, chief executive of the Jackson Hole Group, a Wyoming organization that is given credit for the concept of managed competition, which is expected to be part of the Clinton health-care plan.

Vermont Gov. Howard Dean will deliver Friday's keynote speech.

All meetings will be at UNL's Kimball Hall except the Friday luncheon, which will be at the student union on UNL's City Campus. The entire conference had been scheduled for the student union, but Kimball Hall has larger seating capacity and better accommodations for news organizations.

The Saturday meeting will focus on health-care actions that have been taken by Nebraska and other states.

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PAPER Lincoln Journal

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Reform must address case of the uncovered midwife

In pursuit of health care reform, Hillary Rodham Clinton and her crew need to pay attention to the plight of people like Joanne Bronson and her patients.

Bronson is Lincoln's only nurse-midwife. Midwives have been recognized in Nebraska's law since 1984, and Bronson is fully qualified. She attended midwife school in California, passed our state's certification examination and practices with a group of doctors specializing in obstetrics and gynecology. And yes, she has delivered babies.

In the eyes of some health insurance companies, however, Bronson has no standing. They refuse to cover her services. A patient whose medical insurance is carried by one of those firms is out of luck if she wants to avail herself of Bronson's care. So is Bronson.

And so are all of us. A midwife's fees are less than those charged by an ob-gyn practitioner. In what seems like an extreme case of shortsightedness, the insurer ends up paying more when a patient is forced, for reasons of reimbursement, to forego a midwife's services in favor of an M.D.'s. But of course the insurance company can compensate by charging all its policyholders a little more.

Exactly what shape health care reform in this country will take is not yet certain. But clearly it has two goals. One is holding down costs. Midwife services can help do this. Another is retaining for patients as much choice among providers as is feasible. Some patients prefer entrusting their care to a qualified midwife.

The insurance companies themselves have it in their power to correct this situation. If they don't — and if federal mandates don't address the problem — then it's up to Nebraska's Legislature: Spell out in law that qualified midwife services are to be included in health insurance coverage.

Howard Dean, M.D.
Governor

State of Vermont
Office of the Governor
Pavilion Office Building
Montpelier, Vermont 05609
(802) 828-3333

March 11, 1993

Ira Magaziner
Senior Domestic Policy Advisor
White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Ira:

In our meeting last week, I expressed serious concerns about the proposals under consideration by the administration for achieving health care cost savings during the next two years.

In response to my protest, you suggested that I write down my thoughts about better methods for meeting your short-term cost control goals. Accordingly, I have outlined below two cost control options which I believe are preferable to the options currently under consideration. However, I feel it is important to state that I remain concerned about any attempt to impose strict controls on health care expenditures in the absence of universal access and health care delivery system reforms. All options are inherently problematic, will have unintended consequences, and may very well run counter to your long term reform goals.

I am operating under the assumption that you are serious about maintaining a key role for the states in administering a national health care reform plan. I also assume you recognize that none of us really knows how to do such things as global budgeting, and that we have much to learn before that system is perfected. It is my belief that the federal government can learn much from the current cost control efforts of some states, including the attempts of states such as Vermont, Minnesota and Colorado to develop a workable global budgeting process.

My first suggestion is an interim cost containment scheme that allows states three program options. Option one would be to fall under a national scheme of all-payor ratesetting or price controls, administered directly by the federal government. Option two would be to develop a state-specific ratesetting system. Maryland and New York are good examples of

states that would likely prefer their own, well-developed ratesetting system to a national system, and likely could meet national standards using those systems. Option three would be imposition of all-payer premium controls, administered by the state. For states that have significant managed care penetration, or have well-developed plans for global budgeting, this approach would be preferred, as it allows for budgeting on a per-capita basis. Vermont and Minnesota would probably prefer this approach because it is not inconsistent with their long term plans for systemic health care reform.

Regardless of the cost control option chosen by a state, a state would be held to the same standards of accountability for achieving savings as those choosing other options. This presumes a level of data availability regarding state-by-state expenditures which may not exist, but you will face that problem in implementing any of the options currently under consideration.

The ability of states to meet your short term goals would be greatly enhanced through passage this year of statutory changes to Medicaid law and ERISA. Greater flexibility to implement Medicaid managed care and to include self-insured firms in our system designs will increase significantly our ability, and hence the federal government's ability, to control health care costs.

My second suggestion is simply a variation on your price control proposal. My most serious concerns about price controls are, 1. that they will inhibit, during the next two years, the type of delivery system reform and resource reallocation that is so essential to health care cost containment in the long run, and 2. that they will become permanent, rather than temporary, and that attempts to control costs the right way will be abandoned in favor of flawed regulatory approaches.

Therefore, I suggest that, if you impose price controls, you exempt from those controls any plans that reimburse on a fully-capitated basis. Further, I suggest that you allow states to "come out from under" price controls on a state-by-state basis when a state can demonstrate the existence of at least one viable HIPC within its borders with a given percentage of the population being served by the HIPC.

These suggestions represent my own personal opinions and do not represent official policy of the National Governors' Association. I believe most of my colleagues are equally concerned by the interim cost control options that are on the table, though I suspect that most of them would see the suggested refinements outlined above as at least an improvement over nationwide ratesetting, price controls or premium caps.

I hope this is useful to you. I appreciate the opportunity to offer my thoughts. Please let me know if you have questions or comments.

Sincerely,

Howard Dean, M.D.
Governor

HD/ar

cc: Hillary Rodham Clinton
Governor Roy Romer
Governor Carroll Campbell
Governor George Mickelson

Howard Dean, M.D.
Governor

State of Vermont
Office of the Governor
Pavilion Office Building
Montpelier, Vermont 05609
(802) 828-3333

March 30, 1993

Ira C. Magaziner
Senior Domestic Policy Advisor
216 Old Executive Office Building
Washington, DC 20500

Dear Ira:

Per your request, I have outlined in the attached paper the "global targeting" option for short term cost control which I advanced at our meeting last week. While it is certainly not perfect, I believe this method is far preferable to some of the other options under consideration.

I would like to make it absolutely clear that this paper represents my own thoughts and not those of Governors in general. Many Governors remain very concerned about global budgets, and would probably see the timeline I have outlined as overly-ambitious.

Please let me know if you have questions or comments about the attached.

Sincerely,

Howard Dean/AR

Howard Dean, M.D.
Governor

HD/ar

cc: Governor Roy Romer
Governor Carroll Campbell
Governor George Mickelson

GLOBAL TARGETS AS SHORT TERM COST CONTROLS

If one of the long term goals of health reform is to develop the capacity to construct and enforce global budgets on a state-by state basis, then it makes sense to takes steps in the short run to achieve this goal. Short term cost controls should enhance the ability of states to monitor and control total system costs. However, some suggested interim cost controls will require significant investment of time and resources during the next several years, but will not ultimately complement national reform objectives.

A voluntary "dry-run" of a global budgeting or expenditure targeting process could be implemented during the period between passage of national health care reform legislation and full implementation of reforms. Targeting could result in significant cost control and would contribute to the development of the infrastructure for the new system. By requiring states to gather the information necessary for targeting, and engaging them in the technical process of targeting, you will be preparing for future reforms.

Global targets are essentially a challenge to providers and payers to live within budgetary restraints on a voluntary basis. Providers and payers could be compelled to cooperate in achieving the targets through the threat of imposing more regulatory cost control regimes. If voluntary limits were exceeded, cost controls could be imposed directly from the federal government or states to providers. These controls could take the form of all-payor rates, price controls, or premium caps. To make this threat stick, it is essential that data systems be put in place to track compliance with the voluntary limits.

Precursors to Development of Targets

Implementation of expenditure targets should be combined with three mandates at the national level. The first is a requirement that all insurers use a common claims form as defined by the federal government. At the outset, mandated use of a standard HCFA form would probably make sense. However, use of a form that does not capture information about out-of-pocket expenditures will significantly limit our ability to track total costs.

Second, each state should be required to establish an insurance claims database that is capable of collecting all of the claims data from all payers in the state. This claims database can form the foundation for a much more comprehensive database that serves a variety of purposes in the reformed system. With the common claims form in use, and mandated collection of the information from those forms, states can at least begin to track expenditures and utilization with some accuracy.

Third, insurance rating reforms should be mandated at the federal level prior to implementation of global targets. Implementation of some form of modified community rating will make it easier for states to comply with a global target by controlling insurance premiums, the enforcement mechanism that will probably be favored in the long run. Greater uniformity in insurance rating practices would facilitate across-the-board control of insurance premiums, something that would be very difficult in some states at this time. In addition, insurance reforms will likely cause some insurers to cease doing business and the resulting consolidation of the

insurance marketplace will aid the imposition of cost controls.

The three of these measures should be implemented as rapidly as possible, as they are essential precursors to the development and enforcement of global targets.

Given the proper tools, states will be better able to control health care costs both short term and long term. However, federal laws and regulations currently inhibit our ability to control some costs. States should be given the ability to implement, in an expedited manner, Medicaid managed care and to include self-insured firms and Medicare in their health care reform designs. Changes to Medicaid and Medicare law and regulation and ERISA are essential and will significantly enhance the ability of states to implement global targeting and, ultimately, global budgeting.

The global targeting method should be combined with capitating Medicaid and Medicare payments to states to allow greater leverage and flexibility in meeting the targets. However, capitating these programs should not be expected to yield dramatic savings in the short run, given low current reimbursement rates.

How to set the targets

Using information available from the major payers (Medicare, Blue Cross and Blue Shield of America and Kaiser Permanente, for example), it should be possible to develop a per-person expenditure target for the average American. It would then be possible to adjust that number regionally based on the methodology utilized by Medicare to adjust payments to HMCs for Medicare enrollees. Further age/sex adjustment would be necessary, as would some adjustment to account for the fact that Medicare traditionally underpays rural primary care providers and hospitals. This regional per-person target would then be used to compute a state target, based on census bureau population data. This would constitute the first year target for states. Obviously, this methodology is crude and might result in targets that differ dramatically from actual expenditure levels. However, it would give the federal government a very rough measure of state-by-state performance at the same time that the new datasystem allows for tracking of actual expenditures.

Once a year's worth of data had been collected through the state claims databases, the targeting process could be refined. An acceptable rate of increase in expenditures could be defined and serve as the target for the state for the coming year. The rate could be the same across all states or could vary from state to state. Various adjustments to the allowable rate of increase could be made to account for local factors affecting health care cost increases.

In the third year, the targeting process would be further refined. An assessment of state performance could be made at the end of the third year, at which time the federal government could impose federal cost controls on insurers or providers in those states that are failing to meet the targets. By the fourth or fifth year, it might be possible to implement binding budgets in most states. Presumably the imposition of a binding budget would carry with it some incentives for the state in terms of increased matching funds to cover the uninsured or other enhanced resources. Hence, states would have an incentive to develop their budgeting and budget

enforcement capacity as quickly as possible. Some states, such as Vermont, would likely be able to enforce a binding global budget in fewer than four years.

Scorable Savings/Recapture

A plan is necessary to convert current cost shift to employers to increased funding for people whose coverage is publicly-subsidized (low-income, Medicaid, Medicare). Payments to providers from payers must be equalized, but current payments from the private sector should not be lost as cost controls yield savings.

The most logical method for "capturing" the cost shift is through imposition of a premium or provider tax. A premium tax is probably preferable in that it allows insurance plans some flexibility in spreading the cost of the tax among providers. Once the global budget becomes binding on a state, it can be assumed that the cost of the tax is not shifted to consumers and instead comes from foregone cost increases at the health plan and/or provider level. While this assumption can not be made if budgets are non-binding, the threatened federal controls can be used as a safeguard against cost shifting to consumers. For example, if Vermont did not comply with its target in years two and three, the federal government would apply some form of direct controls on health care providers or insurers. If the federal government wanted to "make up for" those over-runs, the federal controls could actually take the form of a price cut to insurers or providers. This method strengthens the threat of the federal controls, and provides some comfort for the federal government that cost savings will actually be achieved and recaptured.

Howard Dean, M.D.
Governor

State of Vermont
Office of the Governor
Pavilion Office Building
Montpelier, Vermont 05609
(802) 828-3333

February 16, 1993

Hillary Rodham Clinton
Chair, White House Health Care Task Force
White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Hillary:

I read with interest, but also alarm, the article in the February 14 edition of the New York Times about the administration proposal to cut expenses in the Medicare program. While I, and the National Governors' Association, fully support taking steps to deal with the deficit, I believe that the methods reportedly chosen to cut Medicare are contrary to NGA policy and will undermine the credibility of the administration's attempts to reform the health care system.

I personally believe that we need to deal with the expanding Medicare budget in order to cut the deficit. However, the methods described in the New York Times have basically been tried in the past and failed.

I believe the effect of the proposals that I read about in the New York Times would be as follows:

1. As pertains to fee restrictions, enactment will result in subsequent rapid increases in the volume of services provided to Medicare patients, thus negating some of the expected savings.

2. Primary care providers will bear the brunt of the adverse effects of this policy. These physicians do not make the kind of money reported in the New York Times article and their office expenses rise with medical inflation. The effect of the policy outlined in the New York Times article will be, over a relatively short period of time, to cause primary care physicians to opt out of serving Medicare patients, because they will not be able to afford to do it.

3. Undoubtedly there will have to be a substantial increase in the already horrendous Health Care Financing Administration bureaucracy in order to attempt to discern whether physicians' price increases are in fact the result of a cost shift due to Medicare capping, or are due to some other cause.

4. Finally, and most seriously of all, a return to the old HCFA philosophy would signal a marked retreat from the aggressive, and very refreshing, approach that has been taken heretofore by the Clinton administration in dealing with overall health care reform.

It is not possible to legislate against cost shifting without capping expenditures in the entire health care system. I have repeatedly tried to make the point that you cannot cap any aspect of the health care system without capping the entire system. My own view is that tremendous savings can be obtained in the Medicare system using a capitated care approach, which will limit both volume and price.

I very much hope that the President will not be specific on Wednesday about the way in which he intends to save Medicar dollars. We need to deal with Medicare expenditures in the context of overall reform, and the nation's Governors remain committed to helping you with that task. I feel very strongly that to depart from a recognition that health care reform must be comprehensive and retreat to the failed formulas of the past will undercut our entire effort.

Sincerely,

Howard Dean/AR

Howard Dean, M.D.
Governor

HD/ar
cc:
President Bill Clinton
Health and Human Services Secretary Donna Shalala
Governor Roy Romer
Governor Carroll Campbell
Governor George Mickelson
Ira Magaziner
Mark Gearan