

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Patti Thomas Harper to Chris Jennings re: phone number (partial) (1 page)	10/08/1999	P6/b(6)
001b. memo	Andy Hronek to Theresa re: Christus Health System Meeting (partial) (1 page)	10/13/1999	P6/b(6)
002a. form	Wave requester information form re: SSN and DOB (partial) (1 page)	06/11/1999	P6/b(6)
002b. note	re: SSN and DOB (partial) (1 page)	06/11/1999	P6/b(6)
003a. email	Waves to Teresa M. Jones re: Waves Confirmation (partial) (1 page)	06/03/1999	P6/b(6), b(7)(C), b(7)(E), b(7)(F)
003b. form	Wave requester information form re: SSN and DOB (partial) (1 page)	06/04/1999	P6/b(6)
004a. memo	Joanne Gardner to Teresa re: Meeting (partial) (1 page)	06/14/1999	P6/b(6)
004b. form	Wave requester information form re: SSN and DOB (partial) (1 page)	06/15/1999	P6/b(6)
004c. note	Requests for Chris re: phone number (partial) (1 page)	06/15/1999	P6/b(6)
004d. memo	Marc J. Scheineson to Teresa re: Meeting (partial) (1 page)	05/24/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Meetings, Trips, Events)
OA/Box Number: 17045

FOLDER TITLE:

Speaking Engagements (January - August 1999) [2]

2011-0747-S

rc414

RESTRICTION CODES

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

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

P1 National Security Classified Information [(a)(1) of the PRA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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.

**CHRISTUS
SCHUMPERT
Health System**

mtg thurs. 10/14/99
1215 pm

AIRMAIL MESSAGE

VIA

Government Affairs and Public Policy

Phone: (318) 681-7183

FAX: (318) 681-6999

NUMBER OF PAGES, INCLUDING COVERSHEET 6

(X) URGENT

() CONFIDENTIAL

**To: Senator Mary Landrieu
Attn: Norma Jane
Andy**

From: Patti T. Harper

Date: October 8, 1999

Re: Appointment

I am attaching a list of names and general info on CHRISTUS Health. If it is helpful information I believe that we are the largest private non-profit health system in Louisiana and we employ in excess of 10,000 people in the state.

Call if you have other questions and thanks so much for your help!

*LM w/ Theresa 2:45pm 10/8
456-5560
456-5557 fax*

Contact

*HALLIE-224-9739
ANDY-224-1521*

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October 8, 1999

Mr. Chris Jennings
The White House
1600 Pennsylvania Avenue
Washington, D. C. 20500

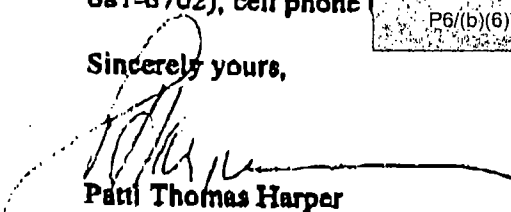
Dear Mr. Jonnings:

As a representative of CHRISTUS Health System, I am writing to request an opportunity to meet briefly with you at your convenience on Thursday, October 14 to discuss the provider prospective on the BBA problems and potential administrative options in achieving relief in this health care crisis. Members of our Senior Leadership team attending the meeting will include

Dr. Tom Royer	CEO	CHRISTUS Health
Peter Maddox	Sr. Vice President	CHRISTUS Health
Dan Rissing	Sr. Vice President	CHRISTUS Health Louisiana
Deborah Randolph	Vice President, Government Affairs	
Patti Harper	Vice President, Government Affairs	
Janie Carver	CEO	Dubuis Long Term Care System
Jack Bresch	Catholic Health Association	
Dr. Milton Chapman	Vice President, Medical Staff	
(Dr. Chapman's sister is Milli Alston, White House Director of Personal Communications)		

I know that during this hectic week of markups and debates your schedule is extremely tight, and if another day or week is more convenient, we would certainly make every effort to be available. We are, however, already scheduled to be in Washington Tuesday through Thursday next week for Congressional meetings. If you have questions, or should need to contact me, I can be reached at my office (318-681-6702), cell phone [REDACTED] or home number [REDACTED] [0019]

Sincerely yours,


Patti Thomas Harper
Vice President,
Government Affairs

12:15pm Thurs.

Rm 216 OFOB



Our Mission "To extend the Healing Ministry of Jesus Christ"

Fact Sheet

CHRISTUS Health – An Overview

BACKGROUND

CHRISTUS Health was formed in February 1999 and consists of virtually all the hospitals and services that once made up Incarnate Word Health System, based in San Antonio, and the Sisters of Charity Health Care System, based in Houston. CHRISTUS Health is sponsored jointly by the Congregations of the Sisters of Charity of the Incarnate Word in Houston and the Sisters of Charity of the Incarnate Word in San Antonio.

MISSION & VISION

The CHRISTUS Health Mission is: To extend the healing ministry of Jesus Christ.

The CHRISTUS Health Vision is to:

- Strengthen current ministries and expand into new locations and services
- Implement innovative approaches to caring for the whole person
- Increase access to health care for the poor and underserved through advocacy and other initiatives
- Make significant contributions to creating healthy communities
- Create a work environment filled with hope, dignity and mutual respect.

FACT & FIGURES

CHRISTUS Health includes more than 30 hospitals and other health care ministries in more than 60 communities in Texas, Louisiana, Arkansas, Utah and Oklahoma.

CHRISTUS Health has more than 23,000 employees and nearly 8,000 staffed beds, with assets of \$3.4 billion and annual revenues in the range of \$2 billion.

CHRISTUS is one of the 10 largest Catholic health systems in the country and one of the 20 largest of all health systems in the nation.

6283 North Highway 181, Suite 450 | Irving | Texas 75038
Tel 877-880-0100 | Fax 214-273-5030

CHRISTUS Health Overview - 2

CHRISTUS Health is headquartered in Dallas, with system support centers located in Houston and San Antonio.

CHRISTUS HEALTH LEGACY

The shared mission of the two sponsoring religious congregations of CHRISTUS Health dates back to 1866, when three young women came to Texas from France in response to a call from the Catholic Bishop of Texas Claude Dubuis. His call, "Our Lord Jesus Christ, suffering in the persons of a multitude of sick and infirm of every kind, seeks relief at your hands," was answered by three brave Sisters from Lyons, France.

Those Sisters opened the first Catholic hospital in the state in Galveston, Tx., and founded the Sisters of Charity of the Incarnate Word.

In 1869, three members of the congregation traveled to San Antonio, again in response to a call from the Bishop, and established Santa Rosa Hospital and a separate Sisters of Charity of the Incarnate Word congregation.

The health ministries of each congregation ultimately grew to become the Sisters of Charity Health Care System and Incarnate Word Health System.

OUR NAME & SYMBOL

CHRISTUS is Latin for "Christ," and proclaims publicly the core of our Mission. Our name choice also recognizes the heritage of our two congregational sponsors, the Houston and San Antonio congregations of the Sisters of Charity of the Incarnate Word. Jesus Christ is the Incarnate Word, the word of God made flesh. It is, therefore, only fitting that it is in another form of His name that our health ministries are called together.

The healing ministry of Jesus Christ is reflected in our symbol - a combination of a medical cross and a religious cross. The flowing banner on the cross is a common symbol of the risen Christ, while the royal purple signifies Christ. The flowing banner also conveys a sense of motion as we move forward into a new era of continued service to our communities.

CHRISTUS HEALTH FACILITIES AND SERVICES

Texas Facilities

CHRISTUS St. Catherine Health and Wellness Center,
West Houston -- 60 beds (opening February 2000)

CHRISTUS Health Overview - 3

CHRISTUS St. Elizabeth Hospital, Beaumont - 474 beds
CHRISTUS St. John Hospital, Nassau Bay - 140 beds
CHRISTUS St. Joseph Hospital, Houston - 838 beds
CHRISTUS St. Joseph's Health System, Paris - 212 beds
CHRISTUS St. Mary Hospital, Port Arthur - 270 beds
CHRISTUS St. Michael Health System, Texarkana - 239 beds
CHRISTUS St. Michael Rehabilitation Hospital, Texarkana - 80 beds
CHRISTUS Jasper Memorial Hospital, Jasper - 95 beds
CHRISTUS Santa Rosa Hospital, San Antonio - 402 beds
CHRISTUS Santa Rosa Children's Hospital San Antonio - 262 beds
CHRISTUS Santa Rosa Medical Center, San Antonio - 172 beds
CHRISTUS Santa Rosa Rehabilitation Hospital, San Antonio - 34 beds
CHRISTUS Spohn Hospital Shoreline, Corpus Christi - 458 beds
CHRISTUS Spohn Hospital Memorial, Corpus Christi - 397 beds
CHRISTUS Spohn Hospital South, Corpus Christi - 102 beds
CHRISTUS Spohn Hospital Beeville, Beeville - 70 beds
CHRISTUS Spohn Hospital Kleberg, Kingsville - 100 beds
CHRISTUS Spohn Hospital Alice, Alice - 50 beds
CHRISTUS The Regis/St. Elizabeth Centers, Waco - 325 beds
Rice Medical Center, Eagle Lake - 47 beds (*managed facility*)
Baptist St. Anthony Health System, Amarillo - 380 beds
(two-hospital system owned 50 percent with Baptist Community Services, Amarillo)
Covenant Behavioral Health, San Antonio - 160 beds
(joint venture)

Louisiana Facilities
CHRISTUS Coushatta Health Care Center, Coushatta - 60 beds
CHRISTUS St. Frances Cabrini Hospital, Alexandria - 265 beds

CHRISTUS Health Overview - 4

CHRISTUS St. Patrick Hospital, Lake Charles - 396 beds

CHRISTUS Schumpert Health System, Shreveport - 601 beds

CHRISTUS Schumpert Bossier, Bossier - 170 beds

CHRISTUS St. Joseph's Home, Monroe - 132 beds

Natchitoches Parish Hospital, Natchitoches - 98 beds (*managed facility*)

Arkansas Facility

Magnolia Hospital, Magnolia - 65 beds (*managed facility*)

Utah Facility

CHRISTUS St. Joseph Villa, Salt Lake

Long-Term Acute Care Centers

The Dubuis Hospital for Continuing Care, Inc. long term acute care facilities are located in the following cities :

Beaumont, Tx. - 36 beds

Alexandria, La. - 35 beds

Houston, Tx. - 30 beds

Port Arthur, Tx. - 19 beds

Texarkana, Tx. - 34 beds

Lake Charles, La. - 20 beds

Shreveport, La. - 24 beds

Physicians' Services and Medical Groups

CHRISTUS Medical Group - 100 physician group sites in Texas and Louisiana

CHRISTUS Primary CareNet of Texas - 153 physicians, over 600 specialists and 15 business clients

(September 1999)

Withdrawal/Redaction Marker

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To: Theresa
From: Andy Hronek
Re: Christus Health System Meeting
Date: 10/13/99

Here are the names and clearance information for the meeting tomorrow at 12:15pm in Room 216, OEOB:

Dr. Thomas Royer

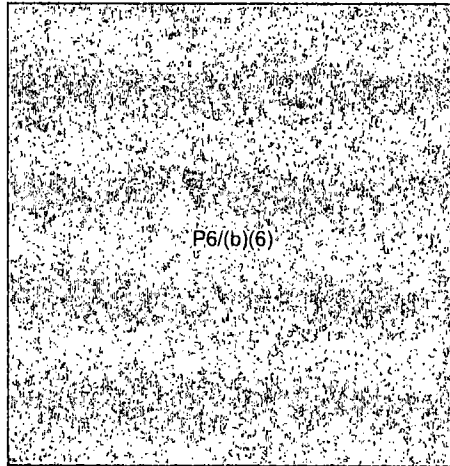
Peter Maddox

Patricia Harper

Deborah Randolph

Felicien Brown

Jamie Carver



[0016]

I apologize for the delay. Thank you for all your help. I can be reached at 224-1521 if you need to contact me.



U.S. Senator
Mary L. Landrieu
Louisiana



Phone: (202) 224-5824
Fax: (202) 224-9735

FAX TRANSMISSION

To: Theresa Fax: 456-5557

From: Andy

Date: 10/13

Number of pages, including the cover: 2

Comments: Clearance info. for tomorrow's
meeting w/ Christus Health at
12:15pm

Please call (202) 224-5824 if there is a problem with this transaction.

NATIONAL DISABILITY EMPLOYMENT AWARENESS MONTH PRESS BRIEFING
Roosevelt Room, The White House
Thursday, October 14, 1999, 12:30 – 3:00 p.m.

Planned Agenda

WELCOME

Joe Lockhart, Assistant to the President and Press Secretary

12:30 – 12:50 p.m.

ADMINISTRATION OVERVIEW

Speaker: **Rodney Slater**, Secretary, U.S. Department of Transportation

Topic: The Administration's efforts and accomplishments on behalf of the disability community, including transportation access issues

12:50 – 1:10 p.m.

DISABILITY AND CULTURAL AWARENESS

Speaker: **William Kennard**, Chairman, Federal Communications Commission

Topic: Diversity issues in the disability community, including access to telecommunications

1:10 – 1:30 p.m.

CIVIL RIGHTS ENFORCEMENT

Speakers: **Bill Lann Lee**, Assistant Attorney General for Civil Rights, U.S. Department of Justice; and

Edward Correia, Special Counsel to the President for Civil Rights

Topic: Civil Rights and the disability community, Hate Crimes legislation

1:30 – 1:50 p.m.

HEALTH CARE POLICY

Speaker: **Chris Jennings**, Deputy Assistant to the President for Health Care Policy

Topic: Patient's Bill of Rights, long-term care, access to specialists

1:50 - 2:10 p.m.

SOCIAL SECURITY AND MEDICARE REFORM

Speakers: **Gene Sperling**, Assistant to the President and Director of the National Economic Council (NEC); and

Jeanne M. Lambrew, Ph.D., Senior Health Policy Analyst, NEC

Topic: Social Security and Medicare issues unique to the disability community

2:10 – 2:30 p.m.

EDUCATION

Speakers: **Judith E. Heumann**, Assistant Secretary, Office of Special Education and Rehabilitative Services (OSERS), U.S. Department of Education;

Norma V. Cantu, Assistant Secretary for Civil Rights, U.S. Department of Education

Topic: Coordinating programs and funding for special and general education, including Title One, and school construction and access; How disability issues relate to civil rights and education.

2:30 – 3:00

EMPLOYMENT

Speaker: **Frederic Schroeder**, Commissioner of the Rehabilitative Services Administration, OSERS, U.S. Department of Education

John Lancaster, Executive Director, President's Committee on Employment of

People with Disabilities

Topic: Employment issues, including the Work Incentives Improvement Act

CLOSING REMARKS

Mary Beth Cahill, Assistant to the President and Director of the Office of Public Liaison

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CLOSING REMARKS

Mary Beth Cahill, Assistant to the President and Director of the Office of Public Liaison

SUSAN J. WHITE & ASSOCIATES, INC.
1020 North Fairfax Street, Suite 202
Alexandria, Virginia 22314

(703) 683-2573 phone
(703) 683-0865 fax

mtg 10/14/99
1100
Karent. ofc

FAX COVER SHEET

TO:

Chris J. Mung

FAX NO:

(202) 456-5557

FROM:

Susan White

DATE/TIME:

10/12/99

NO. of PAGES:

17

(including cover sheet)

SUBJECT:

*Materials for meeting 10/14 with Frank
P. Muncie*

MESSAGE:

This telecopy may contain CONFIDENTIAL INFORMATION, which also may be LEGALLY PRIVILEGED and which is intended only for the use of the addressee(s) named above. If you are not the intended recipient of this telecopy, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination or copying of this telecopy may be strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone and return the original telecopy to us at the above address via the postal service. Thank you.

Susan J. White & Associates, Inc.

1020 North Fairfax Street

Suite 202

Alexandria, VA 22314

TELEPHONE: 703 683-2573

TELECOPIER: 703 683-0865

Memo To: Chris Jennings, Deputy Assistant to the President for Health Policy Development

From: Susan J. White, Los Angeles County Washington DC Representative for Health Issues

Date: October 12, 1999

Subject: **Materials for Meeting with Mark Finucane 10/14, 11:00 AM**

In advance of your meeting with Mark Finucane this Thursday, I thought it might be helpful for you to have the latest document on Los Angeles County's 1115 Waiver, an Executive Summary dated October 4.

I am also sending a second document which is titled '*Abstract*'. This paper is a summary of the survey of patient satisfaction conducted by the University of California at Los Angeles. I would be happy to furnish the full survey document if you would like that as well.

Please let me know how I can be helpful.

Attachments

file W. White

**MEDICAID DEMONSTRATION PROJECT FOR LOS ANGELES COUNTY
1115 WAIVER EXTENSION PROPOSAL
FISCAL YEARS 2000-2005**

EXECUTIVE SUMMARY

This is a request to extend the Medicaid Demonstration Project for Los Angeles County ("1115 Waiver," "Waiver," or "Demonstration Project") for five years to continue the transformation of the second largest County health care system in the nation.

INTRODUCTION

At the start of the 1995-96 fiscal year, Los Angeles County was faced with an unprecedented \$655 million budget deficit in health services—the loss of one out of every two dollars available—and a devastating collapse of the safety net. In response, State, Federal, and County officials intensively collaborated to develop a five-year Medicaid Demonstration Project to address the County's structural and financing crisis by helping to stabilize the County Department of Health Services ("DHS") system, and, over time, move it away from expensive hospital services toward community-based primary and preventive care services.

DHS has made notable progress toward meeting the Demonstration Project goals. However, the fundamental restructuring goals of reducing inpatient and expanding outpatient care cannot be fully met by the end of the current Project term, June 30, 2000. The County's considerable progress cannot be sustained unless the structural and financial problems which contributed to the original fiscal crisis are addressed. Continued State, Federal and County collaboration is needed to address the underlying problems confronting the County, which have not been resolved, including:

Welfare Reform and Declining Medi-Cal — After more than twenty years of steady growth, the number of Medi-Cal eligibles has declined throughout the State. For example, the number of Medi-Cal eligibles in Los Angeles County has steadily decreased from 1.9 million to about 1.7 million since 1995. Between January 1996 and January 1998, the number of AFDC/TANF cases in Los Angeles County decreased by 23%. Major studies demonstrate that welfare reform has been a significant factor in the decline in Medicaid enrollment.

Shift of Medi-Cal Population/Reliance on Safety Net — The County public hospital system has lost 132,000 Medi-Cal inpatient days, a 26.1 percent drop, since FY 1994-95. This has serious implications for the County's health care system, which provides over 85% of all uncompensated care in Los Angeles County. Because the County relies heavily on revenue from inpatient hospital services, these reductions jeopardize the continued ability of the health care safety net to serve both Medi-Cal and indigent patients.

Limited Success of Expanding Insurance Coverage — Despite recent improvements to expand insurance coverage to children at the Federal and State levels, these do not offset the annual declines in Medi-Cal coverage and the low rate of job-based insurance. The uninsured rate for children has not changed significantly; even under the "best case" scenarios there would still be more than 300,000 children uninsured.

Large and Rising Uninsured — The uninsured population has steadily increased despite a rebounding local economy. Most estimates indicate that the highest job growth has been in low-wage jobs that typically do not offer health insurance coverage. Thus, the uninsured population is expected to continue to rise. Over the past two years, the County has averaged about 150 new uninsured persons per day.

Continued financial incentives for inpatient and emergency services — Despite the program changes that have reduced inpatient and inappropriate emergency services, very little net savings to the County have resulted due to loss in Federal and State revenues. The current Medi-Cal funding mechanisms create a "Catch 22" for County DHS. Progress toward the County's restructuring goals does not produce the significant financial savings necessary to maintain the changes.

Limits in Payments to Safety Net — Even with 1115 Walver funds, the total federal funding available to County DHS has declined from \$1.2 billion to \$1.1 billion since the beginning of the Demonstration Project. The proportion of the DHS budget composed of federal funds has dropped from 50 percent of total funding to 47 percent. The Disproportionate Share Hospital program is scheduled to decline by 18% in FFY 2002, based on the Balanced Budget Act of 1997 (BBA). Moreover, the elimination of Federal cost-based reimbursement for Federally Qualified Health Centers, relied upon by many of the County's private partners, is proceeding in phases and will end after FFY 2003.

JUSTIFICATION

An extension is justified because:

- Although the County has made a fundamental shift in the delivery of health

care, more work is needed to achieve the complex and difficult process of restructuring. Major goals of the Demonstration Project have not yet been fully accomplished. While the County has demonstrated a firm commitment to change, restructuring that expands ambulatory care, integrates public and private partners, and changes long-standing clinical practices requires additional time.

- Continuation of the current Project funding and the addition of the Healthy Students Partnership, Workforce Retraining and other requested funding components will provide the funding flexibility necessary to support progress toward community-based primary and preventive care services and the implementation of inpatient efficiencies.
- Continuation of the Demonstration Project will allow the County to build on the initial phase of stabilization and structural changes to improve the management of diseases for at-risk-Medicaid and the indigent population.
- Los Angeles County has a disproportionate share of the nation's working uninsured—twice the nation's rate. The total number of uninsured is projected to be 3 million by the year 2005. In the absence of national health policy reform, the Demonstration Project provides the vehicle for the federal government to assist the County in responding to the financial pressures on its health care system brought about by the expanding uninsured population and to maintain the safety net that serves Medicaid beneficiaries and the indigent.
- The aggressive expansion of managed care and the reduced revenue associated with low capitation payments strain and reduce the resources of those safety net providers that serve substantial number of Medicaid eligibles and serve as the last resort for the uninsured.
- Public schools must become a partner in the emerging public and private delivery system to better serve the children eligible under Medicaid and the State's Children's Health Insurance Program (i.e., "Healthy Families"). This will expand access to ambulatory care, provide a nexus for increased enrollment in the Medi-Cal and Healthy Families programs, and improve the health status of children and youth where they are—in school.
- A labor-management initiative that retrain and prepares the workforce that serves both Medicaid and indigent populations is essential to sustaining the ongoing restructuring under the Project. As the County system undergoes dramatic changes, it needs a workforce prepared for new responsibilities with new or enhanced skills responsive to the dynamic health care environment.
- Increased demand for specialty services, a consequence of the expansion of primary care, needs to be accommodated.

Without continuation of federal assistance through a Waiver extension and new amendments, accomplishments to date could be jeopardized and emerging opportunities will not be realized. Approval of this request would reaffirm the Initial commitment of the Federal government to the restructuring of the County's health care system, and incorporate new strategies consistent with existing efforts.

MAJOR RECOMMENDATIONS

The restructuring process requires fundamental changes throughout the County's health care system. The County has demonstrated its deep commitment to making the necessary changes. However, once the changes are made, they must become institutionalized in policies and in the behavior of individuals throughout the system, from County employees to public/private partners. A continuation of the Demonstration Project will support this effort through the following elements:

A five-year extension of the core financing elements in the existing Terms and Conditions, enabling the Department to:

- Support and continue the restructuring efforts achieved through June 30, 2000.
- Advance integration of public and private health services for the indigent and Medi-Cal populations.

A Restructuring/Stabilization Program that changes financial disincentives to invest in ambulatory care expansion and disease management interventions that can ultimately reduce the burden of disease. The recommended fiscal amendments would enable the Department to:

- Expand community-based ambulatory care services by 900,000 additional visits through public and private providers to reach the initial target of 3.9 million.
- Reduce by another 10 percent the inappropriate utilization of inpatient care.
- Implement a new approach that is not solely geared to reducing beds, but also managing diseases more effectively. The implementation of disease management programs for pediatric asthma, diabetes, congestive heart failure, HIV/AIDS, and other selected diseases, will decrease resource consumption, change clinical practices, and improve the health status of patients.

- Expand community-based risk reduction programs for high-risk families and individuals to reduce reversible risk factors for common diseases and injuries, including tobacco, alcohol, drug abuse, poor diet, sedentary life style, and violence.
- Gain flexibility in obtaining disproportionate share hospital ("DSH") revenues to enable County DHS to receive a one-to-one replacement of DSH dollars lost from inpatient reductions by increasing Supplemental Project Pool funds available for ambulatory care under the Waiver.
- Gain State and HCFA approval of budget neutrality limits based on: (1) FY 1999-2000 budget neutrality limit, (2) carryover of budget neutrality savings expected under the current Waiver (as was granted for Oregon), and (3) non-DSH Medicaid inflation rate factor of 8.4% per year.
- Engage the State and HCFA in identifying/developing funding mechanisms to realize additional revenues allowed under renewed budget neutrality limits.
- Institutionalize funding arrangements to the extent that successful program changes demonstrate efficient use of resources.

An amendment to fund the Healthy Students Partnership program for school-based and school linked services with public school districts, enabling:

- Expansion of ambulatory care services, targeting uninsured school-age children and youth, for a projected 500,000 annual visits by 2005.
- Linkage of schools with the emerging public and private health care delivery system of DHS clinics and partners to secure more effective outreach, health promotion, enrollment in Medi-Cal and Healthy Families, and coordination of care.

An amendment to fund an essential multi-year Health Care Workforce Retraining Project based on the recommendations by the *President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry*. This project would:

- Design and implement workforce training and retraining programs for an estimated 2,400 workers at immediate risk due to restructuring.
- Retrain employees to change organizational culture and accelerate transition towards an integrated delivery system, guided by public health principles, and facilitated by a strategic alliance between management and SEIU Local 660.
- Assure a properly staffed delivery system for Medi-Cal beneficiaries and the indigent.

An amendment to provide specialty care services at public hospitals to medically indigent patients, enabling the Department to:

- Support the changing role of public hospitals in the coordination and provision of 250,000 added specialty care visits above the current level of services.
- Reduce waiting times to less than 21 days for high-demand specialty care services (as a result because of expanding access to primary care).

THE FIRST FIVE YEARS: CHARTING A NEW COURSE

During the current five-year Demonstration Project, the County has shifted the direction of DHS and achieved notable progress in key areas, including:

Expansion and Restructuring of Ambulatory Care Capacity and Access

- Increased ambulatory care sites throughout the County, from 45 to 149 sites, through a new Public/Private Partnership ("PPP") program with safety net and traditional providers.
- Increased ambulatory care visits by 600,000 after stabilization, mostly for primary care services.
- Decreased inappropriate use of the emergency room by 27%.
- Established specialty care referral centers to coordinate care for the medically indigent patients referred by DHS and PPP providers. (Long appointment waiting times for specialty care continues to be an issue for DHS.)
- Developed an innovative set of ambulatory care indicators to assess the full extent of increased access, including nurse encounters, home health visits, telephone contacts, nurse triage, etc.
- Initiated a comprehensive, community-based health planning process, involving over 400 participants and using data from the L.A. County Health Survey, that produced the County's first Ambulatory Care Plan approved by the Board of Supervisors in February 1999.
- Established the Office of Ambulatory Care to develop policies that increase access to cost-effective ambulatory care services and effective health promotion and disease prevention programs.

Reduced Inpatient Services

- Decreased budgeted beds by 28%—five times higher than the State trend and three times the national trend.
- Decreased average daily census by 24%—five times higher than the State trend and three times the national trend.
- Reduced average length of stay from 6.4 days to 5.9.

Improved Cost Management

- Reduced expenditures, including staff for hospital services in the County DHS public system, by \$123 million from FY 1994-95 to FY 1997-98.
- Reduced the annual federal funding levels by an average of \$174 million, even with the inclusion of Demonstration Project funds, through FY 1998-99.
- Projected savings of \$408 million in federal revenues below the budget neutrality limit.
- Reduced the workforce by 15 percent, a decrease of 4,300 employees (permanent and temporary workers) and 2,500 layoffs, between October-November 1995 and July 1998.
- Began a system-wide reengineering process with savings targets of \$40.7 million for FY 1998-99.

Forged New Community Initiatives

- Initiated the Healthy Students Partnership process with public school districts, targeting uninsured school-age children. Implementation of this program is expected to result in 500,000 ambulatory care and prevention visits.
- Developed a cooperative project with SEIU Local 660, partially funded by a \$1.2 million grant from the US Department of Labor, to plan for the retraining of workers at-risk due to restructuring.
- Developed a system-wide workforce and diversity training program.
- Established the Office of Women's Health to develop policies and programs that improve the health status of women.
- Began a series of Initiatives to Improve the health status of children, such as the Healthy Students Partnership, the first Children's Health Policy Summit, and a set of priority "Interventions for Children 0-5" years of age.

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- Conducted a countywide health survey to document a profile of the insured and uninsured, and their health status—with results reported in a new periodic DHS publication, *L.A. Health*.
- Incorporated survey data into the community-based planning process.

Expanded Managed Care

- Increased the enrollment of Medi-Cal members in the County's HMO, CHP, from 14,000 to approximately 95,400 lives as of March 1999.
- Earned State designation for two consecutive years as the preferred "Community Provider Plan" in Los Angeles County for Healthy Families—California's SCHIP program.

GOALS NOT YET MET

Although substantial progress has been made, major objectives during the first five years were not fully accomplished and require additional time, including:

- Achieving the ambulatory care access objective of increasing access by 50%. The Department has not yet met the initial target of 3.9 million visits.
- Implementing cost efficiencies and service consolidations. The initial reengineering targets were unrealistic. A revised target to save \$82 million annually by FY 2000-01 has taken into consideration the complex issues of system-wide implementation.

GENERAL LESSONS LEARNED

The first years of the Demonstration Project provide several significant lessons to guide the process for the next five years. These include:

- Privatization demands adequate reimbursement for uncompensated care.
- Public/private partnerships are effective in increasing ambulatory care access.
- Increased access is more than increased number of visits. It includes other cost-effective methods such as nurse encounters, home health visits, telephone contacts, nurse triage, etc.

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- Reforming a health care system requires broad participation from community, labor, and other stakeholders, with an emphasis on reducing the burden of disease.
- Appropriately assessing the special circumstances of large public teaching hospitals is a necessary part of developing benchmarks and determining any potential revenue impacts.
- Fiscal reform will be essential to advance community-focused restructuring.

THE NEXT FIVE YEARS: MANAGING DISEASE AND PATIENT CARE

The next phase in charting the new course is rooted in the general lessons learned during the current Demonstration Project period. It involves (1) a continuation of the structural changes already underway, (2) realization of expanded ambulatory care services to the medically indigent, and (3) a concerted effort to reduce the burden of chronic disease through patient/disease management and disease prevention. These combined efforts are reflected in the following strategies and objectives outlined for the next five years. These include:

Further Increasing Access

- Meet the initial target of 50 percent increase in access by delivering 900,000 additional annual visits through public and private partnerships by 2004-2005.
- Implement Healthy Students Partnership, targeting uninsured school-age children—resulting in 500,000 additional visits by 2005.
- Expand specialty care services by 250,000 additional annual visits by 2005.
- Enhance the mix of services through cost-effective methods that serve uninsured patients relying on the safety net system.
 - Expand home health services by at least 50%
 - Increase telephone encounters (including pharmacy) by at least 50%
 - Increase nurse only visits by at least 50%
 - Increase referrals by at least 50%
- Create a community assistance program under the Office of Ambulatory Care to inform consumers and stakeholders, respond to community concerns, and focus on other areas of improvement.

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Managing Disease

- Reduce by 10 percent the number of preventable hospitalizations in each acute care hospital by implementing disease management programs for:
 - Pediatric Asthma
 - Diabetes
 - Congestive Heart Failure
 - HIV/AIDS
- Reduce the number of inappropriate emergency room visits by an additional 10%.
- Expand community-based risk reduction programs for high-risk families and individuals.

Service and Quality Improvement

- Improve the performance of safety net systems for Medi-Cal and uninsured populations through enhanced monitoring of networks, contracts, and service standards.
- Improve quality assurance programs based on a consumer-driven and continuous service/quality improvement process. The biannual L.A. Health Survey and the current patient survey being conducted by UCLA will help in assessing the effectiveness of a "restructured system," focusing on major areas of care.
- Invest in planning and evaluation functions to ensure integrated networks of public health and managed health care services that meet the health needs of communities.

New Initiatives

- Increase the focus of graduate medical training programs on primary care based on the newly negotiated affiliation agreements.
- Institute a public health rotation for graduate medical trainees in the County system by academic year 2002.
- Expand the community-based planning process using the findings from the L.A. Health Survey—which is conducted every two years—to address reversible risk factors for common diseases and injuries.
- Respond to strategies and recommendations developed by the Women's and Children's Health Policy Summits.

Managing Costs

- Continue implementation of cost efficiencies and service consolidations. The enterprise-wide reengineering project is still underway, with a revised target to save \$82 million annually by FY 2000-01.
- Improve the cost-effectiveness of inpatient services by 5% through the implementation of clinical pathways (e.g., improve management of cellulitis, pneumonia, and congestive heart failure).

Reducing the Burden of Disease

- Complete the reorganization of public health to improve the assessment of health needs and priorities for each major planning area.
- Reduce reversible risk factors for common diseases and injuries, including tobacco, alcohol, drug abuse, sedentary life style, and violence.

Health Care Workforce Retraining

- Enhance the skills of ambulatory care workers to meet the evolving and changing demands under managed care through a collaborative labor-management process.
- Support assessment, training, placement, and other transition strategies for the 2,400 hospital-based employees at-risk due to the largest and most complex reengineering project in the nation among public health systems.
- Improve core public health competencies of 3,700 workers and prepare new employees for emerging roles in the assessment, development, and evaluation of health services.

The approval of the extension request and the proposed amendments to the Medicaid Demonstration Project for Los Angeles County will advance the restructuring of the County health system, and assist in implementing new programmatic initiatives through fiscal reform.

* * *

Under the current Demonstration Project, the County has made significant progress toward structural changes and seeks to continue that process and move toward managing disease and patient care. Restructuring that involves expanding ambulatory care, integrating public and private providers ("partners"), changing fiscal disincentives and long-standing clinical practices requires both time and the commitment of resources. To continue the restructuring process,

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the County is requesting the State and Federal governments to extend the Project for another five years.

The extension of the Project will allow the County to continue working with its partners, including private health service providers, free and community clinics, health care organizations, academic institutions, labor, and consumer advocates/community representatives to realize a common vision: a vastly improved health services system for the County's vulnerable Medi-Cal and indigent populations.

ABSTRACT

To assess both patient satisfaction levels and how the recent expansion of ambulatory care services has impacted the Los Angeles County health care delivery system, an independent research study was conducted by a team of researchers from the University of California Los Angeles. Respondents were recruited over a sixteen week period from primary care clinics at fifty different facilities located throughout Los Angeles County: 5 hospitals, 6 Comprehensive Health Centers and 19 Health Centers operated by Los Angeles County and 20 private-public partners. A total of 2564 adult and pediatric patients were interviewed face-to-face in multiple languages: English, Spanish, Armenian, Chinese, Korean, and Tagalog. The general findings were as follows:

Population Characteristics:

- The overall response rate to this voluntary survey of 78%.
- Median income was between \$5,000 and \$9,999.
- Overall, 68% were uninsured.
- Patients seen at DHS and PPP facilities had a higher burden of disease and were in poorer health in overall than the general population.

Patient Relations:

- 91% reported that their health care provider usually or always listened to them;
- 89% said that their health care provider usually or always showed respect;
- 87% said that their health care provider usually or always explained things to them in a way they could understand;
- 82% reported that their health care provider usually or always spent enough time with them;
- 85% replied that they were usually or always treated with courtesy and respect by staff at County facilities; and
- 83% said that staff were usually or always as helpful as the patient thought they should be.
- 66% of patients that were non-English speakers reported that their provider usually/always spoke their preferred language.

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Patient Satisfaction:

- Respondents rated their overall experience at DHS and PPP facilities within the past 12 months at a median of 9.
- On the day of their interview the respondent rated their health care provider with a median of 10, and their overall experience at the clinic with a median of 9.

Access:

- 76% reported that DHS and PPP facilities were close to their home.
- 81% reported that they could get medical care whenever they needed it.
- 83% of those referred to specialty care saw a specialist at least once.
- 81% of those seen for regular or routine health care usually or always got an appointment as soon as they needed it.

Use of Preventive Health Services:

- 99% of adults had their blood pressure checked at least once within the 12 months prior to their current visit.
- 88% of pediatric patients up to age 2 with immunization records had received the recommended number and type of immunizations.
- 88% of women with an intact uterus had received a pap smear within 3 years.
- 64% of women needing prenatal care and receiving care at a County or PPP facility had been seen by a physician during their first and second month of pregnancy.
- 82% of women age fifty or older had a mammogram within the preceding two years.

Quality of Care:

- 95% of patients with diabetes reported that their provider had measured serum glucose or glycosylated hemoglobin with the past 12 months.
- 90% of patients with diabetes had undergone cholesterol testing within the preceding 3 years.
- 84% of patients with hypertension had been advised to eat less salt.
- 86% of patients with hypertension had their cholesterol checked within the past 3 years.

Barriers to Care:

- 21% reported going without needed medical care at sometime during the prior 12 months because it was necessary for them to spend their money on food and/or clothes.
- 45% reported that they had not received medical care because of the financial expense.
- Among those patients who were not U.S. born, 31% thought that applying for Medicaid or other government health care program would affect their ability to become a U.S. citizen.
- 11% of patients had left the clinic without care because of an excessively long waiting time.
- Of those who missed an appointment, 16% reported they did so because they were unable to take time off work, and 14% because they had no transportation.

It should be noted that there are some variation by facility and SPA. The complete final analysis will show these variations.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

SEP 14 1999

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

MEMORANDUM FOR THE HONORABLE CHRISTOPHER JENNINGS

OK if someone helps me prepare. I need to talk w/ FRANCIS Collins. Get Deborah to set up & see if Sarah can join conference call.

The Secretary's Advisory Committee on Genetic Testing (SACGT) is interested in learning about the Administration's efforts to prevent genetic discrimination in employment and health insurance. Given your pivotal role in developing these policies, the SACGT Chairman, Dr. Edward McCabe, and I would be most appreciative if you could address the Committee on October 25-26, 1999, in Rockville, Maryland. If possible, we would like to schedule the briefing on the afternoon of October 26.

The SACGT was established to advise the Secretary of Health and Human Services on the complex medical, ethical, legal, and social issues raised by genetic testing and to formulate policy advice to ensure the appropriate incorporation of genetic tests into health care and public health practice. At its inaugural meeting on June 30, 1999, the SACGT reviewed a broad range of issues in genetic testing and identified a subset of issues that warrant high priority attention over the next 1-2 years. Because the misuse and stigmatizing potential of genetic information was among the Committee's top concerns, the Committee wants to be knowledgeable about the policy approaches that already have been developed to prevent genetic discrimination in employment and health insurance.

Please let me know if you would be available to brief the SACGT on this important topic. Ms. Sarah Carr, SACGT Executive Secretary, at 301-498-9838 can answer any questions you or your staff may have about the SACGT and the October meeting. Thank you for your consideration of this request.

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
U.S. Surgeon General

*mtg w/ Francis Collins -
genetic code, & entrepreneurs,
and patents.*

George L. ...
U.S. Public Health Service
690-7694

Brenda Farmer
301 435-2138

Devorah R. Adler
09/24/99 12:23:02 AM

Record Type: Record

To: Teresa M. Jones/OPD/EOP@EOP

cc:

Subject: meeting with Francis Collins

Can you please set up a conference call with Dr. Francis Collins from NIH for next week?

Thanks.

Devorah

301-496-4000 Main
301 496-0844-Frances
Scheduler Patty

Devorah Adler



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

October 12, 1999

MEMORANDUM FOR THE HONORABLE CHRISTOPHER C. JENNINGS

On behalf of Dr. David Satcher, Assistant Secretary for Health and Surgeon General, and Dr. Edward McCabe, Chairman of the Secretary's Advisory Committee on Genetic Testing (SACGT), I want to thank you for agreeing to brief the SACGT on the Administration's efforts to address genetic discrimination in health insurance and employment. The misuse and stigmatizing potential of genetic information is a high priority issue for the SACGT, and the Committee wants to be knowledgeable about the Administration's policies on genetic discrimination and the steps being taken to implement them.

The meeting is being held at the Doubletree Hotel Rockville, Regency Ballroom, 1750 Rockville Pike, Rockville, Maryland. Your presentation is scheduled for Monday, October 25, 1999, at 3:00 p.m. Dr. McCabe hopes that you would provide a 15-20 minute presentation followed by 15-20 minutes of discussion with the SACGT members.

During the discussion period, members may pose questions such as the ones that follow. If I can be of any assistance, please let me know.

- Does the Administration differentiate between anti-discrimination and the medical records privacy/confidentiality?
- Does the Administration's policy approach provide sufficient protection against the additional discrimination ethnic groups may face?
- What steps are being taken to address genetic discrimination in life insurance?
- It may be possible in the future to develop genetic tests for conditions that may not be solely health-related such as obesity or drug addiction. Would the current approach provide protection against discrimination based on this kind of genetic information?

Jennings

Page 2 – The Honorable Christopher C. Jennings

- During the public comment period of the first SACGT meeting in June, the executive director of the National Commission on the Future of DNA Evidence informed the SACGT about the work of the Commission, which was established at the request of the Attorney General for “the purpose of maximizing the value of DNA evidence in the criminal justice system.” Is the Administration developing policy to provide safeguards against the misuse of information gathered for criminal justice purposes?

The draft meeting agenda and background information about the SACGT are attached for your reference. If you need additional information in preparation for the SACGT meeting, please do not hesitate to contact me at 301-496-9838.

Thank you again, on behalf of Dr. Satcher and Dr. McCabe, for taking time to brief the SACGT on the Administration's efforts in this area.



Sarah Carr
Executive Secretary
Secretary's Advisory Committee on Genetic Testing

Attachments:

SACGT Meeting Agenda, Charter, Roster, and First Meeting Highlights

cc: Dr. Satcher, ASH and Surgeon General, DHHS
Dr. McCabe, SACGT Chairman
Mr. Ottenstein, White House Liaison, OS, DHHS
Dr. Hamburg, Assistant Secretary for Planning and Evaluation, DHHS
Mr. Tarplin, Assistant Secretary for Legislation, DHHS
Ms. McHugh-Wytkind, Deputy Assistant Secretary for
Public Affairs/News and Strategy, DHHS
Dr. Varmus, Director, NIH
Dr. Collins, Director, NHGRI/NIH
Dr. Skirboll, Associate Director for Science Policy, NIH
Dr. Patterson, Director, Office of Recombinant DNA Activities, OSP/NIH

DRAFT

Second Meeting
of the
SECRETARY'S ADVISORY COMMITTEE ON GENETIC TESTING
Monday, October 25 - Tuesday, October 26, 1999
Doubletree Hotel Rockville
Regency Ballroom
1750 Rockville Pike
Rockville, Maryland 20852

Meeting Agenda

Monday, October 25, 1999

9:00 a.m. - 9:10 a.m.	Chairman's Remarks - Dr. McCabe
9:10 a.m. - 9:15 a.m.	Administrative Matters -- Conflict of Interest Guidance
9:15 a.m. - 9:30 a.m.	Criteria for Assessing Risks and Benefits of Genetic Tests: Possible Approaches to Oversight Issue 1 - Dr. Burke
9:30 a.m. - 10:30 a.m.	Discussion of Issue 1
10:30 a.m. - 10:45 a.m.	B R E A K
10:45 a.m. - 11:15 a.m.	Characteristics of Genetic Tests that Increase or Decrease Concerns about Risks - Allen Buchanan, Ph.D., Professor, Department of Philosophy, University of Arizona
11:15 - 12:00 p.m.	Continued Discussion of Oversight Issue 1
12:00 p.m. - 1:00 p.m.	L U N C H
1:00 p.m. - 2:00 p.m.	Public Comment

2:00 p.m. - 2:15 p.m.	Discrete Risk Categories of Genetic Tests: Possible Approaches to Oversight Issue 2 – Dr. Burke
2:15 p.m. - 3:00 p.m.	Discussion of Oversight Issue 2
3:00 p.m. - 3:20 p.m.	The Administration's Efforts to Address Genetic Discrimination in Health Insurance and Employment – Christopher C. Jennings, Deputy Assistant to the President for Health Policy
3:20 p.m. - 3:45 p.m.	Discussion
3:45 p.m. - 4:00 p.m.	B R E A K
4:00 p.m. - 4:15 p.m.	Report of the SACGT Working Group on Outreach – Dr. Lewis
4:15 p.m. - 4:45 p.m.	Consulting with Diverse Communities on Issues in Genetics – Vence Bonham, J.D., Co-Investigator, Communities of Color and Genetics Policy Project, University of Michigan School of Public Health/Michigan State University/Tuskegee University
4:45 p.m. - 5:30 p.m.	Discussion of Outreach Mechanisms Proposed by the SACGT Working Group on Outreach

R E C E S S

Tuesday, October 26, 1999

- 8:30 a.m. - 9:10 a.m. The Role of the States and Private Sector Organizations in Oversight of Genetic Tests –
- Ann Willey, Ph.D., Director, Laboratory Policy Development,
New York State Department of Health
- Rod Howell, M.D., President, American College of Medical Genetics
- Walter W. Noll, M.D., Member, College of American Pathologists
Molecular Pathology Committee and CAP-ACMG Joint
Committee on Biochemical and Molecular Resource Committee
- Dale H. Altmiller, Ph.D., Member, Area Committee on Molecular
Methods and Chairholder, Subcommittee on Molecular Genetics,
NCCLS
- 9:10 a.m. - 9:45 a.m. Discussion of Roles in Oversight
- 9:45 a.m. - 10:00 a.m. B R E A K
- 10:00 a.m. - 10:30 a.m. Discussion of CLIAC Recommendations for Genetic Testing
- 10:30 a.m. - 10:45 a.m. Options for Oversight of Genetic Testing: Possible Approaches to Oversight Issue 3 – Ms. Beardsley/Mr. Hillback
- 10:45 a.m. - 12:00 p.m. Discussion of Oversight Issue 3
- 12:00 p.m. - 1:00 p.m. L U N C H
- 1:00 p.m. - 1:15 p.m. Appropriate Levels of Oversight for Categories and Data Collection, Evaluation, and Dissemination: Possible Approaches to Oversight Issue 4 – Ms. Beardsley

- 1:15 p.m. - 1:30 p.m. Data Collection Strategies in Genetic Testing: DHHS
Public/Private Partnership Pilot Project – Dr. Khoury
- 1:30 p.m. - 2:00 p.m. Discussion of Oversight Issue 4
- 2:00 p.m. - 3:00 p.m. Discussion of Conceptual Questions Regarding Oversight Issues
- Does the complexity of the factors that need to be considered in assessing risks and benefits of genetic tests present a challenge to the assignment of genetic tests to distinct risk categories?
- Are the distinctions between clinical validity and clinical utility important with respect to oversight?
- Can oversight be flexible enough to respond to rapid advances in knowledge of genetics?
- Are additional or different oversight options needed to address genetic tests that have significant social implications?
- 3:00 p.m. - 3:15 p.m. BREAK
- 3:15 p.m. - 4:00 p.m. Discussion/Approval of Draft Consultation Document and Outreach Mechanisms
- 4:00 p.m. - 5:00 p.m. Discussion of Other Issues

A D J O U R N

Roster of Presenters

Dale H. Altmiller, Ph.D.
Associate Professor
Department of Pathology
University of Oklahoma Health Sciences Center
1100 North Lindsay
Oklahoma City, Oklahoma

Allen Buchanan, Ph.D.
Professor
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Vence Bonham, J.D.
Assistant Professor of Health Law and Policy
Michigan State University
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R. Rodney Howell, M.D.
Professor and Chairman
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Miami, Florida 33101

The Honorable Christopher C. Jennings
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Marc R. Schlank, M.T.(ASCP), M.S.
Assistant Standards Administrator
NCCLS (formerly known as the National Committee for Clinical Laboratory Standards)
940 West Valley Road Suite 1400
Wayne, PA 19087-1898

Ann Willey, Ph.D.
Director, Laboratory Policy Development
Wadsworth Center
New York State Department of Health
Empire State Plaza
Albany, New York 12201

CHARTER

SECRETARY'S ADVISORY COMMITTEE ON GENETIC TESTING

Purpose

Innovations in molecular genetics and genetic testing are bringing about rapid changes in health care. These changes have far-reaching medical, social, ethical, and legal implications and raise many practical challenges for health care providers, clinical laboratories, patients and their families, and regulatory agencies. Genetic testing promises tremendous potential benefits with respect to preventing or treating inherited diseases and disorders. But genetic testing also can result in considerable harm if the tests are flawed or used inappropriately, if test results and their significance are communicated inaccurately or incompletely to health care providers and patients, or if test results are handled without adequate attention to privacy and confidentiality.

The Department of Health and Human Services (DHHS) has a vital role in safeguarding public health while fostering the development of valid genetic tests and facilitating their availability and beneficial use for medical and public health purposes. The several agencies within the Department that help carry out this role must collectively address the broad array of important and complex policy issues raised by genetic testing. To assist in addressing these cross-cutting policy issues, the Secretary's Advisory Committee on Genetic Testing identifies policy issues raised by genetic testing and makes policy and procedural recommendations to the Secretary on how such issues should be addressed.

The establishment of such a Committee was recommended by the Task Force on Genetic Testing (TFGT) of the NIH-DOE Working Group on the Ethical, Legal and Social Implications (ELSI) of the Human Genome Project as well as the Joint NIH-DOE Committee to Evaluate the ELSI Program of the Human Genome Project.

Authority

42 U.S.C. 217a, Section 222 of the Public Health Service Act, as amended. The Committee is governed by the provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Function

The Secretary's Advisory Committee on Genetic Testing shall advise and make recommendations to the Secretary through the Assistant Secretary for Health on all aspects of the development and use of genetic tests. The scope of the Committee's charge includes recommending policies and procedures for the safe and effective incorporation of genetic technologies into health care; assessing the effectiveness of existing and future measures for oversight of genetic tests; and identifying research needs related to the Committee's purview.

Structure

The Committee shall consist of a core of 13 members, including the Chair, and the following 6 nonvoting, *ex officio* members: the Administrator, Agency for Health Care Policy and Research; the Director, Centers for Disease Control and Prevention; the Commissioner, Food and Drug Administration; the Administrator, Health Care Financing Administration; the Administrator, Health Resources and Services Administration; and the Director, National Institutes of Health; (or their designees); and any additional officers or employees of the United States as the Secretary determines necessary for the Committee to effectively carry out its function. Members and the Chair shall be selected by the Secretary, or designee, from authorities knowledgeable in fields of genetic testing, medical genetics, genetic counseling, ethics, law, primary health care, public health, clinical laboratory management, diagnostic technology, psychology, social sciences, and other relevant disciplines. Of the appointed members, at least one shall be a current member of the Clinical Laboratory Improvement Advisory Committee, at least one shall be a current member of the Medical Devices Advisory Committee, and at least one member shall be specifically selected for knowledge/expertise as a consumer of health care services.

Members shall be invited to serve for overlapping terms of up to four years; terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination. Members may serve after the expiration of their term until their successors have taken office.

A quorum for the conduct of business by the full committee shall be six of the appointed members.

As necessary, standing and ad hoc subcommittees composed of members of the parent committee may be established to perform specific functions within the Committee's jurisdiction. The Department Committee Management Officer will be notified upon establishment of each standing subcommittee and will be provided information on its name, membership, function, and estimated frequency of meetings.

The Committee shall be able to call upon special consultants, assemble ad hoc working groups, and convene conferences and workshops as necessary to assist in the work of the Committee.

Coordination of agenda development and management and operational services shall be provided for the Committee by the Office of Science Policy, Office of the Director, National Institutes of Health, with direction and guidance from the Assistant Secretary for Health.

Meetings

Meetings shall be held at least two times per year at the call of the Chair with the advance approval of a Government official, who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public except as determined otherwise by the Secretary or other official to whom the authority has been delegated; notice of all meetings shall be given to the public.

Meetings shall be conducted and records of the proceedings kept, as required by applicable laws and Departmental regulations.

Compensation

Members shall be paid at a rate not to exceed the daily equivalent of the rate in effect for Executive Level IV of the General Schedule for each day they are engaged in the performance of their duties as members of the Committee. Members shall receive per diem and travel expenses as authorized by Section 5703, Title 5 U.S.C. for persons employed intermittently in the Government service. Members who are officers or employees of the United States Government shall not receive compensation for service on the Committee.

Annual Cost Estimate

Estimated annual cost for operating the Committee, including compensation and travel expenses for members but excluding staff support is \$129,692. Estimated annual person-years of staff support required is 2.25 at an estimated annual cost of \$146,570.

Reports

In the event a portion of a meeting is closed to the public, an annual report shall be prepared which shall contain, at a minimum, a list of the members and their business addresses, the Committee's function, dates and places of meetings, and a summary of committee activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

Termination Date

Unless renewed by appropriate action prior to its expiration, the Secretary's Advisory Committee on Genetic Testing will terminate two years from the date this charter is approved.

*Approved June 10, 1998
Amended November 2, 1998
Amended January 25, 1999*

Secretary's Advisory Committee on Genetic Testing Roster

Chair

Edward R.B. McCabe, M.D., Ph.D.
Professor and Executive Chair
Department of Pediatrics
University of California, Los Angeles
Physician-in-Chief
Mattel Children's Hospital
10833 Le Conte Avenue, 22-412 MDCC
Los Angeles, CA 90095

Members

Patricia A. Barr
Partner
Barr, Sternberg, Moss, Lawrence, & Silver, P.C.
507 Main Street
North Bennington, VT 05257

Kate C. Beardsley, J.D.
Partner
Buc & Beardsley
919 Eighteenth Street, N.W.
Washington, DC 20006

Ann Happ Boldt, M.S.
Certified Genetic Counselor
Maternal Fetal Medicine and Genetics Center
St. Vincent Hospital Family Life Center
2001 West 86th Street
Indianapolis, IN 46240

Joann Boughman, Ph.D.
Vice President for Academic Affairs
Dean of the Graduate School
University of Maryland, Baltimore
520 West Lombard Street
Baltimore, MD 21201

Wylie Burke, M.D., Ph.D.
Associate Professor of Medicine
Department of Medicine
Division of General Internal Medicine
University of Washington School of Medicine
4245 Roosevelt Avenue, N.E.
Seattle, WA 98105

Patricia Charache, M.D.
Program Director
Quality Assurance and Outcomes Assessment
Department of Pathology
Johns Hopkins University Hospital
600 North Wolfe Street
Baltimore, MD 21205

Mary E. Davidson, M.S.W.
Executive Director
Alliance of Genetic Support Groups
4301 Connecticut Avenue, N.W., Suite 404
Washington, DC 20008

Elliott D. Hillback, Jr.
Senior Vice President
Corporate Affairs
Genzyme Corporation
One Kendall Square
Cambridge, MA 02139

Barbara A. Koenig, Ph.D.
Executive Director
Stanford Center for Biomedical Ethics
Stanford University
701A Welch Road, Suite 1105
Palo Alto, CA 94304

Judith A. Lewis, Ph.D., R.N.
Associate Professor
Maternal Child Nursing
Director of Information Technology
School of Nursing
Medical College of Virginia
Virginia Commonwealth University
1220 East Broad Street
Richmond, VA 23298

Victor B. Penchaszadeh, M.D., M.S.P.H.
Professor of Pediatrics
Albert Einstein College of Medicine
Chief, Division of Medical Genetics
Department of Pediatrics
Beth Israel Medical Center
First Avenue at 16th Street
New York, NY 10003

Reed V. Tuckson, M.D.
Senior Vice President
Professional Standards
American Medical Association
515 North State Street
Chicago, IL 60610

Secretary's Advisory Committee on Genetic Testing Roster

Ex Officio Members

Agency for Health Care Policy and Research

John M. Eisenberg, M.D.
Administrator

Alternate:
David Lanier, M.D.
Acting Director
Center for Primary Care Research

Centers for Disease Control and Prevention

Jeffrey P. Koplan, M.D., M.P.H.
Director

Alternate:
Muin Khoury, M.D., Ph.D.
Director
Office of Genetics and Disease Prevention

Food and Drug Administration

Jane E. Henney, M.D.
Commissioner

Alternate:
David W. Feigal, Jr., M.D., M.P.H.
Director
Center for Devices and Radiological Health.

Health Care Financing Administration

Nancy-Ann Min DeParle, J.D., M.P.H.
Administrator

Alternate:
Jeffrey L. Kang, M.D., M.P.H.
Director
Office of Clinical Standards and Quality

Health Resources and Services Administration

Claude Earl Fox, M.D., M.P.H.
Administrator

Alternate:
Michele Lloyd-Puryear, M.D., Ph.D.
Chief, Genetic Services Branch
Maternal and Child Health Bureau

National Institutes of Health

Harold Varmus, M.D.
Director

Alternate:
Francis Collins, M.D., Ph.D.
Director, National Human Genome Research Institute

Executive Secretary

Sarah Carr
Executive Secretary
Secretary's Advisory Committee on Genetic Testing
Office of Recombinant DNA Activities
Office of Science Policy
National Institutes of Health
6000 Executive Boulevard, Suite 302
Bethesda, Maryland 20892

**Highlights of the
First Meeting of the
Secretary's Advisory Committee on Genetic Testing
Wednesday, June 30, 1999
Building 31C, Sixth Floor, Conference Room 10
31 Center Drive
Bethesda, Maryland**

Overview

The first meeting of the Secretary's Advisory Committee on Genetic Testing (SACGT), chaired by Edward R.B. McCabe, M.D., Ph.D., was held June 30, 1999. The 13-member committee was chartered last year to help the department formulate policies on the development, validation, and regulation of genetic tests, particularly DNA-based diagnostics.

The meeting began with welcoming remarks and the committee charge by U.S. Surgeon General Dr. David Satcher. It included presentations on a number of topics relevant to the work of SACGT such as the Human Genome Project and its impact on the development and application of genetic tests; an overview of DHHS Clinical Laboratory Improvement Amendments regulations and the Clinical Laboratory Improvement Advisory Committee recommendations on genetic testing; and the status of the Food and Drug Administration's (FDA's) regulatory oversight of genetic tests. In addition, Dr. Neil Holtzman discussed the final report of the NIH/DOE Task Force on Genetic Testing. During the afternoon, committee members participated in working sessions to determine how the committee will proceed in responding to the oversight questions presented in the charge as well as to identify additional topics for SACGT to consider over the next one to two years. The meeting also included a period for public comment.

Highlights

Introductions

In preparation for the afternoon discussion of additional issues in genetic testing to be considered by the committee, each member and *ex officio* member during introductions suggested an issue or topic that he or she believed to be of high priority, unique to genetic testing, or in need of enhanced public understanding.

Final Report of the NIH/DOE Task Force on Genetic Testing

Dr. Holtzman reviewed the most recent task force's recommendations, one of which was to form SACGT, and noted that the FDA will be adding a genetics panel to its advisory panels. He urged members to focus on areas in which the committee could have the greatest impact in its role of advising the Secretary and emphasized the importance of ensuring the clinical validity and the utility of genetic tests as well as the need to look carefully at the need for FDA authority in this area.

Discussion of Oversight of Genetic Tests

Ms. Beardsley led the committee in discussion of its charge from Dr. Satcher to address several specific questions regarding the adequacy of governmental oversight of genetic tests and to gather public perspectives about the questions. She suggested that the committee review the three questions presented to them in the charge and consider whether any clarification is required; determine whether any additional information is needed by the committee; and develop a work plan to gather input from the public and prepare a report for Dr. Satcher by December 1, 1999.*

Dr. Francis Collins proposed that the committee consider the following four questions rather than the three presented in the charge:

- Are there genetic tests that require greater scrutiny than the current system offers? If so, how should stringency criteria be defined?
- If yes, what kind of data is needed before such tests become used in clinical, as opposed to research, activities?
- Who should be responsible for collecting the data? Where will the data come from?
- Who will review the data and decide whether they are convincing and therefore that the test is ready for clinical application?

In response to the committee's concerns regarding whether the wording of the oversight questions as charged by Dr. Satcher could be revised, Dr. William Raub (Deputy Assistant Secretary of Science Policy, Office of Planning and Evaluation, Office of the Secretary) informed committee members that they have latitude in how they approach this task and are not limited to addressing the questions as they currently are presented.

Some members proposed policy addenda to the questions. It was agreed that the report should include a preamble that explains the purpose of addressing the questions. Dr. McCabe suggested something along the following lines:

The Committee is seeking public perspectives on the considerations associated with the regulation of genetic tests to assist in providing advice to the Department of Health and Human Services about whether additional oversight of genetic tests is necessary. The Department is endeavoring to ensure that its regulatory framework in this area is appropriately tailored to meet current and emerging needs and technologies and that it is capable of protecting and benefitting those undergoing testing.

Dr. Holtzman commented that the Task Force on Genetic Testing failed to reach full agreement in only one specific area covered by the suggested questions. He remarked that the committee can best build on the task force's work by considering carefully its full report and moving forward to address areas in which agreement has not been reached.

Dr. McCabe proposed that the committee hold an additional meeting, possibly in early September. He also proposed that at this time a working group should be formed to move forward in the area of addressing the oversight charge. The Oversight Working Group is to be chaired by Ms. Beardsley and will include the following members: Dr. Boughman, Dr. Burke, Dr. Charache, Mr. Hillback, and Dr. Penchaszadeh. Dr. McCabe will serve as an *ex officio* member. The working group will generate an outline for reaction from the larger group on the oversight charge. This plan of action was accepted by the full committee.

Ms. Beardsley summarized the charge and next steps agreed upon by the committee. The charge to the Oversight Working Group is to review the HHS staff paper on "Oversight of Genetic Tests" and develop a plan for responding to the questions to be addressed. The Working Group will: 1) recast to some degree the original questions presented in the staff paper, possibly using the four questions proposed at the meeting by Dr. Collins; 2) gather relevant background information from the Task Force report and other materials; and 3) develop an outline or framework that includes a concise preamble defining the purpose of the oversight review and summarizes information necessary for a consideration of the questions both by the Committee itself at the next meeting and subsequently by the public. The Working Group will also develop a list of possible mechanisms for soliciting public comment.** Before the next meeting, the Working Group will present a draft report to committee members for feedback.

Discussion and Prioritization of Other Issues

Dr. McCabe led committee members in a discussion aimed at identifying five to ten high priority issues that warrant committee consideration over the next one to two years. The discussion was in part based on members' introductory comments in which they suggested issues that they consider high priority, unique to genetic testing, or in need of enhanced public understanding.

After an extensive discussion of a broad range of issues, the Committee identified the following issues as high priority:

- education, including counseling and comprehensive education of professionals and the public;
- access to testing;
- diversity issues, particularly special concerns raised by the use of genetic tests in ethnic and minority populations;
- stigmatization, including concerns about insurance discrimination and privacy and confidentiality;
- rare disorders, including access to rare disease testing;

- introduction of tests into clinical practice;
- use of evidentiary-based models and outcomes assessment;
- economic issues in genetic testing and oversight; and
- the impact of direct marketing of tests.

Committee members acknowledged the broad scope of these issues, and the role of other entities in addressing some of them. They recognized the need to focus their attention on matters upon which they can make a unique contribution and have the highest impact. The SACGT also made a commitment to evaluate its role, effectiveness and accomplishments at the end of two years of operation.

*Dr. Satcher subsequently extended the deadline for completion of the report to March 15, 2000.

**After the meeting adjourned, Dr. McCabe decided that the task of considering mechanisms for gathering public perspectives should be shared by a second working group given the importance of this element of the assignment. He tasked Dr. Lewis with chairing the Outreach Working Group, whose members will be Ms. Barr, Ms. Boldt, Ms. Davidson, Dr. Koenig, and Dr. Tuckson. Dr. McCabe will also serve as an *ex officio* member of this working group. The charge to the Outreach Working Group is to develop several options for assessing public perspectives on oversight issues that go beyond the traditional method of soliciting comments through the Federal Register. The Outreach Working Group will also develop cost estimates and timelines for each option.

POWERS
PYLES
SUTTER &
VERVILLE PC
ATTORNEYS AT LAW

FILE ID:

TWELFTH FLOOR
1875 EYE STREET, NW
WASHINGTON, DC 20006-5409
PHONE: (202) 466-6550 FAX: (202) 785-1756

FAX COVER SHEET

To:	Chris Jennings	From:	Peter Thomas
Fax:		Pages:	5
Phone:		Date:	June 3, 1999
Re:	Request		

☒ **Urgent** ☐ For Review ☐ Please Comment ☒ **Please Reply** ☐ Please Recycle

Note:

Chris, I hope you can see me. Thanks, Peter

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL ENTITY TO WHICH IT IS ADDRESSED, AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL, AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE U.S. POSTAL SERVICE. THANK YOU.

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PYLES
SUTTER &
VERVILLE PC**
ATTORNEYS AT LAW

Twelfth Floor
1875 Eye Street, NW
Washington, DC 20006-5409
Phone: (202) 466-6550 Fax: (202) 785-1756

6/11/99 - 3:00pm
Rm 180
Teresa Beck
Please on this WAVE file
Harriet (G. Thomas WAVE)

MEMORANDUM

To: Chris Jennings/ c/o Teresa Jones
From: Peter Thomas *P. Thomas*
CC:
Date: June 3, 1999
Re: Request for Meeting on Medicare ESRD Proposals

Chris, I need your help. My client, Ben Lipps, CEO of Fresenius Medicare Care North America (FMCNA), and I would very much like to meet with you on June 11 to discuss a proposal which addresses the Medicare ESRD program. I will follow up with your office to see if your schedule permits such a meeting.

Attached please find a summary of this proposal as well as the first page from the June report from MedPAC on the ESRD program, which is largely consistent with Fresenius' proposal. FMC is the nation's largest provider of kidney dialysis services, providing care to one in four Americans with chronic kidney failure.

We have discussed these proposals with Tom Hoyer and Jeff Kang, M.D., of HCFA and we are currently scheduled to meet with Nancy-Ann Min DeParle next Friday, June 11, 1999. I have also shared this proposal with Vadim Lubarsky and Bonnie Washington of HCFA.

I hope you will consider the attached language for inclusion in the Administration's Medicare reform proposal and look forward to discussing these proposals with you in more depth. Thank you for your cooperation.

Chris - Hope you can see me.

Thanks - Peter



Fresenius Medical Care

PROPOSAL FOR MODERNIZATION OF THE MEDICARE ESRD PROGRAM

This proposal is designed to improve the quality of care to beneficiaries in the Medicare end-stage renal disease program, eliminate fee-for-service incentives for providers to overutilize separately billable Medicare services, and improve administrative efficiency by bundling nutrition therapy and laboratory services, which are currently billed separately, into an expanded composite rate.

The Problem

- Malnutrition is a major contributor to morbidity and mortality in patients with chronic renal failure. However, ESRD beneficiary access to nutritional therapies, specifically intradialytic parenteral nutrition (IDPN) and intraperitoneal nutrition (IPN) has been dramatically limited since HCFA has taken the position that these therapies are not covered except in the most restrictive of circumstances. Approximately 4 percent of the ESRD population has severe protein-calorie malnutrition and could benefit from these therapies. Lack of adequate access to nutrition therapy leads to higher hospitalization rates and costs to the ESRD program and to these patients and their families.
- The medical necessity and frequency of separately billable laboratory tests for ESRD beneficiaries is being second-guessed by various government agencies, potentially compromising the quality of care in the program as a result of increasingly restrictive coverage policy. In addition, significant amounts of money are being spent administering and policing this Medicare benefit.
- The "composite rate" paid to outpatient dialysis facilities represents the national median cost per treatment, weighted by the percentage of patients that dialyzed in facilities and at home. The rate was calculated in 1983 based on a sample of cost reports from 1977 through 1979. Unlike Medicare payments to other types of providers, Congress did not legislate an annual update to the composite rate for dialysis facilities. Aside from a \$2.00 decrease in 1986 and a \$1.00 increase in 1991, the composite rate has remained unchanged since 1983. When compared to the rate of medical inflation during this same period, the composite rate has decreased significantly in relative terms. MedPAC has recommended increases of between 2.4 and 2.9 percent for the past several years, but Congress has not yet acted on these recommendations.
- The current reimbursement methodology of paying dialysis facilities a fixed amount for each dialysis treatment fails to incent providers to provide the

Fresenius Medical Care North America

Corporate Headquarters: Two Ledgecroft Center 95 Hayden Avenue Lexington, MA 02420-5192 (781) 402-9000

highest quality care possible. Clinical outcome measures for this patient population have been established by the National Kidney Foundation/Dialysis Outcomes Quality Initiative (NKF/DOQI) in the areas of dialysis adequacy and anemia status. The NKF/DOQI recommendation with regard to nutrition is underway and is expected to be published soon. Many health quality experts have called for the linking of payment with the achievement of quality outcomes. The field of ESRD is ideally suited for a demonstration project in this area.

The Proposal

1. Bundle all laboratory services provided to ESRD beneficiaries which are currently billed separately into an expanded composite rate and increase the rate according to historical laboratory testing costs (budget neutral).
2. Provide a 2.9 percent MedPAC-recommended increase to the composite rate and include in the rate the provision of nutrition therapy and supplements to address malnutrition in this patient population.
3. With this more comprehensive composite rate bundle, include an annual medical inflation update to the composite rate.
4. Design a demonstration project, administered by HCFA, to examine the impact that payment incentives to providers would have on the quality of care in the ESRD program. Such incentives would be based on the achievement of quality indicators established by the NKF/DOQI initiative.

Suggested "Placeholder" Language To Be Inserted in Administration's Medicare Modernization Proposal

The Administration's Medicare modernization proposal for the ESRD program reflects the importance of increasing the efficiency of the program and improving the quality of care delivered to beneficiaries by bundling more separately billable services into the composite rate, making providers more accountable for the services they provide, and accurately reflecting the cost of providing high quality care in reimbursement rates. The proposal is designed to improve the length and quality of life for patients with chronic renal failure, while controlling the costs and integrity of the ESRD program.

Improving the quality of care for beneficiaries with end-stage renal disease

In this chapter

- Patient population and treatment
 - Quality of dialysis care
-

Medicare's payment for dialysis, which has not increased since 1991, affects the quality of care for dialysis patients. Payment policies for treating anemia and malnutrition—complications of end-stage renal disease—also may affect the quality of care. The Medicare Payment Advisory Commission recommends that the Secretary of Health and Human Services improve the quality of dialysis care by modifying payments for dialysis, covering nutritional therapy for malnourished end-stage renal disease patients as a renal benefit, and considering the quality assessment and assurance efforts of renal organizations. Certain clinical outcomes and patient survival over the past five years have improved, but policy changes to permit higher doses of dialysis and appropriate clinical use of nutritional supplements could foster further improvement.

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002a. form	Wave requester information form re: SSN and DOB (partial) (1 page)	06/11/1999	P6/b(6)
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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Meetings, Trips, Events)
OA/Box Number: 17045

FOLDER TITLE:

Speaking Engagements (January - August 1999) [2]

2011-0747-S

rc414

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]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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- 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]

Requestor Information

Requestor Name	Jones, Teresa
Requestor Phone	4565594
Requestor Pass	WHS

Appointment Information

Appointment With	jennings, christopher
Appointment Date	06/11/99
Appointment Room	180 <- Lookup Room Number
Appointment Building	Old Executive Office Building

Other Information (click here for WAVES appointment number (U #))

UNumber
Comments

Visitor Information (Use Tab key to advance between fields)

Time	Last Name	First Name	Date of Birth	SSN (### -## -####)	U.S. Citizen	Country Of Origin
03:00:00 PM	THOMAS	PETER	.P6/(b)(6)		Y	US
03:00:00 PM	BILOW	HOWARD			Y	US
03:00:00 PM	SMITH	KATHLEEN			Y	US
03:00:00 PM	LAZARUS	JOHN			Y	US
03:00:00 PM	LIPPS	BEN			Y	US

Enter This Visitor**Remove A Visitor****Edit A Visitor**

6/9/99

THE WHITE HOUSE
WASHINGTON

— Tentatively scheduled
for 6/11/99 300 pm
Room 180

~~6/9/99~~ copy to Chris for
approval.

6/9/99 - call Peter w/
Room # ✓ (OK)

—

REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
620	6/11/99 3:00pm MEETING <u>LOCATION:</u> Room 180 OEOB	Peter Thomas Powers, Pyles, Sutter & Verville PC (Attorneys at Law) CONTACT: Peter Thomas – 202-466-6550	Meeting on Medicare ESRD Proposals <u>PARTICIPANTS – BIO's attached</u> Peter Thomas Ben Lipps Howard Bilow Kathleen Smith J. Michael Lazarus

Kathleen T. Smith, RN, BS, CNN
Vice President, Government Affairs
Twelfth Floor
1875 Eye Street, NW
Washington, DC 20006
PHONE: 202-296-8632
FAX: 202-296-8634
Email: Ksmith@corp.fmcna.com

**Fresenius Medical
Care No. America**

Fax

To: Teresa Jones

From: Kathleen Smith

Fax:

Pages: 7

Phone:

Date: June 9, 1999

Re:

CC:

☐ **Urgent** ☒ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

We are please to be able to meet with Chris Jennings this Friday at 3:00 pm. Attached please find the clearance information and bios on the individuals who will be attending that meeting. Thanks again.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002b. note	re: SSN and DOB (partial) (1 page)	06/11/1999	P6/b(6)

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**ATTENDEES AT JUNE 11, 1999 MEETING WITH CHRIS
JENNINGS FROM FRESINIUS MEDICAL CARE NORTH
AMERICA**

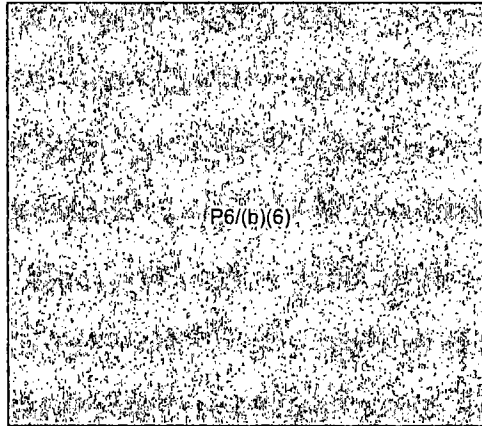
Peter Thomas

Joseph
Ben Lipps

Howard Bilow

Kathleen Smith

J. Michael Lazarus



[0026]

John



Fresenius Medical Care

BIOGRAPHY

BEN J. LIPPS PRESIDENT AND CHIEF EXECUTIVE OFFICER FRESENIUS MEDICAL CARE NORTH AMERICA

Ben J. Lipps is the Chief Executive Officer and Chairman of the Managing Board of Fresenius Medical Care-AG; President and Chief Executive Officer of Fresenius Medical Care North America; and the Chief Operating Officer and Director of Fresenius USA. He has served in a number of capacities with FMCNA and its predecessors since 1985.

Dr. Lipps brings a wealth of research and management experience to his jobs. He began his career in 1966 with Dow Chemical Co. where he led the research team that developed the first commercial hollow fiber artificial kidney. As a research manager in their Industrial and Medical Membrane Devices division he led cutting-edge research and development into reverse osmosis, medical membranes, blood oxygenation and artificial kidneys.

After serving as Vice President of Research and Development and Site Manager for Cordis Dow (1975-1982), he became President and CEO of Seratronics, Inc. In 1987, he was named Chief Executive Officer of Fresenius USA.

Dr. Lipps earned his Bachelor of Science degree from Purdue University and his master's and doctoral degrees from the Massachusetts Institute of Technology in chemical engineering.

Fresenius Medical Care North America

Corporate Headquarters: Two Ledgemont Center 95 Hayden Avenue Lexington, MA 02420-9192 (781) 402-9000



Fresenius Medical Care

BIOGRAPHY

J. MICHAEL LAZARUS, M.D.

**MEDICAL DIRECTOR AND SENIOR VICE PRESIDENT OF CLINICAL
QUALITY
FRESENIUS MEDICAL CARE NORTH AMERICA**

J. Michael Lazarus, M.D., is the Medical Director and Senior Vice President of Fresenius Medical Care North America. As Medical Director of the nation's largest provider of dialysis services, Dr. Lazarus is responsible for the continuous improvement of care and results of FMCNA's dialysis patients at the company's more than 750 centers.

In addition to his work at FMCNA, Dr. Lazarus is an Associate Professor of Medicine at Harvard Medical School and a senior physician at the Brigham and Women's Hospital in Boston, Massachusetts.

Dr. Lazarus graduated with honors from the University of North Carolina at Chapel Hill, earning a Bachelor of Science degree from their School of Pharmacy. He received his medical degree with honors from Tulane University's School of Medicine. Dr. Lazarus completed his medical internship at Tulane University-Charity Hospital in New Orleans, and his nephrology fellowship at Peter Bent Brigham Hospital-Harvard Medical School in Boston.

Over the last 30 years, Dr. Lazarus was the recipient of multiple grants and worked extensively in the field of nephrologic research, specifically clinical research in ESRD care. In addition to his research, Dr. Lazarus had an extensive clinical practice primarily at the Brigham and Women's Hospital, one of the leading hospitals and dialysis centers in the Boston area. Dr. Lazarus was Director of Clinical Services for the Nephrology Division at the Brigham and Women's Hospital from 1989-1996.

Dr. Lazarus is widely published and has lectured nationally and internationally on a broad variety of topics relating to end-stage renal disease and its treatment. He has served on the editorial boards of leading medical journals including the *Journal of the American Society of Nephrology*, *Current Opinion in Nephrology and Hypertension*, *Advances in Renal Replacement Therapy*, and *Seminars in Dialysis*.

Fresenius Medical Care North America

Corporate Headquarters: Two Ledgeмонт Center 95 Hayden Avenue Lexington, MA 02420-9192 (781) 462-9000



Fresenius Medical Care

BIOGRAPHY

HOWARD L. BILOW

VICE PRESIDENT CORPORATE MARKETING AND MANAGED CARE FRESENIUS MEDICAL CARE NORTH AMERICA

Howard L. Bilow is the Vice President of Corporate Marketing and Managed Care for Fresenius Medical Care North America. In this position, he is responsible for market analysis and research, corporate communications, government relations, and contracting with HMOs and third party payors.

Mr. Bilow is a nationally recognized leader in developing business strategies for disease management with end stage renal disease patients. He is a founder and board member of Renaissance Health Care, a management services organization and the country's first national nephrology network. He was also instrumental in the development of Optimal Renal Care, Fresenius' disease management joint venture with Kaiser Health Plan's Southern California Permanente Medical Group.

Mr. Bilow serves as the director of U.S. Vascular Access Centers, LLC, a company committed to improving dialysis patient care through better vascular access management.

Prior to his current position, Mr. Bilow held a variety of business development and strategic market planning positions with National Medical Care (NMC). Before joining NMC in 1981, he was a management consultant with Arthur Andersen and Company. Mr. Bilow has served as a member of the Board of Advisors to the *Journal of Business Strategy*.

He received both his undergraduate and master's of business administration degrees from Boston University.

Fresenius Medical Care North America

Corporate Headquarters: Two Lodgemont Center 95 Hayden Avenue Lexington, MA 02420-9192 (781) 402-9000

PETER W. THOMAS

Peter W. Thomas is a principal in the Washington D.C. law firm of Powers, Pyles, Sutter & Verville, P.C. Mr. Thomas has a federal law and legislative practice in the areas of health care reform, managed care, reimbursement policy, Medicare and Medicaid, and rehabilitation research appropriations. Mr. Thomas recently served on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry where he chaired the Subcommittee on Consumer Rights, Protections and Responsibilities, the Subcommittee that developed the Patient's Bill of Rights. He currently serves on the National Advisory Council of the Agency for Health Care Policy, Research and Evaluation of the U.S. Department of Health and Human Services and as a member of the Quality Forum Planning Committee, a public-private partnership tasked with creating the structure for a national organization which focuses on health care quality improvement.

Mr. Thomas served as Co-Chair of the Health Task Force of the Consortium for Citizens with Disabilities (CCD), a Washington-based working coalition of over 100 national disability-related organizations, from 1994 to 1998. He is also a board member of two nonprofit organizations, Physicians Against Land Mines and the Center on Disability and Health. Mr. Thomas recently completed a 5-year position on the National Advisory Board for the Center on Medical Rehabilitation Research at the National Institutes of Health. He has personal experience with physical disability, using bilateral leg prostheses since the age of ten. Mr. Thomas is the co-author of an employment guidebook published in March 1993 entitled, *The Americans with Disabilities Act: A Guidebook for Management and People with Disabilities*. Mr. Thomas is admitted to practice law in New York State and the District of Columbia and holds a bachelor's degree from Boston College and a law degree from Georgetown University Law Center.



Fresenius Medical Care

BIOGRAPHY

KATHLEEN T. SMITH, RN, BS, CNN VICE PRESIDENT GOVERNMENT AFFAIRS FRESENIUS MEDICAL CARE NORTH AMERICA

Kathleen Smith is a registered nurse with degrees in both nursing and health care administration. She has been involved in government relations for nearly twenty years, beginning as a volunteer for the American Nephrology Nurses' Association (ANNA), then in her role as Director of Legislative Services for *Nursing Economic\$*, where she represented a number of nursing and allied health organizations, including ANNA, in Washington.

In her current role as Vice President for Government Affairs for Fresenius Medical Care North America, a position she assumed in 1998, Ms. Smith serves as a health policy advisor to senior management of the company, and is responsible for coordinating and communicating FMC's public policy positions in Washington and throughout the company.

She has numerous publications and presentations to her credit and has been a contributing editor covering health care policy issues for *Nursing Economic\$*, *Pediatric Nursing*, and *MEDSURG Nursing*. In addition, she was a contributor to *Policy and Politics for Nurses* (3rd edition), the *Core Curriculum for Nephrology Nursing* (1st edition), and *Contemporary Nephrology Nursing*. Her work has appeared in various nursing specialty association publications.

Prior to her career in public policy, Ms. Smith held a variety of clinical, administrative, and management positions, primarily in nephrology nursing.

Fresenius Medical Care North America

Corporate Headquarters: Two Lodgement Center 95 Hayden Avenue Lexington, MA 02420-9192 (781) 402-9000

THE WHITE HOUSE
WASHINGTON

5/20/99 - N/A - will C/B
cc - Jeanne

- get exact times
for Chris

- Sent in BVP
Card

617-736-3803

6/9/99 - ask Jeanne for photo

6/9/99 ~~ask~~ ^{from} agents to Jeanne

A

**Council on the
Economic Impact of
Health System Change**

ECONOMISTS

Henry Aaron, Ph.D.
The Brookings Institution

Karen Davis, Ph.D.
The Commonwealth Fund

Paul R. Ginsburg, Ph.D.
Ctr. for Studying Health System Chg

Michael J. Graetz, L.L.B.
Yale University

Lawrence R. Klein, Ph.D.
University of Pennsylvania

Judith R. Lave, Ph.D.
University of Pittsburgh

Harold S. Luft, Ph.D.
University of California at S.F.

Joseph P. Newhouse, Ph.D.
Harvard University

Mark V. Pauly, Ph.D.
University of Pennsylvania

Uwe E. Reinhardt, Ph.D.
Princeton University

Robert D. Reischauer, Ph.D.
The Brookings Institution

Robert M. Solow, Ph.D.
Mass. Institute of Technology

Burton Weisbrod, Ph.D.
Northwestern University

Gail R. Wilensky, Ph.D.
Project Hope

HEALTH & INDUSTRY

Joyce C. Clifford, Ph.D., R.N.
Beth Israel Deaconess Medical Center

Douglas A. Fraser
Wayne State University

James Mongan, M.D.
Massachusetts General Hospital

Woodrow A. Myers, Jr., M.D.
Ford Motor Company

Patricia Nazemetz
Xerox Corporation

William L. Roper, M.D., M.P.H.
University of North Carolina

Charles Sanders, M.D.
Retired Chairman & CEO Glaxo, Inc.

Leonard D. Schaeffer
WellPoint Health Networks Inc.

Gail L. Warden
Henry Ford Health System

Anthony L. Watson
Health Insurance Plan of Greater NY

CONSULTANT

Kenneth E. Thorpe, Ph.D.
Tulane University

May 5, 1999

Christopher Jennings
Domestic Policy Council
1700 Pennsylvania Avenue
Washington, DC 20502

Dear Chris,

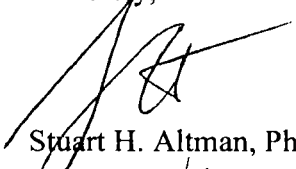
I would like to extend an invitation to you to join us on June 14th for our Summer Council meeting. The objective of the meeting is to examine the impact of the Balanced Budget Act of 1997 (BBA) on managed care organizations, hospitals, and post-acute care providers, and to discuss whether changes to the BBA might be appropriate.

The BBA has reduced anticipated federal spending on health care by billions of dollars. However, the consequences of some of these spending reductions have brought vociferous complaints from industry representatives. As a result, recommendations have been made to re-visit and adjust some of the provisions of the BBA to alleviate some of its negative financial impact on HMOs, hospitals, home health care agencies, skilled nursing facilities and other providers. Policy makers in the 106th Congress will be considering whether or not to make changes in the BBA and what policy alternatives may be available.

We are fortunate to have three outstanding and thoughtful speakers to highlight this program: Kenneth Thorpe will address the impact of the BBA on managed care plans; Stuart Guterman will assess the BBAs impact on hospitals; and Laura Dummit will examine the impact of the BBA on post-acute providers. In addition, responses will be given by major industry stakeholders.

The meeting will be held at the National Press Club in Washington and a block of rooms has been reserved at the Marriott Hotel at 1331 Pennsylvania Avenue (202-393-2000). This meeting is by invitation only, and limited space will be reserved in the order that replies are received. We ask that you reply at your earliest convenience and request that you reply even if you cannot attend. This will allow us to make appropriate meeting arrangements and to update our database for future meeting invitations. There are no conference fees, but you will be responsible for your own transportation, lodging, and incidental expenses. I hope you will be able to participate in this exciting program.

Sincerely,


Stuart H. Altman, Ph.D.

781-736-3803

6/14/99
CC: JEANNE

Stuart H. Altman, Ph.D.

Brandeis University

Chair

David S. Glickman, MPA

Project Director

Jeane will do draft 6/08
PROBABLY not Chris

pat on
Jeane's calendar
tentatively

Council on the Economic Impact of Health System Change

AGENDA
RE-OPENING THE BBA

MONDAY JUNE 14TH - THE NATIONAL PRESS CLUB
14TH AND F STREETS, NW
WASHINGTON, DC 20045
(202) 662-7500

9:00 Continental Breakfast

9:50 **Stuart Altman** Council Chair Welcome and Introduction

10:00 **Kenneth Thorpe** Director, Institute for Health Services Research
Tulane University The Impact of the BBA on Managed Care Plans

10:30 Discussant- TBA

10:40 General Discussion

11:15 Break

11:30 **Stuart Guterman** Principal Research Assoc. The Urban Institute The Impact of the BBA on Hospitals

12:00 **Carmela Coyle** Senior Vice-President For Policy
American Hospital Assn. Discussant

12:10 General Discussion

1:00 **Lunch**

2:00 **Laura Dummit** Assoc. Director, Health Financing & Public Health Issues, USGAO The Impact of the BBA on Post-Acute Providers

2:20 **Penny Feldman** Program Director Visiting Nurse Svc. of NY
Cntr. for HC Policy & Rsch. Discussant

2:30 Discussant - TBA Skilled Nursing Facilities

2:40 General Discussion

3:20 **Stuart Altman** Council Chair Summary

3:30 **Public Meeting Adjourns**

3:40 **Council Executive Session** *Council Members meet in closed session on consensus statement and Council business.*

5:00 **Council Executive Session Adjourns**

REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
606	6/14/99 9:00 am – 3:30pm SUMMER COUNCIL MEETING	Stuart Altman Council on the Economic Impact of Health System Change <u>CONTACT:</u> Pat Aloise 781-736-3807	Chris agreed tentatively to attend. He will take Jeanne Lambrew with him. LOCATION: National Press Club - Homan Lounge NOTE: I will confirm with Chris the timeframe he plans to attend.

—
THE WHITE HOUSE
WASHINGTON

5/20/99 - left message
to call me to
get up.

- orientation scheduled
6/20 will send letter
to confirm room, etc.

- participants

Rm 116 Ross Hall
George Cook Van
Campus

Jack D Lender
Langer W

D Lender & ASSOC
will ~~attend~~ attend the tour

Washington Health Policy Fellowship Program
Summer 1999 (Tentative Schedule 4/28/99)
June 14 – Aug. 6, 1999

Merck & Co., Inc.-
 601 Pennsylvania Ave.
 North Bldg., Suite 1200
 Washington, DC 20004

I. Orientation Week

<u>Date & Time</u>	<u>Seminar</u>	<u>Tentative Speaker</u>
<i>Monday, June 14</i>		
8:30-10:00 AM	Welcome! Introductions & Breakfast	Dave Grande AMSA President
10:00-12:00 Noon	Advocacy Process, Lobbying, & Merck	Ian Sapiz Merck & Co.
<i>ok</i> 12:00-1:30 PM	Lunch w/ Preceptors: Expectations, Goals, and Health Care	Health Policy Coord. AMSA
<i>ok</i> 1:30-2:45 PM	Role of the Exec. Branch in Policy Dev.	Christopher Jennings Domestic Policy Council
2:45-3:45 PM	Health Policy & Politics on the Hill	David Nexon Health Policy Director Minority Staff Sen Labor and Human Resources Committee
3:45-5:00 PM	Regulatory Process	Suzanne Barone Proj. Mgr. For Poison Prevention US Consumer Prod Safety Commission
<i>Tuesday, Jun 15</i>		
9:00-12:00 Noon	Tort Reform Debate <i>(Med. Malprac)</i>	Lisa Astilla American Tort Reform Assoc. Jack Olender Oldender & Assoc.

du 5/24

12:00-1:00 PM

Lunch

1:00-2:30 PM

Advocacy Process

Ron Pollack
Families USA

2:30-5:00 PM

Overview of Federal Government's
Role in HealthD.W. Chen, MD. MPH
U.S. Dept. of Health &
Human Services
Administration (HRSA)



The American Medical Student
Association/Foundation

FAX

Date

5/25/99

Number of pages including cover sheet

3

TO: Teresa Jones

Phone (202) 456-5594

Fax 202-456-5557

FROM:

Yvonne Fulbright

AMSA

1902 Association Dr.

Reston, VA 20191

Phone

(703) 620-6600 x204

Fax Phone

(703) 620-5873

CC:

REMARKS:



Urgent



For your review



Reply ASAP



Please Comment

As soon as more speakers have confirmed, I will send you an updated schedule.

CONFIDENTIALITY NOTICE: This facsimile message and accompanying document are intended for the exclusive use of the individual or entity to which this message is addressed. This facsimile may contain information which is legally privileged, confidential or exempt from disclosure. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any review, disclosure, photocopying (or other reproduction), communication or distribution of this facsimile, or the taking of any action in reliance on the contents of this facsimile, is strictly prohibited. If you have received this fax in error, please immediately notify us by telephone to arrange a return of the documents at our expense. Thank you.

Please call if any pages are missing. Thank you!

REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
609	6/14/99 1:30 – 2:45pm Speaking Engagement	AMSA's Washington Health Policy Fellowship Program (WHPFP) <u>CONTACT:</u> Yvonne Fulbright 703-620-6600 Ext 204	LOCATION: George Washington University Campus Ross Hall – Room 116 2300 'I' street N.W. 5/25/99 – Tentative Schedule/Agenda is attached.

CC: Deborah 6/9

June 3, 1999

Christopher Jennings
Domestic Policy Council
216 Old Executive Office Bldg.
17th & Pennsylvania Ave., NW
Washington, D.C. 20502

Dear Mr. Jennings,

Thank you for agreeing to take part in the Washington Health Policy Fellowship Program (WHPFP). Enclosed are the orientation schedule of seminars for the program and a roster of this year's fellows.

This is to confirm your participation in a seminar on Monday, June 14th, at 1:30 p.m. on the topic of "The Role of the Executive Branch in Policy Development." The seminar is being held in 116 Ross Hall on George Washington University's campus - 2300 I St., NW, Washington, D.C. The seminar room will have overheads and slide projectors available for you to use should you wish. I look forward to meeting you. Please call me at (703) 620-6600, ext. 204 if you have any questions.

Sincerely,

Yvonne K. Fulbright

Yvonne K. Fulbright, MS.Ed.
SHPFP Project Manager, AMSA

American

Medical Student

Association/Foundation

1902 Association Drive

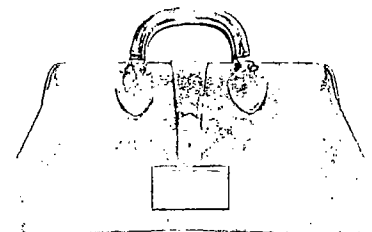
Reston, VA 20191-1502

Tel 703.620.6600

Fax 703.620.5873

Web <http://www.amsa.org>

amsa®



Washington Health Policy Fellowship Program
Summer 1999 (Tentative Schedule 6/1/99)
June 14 – Aug. 6, 1999

I. Orientation Week

<u>Date & Time</u>	<u>Seminar</u>	<u>Tentative Speaker</u>
<i>Monday, June 14</i>		
8:30-10:00 AM	Welcome! Introductions & Breakfast	Dave Grande, MD AMSA President
10:00-12:00 Noon	Advocacy Process, Lobbying, & Merck	Ian Spatz Merck & Co.
12:00-1:30 PM	Lunch	
1:30-2:45 PM	Role of the Executive Branch in Policy Development	Christopher Jennings Domestic Policy Council
2:45-3:45 PM	Health Policy & Politics on the Hill	David Nexon Health Policy Director Minority Staff Senate Labor and Human Resources Committee
3:45-5:00 PM	Regulatory Process	Suzanne Barone, Ph.D. Project Manager For Poison Prevention U.S. Consumer Product Safety Commission
<i>Tuesday, June 15</i>		
9:00-12:00 Noon	Tort Reform & Medical Malpractice Debate	Lissa Astilla, J.D. American Tort Reform Association Jack Olender Olender & Associates

12:00-1:00 PM	Lunch w/ Preceptors: Expectations, Goals, and Health Care	Health Policy Coordinator AMSA
1:00-2:30 PM	Advocacy Process	
2:30-4:00 PM	Overview of Federal Government's Role in Health	D.W. Chen, MD. MPH Director, Division of Transplantation Health Resources & Services Administration U.S. Dept. of Health & Human Services
4:00-5:00 PM	Question & Answer Session	

Washington Health Policy Fellowship Program 1999 Fellows & Placement Sites

Kristine Arnold

School: University of Health Sciences COM

Site: National Rural Health Association

Michael Bartholomew

School: Dartmouth Medical School

Site: CPS- Indian Health Service Office of Public Health

Jeremy Chun

School: George Washington University SOM

Site: US Sen. Daniel Inouye

Keith Downing

School: University of Rochester SOM

Site: National Committee for Quality Assurance

Kani Ilangovan

School: University of Illinois at Chicago

Site: Jacobs Institute of Women's Health

Laron Johnson

School: University of Chicago Pritzker School of Medicine

Site: GWU Medical Center - Center for Health Services Research & Policy

Anita Krishman

School: Northwestern University Medical School

Site: Senate Labor Committee - Subcommittee on Aging, Minority Staff

Robert Levy

School: SUNY HSC at Syracuse

Site: Health Sciences Section - Institute of Medicine/National Academy of Sciences

Laurie MacDonald

School: Georgetown University

Site: National Conference of State Legislatures

Roger Oen

School: George Washington University School of Medicine

Site: Coalition to Stop Gun Violence & the Educational Fund to End Handgun Violence

Parag Parekh
School: University of Pennsylvania
Site: US Senator Tom Harkin

Charles Perry
School: Columbia University College of Physicians & Surgeons
Site: US Senator William Frist

Mohit Rastogi
School: Georgetown University SOM
Site: American Pharmaceutical Association

Stephanie Weller
School: University of Illinois at Chicago COM
Site: US-DHHS – Office of Disease Prevention & Health Promotion

Karen Amanda Williams
School: University of Illinois at Chicago COM
Site: US-DHHS – Office of Disease Prevention & Health Promotion

Fax Cover Sheet

DATE: May 25, 1999

CODE: 160

TO: Chris Jennings
Teresa Jones

FAX: 202-456-5557

FROM: Tony Podesta
Karen Lewis

302
EXT

PHONE: 202-393-1010

FAX: 202-393-5510

Number of pages, including cover sheet: 2

MESSAGE

Meeting request for Alan Holmer of PhRMA.

Yes, but make certain that

Don Mendelson can join us. phone
662-30-6280 - MINDY 62878 - Peter 62804
Larry Stein or Gene Jennings 62807

might like to attend too
make them a second they do
Also ask Tim L. to

IF A PROBLEM OCCURS WITH THIS TRANSMISSION,
PLEASE CALL 202.393.1010

Memorandum

DATE: May 25, 1999

TO: Bruce Reed
Chris Jennings

FROM: Tony Podesta

RE: Proposed Meeting with Alan Holmer of PhRMA

Alan Holmer is the President of the Pharmaceutical Research and Manufacturers of America (PhRMA), which represents the nation's leading research-based pharmaceutical and biotechnology companies. As the Administration works towards completion of a Medicare reform package, Mr. Holmer is interested in meeting with you to discuss the prescription drug benefit issue.

Would it be possible to setup a meeting on Wednesday, June 2, or Thursday, June 3? Karen Lewis will be calling your office to try to identify a time on your calendar that may be available for a meeting. Thank you in advance for your consideration. Should you need additional information, you may reach Karen or Matt Gelman at 202-393-1010.

1001 G Street, NW

Suite 900 East

Washington, DC 20001

T 202.393.1010

F 202.393.5510

www.202.393.1010

TENTATIVELY SET FOR:
6/3/99 11:00 am

Fax Cover Sheet

DATE: May 25, 1999

CODE: 160

TO: Chris Jennings
Teresa Jones

FAX: 202-456-5557

FROM: Tony Podesta
Karen Lewis

PHONE: 202-393-1010
FAX: 202-393-5510

Number of pages, including cover sheet: 2

MESSAGE

Meeting request for Alan Holmer of PhRMA.

Yes, but make certain that
Dan Mendelson can join us.
Larry Stein or Gene Sperling
might like to attend too.
Invite them & see if they do.
Also ~~could~~ pl. ask Jeanne L. to

**IF A PROBLEM OCCURS WITH THIS TRANSMISSION,
PLEASE CALL 202.393.1010**

1001 G Street, N.E.
Suite 900 East
Washington, DC 20002

T 202.393.1010

F 202.393.5510

www.phrma.org

www.ada.com

Memorandum

DATE: May 25, 1999

TO: Bruce Reed
Chris Jennings

FROM: Tony Podesta

RE: Proposed Meeting with Alan Holmer of PhRMA

Alan Holmer is the President of the Pharmaceutical Research and Manufacturers of America (PhRMA), which represents the nation's leading research-based pharmaceutical and biotechnology companies. As the Administration works towards completion of a Medicare reform package, Mr. Holmer is interested in meeting with you to discuss the prescription drug benefit issue.

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1001 G Street, NW

Suite 900 East

Washington, DC 20001

T 202.393.1010

F 202.393.5510

www.ada.com

*** TX REPORT ***

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CONNECTION TEL 66220
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THE WHITE HOUSE



Christopher C. Jennings
Deputy Assistant to the President for Health Policy
216 Old Executive Office Building
Washington, DC 20502
phone: (202) 456-5560
fax: (202) 456-5557

Facsimile Transmission Cover Sheet

To: Mindy Meyers

Fax Number: 6-6220

Telephone Number: _____

Pages (Including Cover): 3

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003a. email	Waves to Teresa M. Jones re: Waves Confirmation (partial) (1 page)	06/03/1999	P6/b(6), b(7)(C), b(7)(E), b(7)(F)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Meetings, Trips, Events)
OA/Box Number: 17045

FOLDER TITLE:

Speaking Engagements (January - August 1999) [2]

2011-0747-S

rc414

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]



WAVES_CONF@PMD.F.EOP.GOV

06/03/99 06:07:09 PM

Record Type: Record

To: Teresa M. Jones/OPD/EOP

cc:

Subject: WAVES Confirmation

ADDRESSEES: TERESA_M_JONES

SUBJECT: CONFIRMATION: APPT. REQUEST FOR JENNINGS, CHRISTOPHER

FROM: WAVES OPERATIONS CENTER - ACO:

P6(b)(6), (b)(7)(c), (b)(7)(e), (b)(7)(f)

[003a]

Date: 06-03-1999

Time: 18:03:12

This message serves as confirmation of an appointment for the visitors listed below.

Appointment With: JENNINGS, CHRISTOPHER

Appointment Date: 6/4/99

Appointment Time: 12:00:00 PM

Appointment Room: 100

Appointment Building: OEOB

Appointment Requested by: JONES TERESA

Phone Number of Requestor: 65594

WAVES APPOINTMENT NUMBER: U88057

If you have any questions regarding this appointment, please call the WAVES Center at 456-6742 and have the appointment number listed above available to the Access Control Officer answering your call.

TOTAL NUMBER OF NAMES SUBMITTED FOR ENTRY : 5

TOTAL NUMBER OF NAMES OF CLEARED FOR ENTRY: 5

BELLO, JUDITH
CALDWELL, BARRY
GELMAN, MATTHEW
HOLMER, ALAN
PODESTA, ANTHONY

P6(b)(6)

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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003b. form	Wave requester information form re: SSN and DOB (partial) (1 page)	06/04/1999	P6/b(6)
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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Meetings, Trips, Events)
OA/Box Number: 17045

FOLDER TITLE:

Speaking Engagements (January - August 1999) [2]

2011-0747-S

rc414

RESTRICTION CODES

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

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

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]

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

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.

Requestor Information

Requestor Name Jones, Teresa
Requestor Phone 4565594
Requestor Pass WHS

Appointment Information

Appointment With jennings, christopher
Appointment Date 06/04/99
Appointment Room 100 <- Lookup Room Number
Appointment Building Old Executive Office Building

Other Information (click here for WAVES appointment number (U #))

UNumber
Comments

Visitor Information (Use Tab key to advance between fields)

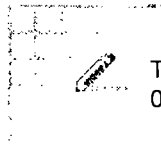
Time	Last Name	First Name	Date of Birth	SSN (###-##-####)	U.S. Citizen	Country Of Origin
12:00:00 PM	GELMAN	MATTHEW	[REDACTED]	P6(b)(6)	Y	US
12:00:00 PM	HOLMER	ALAN			Y	US
12:00:00 PM	BELLO	JUDITH			Y	US
12:00:00 PM	CALDWELL	BARRY			Y	US
12:00:00 PM	PODESTA	ANTHONY			Y	US

Enter This Visitor

Remove A Visitor

Edit A Visitor

[0036]



Teresa M. Jones
06/04/99 10:46:04 AM

Record Type: Record

To: Gina Mooers, Mindy Myers, Peter Weissman, Jeanne Lambrew/OPD/EOP

cc: Devorah R. Adler/OPD/EOP

Subject: CANCELLATION - Meeting Today with Tony Podesta

The meeting with Tony Podesta which was scheduled for Friday, 6/4/99 from 12:00 to 1:00pm in Room 100 OEOB is **CANCELLED**. I will notify you when/if it is rescheduled. Thanks!!!



OEOb CONFERENCE & ROOSEVELT ROOM RESERVATION

Date of Meeting:

6/14/99

Time:

500

To:

600 PM

All reservation forms should be submitted at least 48 hours prior to events.

Name of Individual Hosting Event: <u>Chris Jennings</u>		Office/Agency: <u>DPC</u>	
Staff Contact: <u>Teresa Jones</u>	Extension No.: <u>65560</u>	Pager No.: <u>—</u>	Room No.: <u>216</u>
Type of Event: ☒ Meeting ☐ Reception ☐ Other _____			
Name/Description of Event: _____			
Number of Outside Guests: _____		In Attendance:	
Total Number of Attendees: _____		☐ President ☐ First Lady ☐ Vice President ☐ Mrs. Gore	
Room(s) Requested: ☐ Roosevelt Room * ☒ Room 180 ☐ Room 472 ☐ Room 474 (Indian Treaty Room) ☐ Room 476 ☐ Room 450 ☐ Room 459			
General Services: ☐ Elevator Service (elevator #4)			
Time Reserved: _____ ☐ Podium ☐ Flags			
Special Room Arrangements for the Indian Treaty Room: ☐ Conference Style ☐ Theatre Style ☐ Other _____			
Number of Chairs: _____		Number of Table(s): _____	
Entrance/Gate Preferred: ☐ Pennsylvania Avenue (OEOb) ☐ East Visitors Gate Note: the 17th & "G" Street entrance is wheelchair accessible.			
Additional Requirements or Requests: _____ _____ _____ _____			

* Roosevelt Room Reservation Forms must be returned to the West Wing receptionist (FAX # 6-1210)

OEOb Room Reservation Forms must be returned via FAX at 456-6791

All reservation forms should be submitted at least 48 hours prior to events.

Name/Description of Event: _____

Number of Outside Guests: _____

In Attendance:

Total Number of Attendees: _____

☐ President ☐ First Lady ☐ Vice President ☐ Mrs. Gore

Room(s) Requested:

☐ Roosevelt Room *

☒ Room 180

☐ Room 472

☐ Room 474 (Indian Treaty Room)

☐ Room 476

☐ Room 450

☐ Room 459

General Services:

☐ Elevator Service (elevator #4)

Time Reserved: _____ ☐ Podium ☐ Flags

Special Room Arrangements for the Indian Treaty Room:

☐ Conference Style

☐ Theatre Style

☐ Other _____

Number of Chairs: _____ Number of Table(s): _____

Entrance/Gate Preferred:

☐ Pennsylvania Avenue (OEOb)

☐ East Visitors Gate

Note: the 17th & "G" Street entrance is wheelchair accessible.

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OEOb Room Reservation Forms must be returned via FAX at 456-6791

All reservation forms should be submitted at least 48 hours prior to events.

TRANSMISSION OK

TX/RX NO
CONNECTION TEL
SUBADDRESS
CONNECTION ID
ST. TIME
USAGE T
PGS. SENT
RESULT

OK

1

00.33

06/11 15:35

WH CONFERENCE CE

66791

1631

*** TX REPORT ***

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004a. memo	Joanne Gardner to Teresa re: Meeting (partial) (1 page)	06/14/1999	P6/b(6)

COLLECTION:

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

6/15/99 11:45 AM
RM 2-11

VERNER LIPPERT
BERNHARD MCPHERSON & HAND
CHARTERED

901 - 15TH STREET, N.W.
WASHINGTON, D.C. 20005-2301
(202) 371-6000
FAX: (202) 371-6279

MEMORANDUM

TO: Teresa

FROM: Joanne Gardner for
Andrew D. Eskin

RE: Meeting on June 15, 1999, with Chris Jennings, Rite Aid and
PCS Health Systems, Inc.

DATE: June 14, 1999

Attached is a list of the participants planning to attend the meeting with Chris Jennings scheduled for 11:45 a.m. on Tuesday, June 15, 1999.

Mr. Timothy Noonan ✓
President & COO
Rite Aid Corporation

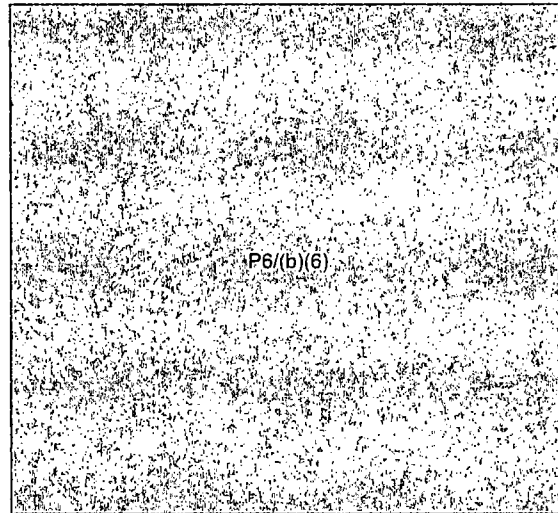
William Titelman, Esq. ✓
Executive VP-Managed Care
& Public Affairs
Rite Aid Corporation

Ms. Elizabeth Dichter ✓
Executive VP-Strategic Marketing
PCS Health Systems

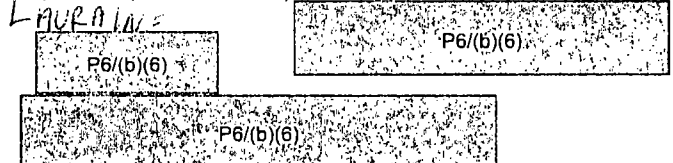
Diane Sacks, Esq. ✓
VP for Government Affairs
PCS Health Systems

L Laurie Sullivan, Esq. ✓
Verner, Liipfert, Bernhard,
McPherson and Hand

Marc Scheineson, Esq. ✓
Reed Smith Shaw & McClay



(To be provided separately)



Thank you for your assistance in this matter.

VERNER, LIIPFERT, BERNHARD, McPHERSON AND HAND

Chartered

901 - 15th Street N.W., Suite 700**Washington, D.C. 20005-2301****(202) 371-6000****Telex: 1561792 VERLIP UT****Telecopier: (202) 371-6279****TELECOPIER COVER PAGE**

DATE: June 14, 1999

TO: Teresa

COMPANY NAME: Office of Chris Jennings

FROM: Andrew Eskin

ORIGINATOR'S NO.: (202) 371-6052

TELECOPIER NO.: (202) 456-5557

TOTAL NO. OF PAGES 2
(INCLUDING COVER PAGE)

CONFIRMATION NO.: (202) 456-5594

CLIENT/MATTER NO.: 06055.0900

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SPACE FOR ADDITIONAL MESSAGE**FOR TELECOPIER OPERATOR ONLY**

TRANSMITTED: DATE: _____ TIME: _____ OPERATOR: _____

FOR ASSISTANCE CALL TELECOPIER OPERATOR AT (202) 371-6245

**RITE AID Corporation**

WILLIAM A.K. TITELMAN
Executive Vice President
Managed Care & Public Affairs

• **MAILING ADDRESS**
P.O. Box 3165
Harrisburg, PA 17105

• **GENERAL OFFICE**
30 Hunter Lane
Camp Hill, PA 17011

• **(717) 975-3740**
• **(717) 975-3760 Fax**
• **wtitelman@riteaid.com**

MEMORANDUM

cc: Chris Jennings

To: John Podesta

From: Bill Titelman

Re: Medicare Coverage of Prescription Drugs: Rite Aid/PCS Health Systems Recommendations

Date: June 11, 1999

As you may know, Rite Aid Corporation is one of the nation's leading community pharmacies and we recently acquired PCS Health Systems, the nation's largest pharmaceutical benefit manager (PBM). Senior executives from Rite Aid and PCS will be meeting at ~~11:00~~ ^{11:45} AM on Tuesday, June 15th with Chris Jennings to discuss their recommendations with respect to the coverage of prescription drugs by Medicare. At the meeting will be Tim Noonan, Rite Aid's President and COO; Elizabeth Dichter, PCS's Executive Vice President, Strategic Marketing; and me, Rite Aid's Executive Vice President for Managed Care and Public Affairs. Given this group's experience and expertise concerning the design of prescription drug benefit packages, we thought it would be valuable for you to review our recommendations (which I have enclosed) prior to finalizing the President's package.

We would be happy to meet with you either on Tuesday or at your earliest convenience to further discuss these issues with you.

Please feel free to call me with any questions.

WAKT:gr

Enclosure

CC: Donovan
6/14

MEDICARE DRUG BENEFIT PLAN DESIGN SUGGESTIONS

In order to provide a meaningful and effective drug benefit for the elderly, it is critical that the plan (a) works for seniors, i.e. is simple, convenient, and does not impose barriers on access, but instead encourages seniors to seek out, use and remain compliant with appropriate drug therapy; and (b) allows the flexibility necessary to manage utilization and costs while preserving and enhancing the quality of care. The following suggestions are offered with these goals in mind:

- **Private sector delivery mechanism should be utilized.** Private entities, such as pharmacy benefit management and other companies with similar capabilities, which have the expertise, operational capacity and sophistication and, most important, experience in managing pharmacy benefits on a large scale, should be utilized to provide the benefit. These entities already have in place the mechanisms necessary to deliver of a cost effective drug benefit, and have proven themselves able to manage utilization through innovative programs which do not sacrifice clinical quality or consumer choice. Successful mechanisms include online claims adjudication, formulary management, pharmacy network contracting, rebate negotiation, generic substitution and therapeutic interchange, physician drug utilization review, utilization management (including drug limits, prior authorization, step therapy) and disease management.
- **Standard basic benefit package with ability to offer variations.** To ensure adequacy of the benefit and a basic level of uniformity, there should be a standard core benefit package. This core package should cover all FDA-approved drugs determined to meet essential clinical needs, but should not mandate coverage of every FDA-approved drug. Discretionary or lifestyle drugs excluded from the basic benefit package could be covered in supplemental benefit packages and options, which should be permitted to be offered so as to increase consumer choice and encourage competition.
- **Use Flexible Methods to Control Costs Without Discouraging Appropriate Utilization.** There are several ways in which this can be achieved:
 - **Separate plan design for low-income beneficiaries.** While every senior paying into the Medicare system should be eligible for a drug benefit, the benefit's costs should be lower for low-income beneficiaries. This is critical to ensure that those most in need have affordable access to the benefit. In addition to lower premiums, low-income beneficiaries could pay a minimal deductible with a lower, or even zero, copayment. This system would promote accessibility and better manage program costs.

- **Minimize deductible and utilize fixed copayments rather than percentage coinsurance.** The willingness and ability of the elderly to access and utilize the drug benefit will depend upon its affordability and simplicity. A high deductible (which requires that the initial drug costs up to a fixed dollar limit be borne by the consumer) and percentage coinsurance (where a fixed percentage of the cost of every prescription is borne by the consumer) act as barriers to appropriate drug use. Fixed copayments (where a set dollar of the cost of the prescription is paid by the consumer), indexed as necessary to drug cost increases, are preferred by the elderly because they are predictable, simpler to budget for, and easier to remember. Copayments could also vary based on a clinical classification of different prescriptions, with those meeting core clinical needs requiring the lowest, or even a zero, copayment. In addition, as mentioned above, the plan for low-income beneficiaries could be designed with no deductible or copayment required for the core benefit package.
- **Beneficiary drug purchases for covered drugs up to any deductible or beyond any dollar cap should be at contract price.** If a deductible or dollar cap is imposed, beneficiaries should be entitled to the same contract price as the government for covered drugs they are required to purchase to meet the deductible or that exceed the cap. This will ensure that there is no cost shifting to the elderly to the extent they bear their own basic drug costs.
- **Use flexible drug utilization management techniques instead of arbitrary dollar benefit caps.** Dollar caps, which limit the total annual reimbursement per patient, impose arbitrary and inflexible ceilings on drug use. Historically, caps have distorted utilization patterns and/or increased noncompliance (e.g. pill-splitting, skipping year-end refills). Today there exist many more sophisticated, flexible and clinically-based formulary and drug utilization management tools that contain drug costs without sacrificing the quality of care afforded to the elderly, such as:
 - a clinical-needs based formulary that excludes certain discretionary or lifestyle drugs;
 - three-tiered copayments (generic, preferred, non-preferred);

- mandatory generic substitution and voluntary therapeutic interchange;
 - prior authorization, managed drug limits and step-therapy;
 - drug utilization review;
 - disease management;
 - case management for high-cost beneficiaries.
- **Require pharmacy networks to meet minimum accessibility standards, and permit the development of performance-based networks.** At a minimum, a national pharmacy network which meets Medicaid accessibility standards should be required. Subject to these standards, plans should have the flexibility to develop performance-based networks, i.e. networks of pharmacies which undertake, and are proven, to meet higher service and cost containment standards such as higher generic dispensing rates.
 - **Allow beneficiaries equal choice of their local community pharmacist or mail order.** Plans offering incentives to use mail should be required to offer a retail maintenance option to beneficiaries. This option would allow the elderly to obtain drugs at their community pharmacies on the same terms and in the same quantities as they would obtain these drugs through the mail. This would allow the elderly, who more than any other group, need, seek out and benefit from the personal contact and counseling available from community pharmacists, the flexibility to choose the delivery channel most convenient and appropriate for them. Internet pharmacies should also be permitted as an additional delivery channel option for the elderly.
 - **Employers must receive incentives to maintain retiree drug benefits.** Currently, a significant portion of the elderly population receives good, often generous, drug coverage through employers. However, increasing drug costs are causing many employers to reduce or eliminate these benefits. Employers should be encouraged, through economic incentives such as tax credits or other tax preferences, to continue to offer these benefits. Preserving existing employer plans in this way will reduce the government outlay for a Medicare drug benefit without imposing an economic penalty on those employers who have chosen to provide this benefit to their retirees.
 - **Preemption from conflicting state laws.** In order to provide the benefit in a consistent and efficient manner, it is essential that the program be allowed to operate free from the myriad of often conflicting and inconsistent

state laws regulating every aspect of pharmacy practice and benefit management, from provider networks to formularies to the details of plan design.

- **Mandatory beneficiary education and information.** Educating and advising beneficiaries about their drug benefit, and about drug use and compliance in general, is an integral part of any benefit, and is especially critical for the elderly. Some elements of an appropriate education program might include:
 - information to help beneficiaries evaluate their drug benefit choices;
 - an explanation of how to use the drug benefit, from what to ask the doctor, going to the pharmacy, differences between brands and generics;
 - compliance and drug usage information, such as directions for use, dosage and administration, drug interactions and precautions, and disposal of old medications.
- **A mechanism to evaluate the impact of the program on the healthcare system.** The program should establish funding to research the impact of improved drug usage and compliance on the healthcare system, including any reductions in medical costs and improvements in the quality of life of beneficiaries.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004b. form	Wave requester information form re: SSN and DOB (partial) (1 page)	06/15/1999	P6/b(6)

COLLECTION:

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Requestor Information

Requestor Name Jones, Teresa
Requestor Phone 4565594
Requestor Pass WHS

Appointment Information

Appointment With jennings, christopher
Appointment Date 06/15/99
Appointment Room 211 <- Lookup Room Number
Appointment Building Old Executive Office Building

Other Information (click here for WAVES appointment number (U #))

UNumber
Comments

Visitor Information (Use Tab key to advance between fields)

0046

Time	Last Name	First Name	Date of Birth	SSN (###-##-####)	U.S. Citizen	Country Of Origin
11:45:00 AM	NOONAN	TIMOTHY	P6/(b)(6)	P6/(b)(6)	Y	US
11:45:00 AM	TITELMAN	WILLIAM			Y	US
11:45:00 AM	DICHTER	ELIZABETH			Y	US
11:45:00 AM	SACKS	DIANE			Y	US
11:45:00 AM	SCHEINESON	MARC			Y	US
11:45:00 AM	SULLIVAN	LAURINE			Y	US

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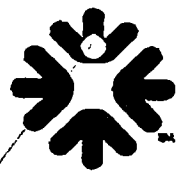
Edit A Visitor

THE WHITE HOUSE
WASHINGTON

Follow up mtg
6/15/99 1100 am
Room 211

6/01/99 400 PM
Rm 100 *

#514



PCS Health Systems

May 5, 1999

I thought I #514
said yes to
this already
(C)

To: Appointment Secretary

On behalf of PCS Health Systems, Inc (PCS), we respectfully request a meeting on either May 17 or 18, 1999. PCS is the nation's largest pharmacy benefits manager (PBM) responsible for the drug benefits of approximately 56 million Americans. It represents over 1,000 health plans, including Federal and state health plans, self-insured employers, insurance carriers, HMOs, PPOs, and Blue Cross/Blue Shield plans. The purpose of the meeting would be to discuss the following issues:

- The programs pharmacy benefit managers use to improve utilization of Rx drugs and reduce cost.
- Confidentiality of medical records
- Medicare Rx drug benefit

Participants from PCS who will be in Washington, D.C. to participate include:

- Jeffrey Sanders, Senior Vice President, Value Development
- Diane Sacks, Esq, Vice President for Government Affairs
- Marc Scheineson, Esq. (Reed Smith-Legislative/Regulatory Counsel)

Please call Marc at 202-414-9243 (or mischein@rssm.com) to schedule a convenient time to meet on either of those two days.

Thank you for your consideration and the opportunity to meet to discuss these issues.

Thanks, Marc

CC: J. M. ...

PHOTOCOPY
PRESERVATION

REED SMITH SHAW & MCCLAY LLP

1301 K Street, N.W.

Suite 1100 - East Tower

Washington, D.C. 20005-3317

Phone: 202-414-9200

Fax: 202-414-9299

ALBANY, NY ALBUQUERQUE, NM ANCHORAGE, AK ANN ARBOR, MI ARLINGTON, VA ASHEVILLE, NC

TO: Mr. Christopher C. Jennings

FROM: Marc J. Scheineson, Esq.

CO./FIRM: Office of Health Policy

PHONE: (202) 414-9243

FAX NO.: 202-456-5557

DATE: May 5, 1999

TOTAL NUMBER OF PAGES INCLUDING COVER PAGE: 2

ORIGINAL will follow via: ☐ Regular Mail ☐ Overnight Delivery ☐ Messenger ☒ None

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NOTES:

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ATTORNEY NO: 1612

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FINISH TIME:

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F

REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
514	5/27/99 1:00pm MEETING	PCS Health Systems Marc J. Scheineson, Esq. <u>CONTACT:</u> Marc Scheineson 202-414-9243	Chris agreed to meet with this group. - approximately ⁶ 4 persons will meet with Chris - a list of participants will be fax to us today <i>5/25 - Will fax list of participants</i> <i>5/25 - rec'd list " "</i>



OEOP CONFERENCE & ROOSEVELT ROOM RESERVATION

Date of Meeting: 5/27/99
Time: 100 To: 500 PM

All reservation forms should be submitted at least 48 hours prior to events.

Name of Individual Hosting Event: <u>Chris Jennings</u>		Office/Agency: <u>DFC</u>	
Staff Contact: <u>Teresa Jones</u>	Extension No.: <u>65514</u>	Pager No.: <u>—</u>	Room No.: <u>216</u>
Type of Event: ☒ Meeting ☐ Reception ☐ Other _____			
Name/Description of Event: _____			
Number of Outside Guests: _____		In Attendance:	
Total Number of Attendees: _____		☐ President ☐ First Lady ☐ Vice President ☐ Mrs. Gore	
Room(s) Requested:			
☐ Roosevelt Room *		☐ Room 180	
☒ Room 476		☐ Room 472	
		☐ Room 450	
		☐ Room 474 (Indian Treaty Room)	
General Services: ☐ Elevator Service (elevator #4)			
Time Reserved: _____ ☐ Podium ☐ Flags			
Special Room Arrangements for the Indian Treaty Room:			
☐ Conference Style ☐ Theatre Style ☐ Other _____			
Number of Chairs: _____		Number of Table(s): _____	
Entrance/Gate Preferred:			
☐ Pennsylvania Avenue (OEOP)		☐ East Visitors Gate	
Note: the 17th & "G" Street entrance is wheelchair accessible.			
Additional Requirements or Requests: _____			

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REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
514	6/1/99 ~~5/27/99~~ ~~1:00pm~~ 4:00pm MEETING	PCS Health Systems Marc J. Scheineson, Esq. <u>CONTACT:</u> Marc Scheineson 202-414-9243	Chris agreed to meet with this group. - approximately 6 persons will meet with Chris - a list of participants will be fax to us today 5/25/99 – Ann Richards (Governor) added to list of participants



Teresa M. Jones
06/01/99 11:02:58 AM

Record Type: Record

To: jeanne lambrew

cc:

Subject: Reminder - Meeting with PCS Health Systems

The meeting with Marc Scheineson from PCS Health Systems is scheduled for today at 4:30pm in Room 100. Chris has requested that you attend. Thanks!!!

Note: Other participants:

William Titelman - Executive VP-Managed Care & Public Affairs Rite Aide Corp.

Diane Sachs - VP for Government Affairs, PCS Health Systems

Andrew Eskin - Verner Liipfert

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004c. note	Requests for Chris re: phone number (partial) (1 page)	06/15/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Meetings, Trips, Events)
OA/Box Number: 17045

FOLDER TITLE:

Speaking Engagements (January - August 1999) [2]

2011-0747-S

rc414

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]

REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
615	6/15/99 11:00am MEETING	Bill Titelman, Executive VP Rite Aid Corp. CONTACT: Bill Titelman [004c] [Redacted] (b)(6) <i>Henry P. [Redacted]</i> <i>371-2222-5452</i>	This group met with Chris on 6/1 at 4:30. After the 6/1 meeting a followup meeting was agreed on to discuss Medicare Pharmacy Benefit/Confidentiality. 6/3/99 - Bill Titelman is putting together some background material and should have it ready sometime next week. He will fax then. PARTICIPANTS - The same group from meeting on 6/1. (List attached) <i>6/10/99 - Fax sent</i> <i>6/10/99 Laurie G. H. added to list of invitees</i>

6/15/99

1100 AM

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004d. memo	Marc J. Scheineson to Teresa re: Meeting (partial) (1 page)	05/24/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Meetings, Trips, Events)
OA/Box Number: 17045

FOLDER TITLE:

Speaking Engagements (January - August 1999) [2]

2011-0747-S

rc414

RESTRICTION CODES

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RITE AID CORPORATION**P. O. BOX 3165
HARRISBURG, PA 17105****Date:** June 10, 1999
of pages including cover sheet 6**FAX****To: The Honorable Christopher Jennings
Deputy Assistant to the President
For Health Policy
FAX: 202-456-5557****From: William A. K. Titelman
Executive Vice President,
Managed Care & Public Affairs
Phone #: 717/975-3740
FAX #: 717/975-3760****Message:**

Following is our letter with our recommendations concerning the design and structure of the Medicare drug benefit as promised. The original will be forwarded via Federal Express today. Thank you.

If you do not receive all pages indicated, please call 717/731-6580. Thank you.

CONFIDENTIALITY NOTE: The documents accompanying this facsimile transmission contain information from Rite Aid Corporation which is privileged and confidential and/or proprietary. The information is intended for the individual or entity named on this facsimile cover sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action on the contents of this information is strictly prohibited and that the documents must be returned to us immediately. In this regard, if you have received this telecopy in error, please call the above phone number immediately so that we can correct our error and direct the message to the proper destination. **THANK YOU.**

**RITE AID Corporation**

WILLIAM A.K. TITELMAN
Executive Vice President
Managed Care & Public Affairs

• MAILING ADDRESS

P.O. Box 3165
Harrisburg, PA 17105

• GENERAL OFFICE

30 Hunter Lane
Camp Hill, PA 17011

• (717) 975-3740

• (717) 975-3760 Fax

• wtitelman@riteaid.com

June 9, 1999

The Honorable Christopher C. Jennings
Deputy Assistant to the President
For Health Policy
Old Executive Office Building
17th Street & Pennsylvania Avenue, NW
Room 216
Washington, D.C. 20500

Re: Medicare Rx Drug Benefit

Dear Chris:

Thank you for the opportunity to meet with you briefly on June 1, 1999 and discuss the content of an Administration proposal to create a Medicare drug benefit. Rite Aid and our pharmacy benefits management subsidiary, PCS Health Systems, together have considerable expertise and experience in all aspects of prescription drug management and dispensing, as well as cost and other aggregate prescription data that we would be pleased to make available to you as you refine your proposal. We look forward to furthering our discussion on June 15, 1999.

When we met, you requested that we provide you with recommendations concerning the design and structure of a Medicare drug benefit. The attached document is offered in response to that request. It focuses on fundamental design elements which we believe are essential to get right if a Medicare drug benefit is to work and be meaningful to the elderly. We believe it is important that these basic elements be spelled out at the outset, so that there is less risk that they will be overlooked or incompletely considered later.

Thank you for your continued consideration. Please call us with any questions and if we may be of further assistance.

Best personal regards.

Sincerely,

A handwritten signature in black ink, appearing to read "William Titelman", written over a horizontal line.

William Titelman

WT:gr

Enclosure

MEDICARE DRUG BENEFIT PLAN DESIGN SUGGESTIONS

In order to provide a meaningful and effective drug benefit for the elderly, it is critical that the plan (a) works for seniors, i.e. is simple, convenient, and does not impose barriers on access, but instead encourages seniors to seek out, use and remain compliant with appropriate drug therapy; and (b) allows the flexibility necessary to manage utilization and costs while preserving and enhancing the quality of care. The following suggestions are offered with these goals in mind:

- **Private sector delivery mechanism should be utilized.** Private entities, such as pharmacy benefit management and other companies with similar capabilities, which have the expertise, operational capacity and sophistication and, most important, experience in managing pharmacy benefits on a large scale, should be utilized to provide the benefit. These entities already have in place the mechanisms necessary to deliver of a cost effective drug benefit, and have proven themselves able to manage utilization through innovative programs which do not sacrifice clinical quality or consumer choice. Successful mechanisms include online claims adjudication, formulary management, pharmacy network contracting, rebate negotiation, generic substitution and therapeutic interchange, physician drug utilization review, utilization management (including drug limits, prior authorization, step therapy) and disease management.
- **Standard basic benefit package with ability to offer variations.** To ensure adequacy of the benefit and a basic level of uniformity, there should be a standard core benefit package. This core package should cover all FDA-approved drugs determined to meet essential clinical needs, but should not mandate coverage of every FDA-approved drug. Discretionary or lifestyle drugs excluded from the basic benefit package could be covered in supplemental benefit packages and options, which should be permitted to be offered so as to increase consumer choice and encourage competition.
- **Use Flexible Methods to Control Costs Without Discouraging Appropriate Utilization.** There are several ways in which this can be achieved:
 - **Separate plan design for low-income beneficiaries.** While every senior paying into the Medicare system should be eligible for a drug benefit, the benefit's costs should be lower for low-income beneficiaries. This is critical to ensure that those most in need have affordable access to the benefit. In addition to lower premiums, low-income beneficiaries could pay a minimal deductible with a lower, or even zero, copayment. This system would promote accessibility and better manage program costs.

- **Minimize deductible and utilize fixed copayments rather than percentage coinsurance.** The willingness and ability of the elderly to access and utilize the drug benefit will depend upon its affordability and simplicity. A high deductible (which requires that the initial drug costs up to a fixed dollar limit be borne by the consumer) and percentage coinsurance (where a fixed percentage of the cost of every prescription is borne by the consumer) act as barriers to appropriate drug use. Fixed copayments (where a set dollar of the cost of the prescription is paid by the consumer), indexed as necessary to drug cost increases, are preferred by the elderly because they are predictable, simpler to budget for, and easier to remember. Copayments could also vary based on a clinical classification of different prescriptions, with those meeting core clinical needs requiring the lowest, or even a zero, copayment. In addition, as mentioned above, the plan for low-income beneficiaries could be designed with no deductible or copayment required for the core benefit package.
- **Beneficiary drug purchases for covered drugs up to any deductible or beyond any dollar cap should be at contract price.** If a deductible or dollar cap is imposed, beneficiaries should be entitled to the same contract price as the government for covered drugs they are required to purchase to meet the deductible or that exceed the cap. This will ensure that there is no cost shifting to the elderly to the extent they bear their own basic drug costs.
- **Use flexible drug utilization management techniques instead of arbitrary dollar benefit caps.** Dollar caps, which limit the total annual reimbursement per patient, impose arbitrary and inflexible ceilings on drug use. Historically, caps have distorted utilization patterns and/or increased noncompliance (e.g. pill-splitting, skipping year-end refills). Today there exist many more sophisticated, flexible and clinically-based formulary and drug utilization management tools that contain drug costs without sacrificing the quality of care afforded to the elderly, such as:
 - a clinical-needs based formulary that excludes certain discretionary or lifestyle drugs;
 - three-tiered copayments (generic, preferred, non-preferred);

- mandatory generic substitution and voluntary therapeutic interchange;
 - prior authorization, managed drug limits and step-therapy;
 - drug utilization review;
 - disease management;
 - case management for high-cost beneficiaries.
- **Require pharmacy networks to meet minimum accessibility standards, and permit the development of performance-based networks.** At a minimum, a national pharmacy network which meets Medicaid accessibility standards should be required. Subject to these standards, plans should have the flexibility to develop performance-based networks, i.e. networks of pharmacies which undertake, and are proven, to meet higher service and cost containment standards such as higher generic dispensing rates.
 - **Allow beneficiaries equal choice of their local community pharmacist or mail order.** Plans offering incentives to use mail should be required to offer a retail maintenance option to beneficiaries. This option would allow the elderly to obtain drugs at their community pharmacies on the same terms and in the same quantities as they would obtain these drugs through the mail. This would allow the elderly, who more than any other group, need, seek out and benefit from the personal contact and counseling available from community pharmacists, the flexibility to choose the delivery channel most convenient and appropriate for them. Internet pharmacies should also be permitted as an additional delivery channel option for the elderly.
 - **Employers must receive incentives to maintain retiree drug benefits.** Currently, a significant portion of the elderly population receives good, often generous, drug coverage through employers. However, increasing drug costs are causing many employers to reduce or eliminate these benefits. Employers should be encouraged, through economic incentives such as tax credits or other tax preferences, to continue to offer these benefits. Preserving existing employer plans in this way will reduce the government outlay for a Medicare drug benefit without imposing an economic penalty on those employers who have chosen to provide this benefit to their retirees.
 - **Preemption from conflicting state laws.** In order to provide the benefit in a consistent and efficient manner, it is essential that the program be allowed to operate free from the myriad of often conflicting and inconsistent

state laws regulating every aspect of pharmacy practice and benefit management, from provider networks to formularies to the details of plan design.

- **Mandatory beneficiary education and information.** Educating and advising beneficiaries about their drug benefit, and about drug use and compliance in general, is an integral part of any benefit, and is especially critical for the elderly. Some elements of an appropriate education program might include:
 - information to help beneficiaries evaluate their drug benefit choices;
 - an explanation of how to use the drug benefit, from what to ask the doctor, going to the pharmacy, differences between brands and generics;
 - compliance and drug usage information, such as directions for use, dosage and administration, drug interactions and precautions, and disposal of old medications.
- **A mechanism to evaluate the impact of the program on the healthcare system.** The program should establish funding to research the impact of improved drug usage and compliance on the healthcare system, including any reductions in medical costs and improvements in the quality of life of beneficiaries.

#618



Health Insurance Association of America

6/14/99 7pm

Drinks - 6:30

Dinner - 7:00

You should advise
these guys that about
I want to go to that
last second
scheduling conflict
may well
preclude me
from
coming

June 1, 1999

Chris Jennings
Deputy Assistant to the President for Health Policy
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Chris:

It was good speaking with you this afternoon about Medicare and other matters. I'm messengering over a copy of the HIAA's recent study on the cost impact of a prescription drug mandate on the Medicare Supplemental (Medigap) market.

As we discussed, HIAA is hosting a small dinner next Monday, June 14th for several HIAA member company CEOs. I am glad that you will be able to join us and thank you for your willingness to make a few remarks on Medicare, managed care and confidentiality. The dinner will be held in the downstairs private room of the Old Ebbitt Grill [675 15th Street, N.W.]. Drinks will be served at 6:30 p.m. and dinner will follow at 7 p.m. I expect that the evening should run no later than 8:30 p.m.

If you have any questions, please don't hesitate to call me at 824-1845.

Regards,

Sharon L. Cohen

Senior Vice President, Federal Affairs

P.S. I've also enclosed a copy of
our proposal on the uninsured.

Katie Kuesters



Health Insurance Association of America

FAX TRANSMISSION

Date: June 9, 1999
3:24 PM
Pages: 14

From: Sharon Cohen

Phone: 202-824-1845
Fax: 202-824-1651

In case of problems with transmission, please contact Katie Kneesters (202) 824-1751

Deliver To: Teresa Jones

Company: Office of Chris Jennings

Phone: **Fax:** 456-5557

Message:

Attached is the "InsureUSA" proposal.

Please call with any questions.

Disclaimer: The information contained in this telecopy message is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, or as the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this message in error, please immediately notify us by telephone and return the original message to us at the address below via the U.S. Postal Service. Thank you.

InsureUSA

An initiative to increase
health coverage



HIAA

Health
Insurance
Association
of America



Currently, 168 million nonelderly Americans enjoy the security of private health insurance; and the vast majority gets its coverage at the workplace. But for too many Americans, private health insurance is unaffordable . . . and often, government programs like Medicaid do not cover these needy adults.

At last count, 43 million people had no health insurance coverage. This must change.

HIAA's initiative to increase health coverage combines targeted subsidies, incentives, cost-control measures, and education. Importantly, it builds on the foundation of the private employer-based system while recognizing that government also has an important role. This brochure gives the outlines of our proposal. For more information, log on to www.insureusa.org.

A Safety Net for the Neediest

Many low-income Americans who can't afford private health coverage do not qualify for public programs or subsidies. (Married couples without children and single men are the least likely to have insurance.) Among those whose incomes are below 100% of the federal poverty level (about \$8,480 for one person), only 14% have employment-based coverage.

We propose a public health insurance program for adults whose incomes are below 100% of poverty.

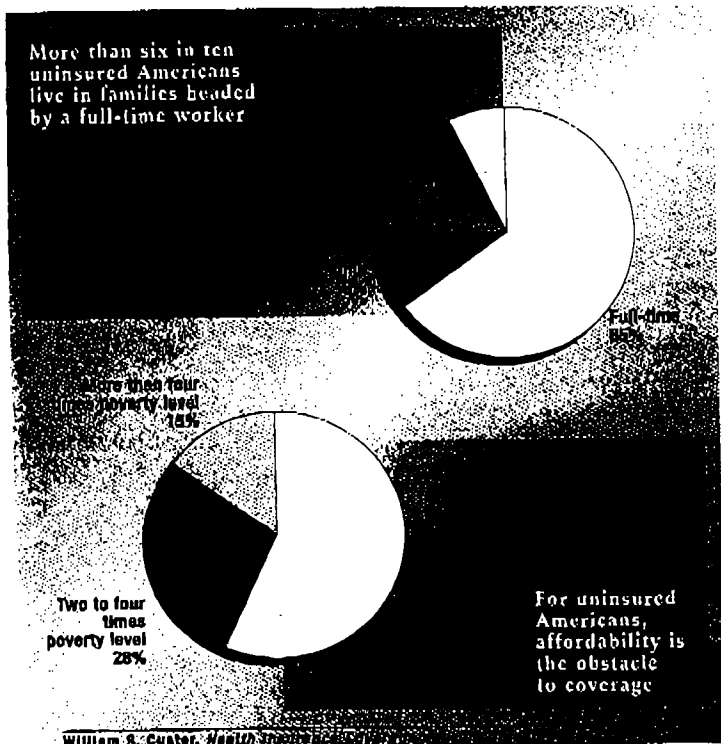
- The federal government and the states should jointly fund the program; the Children's Health Insurance Program (CHIP) provides a model.
- States would have significant flexibility as to benefits and program structure.
- Incentives would exist to subsidize private coverage with program funds.

Private Coverage for the Working Poor

People who have incomes above 100% (and up to 200%) of the federal poverty level also need help to purchase coverage. Many are not eligible for public programs. And while 44% of these Americans get health insurance at the workplace, the rest don't have access to employer-sponsored coverage or cannot afford it. For them, a voucher system could go a long way.

We propose a federal voucher of approximately \$2,000 (that's about 75% of the average Federal Employee Health Benefit Plan premium) to help low-income workers obtain affordable coverage.

- For people whose employers offer coverage, the voucher would pay for part of the premium—the “employee contribution.”
- For others, the voucher could apply to any “creditable coverage” under federal law for which the individual is eligible.



Tax Incentives and Subsidies for Businesses, Individuals, and the Self-Employed

Many businesses, individuals, and the self-employed cannot “spread the risk” among a large group of health insurance beneficiaries. Inequities within the tax code further exacerbate the problem.

To make coverage more affordable for these key groups, we propose that:

- Small employers—many of whom do not offer coverage—should get a tax credit that could be phased-in beginning with smallest firms:
 - 40% credit for employers with fewer than 10 employees
 - 25% credit for employers with 10-25 employees
 - 15% credit for employers with 26-50 employees
- Employee contributions for health insurance should not be considered taxable income (even if not made through a Section 125 cafeteria plan). This would primarily benefit those who work for small employers who generally do not have access to cafeteria plans.
- Individual purchasers of health insurance and the self-employed should be able to fully deduct the cost of premiums.
 - Under current tax law, individuals can’t deduct health insurance premiums they pay until their medical costs exceed 7.5% of income. And the self-employed will have to wait until 2003 for full deductibility. Changes in tax law would result in greater equity . . . and make coverage more affordable for these purchasers.
- Medical Savings Accounts (MSAs) should be made more attractive:
 - Simplify rules
 - Eliminate “sunset” provision for MSAs available to the self-employed and small employers
 - Extend availability to large employers
 - Permit both employees and employers to contribute to MSAs
 - Make it easier for PPOs and other network-based plans to offer MSAs

Access for Those in Poor Health

Some people—who may be able to afford a premium, or are eligible for a voucher or other subsidy—may not qualify for private insurance because of their poor health. While states have chosen various mechanisms to guarantee access to coverage to these individuals, high-risk pools have demonstrated the most success.

We propose that the federal government make risk pools more attractive and increase their likelihood of success by providing:

- Seed money and block grants to help defray costs.
- Matching funds (50/50) to help pools with underwriting losses on premiums down to 150% of the standard rate.
- Reinsurance to cover 75% of claims over \$1 million for an individual pool enrollee (indexed to medical inflation).
- Funds, antitrust exemptions, and tax credits for risk pools sponsored by private industry.

If neither the state nor private industry establishes pools, the federal government should do so.

Lower Health Care Costs

Mandates cost money . . . and recent studies show they account for lack of coverage in up to one out of four uninsured Americans. Mandates also stifle innovation and hinder the ability of insurers to respond to customers. While there may be limited societal costs to eliminating some mandates, these should be more than offset by the decrease in the number of Americans who lack coverage and by the increase in affordability for all purchasers.

We propose reducing regulatory (and other) burdens that contribute to the cost of coverage:

- Benefit mandates passed by states should be preempted.
- Small-group laws and regulations should be modified and restrictions eased.
- Liability laws must undergo reform and limits set on damages.
- Fraud and abuse initiatives (including extending liability for private sector fraud violations) must be aggressively pursued.
- Federal requirements on administrative simplification must apply to all players in the health care industry, including providers.



Uninsured...

...and currently uninsured. Almost 40 million Americans lack health insurance. The cost of the uninsured is the largest single factor in the firm, the less the firm's cost of care. For young adults up to age 34, the cost of care represents nearly 40% of the total cost of care. For those who lack health insurance, the cost of care is that they cannot afford to pay for it. For those who are too low to qualify them for insurance, the cost of care is that they cannot afford to pay for it. The increase in the cost of care is the largest single factor in the firm, the less the firm's cost of care. For young adults up to age 34, the cost of care represents nearly 40% of the total cost of care. For those who lack health insurance, the cost of care is that they cannot afford to pay for it. For those who are too low to qualify them for insurance, the cost of care is that they cannot afford to pay for it.

A Better Public Health System

The nation's public health system is critical to uninsured individuals who need physical, mental health, or substance abuse services, and the federal and state governments have important roles to play.

We propose restructuring funding sources to improve the system's infrastructure and encourage better coordination among systems of care.

Personal Responsibility

Personal responsibility not only extends to health habits—eating sensibly, exercising, engaging in wellness activities, and following treatment and prevention regimens—but to protecting oneself from risk. People should obtain insurance if they can; those who choose not to purchase it should shoulder greater responsibility for the cost of their care.

We propose promoting responsible behavior through education on:

- Wellness and prevention.
- Adherence to treatment regimens.
- The importance of health insurance.

faces of the uninsured

Workers

To many people, it's almost a truism: If you work, or if you live in a household headed by a worker, you have health insurance coverage. But nothing could be further from the truth. More than six out of 10 uninsured Americans live in a family whose head of household works full-time, month in and month out. Some work for firms that don't offer insurance; others work for firms that offer coverage but don't pick up any part of the cost, and the worker finds the premium out of reach financially. Others had employer-sponsored coverage at one time and could afford to pay their share. But over the past decade, the percentage of the premium that the worker must pay has increased, and many workers have ultimately faced a difficult financial decision: pay more for health insurance coverage and have less to spend on essentials, or assume the risks associated with not having coverage.

Young Adults

Sure, young adults are one of the healthiest groups in the nation. But they account for nearly 40% of those who don't have coverage! In fact, nearly one out of every four people up to the age of 34 doesn't have health insurance. Why are these numbers so disturbingly large? When young people reach a certain age, they are no longer eligible as dependents on their parents' insurance policy. Any health coverage they had through a college- or university-based program usually ends when they accept their diploma. Many young people work for firms that don't offer coverage. And many whose employers do offer coverage don't choose to participate. After all, when you're young and healthy, and you've a choice between contributing to your employer's plan or spending that money elsewhere, elsewhere can look like a real fine place to be.

Those in Poorest Health

People in extremely poor health are sometimes unable to afford adequate health insurance coverage on the open market, yet do not qualify for government aid. Further, some of these individuals either never had access to employer-sponsored group coverage or lost it when a company downsized or went out of business, and do not have access to any other group plan, for instance, one sponsored by a professional association or union. Individuals who did have employer-sponsored coverage can continue this coverage (under COBRA) for 18 months if they pay the full cost of the group health premium out-of-pocket, and the Health Insurance Portability and Accountability Act of 1996 guarantees them access to an individual policy when the COBRA period is over. But guaranteed access does not guarantee a premium that will fit within their budget. In states that do not have high-risk pools or similar programs, the cost of coverage may be beyond the reach of many of these individuals who arguably have the greatest need for health insurance.

Neediest

It isn't widely known, but many of America's poorest nonelderly citizens are not eligible for health coverage through Medicaid. A married couple without children, or a single male who is neither blind nor disabled, has only a slim chance of qualifying for public coverage. And it may go without saying, but the nation's poorest individuals, those with incomes under the federal poverty level, don't, for the most part, have a solid connection with the work force, and few have any kind of employment-based coverage.

THE PROPOSAL

- A SAFETY NET FOR THE NEEDIEST
- PRIVATE COVERAGE FOR THE WORKING POOR
- ACCESS FOR THOSE IN POOR HEALTH
- TAX INCENTIVES FOR BUSINESSES, INDIVIDUALS, & THE SELF-EMPLOYED
- LOWER HEALTH CARE COSTS
- A BETTER PUBLIC HEALTH SYSTEM
- PERSONAL RESPONSIBILITY



key principles

The time is ripe.

Today there are over 48 million uninsured Americans. By the end of the next decade that number will grow to at least 58 million—one in every five nonelderly Americans. If the economy sours, it could be one in four. That's right. One quarter of working-age Americans and their families could find themselves without health insurance coverage of any kind.

Affordability is key.

The major reason that Americans are uninsured is because they cannot afford coverage. Reforms must reduce the costs of health insurance and provide financial support for those who cannot afford coverage.

A multifaceted problem.

The uninsured have many faces. While affordability is central, many factors contribute to or exacerbate the problem. That's why there's no single, overarching approach to insuring more Americans. What we need is a multifaceted program that attacks the underlying reasons that people are uninsured.

Maintain a strong, vibrant private health insurance market.

A competitive market remains the best way to provide customers with coverage. Regulation that stifles innovation, flexibility, and responsiveness should be discouraged.

Keep the employment-based private health care system.

Nine in every 10 Americans with health coverage get their insurance through their employer. And while coverage has declined overall, the percentage of Americans with employment-based health coverage has increased during the past few years. Reforms must build on the critical cornerstone of employment-based private health insurance.

Financing reform should be broad-based.

State and federal policy makers should be encouraged to finance reforms with broad-based funding sources, not premium taxes. Such sources should include state and federal budget surpluses and state funds related to health, such as tobacco recoveries.

InsureUSA is an initiative to extend health insurance coverage to millions of Americans. It relies upon the following key tenets: mending the safety net for the neediest; subsidizing coverage for the working poor; guaranteeing access to those in poor health; offering tax incentives to individuals and small businesses; lowering health care costs; and promoting personal responsibility.

On HIAA's InsureUSA website, you'll find:

- HIAA's proposal to extend coverage to millions of Americans;
- a unique "counter" that will show you how many Americans, at specific times in the future, will not have coverage if no action is taken;
- research data, including two HIAA reports and summaries of studies from other organizations;
- tax-related federal bills that would help make insurance more affordable for the self-employed, for employees of small businesses, and others;
- consumer information, including guides to health insurance and a list of state insurance departments;
- facts about the uninsured; and
- polling data that demonstrate widespread support for extending health insurance coverage to the greatest possible number of Americans.

© 1999 HIAA Washington, D.C.

**HIAA**

Health
Insurance
Association
of America

Reactions to InsureUSA

InsureUSA is an initiative to extend health insurance coverage to millions of Americans. It relies upon the following key tenets: mending the safety net for the neediest; subsidizing coverage for the working poor; guaranteeing access to those in poor health; offering tax incentives to individuals and small businesses; lowering health care costs; and promoting personal responsibility.

"HIAA has developed a credible and comprehensive solution to make health care more affordable and accessible to all Americans. HIAA's action steps would help put health coverage within reach for all Americans. Congress should take notice and act swiftly to enact these proposals."

— Thomas J. Donohue
President and CEO
U.S. Chamber of Commerce

"Assuring health coverage to all Americans should be the nation's top priority. We agree with HIAA that the time is ripe."

— Andrew L. Stern, President
Service Employees International
Union, AFL-CIO

"We commend the HIAA for joining the effort to increase coverage for Americans."

— Richard J. Davidson, President
American Hospital Association

"HIAA is moving in the right direction; the structure and state flexibility are worth the states' looking at seriously."

— Ray Scheppach
Executive Director
National Governors' Association

"The Business Roundtable supports HIAA's goal of increasing access to needed health care services. By providing tax incentives that would enable additional individuals to purchase coverage, we can reduce the burden on public programs. HIAA's proposals to establish tax credits for individuals, create markets for small group purchasing, and oppose individual state mandates would work to address the growing problem of the uninsured."

— The Business Roundtable

**HIAA**Health
Insurance
Associatio
of America

Investor's Business Daily

FOR PEOPLE WHO CHOOSE TO SUCCEED

Tuesday, April 13, 1999

ECON ONE ON ONE

Insurance Association's Chip Kahn On The Growing Uninsured

By Gloria Lau

Investor's Business Daily

Though the economic expansion is in its eighth year, the number of uninsured workers continues to climb and the number of small companies offering health coverage continues to shrink.

Despite the economy's fast growth, the percentage of workers with health insurance from small employers fell to 47% from 52% in the last two years, according to a recent Henry J. Kaiser Family Foundation study.

This is the first time that fewer than half these workers have coverage in the eight years since Kaiser has tracked the figures.

It's not that uninsured Americans don't work. In fact, 60% of the country's 43.4 million uninsured people do work. But two-thirds of these workers labor full-time for small business owners, many of whom can't afford to offer workers health benefits.

Most Common Mandates in 1996

Providers	Number of states with mandates
Chiropractors	41
Psychologists	41
Optometrists	37
Dentists	34
Benefits	
Mammography Screening	46
Alcoholism Treatment	43
Maternity Length-of-Stay	34
Mental Health Care	32
Coverage Extended	
Conversion to Non-Group Policy	39
Continuation Coverage for Employees	38
Continuation Coverage for Dependents	35
Handicapped Dependents	34

UNINSURED NUMBERS RISE: Mandates boost costs, forcing more people to drop coverage.

Insurance comes down the line behind food, clothing and shelter. Six out of 10 uninsured families of four have incomes below \$33,600. That makes it tough for them to buy insurance because they have to pay the rent and feed the family.

Few studies have asked uninsured people why they don't buy coverage. The most recent one was from a 1994 Kaiser Family Foundation study.

When asked about the primary reason they didn't have coverage, 59% of uninsured adults said they couldn't afford it; 22% said their employer didn't offer it as a benefit; 7% said they chose to be uninsured or didn't feel they needed it; and 3% said they couldn't obtain it because of ill health.

The 7% are mostly young people who can afford coverage and make the decision not to be insured. They keep themselves out of the pool. If they bought insurance, care would be cheaper for everyone. The more people who pay for insurance, the more you can spread out the costs of health insurance and keep the cost per person down.

IBD: Ultimately, insured Americans and taxpayers foot the bill for health-care services used by the uninsured. How will these costs surface?

Kahn: Just because an American isn't insured doesn't mean he has no access to hospitals. Whether it's a free-care center or an emergency room, people who are sick with no insurance still receive care.

But someone has to subsidize that. That's the dilemma. Frequently the care they receive is not the most efficient or the best, compared to what they would have gotten had they been insured.

The issue of efficiency is key. If an uninsured diabetic goes through an emergency room and ends up in a hospital, he could end up with an extremely

expensive amputated leg. But if he had insurance, he would probably have (gotten preventative care), avoided the amputated leg and saved money.

IBD: How do mandates affect the number of Americans with insurance?

Kahn: Mandates contribute to Americans losing their coverage because they increase its cost. California, Maryland and Florida all have more than 28 mandates in place. For every 1% increase in premiums, the Congressional Budget Office has projected that 200,000 people lose health coverage.

Well-intentioned reforms lead to more people losing their insurance because there's a direct relationship between increasing cost and employers — particularly small employers — dropping coverage.

All mandates increase cost. So whatever the public purpose of these mandates, whether they be to reduce premium rates or to require coverage of certain diseases, they're at cross-purposes with their missions if they're leading to less coverage rather than more.

IBD: What kinds of mandates are we talking about?

Kahn: Mandates come in three varieties. One type requires health plans to improve market conduct and ratings. A second is disease-related. It might require you to cover psychiatric or mental-health services exactly as you would cover services for physical health. Or it requires you to cover contraceptives or in-vitro fertilization.

The third type forces health plans to cover chiropractic care and alternative services like massage. Though it requires coverage for services, it effectively forces plans to pay a whole new set of providers.

Q&A

Charles "Chip" Kahn III

■ President,
Health Insurance
Association of
America



IBD spoke to Charles

"Chip" Kahn III, head of the Health Insurance Association of America.

IBD: What concerns do you have about the number of uninsured people trending upward?

Kahn: When times are good, more employers usually feel comfortable offering workers health coverage, so the number of uninsured drops. But in recent years, we've had one of the greatest economic expansions in the country's history and the number of uninsured actually increased.

Previously, in economic downturns, the number of uninsured people went up. So if there's another downturn, the number of people without coverage will grow tremendously. That provides a worrisome harbinger for what may come next in any economic downturn, whether it's mild or severe.

IBD: Are the uninsured too poor to buy health coverage? Or are some just gambling that they'll stay healthy?

Kahn: The question is affordability. Health in-

THE UNINSURED/SURVEY SUMMARY

1. *When presented with a list of five goals that could be followed in changing our health care system, "providing basic health insurance coverage to all Americans" ties with "making health care more affordable" as the country's number one objective.*
 - Public Opinion Strategies has conducted a series of health care trend research since the fall of 1991. This trend data demonstrates the growing salience of the issue of the uninsured and the affordability of health care.
 - Interestingly, results among those currently uninsured or who have had no insurance in the past year are equally split between the concern about making health care more affordable and the issue of the uninsured.
2. *The survey demonstrates a large percentage of the population who shift in and out of having health insurance coverage.*
 - Nine percent (9%) of respondents say they have no health coverage at all (somewhat under the estimated 15% of the population with no coverage). But among these currently uninsured respondents, 40%, or 4% of the entire population, had health insurance coverage sometime in the last year. But 12% of those currently insured (10% of the entire population) say they had no coverage sometime in the last year. So, while "only" 9% say they are currently uninsured, this data tracks our past observation that roughly one out of five adult Americans are "at risk" in terms of being without health insurance.
3. *Given this data, it's not surprising that 70% would want to see the government act on this issue. But people want to see a solution that expands on an employer based system, not a single government plan.*
 - There are a number of ways respondents told us they would rather build on an employer based system. Seventy-one percent agreed "reforms are needed to make sure more Americans receive health care coverage, but we should make the changes needed to the current system where most people get coverage through their employer rather than replacing this system with a single government plan to provide health insurance to all Americans."
4. *A description of the HIAA plan combining additional tax credits/deductions, giving more flexibility to reduce regulation to offer lower cost basic coverage and expanding Medicaid tests exceptionally well with 83% of Americans supporting this proposal.*
 - Respondents were presented with a brief summary of "different ways to guarantee health insurance for more Americans that would be financed by the taxpayer."

- We also asked a very minor variation of a question first posed by the Kaiser Family Foundation/Harvard School of Public Health with similar results. A majority of respondents (54%) said they opposed "a national health plan in which all Americans would get their insurance from a single government plan," while 41% say they would favor this proposal.

5. *When presented with more details about the HIAA plan, each element is well received with the highest support for cutting down on excessive government regulation and providing new tax incentives for small employers and people who purchase their own health insurance.*

6. *Sixty percent (60%) of those who favor the HIAA plan continue to support it even when told it would raise their taxes by roughly \$100 per year. Majority support can also be seen; when told it would leave 10 million Americans without coverage, 53% agree the HIAA plan "is a needed and positive step."*

- Based on years of polling and initiative experience, we know the difference between what appears to be high support versus peoples' willingness to fund different proposals. So, among the 82% who said they favored the HIAA proposal, we then asked if they would still favor it if it raised their taxes by \$100, or would they be more undecided or would they now oppose this proposal. Sixty percent (60%) said they would still favor the proposal versus only 16% who would now oppose it (with 24% moving to "more undecided"). We do this format a lot and a 60% "still favor" is a solid number that demonstrates a core and active support.

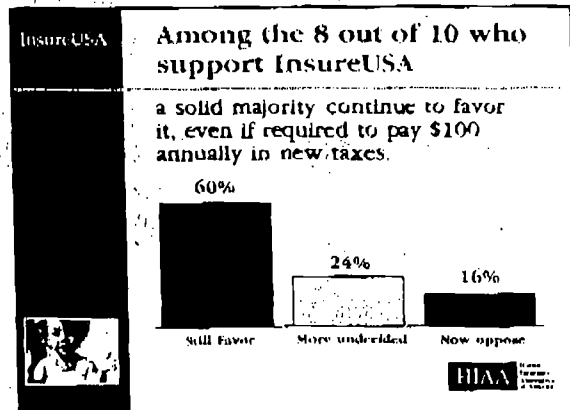
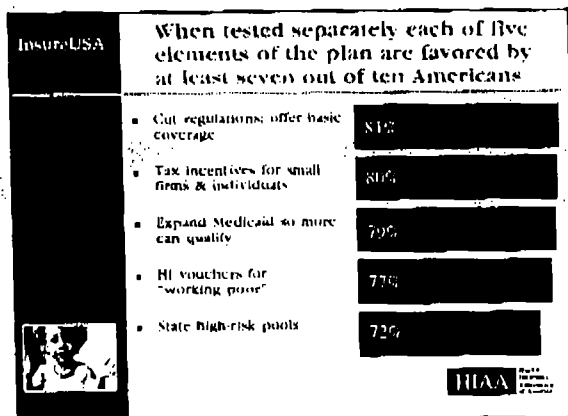
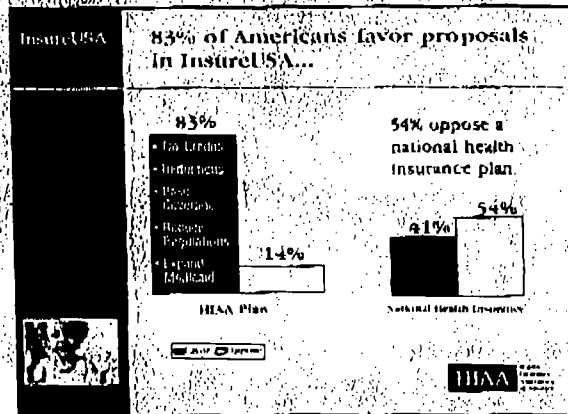
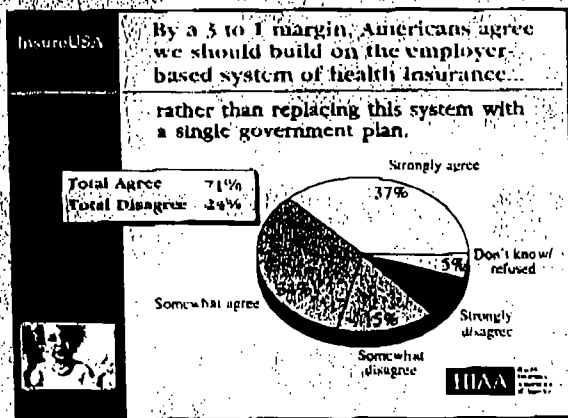
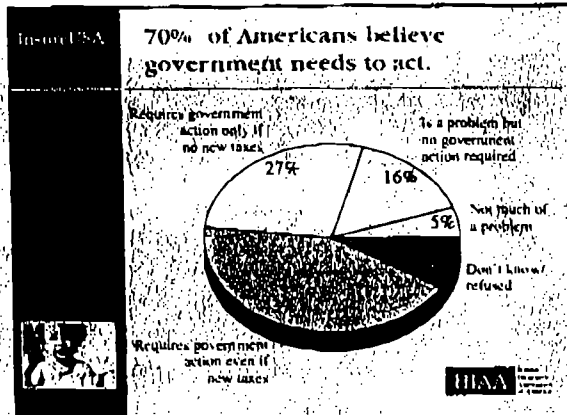
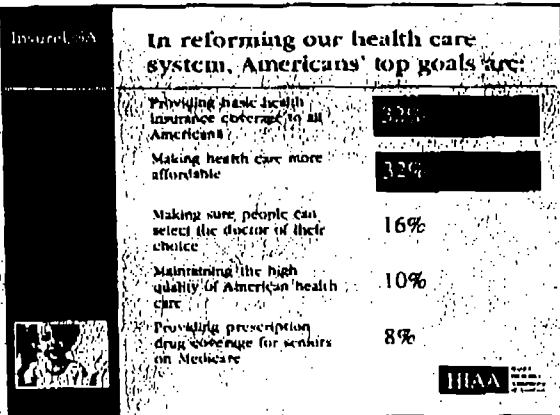
- We specifically tested another line of attack (among a half-sample of respondents): That this proposal might mean that as many as ten million Americans would still have no coverage. However, 53% of Americans said this plan "is a needed and positive step covering millions of people while allowing people with good private health insurance to keep the plans they have chosen," while 36% said this plan "does not go far enough as every American has the basic right to health care and we should instead adopt a single government plan to provide health insurance for all Americans."

7. *Another way to measure the salience of this issue is to track the dramatic margin by which people would rather see the federal surplus be used to provide health insurance coverage rather than expanding a Medicare drug benefit.*

- When told there was a discussion about using projected federal surplus funds for health care reform, 69% of Americans said they would rather these funds be used for "providing basic health insurance coverage to all Americans" versus only 24% who said "providing prescription drug coverage for seniors on Medicare." Even people on Medicare select basic coverage over a drug benefit (55% to 36%).

METHODOLOGY:

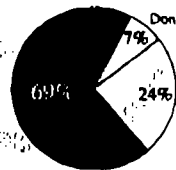
Public Opinion Strategies is pleased to present the key findings of a national survey of 800 adults. The survey was conducted from May 5-8, 1999, and has a margin of error of $\pm 3.46\%$.



InsureUSA

By a 45 point margin...

Americans would rather use the federal budget surplus to pay for basic health insurance for the uninsured rather than drug coverage for seniors.



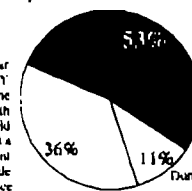
Option	Percentage
Basic health insurance coverage to all Americans	69%
Prescription drug coverage for seniors on Medicare	24%
Don't know/refused	7%

HIAA

InsureUSA

Even when faced with the realization InsureUSA might leave some without coverage...

A majority support the proposal over a single government plan to cover everyone.



Option	Percentage
A needed and positive step covering millions of people while allowing those with good private health coverage to keep plans they have chosen	53%
Does not go far enough as EVERY American has the basic right to health care and we should instead adopt a single government plan to provide health insurance for all Americans	36%
Don't know/refused	11%

HIAA

InsureUSA

Is there public support?

- 70% believe government should address this problem
- Top goals for Americans are (1) to provide basic health coverage to all and (2) make coverage more affordable
- 5 to 6 Americans want to build on employer-based system, not adopt a government insurance plan
- 8 out of 10 support proposals in InsureUSA
- Of those, 66% would continue to support InsureUSA even if required to pay \$100 annually in new taxes



HIAA

REQUESTS FOR Chris Jennings

No.	Req. Date	Requestor/Organization Contact/Phone#	Request/Status
618	6/14/99 6:30 to 8:30pm 6:30-Drinks 7:00 Dinner Keynote Speaking/Dinner	Sharon Cohen (HIAA) Health Insurance Assoc. of America CONTACT: Katie Kuesters 824-1845	<u>NOTE: Chris is only speaker scheduled.</u> Subject: Medicare, managed care and confidentiality. LOCATION: Old Ebbitt Grill , 675 15th Street, N.W. (Private room Downstairs)



Health Insurance Association of America

FAX TRANSMISSION

Date: June 9, 1999
6:41 PM
Pages: 3

From: Sharon Cohen

Phone: 202-824-1845
Fax: 202-824-1651

In case of problems with transmission, please contact Kate Kulesa at (202) 824-1125.

Deliver To: Teresa Jones**Company:** Office Of Chris Jennings**Phone:**
Fax: 456-5557**Message:**

Attached is the list of attendees who will be at the event on June 14th.

Please call with any questions.

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CC: Devorath 6/10