Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Great Plains' Summit - Citizen Participants [partial] (4 pages)	2/15/94	b(6)
002. memo	From: Kathy Sykes, Congressman Obey's Office, To: Liz Bowyer, Re: Hillary Clinton's Trip to Steven's Point [partial] (1 page)	2/17/94	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3983

FOLDER TITLE:
[HRC Background File] Friday, February 18 [1994] [2]

2014-0483-S
sb394

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]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Details of first lady's Wausau visit still being worked out

Hillary Clinton to speak Friday at Grand Theater

By Chuck Baldwin
Wausau Daily Herald

Tickets still are available for first lady Hillary Rodham Clinton's Friday night talk in Wausau, but details of her visit remain unclear.

"We're still getting a lot of calls and still selling a lot of tickets," said Josh Zepnick of Citizens for Dave Obey, which is paying for the visit.

Zepnick said the Grand Theater, where Rodham Clinton will speak and answer questions, seats about 2,200.

"I don't anticipate a cutoff" for tickets, Zepnick said.

Rodham Clinton will appear as part of a Better Way Club event. The club is a fund-raising organization for Obey, a Democratic congressman from Wausau who is up for re-election this year.

Membership to the Better Way Club is $60; another $40 gets members into a private reception with Rodham Clinton before her speech. Zepnick expects several hundred people to be at the reception.

The club brings in two high-profile speakers a year. Last fall, Health and Human Services Secretary Donna Shalala was the guest speaker.

Zepnick emphasized that as a fund-raising event, Obey's campaign — not tax dollars — will pay for all costs associated with the first lady's visit. Obey has more than $370,000 in his campaign chest for a re-election bid, which he hasn't announced.

Zepnick was unsure of the trip's cost and of the details. He didn't know where Rodham Clinton would be flying from, and the Democratic Party only announced Monday that she would leave Wausau for a party fund-raiser Saturday in Milwaukee.

Wausau Police Chief Bill Brandimore said Tuesday he didn't even know "what time she's coming in." He said a meeting had been scheduled for Thursday with the Secret Service to learn what arrangements the police department should make.

Brandimore hoped, though, there would be little traffic disruption caused by the visit.

"I don't think it will be as elaborate as it would be if the president or vice president would come in," he said.

Schedule

Tentative schedule of first lady Hillary Rodham Clinton (times approximate) includes:

- 7:30 p.m. arrival at Central Wisconsin Airport.
- 8 p.m. private reception at Grand Theater.
- 8:30 a.m. speech and question-and-answer period at Grand Theater.
- 10 p.m. departure for airport.

Central Wisconsin Airport Manager James Hansford also was waiting for more information. He anticipated a meeting with the Secret Service this afternoon — late by normal standards of high-profile visits.

"We get the details about a week in advance, usually," Hansford said. "I guess what she's doing is up in the air."

State Democratic Party Chairwoman Marlys Matuszak of Wausau said that's to be expected.

"All the little details are still being worked out," she said. "These things are always last-minute. It's the first lady, not the president or vice president, and that makes a difference.

"It's a whole different routine for someone who's not the leader of the nation."

THOMAS DASCHLE
SOUTH DAKOTA

COMMITTEES
AGRICULTURE
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INDIAN AFFAIRS
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NATIVE AMERICANS

United States Senate

WASHINGTON, DC 20510-4103

515 SOUTH MAIN STREET
P.O. BOX 1536
ABERDEEN, SD 57401
(605) 225-8823

616 6TH STREET
P.O. BOX 8168
RAPID CITY, SD 57709
(605) 348-7551

810 SOUTH MINNESOTA AVENUE
P.O. BOX 1274
SIOUX FALLS, SD 57101
(605) 334-9596
TDD (605) 334-4632

TELECOPY COVER SHEET

DATE: _____

TO: Liz Bowyer

FAX NO.: 202 456-2239

FROM: Mike BROGIOLI

Office of Senator Thomas A. Daschle
810 South Minnesota Avenue
Sioux Falls, SD 57104
Telephone: (605) 334-9596
FAX Number: (605) 334-2591

MESSAGE: hope this helps!

No. of Pages (Including Cover Sheet): 15

Memorandum

TO: Liz Bowyer

FROM: Mike Brogioli, Senator Daschle's staff

RE: **Background information for Great Plains Summit**

DATE: February 15, 1994

Following is the information you requested regarding Mrs. Clinton's upcoming trip to South Dakota. I've included copies of memoranda sent recently to Melanee Verveer and Patti Solis on proposed schedules and agendas as well as information on proposed site visits. You will also find a photocopy of the Summit invitation that went out two weeks ago.

Information on Breakouts (workshops)

As I mentioned over the phone, several workshops will be held following the roundtable discussion with Mrs. Clinton (from 2:30-4:00pm in classrooms at Lennox High.) As of 2/15, the following workshops will be held:

- Questions and Answers on the Clinton Plan
- Health Care Providers
- State and Local Role in Reform (to be facilitated by Nebraska Lt. Gov. Kim Robak)
- Small Business
- North Dakota Workshop (to be facilitated by Senator Conrad and Rep. Pomeroy)

Information on the town of Lennox and Lennox High School

Lennox is a small town (pop. 1800) located 20 miles south of Sioux Falls.

Lennox High School serves a four town school district (Chancellor, Tea, Worthing and Lennox).' The *district* has 1487 students (kindergarten through 12th grade). The *high school* has 388 students, grades 9 through 12.

100 high school students, representing grades 9-12, will attend the study hall session with Mrs. Clinton. They will be joined by most of the school's 25 faculty and staff. (Classes will not be in session that day due to the Summit). The school's student council officers would like to present Mrs. Clinton with a hat and/or sweatshirt during her visit with them.

Included in this fax is a newsclip on the town's preparation for Mrs. Clinton's visit.

Memorandum

TO: Melanne Verveer

FROM: Mike Brogioli, Senator Daschle's staff

RE: **Proposed Great Plains Summit Agenda**

DATE: February 9, 1994

The following is a proposed agenda for the the Great Plains Summit on Rural Health Care, to be held in Lennox, South Dakota on February 18.

11:30-11:55	Mrs. Clinton's down time in her holding room; she will have the chance to visit with citizen-participants and members of Congress in their holding room (they will share the band room prior to the event) and to do photo-op with sponsors.
11:55	Citizen-participants and members of Congress are escorted into the gymnasium and seated at the roundtable.
12:00	Senator Daschle escorts Mrs. Clinton into the gymnasium (their entrance will be announced.) Mrs. Clinton and Senator Daschle will sit at the head of the table, with a citizen-participant seated between them.
12:00-12:15	Senator Daschle makes welcoming remarks; he will mention members of Congress who are present and will recognize the sponsors (representatives of the *Argus Leader* and KSFY-TV who will be seated in VIP area.) Senator Daschle introduces the moderator, Lois Quam, who will enter the area in the middle of the tables (she will sit adjacent to the table prior to her introduction.) Lois Quam introduces the citizen-participants (by going around the table and asking each citizen to introduce themselves.)
12:15	Senator Daschle introduces Mrs. Clinton.
12:15-12:30	Mrs. Clinton makes introductory remarks to set the stage for the roundtable discussion.
12:30-1:55	Roundtable discussion involving the citizen-participants, members of Congress and Mrs. Clinton. As in Boston, the moderator will set the stage for each area of discussion (business concerns, role of providers, rural elderly -- approximately 25 minutes per issue area) and will involve the appropriate participants in a prearranged order. Participants will be encouraged to avoid

prepared statements. Instead, they will each briefly share their experience and raise a question for Mrs. Clinton. Mrs. Clinton will respond to each participant's concerns. Members of Congress will be asked to participate in, but not dominate, this discussion.

[As of 2/8, Senators Daschle, Pressler, Conrad, Kerrey, Wellstone and Representatives Minge and Pomeroy are confirmed.]

1:55 Mrs. Clinton's closing remarks.

2:00 Senator Daschle closes the roundtable discussion.

2:10 The announcer offers information/directions on the various workshops.

2:30-4:00 Workshops.

FILE

Memorandum

TO: Melanne Verveer and Patti Solis

FROM: Mike Brogioli, Senator Daschle's office

RE: **Proposed schedule for Mrs. Clinton's visit to South Dakota**

DATE: February 9, 1994

The following is a proposed schedule for Mrs. Clinton's visit to South Dakota on February 18 to attend the Great Plains Summit on Rural Health Care:

10:00 AM — Arrive Sioux Falls

10:00 - 10:30 AM — Drive time to Lennox

10:30 - 10:50 AM — Site visit/photo op with Senator Daschle at Lennox Area Medical Center

This is a store front primary health care clinic located on Main Street and staffed by a nurse, physician assistant and a one-day-a-week doctor; our Sioux Falls staff will have more information on this by the end of the week.

10:50 - 11:00 AM — Drive time to Lennox High School

11:00 - 11:30 AM — Visit with Lennox students and faculty. Approximatley 100 students and faculty will assemble in the school's study hall. Following an introduction by Senator Daschle, Mrs. Clinton will make brief remarks and perhaps take questions from students.

A visit with students would be much appreciated since they will not be able to attend the Summit due to space constraints.

Channel One, the national cable program that 1000 high schools across the country subscribe to, has indicated that it will broadcast this meeting.

11:30 - 12:00 NOON — Down time and photo-op with Summit sponsors

Mrs. Clinton will have the opportunity if she chooses to visit with citizen-participants and members of Congress in their holding room.

Representatives from the sponsoring organizations, the Argus Leader and KSFY-TV, will stop by for a quick photo-op with Mrs. Clinton.

12:00 - 2:00 PM	Great Plains Summit on Rural Health Care
	Mrs. Clinton will participate in the roundtable discussion with citizen-participants and members of Congress. Lois Quam will moderate. [See Summit agenda memo for details]
2:00 - 2:30 PM	Press interviews
	Senator Daschle is especially concerned that Mrs. Clinton have time to be interviewed by the Argus Leader, South Dakota's largest newspaper.
2:30 - 3:00 PM	Drive time to Sioux Falls Airport
3:00 PM	Depart Sioux Falls

Memorandum

TO: Patti Solis

FROM: Mike Brogioli, Senator Daschle's staff.

RE: **Information on Long-Term Care Site in Lennox**

DATE: February 14, 1994

Following this memo is information on the Good Samaritian Center, a nursing home facility located in Lennox, South Dakota (the site of the Summit).

Jay Thomas, the facility's administrator, expressed interest in hosting Mrs. Clinton on a tour of the center several weeks ago and would be happy to roll out the red carpet for her (but is aware that she is tentatively scheduled to visit a different site)

Please keep us posted on where you are at regarding a site visit; we should discuss the meeting with students further as well.

Some Important Facts

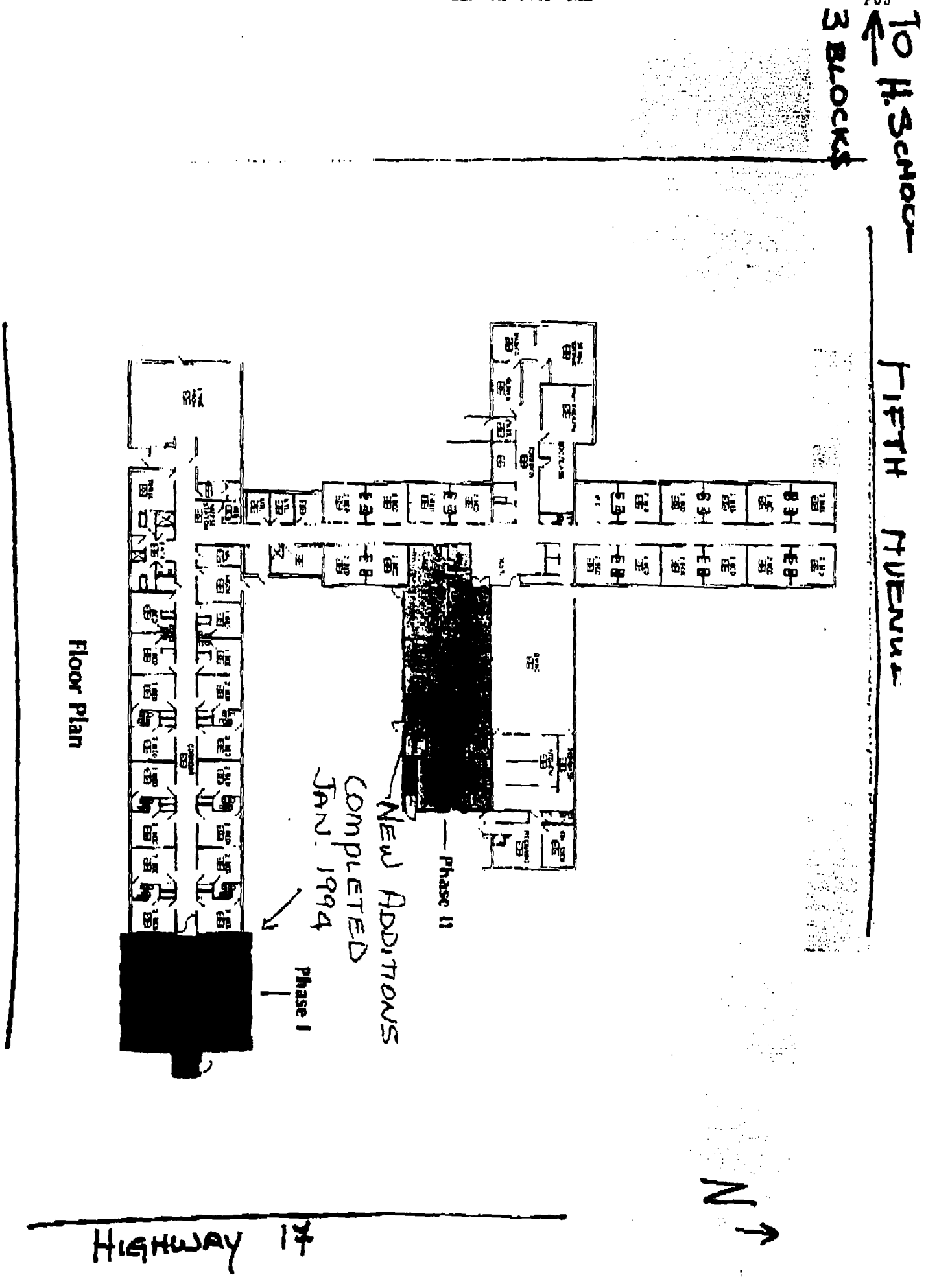
- The Center is licensed to provide 69 beds and averages a 98.5 percent census. Ninety percent of the Center's residents are from the immediate service area.
- The Center employs 75 full- and part-time staff members, and has an annual payroll of $890,000. With local purchases of goods and services, the annual economic impact is over $5.7 million.
- The Center is owned and operated by The Evangelical Lutheran Good Samaritan Society, a Christian nonprofit organization with a 70 year tradition of caring. The Society's nonprofit status means that no one receives a profit or an excessive salary. Any funds left over after the Center's bills are paid remain in the community and are used to improve resident care.

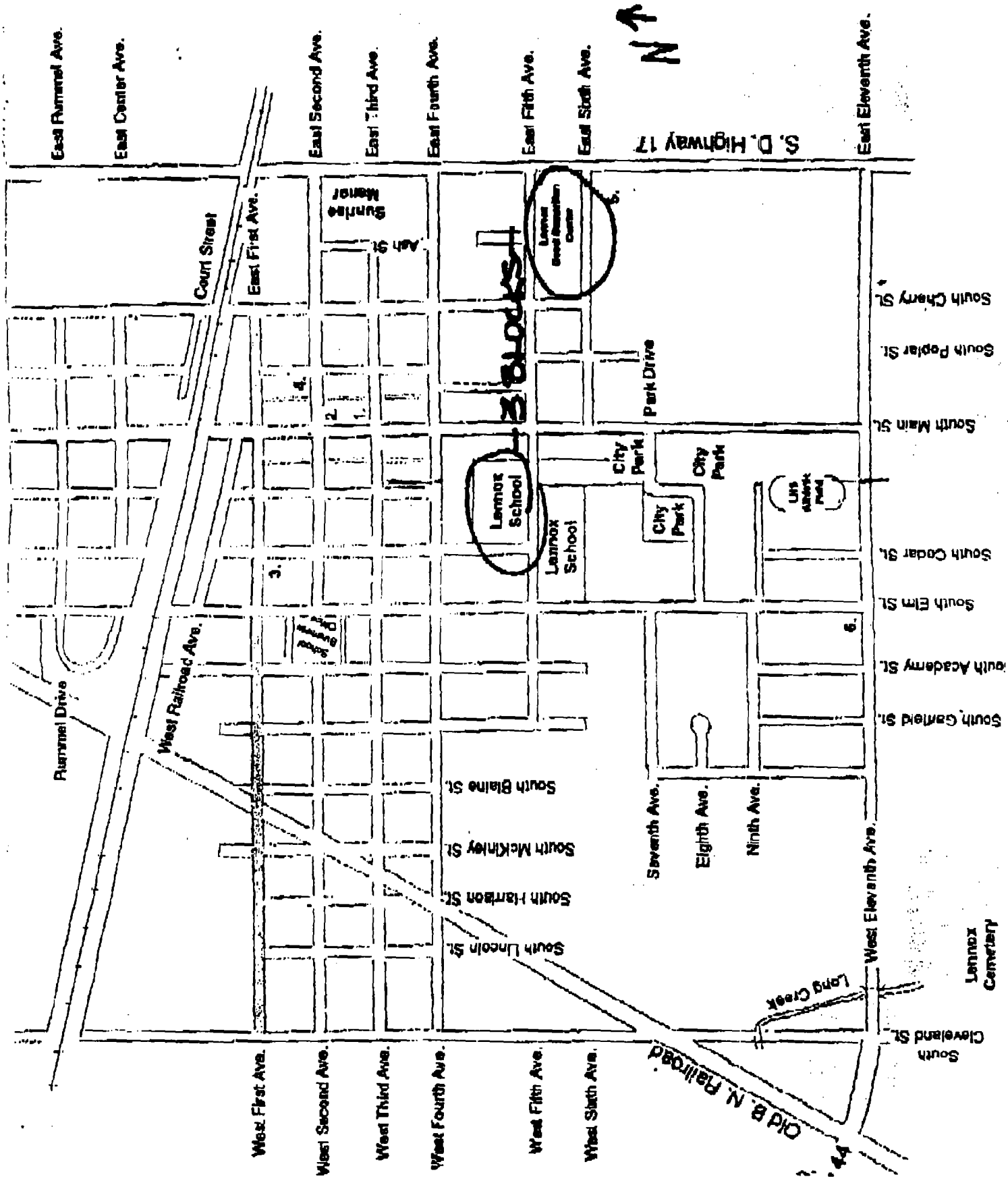
J. Thomas, **Administrator**
Rebecca Hofer, **Resource Development Coordinator**

ADVISORY BOARD MEMBERS
David Corseth
Joel Klusmann
Dan Hoogestraal
Evelyn Miller
Helmer Hanson
Judy Finnell
Frances Smit
Mary Kuper
Mary Gorrell

DEPARTMENT HEADS
Jan Steadman - Director of Nursing
Joietta Blackmore - Social Services Coordinator
Cel Anderson - Activities Coordinator
Betty Montgomery - Laundry & Housekeeping Supervisor
Linda Gaiken - Food Service Supervisor
Jim Rasmussen - Maintenance Supervisor
Mary Weeldreyer - Office Manager
Cheryl Barun-Buse - Medical Records Coordinator
Marie Bultena - Staff Development Coordinator

Lennox Good Samaritan Center
405 E. 5th Ave.
Box 78
Lennox, SD 57039
Phone (605) 647-2251


TO H. SCHOOL
3 BLOCKS
FIFTH AVENUE
SIXTH AVENUE
Floor Plan
NEW ADDITIONS
COMPLETED
JAN. 1994
Phase I
Phase II
HIGHWAY 18
N


N
East Rummel Ave.
East Center Ave.
East Second Ave.
East Third Ave.
East Fourth Ave.
East Fifth Ave.
East Sixth Ave.
East Eleventh Ave.
S. D. Highway 17
Court Street
East First Ave.
Sunrise Manor
Ash St.
Lennox Good Samaritan Center
3 Blocks
Park Drive
South Cherry St.
South Poplar St.
South Main St.
City Park
City Park
City Park
Lennox School
Lennox School
Lincoln Park
South Cedar St.
South Elm St.
South Academy St.
South Garfield St.
Rummel Drive
West Railroad Ave.
South Blaine St.
South McKinley St.
South Harrison St.
South Lincoln St.
Seventh Ave.
Eighth Ave.
Ninth Ave.
West Eleventh Ave.
Long Creek
Lennox Cemetery
South Cleveland St.
Old C. & N. Railroad
West First Ave.
West Second Ave.
West Third Ave.
West Fourth Ave.
West Fifth Ave.
West Sixth Ave.
44

February 9, 1994

Senator Daschle:

Lennox Area Medical Center opened on July 18, 1977. At that time the Medical Center was owned and operated by Lennox Area Development Corporation a non profit corporation. Lennox Area Medical Center is a rural health clinic and received rural health clinic federal grant funds from 7-18-77 to 9-1-82. Larry L. Sittner, MD, purchased the Lennox Area Medical Center on 9-1-82 and continues to operate it as a rural health clinic. Since the purchase of the medical center by Dr. Sittner no grant funds have been received. Scott Rogers PA-C has been employed at the Lennox Area Medical Center since July 18th, 1977. Dr. Larry Sittner has been supervising physician for Scott Rogers PA-C since September, 1978.

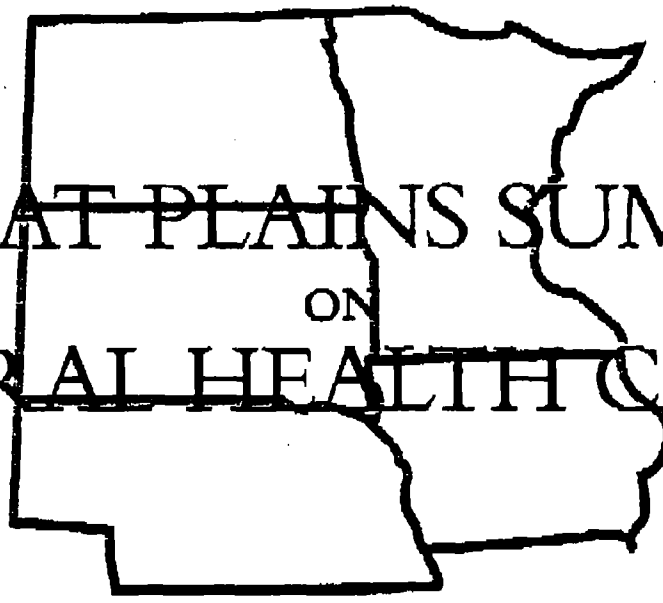
The Lennox Area Medical Center provides outpatient rural health clinic services, family practice care, including diagnostic lab and x-ray.

General concerns regarding medical care.

1. Concerns about revoking some of the more unnecessary changes brought about by CLIA.
2. Concerns in regards universal health care coverage.
3. Concerns about any changes in the health care systems affect on increasing or decreasing access to medical care
4. Right along with the above are concerns as to the affect on the front line medical providers, for example, family practice physicians, physician assistants and nurse practitioners.
5. Concerns about increasing federal involvement in medical care and therefore along with that increasing the amount of control and bureaucracy, not to mention the cost of medical care.
6. In addition concerns about the increased costs to small businesses in general but in particular small rural clinics which would not only have increased cost in trying to cover employees medical "premiums" but in addition a concern about the amount of money the clinic takes in because of reduced medical fees for one reason or another.
7. Additional paper work.
8. What percent of every dollar will go for administration and what percent will actually be spent on health care.

Larry L. Sittner, MD & Staff
Lennox Area Medical Center
Box 662
Lennox, SD 57039

INVITE (front)



GREAT PLAINS SUMMIT
ON
RURAL HEALTH CARE

Invite (inside)

The Sioux Falls Argus Leader
KSFY-Television &
South Dakota Public Broadcasting
cordially invite you to attend the

GREAT PLAINS SUMMIT
ON
RURAL HEALTH CARE
with
First Lady Hillary Rodham Clinton

and special guests
Members of Congress from
South Dakota, Iowa, Minnesota, Nebraska and North Dakota

Friday, February 18, 1994

12 noon
Lennox High School Gymnasium
Lennox, South Dakota

RSVP by phoning
(605) 334-9596

Due to space limitations,
RSVPs must be made by February 11.

You must bring invitation and
photo identification for admittance.

Lennox prepares to meet first lady

By RANDY HASCALL
Argus Leader Staff

LENNOX — First lady Hillary Rodham Clinton won't be the most famous person to ever set foot in town.

Theodore Roosevelt once stopped here during a campaign trip by train, said Verlyn Hofer, president of the Lennox Commercial Club.

Although Clinton might have to settle for second place, she'll receive a first-rate reception and likely won't encounter any protesters, Hofer said.

"We're a pretty strong Republican community, but we're too polite for that," he said. "We'll try to put our best foot forward, be polite and considerate."

Clinton will be in town Feb. 18 for a forum on rural health care.

Mayor Floyd Beach was busy Tuesday distributing new welcome banners that arrived in the mail. Business owners will hang them in their windows, and the American Legion will display U.S. flags downtown. Then, they'll all hope the entourage arrives or departs over main street.

As Clinton's trip nears, rumors grow.

According to one story, Secret Service agents have been roaming the halls and classrooms at Lennox High School — the site of the forum — checking out the school and students.

The wildest rumor is that the Secret Service fastened down all manhole covers on main street so no one could pop up with a gun to ambush Clinton's caravan.

Despite what people say, no Secret Service agents have been to town as far as high school principal Alan Rops knows. He said the strangers in suits are members of Sen. Tom Daschle's staff who have made three visits.

After classes Feb. 17, Rops will turn the school over to the Secret Service.

Details of Clinton's visit are sketchy, Rops said. She's scheduled to arrive in Lennox between 11 a.m. and noon, conduct a national news conference in the school library and

L /See 2A

Lloyd E. Cunningham/Argus Leader

Lennox Mayor Floyd Beach inspects his work after hanging a banner in the front window of his hardware store on Main Street on Tuesday. The town's Commercial Club bought 18 welcome banners to display during First Lady Hillary Rodham Clinton's visit next week.

Summit tickets available today

Tickets for the Great Plains Summit on Feb. 18 in the Lennox High School gymna. Rural Health Care with First Lady Hilary Rodham Clinton will be available today at the Argus Leader.

To get a ticket, you must have photo identification and your Social Security number. Use the south entrance. The ticket from 7 to 9 a.m. at the Argus, 200 S. must be for you, not someone else. Minnesota Ave. The summit will be at noon.

Lennox: Town prepares for first lady

Continued from 1A

then give her presentation to about 1,000 people in the gym.

Ten or 11 classrooms will be open to those without tickets, and they can watch the summit on TVs.

Rops said he expects to get a one-on-one session with Clinton and would like to put her in touch with students. Meeting the first lady could be a highlight for many, particularly teen-age girls who look up to Clinton.

To accommodate the crowd, school and city workers will clear snow to turn the practice football field into a parking lot. Twenty additional phone lines have been installed for the media and White House staff.

Rops said volunteers will direct parking and help with coat checks and other tasks.

The community's response indicates that Rops will have no trouble finding volunteers.

"There's a lot of excitement," Mayor Beach said.

"Something like this doesn't happen often, said Barb Scott of Lennox."

"It's nice she's coming to a small town," said Marilyn Renback, who lives in Harrisburg and works in Lennox.

Jack Jacobson, a 16-year-old sophomore from rural Tea, said he'll be in Sioux Falls before 7 a.m. today to try to get a ticket.

Jacobson said he hopes to learn more about the Clinton administration's health plan so he can answer the questions of his grandparents, who need medical care.

Scott Rogers, a physician's assistant at the Lennox Area Medical Center, said there's talk that Clinton might stop at the clinic.

"No one has officially notified us," he said. "I'm a Republican, but I hope she stops by. How often do you get a first lady in town?"

Hofer said a number of residents are concerned that not many local people will have an opportunity to attend the event.

"I'll go if I can get a ticket," he said. "If not, I'll watch from the outside."

Great Plains' Summit - Citizen Participants

Roger Andal, Brandon, South Dakota
Disabled Veteran
Age: 45

Mr. Andal has been self-employed, worked for the federal government, and now receives his health care through the V.A. system. He is satisfied with the health care he receives, but wonders what will happen to the V.A. system under health care reform.

He is married and has 4 children.

Native of South Dakota.

Carla Anderson, Center, North Dakota
Administrator, Square Butte Health Center
Age: 34

Center is a town of 1,000 people that had no medical services until 12 years ago. At that time, the community sought and received federal funds to build a clinic. The clinic enjoys wide community support and provides a wide range of health services. The town is now served by a nurse practioner, physicians, a dentist, and opthamologist. Ms. Anderson has been with the clinic from the start and is knowledgeable and articulate on the delivery of health care in small communities.

The Square Butte Health Center merged with Med Center One this past year. They are happy with the managed care system and believe that it is headed in the right direction.

She is married and has two sons, ages15 and 3 .

Native of North Dakota.

John Blackhawk, Winnebago, Nebraska.
Chairman of the Winnebago Tribe and Aberdeen Tribal Chairman's Health Board serving Nebraska, Iowa, South and North Dakota Native Americans.
Age: 40

As chairman of the Health Board, John has followed the issue of health reform with the interests of the Native American community in mind. He will address the health care needs of the population and the problems and advantages of the Indian Health Services that serve his community.

He is married with 2 children.

Native of Nebraska.

Gregg Bourland, Eagle Butte, South Dakota.
Tribal Chair of the Cheyenne-River Sioux and Chair of the Aberdeen Tribal Chairman's Health Care Reform Task Force.
Age: 38

Gregg like, John Blackhawk, has been active in health reform and represents tribes in Nebraska, South and North Dakota, and Iowa. He is familiar with the health reform plans proposed, and will be able to talk about the reform ideas and needs of the Native American population.

He is married with 2 children, a son -12 and a daughter - 6.

Born in Utah.

Dr. Ray Christenson, Mooselake, Minnesota
Rural Family Physician
Age: 50

Mr. Christenson grew up in rural Wisconsin and practices in rural Minnesota. He is active with rural physicians on recruitment and retention issues and with the Minnesota Department of Health on improving access to care in rural Minnesota. His current practice was started in 1972, and currently has with 6 physicians and 2200 charts.

He is married and has 2 daughters.

Native of North Dakota.

John Dean, Willmar, Minnesota
Principal of Affiliated Insurance Service
Age: 51

Mr. Dean is currently associated with National Travelers Life Insuranceand is a principal in Affiliated Insurance Services in Willmar. As an insurance broker, he understands the needs to be a player in the health care reform debate While he sees many of his colleagues fighting to stall health care reform, John has become a leader in his industry. He believes that there should be universal coverage and reform in pre-existing conditions and portability problems. He does have some questions on the mandatory health alliances. He is also involved in long-term care issues in his community as a volunteer.

He is married and has 4 children, and 3 granddhildren.

Native of Minnesota.

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Cecelia Firethunders, Martin, South Dakota
Nurse, South Dakota Department of Health
Age: 48

Cecilia joins her colleagues in discussing the Indian Health Service's ability to provide adequate health care for the Native American community. She is very concerned about the uninsured (b)(6) (b)(6) 001 uninsured). She has a particular interest in wellness and prevention programs, and the urban Indian population.

She is single, has 2 sons ages 27 and 25.

Native of South Dakota.

Beth Furlong, Omaha, Nebraska
Nurse, Coordinator for Community Health Nursing
at Creighton University, School of Nursing
Age: 52

Ms. Furlong has been teaching public health nursing for 22 years and just recently completed her PhD in political science. She has been active in community activities and is a strong believer in universal access and preventative care. She serves on the Board of Directors of the Wellness Council of the Midlands for health promotion.

She is single.

Native of Iowa.

Marilyn Harms, Sioux Falls, South Dakota
Physician Assistant
Age: 54

Ms. Harms has been a physician assistant for 15 years. She is the President-elect of the South Dakota Academy of Physician Assistants and serves on the nominating committee of the American Academy of Physician Assistants. She is concerned by the number of patients she sees that are receiving false information from the insurance companies about the effects of health care reform. She believes everyone must be covered in order to get our health system back on track.

She is divorced, has 3 children.

Native of South Dakota.

Cecilia Humphrey, Sioux Falls, South Dakota
Senior Citizen
Age: 85

Mrs. Humphrey currently lives in the Good Samaritan Village in Sioux Falls. She has been in the long-term care facility for the last 5 years, having decided herself that she needed assistance. She is very active in the Village and is well read on current issues. She participated in a seminar about health care last year. *The points that she wants to make is that reform is good but she is worried that she won't be able to choose the doctor of her choice, which she has gone to be the last 30 years. She also pays over $200 a month for her prescriptions.* She is on Medicare, Social Security, and receives her husband's small veterans pension.

She has been widowed for the last 31 years, and has no children.

Native of South Dakota .

Dr. Clayton Jensen, Grand Forks, North Dakota
Interim Dean of the University of North Dakota School of Medicine and is Professor and Chairman of the Dept. of Family Medicine.
Age: 66

Dr. Jensen has been a family physician and currently teaches and promotes family medicine at the University of North Dakota. He has spent his entire life in North Dakota working in this field. He is articulate and can ask questions and express points of view from the unique perspective of family doctors in rural America.

He is married with 2 sons and 3 grandchildren.

Native of North Dakota.

Larry Juhl, New London, Minnesota
Owner and Administrator of the GlenOaks Long Term Care Campus
Age: 43

Mr. Juhl runs the GlenOaks Adult Day Services, an adult day care center opened in 1991. GlenOaks goal is to keep the seniors in the least restrictive setting as long as possible, avoiding or delaying institutionalization. GlenOaks has received state and national recognition for its comprehensive long term care campus. New London is a town of 1,000 people, and currently there are 4-5 people per a day enrolled in the adult day care program. Larry is also the mayor of New London.

He is married and has 2 children.

Native of Minnesota.

Carol Kobberman, Hancock, Minnesota
Dairy Farmer
Age: 55

Mrs. Kobberman and her husband run a dairy farm of 360 acres, and a herd of 80 cows. She receives her insurance through the group dairy association, and has fairly good coverage. However, she says that the group association had to change insurers this year to keep costs down, and worries about the changing nature of insurance.

She is married with 9 children and 14 grandchildren.

Native of Minnesota.

Joe Lathrop, Valley, Nebraska
Owner and Pharmacist of Valley Pharmacy
Age: 40

Valley, Nebraska is a town of 1,716 people. Mr. Lathrop has run the pharmacy for 12 years and is a graduate of the University of Nebraska Pharmacy School. His pharmacy fills about 150 prescriptions a day, handles prescriptions for the local nursing home, as well as the Medicare population of the area. He will speak to the high cost of drugs for seniors and the hard choices he sees many of his customers making everyday. *He is also a small businessman and can address the issue of providing insurance as a business owner.* He currently provides insurance for his one full time employee, another pharmacist.

He is married with two small children, ages 1 and 3.

Native of Nebraska.

Anne Nation, Friend, Nebraska
Consultant and free lance writer
Member of the Board of Directors, Nebraska of Comprehensive Health Insurance Pool
Age: 42

Ms. Nation has experienced the health care system [redacted] and as a member of the state board that provides insurance for high risk individuals. Anne served on the Governors' Blue Ribbon Coalition to Study Health Care in Nebraska.

Interestingly, Anne and her husband lived in Canada for a year in 1975 and experienced first-hand the Canadian single-payer system. This gives Anne an unique advantage to comment first hand on both systems.

She is married, has no children.
Native of Nebraska.

Kathleen Piper, Yankton, South Dakota
Owner of Pied Piper Flower shop, and County Commissioner
Age: 43

Ms. Piper is the owner-operator of a small business in Yankton. She carried health insurance for her 8 employees until the cost became too high and she had to drop the coverage. She waited until all her employees could receive coverage elsewhere before dropping her insurance. She would like to provide coverage *but can't afford it today*. She, herself, receives insurance through her position as county commissioner. She can speak as a small business person and from the perspective of a county commissioner.

She is married with two children.

Native of Iowa.

(b)(6) 001

(b)(6) is known throughout the Great Plains area as a farm hero, having survived a farm accident in January of 1992. Both of (b)(6) arms were amputated in a ghastly accident (he was caught in a farm machinery shaft.) He was alone on the farm when the accident happened, struggled to get to the house to use a pencil to dial the phone, and then waited for help in the bathtub to avoid bleeding on the carpet.

He continues to have physical therapy and will need future surgery. But, the operation to save his arms has been deemed a success.

(b)(6) is articulate about the problems that farmers face in emergency care needs and the problems of receiving physical therapy.

Single.

Native of North Dakota.

Dr. Allen Van Beek, Edina, Minnesota
Surgeon, North Memorial Medical Center
Age: 51

Dr. Van Beek is the surgeon who provided the emergency care for (b)(6) 001 (b)(6) He is active in educating farm families on the need for emergency care and will comment on how important the need for quick service is in cases like (b)(6) 001

Marvin Wangen, Albert Lea, Minnesota
Mayor of Albert Lea, and small businessman
Age: 63

Mayor Wangen has viewed the health care crisis both as a patient and as an employer trying to provide health insurance for his employees. As a small businessman, Marvin has experienced incredible premium increases in his 4-person group policy [redacted (b)(6)] He has had a similar experience with the city's insurance plan when 2 or the 150 employees had to undergo heart transplants.

Married with 4 children.

Native of Minnesota.

Dan Wogsland, Hannaford, North Dakota
Family farmer
Age: 38

Mr. Wogsland has run his family farm full time since 1977. He also is serving his third term as state senator and majority leader for the North Dakota State Legislature. Mr. Wogsland farms small grains and row crops, no livestock. While he is able to get his insurance through the state, he has witnessed many of his neighbors' troubles in obtaining insurance or being priced out of the market.

Married with 3 children.

Native of North Dakota.

Dana Hyde 202-456-6704

John Maynor 202-720-8819

Kevin Thurm 202-690-7755

Robert Van Hook 202-690-6518

Judy Whang 202-690-6518

Kathryn Balsam-Schwaber 202-456-2362 (or 5485)

Lois Quam 612-645-4423

separate Transmission

MESSAGE TO THE FOLLOWING: Chris Jennings, Dana Hyde (White House), Kevin Thurm, Judy Whang, Bob Van Hook (DHHS), John Maynor (USDA).

Here is the newest version of the booklet on the Health Security Act as is would work in rural areas. This version reflects an edit by Judy Whang and includes other changes suggested by Bob Van Hook, Catherine Balsam-Schwaber and Lois Quam.

We think we are ready for review from DHHS/OGC and OMB. If you have any final changes please call us ASAP.

The Health Security Act and Rural Americans

"Rural Americans know the inequities of today's health care system. They often pay high insurance premiums, receive low reimbursements and lack for providers. The Health Security Act will conquer these classic problems. First, it will give rural residents the bargaining power that others enjoy. Second, it will create an attractive marketplace for rural practitioners."

- President Bill Clinton

The Health Security Act of 1993

Responding to the Needs of Rural Americans
With Health Care That's Always There

What's Wrong With Health Care in Rural America

- **Lack of Security.** Nearly one in five rural Americans has no health insurance, including 18% of all farm families. Rural residents have higher rates of serious illness, and many, especially those who work in farming, mining, and other high-risk occupations, face a constant fear that their insurance will be cancelled if they get sick or injured. Others cannot even obtain insurance because they have a "pre-existing condition."

- **Skyrocketing Premiums.** Rural Americans with insurance face skyrocketing premiums because they are often self-employed or work in a small business and have to purchase coverage alone. They do not have the buying power of a large business that can successfully negotiate lower premiums. When the insurance company raises rates, there is nothing that these rural residents can do.

- **Inadequate Coverage.** The insurance that rural Americans have often does not cover the health services they need, such as primary and preventive care. Frequently, there are also high deductibles and severe limits on catastrophic coverage.

- **Lack of Choice.** Rural Americans have very little choice as to what type of health insurance they will buy. Most work for small businesses that offer no choice of coverage. Nationwide, only 3 out of every 10 employers with fewer than 500 employees offer any choice of health plan.

- **Lack of Providers.** Physicians and other health care providers currently find few incentives to practice in rural areas. The fragile economies of rural communities and poor health insurance coverage provide little financial stability for rural health care practitioners and hospitals. Meanwhile, long hours and isolation wear rural providers out. As a result, over 400,000 rural Americans live in counties without a single doctor and 34 million people live in rural areas with inadequate health care.

- **Lack of Transportation Services.** Rural Americans have a harder time getting to the services that *are* available. Most rural communities lack any public transportation system. More than half of the rural poor do not own a car, and nearly 60% of the rural elderly are not licensed to drive.

The Health Security Act of 1993

Every citizen will receive a Health Security Card that can never be taken away. All Americans will be guaranteed an affordable, comprehensive package of benefits, no matter where they live, whether they change jobs, start a business, or lose a job.

The Health Security Act is President Clinton's plan for comprehensive health care coverage for all Americans, submitted to Congress November 20, 1993. The plan builds on our private health care system, but reforms it to strengthen consumer bargaining power. It guarantees everyone, including rural Americans, access to health care.

Reform With a Rural Side

The Health Security Act recognizes the particular needs of rural Americans. From the earliest stages of its development, a special Working Group on Rural Health Care advised the White House Task Force on Health Care Reform. Rural health experts throughout the country -- providers, businesses, rural organizations -- participated in the design.

Affordable and Available

Rural citizens need affordable insurance and more physicians and other health care providers if they are to have real security. The President's plan provides both: training and incentives for rural practitioners, and insurance reforms that lay a solid foundation for growth in rural health care services.

Local Control

The Health Security Act provides a national framework for health care security. It also leaves room for states and local communities, businesses, and practitioners to be the architects of change.

Universal Coverage and Savings?

Yes. The Health Security Act reshapes *the way we spend* our health care dollars. The plan:

- brings consumers and small businesses together for the buying power to negotiate reasonable prices,

  trains more of the primary care physicians needed in rural areas,

- puts a priority on preventing illness and treating problems early.

- eliminates costly paperwork by creating a single claims form to replace more than 1,500 different insurance forms.

How The Plan Works

The President's plan improves our current employer-based system by leveling the playing field for the consumers and small business. The plan also creates economies of scale and reduces administrative costs. Here's how:

The Health Security Act uses a strategy similar to one used by rural Americans -- the purchasing cooperative. To strengthen their bargaining power in the market-place, employers and individuals in a geographic area will pool their purchasing power by joining a *regional alliance*. Large employers (including rural electric and telephone cooperatives) may operate as *corporate alliances*. The alliances will contract with a range of health plans which their members will be able to choose from. Alliances will negotiate prices, pay plans, and administer subsidies on behalf of their members.

The bottom line under the Clinton Plan is this: For the first time, every American -- wherever they work or live -- will have purchasing power through an alliance. And, *it will be illegal for any health plan to reject an individual or charge more to an individual for being sick.*

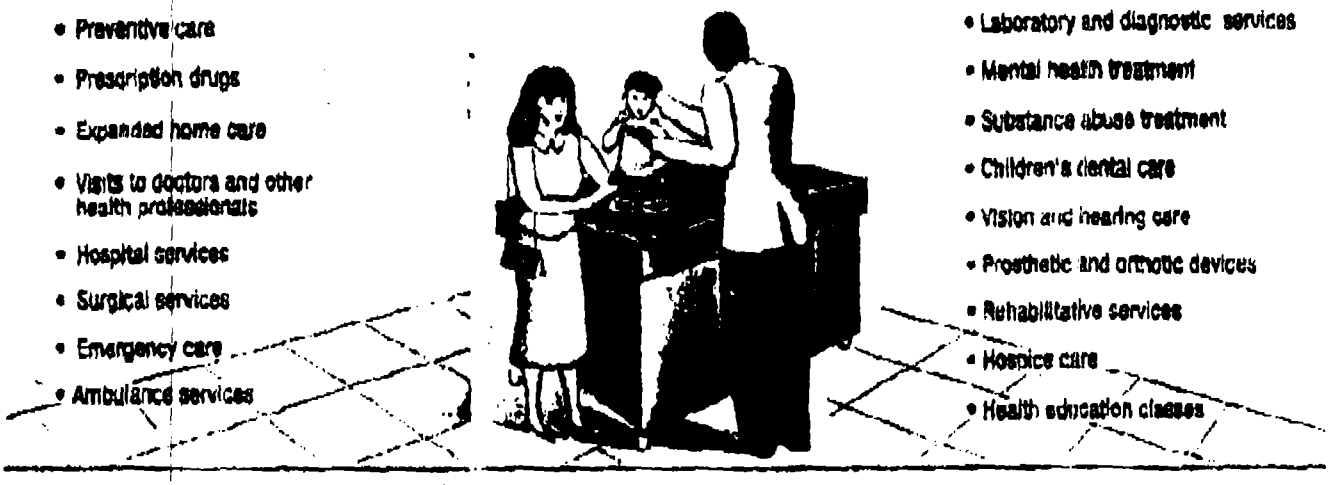
Expanding Rural Choices

Everyone will choose their health plan and their own doctor. With universal coverage, rural markets will have new purchasing power to attract health plans. The act also provides special assistance to rural communities to develop practitioner networks and managed care plans.

More Rural Doctors

The Health Security Act reforms medical education to increase the availability of family physicians and other generalists who make up the backbone of rural medicine. To expand the number of primary care providers in rural America, the act also *boosts education funding for primary care physicians, physician assistants, and nurse practitioners to work in underserved areas.* And to enhance rural practice, the plan offers substantial tax breaks as well as support for the development of practitioner networks and telemedicine links that reduce isolation.

Comprehensive Coverage For Every American



A Comprehensive Benefit Package

All health care plans will offer a comprehensive benefits package, one as generous as those offered by most Fortune 500 companies. This package goes well beyond the coverage most rural Americans enjoy today: It pays *100 percent* of the costs for a wide range of *preventive care services*, including prenatal care, well-baby care, immunizations, and adult screenings like mammograms, Pap smears, and cholesterol tests. Other features of the benefit package include home care benefits, rehabilitation benefits, prescription drugs, and hospice care.

Protecting Older Americans

Medicare will be expanded to cover prescription drugs. In addition, a new home and community-based long-term care benefit is created. These will be an important benefits for rural communities, which have a high proportion of seniors.

No Time Limits on Coverage

The plan prohibits annual or lifetime cost or time limits on care. Today 76% of insurance companies have lifetime limits in their plans.

Right to Choose Your Doctor

The plan guarantees Americans the right to continue receiving care from their physician on a traditional fee-for-service basis. This is important to rural areas that may be without integrated health plans. Also, a "point-of-service" feature gives consumers the choice to belong to an HMO-type plan but with the option to see another doctor outside the plan by paying a little bit more.

Rural Access & Quality Assurance

The Health Security Act holds states responsible for assuring that *every* resident has access to quality health care. Alliances will have funding to assure that rural Americans are not isolated from good quality care.

Report Cards

Alliance members will receive an annual report card on area health care plans that will offer objective information (such as on enrollee satisfaction, immunization rates, etc.) with which to compare plans. Consumers can use the information to compare the quality of their plans, and to decide whether to change plans during annual open-enrollment periods.

Premium Costs: Everyone's Responsibility

Employers contribute 80 percent of the insurance premiums based on the average premium among health plans in their area alliance. (This average payment varies, of course, by type of coverage -- single, married, family, etc.) To help employers meet their responsibility without putting them at risk, their contributions for insurance premiums are capped at a maximum 7.9 percent of their payroll.

Employees will pay the difference between the employer share and the cost of their own plans. If an employee selects an average cost plan, this share will amount to 20% of the total premium. Those who choose a lower cost plan from among those offered, will pay less, and those who choose a more expensive plan will pay a little more.

Low income individuals, whether they are self-employed, employees, or unemployed, will be eligible for discounts on their premium share, depending on their incomes.

Protecting Retirement

Nearly a quarter of America's elderly are rural citizens. Retired persons 65 or older will continue to receive their health care under Medicare, with the added security of prescription drug coverage.

Retirees 55-65 will only be responsible for the 'employee' share of the premium -- the difference between the cost of the plan and 80% of the average plan premium. The 80% employer share will be paid by the federal government. Former employers who wish to cover the 20% employee share can do so. Working people over 65 and their spouses, on the other hand, will be covered through the health alliances.

Discounts for Small Businesses & Self-employed

There is a protective limit on the premium obligations of the employer in small firms with fewer than 75 workers. Depending on the number of employees, the cap ranges from 7.9% of payroll to as little as 3.5% of payroll -- discounts of 30 to 80% of what big business pays today.

For the self-employed, the Health Security Act also increases the personal tax deductions for health care from 25 to 100 percent of costs. For the first time, rural Americans who are self-employed will be able to subtract all of their premium from taxable income.

Small Business Discounts:

Average Pay: (same categories as before)

firm size:	<12K	<15K	<18K	<21K	<24K	24K+
< 25	3.5	4.4	5.3	6.2	7.1	7.9
< 50	4.4	5.3	6.2	7.1	7.9	7.9
< 75	5.3	6.2	7.1	7.9	7.9	7.9

An employer is considered a small employer for a year if it does not employ, on average, more than 75 full-time equivalent employees during the year. Average annual

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Jeff - call me questions. - J.W.

A Boon for Small Community Businesses and Employees

For farmers and other self-employed rural residents, the plan provides the unprecedented opportunity to insure their employees as well as their families.

Small businesses are financial anchors in rural communities and the creators of new jobs everywhere. Under the Health Security Act, the cost of providing insurance will go down for most small businesses that currently provide it. Those businesses that do not provide coverage will be better able to afford insurance for their employees, compete for qualified workers, and stabilize their workforces. Also under reform, the cost of providing family insurance is shared between spouses' employers. Today, one employer may pay the entire insurance for a family while the other pays nothing at all.

The President's plan also frees businesses from the burdens of administering an employee plan -- paperwork which today costs *small* businesses as much as 40% of their premium dollars. At the same time, their employees will have more plans to choose from.

Support for Rural Providers

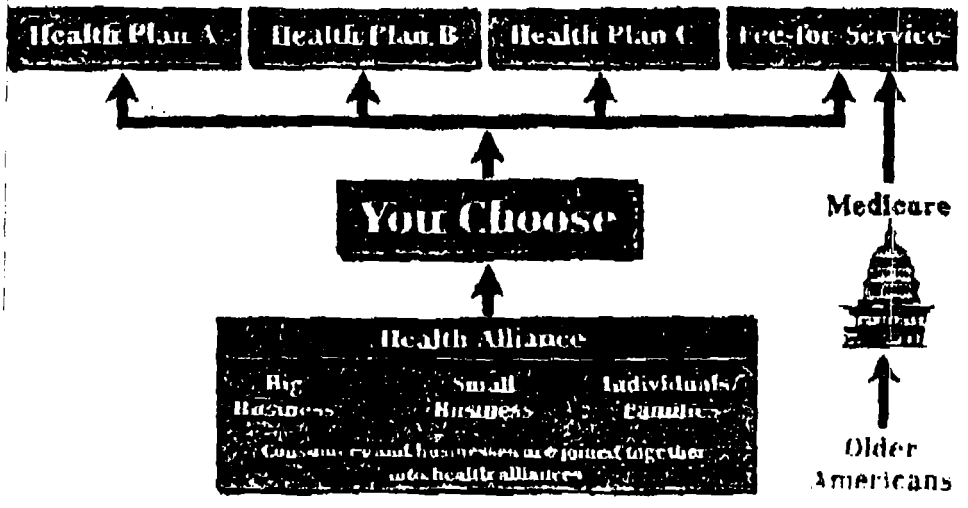
Today's rural providers -- hospitals, physicians, and other primary care practitioners -- often provide care free or at reduced cost for those who can't afford it. The Health Security Act will, for the first time, make sure practitioners are paid for their work because their patients will have adequate insurance coverage.

In addition, The Health Security Act improves Medicare payment for all primary care providers, an important change for rural practitioners whose practices include many Medicare patients.

The plan also frees rural providers from excessive administrative costs by reducing the variety of claim forms and reporting requirements.

The Health Security Act provides substantial incentives for more family practice doctors, nurse practitioners and physician assistants to work in underserved rural communities. These include training opportunities in rural settings, increased payments under Medicare, loan forgiveness, tax credits, and an array of grants for network-building.

Health care reform brings people closer to their doctors and the high quality, affordable care they deserve.



Savings and Better Coverage Under the Health Security Act

Rural Family of Four:

Today:

Dave and Mary Jones are employed at a rural canning factory and have combined earnings of $35,000. They have no insurance through the factory, so they pay $5,000 per year for a private policy that covers only hospitalization, limited doctor services, and no preventive care for themselves or their two children. When they visit a doctor or an outpatient clinic, they pay 40% of the charges. They pay a total every year for their medical and dental care of approximately $6,500.

Reform:

The Jones family could pay as little as $1000 per year out of pocket for their health care instead of $6,500 and they will have fuller coverage. They would pay 20% of the average premium in their area ($4,200 per year) or $840 for their plan. In return, they would receive preventive care (including dental) as well as sick care. Their co-payments will be as low as $10 per visit and no more than $20 per visit, depending on the health plan they select.

	Policy Type	Premium	Per Year	Per Month
TODAY	Two-parent Family	$5,000	$5,000	$416.66
REFORM	Two-parent Family	$4,200	$840	$70

Self-employed Farmer (without employees)

Today:

James Huggins, a self-employed family farmer in Kansas, makes $25,000 a year and has struggled to pay for health care coverage for himself, his wife and his 10-year-old son. James, like many rural residents, has had trouble getting and keeping insurance. And unlike a business, he is only able to deduct one fourth of the $4,000 he pays in premiums each year.

Reform:

If James enrolls in an average cost plan, he will pay 20% of the $4,360 annual family premium or $872 a year. Like a business, James will also pay the employer share of his premium, which would normally be $2,479. However, that amount would exceed 7.9% of James' $25,000 income, the limit on what employers are required to pay. Instead, James will pay 7.9% of $25,000 or $1,975 for his employer share. James will pay a total of $2,847 a year, or $237 a month. For the first time, James Huggins will also be able to deduct from taxable income the full cost of his health care premiums. Assuming he is in the 20% tax bracket, his after-tax monthly cost would be $189.60 compared to $333 under the current system. [check tax bracket]

	Policy Type	Premium	Fmly Share	Empl. Share	/Yr.	/Mo.
TODAY	Two-Parent Family	$4,000	NA	NA	$4,000	$333
REFORM	Two-Parent Family	$4,360	$872	$1,975*	$2,847	$237

*Capped at 7.9%

Small Farmer/businessperson with employees:

Today:

Fred Sanderson is a farmer who employs the equivalent of four full-time workers (himself, another full-time employee, and 4 half-time workers). While he feels he cannot afford to provide health insurance for his employees, he does purchase it for himself and his family. Because of his occupation and the fact that he has had two serious farm accidents, he is 'redlined' in a high risk category by his insurer. His premium is $7,200 per year. As is the case today with other self-employed people, only 25% of his premium ($1,800) is tax deductible.

Reform:

Mr. Sanderson will be able to insure his employees as well as his family for approximately $9,820. The 80% employer share of the workers' premiums (.80 X $4,200 X4) would total $13,440 or $3,360 for each employee, but a small-business cap on that obligation of 6.2% of payroll brings that expense down to $8,680. (Calculated on a payroll of $140,000 or $20,000 average for workers and $60,000 for Mr. Sanderson.)

Mr. Sanderson will also pay the personal share of his own family insurance, and he has chosen a plan with a family premium of $4,500 -- a little higher than the $4,200 average in his alliance. He will pay $1,140 for his share, which is the difference between $3,360 and the cost of his selected plan.

Mr. Sanderson's total insurance bill is $9,820, all of which is tax deductible. Another way of looking at it is that for $4,500 Mr. Sanderson can insure himself and his family, and for just $655 per person or $2,620 more than he currently pays out, he can insure his employees, as well. The total insurance bill of $9,820 is all tax deductible.

Provisions that Preserve and Develop Rural Services

The Health Security Act includes major provisions to improve access to health services for rural residents. It will increase the number of physicians and other health professionals in underserved communities, most of which are rural, and help them develop local networks that reduce isolation.

Accountability for Rural Needs

The Act holds health plans, alliances, and states accountable for making sure that the unique needs of rural Americans are met. Alliances representing consumers and employers may use financial incentives to encourage health plans to expand to or develop in rural areas where necessary. In addition, states may take additional steps to assure that health plans adequately serve rural areas.

Financial Incentives for Practitioners

- The Health Security Act creates tax incentives for new practitioners in areas designated as underserved: a $1,000 per month tax credit for up to five years for physicians and a $500 per month tax credit for up to five years for physician assistants, nurse practitioners, and certified nurse-midwives - a total value of $60,000 and $30,000 respectively.
- Medicare's 10 percent bonus payment for primary care physicians practicing in rural underserved areas is increased to 20 percent.
- The allowable depreciation expense for medical equipment is increased by $7,500 for all doctors and by an additional $10,000 for primary care physicians practicing in designated underserved areas.

Workforce Training

- The Health Security Act reforms the public funding of graduate medical education with the goal of increasing the percentage of physicians practicing primary care (currently 33%) as compared with specialists. Under the plan, 55% of the residency training positions in 1998 will be in primary care.
- The act creates an alliance funding pool of $200 million per year for graduate nursing education to expand the supply of advanced practice nurses, on whom many rural communities depend: nurse practitioners, nurse midwives, nurse anesthetists, and other advanced practice nurses.
- To further expand the range of primary care providers, the act also proposes that current federal appropriations for the education of advanced practice nurses and physician assistants be more than doubled.
- The act greatly expands the range of sites for medical training, making it possible to expose more medical students to rural practice. Residencies will include rural sites such as rural hospitals, rural clinics and other community settings.
- The National Health Service Corps, which provides scholarship and loan repayment assistance in return for service in an underserved area, will be dramatically expanded from its 960 rural placements today to some 4,000 rural placements by 2004.

Q. Can I buy extra insurance if I want to?

A. Of course. You will always be free to purchase any *additional* insurance you want and insurance companies will not be allowed to drop you or deny you coverage.

Q. I have heard there will be Medicare cuts to pay for reform. Wouldn't that force our rural hospitals, which depend heavily on Medicare payments, to close?

A. These are not cuts to what Medicare pays out for service. They are projected reductions in the growth of Medicare spending -- savings from the greater efficiencies that will come from reducing everyone's cost of service. It is with this savings that we propose to expand services. Currently, Medicare expenditures are growing at 3 times the rate of general inflation, and reform would merely reduce that to 2 times general inflation. For rural hospitals, keep in mind that under reform, they will no longer be providing health care to large numbers of people who cannot pay. Everyone, including the poor, will have health care coverage. In addition, a non-profit hospital that continues to provide community services like educational programs, screenings or immunizations, will still be able to retain its tax exempt status under the plan. Finally, many rural hospitals will become sites for training physicians, which will create a new source of funding.

Keep in mind, also, that rural communities have a significantly higher proportion of Medicare patients and a significantly high proportion of uninsured. Gains to providers whose patients will now be insured, will more than offset any slowing in the growth of Medicare.

Q. Is the plan flexible enough for migrant workers? How will they be covered?

A. In addition to the added funding available for the migrant health centers situated along the migrant 'stream,' the health care choices of migrants will be improved in several ways. Those who are American citizens or legal residents will receive a health security card and they will be members of a home alliance. Funding transfers between alliances will permit them to use their cards for emergency services elsewhere. They can also receive routine care outside their alliance area through the point-of-service option, but higher co-payments would apply to those in HMOs and PPOs.

Q. Will Native Americans get subsidies if they use IHS facilities? Also, the Indian Health Service is a big provider in our area. Will it be off-limits to others?

A. The President's plan fosters greater cooperation between IHS and other providers in its operating regions. The IHS may serve non-Indians in its area on a contract basis. Native Americans will receive care free of charge at IHS or tribal facilities.

Q. I'm retired and on a fixed income. Will my Medicare coverage be affected?

A. No. Older Americans who receive Medicare will continue to receive all the benefits they d today. In addition, the Medicare program wil be strengthened by adding prescription drug coverage and new community-based long-tern care benefits.

Q. I'm not 65 yet, but I will be soon. Can I st with my alliance or do I have to transfer to Medicare?

A. You have a choice. If you are happy with your plan, you may remain a member of yot alliance. You may wish to stay with your lc alliance in order to choose among different health plans. You may find over time that your alliance can provide fuller benefit packages and lower payments.

Q. *I employ lots of part-time workers. Will I be required to pay for all of their health care?*

A. No. Businesses will be required only to pay a prorated share of the employer portion of the health care premium for part-time workers. Businesses will be required to pay nothing for the health care of part-time workers who are full-time students and who are under the age of 23.

Q. *Doesn't this plan eliminate the tax benefits I have today?*

A. No. Health care premium payments for basic benefits will continue to be tax-deductible for employers and will not be included in your employees' taxable income. If you offer your employees more generous benefits than in the nationally guaranteed benefit package, your premium contributions for those extra benefits will continue to be tax-deductible for 10 years, as long as that plan was in force at the beginning of 1993.

Q. *The plan relies on HMOs, but we don't have any HMOs and never will.*

A. The reform offers Americans choices of different types of insurance -- all providing the comprehensive benefit package. A traditional fee-for-service plan will be available to everyone, whether or not there is an HMO. The plan also will foster development of managed care plans, especially in rural areas, so that Americans will have a choice.

Q. *What if I want to see a specialist who is not part of my health plan network?*

A. The point-of-service option in the Health Security Act means you would be able to do so and still be reimbursed. You would be reimbursed for that amount which your plan had agreed to pay its own providers. You would pay any amount above that, yourself.

Q. *I have worked hard to provide health care coverage for myself and my family. Why should I be involved in insuring people who have not taken responsibility for their health?*

A. We share your view that everyone should take responsibility. Unfortunately, some do not. Under the Clinton Plan, everyone will share in the costs. Everyone will be involved in preventive health care by being linked with a provider. Today without reform, you still pay for the cost of the uninsured and you pay more -- for neglected health problems that reach the hospital emergency room. It's estimated that ten percent of your premium dollar goes to cover uncompensated care and a significant portion of your taxes, both federal and state, is used to provide 'charity' care.

Q. *I have a group insurance policy through my employer. Will that change?*

A. Probably not. The health plans we have today, including yours, are likely to continue under reform, as long as they meet high quality standards and offer the comprehensive benefits package. You will also probably have a choices of other health plans.

Q. *Will our premiums and co-payments go up?*

A. Probably not. Reform will get premiums and copayments *which have been skyrocketing for years* under control. After reform, premiums will vary from plan to plan and state to state as they do today. Even in the most costly plans, no individual will pay a basic deductible of more than $200 per year. Family deductibles will be capped at $400 per year. Also, employers may continue to pay 100% of the premium if they choose, but no employer can ask an employee to pay more than 20% of the cost of the average premium.

A. Over time, the plan works to narrow the impact of spending differences between geographic areas. It is important to realize that in rural areas, like the rest of the country, health care costs are increasing much more rapidly than people's wages. The purpose of the budget targets is to bring the rate of increase of health care expenditures down to the rate of increase in the general economy. When that happens, we can have money available for education, roads, vacations, and other things we need or want.

Q. ***Isn't it going to be complicated and expensive to administer health coverage through all these alliances?***

A. No more complicated than what your average corporate personnel office accomplishes for its employees when it evaluates and contracts with health care plans. There will be a savings of $35-$40 billion, alone, by consolidating the small insurance market. For economies of scale, it's hard to improve on Medicare, a program with an administrative overhead of only one percent. Of course, a single-payer system, in which the federal government was the insurer, would be the simplest. But the American people want the kind of flexibility and choice that's available through a de-centralized, private-sector health care system.

Q. ***Why can't we just require every American to buy health insurance and forget about all these alliances?***

A. Individual mandates would not create affordability. Insurance companies would still be able to gerrymander plans and rates to insure themselves, not Americans, against loss. By offering membership and large-group purchasing power to everyone, the alliances will make health care coverage affordable.

Q. ***How will these alliances be formed and who will they answer to?***

A. The regional alliances and their geographic boundaries will be established by the states. As entities of the state, alliances will report to the states. In each state, the health alliances will be run by boards comprised of employers and consumers.

Q. ***I am a business person in a moderately large company that has worked hard to provide outstanding health care coverage, including a wellness program. It seems like the President's plan is going to penalize us for making life better for our employees. Won't our premiums go up under community rating?***

A. Most businesses, including small businesses, provide health insurance. Fortunately, health care reform creates a stronger market for prevention, with national incentives for more companies and individuals to do what you have done put the emphasis on the preventive dollar. Remember that right now, when health care costs go up for others in society, they do not, over the long run, go down for your company.

Q. ***Won't health care reform drive thousands of small companies out of business?***

A. No. Most small businesses that provide insurance today will enjoy significant cost decreases. Businesses without insurance today will enjoy affordable health insurance for the first time ever. Remember, the Health Security Act was designed specifically to protect small businesses. No business will pay more than 7.9 percent of their payroll for health care. Most will actually pay less. Right now, most businesses who offer health benefits find that their premium obligations consume a much higher percentage of payroll costs.

Questions and Answers

Q. ***Doesn't the Clinton plan add more layers of government bureaucracy to health care?***

A. No. The President specifically rejected a government-run health care system in favor of our current, private-sector care. The Health Security plan merely levels the playing field by including *all* Americans in the health care system and setting standards of accessibility. The plan actually *simplifies* administration, introduces economies of scale, and *increases* consumer influence in the marketplace.

Q. ***When would the Health Security Act be in place?***

A. Under the plan, some states may be ready to provide health security to their citizens in 1995. More states will join in 1996, and by the end of 1997, everyone must be guaranteed a comprehensive package of benefits that can't be taken away.

Q. ***How can I be sure the new system will really control costs?***

A. A tough market approach to controlling costs is a cornerstone of the Health Security Act. In the last five years, health care costs for employers have risen almost 15 percent every year. Small business costs have risen even faster. Universal coverage will, first, reduce the cost of uncompensated care -- which we all pay for through taxes, higher prices, and runaway illnesses. Streamlining administration, making everyone responsible for premiums, and increasing consumer awareness will all reduce costs. As a backstop to containing costs, premium increases in the whole system (including Medicare and Medicaid) will also be limited.

Q. ***I live in a very rural state and our problems are very different from many other states. We don't want a one-size-fits-all plan for health care.***

A. President Clinton was a state governor, and his plan for health care reform takes much of its inspiration from reforms already initiated in many states. The President's plan is really a national 'framework' that leaves room for states to adopt health reform arrangements of choice, including single payer, managed competition, and other arrangements as long as they meet federal standards for universal coverage and access, comprehensive benefits, quality of service, and cost containment.

Q. ***Our state has very few people. Is it possible under the plan to have just one alliance?***

A. Yes. Actually, the plan allows any state to create a single-payer plan, if that is their desire. It must, of course, still meet the same national standards for universal access, quality of care and basic coverage.

Q. ***Some people live in one state and get their medical care in another state. Can alliances cross state borders?***

A. Alliances remain within state borders, but health plans can cross state lines. This is an important consideration for sparsely-populate states, such as North Dakota and South Dakota, where markets may cross state lines.

Q. ***I understand there will be budget targets for every state. Won't this hurt rural areas, because the formula is based on current expenditures which are already low?***

Provisions that Preserve and Develop Rural Services

Protection for Essential Community Providers

The Health Security Act assures a smooth transition under health care reform for physicians and other health professionals in underserved rural areas. To ensure that they can continue in their essential role, the Act:

- Enables health professionals in private practice to apply for protection as *essential community providers*.
- Mandates that area health plans contract with essential community providers and that they provide adequate compensation. After five years, the law provides for further consideration of this provision by the Secretary and by Congress.
- **Certain providers** are automatically designated: Community and Migrant Health Centers, Medicare-designated Rural Health Clinics and Federally-Qualified Health Centers, Indian Health Service facilities including tribal units and Section 638 contractors, and any other federal grantees serving special populations.
- In addition, other providers such as public hospitals, Medicare-designated Sole Community Hospitals, and local health departments may apply to the Secretary of Health and Human Services for essential community provider designation.
- **The Indian Health Services** is extended and its benefits package is broadened. Native Americans may also choose to be covered by a health plan offered through a regional alliance -- giving them a choice for the first time.
- **Community and Migrant Health Centers** are provided $100 million per year in additional funding through the year 2000.

School-based Services for At-Risk Adolescents

The Health Security Act supports school-based health care services in hard-pressed rural communities. A program of grants totalling more than $1.5 billion through the year 2000 would be available for rural and other medically underserved communities wanting to develop school-based services for their youth.

Rural Links to Academic Health Centers

Through a new grant program, the Health Security Act links rural communities with state-of-the-art medical centers -- medical schools grouped with teaching hospitals and affiliated health professions schools. Grants are available for academic health centers to extend services to rural residents and to health plans in rural areas.

Community-based Plans and Networks

The Health Security Act proposes $2.7 billion in expenditures through the year 2000 for a program of flexible grants, contracts and loans for the development of community practice networks and health plans in medically underserved areas. These would be funds made available by the Secretary of Health and Human Services to communities to form provider networks and community-based health plans.

A qualified community practice network would be a consortium of providers that would include two or more providers from a wide range of entities, such as private practitioners, migrant and community health centers, rural health clinics, and state or local public health agencies.

Grant funds could be used to plan the networks or health plans, recruit and compensate health and administrative staff, or expand facilities, or develop information systems.

For many rural residents, access to care also requires transportation, translation and other *enabling services*. The community-based networks and plans would qualify to receive funding to provide such assistance.

Telecommunications

Telemedicine has extraordinary potential to reduce isolation for rural practitioners and expand services. The Health Security Act makes grants available for telecommunications systems that link providers in underserved areas with each other and with regional health care institutions and academic health centers.

Clearing Obstacles

- The Health Security Act clarifies antitrust laws to support the creation of local health care networks.

- Many rural communities without a doctor receive their primary care from nurse practitioners and physician assistants. The act responds to this trend with model practice statutes that encourage the expanded role of mid-level providers and the removal of inappropriate state barriers to their use.

- The Clinton plan reforms the Clinical Laboratory Improvement Act, which overwhelms small rural laboratories with unnecessary regulatory burdens.

LINCOLN CENTER

Lincoln Center-- run by the County Department on Aging (offices are in Lincoln center -- a multipurpose senior center) small rural county 8,000 over 60 in county (60,000 total)

In 1989, award from the National Administration on Aging for being one of 10 best aging programs in the state

services:

transportation,
legal services
meals
foster grandparent
adult day care
RSVP

about 2000 participate in services

probably serve about 60-70 percent of the elderly population in the county in one service or another

senior center operates as adult education center as well -- at any one time 60 classes going on in a semester -- indoor sketching, antiques , art, crocheting , quilting, "Meeting with your elected officials", professors come over and do current issues sessions, creative writing , language classes

Friday -- no classes

group of 12-18 seniors to talk about health care issues -- some 55 - 65

Health reform hearing there --

The Portage County Department On Aging is an "Information Place." We can provide information on many services and activities that are available to help people age 60 and over maintain their independence and quality of life.

Our Information and Assistance Worker will meet with you personally to explain Department On Aging services and programs that may meet your specific needs. If the help that you need is not available here, we will refer you to other agencies in the community that will be able to help you. If you want more than just printed information about services from other agencies, we will provide you with personal and individual assistance to obtain what you need.

Here are some of the concerns and needs that the Information and Assistance Worker is prepared to discuss with you:

- ***Nutrition***
- ***Health care concerns***
- ***Housing options***
- ***Nursing homes, group homes, and adult foster care***
- ***Transportation assistance***
- ***Home chore service needs***
- ***Personal care needs***
- ***Elder abuse***
- ***Financial needs***
- ***Consumer problems***
- ***Problems with Medicare, supplemental insurance, Social Security, Supplemental Security Income, Medical Assistance and other public benefits***
- ***Adult day care/respite services for caregivers***
- ***Mental health needs such as coping with grief, depression and isolation***
- ***Information for families concerned about elderly relatives***
- ***Volunteer opportunities***
- ***Educational opportunities***
- ***Craft outlet***

If you aren't sure that your need or concern is included in this list, arrange for a visit with the Information and Assistance Worker anyway. If we don't have the answers you need, we'll put you in touch with someone who does.

Portage County
Department On Aging
Lincoln Center
1519 Water Street
Stevens Point, WI 54481
(715) 346-1401

Portage County Department On Aging

LINCOLN CENTER
1519 WATER STREET
STEVENS POINT
WISCONSIN 54481
(715) 346-1401
FAX (715) 346-1486

TO LIZ BOWYER

FROM PAT STADE

DATE 2-17-94

OF PAGES INCLUDING THIS SHEET 17

WHAT IS THE DEPARTMENT ON AGING?

The Portage County Department On Aging is a central resource agency which addresses the needs and interests of adults 60 years and over. A wide range of services is provided to assist people to live independent, dignified and secure lives.

Whether the Department On Aging has the services available or a staff person provides assistance in contacting other local service agencies people will receive reliable information to help them in making decisions.

The nine-member Commission On Aging is appointed by the County Board of Supervisors and is responsible for Department governance. Program advisory councils assure that services are targeted to the expressed needs of the retired population.

Funding for services is provided through grants and allocations from federal, state and county governments, the United Way, underwriting by local businesses, private contributions, and participant fees and donations.

WHERE IS THE DEPARTMENT ON AGING?

Offices of the Department On Aging are located three blocks south of the Clark Street bridge at the

Lincoln Center
1519 Water Street
Stevens Point, Wisconsin 54481
Telephone (715) 346-1401

HOW DO I S' 'AR' ?

People interested in receiving information or in participating in any program may:

CALL the Department On Aging at (715) 346-1401 and tell the receptionist you want to talk to someone about a program, a service or a concern. The receptionist will connect you with the appropriate staff person.

Just **WALK IN.** Someone is always available to show you around and tell you about our programs. Have a cup of coffee and relax in our comfortable lounge with the large-screen TV, library collection, and bulletin-board with announcements of current activities.

ASK FOR THE INFORMATION AND ASSISTANCE WORKER to visit your home to help match services with your needs.

If you live outside of Stevens Point, **VISIT THE NEAREST MEAL SITE** and ask the Site Manager for information.

ASK TO BE PUT ON THE POST MAILING LIST. Our quarterly newsletter is full of information about everything from Medicare benefits to bus routes to new class offerings.

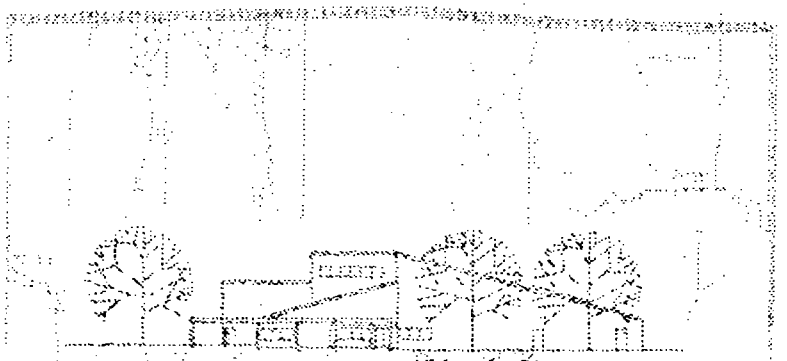
VOLUNTEER your services—people are always needed to teach classes, deliver meals, stuff envelopes, provide rides to medical appointments or perform other services. Just ask how you can help. The work of the Department On Aging is accomplished by an effective combination of trained staff and volunteers.

Please open up for a listing of Department On Aging services.

- Lincoln Center is available as a meeting place for senior groups and public and private non-profit organizations.
- Department On Aging staff and volunteers make presentations to church, school and civic organizations by request.

For additional information on Department On Aging services call (715) 346-1401 Monday through Friday, 7:30 A.M. to 4:30 P.M.

Portage County provides employment and services to any eligible person without regard to age, race, religion, sex, national origin, sexual orientation, handicap, color, marital status, physical condition, developmental disability or ability to pay.



Lincoln Center
1519 Water Street
Stevens Point, WI 54481
(715) 346-1401

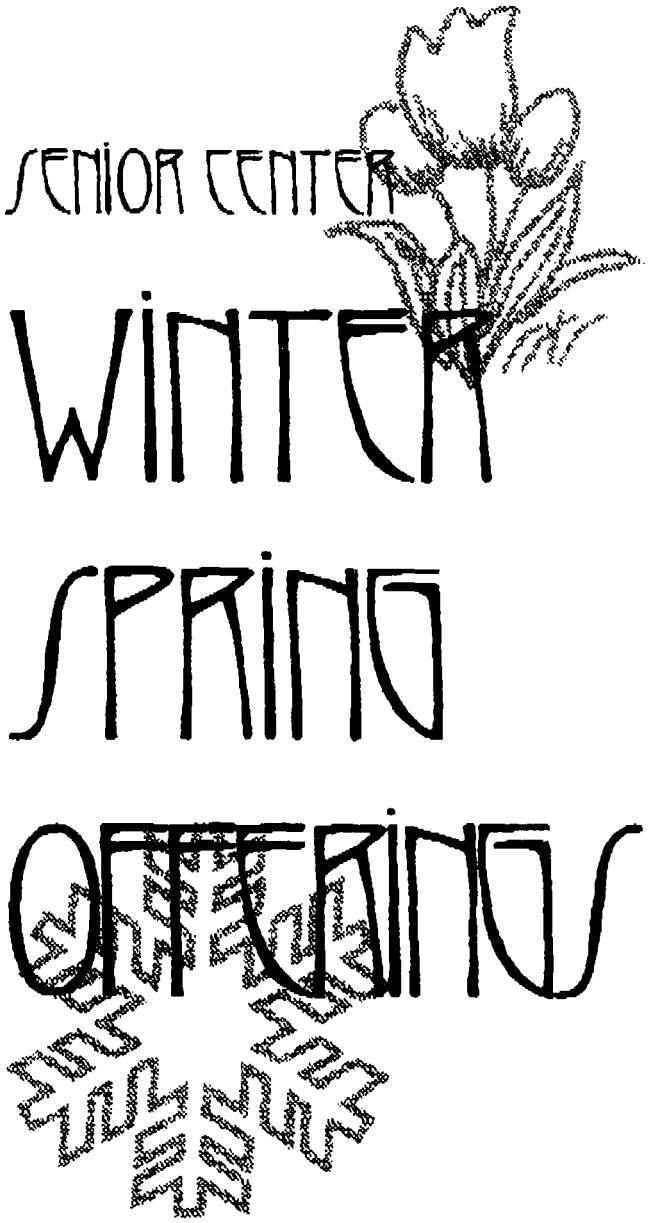
Portage County Department On Aging

I hope that when your daughters are CEOs of major companies that they will invite me to come and visit them.

The seven women we honor tonight have [with their election to the Board of Directors of their Companies] shattered the glass ceiling in Corporate America. And it is up to all of us to remove all the shards and pieces of glass that remain.

SENIOR CENTER

WINTER SPRING OFFERINGS



Registration

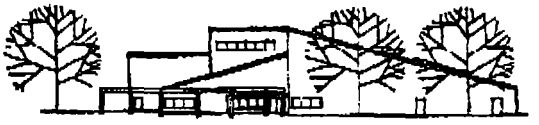
Registration for Winter/ Spring classes will be held at Lincoln Center on Tuesday and Wednesday, January 11 and 12, 1994, from 9:00 A.M. to noon.

Please Note: Even those who have participated before in these classes must register again for the new semester.

Free refreshments during registration and drawings for these prizes:

- **Two free tickets for the Cabin Fever Party**
- **Two free tickets for the Spring Dinner Dance**
- **Two free tickets for the Sizzling Summer Party**
- **$10 off on future class fees**

Portage County
Department On Aging
Lincoln Center
1519 Water Street
Stevens Point, Wisconsin 54481
(715) 346-1401



The mission of the Department On Aging is to assure that Portage County is a good place in which to grow old.

This catalogue lists the 1994 classes and activities schedule for January through May. Inevitably there are some changes in scheduling or cancellations or additions which cannot be anticipated; read the "Senior Spotlight" column in the Stevens Point Journal each Saturday for updates and further information about classes or activities.

surmount. There is no glass ceiling strong enough to keep us down.

The women that we celebrate tonight defy the edicts of the past. They show that nothing is impossible. And these women show the promise of the future. By working hard to ensure that the future of this country [and for women in it] is bright and strong. And by providing wonderful role models for young [Hispanic-American] women.

Crocheting

Tuesdays, Jan. 18-Feb. 15, 9:30-11:30 A.M.

Create some beautiful crocheted pieces under the direction of Rose Cobb of MSTC. Cost is $8.50 for people age 62 and over or $22.45 for those under 62. Class location is Lincoln Center.

Origami Workshop

Wednesday, Mar. 16, 1-3 P.M.

Learn the oriental art of paper-folding in this one-day workshop taught by Mary Ellen Bemowski. Cost is $1.

Wood Carving

Wednesdays, Feb. 16-Apr.13, 9-11:30 A.M.

Bill Maronek will teach students to carve a bird or small animal in wood. Cost is $20.

Sweatshirt Jacket

Tuesdays, Feb. 1 & 15, 1-4 P.M.

Make a jacket from a sweatshirt during this two week workshop under the direction of Dee Christensen (participants will need to have some sewing skills). Cost: $4. Class size is limited.

Porcelain Dolls

Thursdays, Jan. 27-Feb. 24, 1-3 P.M.

The first class will meet at Lincoln Center on Jan. 27, and the next four will meet at the home of instructor Shirley Fox (transportation will be provided). Cost depends upon which doll is made, ranging from $24 to $40. Class size is limited.

Oil Painting

Thursdays, Jan. 27-Mar. 17, 1-3:30 P.M.

Get out some brushes and learn the art of painting with oils with Suzanne Mahr of MSTC. Cost: $11.50 for people age 62 and over or $29 for those under 62. Class location is Lincoln Center.

Mixed Media Art

Tuesdays, Jan. 18-May 24, 9:30-11:30 A.M.

Like to dabble in any visual art medium? Bring in projects and work in a friendly group setting with other artists. Toni Carlstrom and Mary Ellen Bemowski are the coordinators. No cost, but bring your own supplies.

Beginning Sewing

Fridays, Jan. 21-May 27, 12:30-2:30 P.M.

This class is designed for elder Hmong women and is taught by Marian Welke. An interpreter is available (funded by the Plover Kiwanis Club). Cost is $1.00.

Intermediate Sewing

Thursdays, Jan. 20-May 26, 9-11:30 A.M.

Bring in current sewing projects and work with others. Marian Welke will be there to answer questions. Cost is $1.

Weaving

Marian Welke teaches weaving by appointment. Cost is $1. Interested students should call her at 344-3213.

Quilting: New Sampler

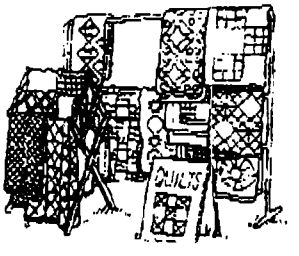
Wednesdays, Jan. 26-Feb. 16, 9-11 A.M.

Rose Cobb of MSTC will teach how to quilt this new design in this four-week course. Cost: $3.50 for people age 62 and over or $16.60 for those under 62. Class location is Lincoln Center.

Quilting: Kaleidoscope

Wednesdays, Mar. 23-Apr. 13, 9-11 A.M.

Make a colorful quilt with the kaleidoscope design with Rose Cobb of MSTC. Cost is $3.50 for people 62 and over or $16.60 for those under62. Class location is Lincoln Center.



Stitch N' Chat

Mondays, Jan. 17-May 23, 9-11:30 A.M.

Join Virginia Stark's group for conversation and countless stitching ideas. Bring in projects to work on in this friendly atmosphere. No cost.

twofold. It is hard enough to be the token woman in a firm, but to be the token Hispanic as well is extraordinarily difficult.

Discrimination-- be it on the grounds of sex, ethnicity or race-- has no place in a country such as our own. And we must continue our fight to break down barriers. But what the seven award recipients and all the women here tonight have shown is that there are no obstacles that we cannot

Let's Learn

FRIDAY MORNINGS

Set aside Friday mornings for coffee and stimulating lectures, discussions and tours.

January

January 21
Stan Gruszynski, 71st District Assemblyman: legislative issues.
January 28
Joe Ervine, director of the Salvation Army's Hope Center.

February

February 4
Richard Feldman, Professor of Philosophy, UWSP: human rights.
February 11
Dennis Eisenrath, Professor of Psychology, UWSP: healthy living/positive thinking.
February 18
Karl Pnazek, Director of CAP Services: how our community deals with homelessness and housing needs.
February 25
Al Haney, Professor of Natural Resources, UWSP: re-tracing the fur traders from Superior to Hudson Bay.

March

March 4
Janet Meyer, Education Director of Mid-State Epilepsy Association: understanding epilepsy.
March 11
ELDER LAW SERIES: Attorney Mark Ilten on wills and probate.
March 18
To be announced.
March 25
Mayor Scott Schultz: update on local issues affecting our community.

April - May

April 8
ELDER LAW SERIES: Office of the Commissioner of Insurance, Madison: avoiding scams and investment fraud.
April 15
Marv Lang and Don Showalter, Professors of Chemistry, UWSP: exciting, entertaining chemistry demonstration.
April 22
Dwight Stevens, former Superintendent of Schools: relaxation techniques with Tai Chi.
April 29
Tour of the UWSP Learning Resources Center with Ruth Steffan.
May 6
Culmination of the Friday series with the Senior Symposium--watch for more details.

Final Details

Thursday, Apr. 28, 2:30-5:30 P.M.

This MSTC presentation will provide an important guide for survivors when death occurs. Class location is Lincoln Center. Cost: $3.50 for people 62 and over or $7.80 for under 62.

Assertiveness Training

Thursdays, Feb. 24-Mar. 24, 2:30-4:30 P.M.

Learn effective communication skills, and when and how to say "no" in this MSTC course. Class location is Lincoln Center. Cost is $3.50 for people 62 and over or $14.45 for under 62.

It's Music to Our Ears

Tuesdays, Feb. 22, Mar. 22, Apr. 26, 3 P.M.

Excerpts from and discussion about opera will continue to be the focus this semester, including La Boheme by Puccini and Verdi's La Traviata. The group will decide on a third. Betty Jenkins is the group leader.

Hooked on Books

Fridays, Jan. 21, Feb. 11, Mar. 18, Apr. 15, 11:30 A.M.

For those who love to read, Lincoln Center offers a book discussion group. The group has lunch at 11:30 and discussion follows. Mary Croft and Eva Mae [illegible] are the group leaders (reservations for lunch must be made each time; suggested donation $2.50).

women who are breaking barriers. They are seizing opportunities for themselves, and in so doing they are creating opportunities for others.

Unfortunately, all of us are familiar with sexual discrimination. The discriminatory practices that attempt to keep qualified women from rising to the top despite their education, experience, or years of service, are real barriers with pernicious effects. For Hispanic women the problems are

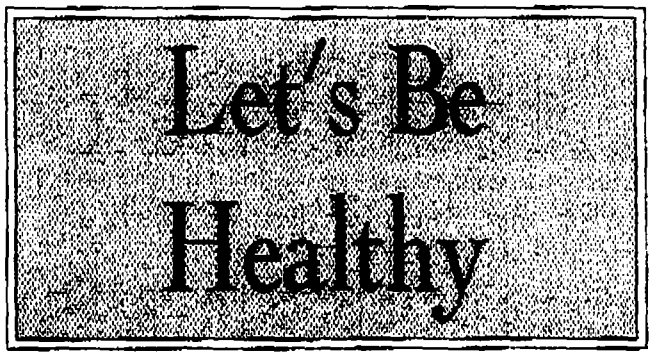
ELDER LA SERIES

This semester Lincoln Center will offer the Elder Law Series: information on legal and consumer issues of special interest to older adults.

Friday, March 11, 9:30 A.M.
Attorney Mark Ilten will discuss wills and probate.

Friday, April 8
How to avoid scams and investment fraud, Office of the Commissioner of Securities, Madison.

Friday, April 15, 1:30 P.M.
The Stevens Point Area Retired Teachers Association will present information on the Durable Power of Attorney for Health Care.



START OUT THE NEW YEAR RIGHT!

Massage Techniques

Fridays, Jan. 28-Mar. 18, 9:15-10:15 A.M.

Massage therapy can improve one's well-being by reducing stress and promoting relaxation. This MSTC class will be taught by Tom Woyte, L.M.T. Class location is Lincoln Center. Cost: $7.50 for people 62 and over or $16.25 for under 62.

Healthy Choices

Mondays, Jan. 31-Apr. 18, 2:30-3:30 P.M.

Looking for a way to maintain weight and feel better? Plan to join the Healthy Choices group for up-to-date information on a wide variety of topics that affect health, diet and everyday lifestyle. There will be information available to take home regarding moderation and dietary/eating habits. There will also be a weekly confidential weigh-in. Cost is $1 per week.

Lincoln Center Mall alkers

Weekdays, 8 A.M.

Walking is one of the best methods of keeping fit. Members walk in the CenterPoint Mall between 8 and 10 A.M. Monday through Friday. Register at the mall with coordinator Jim Dunn.

Don't miss the following special events that have been planned (all at 8 A.M.):

Tuesday, January 18
Decaffeinated coffee—which method is best: water or methylchlorine. Confused about sweeteners? Which ones are the healthiest to use? Presented by Trenace Buckner, Nutritional Sciences graduate student at UWSP.

Tuesday, January 25
A nutritional update on oils; monosaturated vs. polyunsaturated. Which ones make for healthy choices? Presented by Dena Mayer, Nutritional Sciences graduate student at UWSP.

Tuesday, February 22
Ways to a healthy back will be presented by Dick Deaver, P.T., of St. Michael's Hospital Rehab Services. Included will be the anatomy of the back, strengthening and stretching exercises, and proper body mechanics to include posture and proper lifting techniques.

Tuesdays, January 11, February 1 & 15, March 15
Blood pressure screening with Marge Lundquist.

BANK ONE.
Whatever it takes.℠

"In Your Prime"

Second Monday of the month, 1:30 P.M.

"In Your Prime" is a series on health-related topics of interest to older adults sponsored by Bank One, Stevens Point. Become a conscientious health care consumer by attending these presentations to learn more about a variety of health issues.

Hillary Rodham Clinton
Vista Magazine Corporate Achievement Awards Reception
15 February, 1994
Talking Points

Acknowledgements

It is so wonderful to be here tonight. I would like to thank VISTA Magazine for inviting me and for giving me this award.

As I look out into the audience I am extraordinarily proud of what I see. Here tonight are a group of women who are working hard and working together to make our world a more equitable place. Here are

Let's Have Fun

Mad Hatters Storytelling

The Mad Hatters is a group of people who read or dramatize stories to young children at day care centers and pre-schools. Performances will be in March, April and May, with practices beginning mid-March. Judy Weckerly is the coordinator and there is no cost. People wishing to join should pre-register.

Monthly Hmong Elders Gatherings

Fourth Friday of the month, 12 P.M.

Hmong seniors are invited to gather monthly at Lincoln Center for lunch and activities. Transportation is available, and reservations for rides and the meal should be made at least 48 hours in advance.

Country Line Dancing

Mondays, Feb. 7-Mar. 14, 4:30 P.M.

This six-week course costs $15 and will fill up fast, so be sure to register because class size is limited. Note: dancers must wear soft-soled shoes.

Folk Dancing

Second and fourth Thursdays of the month, 7:30 P.M.

Learn how to folk dance—it's fun and great exercise, too. The first hour and a half of each session is for simpler dances and instruction while the second half is for more complicated steps and experienced dancers. For more information call Marla Schultz at 341-1415.

Square Dancing

Thursdays, 1:30 P.M.

Second semester is for experienced dancers only (beginners will be welcome next fall). Dancers are asked for $2.00 per week to help with expenses. David Kumm is the caller.

Round Dancing

Tuesdays, 6:30-8:30 P.M.

Experienced dancers are welcome (new members can join next fall). David Kumm is the cuer and cost is $2.50 per week.

Smear

Tuesdays and Thursdays, 10 A.M.

Take a seat in the Lincoln Center lobby with the smear players twice a week. New players are always welcome.

Pinochle

Wednesdays, 1 P.M.

New players (experience preferred) are welcome to join the Wednesday pinochle group. Ruth Rakowski is the coordinator.

Cribbage

Wednesdays, 9-11:30 A.M.

Vi and Jack Carlson will be glad to show the basics of this popular card game.

Sheepshead

Mondays, 1 P.M.

Joe Hanzel is the coordinator and new members are welcome.

Scrabble

Tuesdays, Jan. 18-Mar. 22, 1-3 P.M.

Join this new group for playing the popular word game. Gertrude Dixon is the coordinator.

Bridge Clubs

Mondays, 1 P.M.

There are two groups which meet on Mondays: one for intermediate and one for advanced players. The coordinators will be notified of the new members who register.

Lincoln Center Meal Site Birthday Party

Second Friday of the month, 12:30 P.M.

The Lincoln Center meal site celebrates participants' birthdays on the second Friday of each month with lunch at noon followed by games. Reservations are necessary for the meal.

SUPPORT GROUPS AND OTHER SERVICES

Self-Help for the Hard of Hearing Support Group

First Friday of the month, 1 P.M.

SHHH invites older adults with hearing problems to join them for discussions, presentations, tours and problem-solving ideas. Learn about the latest research and adaptive aids. Sally Hanson is the president.

Living With Cancer Support Group

First Thursday of the month, 6:30 P.M.

This group is for cancer patients and their families or caregivers and is sponsored by the American Cancer Society. New members are always welcome. For information call Carol Koziol at 341-1553.

Alzheimer's Caregiver Support Group

Second Thursday of the month, 6:30 p.m.

Family members and/or caregivers of people with Alzheimer's disease or other dementias are invited to join. Find out what works—and doesn't work —in providing care, and share suggestions, participate in discussions and learn about the latest research. Linda Hoppenrath is the facilitator.

Visually Impaired Persons Support Group

Second Wednesday of the month, 1 P.M.

People with visual impairments are invited to join VIP for updates on visual aids, to take part in discussions and share ideas. Come for lunch and then stay for the monthly meeting. Ramona Wroblewski is the coordinator.

Arthritis Support Group

First Tuesday of the month, 1 P.M.

Learn about coping with arthritis through proper exercise and good nutrition. Members share problem-solving ideas with one another. Harry and Susan Pokorny are the group leaders.

Laryngectomy Support Group

Fourth Tuesday of the month from April to October, 7 P.M.

People who have had cancer of the larynx are welcome to join. For information call Bill Ogdon at 341-0362.

Information and Help for Caregivers

Tuesdays, Jan. 18, Mar. 15, Apr. 19, 2 P.M.

This series is designed for people who are caring for a frail older adult and is being co-sponsored by Elder Haus. Topics will include normal aging and memory loss, activities for making it through the day, and creative reality and the Alzheimer's patient. If respite is needed in order to attend, call Lincoln Center. Linda Hoppenrath, Elder Haus Director, is the coordinator.

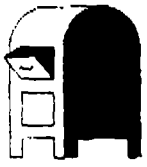
Social Security Administration Office Hours

First and third Thursdays of the month, 1-4 P.M.

A representative from the Wisconsin Rapids Social Security Administration holds office hours at Lincoln Center twice monthly. Appointments are not necessary.

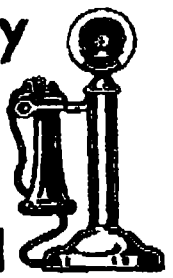
Post Office Substation

Second Tuesday of the month, 11:15 A.M.-12 P.M.



As part of its outreach effort to the community the Stevens Point Post Office sells stamps and other postal supplies at Lincoln Center once a month.

Portage County Department On Aging (715) 346-1401



IF YOU CAN'T R GISTER IN PERSON . . .

You may complete this form and send it to Lincoln Center (along with your check for any class fees where applicable). ***Remove this entire sheet so that your address label below will be included.***

Please PRINT:

Name_____

Street_____ City_____ Zip_____

Telephone_____

I wish to register for the following WINTER/SPRING OFFERINGS classes at Lincoln Center:

	Fee (if any)
_____ _____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

TOTAL $_____

Make checks payable to Lincoln Center

FOR OFFICE USE ONLY

_____Registered _____MSTC card sent (if applicable)

_____Paid: $_____

_____Supplies list sent (if applicable) Registrar_____

PORTAGE COUNTY DEPARTMENT ON AGING
LINCOLN CENTER
1519 WATER STREET
STEVENS POINT, WI 54481

Non-Profit Org.
U.S. POSTAGE
PAID
Stevens Point,
WI 54481
Permit No. 85

ADDRESS CORRECTION REQUESTED

Pool

Lincoln Center has two pool tables which can be used at any time. Or, join the pool league for tournament play beginning in January.

SPECIAL EVENTS

New Year Celebration

Friday, Jan. 7, 4:30-8 P.M.

Welcome in 1994 with an early supper followed by dancing to live music and prizes. A hat theme will be featured, so wear a hat depicting a favorite hobby or pastime. Reservations necessary for the meal; suggested donation $4.

Ponzcka Party

Friday, Feb. 11, 12:30-2:30 P.M.

Come for lunch followed by fresh-baked ponzckas and games.

Volunteer Valentine Tea

Monday, February 14, 1:30-2:45 P.M.

A style show and refreshments are planned as a thank-you to Lincoln Center volunteers (Holly Shoppe, Nutrition Program, Adult Day Care, Senior Center and office assistants).

"Cabin Fever" Party

Sunday, Mar. 20, 2-5:30 P.M.

Chase away the winter "blahs" with an afternoon of card games, music and prizes. There'll be an early dinner, too. Reservations required for the meal; suggested donation $4.

Spring Dinner Dance

Thursday, Apr. 14, 4:30-8 P.M.

Celebrate the start of a new season at the annual Spring Dinner Dance with great food, music, dancing and prizes. Reservations will be necessary for the meal; suggested donation $4.

Mother's Day Recognition

Friday, May 6, 12-1 P.M.

All moms will receive a gift and special salute at this luncheon. Please make reservations in advance for lunch.

Gay 90's Luncheon

Friday, May 20, 12-1:30 P.M.

All seniors are invited, with special recognition to Portage County residents age 90 or over. In addition to lunch there'll be music and entertainment. Reservations are needed for the meal.

COMING THIS SUMMER...

Father's Day Recognition

Friday, June 17, 12-1 P.M.

It'll be the dads' turn for a gift and salute at the Father's Day recognition luncheon. Please reserve meals in advance.

Ice Cream Social

Tuesday, Jun. 28, 12-1 P.M.

What would Summer be without a good old-fashioned ice cream social? Ice cream with strawberries will be served after lunch.

Indoor Picnic

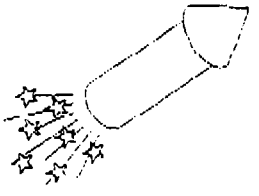
Thursday, Jul. 14, 12-1 P.M.

No ants—just great food and fun at the indoor picnic with lunch, games and prizes.

Sizzling Summer Dance

Sunday, Jul. 31, 4:30-8 P.M.

This special summertime event will be held at the Stevens Point Elks Club. Cash bar before an early supper will start the evening, and the sizzling will start when the band heats up for dancing. Reservations must be made by July 18. Cost will be $5 per person (except for cash bar) which includes the meal, refreshments and entertainment.



Bring-A-Kid-To-Lunch Day

Wednesday, Aug. 17, 12-1 P.M.

Bring a grandchild or young friend or neighbor to lunch at Lincoln Center followed by prizes and entertainment. Reservations required for lunch.

February 14
"Laser Eye Surgery", Thomas P. O'Malley, Jr., M.D., Doctor of Ophthalmology, Rice Clinic Medical Center.
Dr. O'Malley will discuss the common uses as well as the limitations of modern ophthalmic laser surgeries.

March 14
"Total Joint Replacement", John M. Kirsch, M.D., Orthopedic Surgeon, Bone and Joint Clinic of Stevens Point, a division of Rice Clinic Medical Center.
Dr. Kirsch will discuss current methods and results of total joint replacement with emphasis on total hip and knee replacement

April 11
"Exploring Laser Surgery Alternatives", Thomas Wagner, M.D., General and Vascular Surgeon, Rice Clinic Medical Center.
Learn more about the use of lasers in surgery at this program to find out about the latest surgical techniques.

May 9
"Health Secrets From the Orient", Dr. James Chang, Lotus Healing Arts.
Dr. Chang will explain the use of herbal medicines and acupuncture which have been used for over 23 centuries.

The Senior Center is one of many programs offered by the Department On Aging for older adults in the community. Information on the Department's other services may be obtained by calling 346-1401

Aerofit Exercise
Tuesdays and Thursdays, 9:15 A.M., starts Jan. 18

This exercise-to-music class is very popular and lots of fun! The exercises are slower-paced and are taught by Y.M.C.A. staff. The cost for a ten-week period (20 lessons) is $10.

Pace Exercise
Tuesdays and Thursdays, Mar. 15-Apr. 14, 10:30 A.M.

Pace exercise is designed especially for people with arthritis and will be taught by Karie Simpson, an Arthritis Foundation trained instructor. Cost for 10 lessons will be $15.

Blood Pressure Screening
Second Thursday of the month, 10 A.M.-12 P.M.

Registered nurses will check blood pressure and provide up-to-date information on control. Cost is $1 and reservations are not required. This service is coordinated by Anne Klesmith, R.N.

Health Concerns
Tuesdays, 10 A.M.-Noon

Older adults with problems or concerns about how many, how much, or why they're taking prescription medications; whether medications should be taken with or without food; or if there are other health questions of concern, Fern Johnson, R.N., can help. She'll be happy to look up information and write it down in a free booklet which people may keep and use when visiting a physician. Local doctors and pharmacists recommend use of this service—drop in or make an appointment.

Health Programs "On the Road"

RSVP volunteer nurses will conduct blood pressure screening at the Nutrition Program meal sites as follows:
Junction City Thursdays, Feb. 3, Apr. 7, Jun. 2, 11 A.M.-1 P.M.
Plover Tuesdays, Jan. 4, Feb. 1, Mar. 1, Apr. 5, May 3, 11 A.M.-noon.
Almond Tuesdays, Jan. 11, Mar. 8, May 10, 11 A.M.-1 P.M.
Amherst Wednesdays, Jan. 26, Mar. 23, May 25, 11 A.M.-1 P.M.
Bancroft Wednesdays, Feb. 9, Apr. 13, Jun. 8, 10:30 A.M.-1 P.M.
Rosholt Wednesdays, Feb. 23, Apr. 27, Jun. 22, 11 A.M.-1 P.M.

Our Fellow Immigrants Series

Tuesday, Mar. 1, 3 P.M.

The focus will be on France, so take this opportunity to learn more about our neighbors—their history, culture, music, dress and cuisine. Please be sure to pre-register.

Tuesday, Apr. 5, 5:30 P.M.

The Festival With a Foreign Flavor offers an evening of culinary delight combined with music and entertainment. Please bring a dish to pass around and remember to pre-register.

Creative Writing

Fridays, Mar. 4-May 6, 1 P.M.

Class will include a variety of writing activities, collaborative work, discussion, and individual assistance. No previous writing experience is necessary and class is limited to 15 people. Betsy Wise is the instructor. Cost is $2.50.

Conversational Polish

Wednesdays, 1 P.M., starts Jan. 19

Participants will need a basic grasp of Polish to join this group to practice skills. Julia Szczepanski is the group leader.

Beginning Spanish

Mondays, 12:30 P.M., starts Jan. 17

New students are welcome to join this class for second semester with instruction by Sister Juliana Stencel.

Advanced Spanish

Thursdays, 12:30 P.M., starts Jan. 20

This class is for students who have prior knowledge of Spanish and wish to learn more about the language and culture of Spanish-speaking people. Sister Juliana Stencel is the instructor.

Durable Power of Attorney for Health Care

Friday, Apr. 15, 1:30 P.M.

The Durable Power of Attorney for Health Care is a tool which can help people plan for making difficult decisions about life-extending health care. Find out more at this workshop funded and presented by the Stevens Point Area Retired Teachers Association. An informational packet will be available which includes directions and the necessary form.

HomeService by SPARTA Volunteers: For people who are unable to leave their home, a volunteer will visit to explain the Durable Power of Attorney procedures. To request this service call 346-1401—a volunteer will call to arrange an appointment.

Planning for Retirement

Mondays, Mar. 7-28, 6:30-9 P.M.

Retirement brings with it a lot of questions and concerns including housing, income and community services. Get some basics in this course offered by MSTC. Cost: $5 for people age 62 and over or $15.95 for under 62.

Alone and Okay

Thursdays, Feb. 3-17, 2:30 P.M.

Living alone can sometimes be difficult, but is possible without loneliness. Learn how to cope with everyday situations or problems in this class offered by MSTC. Cost is $3.50 for people 62 and over or $10.10 for those under 62.

55 Alive

Monday and Tuesday, Mar. 28 & 29, 9:30 A.M.-2:30 P.M.

The Department On Aging and the American Association of Retired Persons will again offer "55 Alive", a refresher course designed for older drivers. Participants must attend both sessions on March 28 and 29. Cost is $8.

Financial Help Available for Seniors to Attend MSTC

Mid-State Technical College is accepting applications from people age 55 and over who wish to attend MSTC classes to gain the necessary training and skills for employment. The Job Training Partnership Act has funds which can cover the costs of tuition, books or transportation. To apply, call 344-3063 and ask for an appointment with JTPA Specialist Sarah Dunham.

Flower Arranging

Mondays, Mar. 7 & 14, 1-4 P.M.

Create an Easter or Spring centerpiece in this class taught by Verona Herek. First class is "how-to" and the second is putting the arrangement together. Bring a basket or vase and silk or dried flowers. Cost is $2 and class size is limited.

Ceramics

Mondays, Jan. 17-May 23,
8:30 A.M.-12 P.M.

Verona Herek will teach the art of ceramics. Class size is limited and cost is $5 (excluding greenware).

Quilt Club

Fridays, Jan. 21-May 27, 9 A.M.-12 P.M.

The Quilt Club is a service group which ties and finishes quilts. People can join and help or bring in quilts to be tied at a reasonable price. No class fee.

RSVP Silver Threads Sewing Group

Second and fourth Tuesday of the month, 1 P.M.

This RSVP group puts its sewing talents to work for the entire community. In the past year they've made costumes for the community theatre, Peter Rabbit for a school library, play smocks for Head Start, and Reach for Recovery bags for St. Michael's Hospital. They've also made dozens of teddy bears and donated them to local agencies that work with children. People interested in joining the group should contact the RSVP office at Lincoln Center.

Lincoln Center Gallery

When visiting Lincoln Center be sure to take some time to see our monthly exhibition of works by local artists.

January
Acrylics and pastels by Sherry Varga

February
Pastels and portraits by Jody Leigh Frie

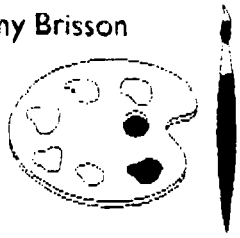
March
Paintings by Mary Ellen Bemowski and Paula Malik

April
Photographs by Julie Krueger and Sister Rosella Reinwand

May
Lincoln Center mixed media class show

June
Drawings and cartoons by Jeremy Brisson

July
Oil paintings by Melanie Zietlow



Are you new to the community or to Lincoln Center?

Judy Lokken, Senior Center Director, would like to meet you and give you a tour and introduction to the center.

Please call 346-1401 and tell the receptionist you're new here and you wish to speak with Judy.

WINTER/SPRING OFFERINGS is published by the Portage County Department On Aging, Lincoln Center, 1519 Water Street, Stevens Point, WI 54481. Telephone (715) 346-1401.

Let's Create

NEW....NEW....NEW

Indoor Sketching
Mondays, Wednesdays and Fridays,
Jan. 24-Feb. 4, 9:30-11:30 A.M.

This is an intense mini-course for those wishing to learn to sketch using line and tone for still-lifes, portraits and indoor settings, amongst other projects. George Gard is the instructor and cost is $8 (which includes materials). Class size is limited.

Rosemaling
Tuesdays, Feb. 8-Mar. 15, 1-3:30 P.M.

Learn the art of rosemaling with Suzanne Mahr of Mid-State Technical College. Cost: $11.50 people 62 and over or $29 under 62. Class will be held at Lincoln Center.

Antique I.D. and Evaluation
Fridays, Feb. 18 & May 13,
10:30 A.M.-12 P.M.

Bring in an antique for identification and evaluation by Jay Price. Cost is $1.

Crayon Art
Tuesday, Feb. 22, 9:30-11 A.M.

Learn to decorate stationery and notecards using crayons and heat to make individual pieces of art. John Tuchel is the instructor and cost is $2.

Scandinavian Birch Bark Boxes
Tuesday, Mar. 1, 9:30-11:45 A.M.

Students will learn how to make a complete birch bark box in one lesson under the direction of Dick Schneider. Cost is $3 and class size is limited.

Creative Memories
Tuesdays, Jan. 25 & Feb 1, 9:30-11:30 A.M.

Looking for a creative way to organize photographs, greeting cards or other memorabilia? Misty Winkelman, Creative Memories consultant, will show how to make an heirloom album page. This two-week course costs $10 (which includes all materials) and class size is limited.

Negligee/Swimsuit Sewing
Wednesdays, Feb 23-Mar. 16, 9-11 A.M.

Learn to make a lovely piece of lingerie or a swimsuit for summer with Rose Cobb of MSTC. Cost is $3.50 for people 62 and over or $16.60 for under 62. Class location is Lincoln Center.

WHERE APPLICABLE, STUDENTS WILL GET A LIST OF REQUIRED SUPPLIES FOR CRAFT CLASSES WHEN THEY REGISTER.

RETURNING FAVORITES

Basket Making
Wednesday, Mar. 2, 12:30-4 P.M.

Make a bow basket for Easter with instruction by Karin Charland. At the end of class the basket will be complete. Cost is $2 and all materials will be supplied. Class size is limited.

Punjabe Chairs
Wednesdays, Apr. 20 & 27, 1-3 P.M.

Renew those old lawnchairs by weaving a new back and seat in this class taught by Thelma Harp. Cost is $5 and class size is limited.

Knitting
Tuesdays, Feb. 22-Mar. 22,
9:30-11:30 A.M.

Bev Chesbrough of MSTC will teach this class for beginning and intermediate knitters. Cost is $8.50 for people 62 and over or $22.45 for those under 62. Class location is Lincoln Center.

Obey hears health care concerns

Testimony focuses on insurance costs, need for long-term care

By BRENDA MAURER
of the Journal

Edith Hoffman is probably just one of many Americans who doesn't visit the doctor on a regular basis.

She's a healthy woman and last had a complete physical four years ago. Hoffman, 58, does go to the doctor if she's sick, but getting a checkup is just too expensive.

"The companies raise the premiums out of sight and you can't afford them," she said. "We live in fear of getting sick."

Hoffman was just one of more than 20 people who testified at a public hearing on health care Thursday at the Lincoln Center.

More than 200 people listened to comments at the hearing held by U.S. Rep. Dave Obey, D-Wausau. The two and a half hour hearing was just one of 14 town meetings Obey held this week across central Wisconsin.

Hoffman and her husband live in Amherst and paid $11,300 last year for the basic cost of health insurance. That amount didn't include dental or eye care.

"In the last four years, the premiums have increased over 25 percent per year," she said.

She does have one pre-existing condition, an enlarged heart that she's had since fifth grade when she had rheumatic fever. She knows her abilities and monitors her physical exertion.

She's employed and is covered through a state insurance pool, the Wisconsin Health Insurance Risk Sharing Plan, a plan for those who are turned down by private insurance companies. But those high premiums prevent her from visiting the doctor unless she needs to.

"We are caught between a rock and a hard place," she said. "Health insurance costs are eating up our savings and yet we must pay or face bankruptcy costs, should we have serious problems. It almost seems like legal extortion."

At the hearing, many testified about what they would like to see changed or retained in a national health plan.

"We're talking about how to deal with problems that face people in real life," Obey said. "We have never sat down as a country and tried to work on health care."

The United States spends $800 billion on health care and that amount could double in the next seven to eight years, he said.

"By far, the most expensive thing to do is nothing," Obey said.

There at the hearing agreed that measures must be taken. From business owners to citizens, they all had their opinions.

An overwhelming number of people asked Obey to make sure that the Community Options Program (COP) will continue under any national program.

COP is a state and federal government-run project that provides staff to the elderly, physically and developmentally disabled and the mentally ill, allowing them to stay in their homes. The program is already being used as a model for long-term care under President Bill Clinton's health plan, Obey said.

For Fran Estrin, COP has enhanced her life. Estrin, who testified in a wheelchair, said the program has enabled her to move into an apartment and live by herself. She volunteers her time at the Department of Aging and for the Meals on Wheels program.

"If it was not for COP, I would be living in a nursing and not serving my community as I am now," she said.

Others also had strong support for COP.

(see health, page 8)

health (continued from page 1)

"I spent today at a genuine service," said Ann Buck, Plover.

Many seniors want to remain in their own home as long as possible even if they couldn't care for themselves, she said. Long-term care, such as COP, allows older people to stay at home and out of nursing homes, Buck said.

Other issues raised included the uninsured and the willingness of everyone to contribute to health reform.

Dr. Donald Nystrom, director of patient financial services at the Marshfield Clinic, testified on behalf of himself, saying he was concerned about the uninsured.

It's estimated that half of the 37 million uninsured people may choose to be without coverage, he said. These people can be young people in school who have little or no assets, early retirees and many others. They can be

SPJ
12-10-93

Dave
Kathy
Jack

(2)

INFORMATION AND ASSISTANCE WORKER makes home visits and helps people obtain needed services from the Department On Aging or other agencies.

HOUSING ASSISTANCE helps people locate appropriate housing.

FAMILY CONSULTATIONS survey the range of community services available for family members age 60 and over.

CHORE SERVICE COORDINATION matches workers with people needing house and yard maintenance.

NEWSLETTER: THE POST informs people about current activities and programs.




BENEFIT SPECIALIST helps people cut the red tape involved with health care and public benefits. Addresses problems with Medicare, Medicare supplements, Social Security, Supplemental Security Income (SSI), Medical Assistance, disability claims and other benefits.

PARTNERCARE CARD reduces health care costs for income-eligible people age 65 or older.

VOLUNTEER ENERGY ASSISTANCE AND HOMESTEAD TAX COUNSELING assists people in filling out applications.

SOCIAL SECURITY ADMINISTRATION holds office hours regularly at Lincoln Center.

Located in Lincoln Center, the Adult Day Care Center serves frail and disabled adults age 60 and over who need supervision and individualized activities; open Monday through Friday from 8:00 A.M. to 4:00 P.M. Clients pay an hourly fee and choose the days and times of participation.

HOLLY SHOPPE sells handcrafted items made by county residents age 60 and over. This income supplement program is located at Lincoln Center.

RSVP MERCHANTS' OLDER BUDDIES (M.O.B.) DISCOUNT PROGRAM provides discounts for goods and services from area merchants and businesses for people 65 and over.

TELECARE reassures homebound people with a daily telephone call.

ELDER ABUSE REFERRALS made in areas of financial, physical or emotional abuse or self-neglect.

VOLUNTEER PEER COUNSELORS help individuals with grief, isolation, depression and other life adjustment situations.

VOLUNTEER FRIENDLY VISITORS visit homebound or isolated people age 60 or over.

SUPPORT GROUPS at Lincoln Center include: Visually Impaired Persons (VIP), Self-Help for the Hard of Hearing (SHHH), Alzheimer's Caregiver, Loss of Spouse (LOSS), Arthritis, Living With Cancer.

February 16, 1994

VISIT TO LINCOLN CENTER

DATE: **February 18, 1994**
TIME: **5:15 pm**
LOCATION: **Lincoln Center, Wausau**
FROM: **Liz Bowyer, Angela Buchanan**

I PURPOSE

To tour the Lincoln Center and visit with some of the senior patients.

II BACKGROUND

The Lincoln Center is run by the Portage County Department on Aging and is a central resource agency which addresses the needs and interests of adults 60 years and over. The nine-member Commission On Aging is appointed by the County Board of Supervisors and is responsible for Department governance. Funding for services is provided through grants and allocations from federal, state and county governments, the United Way, underwriting by local businesses, private contributions, and participant fees and donations. The department offices at the Lincoln center, a multipurpose senior center, in the town of Stevens Point, a small rural county of some 60,000 with 8,000 of those person being over the age of 60.

In 1989 the Lincoln Center received an award from the National Administration on Aging for being one of 10 best aging programs in the state. It provides needed services such as: transportation, legal services, meals, foster grandparents, and adult day care. Some 2000 seniors regularly participate in services made available by the Lincoln Center. In addition, estimates show that 60-70 percent of the elderly population in the county benefit from the center in one service or another.

The senior center operates as an adult education center as well with at any one time 60 classes going on in a semester. Such classes include: indoor sketching, antiques, art, crocheting, quilting, "Meeting with your elected officials", professors lecturing on current issues, creative writing, and foreign language classes.

There are no classes on Friday, hence HRC will not be able to tour classes in progress. HRC will tour the facility with the participants and have a discussion beforehand.

III PARTICIPANTS

HRC
Sen. Russell Feingold
Sen. Herb Kohl
Cong. David Obey

IV. SEQUENCE OF EVENTS

HRC arrives
Tour center
Open discussion
HRC exits

V PRESS PLAN

Open Press

VI REMARKS

see attached

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	From: Kathy Sykes, Congressman Obey's Office, To: Liz Bowyer, Re: Hillary Clinton's Trip to Steven's Point [partial] (1 page)	2/17/94	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3983

FOLDER TITLE:
[HRC Background File] Friday, February 18 [1994] [2]

2014-0483-S
sb394

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]

Stevens Point

To Liz Boyer
From Kathy Sykes, Congressman Obey's Office

RE: Hillary Clinton's trip to Stevens Point

February 17, 1994

In December 1993, Congressman Obey held 14 town meetings on the President's health care plan. One of the best sessions was held in Stevens Point. This is the same location I understand the First Lady will be visiting on Friday. I have enclosed a press clipping form the local newspaper regarding the hearing and listed a few persons who did a good job articulating the need for having long term care be an integral part of health care reform or their problems with the current health care system.

002
(b)(6) - 59 year old woman -- escalating cost of health insurance. She and her husband are self-insured and premiums have doubled in the past five years. Has pre-existing heart condition and is covered under the State's Health Insurance Risk Sharing Pool (HIRSP).

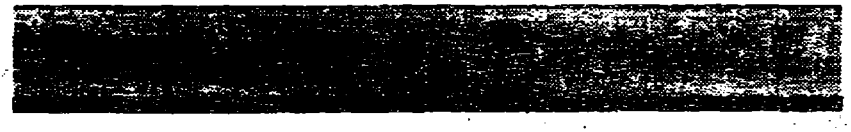
(b)(6) 002
Discussed the needs of her parents who have had needed community based supportive services following their hospitalizations.

002
(b)(6) -- Under 65 and wheelchair bound, her husband up until 10 years ago was her sole caregiver. Luckily for her, Wisconsin had the community options program which has allowed her to continue to live in her own apartment.

002
(b)(6) -- Displaced homemaker has had a hard time choosing between paying for health insurance premiums and buying food for her family.

002
(b)(6) -- Has MS and supports health care reform. Manages a family planning clinic.

Tom Dean



Contributions to Open Letter are limited to 300 words. Letters from the same person will be printed no more frequently than once every two weeks, with exceptions for unusual circumstances. Letters must bear the name, address and, if possible, the telephone number of the writer. Only for unusual cause will names be withheld from publication. Letters from organizations must contain the name of a spokesperson. Letters should be addressed to the Journal and its readers. We do not reprint letters to others. The Journal reserves the right to reject letters or delete portions.

Obey listens to concerns about health care reform

To the Journal—Congratulations to Congressman Dave Obey and his staff for holding the recent round of hearings in the 7th Congressional District on the need for national health care reform. It is hard to imagine a single issue which has more of an impact on America today. Health care affects the national debt, global competition, worker productivity, welfare reform, national and state tax policies, and a host of other issues.

By holding these hearings, Congressman Obey reaffirmed his commitment to listen to his constituents, not Washington-based lobbyists, about the needs of north central Wisconsin. Too often, politicians in Washington (both Democrats and Republicans), reply on "special interests" who have the time and money to maintain an ongoing presence in Washington, D.C. Too often, the needs and views of average working men and women take a back seat because the only time politicians care about their views are during an election.

Congressman Obey's hearings show a willingness to listen and learn about a problem before the process begins, not after a solution has been passed into law. It is an approach based on the Jeffersonian belief that the best and most valuable advice is that given by real people, living average lives, who face the every day problems involved in raising a family and giving their children the best opportunities for success.

Thanks for the opportunity, congressman!

KARL S. PNAZEK
Plover

Is ropes course an essential?

To the Journal—May we soon hope that the school board will apply the same rigorous activity to every budget item as we must to our individual expenditures? First, the essentials; then, the nice-to-haves.

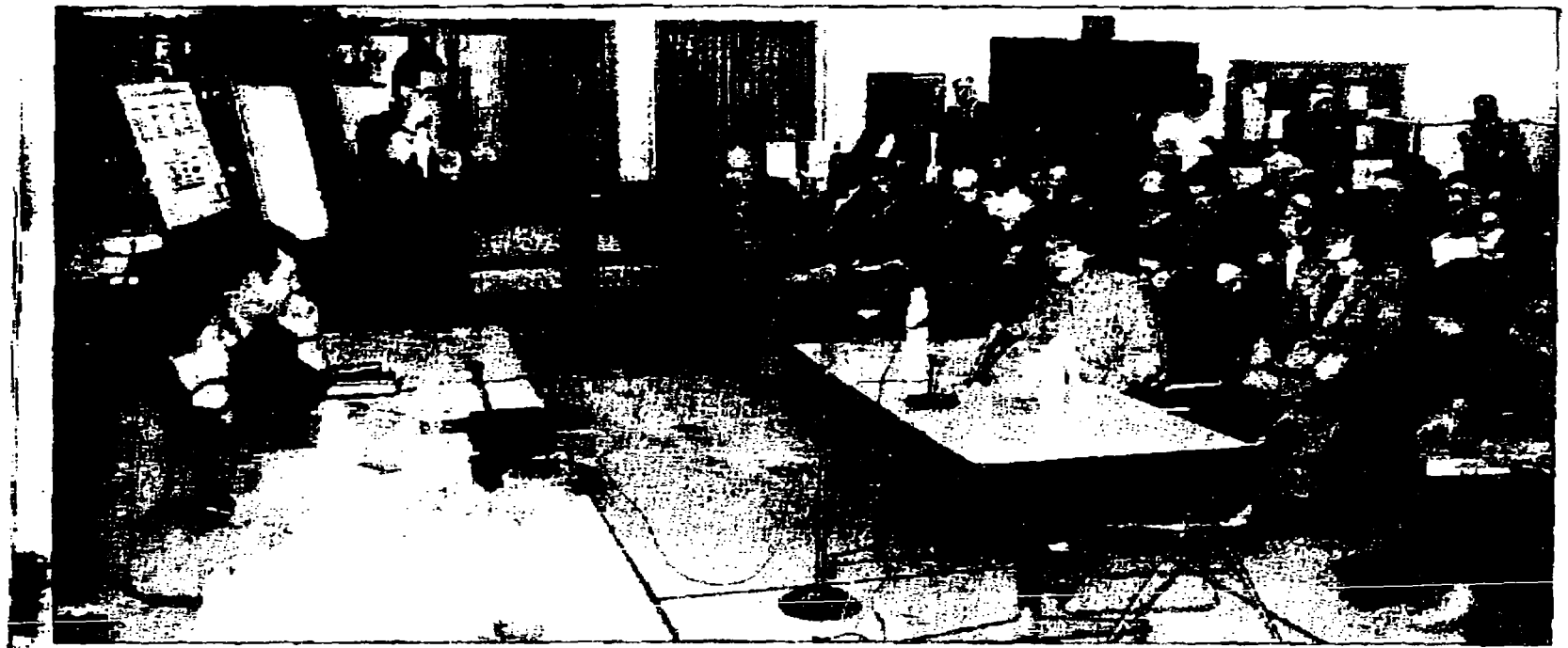
Where does the Ropes Course belong?

NANCY WHITMIRE
Stevens Point

Stevens Point Journal

Friday, December 10, 1993 — 4 Sections—28 Pages

Dave
Kathy
Jack



LISTENING TO TESTIMONY, [From left] Kathy Sykes, an aide, and U.S. Rep. Dave Obey, D-Wausau, hear Edith Hoffman, Amherst, one of many people who testified at a public hearing on health care at the Lincoln Center Thursday. [Journal photo by Tom Kuiawski]

Marshfield Clinic Vice President Michael J. Kryda, M.D.

Pulmonary Disease Specialist Michael J. Kryda, M.D., is Vice President of Marshfield Clinic. He has served in various positions on the Clinic Executive Committee since 1986.

Dr. Kryda joined the Marshfield staff in 1977, leaving for two years to undertake further training in pulmonary disease at the University of Illinois Hospitals, Chicago. He undertook a fellowship in pulmonary disease there and at Marshfield Medical Research Foundation. He rejoined Marshfield's medical staff in 1981.

Dr. Kryda received his medical degree from the University of Illinois College of Medicine, Chicago. From 1975-77 he served in the United States Navy as a staff internist at Camp Pendelton, California. He has published numerous articles on occupational hazards to pulmonary health. He lives in Marshfield with his wife and three children.

Marshfield Clinic Executive Director Robert J. DeVita

As Executive Director, Robert J. De Vita is the chief administrative officer for Marshfield Clinic, Marshfield, Wisconsin. He joined the clinic in 1984 as Associate Director. He has served in senior administrative positions for university medical groups in both Virginia and Tennessee and was administrator of the HMO subsidiary for Blue Cross and Blue Shield in Memphis, Tennessee.

A native of Milwaukee, Mr. De Vita earned his B.B.A. and M.B.A. from the University of Milwaukee School of Business Administration. He was National HMO Management Fellow at Georgetown University and Marshfield Clinic. He is a member of the Medical Group Management Association and a candidate for fellowship in the American College of Medical Group Administrators. He lives in Marshfield with his wife, Jean, and their son.

Marshfield Clinic Advisor to the President Frederick J. Wenzel

Frederick (Fritz) Wenzel has been a leader and spokesperson of Marshfield Clinic for more than 40 years. He served as Marshfield Medical Research Foundation Director from 1965-1977 and as Marshfield Clinic Executive Director from 1976-1993.

In his role as Advisor to the President, Mr. Wenzel continues to focus on legislative initiatives at the state and federal levels, public policy and national health care reform. He also serves as a consultant to the Clinic's National Advisory Council and Resource Development Committee. He often speaks about health care integration and reform issues on the national lecture circuit.

Mr. Wenzel is president of the American College of Medical Group Administrators and Acting Director of Medical Group Management Association in Denver, Colorado. He is a member of the Wisconsin Vocational, Technical and Adult Education Board and an author or coauthor of some 100 publications covering a range of clinical, management and economic topics.

Saint Joseph's Hospital President and CEO Michael A. Schmidt

Michael A. Schmidt joined Saint Joseph's Hospital in 1984 from the public accounting firm of Deloitte, Haskins & Sells, where he managed various audits and consulting services. His positions at Saint Joseph's included Vice President of Finance and Executive Vice President. In 1993, he was named President and Chief Executive Officer of the 524-bed hospital.

He is a member of the Healthcare Financial Management Association, the American Institute of Certified Public Accounts and the Wisconsin Institute of Certified Public Accountants.

Marshfield Clinic Director of Health Systems Research Gregory Nycz (pronounced nich)

Gregory Nycz is an expert on rural health care delivery. He has testified before Congressional subcommittees on the subject. He serves as Director of Health Systems Research in the Marshfield Medical Research Foundation, the research and education division of Marshfield Clinic. He directs Family Health Center of Marshfield, Inc., a federally-funded program which provided low-cost health care to approximately 26,000 uninsured and underinsured residents of 13 counties in central, western and northern Wisconsin in 1993. He is also director of Wisconcare, a state-funded program which serves low-income populations as well.

Mr. Nycz is the Wisconsin coordinator of the National Association of Community Health Center and a member of its National Rural Health Association Joint Task Force Committee. He also serves on the Rural Health Care Advisory Group of the American College of Physicians. He is the author or co-author of dozens of articles on rural health care and utilization of prepaid services.

Mr. Nycz has degrees in mathematics, psychology and computer science from the University of Wisconsin-Stevens Point.

REED E. HALL
General Counsel
Marshfield Clinic

Reed E. Hall has served since 1976 as General Counsel of Marshfield Clinic, Marshfield, Wisconsin. Marshfield Clinic is one of the five largest private medical clinics in the United States. Mr. Hall received his M.S. in Health Law from the University of Pittsburgh Graduate School of Public Health in 1974, J.D. degree from the University of North Dakota in 1973, and B.A. from the University of Wisconsin-Madison in 1970. Mr. Hall served on the Law Review Board of Editors as Case Comment Editor while in Law School. He was in private practice in Milwaukee, Wisconsin with the Purtell, Purcell, Wilmot & Burroughs Law Firm for two years prior to joining the Clinic. He has served as past President of the Health Law Section of the State Bar of Wisconsin. Mr. Hall has published and has given several presentations to National Health Law Programs.

Security Health Plan Medical Director WILLIAM J. MAURER, M.D.

Dr. William Mauer serves as medical director of Security Health Plan, Inc., Marshfield Clinic's HMO, and as medical director of the Family Health Center. An internal medicine specialist, Dr. Maurer joined Marshfield Clinic's medical staff in 1968.

During his 25-year tenure at Marshfield Clinic, Dr. Maurer served 11 years on the Clinic's Executive Committee, including three consecutive terms as President (1983-85), the Clinic's highest elected office. He also served numerous terms on the Marshfield Medical Research Foundation Board of Directors.

Dr. Maurer earned his medical degree from Marquette University in Milwaukee, WI. He completed residencies in internal medicine at Columbia Hospital and the Veteran's Hospital, University of Wisconsin, also in Milwaukee.

Dr. Maurer and his wife are parents of four children.

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TELECOPY COVER SHEET

DATE: 17 FEB

TO: Vincent Gallen

FAX NO.: 456 - 2239

FROM: Troy Murphy

Office of Senator Thomas A. Daschle
317 Hart Senate Office Building
Washington, DC 20510
Telephone: (202) 224-2321
Telecopier: (202) 224-2047

MESSAGE:

FYI

Any ? → pls call

Thanks

Troy

NO. OF PAGES (Including Cover Sheet) 10

To: Liz Bowyer
From: Bob Simpson, Daschle Staff Assistant
RE: South Dakota Background

° South Dakota is the 42nd state in the Union. It has a population of approximately 700,000 people and is one of the most rural states in the country. It's two main population centers, Sioux Falls (pop. 110,000) and Rapid City (pop. 75,000), are located on the extreme eastern and western ends of the state. Only ten communities in South Dakota have populations of 10,000 people or more. The central portion of the state is extremely rural with the majority of citizens there living in medically underserved areas.

° South Dakota is home to 8 Indian Reservations. 7% of the state's population is Native American. Three of the ten most impovershed counties in the United States are located on Indian Reservations in South Dakota. The Indian Reservations here are generally impoverished and also medically underserved.

° Geographically, South Dakota is divided in half by the Missouri River. People living in the western half of the state, or "West River", tend to be more conservative in their beliefs than their East River counterparts. The West River economy also tends to rely more on mining, tourism, and ranching than in the East where farming and commerce are the major sources of revenue.

° Hunting and fishing are both very popular in South Dakota. South Dakotans are especially proud of their pheasant hunting, which is considered to be the best in the nation.

° South Dakota is home to the Black Hills, the Badlands and Mt. Rushmore. It also where Kevin Costner filmed the academy award winning "Dances with Wolves".

° Politically, South Dakota is 48% Republican, 42% Democrat, and 10% Independent. While many liberal, democratic Senators and Congressman have been elected in South Dakota, the majority of elected offices still go to Republicans. Over the last 60 years, only three Democratic governors have been elected, and only four Democratic presidential candidates have carried South Dakota since the state was admitted the Union in 1889.

° Among the more famous native South Dakotans are broadcasters Tom Brokaw, Pat O'Brien, and Mary Hart.

° Lennox has a population of 1,827 people, most of whom are conservative and Republican. It has a clinic, a nursing home, and a solid mainstreet economy. Economic Development, however, is always a big concern.

° The school district is very proud of the newly constructed Lennox High School. The school's mascot is the Oriole. Always strong in athletic activities, the Lennox Oriole Boys Basketball team is currently ranked #1 in the state.

° Lennox High also has a very strong teaching staff, and claim one Rhodes Scholar among their graduates (in 1985). Their principal, Alan Rops has been with the school for 17 years.

Other
Other
Rapid City Journal
Sioux Falls Argus Leader
Watertown Public Opinion
Yankton Press & Dakotan

Date 9 Feb 94 Page 1a
Day Wed
Sent by SIOUX FALLS
Attention:

Lennox prepares to meet first lady

By RANDY HASCALL
Argus Leader Staff

LENNOX — First lady Hillary Rodham Clinton won't be the most famous person to ever set foot in town.

Theodore Roosevelt once stopped here during a campaign trip by train, said Verlyn Hofer, president of the Lennox Commercial Club.

Although Clinton might have to settle for second place, she'll receive a first-rate reception and likely won't encounter any protesters, Hofer said.

"We're a pretty strong Republican community, but we're too polite for that," he said. "We'll try to put our best foot forward, be polite and considerate."

Clinton will be in town Feb. 18 for a forum on rural health care.

Mayor Floyd Beach was busy Tuesday distributing new welcome banners that arrived in the mail. Business owners will hang them in their windows, and the American Legion will display U.S. flags downtown. Then, they'll all hope the entourage arrives or departs over main street.

As Clinton's trip nears, rumors grow.

According to one story, Secret Service agents have been roaming the halls and classrooms at Lennox High School — the site of the forum — checking out the school and students.

The wildest rumor is that the Secret Service fastened down all manhole covers on main street so no one could pop up with a gun to ambush Clinton's caravan.

Despite what people say, no Secret Service agents have been to town as far as high school principal Alan Rops knows. He said the strangers in suits are members of Sen. Tom Daschle's staff who have made three visits.

After classes Feb. 17, Rops will turn the school over to the Secret Service.

Details of Clinton's visit are sketchy, Rops said. She's scheduled to arrive in Lennox between 11 a.m. and noon, conduct a national news conference in the school library and

Lennox /See 2A

Continued from 1A

then give her presentation to about 1,000 people in the gym.

Ten or 11 classrooms will be open to those without tickets, and they can watch the summit on TVs.

Rops said he expects to get a one-on-one session with Clinton and would like to put her in touch with students. Meeting the first lady could be a highlight for many, particularly teen-age girls who look up to Clinton.

To accommodate the crowd, school and city workers will clear snow to turn the practice football field into a parking lot. Twenty additional phone lines have been installed for the media and White House staff.

Rops said volunteers will direct parking and help with coat checks and other tasks.

The community's response indicates that Rops will have no trouble finding volunteers.

"There's a lot of excitement," Mayor Beach said.

"Something like this doesn't happen often, said Barb Scott of Lennox."

"It's nice she's coming to a small town," said Marilyn Renback, who lives in Harrisburg and works in Lennox.

Jack Jacobson, a 16-year-old sophomore from rural Tea, said he'll be in Sioux Falls before 7 a.m. today to try to get a ticket.

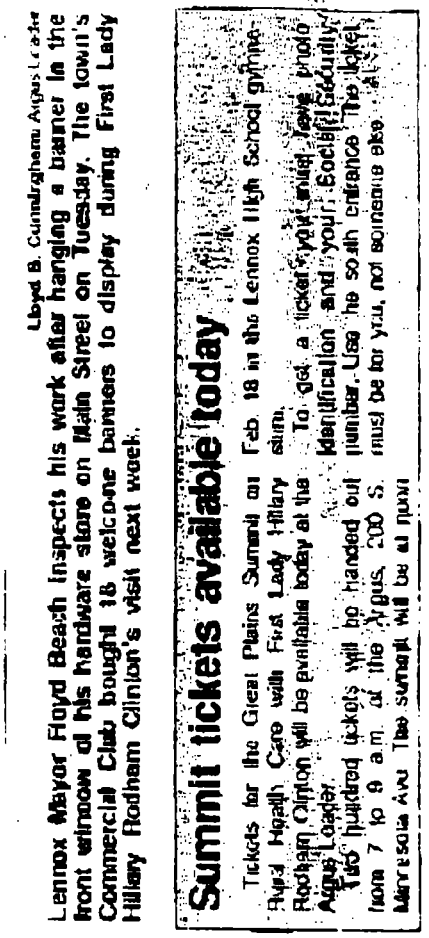
Jacobson said he hopes to learn more about the Clinton administration's health plan so he can answer the questions of his grandparents, who need medical care.

Scott Rogers, a physician's assistant at the Lennox Area Medical Center, said there's talk that Clinton might stop at the clinic.

"No one has officially notified us," he said. "I'm a Republican, but I hope she stops by. How often do you get a first lady in town?"

Hofer said a number of residents are concerned that not many local people will have an opportunity to attend the event.

"I'll go if I can get a ticket," he said. "If not, I'll watch from the outside."



Lennox Mayor Floyd Beach inspects his work after hanging a banner in the front window of his hardware store on Main Street on Tuesday. The town's Commercial Club bought 18 welcome banners to display during First Lady Hillary Rodham Clinton's visit next week.

Lloyd B. Cunningham/Argus Leader

Public opinions

If you could spend a few minutes with first lady Hillary Clinton when she visits Lennox, what would you tell her or try to find out?

Priscilla Buskuhl, 47
medical center
receptionist
Lennox

"I'd tell her the clinic is needed here. The elderly support us with their money and it's important we can serve them."

Tim Raabe, 43
government teacher
Lennox

"I'm not so curious about the health-care plan as if I could ask her how she perceives her role as first lady. I'd like to know the kind of influence she has on decisions made and her opinion on when there will be a female president."

Amber Cheney, 15
sophomore
Tea

"I'd like to find out if she's really as genuine and sincere as she seems. She seems like a '90s woman who doesn't let her husband boss her around."

Ralph Delaney
postmaster
Lennox

"I heard a quote the other day that the health-care plan is a copy of FDR's. Is it? And what about continuous pay? Will it triple or double on us? I think they should make the plan available to everyone but shouldn't force everyone into it."

Onelia Alberda, 75
retired
Lennox

"I'd tell her the most important thing is that everyone can get insurance. My daughter had a brain tumor removed a year and a half ago. She has insurance, but if she leaves the company then she can't get insurance."

Other offices
Sioux City Journal
Sioux Falls Argus Leader
Watertown Public Opinion
Yankton Press & Dakotan

10 Feb 94 Page 10a
Date Thurs
Pay
Sent by SIOUX FALLS
Attention:

Health-care reform

Rural people wonder what's in it for them

Associated Press

First lady Hillary Rodham Clinton headed the health care reform task force that was largely responsible for crafting the president's plan.

From staff and wire reports

WASHINGTON — Carol Miller has good health insurance. But when she became ill during a blizzard, she was caught in her home, a treacherous two-hour drive away from the nearest doctor.

That, she says, is the No. 1 difference between the concerns of city dwellers and those who live in rural communities when it comes to health-care reform. Urban folk wonder if they'll be able to keep their doctor; rural residents wonder whether one will ever move into town.

First lady Hillary Rodham Clinton will come to Lenox on Friday to talk about the issue at the Great Plains Summit on Rural Health Care.

"Having a (health insurance) card is not the same thing as having care," said Miller, a consultant to La Clinica del Pueblo in Tierra Amarilla, N.M., population 900, plus 3,100 more who live in the surrounding mountains.

Advocates for rural communities are, like millions of other Americans, pleased to see that President Clinton has made health-care reform one of his priorities.

After all, rural areas have a greater proportion of uninsured residents than urban areas, often more elderly and poor people, workers at higher risk of injury on the job — farming is among the most dangerous occupations in America in terms of number of injuries — and not enough doctors to beat any of them. But rural advocates also worry that Clinton's plan and its competitors might not work for them as well as the politicians claim they will.

"There are parts of all of them that hospitals see as positive, and there are parts that the hospitals see as stumbling blocks for our communities," said Evonne Ulmer, chief executive officer of Ionia County Memorial Hospital, halfway between Lansing and Grand Rapids, Mich.

But not everyone in rural America is supportive.

Critics of the health-care system might point to Mary Johnson of rural South Dakota as an example of someone who is haunted by today's health-care system.

Johnson, 41, ranches with her husband, Bob, 11 miles from Buffalo. They live in the extreme

Reform /See 5A

The HEALTH DEBATE comes home

Q and A: Answers to some of the most-asked questions about how health-care reform might affect the nation. **Page 4A**

WHAT'S PROMISED: Clinton's benefit package: What's in it for you? **Page 4A**

THE COMPETITION: A comparison of the major reform plans being considered by Congress. **Page 5A**

Associated P

In his State of the Union dress, President Clinton vow to veto any reform bill i didn't include insurance c erage for all Americans.

Date 2-14-94, 1994
Day Monday
Sent by STOCK FALLS
Attention:

P. 1 of 2

__Aberdeen Amer/News
__Brookings
__Huron Plainsman
__Madison Leader
__Mitchell Republic
__Sioux City Journal
__Other p.2 of 2
__Other
__Rapid City Journal
__Sioux Falls Argus Leader
__Watertown Public Opinion
__Yankton Press & Dakotan

Date Jan 17 Page 10A
Day Sun
Sent by SIOUX FALLS
Attention:

Reform: Rural dwellers await plan

Continued from 1A

northwest corner of the state, 60 miles from the nearest hospital in North Dakota.

But Johnson, the mother of three children, said she doesn't fear the distance problem like some might think and credits her attitude to the pioneer spirit.

"When people move here, they think it is so far away from anywhere, but you get used to it. I know people in big cities who have a tougher time getting to a hospital than we do with traffic problems. We have a good physician's assistant in town where we go for colds and go to Rapid City when we have broken bones. That is where my children were born."

Johnson isn't much of a supporter of Hillary Clinton's mission in developing the Clinton administration's plan.

"She criticizes intensive-care nurses for getting too much money. My dad just died last week, and I saw how hard they work. I think Mrs. Clinton ought to follow them around for a while and see what really goes on. I wished she would start doing something about all the malpractice cases. I feel sorry for the doctors," she said.

Plans' shared goals

As far as health care for rural areas goes, the seven major health-care-reform plans being considered in Congress — from the most liberal to the most conservative — share several goals:

■ Incentives ranging from medical school loan forgiveness to tax credits to draw more doctors to rural communities, which have trouble attracting and keeping doctors.

■ Extra money for programs ranging from new community health centers to the expansion of the National Health Service Corps, which provides doctors for both rural and inner-city communities that don't have enough of them.

■ Better access to emergency care, including money for helicopters and other forms of transportation, as well as improved communication.

■ More links to big-city hospitals through formal networking arrangements, telecommunications links or other types of relationships.

In addition, the Clinton plan permits those who receive care through the Indian Health Service to either stay with the IHS, or join one of the separate regional networks that would serve their community. Tribal governments will be allowed to design the system they think works best for them.

Differences in plans

But the plans also differ in some key areas, including:

■ A plan sponsored by Rep. Don Nickles, R-Okla., calls for changes in Medicaid funding to let states spend the money where they think it's most needed. The Clinton plan trims Medicare funding, worrying rural providers who can earn as much as 70 percent of their income from Medicare patients.

■ Clinton's plan and one sponsored by Rep. Jim Cooper, D-Tenn., tinker with the philosophy behind the health-care system, designing networks of doctors and hospitals and demanding that competition between those networks drive prices down. Clinton's alliances are mandatory, although he also gives states the option to make the entire state and all its providers into one network; Cooper's are voluntary.

The emphasis on competition particularly bothers people in rural areas. Who are their few health-care providers supposed to compete with? Some places are lucky to have one doctor, let alone enough to set up a network of managed care. Others are close enough to large cities that they fear a loss of business to bigger hospitals.

Without those networks, however, rural Americans won't get the same cost benefits as those who live in large cities, a top administration official told Congress earlier this month.

"Because they generally lack the benefit of being part of a large business or purchasing group, rural Americans often pay more for health insurance than those living in other parts of the country," said Dr. Philip Lee, assistant secretary for health at the Department of Health and Human Services.

Joining networks would give them the clout to negotiate better prices, he said.

While no rural group has endorsed one plan over another, many feel that those that tamper the least with the existing system of delivering care are the ones that will do the most good.

"I don't believe the market is going to take care of us," said Miller, who is also a trustee for the National Rural Health Association. "We can't even get into certain HMOs now because we're rural. I feel that rural America would be better off if we went to (a government-run system similar to Canada's), which doesn't change the delivery system."

Knowing rural needs

Congressional aides who have worked with both sponsors of the various health bills and with the first lady's health-care-reform task force believe that the administration understands the needs of rural America. After all, they say, the president was once the governor of a rural state.

The man from Hope, Ark., population 10,000, likes to remind people of that fact.

"I spent one full day in the White House talking about rural health care to make sure ... we would have a program that was very sensitive to the needs of rural health care," Clinton told residents of Bernalillo, N.M., population 6,900, last December. "I spent a lot of time as a boy in communities that make this place look like a thriving large metropolis ... so I have a certain familiarity with a lot of the kinds of the problems that you have."

Los Angeles Times

SATURDAY, DECEMBER 25, 1993

Health Problems Tough to Reform in Rural Areas

By KAREN TUMULTY
TIMES STAFF WRITER

LAKE PRESTON, S.D.—One by one, the businesses that once gave this town its vitality have vanished: the meat market, the farm implement dealer, the grocery store, two car dealerships.

But the hardest blow came three years ago, when Lake Preston's little hospital lost a 30-year struggle to stay open and the town's only doctor moved clear across the state. Now a physician makes it through town only once a week, and a nurse practitioner runs the Lake Preston Clinic the rest of the time.

For the 663 people who still live here—many of them old and often sick—treatment as simple as an X-ray is at least 35 miles away. "If it means they have to drive a great distance, they just don't have health care," said Carol Arne, Lake Preston's nurse practitioner.

It is in places like this where President Clinton's health care reform initiative will confront some of the harsh realities of a failing system. Many in this state say they fear that the plan simply cannot work in such a vast and sparsely populated place.

Lake Preston's tale is one that Sen. Thomas A. Daschle (D-S.D.) hears again and again as he drives past great stretches of frozen cornfield, stopping at one farm town after another. Fully two-thirds of South Dakota's counties have been designated by the federal government as medically underserved. What care there is comes dear: The state's citizens rank seventh nationally in the percentage of their income they spend on health.

Daschle says he is convinced that the Administration's reforms

Please see HEALTH, A24

HEALTH: Reform Plan Faces Test in Rural Areas

Continued from A1

can go far toward restoring rural America's crumbling medical network. As point man on a Senate health care task force and a member of the committee with primary jurisdiction over the issue, Daschle is one of Clinton's most important allies on Capitol Hill.

"There's an inevitability to health care reform," the senator recently told a business group in Watertown. "The question is how good will it be."

Clinton's proposal gambles that by banding together into health alliances, consumers can gain enough clout to bring costs into line while improving both quality and access to care. But those assumptions of scale, centralization and competition could fall apart in South Dakota, where a population the size of the Fresno area is scattered across more than 77,000 square miles.

As one constituent demanded of Daschle at a meeting in Sioux Falls: "How's it going to work if nobody wants to practice in Pukwana?"

Few here have much faith in anything that comes to them from Washington.

"In South Dakota, there is a healthy skepticism about the ability of Washington to design any program that meets the unique needs of rural areas," said state Secretary of Health Barb Smith, a Republican who was part of the Clinton health care task force but who now has strong reservations about the resulting plan.

In principle at least, much in the Clinton plan is winning enthusiastic praise from most rural health experts and advocates.

"I think health care reform presents tremendous opportunity for rural areas," said Ira Moscovice, director of the University of Minnesota's Rural Health Research Center and an adviser to the Clinton health care effort. "For the first time, rural lobbyists and advocates were at the table from the beginning with respect to development of the health care plan. Rural concerns were considered."

The plan's promise of universal health insurance coverage is particularly important in rural areas, where people are less likely to have private insurance or Medicaid. Similarly, farmers who now buy their own health insurance will be among the major beneficiaries of the proposal to make those premiums completely tax-deductible for the self-employed.

The plan also envisions funds to expand rural clinics, tax credits and other incentives for those who practice medicine in rural settings, and technological links—such as satellite hookups—between country clinics and city medical centers.

But perhaps the greatest boon to rural communities would be the plan's expansion of the role of primary care providers—not just family practice doctors but also nurse practitioners, nurses and physicians' assistants known as P.A.s.

Lake Preston's lifeline is Arne, a 49-year-old nurse practitioner and P.A. who runs the little clinic that stands alongside what used to be the hospital.

Arne is popular and well respected among her patients, but jobs like hers—she works alone and is on call 24 hours a day—invite burnout. Arne, who has been in Lake Preston since April, is the third P.A. to take over the clinic since the hospital closed.

Nurse practitioners and physicians' assistants, who have less training than doctors, are prohibited by law from performing complicated medical procedures. For heart attack victims, Arne said she can do nothing more than "stabilize them and ship them off."

Still, she added, "I can diagnose and treat probably 90% of what comes in the door."

Nationwide, more than 600 rural hospitals have shut down since 1980, often taking their town's last doctors with them. But only in the last few years have non-physician health care providers won wide acceptance in rural areas.

"As long as people had a thought that they could have a doctor, they wouldn't go to a P.A.," Daschle said.

Lake Preston seems to have adjusted. "Everybody's well satisfied," said John Sittner, former publisher of the town's weekly newspaper. "We're realistic, and that's all we have. Just between you and me, I think that's about all rural America can hope for."

A practice like Arne's demands ingenuity as well as healing skills. Whenever she can, she wheedles visiting pharmaceutical company representatives out of extra free samples so that she can give them to people who might otherwise have to choose between taking their drugs and buying food. But lately, fewer and fewer salespeople are even bothering to call at her isolated clinic.

She said she does hear from medical headhunters three or four times a week, inquiring whether she is interested in openings in other rural communities. Turnover in the field is high and, even with the incentives that would be built into

the Clinton plan, many are skeptical that an adequate supply of primary care providers can be had.

Indeed, some have warned that a shift away from specialization could actually make the shortage worse. Little country clinics may not be able to compete with the wealthier urban health maintenance organizations and hospitals for the limited supply of primary-care providers.

"It's hard to figure out how you're going to pay someone $65,000 when the clinic is only making $40,000," said Dr. Michael Hogue, a physician at Sioux Falls' Central Plains Clinic.

Hogue says he has had a difficult time finding someone to fill a P.A. job that has been open for three months at a satellite clinic in Beresford, a town of 1,800 people that is 30 miles south of Sioux Falls. Except for the half-day a week that Hogue visits, two P.A.s are the town's only health care providers.

"You're trying to compete against a clinic that's going to pay top dollar or better the first year," Hogue said. "A position like this—two or three years ago, we would have had 10 or 15 applicants. This year, we've had three. A lot of it is just people positioning themselves for what they know is coming."

Rural health care providers say they are also concerned about the Administration's plan to curb the growth of Medicare spending by $124 billion over six years to help finance the reform effort.

State Secretary Smith noted that some of the state's hospitals depend on the federal program for as much as 80% of their revenues. Noting that federal formulas already penalize non-urban providers, she said the additional reductions would amount to "a double whammy" for hospitals that already are struggling to keep their doors open.

She said she also worries that Clinton's proposal to require employers to pay the lion's share of their workers' health insurance premiums could cut especially deep in rural areas, where businesses tend to be small and struggling.

Another big question is whether the sprawling private health networks envisioned under the Clinton plan will even want to do business in states like South Dakota, if they are forced to accept everyone, as Clinton has proposed.

Today more than 300 companies offer health insurance in South Dakota, but they focus on the state's only two urban areas, Sioux Falls and Rapid City. It is far from clear whether many will view it as profitable if they had to offer equal benefits in the sparsely populated rural areas as well.

Many in rural South Dakota say they fear that under the Clinton plan they may lose what few health care choices they have now. "If we have only one [health maintenance organization] to take care of the whole state, maybe the only hospital we'll be able to go to is Sioux Falls, 90 miles away," Sittner said.

That is why many say they believe that small states may ultimately be forced to turn to the so-called single-payer system, a government-financed health care system similar to Canada's.

That would be fine with Sittner, who has a brother-in-law in Canada. "He's perfectly happy with it," Sittner said. "It looks to me like single payer is the only one that will give what we want specifically in the small town. We want choice in doctors."

But others, repeating horror stories of long waits for treatment north of the border, note that Canada has been known to ship its citizens to the United States when they need high-tech medicine.

And then there is South Dakota's inherent mistrust of anything that smacks of too much government. "Single-payer is clearly more efficient than anything else that's out there. But politically, I don't think the state's ready for it," Daschle said.

South Dakota's other senator, Republican Larry Pressler, says Clinton's plan does not improve on the current system. At least 80% of the state's residents, he estimates, will end up paying more for worse care.

Republican Gov. Walter D. Miller, equally critical, warns that it could leave the state holding the bag for expensive new entitlements created in Washington.

Ultimately, the University of Minnesota's Moscovice said, the fate of health care reform in rural America will hinge on how it is carried out by state governments and health care providers. "The issue is whether we can get urban providers and health plans sensitive to local concerns," he said. "It's got to be a win-win scenario, or it's not going to play out very well in rural America."

February 17, 1994

Memo to Liz Boyer:

Wausau is Congressman Dave Obey's home town. His 7th Congressional District runs from just south of Stevens Point in central Wisconsin all the way north to Lake Superior. It includes some 16,500 square miles, by far the largest in Wisconsin. It is larger than nine states.

Obey was a leading opponent of the Reagan economic policies from 1981 on. He voted against the Reagan budget and tax plans and told his constituents in a newsletter that they would cause huge deficits, squeeze working families and hurt the country.

Obey was a key leader of the progressive forces in the House during those struggles, offering comprehensive budget alternatives which called for smaller deficits, a fairer distribution of tax burdens between the rich and the middle class and a strengthening of investments that could have helped to restore family income growth. But he lost those battles.

As Obey put it recently, "those misguided policies destroyed fairness for working families, devastated farmers, benefitted only the wealthy and sent the bill to our grandkids--hard working people became angry because they could see that government was not on their side."

Obey believes that President Clinton's economic program is turning the country around. Again, as he said recently: "A big dent has been put in gridlock. In 1993 Congress passed President Clinton's $500 billion deficit reduction package. It is the first step in repairing the damage done to America in the 1980s, returning the country to fiscal responsibility and building a decent economic future for our children."

As chairman of the Joint Economic Committee in 1985 and 1986 (he again is chairman now), he sponsored studies demonstrating that the incomes of ordianry citizens were going down and the wealthy were doubling their incomes over a decade. Obey's studies became the core of the Democratic Party theme about the need to strengthen investments and raise family income, a theme that was utilized by Bill Clinton in his drive to the White House.

Obey has demanded health care reform for years, holding 22 hearings in his district in 1991 and 1992 and another 14 last December. He says that it is the top domestic problem and that Congress must make sure that special interest not block progress.

"The tremendous amount of activity on health care reform clearly shows that, after a decade of drift and gridlock, government is finally back in the business of tackling major problems again," Obey says. "The change of atmosphere in Washington is dramatic."

The Almanac of American Politics calls Obey "one of the most accomplished and effective legislators in the House."

In endorsing Obey for re-election in 1992, the St. Paul (Minn.) Pioneer Press described Obey as follows:

"Mr. Obey is a big player in the biggest game in Washington--economic policy. He has been a thorn in the side of the House leadership on many an issue and an arbitrator often--on campaign finance reform, foreign aid, health care. Pick almost any major Washington issue: it has Mr. Obey's fingerprints all over it, often for the good, always with common sense applied to conventional wisdom."

--Jack Kole, 225-3365.

DEPARTMENT OF HEALTH & HUMAN SERVICES

FOR RELEASE UPON DELIVERY

STATEMENT OF

MICHEL LINCOLN

ACTING DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

January 31, 1994

Good Afternoon.

I am Michel Lincoln Acting Director of the Indian Health Service (IHS). This afternoon I will discuss how the Health Security Act proposes to deal with American Indians and Alaska Natives, the health care system currently in place to serve them, and tribal governments which have a unique status within our Constitutional system.

There are a number of principles affecting Indian concerns which the framers of this bill have adopted in drafting this legislation. These principals are: individual Indians should not have to pay for services that they now receive without charge; supplemental services guaranteed by earlier legislation should continue under health care reform; and the rights of tribes to assume operations of Federal programs through the Indian Self-Determination and Education Assistance Act, Public Law (P.L. 93-638) must be maintained and affirmed. The specifics should be evaluated with these principals in mind.

First, I will describe what the Health Security Act offers to American Indian and Alaska Natives (AI/AN) as individual health care consumers. Second, I will describe the proposed Indian health services delivery system and how it interrelates with alliances. Third, I will describe those provisions that relate to Tribal governments and tribal organizations. I will conclude with a brief description of the consultation process IHS has undertaken with Indian tribes, Indian organizations, and Indian people.

I will begin by providing a very brief summary of the historic Federal health care obligations to Indian Tribes and the health conditions and needs of Indian people. Any reconfiguration of health care services and/or financing for AI/AN people must appropriately address the Federal government's historic responsibility to provide adequate health care to Indian people. The basic legislation encompassing this responsibility is the 1921 Snyder Act which grew out of the historical and Constitutional relationship.

The 1921 Snyder Act was the culmination of the historical provision of services to Federally recognized Indians which grew out of the Constitutionally based primacy of Congress over Indian affairs.

The close involvement of the Public Health Service (PHS) with the Indian health program began in 1926 and was based on the Indian program's need for medical personnel and health service expertise, particularly in communicable disease. The 1955 transfer of programs to the PHS was based on these needs, coupled with the benefits of being located in an agency focusing exclusively on health.

The IHS has developed a health care delivery system and model that combines clinical services for individuals with community and public health programs. Within the limits of IHS' annual funding base, the service delivery system includes the integration of:

* comprehensive, curative, preventive and rehabilitative health care
* supplemental services to improve access and appropriate utilization
* public health, community and population-based programs
* capacity-building programs
* traditional AI/AN beliefs and approaches to personal, spiritual and community health.

The 1990 Census identified approximately two million American Indians and Alaska Natives. This population is growing 2.3 percent annually. Indians live throughout the United States, in urban areas, and on or near rural reservations. The current total AI/AN service population of the IHS is 1.3 million spread throughout 33 states. Services are delivered under circumstances that are overwhelmingly rural and isolated, focusing on relatively small numbers of people in any given area.

According to national estimates, approximately 28 percent of the IHS service population is covered by private health insurance (this figure includes employer provided insurance), and this proportion includes those holding both supplemental policies (e.g., medigap, long-term care, etc.) as well as those with more comprehensive policies. Among AI/ANs in the IHS service population who are employed full time, it is estimated that only 47 percent have employment related insurance. Financial, cultural, and language barriers frequently reduce access to, use of and acceptability of private health care facilities available near Indian reservations and communities.

Health reform will not change the need these small communities have for: public health and other services not part of health care reform proposals; training, recruitment and retention of health professionals.

The IHS addresses the needs of this diverse population through a partnership with more than 500 federally recognized tribes and 34 urban Indian organizations, collectively operating 50 hospitals, 140 service units, 164 health centers, 7 school health centers, 112 health stations, 172 Alaska village clinics, and 28 urban clinics. Services funded by IHS in urban areas range from provision of outreach and referral services to deliver of comprehensive ambulatory health care.

The Indian population is poorer and more disadvantaged than most Americans. More than thirty percent of Indian households live below the poverty level. Indians experience elevated risk for disease and injury that accompanies conditions associated with poverty and cultural dislocation. This risk is reflected in higher rates of illness and death for many diseases and injuries. Despite remarkable gains in the last 35 years, disproportionate numbers of Indian people die prematurely compared to the US all races average.

Indian people experience significant barriers that limit their access to health care services. Low incomes and high rates of unemployment push affordable private insurance out of the reach for many Indian households. Seventy-two percent of the IHS service population have no private

insurance (this figure includes employer provided insurance). Many depend on the IHS and other public insurance such as Medicaid as their sole source of health care.

Many Indian people live in remote and isolated areas. Many reservations are located in the most remote and harshest environments in the United States. Many Indians in these areas must travel long distances to reach a health care facility. Indian people often do not have reliable means of personal transportation and public transport is virtually non-existent in most rural areas. Harsh weather and impassable roads prevent travel altogether during parts of the year.

Indian tribes and Indian people are culturally and linguistically diverse. Non-Indian health care professionals frequently need translators to communicate with Indians who maintain their native language. Trained indigenous members of Indian communities are needed to blend western scientific medical practice with traditional cultural beliefs and ways.

To open my discussion of the Health Security Act, it is worth noting that American Indians and Alaska Natives receive unique treatment under the Health Security Act in recognition of the historic obligations of the government-to-government relationship that exist between the Federal government and Indian tribes. Other health care reform proposals before the Congress contain few, if any, references to Federal health care programs for Indians.

The Health Security Act offers significant new benefits to Indians, as it does for all Americans. Under the Health Security Act, Indian individuals and families receive the same guarantees of universal coverage for comprehensive benefit services as other Americans. Universal coverage will expand health insurance coverage to many Indian people who are currently not covered by any form of private health insurance. Universal coverage is especially beneficial to those Indians who do not reside near IHS facilities.

Like other Americans, Indians will choose a health plan. Eligible Indians may elect to enroll with a health program of the IHS or with a health plan offered through an alliance. An Indian eligible to enroll with a health program of the IHS is the same as defined in the Indian Health Care Improvement Act. It also extends full coverage to Indians living in urban areas in which urban Indian health programs are offered. Indians residing in a geographic area in which a health program of the IHS is not offered must enroll in an alliance health plan.

Consistent with existing Federal policy, the Health Security Act preserves free health care for Indians electing a program of the IHS. Indians enrolled with a program of the IHS will receive the comprehensive benefit package services at no cost. Cost sharing provisions in the Act will apply to Indians enrolling in an alliance health plan. Indians electing alliance plans will be eligible for cost sharing discounts on the same basis as other Americans.

A health program of the IHS may open enrollment to non-Indian family members if enrolled as a family unit by an eligible Indian. Non-Indian family members must pay normal premiums and other cost sharing.

Other non Indians may not enroll in a program of the IHS. However, IHS programs may optionally serve non-enrollees by entering into contracts with alliance health plans to serve their enrollees if the local IHS program determines that services to enrolled Indians will not diminish and the alliance plan reimburses the Indian program as an essential community provider. This is especially important for Public Law 93-638 contractors who wish to compete more broadly in the health care market place.

The comprehensive benefits package defined in the Health Security Act assures a range and scope of medical care that exceeds what the IHS is currently able to provide. While enhancing preventive and curative medical services, the Health Security Act also preserves supplemental IHS programs that are not included in the comprehensive benefits package. Examples of these vitally important programs are public health nursing, community health representatives, environmental health services, and safe water and sanitation facilities. Indians retain their eligibility for supplemental programs regardless of which plan they elect.

I will now turn to the health care delivery system proposed to serve enrolled Indians. The Health Security Act proposes Indian Health Service programs that are distinct and separate from State or alliance control. Programs of the IHS would be operated by the IHS, or under contract with a Tribe or tribal organization or an Urban Indian program.

Indians enrolled with an IHS, tribal, or urban Indian program will receive comprehensive benefit package services either directly from the program's providers or from other providers under contracts arranged by the program. Conversely, the local IHS, tribal, or Urban Indian program may contract with alliance plans to serve their Indian or non-Indian enrollees under conditions I described earlier.

All health programs of the IHS must offer the comprehensive benefits package by January 1, 1999. Many states are proceeding on a faster health care reform track. To assure the financial viability of the IHS programs under reform, the health programs of the IHS should be able to offer the benefit package as states implement reform.

Because the programs of the IHS operate outside of the normal alliance framework, financing for the comprehensive benefits package is somewhat different from that described elsewhere in the Health Security Act. Revenues to fund the comprehensive benefit package will consist of a blend of employer premiums collected by alliances, non-Indian family member premiums, cost sharing discount equivalents for low-income non-employed Indians, reimbursements for services provided to other plans, and Federal appropriations for the comprehensive benefits package.

The Health Security Act authorizes new appropriations of $40 million in FY 1995, $180 million in 1996, and $200 million thereafter for enabling services such as transportation, outreach, translation, and for construction and renovation of facilities to enable the delivery of the comprehensive benefits package. Additionally, the Health Security Act authorizes a new revolving loan program and/or loan guarantees to finance capital improvements and other infrastructure development.

I will turn next to provisions relating to tribes and tribal governments. The Health Security Act recognizes and expressly preserves health related Federal Indian law. This includes the rights of tribes and tribal organizations to contract or compact for Federal Indian programs under the Indian Self-Determination and Education Assistance Act.

The government-to-government principle is recognized and retained. The federal framework is retained by organizing the programs of the IHS outside the jurisdiction of the States and regional health alliances. Whether IHS operated, operated by a tribe or tribal organization, or operated by an Urban Indian program, basic Federal jurisdiction flows through the Secretary of Health and Human Services (HHS). The Secretary of HHS will determine which health plan requirements of the Health Security Act will apply to the programs of the IHS. Health programs of the IHS must meet health plan certification requirements specified by the Secretary by January 1, 1999.

Another principle underlying these provisions is that health care reform will not shift health care costs that are now borne by the federal government to tribal governments. Consequently, the Health Security Act waives employer contributions for Tribal governments and tribal organizations.

Finally, I want to briefly describe a process of consultation that the IHS has undertaken with regard to health care reform. The Health Security Act requires the Secretary of HHS to consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities. Up to now, the IHS has focused on providing information about the Health Security Act throughout Indian country. These efforts have included special presentations to tribes, tribal organizations, and Indian communities throughout Indian country. Health reform has been on the agenda and discussed at virtually every business meeting and conference for 6 months. Additionally, IHS has contracted with the National Indian Health Board to publish an ongoing newsletter and analysis of health reform proposals that affect Indian communities. These are distributed through a mailing list of over 800 tribes, Indian organizations, and Indian leaders.

Recently, Dr. Philip Lee, Assistant Secretary for Health has scheduled a series of public meetings with tribal leaders in four different regions. These 3 day sessions begin February 2 in Albuquerque, New Mexico. Similar forums are scheduled for March in Portland, Oregon, for April in Billings, Montana and for Washington, DC in May. Together with senior HHS and IHS officials, Dr. Lee will consult intensively with tribal leaders regarding their views on national health care reform and other issues affecting Indian tribes and Indian people.

This concludes my remarks. I will be pleased to answer any questions that you may have. Thank you.

MARSHFIELD CLINIC

RICHARD A. LEER, M.D.
PRESIDENT

February 17, 1994

Mrs. Hillary Rodham Clinton
Office of the First Lady
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mrs. Clinton:

We are very excited about your trip to central Wisconsin and are looking forward to meeting you tomorrow night at the Wausau Club. We regret that you will be unable to visit with us in Marshfield. We are proud of our rural integrated health care system and of our accomplishments. We believe that we offer a model for addressing some of the very difficult problems faced by rural communities in recruiting and retaining quality health professionals, an issue that is particularly troubling in many of our northern counties where a high proportion of elderly result in additional demands on existing health care systems. We believe our history and our experience would be helpful to you.

In anticipation of your visit to Marshfield and on advice of Steve Grahm of your staff, we overnight expressed an extensive packet of material to Liz Boyer in your Washington office. Given the change of plans communicated to us by Sara Grote, we have faxed a subset of this information to be used as part of your briefing materials. In addition to brief bibliographies on those who will be meeting with you prior to the VIP reception, we sent the following materials:

- Attachment 1 is Marshfield Clinic's position statement on health reform
- Attachment 2 is a map of Marshfield Clinic and its regional centers, which highlights medically underserved and health professions shortage areas.
- Attachment 3 is an excerpt from Marshfield Clinic Articles of Incorporation which exemplifies the vision of our founders.
- Attachment 4 provides the historical synopsis of the Marshfield Clinic system.
- Attachment 5 is an article on the Greater Marshfield Community Health Plan, a social experiment that survived from 1972 to 1982. The plan could be characterized by one single comprehensive benefit package, true community rating, no pre-existing illness clauses, no waiting periods, and a biannual open enrollment. The rising cost of medical care, predatory insurance industry practices, and mounting Health Plan losses forced an abandonment of these ideals in 1982.

- Attachment 6 provides a brief explanation of the Family Health Center of Marshfield, Inc. a community health center that works in partnership with Marshfield Clinic to provide single door access to health care for over 18,000 Medical Assistance recipients and 6,300 low income (less than 200% of poverty) residents who are eligible for our state's Medicaid plan.

- Attachment 7 is a current fact sheet about Marshfield Clinic.

- Attachment 8 is a current fact sheet about Marshfield Clinic's research programs.

Sincerely,

Dr. Richard A. Leer
President, Marshfield Clinic

Suit Filed Against Marshfield Clinic by Blue Cross-Blue Shield

MILWAUKEE (AP) Feb 16 -- Blue Cross & Blue Shield United of Wisconsin filed a federal lawsuit today against the Marshfield Clinic and its Security Health Plan, accusing them of anti-trust violations.

The suit, which the Marshfield Clinic and its health plan said they would vigorously contest, contends the clinic practiced illegal, monopolistic and anti-competitive activity.

Blue Cross and Blue Shield said it believes the Marshfield Clinic has achieved monopoly status through direct employment and affiliation of physicians in the geographic area it serves.

It said that, in many counties in northern and north central Wisconsin, Marshfield employs or is affiliated with 80 percent to 100 percent of all the medical doctors in particular specialties.

The suit also claims that Marshfield Clinic and Security, a health maintenance organization, have, within areas where Marshfield enjoys monopoly power over physician services, consistently refused to allow its physicians to affiliate with Compcare on any reasonable terms. Compcare is an HMO owned by a Blue Cross subsidiary.

The suit contends illegal monopolistic and anti-competitive activity of the Marshfield Clinic has cost millions of dollars due inflated fees and a limit on competition.

``Today's health care reform debate is centered around the concept of managed competition. However, managed competition can help control health care costs only if there is competition,'' said Thomas Hefty, Blue Cross chairman and chief executive officer.

``In a large section of Wisconsin, true competition is not possible because of Marshfield Clinic's practices.''

But the Marshfield Clinic said it neither excludes, nor attempts to exclude, competing providers or insurance companies from its service area.

It said clinic fees are based on service value and are well within the range of fees charged by similar centers in the Midwest.

The Marshfield Clinic said Blue Cross & Blue Shield had abandoned central and northern Wisconsin in 1986 when a partnership with Marshfield Clinic and St. Joseph's Hospital of marshfield was dissolved. The clinic said it then formed Security.

``If Blue Cross is sincere in its efforts to re-enter the region, it should complement the clinic's initiatives by helping to attract doctors to other underserved communities,'' said Marshfield Clinic executive director Robert De Vita.

``Instead, the BC/BS legal action serves only to waste premium collars collected from its own customers and waste medical care dollars which would otherwise be used by Marshfield Clinic in its mission of caring for people.''

Ozzy Fundraiser
Marshfield stuff

TO: LIZ RM 197
FAX: 802-456-2317

FR: HRC WAUSAU ADVANCE

Marshfield, Blues lock horns

From 10

net income increased as it diversified.

Blue Cross later became interested in expanding Compcare into northern Wisconsin. Last year, Blue Cross began negotiating with the clinic to create a service agreement between Compcare and Marshfield, but those negotiations broke down.

The lawsuit's monopoly claims included:

- At least 80% of all doctors in Clark, Jackson, Rusk and Wood counties are either Marshfield employees or affiliates.
- Since 1980, Marshfield has bought several independent clinics and medical practices, including Internal Medicine Associates of Chippewa Falls, Lakeland Medical Associates, and Rhinelander Medical Center.
- Marshfield hasn't let Compcare deal with its doctors since 1987.

De Vita, however, said the large number of doctors and clinics controlled by Marshfield simply reflect its integrated approach, a common industry practice. That allows Marshfield to provide services, like a radiation therapist in Rhinelander, to rural Wisconsin that otherwise wouldn't exist, he said.

Also, De Vita said Marshfield does business with health care units other than Security, including Valley Health Plan of Rice Lake — which is owned by Blue Cross.

"There's plenty of competition here," he said.

The lawsuit's claims that Marshfield's services are the highest priced in Wisconsin included:

- Prices charged by Marshfield to its patients from May 1992 and through April 1993 were far above the statewide average. For example, charges for general practice services were 54% above average.
- Security's average premiums for state employees were 11.6% higher than the average premium for similar Wisconsin health maintenance organizations in 1992.

De Vita, however, said Marshfield's fees are comparable to other clinics. For example, he cited state records showing that fees for ambulatory surgery (less extensive operations for things like cataracts or hernias) are the region's lowest.

Also, Security's premiums for state employees may be high because the number of workers insured is smaller than the number of insured state employees in areas like Milwaukee, De Vita said. With fewer people in the insurance pool, there's a greater chance one major illness will cause medical costs to increase, he said.

Marshfield singed by Blues

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$850 million in 1992. Compcare has 153,575 customers in southeast and south-central Wisconsin.

Marshfield is the largest doctor-owned clinic in Wisconsin, with revenue of $232 million in 1992. Its health maintenance organization, Security Health Plan of Wisconsin Inc., has 82,000 customers in northern Wisconsin.

Blue Cross, Marshfield Clinic and St. Joseph's Hospital in Marshfield had a health care partnership until 1987. It was dissolved after Blue Cross, citing money losses, asked to bow out, De Vita said.

Security Health took over the old partnership's patients, and has since doubled its annual business.

Blue Cross, meanwhile, expanded other operations — including life and disability insurance, vision insurance and contracts with the federal government to process Medicare claims. Blue Cross'

See Marshfield / 2D

Specialty	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Family practice	75%	100%	100%	100%	100%		83.3%	100%	80%	76%
General surgery	75%	75%	75%		100%		100%	100%	100%	100%
Orthopedic surgery	100%									100%
Orthopedics	100%	100%								
Pediatrics	100%	87.5%						100%	100%	
Radiology	100%		100%					100%		100%
Urology	100%					75%				100%
Anesthesiology		100%								
OB/GYN		100%								100%

Source: Blue Cross & Blue Shield United of Wisconsin

Marshfield's

[redacted]

A health maintenance organization run by Marshfield, which dominates health care in northern Wisconsin, took over the old partnership's patients and eventually doubled its business. Meanwhile, Blue Cross got out of red ink by diversifying.

But Blue Cross now wants to provide medical services in northern Wisconsin. And on Wednesday it sued Marshfield, saying its former partner enjoys monopoly control of doctors throughout the region.

That control creates higher medical costs for patients, said the antitrust lawsuit.

As a result, the suit said, Blue Cross paid millions of dollars in excess costs for its medical insur-

[redacted]

Robert J. De Vita, Marshfield executive director, denied Blue Cross' claims, saying the clinic's fees are within the range charged by similar Midwest clinics. De Vita also said the clinic doesn't block competition.

Blue Cross wants to expand Compcare into northern Wisconsin and is willing to destroy Marshfield to accomplish that goal, said De Vita.

The lawsuit, filed in U.S. District Court in Madison, makes public a battle between two of Wisconsin's largest health care corporations over a lucrative market.

Blue Cross is one of the state's largest insurers, with revenue of

[redacted]

Blue Cross, Marshfield Clinic and St. Joseph's Hospital in Marshfield had a health care partnership until 1987. It was dissolved after Blue Cross, citing money losses, asked to bow out, De Vita said.

Security Health took over the old partnership's patients, and has since doubled its annual business.

Blue Cross, meanwhile, expanded other operations — including life and disability insurance, vision insurance and contracts with the federal government to process Medicare claims. Blue Cross'

See Marshfield / 2D

[redacted]

Family practice
General surgery
[redacted]
Pediatrics
Podiatry
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OB/GYN

Federal Court

Blue Cross sues Marshfield Clinic, claiming antitrust

Insurer says clinic kept out competitors and set high prices

By GEETA SHARMA-JENSEN
Journal business reporter

Blue Cross & Blue Shield United of Wisconsin Inc. filed an antitrust lawsuit Wednesday against the Marshfield Clinic and its health maintenance organization, marking the first challenge to the growing power of health care conglomerates in Wisconsin.

The suit, filed in Federal Court in Madison, accuses the 78-year-old clinic of deliberately keeping competitors out of its markets and setting health care prices artificially high in a large part of the state.

Blue Cross further charges that Marshfield Clinic has prevented the roughly 400 physicians it employs from signing contracts with other health insurance organizations.

Marshfield Clinic, the largest physician-owned clinic in the state, denied the allegations and said it would vigorously contest the lawsuit.

Milwaukee-based Blue Cross, which has been trying for years to enter the northern Wisconsin markets dominated by Marshfield Clinic, says in the lawsuit:

"Marshfield Clinic has willfully and intentionally acquired and achieved monopoly power over physician services, as well as products and services related to physician services, in numerous geographic markets and submarkets in northern and north central Wisconsin."

Such activities, the lawsuit charges, have kept prices artificially high and have cost Blue Cross and other indemnity insur-

Please see **Blue Cross** *page* 4

Blue Cross/Lawsuit filed against Marshfield clinic

From page 1

ers million of dollars in overcharges.

In addition, the insurer says, its own health maintenance organization, Compcare, has lost business since Marshfield Clinic prevents its doctors from contracting with with Compcare or any other HMO.

The doctors are under contract with Marshfield Clinic's own HMO, Security Health Plan, the suit says. Security Health Plan also is named as a defendant in the suit.

HEFTY

Thomas R. Hefty, chairman and chief executive officer of Blue Cross, said the company decided to file the suit because it wanted to ensure high-quality, cost-effective health care for all.

This is especially important today, he said, when both the federal and state governments are pushing health care reform packages that rely on some form of competition.

"Today's health care reform debate is centered around the concept of managed competition," Hefty said. "However, managed competition can help control health care costs only if there is competition. In a large section of Wisconsin, true competition is not possible because of Marshfield Clinic's practices."

Blue Cross says in its suit that Marshfield Clinic employs or is affiliated with 80% to 100% of the physicians in many Wisconsin counties.

Executives of Marshfield Clinic said in a statement that the Blue Cross suit was without merit. They denied that Marshfield Clinic excludes competing providers or insurance companies from its service area.

The executives also defended Marshfield Clinic's fees, saying they are "well within the range of fees charges by similar, sophisticated medical centers in the Midwest."

Robert J. De Vita, executive director of Marshfield Clinic, said in a statement:

"If Blue Cross is sincere in its efforts to re-enter the region, it should complement the clinic's initiatives by helping to attract doctors to other underserved communities."

Marshfield Clinic, based in Marshfield, employs more than 400 physicians and serves about a million people in rural Wisconsin through a network of 21 offices. The clinic also is affiliated with more than 100 other independent doctors. Its yearly revenues total about $230 million.

The clinic's HMO has about 75,000 members.

WEATHER

T: Partly cloudy; lows in upper 20s to low 30s. Southwest winds.
THURSDAY: Partly sunny; 40s.
FRIDAY: Partly sunny; 40s.
Details on B2.

CITY STREETS FLOODED BY MELTING SNOW looked like no problem for James Marlow, 10, who wades across the flooded intersection of W. Locust and N. Holton Sts. Tuesday. But the pool was deeper and colder than he'd thought. Su forecast thro

Obey considered top contender to lead vital House committee

Appropriations chairman's health could open position

By PATRICK JASPERSE
Journal Washington bureau

Washington, D.C. — Sources say that Rep. Dave Obey (D-Wis.) is on the verge of becoming chairman of the House Appropriations Committee, one of the most powerful positions in Congress.

Obey isn't talking about it, but another House Democrat, speaking on condition of anonymity, said: "If the vote were held today, Dave would win it. It's looking good."

If Obey ascends to the chairmanship, it would be a boost for Wisconsin, which in recent years has lost several of its most experienced legislators to retirement, cabinet appointment or election defeat. Five of the state's 11 federal lawmakers have been in Congress for less than six years.

During his career, Obey has earned a reputation as a hard-working, plainspoken defender of the underdog. Unlike some other Appropriations members, Obey has not been accused of using his committee assignment to bring pork barrel projects to his home district.

Obey represents the 7th Congressional District, which covers one-third of Wisconsin, stretching from Stevens Point and Wausau up to Rhinelander and Superior.

The current chairman of the committee, Rep. William Natcher (D-Ky.), is in Bethesda Naval Hospital with what is reportedly a serious heart condition.

DAVE OBEY

The battle to replace Natcher began earlier this month, although no one is campaigning openly out of respect for Natcher, 84, who has served in the

Please see **Obey** *page* **12**

Legislature

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By DAVE DALEY
Journal Madison bureau

Madison, Wis. — take schools off the p by 1995 passed the with surprising strength, but top Sena cans and Gov. T Thompson continue the Democratic-hatch

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Blue Cross sues Marshfield Clinic

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Blue Cross & Blue Shield United of Wisconsin Inc. filed an antitrust lawsuit Wednesday against the Marshfield Clinic and its health maintenance organization, marking one of the first challenges to the growing power of health care conglomerates in Wisconsin.

The suit, filed in Federal Court in Madison, accuses the 76-year-old clinic of deliberately keeping competitors out of its markets and setting health care prices artificially high in a large part of the state.

Blue Cross further charges that Marshfield Clinic has prevented the roughly 400 physicians it employs from signing contracts with other health insurance organizations.

Marshfield Clinic, the largest physician-owned clinic in the state, said it would vigorously

Please see **Blue Cross** *page* **9**

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M/W Journal
2-16-94

Blue Cross/ Insurer sues Marshfield Clinic, HMO

From page 1

contest the lawsuit.

Milwaukee-based Blue Cross, which has been trying for years to enter the northern Wisconsin markets dominated by Marshfield Clinic, says in the lawsuit:

"Marshfield Clinic has willfully and intentionally acquired and achieved monopoly power over physician services, as well as products and services related to physician services, in numerous geographic markets and submarkets in northern and north central Wisconsin."

Such activities, the lawsuit charges, have kept prices artificially high and have cost Blue Cross and other indemnity insurers million of dollars in overcharges.

HEFTY

In addition, the insurer says, its own health maintenance organization, Compcare, has lost business since Marshfield Clinic prevents its doctors from contracting with with Compcare or any other HMO.

The doctors are under contract with Marshfield's Clinic own HMO, Security Health Plan, the action says. Security Health Plan also is named as a defendant in the suit.

'True Competition Not Possible'

Thomas R. Hefty, chairman and chief executive officer of Blue Cross, said the company decided to file the suit because it wanted to ensure high-quality, cost-effective health care for all.

This is especially important today, he said, when both the federal and state governments are pushing health care reform packages that rely on some form of competition.

"Today's health care reform debate is centered around the concept of managed competition," he said.

"However, managed competition can help control health care costs only if there is competition. In a large section of Wisconsin, true competition is not possible because of Marshfield Clinic's practices," Hefty said.

Blue Cross is claiming damages on two fronts.

First, as an insurer, it is asking to be compensated for the extra money it claims to have paid out in fees to the Marshfield Clinic and its physicians.

Second, as the parent of Compcare HMO, it is asking to be compensated for business lost as a result of what it says are the clinic's monopolistic activities in acquiring almost all the physician practices in a wide area.

Blue Cross is asking for three times these alleged losses and overcharges.

Marshfield Clinic Denies Claims

Executives of Marshfield Clinic said in a statement that the Blue Cross suit was without merit. They denied that Marshfield Clinic excludes competing providers or insurance companies from its service area.

The executives also defended Marshfield Clinic's fees, saying they are "well within the range of fees charges by similar, sophisticated medical centers in the Midwest."

Marshfield Clinic, based in Marshfield, employs more than 400 physicians and serves about a million people in rural Wisconsin through a network of 21 offices.

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Blue Cross sues Marshfield Clinic

Conglomerate is blocking insurance competition, lawsuit alleges

By Geeta Sharma-Jensen
Journal Business Reporter

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MARSHFIELD MEDICAL RESEARCH FOUNDATION

For Additional Information Contact:
Brenda L. Johnson, 715-389-3448

FACT SHEET: Marshfield Medical Research Foundation

Founded in 1959 by Marshfield Clinic physicians, Marshfield Medical Research Foundation (MMRF) is the largest private medical research facility in Wisconsin and one of the largest in America. MMRF is the Research and Education Division of the Marshfield Clinic system, Wisconsin's most complete health care network. Other components of the network include more than 400 physician specialists in 23 locations throughout central, northern and western Wisconsin; a multi-state reference laboratory; regional hospital partners (most notably Saint Joseph's Hospital, Marshfield); wholly-owned prepaid health plans and comprehensive residency and continuing medical education programs. MMRF officially joined the Clinic system in 1990.

Specific areas of research interest include:

- **National Farm Medicine Center** – founded in 1981 to provide research, education and community service programs to promote the health and safety of rural Americans.
- **Wisconsin Rural Health Research Center** – one of five federally-funded centers established to study rural access to medical care as well as agricultural health and safety issues and to formulate health care policy recommendations in conjunction with the National Farm Medicine Center.
- **Family Health Center of Marshfield, Inc.** – a program which utilizes state funding in concert with donated services to assist people with health care needs while temporarily disadvantaged by unemployment or under-employment.
- **WisconCare** – a cooperative public-private effort which utilizes funding in concert with donated services to assist people with health care needs while temporarily disadvantaged by unemployment or under-employment.
- **Medical Education** – coordinates residencies and education programs for physicians and allied health personnel within the Marshfield Clinic system.
- **Epidemiology/Biostatistics** – established to participate in studies designed to identify the causes of disease and to assist in the development and evaluation of preventive measures.
- **Research Laboratories** – five complete laboratories, each headed by a Ph.D. scientist and staffed by research associates:
  - Cancer Genetics Laboratory – formed in 1992, funded by restricted donations for cancer gene research.
  - Molecular Genetics Laboratory – studying human DNA to map the genes responsible for a variety of genetic disease.
  - Immunology Laboratory – currently operating a national testing laboratory for farmer's lung disease. Other research includes Lyme disease and testing cancer drugs for their effect on tumor cells.
  - Biochemistry Laboratory – studying a protein in the blood that is the major cause of high blood pressure. Research interests include pregnancy-induced hypertension.
  - Reproductive Physiology – studying steroid biochemistry and reproductive endocrinology. Interests include infertility and hormone receptors in breast and prostate cancer.
- **Current Projects** – More than 200 research projects underway include: study of heart disease, diabetes, thyroiditis, arthritis, psychiatric illness, alcoholism, farm suicide incidence, cancer treatment education, Wisconsin farmers intervention and care of critically ill hospitalized adults.

December, 1993

MARSHFIELD MEDICAL RESEARCH FOUNDATION

1000 North Oak Avenue
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prove their capabilities and to obtain some experience. Because no other physicians practice in Marshfield, we Clinic physicians believed that we could retain our original objectives and yet conduct a meaningful experiment without creating a problem of competition.

The Marshfield Clinic at that time was a multispecialty group of 102 physicians representing virtually all specialties and having had a salary philosophy of equal distribution since 1954. Located in rural central Wisconsin, the city of Marshfield is a community of 15,800 people having a slow but steady growth. We are fortunate to have St. Joseph's Hospital, a well equipped modern facility with 416 beds. Only three active physicians on the Hospital staff are not members of the Clinic. They are based in Colby, a town of 1,500 people 20 miles from Marshfield. The Marshfield Clinic receives referrals from much of northern Wisconsin and upper Michigan. The population within a 15-mile radius of Marshfield is about 35,000, contributes about 20% of total Clinic income and represents a minimal risk, even if a large number should enroll in the plan.

Establishing the Plan

The program was designed to provide total coverage for every person enrolled. Wisconsin Blue Cross and Surgical Care Blue Shield accepted our ideas even though they were not always actuarially sound. The rate structure was developed jointly and was limited by what the insurance company deemed was marketable. We attempted to avoid the "catches" and exclusions so familiar to patient and doctor alike in the average insurance plan. We insisted that we try to enroll the entire population rather than just predictably healthy and productive people.

We believed the coverage adequate but considered the cost out of reach of most families having incomes less than $8,000 a year. To help such families, we went to Washington and proposed an experimental federal subsidy on a sliding scale to support the economically disadvantaged. Thanks to help from Dr. Paul Ellwood, who had just originated the health maintenance organization (HMO) concept, our reception was cordial but, in the absence of specific legislation, received no funding.

A second visit in September resulted in more concrete suggestions, and we began to formulate the specific information requested. By the time this was completed, the people in Washington had been transferred; and we decided that we in Marshfield had neither the capability nor the time to do what was necessary to obtain federal aid. Therefore, we employed a consulting firm that chose to approach OEO. Unfortunately, our proposal was not accepted.

Since that time we have been very fortunate in securing a grant from the Family Health Center Program in HEW to which we applied in April 1972. In June, we were awarded slightly more than $500,000, renewable each year for three years, to help subsidize on a sliding scale those families with annual incomes of less than $7,000. Currently we are trying to arrange the details and implement this program as an integral part of the Greater Marshfield Community Health Plan.

The Plan

Provisions of the Greater Marshfield Community Health Plan:

1. All outpatient Clinic services in full including equipment, medication, supplies, and professional services rendered by physicians and paramedical personnel;
2. Full outpatient Hospital services and 365 consecutive days of inpatient Hospital care per admission including full allowance for semi-private room and 100% of all miscellaneous Hospital services;
3. Care in an approved skilled nursing facility for convalescent and long-term illness, if such services will contribute to the participant's recovery from the condition, disease, or ailment responsible for the hospitalization;
4. Services provided by home-visiting nurses under the direction of Clinic physicians;
5. Emergency out-of-area care in full at reasonable and customary charges;
6. Specialized care not available from the Clinic or Hospital if such care is deemed necessary by a Clinic physician and is based on direct referral from him;
7. Psychiatric care for up to 70 days per period of disability in Hospital, up to 10 Clinic visits for each period of disability, and renewal of coverage after 90 days;
8. Coverage from birth until marriage through the calendar year of age 19 or, if full-time students, through the calendar year of age 25; and
9. Coverage of totally and permanently disabled dependents without age limit.

Exclusions of the Greater Marshfield Community Health Plan:

1. Dental services other than those provided by the Clinic's oral surgeons;
2. Outpatient drugs;
3. Services covered by Workmen's Compensation of Employer Liability Law;
4. Care of tuberculosis after diagnosis;
5. Services of blood donor and blood plasma;
6. Services provided or available under government law;

7. Eye glasses, artificial limbs, and cosmetic surgery (except for trauma or birth defects);
8. Ambulance service;
9. Some examinations for employment, insurance coverage, and the like; and
10. Care rendered by an optometrist or podiatrist outside of the Clinic.

During the first enrollment, all waiting provisions were waived. During the second enrollment, from November 1 to January 1, 1972, a wait of 270 days for maternity care was in effect except in the case of prematurity or existing maternity coverage by another group plan.

Financial Aspects of the Plan

Originally the Clinic received $4.86 as monthly capitation for each participant. The Hospital preferred an allowance per diem for inpatient care and compensation for care in the emergency room. Funds were allocated for out-of-area hospital and physician services at the usual and customary fees for illness or accident outside of our service area. Provision also was made for referral of patients out of the area for services not available in Marshfield. Blue Cross received administrative expenses and budgeted equal amounts for marketing and administration. These were the Plan's original allocations:

Clinic	$ 4.86
Hospital	$ 6.65*
Blue Cross	$ 1.00
Out-of-Area Services	$ .69
Referred Out-of-Area	$ .26
Total	$13.46 per person

* Equivalent to $71 per day plus emergency room charges

The average family size in our area is 3.7 individuals and this multiplied by $13.46 yielded a monthly premium of $49.80 per family. The individual monthly premium was arbitrarily set at $17, too low in retrospect. The Hospital subcontracted for nursing-home care (excluding custodial care) on a 2:1 basis and home-nursing service on a 5:1 basis.

Initially we decided that, if we did not utilize the calculated hospital services, the surplus would be applied to any loss sustained by any partner. Surpluses beyond that would be divided 50% to the Clinic, 25% to St. Joseph's Hospital, and 25% to Blue Cross/Blue Shield. The latter would use their portion of surplus to recover their expense of the developmental program. Any excess beyond that would stay within the community or the Plan. If the money obtained from the original contract did not cover rendered services, it was agreed contractually that this could be recovered in later years.

Enrollees

The first group, about 1500, was the Marshfield Clinic physicians and employees and their families who joined March 1, 1971. St. Joseph's Hospital employees and families, about 1600, became members April 1. Open enrollment lasted until July 1, 1971, during which time a sincere effort was made by Blue Cross to contact all groups and every person within the selected geographic area. Anyone under 65 could join if he could pay the premium. There were no waivers or exclusions for pre-existing conditions. The second open enrollment lasted from November 1, 1971, to January 1, 1972. Enrollment is closed periodically to prevent individuals from delaying enrollment until illness occurs. The third open enrollment lasted from May 1, 1972, to July 1, 1972.

Some Features of the Plan

First dollar coverage; no deductibles. This was based on previous experience convincing us that deductibles would have to be substantial before they would affect the utilization. In our experience, people in our area do not like to come to the Clinic or Hospital unnecessarily, so we started with only minor worries about over-utilization. Also, in our experience, cost of collecting deductibles made their use unfeasible.

Free choice of physician within the Clinic and the area. Patients calling or coming to the Clinic for an appointment were handled just as they had been before the Plan. This meant free choice of physician. One of our first and most important experiences reaffirmed our fundamental belief that patients want free choice. This is illustrated by the community of Spencer and farm areas between Marshfield and Colby where a three-man group has a large office practice and is on the St. Joseph's Hospital active medical staff. Many people preferred the Colby Clinic for their primary care but came to the Marshfield Clinic for what they considered more complicated medical needs. As originally outlined, the Plan would not have allowed them to utilize the Colby Clinic without paying separate fees for service. Because of our long-standing association with these physicians, it seemed simpler to reimburse them on a fee-for-service basis using their usual and customary charges.

This procedure was adopted and subscribers now have a choice between the Marshfield Clinic and the Colby Clinic. Once a month the Colby Clinic bills the Marshfield Clinic for services rendered

and is paid out of the capitation received by the Marshfield Clinic. Since that time we have made a similar agreement with Dr. Frederick Kroeplin, a general practitioner with an office practice in Stratford, and with Dr. Robert Capling, an osteopathic physician with an office practice in Pittsville, 17 miles south of Marshfield. These men have been on the hospital courtesy staff for some time. On July 1, 1972, Dr. Morgan Ellis, an osteopathic physician from Abbotsford, 22 miles north of Marshfield, joined the Plan, slightly expanding our geographic area.

"Anonymity" of patient. We have studiously avoided any method of conveying a patient's method of payment to the physician. Unless the patient reveals this or the physician happens to know the patient works at the Hospital or the Clinic, the physician does not know the patient's method of payment. We have stressed this because we did not want to alter the pattern of care, nor did we want to be accused of giving second-class medicine to any member of the Plan. We have made no effort to send patients to any specific physicians or to use physician assistants.

Community participation. At the suggestion of Blue Cross, a Community Committee was established once the Plan got underway. They were told that they were not to be a rubber stamp but were to advise actively. To date, after spending a good deal of time getting acquainted with the plan, deciding objectives of the Committee, establishing bylaws, and the like, they have made some excellent contributions including the shaping of some of our philosophies. We anticipate a much more important role by the Committee as we start adding other services, public relations, and the like. Currently the Committee is chaired by Dr. Norbert E. Koopman, Dean of the University of Wisconsin Center (in Marshfield) and consists of representatives from the clergy, industry, labor, farming, small communities, government agencies, and others.

Special Groups

Title 19. The State Department of Industry, Labor and Human Relations has expressed a willingness to participate in an experimental program. However, Wisconsin law forbids payment for services before they are rendered. A modification of this law was proposed in the 1972 Legislature. No one opposed it, and we anticipate passage in the 1973 session.

Title 18—Medicare. We chose to wait for passage of HR-1 and expect now to actively pursue incorporating this group in the Plan.

"The near poor." Our major disappointment to date has been failure to make the program available to people who cannot afford to enroll. As mentioned previously, the Family Health Center has just granted funds to help those people not on welfare (Title 19) but whose family incomes are $7,000 or less a year. These federal funds will pay a portion of the premium on a sliding scale. At present we are negotiating to enroll this group as regular members of the Plan so that they will receive exactly the same benefits and same care as any other Plan member. This will require a waiver in the grant, but we are optimistic. An estimated 3,000 to 5,000 individuals are in this group.

Plans for Expansion

When the program started we wanted to keep the geographic area well defined. Addition of physicians in the area did cause minimal expansion. Some participants living 35 miles from Marshfield are enrolled in the Plan through group plans of employers. Apparently some of these people have shifted their medical base from local family physicians to the Clinic in order to enjoy the financial advantage. As a result, we have discussed methods of solving this problem with some of the physicians in the nearby communities. Basically, however, we still believe that the Marshfield Clinic cannot offer primary care to people living more than 20 to 25 miles away.

Results

Financial. During the first 16 months of operation from March 1, 1971 through June 30, 1972, the Marshfield Clinic's contingent liability or loss was more than $409,000 and St. Joseph's Hospital's more than $73,000. The Clinic and Hospital loss represents the cost of delivering the care plus 4%, a concept established at the start. Had the physicians received fee-for-service for services rendered, the contingent liability would have been slightly more than $500,000. We attempted to make this figure accurate by considering uncollectable debts, reduction in administrative paper work, and the like, and discounted a considerable sum for over-utilization on the part of Clinic physicians, their families, Clinic employees, and their families. These first 16 months reestablished the fact that physicians and Clinic employees utilize medical services more than anyone else. Before the Greater Marshfield Community Health Plan, these services were free.

Because the original calculation for hospitalization was based on 0.825 days annually per person and the actual utilization was 0.732, some excess money accumulated. In addition, the out-of-area and referred-out-of-area services were less than those budgeted. These surpluses plus accumulated interest totaled about $170,000 from which the Clinic will receive about $130,000. This means that the Marsh-

field Clinic lost about $280,000 in the first 16 months. Why?

1. Obvious errors in the original calculation based on previous experience, during which time the costs of medical care increased rapidly.
2. An error in judgment by some of us physicians who publicly discussed the Plan. A family of two was enrolled for $34 (two single memberships) because this seemed logical. By the time the insurance company told us that this was not financially feasible, we felt morally committed. Blue Cross estimated that this commitment cost us approximately $108,000 during the first year of operation.
3. Enrolling anyone with a medical problem. The Plan appealed to those individuals who were sick or had large anticipated medical costs. However, despite rumors, people have not moved to Marshfield to take advantage of the Plan.
4. Large families in the Plan. The premium was based on a family size of 3.7 members per family when, in fact, the size is 4.9. This did not include the two-member families enrolled as two singles.
5. The Plan's experimental nature. No effort was made to contain costs because we wanted data to establish the maximum sum currently required for care of the greatest-risk group in our area, at least among those who could afford the premium.
6. Marshfield's typical, rural, midwest conservatism. Many groups and small industries, unions, and the like adopted the attitude of wait and see. Also, union contracts often run for two and three years, so these larger organizations with healthier people were unable to enroll initially.

Utilization

To date the computer has cumulated much information, the significance and evaluation of which are being studied by Dr. John Mitchell. We expected increased utilization in the Plan because some of the subscribers were ill from the start. Perhaps for this reason physicians did not subjectively feel that patients were over-utilizing the Plan. We divide our participants into four major groups.

1. Clinic physicians and employees.
2. Hospital employees.
3. Group participants.
4. Non-group participants (individuals who purchased their own insurance).

The Clinic group utilizes our services at a higher rate than the others. As might be expected, the non-group members are second. Many of these have been unable to get other health insurance because of pre-existing conditions, often serious, and have taken advantage of open enrollment periods to enroll. Third in utilization are the Hospital employees, and last are the members of groups.

If the Clinic's patients were grouped by method of payment, initial data seem to indicate the greatest use of outpatient facilities by Medicare patients, next by Medicaid patients, next by Greater Marshfield Community Health participants, and least by fee-for-service patients. The latter group includes those not insured as well as those in other insurance programs.

Hospital utilization has already been mentioned. It did not change materially during the first year of the Plan. Before the Plan, the state rate quoted by Blue Cross was 1.1 days annually per person. In the general area of the Plan, it was 0.825, and somewhat less in Marshfield. GMCHP participants utilized the hospital during the first 16 months at a rate of 0.732 days per person per year. The physicians and hospital made no effort to reduce hospitalization during this time.

Compared with patients not enrolled in the Plan, departmental utilization based on percentage of total fees showed only a few minor variations. Radiology and the laboratory provided 15% and 14% of services respectively, on either basis. Perhaps, the most striking feature was in Oral Surgery which represented 6% of Plan services, but less than 2% of fee-for-service. Both Pediatrics and Obstetrics/Gynecology showed slightly higher usage by Plan participants as anticipated. Cardiovascular and Thoracic Surgery represented a dramatically greater percentage of fee-for-service patients as would be expected due to the referral nature of this type of problem.

Physician Reactions

Because our situation is unique, it is difficult to obtain meaningful physician reactions. Basically we doctors have seen no change in our pattern of delivering services. We do not know which patients belong to the Plan. Patients have free choice of physician. The major reaction came at the end of the first year when it was determined that, had we charged Plan members fee-for-service, we would have received slightly more income. As might be expected, the reaction was unfavorable. However, it did not materially alter our take-home pay because we all received full annual salary plus a little more. Again, several problems were obviated by the fact that we have a group practice and an equal salary program which is not affected by a physician

taking care of patients in the Plan. It is my belief that the HMO concept, as it generally exists here and elsewhere, has not provided substantial incentive for physician involvement. The best argument for physician involvement is the continuing one, "If you don't do something about this, the Government will do something for you." Whether this philosophy is adequate or acceptable is certainly open to debate.

Patient Reactions

With very few exceptions, patient reaction to date has been highly favorable. It is significant that, to our knowledge, few left the Plan in response to our increasing the premium. Generally speaking, we believe that the Plan has produced some of our finest public relations.

New Rate Structure

When we reviewed our rate based on the first year's experience, we established a new structure starting July 1, 1972. Our comptroller computed a monthly cost of about $7.70 per person for the care rendered by the physicians and Clinic during the first 16 months. Based on this experience, increased costs, and other projections, our initial calculation would have established a monthly rate near $64 per family. Because this was believed too high by the Community Committee and the marketing group, we agreed on $56.90 monthly per family and $25.95 monthly per individual, broken down as follows:

Clinic Capitation	$ 7.50
Hospital	$ 5.84*
Referral Out-of-Area	$ .41
Blue Cross	$ .90
Total	$14.65

* Equivalent to $90 per day plus emergency room charges

A word of explanation about each of these. The capitation will be paid monthly as listed. However, in addition the Clinic has $0.46 deferred capitation per participant per month billed into the premium. This will be paid in December and July if money is available in the fund. The Hospital figures include both inpatient and outpatient care. The inpatient services are based on the first year's utilization rate of 0.732 days per patient year. If money is available in December and July, they will receive up to $0.03 per patient more per day for outpatient care. The cost of referral and out-of-area emergency services which originally accounted for $0.95 of the premium has been reduced to $0.41 based on the first year's experience with $0.03 more allotted if needed and available. The administrative charge for Blue Cross has been reduced to $0.90 and, if available, Blue Cross will receive an extra $0.10 per participant. If capitation deferred is added to the $14.65 paid, the total monthly capitation is slightly higher than that listed above, and it is this multiplied by 3.7 that established the family rate of $56.90.

We also agreed that we would no longer sell two single policies to a husband and wife. They now purchase the family program.

A very significant change in the basic concept has occurred, however. That is, we have agreed to a capitation arrangement by which we can receive up to the foregoing figures as a maximum but can recover no loss. Therefore, Hospital and Clinic now operate at a greater risk. If money is left over, it will probably be used initially to recover the losses incurred during the first 16 months of operation. Eventually, any surplus would be utilized to add more service or to stabilize the rate.

Philosophy

Government and health planners have been proposing the prepaid approach with the HMO philosophy so that the incentive will be to cut costs by providing fewer services and utilizing preventive medicine. Physicians would profit by avoiding overutilization, whereas, under the traditional fee-for-service arrangement, the incentive has been to provide more services for patients. This produces a real quandary about continuing maintenance of high quality medical care. However, it is possible that we may be able to save the patient costly duplication of diagnostic and treatment services by closer supervision.

As a referral center, we cannot afford to miss any diagnosis by ignoring the laboratory, radiology, and full consultation advantages that exist within our group. We do not identify our patients as members or non-members of the Plan. But we can identify the patient as living within our geographical service area. We believe we can avoid some costly diagnostic tests on an initial visit for people from our area since they will return if they need more medical care. Our group of physicians is so indoctrinated with the type of medicine practiced here for years that we have no major concerns about the quality of care suffering as long as we remain in control.

Having determined that we will sincerely try to accept the philosophy of prepayment and capitation, we are making a number of adjustments so that we can live and (we hope) grow with little change in our present capitation figure.

1. We will try to reduce the cost of medical care to people within our primary care area, primarily by educating our physicians to think in these terms and by reviewing hospital utilization and duration of hospital stay. We believe that the Home Nursing Service which

was not utilized during the first 16 months may provide help with this problem.

2. We will try, for what it may be worth, to educate our patients about how to use health-care services more effectively and get involved in preventive medicine, particularly immunizations, "Pap" smears, family planning, and the like. We hope to accomplish some of this by a monthly newsletter to subscribers written primarily by our physicians.

General Conclusions

We believe that the citizens of the United States today have "a right to access to good health care" as outlined. We believe it necessary for the medical profession to deliver as comprehensive total-quality care to *all* people as is possible. There must be a system that will provide accessibility of health care for all and which will ensure that the already sick and poor get adequate care. For that reason, we embarked on our prepaid capitation program as an experiment to see if it offered satisfactory alternatives. The answer is still unknown.

If we can expand our coverage to Title 18, Title 19, and the "near poor," this approach seems to have the advantage of maintaining dignity of all those enrolled by providing accessibility and equal care.

We believe that both fee-for-service and prepaid programs can be operated in a single medical setting and can be mutually beneficial to all patients. This is facilitated by group practice.

We believe it is vital to develop a peer review mechanism that will emphasize quality as an incentive as well as reducing costs.

It is difficult to reconcile the philosophy of preventive medicine as an advantage of the HMO concept; that is, our physicians and employees receiving benefit of preventive medicine for many years are the most expensive to take care of.

We believe that physicians and hospitals must get actively involved in the evolutionary process that is taking place in medicine. If they stand by as spectators or technicians, the political, governmental, and consumer forces will undoubtedly make radical changes in the delivery and financing of medical services which might not be in the best interest of our patients.

We jumped rather precipitously into our program after years of discussion but not much experience in planning. We feel we have learned a lot and, in retrospect, are happy that we proceeded early. Although we might have avoided some problems, at least we feel we are much farther ahead now than we would be, had we continued to plan in depth.

We are grateful to the Wisconsin Regional Medical Program for its help in funding a subsection within our Foundation which is studying these areas in detail and from whom will come a number of reports in the next year.

It is my belief that prepaid capitation for an area like ours can be a voluntary mechanism for providing maximum medical services to all by spreading the risk to all. This, of course, is in contrast to the history of insurance programs which have stressed taking in well people and letting the poor and ill fend for themselves. If this mechanism proves successful, I believe it may be a desirable alternative to federal control which, by and large, is less sensitive to local needs and is considerably more expensive.

It is almost impossible to acknowledge all of the other individuals who worked to get this program going and keep it in effect. We want to especially thank Mr. David Jaye and the Sisters of the Sorrowful Mother representing St. Joseph's Hospital, Mr. David Neugent and his associates from Wisconsin Blue Cross–Blue Shield for their partnership and contributions. Special mention should go to Dr. Ben Lawton, President of the Marshfield Clinic when this Plan was instituted, for his leadership, and to Dr. David Ottensmeyer, the current President, for his leadership in the modifications. Mr. Floyd Detert and Mr. Brad Larsen, former Administrator and Assistant Administrator respectively, contributed greatly in the initial phases of the planning and the establishment of our Plan. Dr. John Mitchell and Mr. Bill Murray have been responsible for many of the statistics and will be reporting more in the future. Dr. Frank Lohrenz and Dr. G. Stanley Custer also helped in this respect. Mr. James Ensign, the Clinic's new Executive Director, has taken over many aspects of the Plan. Mr. Donald Nystrom has been in charge locally at the Clinic in the administration portion. Mr. Frederick Wenzel from the Marshfield Clinic Foundation has contributed, particularly to the Family Health Center grant. Special thanks go to all of these people who helped in writing this paper, especially Dr. Gerald Porter and Mr. Albert Zimmermann. □

GENESIS OF THE FAMILY HEALTH CENTER (FHC) PROGRAM

Marshfield's community health center developed from the federal family health center program initiated in the early 1970s. During that time Marshfield Clinic, St. Joseph's Hospital and Blue Cross Blue Shield United of Wisconsin formed a partnership for the purpose of developing a nationally unique health maintenance organization (HMO), the Greater Marshfield Community Health Plan. The HMO was to serve a large, predominantly rural region of north central Wisconsin. This HMO was unique among HMOs in that it regularly opened its doors to any member of the community, regardless of their health or employment status.

Early on, Marshfield Clinic realized that poverty and distance associated with rural geography represented significant barriers to service, despite the availability of the HMO. Clinic leadership sought the assistance of Marshfield Medical Research Foundation and the Public Health Service (PHS) in addressing these issues.

To that end, in June 1972, Marshfield Clinic and Marshfield Medical Research Foundation received a rural health initiative planning grant from PHS to assist in addressing financial and geographic barriers for residents of north central Wisconsin. Working with local community input, a plan was devised that would provide economically disadvantaged residents access to the same level of comprehensive health services available to their more affluent neighbors. From March 1974 through September 1982 this involved the provision of comprehensive health care (inclusive of inpatient hospital care) on a prepaid basis through a combination of sliding-fee pre-payments, federal grant dollars and provider contributions.

In partnership with FHC, Marshfield Clinic established regional centers in small rural communities facing the loss of physicians or the inability to recruit additional physicians. Since 1982 (when FHC's waiver to provide inpatient services was withdrawn) FHC has concentrated on providing physician, pharmacy, dental and community health programming.

In April, 1990, FHC assumed responsibility for the care of low-income Medical Assistance patients at Marshfield Clinic and its primary care Regional Centers in the FHC service area. The re-integration of Medical Assistance patients into the scope of FHC was made possible by cost-based reimbursement provisions contained in the Omnibus Budget Reconciliation Acts of 1989 and 1990. This change in reimbursement methodology allowed FHC, in partnership with Marshfield Clinic, to redirect resources that had been subsidizing the care of Medical Assistance patients to expand FHC programming. Enrollment in the sliding-fee, pre-paid program has since increased from 3108 in April, 1990 to 6359 as of February, 1994. The addition of Medical Assistance patients in combination with increased sliding-fee patients has had a significant impact on total low-income users. The FHC served 24,659 unique medical users in calendar year 1993, compared to 3711 users in 1989, prior to the inclusion of Medical Assistance patients under Federally Qualified Health Center program (FQHC).

THE FHC COMMUNITY HEALTH CENTER MODEL

A distinguishing feature of the FHC model is that FHC manages and delivers health care services and community health promotion activities in close partnership with the Marshfield Clinic Regional Center System. "Seamless care", a term so popular today, was defined in 1916 by Clinic Founder Dr. Karl Doege and six physician colleagues. They envisioned a comprehensive health care network extending well beyond the conventions of their day and, in some areas of the state and country, beyond what

exists today. It reflects a vision of a system very similar to that which many health care reform proposals today seek to achieve.

Today, Marshfield Clinic is a unique 400-physician, integrated system of 23 regional centers. The system focus on meeting the needs of people where they are. The essential components of its mission -- high-quality patient care, access for all, research and education -- are consistent with FHC's mission, goals and objectives.

FHC serves a predominantly rural area covering approximately 7372 square miles. 75% of the service area is designated as a health professions shortage and/or medically underserved area. The program is governed by a community Board, over half of whose members are users of the program. FHC's integration of primary and specialty care into a single regional delivery system provides all members of FHC's communities with coordinated, high-quality care. FHC, in cooperation with Marshfield Clinic, has also undertaken aggressive efforts to implement the Bureau of Primary Health Care's (BPHC) Clinical Performance Measures and other quality assurance and quality improvement activities to improve the delivery and quality of care for FHC patients.

Similar to traditional community health center models, FHC has a deep commitment to and active project plan in the area of community-based health promotion disease prevention programming. These activities are conducted in partnership with other community-based organizations and local public health agencies in the service area. Through the development of local coalitions, FHC resources have been used to leverage other state and federal funding and local support to create and maintain programs in areas of substance abuse prevention, adolescent pregnancy prevention, hypertension awareness education and cancer screening.

SUMMARY

In addition to describing FHC's current needs assessment and planning, governance, management and finance, clinical and community health promotion activities, this application also describes progress toward goals and objectives outlined in FHC's most recent non-competing application.

The long-term strategic and operational plan development processes will be enhanced through:

* continued Board training;
* more fully developed Committee roles and responsibilities and meeting schedules;
* improved definition of the role of the Health Services Director and procedural linkages among staff, Committees and Board relative to clinical plan development and implementation -- needs assessment, quality improvement, community health promotion, quality assurance and evaluation functions (including measurements to assess improvement in clinical systems and outcomes);
* continued provision of community health promotion through partnership and collaboration with other community based organizations and public health agencies;
* continued involvement in and support of activities of other primary care organizations with missions to meet the needs of the underserved.

These activities will assure strong management and governance in the provision of high quality health services through improved administration and clinical performance now and as the health care environment continues to evolve.

FHC's sliding-fee prepaid program, partnered with an integrated system of health care delivery and collaborative efforts with other community-based and public health organizations is designed to maximize impact on the primary health care needs of the communities in its service area consistent PHS program expectations. Furthermore, as the FHC community health center model enters its third decade of community-based service and as the State of Wisconsin and the Nation embark on a new era of health care reform, FHC's project plan is consistent with the fundamental values and direction of health care reform initiatives at both the state and federal level.

MARSHFIELD MEDICAL RESEARCH FOUNDATION

1000 North Oak Avenue
Marshfield, WI 54449-5790

FAX Cover Sheet

Date 2/17/94 Number of pages (including cover sheet) 29

FAX to:

Name Sara GROTE

Company

City

FAX no. 202/456-2317

From GREG NYCZ Telephone no. 715/387-9137

Department

Comments

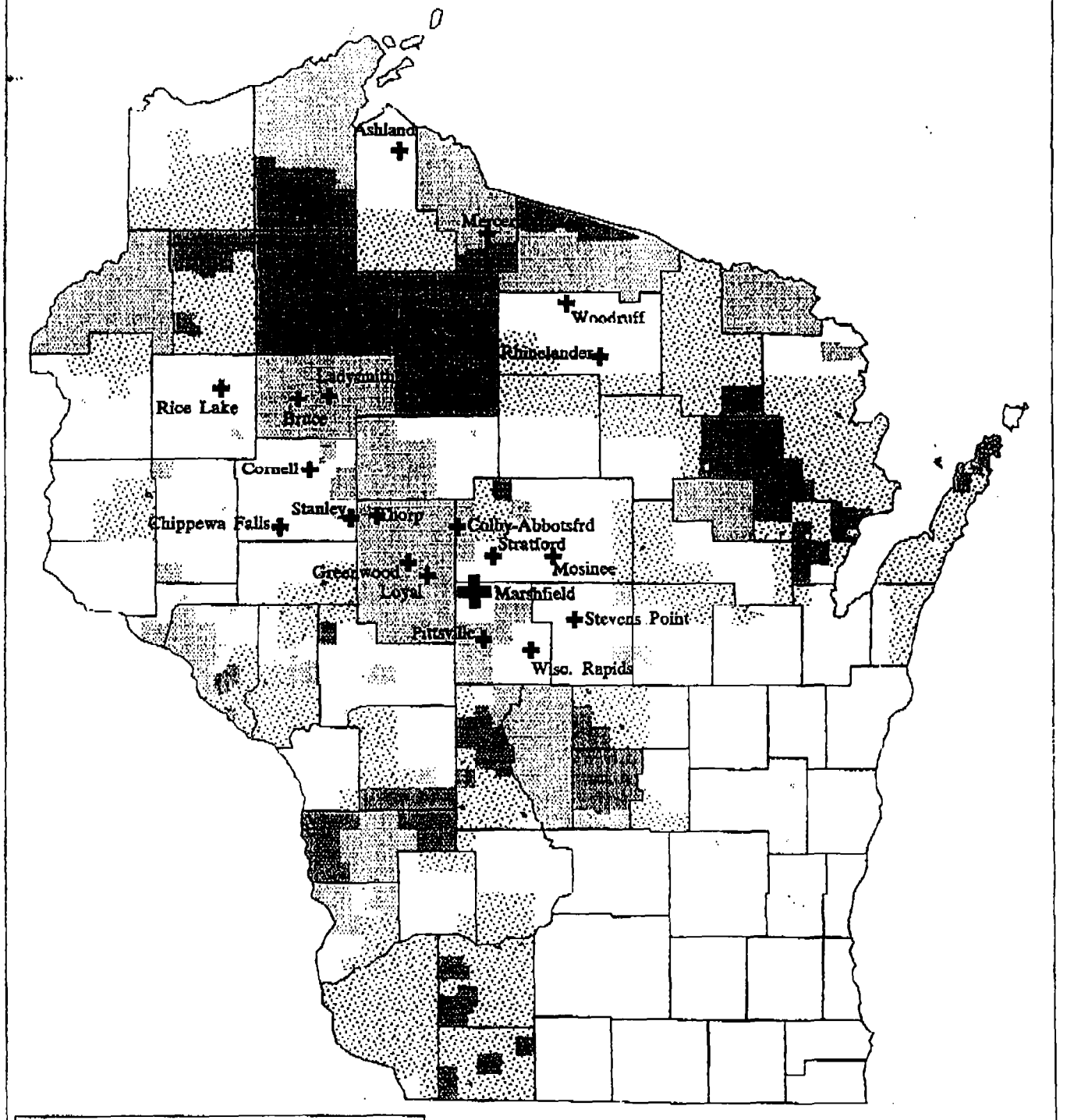
If you do not receive all pages, please call Pam Johnson at 715-387-9128
Our FAX operator is available 8:00 a.m. to 5:00 p.m., Monday-Friday.

Our FAX number is: 715-389-~~3000~~ 4788

It is accessible without operator assistance 24-hours a day.

Attachment 2

Marshfield Clinic Regional Center System, 1994



Attachment 3

Excerpt from Marshfield Clinic Articles of Incorporation

"The business and purpose of the Corporation shall be medicinal, including the establishment and operation of clinics, hospitals, offices, dispensaries and other medical institutions, insurance programs, and the employment of physicians, surgeons and other duly qualified persons for the practice of medicine and surgery."

What began in 1916 with six physicians at one location has grown to over 400 clinic physicians and 2,500 support staff at 21 locations still keeping to the vision of 1916.

MARSHFIELD CLINIC

And so it began

"Marshfield is a growing railroad town in need of a new doctor," the trainman told **Dr. K. W. Doege.** So, in a short time the young physician (who had been born in Settin, Germany, near the Polish border) set up a solo private practice in Marshfield, Wisconsin.

Dr K. W. Doege: In 1916 he had a dream.

That was in 1890, the same time the hospital was built in Marshfield by the Catholic order of the Sisters of Sorrowful Mother. K. W. Doege's practice grew as he became known as a "courageous surgeon."

Soon Dr. Doege's patients outnumbered even his appetite for surgical work. Besides, these patients were demanding that he see them for both eye and gynecology needs!

History fails to record exactly how the six solo practicing physicians actually sought one another out and created their clinic. But, in 1916, the small sign hanging out from a retail building on Marshfield's downtown Central Avenue noted that "Marshfield Clinic" could be found upstairs, above the store! And so it began.

Who were these men, these six pioneering physicians who pooled their skills and specialties so as to "help his colleague in diagnosing especially difficult cases?"

Dr. Victor Mason was the son of a Marshfield photographer. He had trained at Trinity Medical School in Toronto, Canada to specialize in both neurological and orthopedic surgery. Later, he was to augment his orthopedics with postgraduate study in Scotland. His early practice was in nearby Auburndale, Wisconsin.

Dr. Roy Potter wanted to treat children ("loved kids", he is remembered), but Doctor Doege saw the Clinic's need for a radiologist. "You go to Chicago and study radiology with your cousin at the

Continued on page four

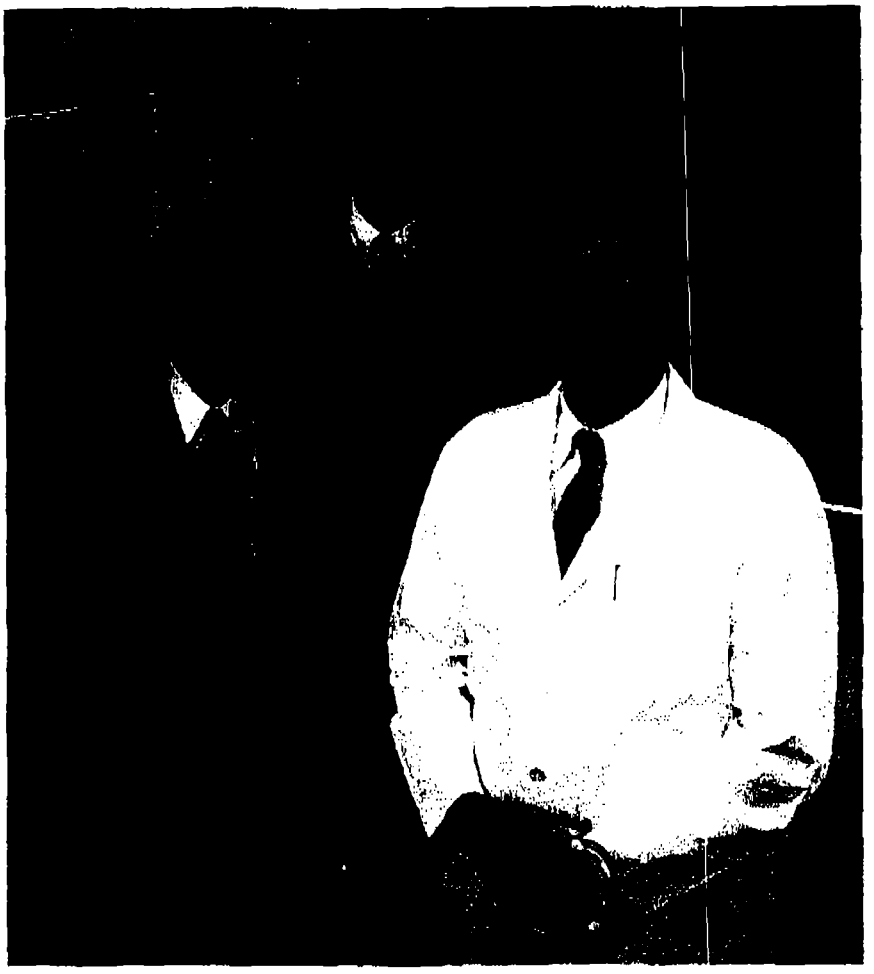
A SYSTEM OF CARE

In recent months we've been using a motto in our formal communications: "Marshfield Clinic. . . . More than a Name, a *System* of Care."

Marshfield Clinic has been a system of care for much longer than we have been telling people about it. In fact, since its inception in 1916, this medical institution has strived to look beyond the obvious, has pushed toward the frontiers in science, and in the way science is organized to maximize its positive impact on people. The earliest documents, framed by the six doctors who joined to form the Clinic seventy-seven years ago, are revealing to the reader today. They envisioned a comprehensive health network extending well beyond the conventions of the day. "Seamless care," a term so popularized in our contemporary lexicon, was defined by Dr. Karl Doege and his colleagues early in this century, right here in Marshfield, Wisconsin.

Today, Marshfield Clinic . . . the *system* . . . extends its medical services over much of the geography of central and northern Wisconsin, and it draws patients from well beyond those perimeters. Some twenty-five local facilities carry Marshfield's uncompromising level of care to as

Marshfield Clinic President Richard A. Leer, M.D., foreground, is joined by Advisor to the President Frederick J. Wenzel (left) and Executive Director Robert J. De Vita (center)



many communities. These services range in scope from single specialties and visiting physicians to full-service, multi-specialty regional centers capable of providing all but the most complex levels of care. In the process of developing this network, we have shared the challenge and the vision with several hospital partners, most notably the Milwaukee-based SSM/Ministry Corporation, whose Saint Joseph's Hospital of Marshfield is our oldest partner. By working in tandem with several fine inpatient facilities, we and they are able to offer integrated care and follow-up. The patient benefits, and that is the objective. Always.

Our *Mission Statement* on the preceding page speaks to our commitment to research and education as essential underpinnings of an interwoven system. They are that. In the text following, the reader will learn of our important laboratory and clinical studies, of our work in the inestimably important field of health systems research, and of our belief that education in all its forms is a pillar in the advancement of medicine. Some of the landmark work at Marshfield Medical Research Foundation since it was formed by the Clinic in 1959 is the very masonry on which exciting new programs, with dramatic potential, are being built. The arenas of biogenetics, epidemiology, and rural health and safety will largely define the Foundation's future, and will coalesce with important efforts at other research centers to make the life experience a healthier, fuller one.

The *system* of care doesn't end there, however.

With its world-class reference laboratory, Marshfield reaches out into a multi-state area to provide diagnostic testing and pathology services to hundreds of clinics and hospitals in small towns and large. In fact, because we recognize that illness on the farm can often affect both its human and animal residents, we've expanded our regional laboratory to serve the needs of veterinary doctors and those who depend on them.

System to us also means helping to bring health care insurance coverage to much of the region we serve. Marshfield has been in the health maintenance organization business since before HMOs had a name. Security Health Plan of Wisconsin, Inc., a wholly-owned Clinic corporation, traces its roots back to 1971 when then-Congressman Mel Laird, along with Marshfield doctors Ben Lawton, Russell Lewis and others, worked together to develop a strikingly new way to make health care available and affordable for whole communities. They were among the pioneers in shaping the part of that effort which sought to underwrite care for those families unable to pay premiums. Even today, the role of our insurance arm is to connect people in need of health care with our system of providing it.

More recently, Marshfield Clinic has joined with Saint Joseph's Hospital and Ministry Corporation in bringing a special focus to its joint services in oncology, neurosciences, cardio-vascular and pediatrics care. Out of this effort has emerged several important initiatives, such as *Marshfield Cancer Center*, among the finest in the Midwest, and *Marshfield Children's*, a tapestry of exciting and vital resources which add new impetus to our tradition of providing excellent care for kids and adolescents.

If 1992 was a year of political change, then 1993 has served as the threshold of a new era in the field of health care. We who are privileged to provide it must be willing to do things differently to ensure that America's tradition of medical excellence is not done in by financial inaccessibility. Marshfield Clinic is poised to do its part, and is committed to *making the changes it must* to accommodate these new paradigms. The reforms we must embrace will transcend any political party or ideology. They must be thoughtful changes for the long haul—for keeps—not expedients. We at Marshfield are confident that the new challenges will be met, and we have taken our place on the front lines of the effort to meet them.

Thank you for taking time to read this report. It is our privilege to share it with you.

Sincerely,

Richard A. Lee, M.D., *President*

Robert J. De Vita, *Executive Director*

Frederick J. Wenzel, *Advisor to the President*

Marshfield Medical Research Foundation, housed in the Lawton Center for Research and Education, is a division of Marshfield Clinic.

To: Liz Boyer

From: Lois Quam

Re: Attached FAX

Date: February 15, 1994

I am faxing you several items. First, the list of citizen participants at the South Dakota event. Second, I am sending a draft copy of a rural health care brochure being developed. It is in draft form but I thought that it may be useful for you in preparing the briefing materials. I am also faxing briefing materials from the President's trip to Nex Mexico which also focused on rural health care. Finally, I am faxing my thoughts on the background material for the trip

Dec 3rd
New
to Mexico

#1 * Quam - Rural Health Policy

* Draft pamphlet

* This trip to Montana Jan 17

① Program Name Worker
② HHS pamphlet
③ Needs...
- Q&A's
- laid out - v

* Hueno College

① Little House on the Prairie
SW Minn. & SDakota

② ~~Desmet~~ Desmet, SD
Waln

① Corn Palace in Mitchell
1½ half around
huge building made out of
corn husks - corn stuff
inside

~~SDakota~~

MCG → East Coast

Ark. appeal

THE LEON (IOWA)
JOURNAL-REPORTER
WED., JAN. 26, 1994

Charla Joy from LeRoy had lunch with her parents, Raymond and Darlene Deemer, Sunday, Jan. 16.

Betty Savely and Edna Quayle went to Des Moines to visit Edna's brother, Marion Morris, in the Methodist Medical Center. He suffered a heart attack, and his condition is improving.

Congressman Lightfoot

Health Care Questions Hit Home

Early Sunday morning the harsh ring of the telephone shattered a good night's sleep. Calls this time of day usually mean one of two things: someone in the district with a problem they have spent the night worrying about or bad news in the family.

Unfortunately, the call this Sunday was not from a constituent.

Several months ago, my parents were leaving the doctor's office when they were involved in a car accident. Both are in their eighties. They had been to the doctor for treatment of Mother's back. For several months, she has been battling severe back pain.

Thanks to seatbelts and an air bag, Dad only suffered a broken sternum and spent one night in the hospital. Mom was not as fortunate. The collision apparently did not do further damage to her back. It did, however, aggravate the existing problem. After several days in the hospital, she returned home.

The pain never quit. In fact, it continued to worsen. Last Saturday night it was more than she could stand, therefore the call from Dad on Sunday.

My wife immediately picked up the telephone and started making calls to doctors. Within an hour arrangements were made and we headed out to the farm to transport Mom to the hospital. Another hour and a half put us seventy miles up the road at the admissions desk of a major hospital in Omaha, NE.

It took a week of tests and redoing one that was unsatisfactory, but a decision was reached to do a surgical procedure. The procedure went well. It will be another week, however, before a final determination can be made as to the effectiveness of the surgery.

Daily trips to Omaha and a lot of time waiting for test results provided many opportunities to analyze our situation. My folks are considered "senior citizens." They don't believe the government owes them anything, so they have found a way to put money aside to buy health coverage above the mandatory Medicare. We picked the doctor and the hospital. Mom was admitted to the closest major medical center, even though it meant crossing a state line. Her admission to the hospital occurred on a Sunday. Discussions with her doctors resulted in doing tests designed to specifically locate the cause of her pain. She decided to have the surgery on her back.

What would have happened to my Mother if the Clinton Health Care Plan were already in place?

First of all, we probably would have had to travel one hundred fifty miles to Des Moines rather than seventy to Omaha, since the Clinton Plan uses a state concept for its health delivery group. We would not have been able to pick our doctor or hospital, since they are across a state line and would not be one of the "groups" available to us. We would have no opportunity to share in deciding what tests were warranted. Because she is a "senior citizen" the length of her stay, treatment and medication would be determined by a government formula rather than her condition. The operation, that we believe will give her an improved quality of life, would not be an option under the Clinton Plan.

Bottom line, the Clinton Plan to socialize medicine would not provide the choice, quality or level of care given to my Mom, or, for that matter, yours.

The scheme that the Clintons

Iowa Department of Management
County No. 27

nated 4	Actual 1993 (H)	
194	1,655,318	1
700	5,755	2
500	143,540	3
994	1,506,023	4
600	9,503	5
500	43,563	6
800	9,867	7
433	2,425,446	8
080	1,326	9
450	105,633	10
305	69,107	11
000	1,225	12
000	55,038	13

the hospital. Mom was not as fortunate. The collision apparently did not do further damage to her back. It did, however, aggravate the existing problem. After several days in the hospital, she returned home.

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Bottom line, the Clinton Plan to socialize medicine would not provide the choice, quality or level of care given to my Mom, or, for that matter, yours.

The scheme that the Clintons are using to sell health care reform, massive change with guaranteed health care for everyone at a reduced cost, is one of the slickest snake oil promotions this nation has ever seen. There never has, and never will be a "free lunch."

I want good health care for my family and yours. We will not get that by turning our system over to the "efficient management" of the United States Government.

• • •

As always, if I can provide you more information on a specific issue or help in any way, contact one of my district offices in Shenandoah, Indianola, Ames, Burlington or Ottumwa. The toll free number is 1-800-432-1984.

Dallas, Texas was named after George Mifflin Dallas. Who was he? Vice-president of the United States in 1845.

Iowa Department of Management

County No. 27

ated	Actual 1993 (H)	
94	1,655,318	1
00	5,755	2
00	143,540	3
94	1,506,023	4
00	9,503	5
00	43,563	6
00	9,867	7
33	2,425,446	8
80	1,326	9
50	105,633	10
05	69,107	11
00	1,225	12
00	55,038	13
62	4,226,731	14
		15
39	329,098	16
00	28,430	17
01	4,584,259	18
186	375,388	19
700	25,113	20
203	231,851	21
799	582,101	22
854	76,446	23
287	237,702	24
101	1,936,005	25
441	131,624	26
954	397,802	27
140	18,140	28
		29
000	92,410	30
665	4,104,582	31
639	329,098	32
304	4,433,680	33
503)	150,579	34
422	1,550,843	35
919	1,701,422	36

eas

CRESTON

To: Liz Boyer

From: Lois Quam

Re: Attached FAX

Date: February 15, 1994

I am faxing you several items. First, the list of citizen participants at the South Dakota event. Second, I am sending a draft copy of a rural health care brochure being developed. It is in draft form but I thought that it may be useful for you in preparing the briefing materials. I am also faxing briefing materials from the President's trip to Nex Mexico which also focused on rural health care. Finally, I am faxing my thoughts on the background material for the trip

marshfield.clinic

February 15, 1994

CLINIC

Established in 1916, the Marshfield Clinic is one of the oldest rural group practices in Wisconsin and is located in a town of 19,000. The Marshfield Clinic created a pre-paid health plan, the Health Security Plan in 1971.

The Family Health Plan is federally funded through the community health center discretionary program. Patients who are eligible for care through the community health center use the same door to the clinic as the private pay patients.

There are over 400 physicians on staff and 51 residents. Last year, there were 967,000 patient encounters at the clinic, 8,400 outpatient surgeries and 4,700 inpatient surgeries. There are 2,600 clinic employees. (The clinic is connected to and shares services with a 524-bed acute care hospital. The hospital employs 2,400 persons.)

The Marshfield Clinic was the recent of the 1990 "Practices Makes Perfect Contest" which was awarded by the Medical Group Management Association and the Zitter Group. The clinic was one of four multi-specialty clinics nationwide recognized for its comprehensive and innovative geriatric services.

SENIORS

The Marshfield Clinic houses the Geriatric Evaluation Center. The Center provides a multidimensional assessment resulting in a care plan tailored to the needs of the patient. Specialists in Geriatric Medicine provides a comprehensive physical exam and a certified gerontologic nurse arranges the services for patients to live in the least restrictive environment. The nurse assesses the individual's mental, physical, financial and ability to perform activities of daily living.

Two other specialty clinics are present at the center, a Parkinson's Disease Clinic and a Memory Disorders Clinic.

Education of the needs of the elderly is an important function of the Center. A geriatrics speakers bureau is available for community groups, professional organizations and nursing home staff. The Marshfield Clinic holds an annual conference for physicians who care for the elderly and a "Faces of Aging" conference targeted to the nonphysician caregiver.

PATIENTS

Reimbursement distribution reflects the patient distribution -- FY 93

Medicare fee-for-service (FFS)	22.6%
Medicare HMO	11.6%
Medicare/Medicaid	4.0%
Medicaid only	7.3%
Family Health Center (CHC)	2.0%
Non-Medicare HMO	12.4%
Non-Medicare FFS	40.2%

PERSONNEL

Dr. Richard Leer, President of the Clinic, Family Practice

Dr. Michael Kryda, (pronounced cryda) Vice-President of the Clinic, Pulmonary Medicine

Dr. Fritz Wenzel, past executive director of the Clinic, participated in Des Moines, Iowa, "Conversations on Health" RWJ sponsored town meeting on health care reform and again on March 26th in Washington, DC.

Robert De Vita, Executive Director of the Marshfield Clinic

Greg Nycz (pronounced Niche), Director of the federally funded community health center--"Family Health Plan"

MARSHFIELD CLINIC

RICHARD A. LEER, M.D.
PRESIDENT

February 10, 1994

The First Lady
Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mrs. Clinton:

As a member of the Better Way Club, I am very happy to hear that you will be in central Wisconsin on February 18 on behalf of Congressman David Obey. Mr. Fritz Wenzel and myself will be attending the Better Way Club activities on the 18th in Wausau and look forward to meeting you and hearing your presentation.

As you recall, Mr. Fritz Wenzel did participate in the "Conversations on Health" that were held March 15, 1993 in Des Moines, Iowa and March 26, 1993 in Washington, D.C. In Des Moines he presented information on the Marshfield Clinic system which we believe is a model for high quality, efficient health care delivery in a rural environment. Marshfield Clinic believes that access to good health care is affected positively by removing financial barriers to care and placing health care providers closer to patients. That is why the Marshfield Clinic has always taken care of patients without regard to their ability to pay for that care and is committed to building a regional system which places providers close to the patients' homes.

For your information, I have attached to this letter Marshfield Clinic's position on health care reform since we believe that physicians should take a proactive role in the health care reform process.

We are looking forward to meeting with you on February 18 and are sure that your journey to central Wisconsin will be a pleasant one.

Sincerely,

RICHARD A. LEER, M.D.
President

kap

Enclosure

1000 NORTH OAK AVENUE MARSHFIELD, WI 54449-5777 FAX 715-387-5240 715-387-5253

Marshfield Clinic and Family Health Center
Activities

Activities related to children

- Immunization
  Through CDC funds, FHC, Marshfield Clinic, local public health agencies, other private immunization providers, and the state Division of Health are collaborating to design an electronic system whereby data can be shared among providers. The purpose of this initiative is to reach 95% compliance with pediatric immunization guidelines.

- EPSDT Screenings (HealthCheck)
  Through a collaborative effort between Family Health Center and the Wood County Health Department, HealthCheck exams increased four-fold on Wood County children at Marshfield Clinic. This successful model is currently being replicated in 10 counties served by Marshfield Clinic Regional Centers.

Activities related to women's health

- Wisconsin Breast Cancer Screening Project
  Through a contract with the Division of Health, the Wisconsin Breast Cancer Screening Project provides free and reduced cost mammograms to women with family incomes at or below 250% of poverty who are age 40 and over and living in six target counties. From July, 1992 thru January, 1994 a total of 1257 women were screened.

- Women's Health Fair
  This event provides free health screening (including pap tests) in three locations to women who are uninsured and underinsured. In 1993, 157 women were served.

Activities related to alcohol, tobacco and other drugs

With funds from the Center for Substance Abuse Prevention, a rural county coalition of business, human service providers, healthcare providers, schools and private citizens is developing community-based solutions to decrease alcohol, tobacco and other drug use among youth and adults.

• **Research on breast and cervical cancer screening in rural areas:** With funding from the National Cancer Institute, researchers at Marshfield Medical Research and Education Foundation (MMREF) are investigating the barriers rural women face in receiving breast and cervical cancer screening. We are also evaluating a variety of strategies (both clinic and community based) for increasing the use of mammograms and Pap tests among rural women.

• **Cancer screening and reproductive health services among migrant farmworker women:** With funding from the National Institute for Occupational Safety and Health, MMREF is providing breast and cervical cancer screening and reproductive health services to migrant women through the use of a mobile clinic. Providing these services free of charge at housing camps in the evening and using female clinicians and translators reduces several of barriers to screening for this medically underserved population.

LATE MORNING
Possible free time. Further testing or consultation, if necessary.

AFTERNOON
Patient and family conference with the Geriatric Evaluation Center staff. The conference will include discussion for the diagnoses and recommendations for follow-up care. Educational material regarding the diagnoses will be provided along with information about available community resources.

Note: All drugs which the person is currently taking should be brought to the initial evaluation. (This includes emptying the medicine cabinet of all medications and bringing them to the physician's office.) The physician can then determine if potent combinations or out-of-date medications are cause for concern.

A written summary of the evaluation will be sent to the patient or family, as well as the primary physician if desired. If the patient does not have a primary physician, the Center can assist the patient in finding one.

Referrals to the Center are accepted from all sources - physicians, nurses, social workers, family, concerned others or the patient.

You can make an appointment with us by telephone or mail:

Marshfield Clinic
Geriatric Evaluation Center
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GERIATRIC EVALUATION CENTER
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For many persons growing older means growing healthy. With few medications, these individuals enjoy an active independent lifestyle. For other persons, aging presents a variety of complex problems that affect the individual and his or her family.

Successful functioning of the older individual is dependent on many things:

- physical health
- mental health
- performance of daily activities
- social supports
- economic resources

A change in any one of these areas could result in a decrease in a person's independence or ability to care for himself. Those problems might include memory loss, change in mood, depression, a changing home situation, a combination of medical ailments, or multiple medications. When any or a combination of these occur, family members or caregivers are often unable to determine what kind of treatment is best or what resources are available.

A multidimensional geriatric assessment is often necessary to fully recognize and evaluate an individual's needs. With this type of team approach a care plan can be tailored to each individual and their specific situation. Our goal is to help the older person maintain as independent a life as possible.

Marshfield Clinic's Geriatric Evaluation Center is one of the few clinic-based programs in the country to offer such a comprehensive assessment.

Our Center is staffed by physicians sensitive to the issues that are unique to the older adult. They have a special interest and extensive training in the health care of this population. The complete history and physical examination they perform is directed at determining the patient's current level of functioning. Using that knowledge, they develop a treatment plan to maintain or improve the individual's abilities.

Our nurse clinician conducts an extensive individual assessment that includes a health screening, an evaluation of the person's home situation, counseling, and matching of community services with the person's needs. She can assist in determining what community services are most appropriate to help the older person in his day to day life.

Marshfield Clinic's full complement of medical specialists is available for consultation.

Medicare, Medicaid, and private insurance companies differ in their rules about what services they will cover. Some of the services that you receive in the Geriatric Evaluation Center may not be covered by your carrier. These services will be carefully explained to you at your first appointment. Our policy is to bill the patient for what the insurance does not cover. You will have an opportunity to ask questions about insurance coverage during your visit.

Families and/or caregivers are welcome and encouraged to accompany the patient. Every attempt is made to complete the entire evaluation in one day. However, should additional testing be required, we may ask you to return on another day (or days) to complete this evaluation.

A typical day's schedule might look like this:

EARLY MORNING

Testing - Laboratory work, EKG, and chest x-ray. These tests will not be repeated if records of the same tests (less than 1 or 2 months old) are available.

AFTER TESTING

Functional assessment inventory - This is an interview to assist the physician in assessing functional status, including physical and mental health, social resources and ability to perform the activities of daily living.

MID MORNING

Doctor's appointment - Comprehensive history and physical examination.

Geriatric Services at Marshfield Clinic

Specialty Clinics:

The Geriatric Evaluation Center (GEC) is our primary program. The GEC provides a multidimensional assessment resulting in a care plan tailored to the needs of each patient. Specialists in Geriatric Medicine provide comprehensive physical exams for persons experiencing the affects of aging on their life-styles. A certified gerontologic nurse arranges services that allow patients to live in the least restrictive environment while maintaining the greatest independence safely possibly. The nurse also assesses the individual's mental and physical health, financial situation, and ability to perform daily living activities. An assessment of the patient's formal and informal support systems is included. Whenever possible, staff involves the family in the interview to ensure reliability.

The Parkinson's Disease Clinic is staffed by neurologists with special training in the diagnosis and care of patients with Parkinson's disease. The initial evaluation consists of a thorough history and examination which generally takes from one to two hours. Specialists in other disciplines such as Neuropsychology, Physical Medicine and Rehabilitation, Nutrition, and Patient Education lend their expertise as necessary.

The Memory Disorders Clinic provides comprehensive evaluation of the complex problems of the person with a memory disorder, along with recommendations for treatment.

Educational Services:

Education is an important part of Marshfield Clinic's Geriatric Services. The Geriatric Speakers Bureau provides speakers for many of the specialties found in our medical complex. Physicians, nurses, and other health professionals are available to talk on a variety of topics pertaining to aging. These talks are presented to a variety of groups—such as senior citizen centers, professional organizations, and nursing home staff.

The Faces of Aging Conference is an extremely popular one-day conference aimed at the non-physician caregiver. Although primarily for nurses, social workers, and therapists, it has also gained the interest of family members that are responsible for providing care. This conference offers in-depth presentations on medical, psychosocial, and ethicolegal health issues.

Marshfield Clinic also provides an annual conference for physicians who care for the elderly. This conference provides general internists, family practitioners, and general practitioners with current methodologies in treating older persons.

Affiliations: Marshfield Clinic is a major corporate sponsor for the Coalition of Wisconsin Aging Groups (CWAG). As the health and wellness sponsor for its annual convention, the clinic provides CWAG with a variety of health screenings and informational talks.

Marshfield Clinic is also affiliated with the Wisconsin Geriatric Education Center (WGEC). The goal of the WGEC is "to enhance the health and quality of life of Wisconsin elderly through the stimulation, implementation, dissemination, and a coordination of geriatric education for health care faculty and providers".

Marshfield Clinic is one of four founding members of the Medical Group Management Association's Geriatric Resource Assembly (GRA). The mission of GRA is "to be an information medium for both multispecialty and single specialty medical groups in the area of geriatrics and care of the increasing number of elderly across the country".

Medical Directorships: Clinic geriatricians serve as medical directors for two area long-term care facilities and one local elderly housing complex.

Awards: Marshfield Clinic was the recipient of the 1990 "Practice Makes Perfect Contest", which was awarded by the Medical Group Management Association and the Zitter Group. The clinic was one of four multispecialty clinics nationwide recognized for its comprehensive and innovative geriatric services.

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