Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. letter	Brandon Hofmeister to Chris Jennings re: personal (2 pages)	n.d.	Personal Misfile
001b. envelope	re: personal (1 page)	n.d.	Personal Misfile
001c. invitation	re: personal (1 page)	06/10/1999	Personal Misfile

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

FOLDER TITLE:
Speaking Engagements (April, May, June 1999) [4]

2011-0747-S
rc422

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]

James D. Shelton, FAHS Chairman
Thomas A. Scully, FAHS President and CEO

Cordially invite you

to attend an open house reception

for friends and colleagues of the

Federation of American Health Systems

at our new offices

R-agretz ✓

✦

Tuesday, June 22, 1999
5:30 – 7:30 p.m.

✦

Market Square
801 Pennsylvania Avenue, NW
Suite 245
Washington, DC 20004-2604

✦

RSVP Jacquie Whitley
202.624.1500

NACDS

National Association of Chain Drug Stores

June 15, 1999

Mr. Christopher Jennings
Deputy Assistant to the President
The White House
Washington, DC 20500

Regrets ✓

Dear Chris:

On Monday, June 21, NACDS is hosting a special dinner for chain community pharmacy's top pharmacists and government relations professionals. We would be honored if you join us for a brief reception and casual dinner.

Attending the dinner will be representatives from chain drug store companies such as Albertson's, Inc., CVS, Drug Emporium, Kmart, Medicine Shoppe, NeighborCare, Rite Aid, Safeway, SUPERVALU Pharmacies, Walgreen, American Drug Stores, Discount Drug Mart, Eckerd Corporation, Kerr Drug, Inc., Longs Drug Stores, Meijer, Phar-Mor, Snyder's Drug Stores, Stop and Shop and Wal-Mart.

We hope the dinner will enable you to get to know representatives of these chain drug store companies that provide pharmacy services to citizens throughout the country.

The dinner will be at the Capitol Hill Hyatt Regency (Congressional Room A&B), at 6:30 p.m.

Please call me at (703) 549-3001 to let me know if you can join us or if you have any questions about the event.

Sincerely,

David F. Lambert, III
Vice President, Government Affairs

413 North Lee Street, P.O. Box 1417-D49, Alexandria, Virginia 22313-1480 Phone: 703-549-3001 Fax: 703-836-4869 Web: www.nacds.org

ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

June 8, 1999

Regrets - but please send my sincere thanks & best wishes for a great evening

Chris Jennings
Domestic Policy Council
OEOB Room 213
17th & G Streets NW
Washington, DC 20501

Dear Chris,

On Tuesday, June 22, the Elizabeth Glaser Pediatric AIDS Foundation will commemorate its 10th anniversary with a gala, "A Night to Unite". This summer dinner, co-hosted by Senators Orrin G. Hatch and Barbara Boxer, will be held at the National Building Museum. We are thrilled that this event has already raised over $1.7 million thanks to the generous support of the Washington, D.C. community.

In the ten years the Elizabeth Glaser Pediatric AIDS Foundation has been in existence, we have been successful in nurturing the best of both collaborative and individual research in the pediatric HIV/AIDS arena. The collaborative model the Foundation has created and used over the years has allowed for a high degree of flexibility in the research process and led to faster outcomes. However, the Foundation's work on behalf of children goes far beyond funding and conducting research. We have made it a high priority to serve as advocates to ensure that children share in the benefits of medical breakthroughs.

"A Night to Unite" is sure to be a memorable evening. A separate invitation has been sent to you by mail, however, we would like to extend a special invitation for you to join us as our guest. The event begins at 6:30 p.m. with a reception, followed by dinner at 7:30 p.m.

Please RSVP to Prema Kerollis at 202-371-0099 no later than Wednesday, June 16. I look forward to seeing you at this wonderful event.

Sincerely,

Kate

Hope you can join us!

Kate Carr
Chief Executive Officer

C-LAUREN HUFF 202-371-0099

2950 31st Street, Suite 125, Santa Monica, California 90405 Tel: (310) 314-1459 Fax: (310) 314-1469 www.pedAIDS.org

ALLIANCE FOR HEALTH REFORM

Regrets ✓

THE COMMONWEALTH FUND

FOR IMMEDIATE RELEASE

CONTACT: Bill Erwin or Rakesh Singh
202/466-5626

FINANCING LONG-TERM CARE: NOT A PHANTOM MENACE

A Briefing on Trends and Policy Options for Now and Tomorrow

Long-term care needs cast a long shadow in America, and the shadow will soon get a lot longer. Of the 13 million Americans needing help with basic tasks of daily living — in need of long-term care — few have insurance to pay for the services they require. Not surprising, since neither Medicare nor private health insurance covers most of the services. And once Baby Boomer demand for long-term care kicks in a generation from now, the late 1990s will look like the Good Old Days.

Medicaid, the federal-state program for the poor, will pay for some long-term care — it pays almost half of all nursing-home bills — but only after an individual becomes impoverished. And even Medicaid doesn't usually help if an elderly or disabled person wants to remain independent by getting home care or moving to an assisted-living facility. Private long-term care insurance is expensive at the age when people are likely to perceive they need it. Employers who offer long-term care insurance for their workers typically do not pay for it, so few enroll.

Proposals have been put forward by the Administration and Congress to help individuals buy long-term care services for current needs, or to help them pay for insurance against future long-term care needs.

How (if at all) should Congress help the growing number of today's frail elders and others with disabilities needing long-term care? Can more people be encouraged to buy private insurance – and should they be? What are the long-term needs for long-term care, and what are the options for addressing them?

To help opinion leaders answer such questions, the Alliance for Health Reform is hosting a June 25 luncheon briefing, with cosponsorship from The Commonwealth Fund. Speakers include **Joshua Wiener**, Urban Institute expert on long-term care; **Jeanne Lambrew**, White House senior health policy analyst; **Charles "Chip" Kahn,** president of the Health Insurance Association of America; and **Martha Phillips** of the Concord Coalition, former Republican staff director for the House Budget Committee. **Sen. Jay Rockefeller**, the Alliance chairman, will moderate.

WHEN: **Friday, June 25, 12:15-2 p.m.** (Lunch available at noon)

WHERE: **Room 216, Hart Senate Office Building**

RSVP: *By 5 p.m. on Wednesday, June 23.* Fax the attached registration form to 202/466-6525, phone 202/466-5626 or register on-line at **www.allhealth.org.** *Seating is limited.*

Registration Form

FINANCING LONG-TERM CARE: NOT A PHANTOM MENACE

A Briefing on Trends and Policy Options for Now and Tomorrow

Friday, June 25, 1999
12:15 p.m. - 2 p.m.
Room 216, Hart Senate Office Building
Washington, D.C.

Name_____

Title_____

Affiliation_____

Address_____

City/State/Zip_____

Telephone ( )_____ Fax ( )_____

E-mail address_____

FAX to Alliance for Health Reform at (202) 466-6525 by 5 p.m., Wednesday, June 23. If you have any questions, please call (202) 466-5626.

ASK YOUR QUESTION IN ADVANCE

If you have a specific question, and want to allow our panelists the chance to provide a considered response, just write your question in the space below. Be sure to note if you want particular panelists to answer. We will address as many of these questions as time permits.

_____

_____

_____

_____

ALLIANCE FOR HEALTH REFORM

SURVEY
Alliance for Health Reform
Capitol Hill Briefings

*****Attention–2nd Request for Survey Input*****

If you have already filled out this survey and returned it to the Alliance, please ignore the following. We thank you for your cooperation.

Please help us better meet your needs in our future briefings by filling out and faxing this survey to: 202/466-6525; or mailing to: Alliance for Health Reform, 1900 L St., NW, Suite 512, Washington, DC 20036. Thank you very much.

1. **Do you wish to be taken off our mailing list?**
   _____ Yes _____ No

2. **Should someone else in your organization be added to our mailing and e-mail list?**
   _____ Yes _____ No If "Yes," please list his/her name, address, fax & e-mail.
   _____
   _____

3. **Approximately how many Alliance briefings did you attend in the past 12 months?**
   _____ None (If "None," please answer question 3a, then skip to question 6.)

   _____ 1 to 5 _____ 5 to 10 _____ more than 10

   3a. Why did you not attend any Alliance briefings?
   _____ *My job no longer involves health policy issues.*
   _____ *My job involves health policy issues not covered by your briefings.*
   _____ *I always have a conflict with the timing of your briefings.*
   _____ *Other (please note)*
   _____
   _____

4. **Do you find the level of discussion in the panel presentations to be:**
   _____ Too simple _____ About right _____ Too complicated

5. **Overall, what do you consider the strengths/weaknesses of Alliance briefings?**
   _____
   _____
   _____

6. **At what time of day do you prefer to attend a two-hour briefing?**
   _____ Noon - 2 (lunch) _____ Other (please list) _____

7. **What days of the week are best for you to attend an Alliance briefing?**
(Please check "Any day" or rank in order of your preference with 1 = first choice, 2 = second choice, etc. Write "No" beside any days when you can never attend.)
_____ Any day _____ Mon. _____ Tues. _____ Wed. _____ Thurs. _____ Fri.

8. **If the Alliance held occasional half-day, more in-depth briefings, would you be likely to attend?**
_____ Probably yes _____ Yes, depending on the topic _____ Probably not

9. **On what topics should the Alliance hold briefings?**
(Please note your degree of interest, with 5 = most interesting, 1 = not of interest.)

_____ The uninsured/under insured
_____ Medicare
_____ Medicaid
_____ Quality
_____ ERISA
_____ Purchasing alliances
_____ Health care costs and cost-containment strategies (public or private sector)
_____ Delivery system change
_____ Insurance reform
_____ Medical malpractice reform
_____ Physician and health professions education
_____ Medical privacy
_____ Long-term care
_____ Prescription drugs
_____ Employers' role
_____ State developments
_____ Children's coverage
_____ Safety net providers
_____ Corporate mergers and acquisitions
_____ Other countries' health systems
_____ Other _____

10. **Have you ever visited the Alliance website, www.allhealth.org?** _____ Yes _____ No
If "yes," what improvements would you like to suggest? _____

11. **What suggestions do you have to make Alliance activity more helpful to you?**

12. **Do you work for:**
_____ Congress or Congressional agency _____ Executive branch agency
_____ News organization _____ Other national organization or agency
_____ Other (please note)_____

Optional: Name _____

Address_____

Phone _____ Fax _____

E-mail _____

FAX COVER SHEET

TO :	SPEICAL ASSISTANT TO THE PRESIDENT FOR
ATTN. :	CHRISTOPHER JENNING
FAX # :	202-456-7431
FROM :	ALLIANCE FOR HEALTH REFORM
FAX # :	202-466-6525
VOICE :	202-466-5626
DATE :	Thursday, June 17, 1999 02:51 pm
PAGES :	5 (including cover sheet) ATTEMPTS : 1

GREENBERG
ATTORNEYS AT LAW
TRAURIG

is pleased to announce that

Russell J. Mueller*

has joined the Firm as
Director of Health and Retirement Policy

Russ worked for 25 years as Actuary and Professional Staff Member for the United States House of Representatives prior to joining the Firm. Russ acted as a spokesman on legislative and technical matters for the House Committee on Education and the Workforce and initiated and monitored legislation and regulations relating to health insurance, pension and social insurance issues. He has also represented members of Congress and served as a liaison to the Executive Branch, Governors, Mayors, State Legislators, and numerous industry, labor, academic and citizen groups.

*Not admitted to the practice of law

Russ can be reached at:
1300 Connecticut Avenue, N.W.
Washington, D.C. 20036
Telephone: (202) 331-3138 · Facsimile: (202) 331-3101
muellerr@gtlaw.com

ShawPittman

A Law Partnership Including Professional Corporations

is pleased to announce

the expansion of its
health law practice
with the addition of

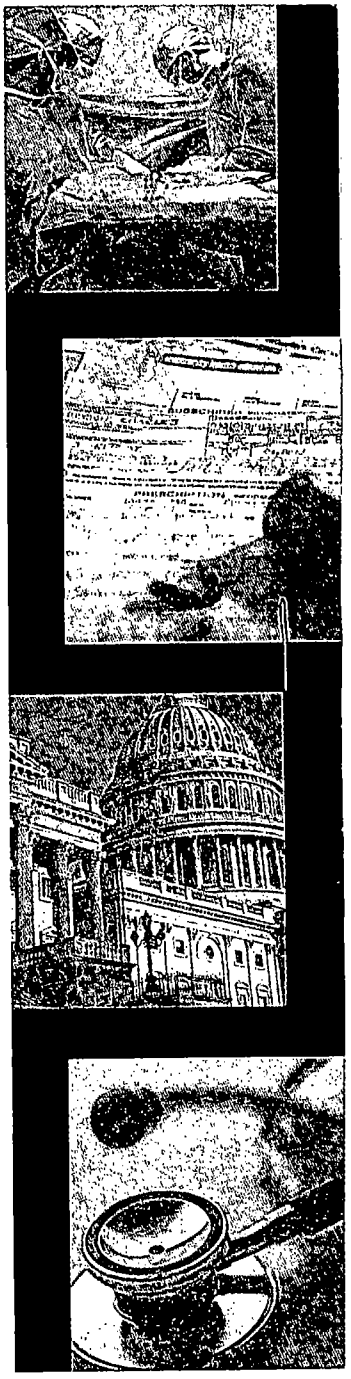
H. Guy Collier

as a partner.

Formerly Partner-in-Charge of the Washington Health Law Department of McDermott, Will & Emery, Mr. Collier will continue to represent health care providers and related entities on a wide range of corporate and regulatory issues, including complex fraud and abuse investigations, compliance plan development and implementation, and the structuring of provider affiliations.

H. Guy Collier
202.663.8138
guy.collier@shawpittman.com

2300 N Street, NW
Washington, DC 20037-1128
202.663.8000
FAX 202.663.8007



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FAX 212.603.6801

1676 International Drive
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703.790.7900
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45 King William Street
London EC4R 9AN
44.171.337.9400
FAX 44.171.337.9401

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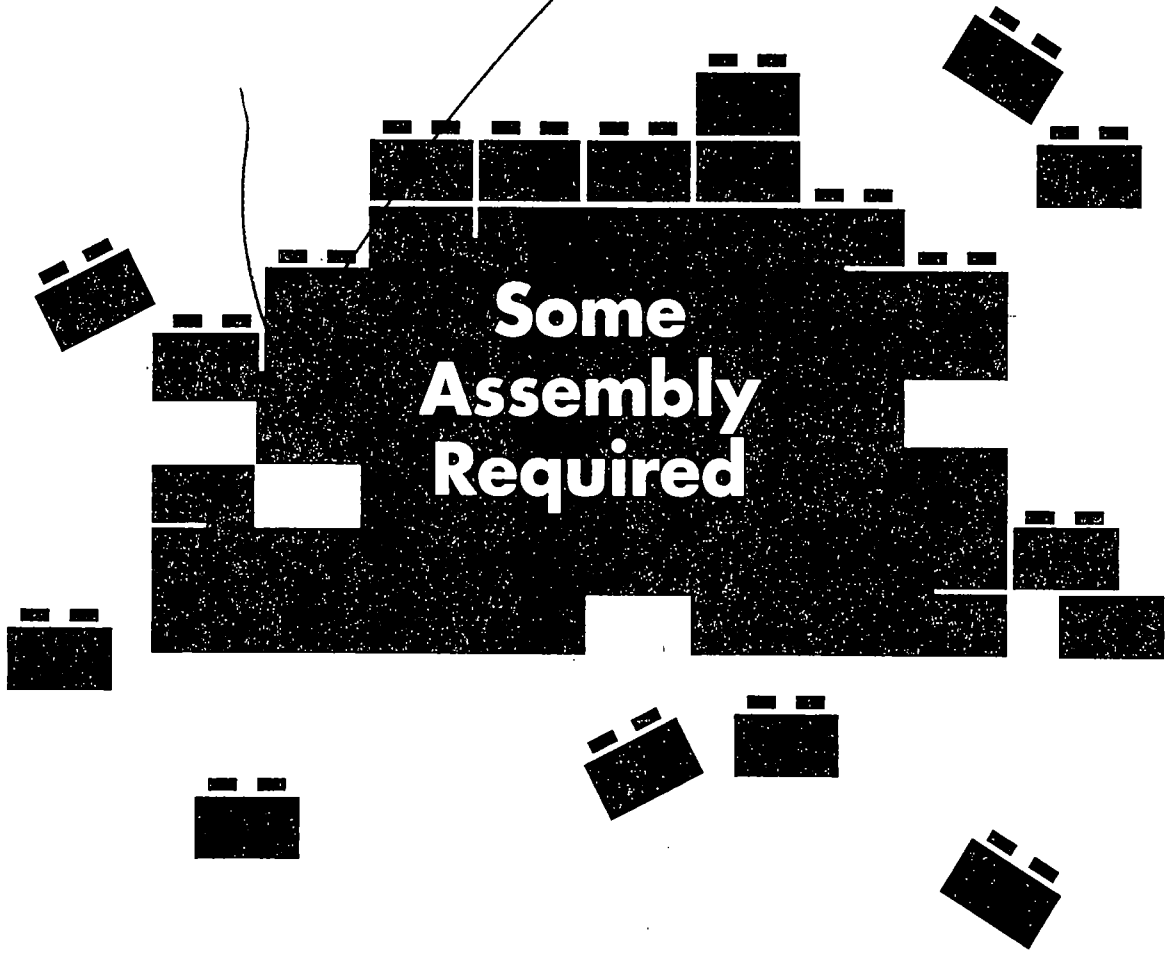
NATIONAL ACADEMY

for STATE HEALTH POLICY

Nope

COHERENT STATE HEALTH POLICY:



12th Annual State Health Policy Conference
August 1-3, 1999
Omni Netherland Plaza, Cincinnati, Ohio

NATIONAL ACADEMY
for STATE HEALTH POLICY

COHERENT STATE HEALTH POLICY: *Some Assembly Required*

This year's conference theme, *"Coherent State Health Policy: Some Assembly Required,"* focuses attention on the challenges states face in implementing a wide array of health policy from CHIP to long-term care, from patient protection to insurance reform. Incremental reforms keep state policymakers busy – we'll provide technical sessions to share what works as well as policy discussions on how to make all the pieces fit into coherent state health policy!

WHO SHOULD ATTEND

- State health policymakers from Governors' offices, human services, public health, Medicaid, insurance, aging, budget and other state agencies
- Legislators and legislative staff
- Others involved in state health policy and delivery

WHY IT IS IMPORTANT TO ATTEND

- This is YOUR conference; planned by states, for states– offering health policy information crucial to YOUR state
- UNIQUE opportunity for state policymakers to discuss common issues with others from across the U. S.
- FOCUSED presentations designed specifically for this conference
- MAJOR gathering of state health policy leaders, cutting across agency lines, turf and disciplines
- Plenty of time for INTERACTION
- SOMETHING FOR EVERYONE a mix of practical workshops and conceptual discussions

CONFERENCE HIGHLIGHTS

- **Monday Plenary: *Will We ALL Be Uninsured? The Future of Private Coverage, Medicare and Medicaid***
  Chip Kahn, *President, Health Insurance Association of America,* Judy Feder, *Georgetown University,* Marilyn Moon, *The Urban Institute,* Jim Tallon, *Chair, Kaiser Commission on Medicaid and the Uninsured,* and Sue Crystal, *Washington State Governor's Office* will examine why, in a booming economy, with low unemployment and expanded state opportunities for health care coverage, the number of uninsured is growing. What's our vision for health coverage for the future?
- **Lessons Learned from CHIP**
  (Tuesday, August 3, 9-10:30 a.m.)
  A summary report from the *states-only* pre-conference – *CHIP's Hot Potatoes* – with the latest developments in CHIP. This session is open to all conference participants.
- **One-Day Conference Intensive: *"Medicaid Managed Care: Are We Getting What We Pay For?"***
  National experts and high level policymakers come together for an in-depth examination of the changing Medicaid managed care marketplace and states' responses to those changes.
- **Value-Added Benefit**
  We are delighted to report that *Health Affairs* has graciously offered all registrants a free six-month subscription to this esteemed journal of health policy!
- **New Topics This Year**
  Medical errors, pharmacy costs, the ADA *and more!* Learn more about a new NASHP/Commonwealth Fund initiative to provide grants to states to create Medicaid initiatives in child development services; attend Monday's Plenary and Tuesday's Bidders' Conference.

BACK BY POPULAR DEMAND

Special Interest Roundtable Discussions:
For the second year in a row, *Monday's luncheon* will feature informal discussions on topics of special interest.

And we will continue the tradition of *Tuesday morning breakfast* roundtables. These facilitated discussions offer further opportunities to address topics of special interest.

COHERENT STATE HEALTH POLICY:
Some Assembly Required

12th Annual State Health Policy Conference
August 1-3, 1999 ***Omni Netherland Plaza, Cincinnati, Ohio***

Sunday, August 1

Pre-conferences	Long Term Care Quality & Care Coordination:	CHIP's Hot	State GME Financing:
9:00 - 4:00	Tough Challenges, New Tools	Potatoes	Recent Developments & Issues
Conference	Reception and Dinner		
5:00 - 8:00	Speaker - To Be Announced		

Monday, August 2

Plenary	"Will We All Be Uninsured? The Future of Private Coverage, Medicare, and Medicaid"					
8:00 - 9:30	Insurance Reform:	Prevention:	ADA: Legal	Eligible	Managed Care:	Report Cards:
10:00 - 11:30	What Have	Where's the Cost-	Issues Facing	But Not	If Not This,	What ARE They
	We Wrought?	Cutting Edge?	States	Enrolled	Then What?	Good For?
11:30 - 1:00	Special Interest Luncheon					
Plenaries	Federalism:	What, Me Worry? What States Can		Medicaid and Early Childhood Health		
1:30 - 3:00	Shift or Shaft?	Do About Provider Quality & Medical Errors		Development Services: First Steps		
3:30 - 5:00	Preparing for the	Health Plan Liability:	Whose I.D.E.A	Think Globally, Act	Performance	
	BBA: Impact	Sense & Sensibility or	Is It anyway?	Locally: Expanding	Based	
	on LTC	Pride & Prejudice?		Access to the Uninsured	Purchasing	
5:30	Monday Dinner Optional Event: River Boat Cruise on the Ohio River					

Tuesday, August 3

7:30 - 8:45	Roundtables	Bidders' Conference: NASHP/Commonwealth Fund Initiative			
Conference	Medicaid Managed Care Intensives: *Are we Getting What We Pay For?*				
Intensive	The Changing Marketplace, How States Are Responding to the Changing Medicaid Marketplace, PCCM Programs				
8:45 - 5:15	That Work, Behavioral Health, Enrollment and Outreach, Risky Business: States Experiences Using Risk-Adjusted Rates				
9:00 - 10:30	Eliminating Health	Medical Privacy...	Lessons Learned	Future Long-Term	
	Disparities Among	What You Know	From CHIP	Care Trends	
	Minority Populations	Can Hurt You			
11:00 - 12:30	Sharing Public Power	Immigration Policy	Cutting-Edge Data Linkages	Pharmacy Costs:	
	with Private Regulators	& Access to Health	in Long-Term Care	A Bitter Pill	
12:30 - 2:00	Lunch and Speaker - To Be Announced				

PRE-CONFERENCES

Sunday, August 1, 1999, 9am - 4pm

Long-Term Care Quality and Care Coordination: *Tough Challenges, New Tools*

Care coordination is an essential part of managing acute and long-term care services in a managed care program. Variations in services covered by capitation and managed by the MCO require very different roles for care managers. This pre-conference presents care management models in fully integrated programs and programs requiring coordination between Medicaid, Medicare, and acute and long-term care services.

CHIP's Hot Potatoes*

This pre-conference will be a moderated discussion among state officials and invited guests on such topics as: outreach, coordination with Medicaid, data and evaluation, HCFA regulations, benefit design, cost sharing and contract management.

** Limited to State Executive Branch officials responsible for CHIP implementation.*

State Graduate Medical Education Financing: *Recent Developments & Issues*

Designed for state policymakers and program administrators, this pre-conference will focus on innovative design and policies for Medicaid GME. Specific presentations and discussions on: HCFA's policies that affect Medicaid financing GME; training in ambulatory settings; and academic health centers and their roles and fiscal problems. Presentations will also include review of recent national surveys of state GME financing and recent national policy developments.

CONFERENCE INTENSIVE

Tuesday, August 3, 1999, 8:45am - 5:15pm

Continental breakfast and lunch provided

Medicaid Managed Care: *Are We Getting What We Pay For?*

This full day program will explore the market forces that are prompting extensive change in the Medicaid managed care marketplace and state responses to those changes. Plans are merging, some are withdrawing, and the BBA has created new administrative requirements. Join national experts and high level policy-makers for an in-depth examination of how states are coping with those changes through financial incentives for plan performance, risk-adjusted rates, enrollment brokers, and PCCM programs that emphasize quality improvement.

GENERAL INFORMATION

Transportation

Delta Air Lines, the preferred airline for NASHP's 12th Annual State Health Policy Conference is pleased to offer special rates. To take advantage of these discounted fares, call Delta **Meeting Networks** Reservations at 1-800-241-6760, weekdays 7:30 a.m. to 11:00 p.m. or weekends 8:30 a.m. to 11:00 p.m. eastern time. Or, have your travel agent call Delta's toll-free number to obtain these same advantages for you. **Refer to File Number 131034A.**

NASHP has arranged a special ground transportation rate from the Cincinnati/Northern Kentucky International Airport to the Omni Netherland Plaza, or other downtown hotels including the Westin Hotel, Crowne Plaza, Cincinnatian, Regal Hotel and the Hyatt Regency Hotel. *Jet'Port Express* will extend to our attendees the special convention rate of $14 for a round trip ticket. A discount coupon will be provided in your confirmation, or you can simply mention the NASHP 12th Annual State Health Policy Conference when purchasing your ticket from the Jet'Port Express ticket agent at the counter in the baggage claim area.

Conference Hotel and Lodging

Located just twenty-five minutes from the Cincinnati/Northern Kentucky International Airport via the Jet'Port Express shuttle, the Omni Netherland Plaza, 35 West Fifth Street in Cincinnati is the host hotel for this year's conference.

For reservations, please call the Omni Netherland Plaza directly at (513) 421-9100. When calling for your reservation, be sure to mention your attendance at the National Academy for State Health Policy's 12th Annual Conference to receive the special discount rates of $85 per single room and $115 per double room. After **July 8, 1999**, rooms and special rates are subject to availability.

Hotel check-in begins at 3:00 p.m. and check-out is by noon; luggage storage is available.

Covered valet parking is available to hotel guests at prevailing daily rates. There is ample municipal parking within walking distance of the Omni Netherland Plaza.

NATIONAL ACADEMY
for STATE HEALTH POLICY

NASHP Announces Two Major New Publications

Medicaid Managed Care: A Guide for States, 4th edition

This 4-volume set provides a detailed analysis of state Medicaid programs and is based on comprehensive surveys of every state and the District of Columbia. The set includes:

Volume 1: Medicaid Managed Care Program Scope and Operations (4/99).
Volume 2: The Directory of Risk Based Medicaid Managed Care Programs Serving the Elderly and People with Disabilities: 1998 (7/99).
Volume 3: Trends in State Managed Care Programs Serving the Elderly and People with Disabilities: 1990-1998 (7/99).
Volume 4: Case Studies: Innovations in Payment Strategies to Improve Plan Performance (9/99).

Price of the four-volume set: $125 for government/non-profit, $175 for all others.

Volume One will be sent upon receipt of your order. Volumes 2-4 will be sent as they are published. Anticipated publication dates are listed above.

Charting CHIP: Report of the First National Survey of the Children's Health Insurance Program

Based on the 1998 survey results of Medicaid CHIP expansion programs and state-designed CHIP programs, *Charting CHIP* provides a comprehensive analysis of CHIP program policies in the 46 states with plans submitted to HCFA as of July 1998. The report includes state-by-state summary tables on such key issues as CHIP program eligibility, cost sharing, crowd-out, benefits, and delivery systems.

Price: $70 for government/non-profit, $125 for all others.

To order, visit the NASHP website at www.nashp.org or call NASHP at 207-874-6524.

Additional Lodging

Conveniently connected to the Omni Netherland via covered catwalk, the **Crowne Plaza** is offereing special discount rates of $95 single and $105 double. The cut-off date to receive these special rates is **July 1, 1999**; after that, rooms and special rates are subject to availability. To make reservations call the Crowne's toll free number: 1-888-279-8260.

The **Hyatt** is also just a few minutes away from the Omni Netherland via covered catwalk. A special convention rate is available until **July 1, 1999**: $125 single and $135 double. After July 1, these rooms and special rates are also subject to availability. For reservations call (513) 579-1234.

There are many more hotels located within a few minutes walk of the Omni Netherland Plaza, additional hotel information will be sent in your confirmation package.

Dinner and Riverboat Cruise

What would the 12th Annual State Health Policy Conference be without "networking on the water?" Join us on the *Queen City Clipper* for an evening dinner cruise on the Ohio River. Take advantage of the food and fun aboard this beautiful river boat. A fee of $36 includes transportation to and from the Omni Netherland Plaza, the cruise and buffet dinner. A cash bar will be available.

"Two or More" Discount for State Agencies

Attention state government staff! Enroll two or more attendees and save $25 on your registration fee. You and your associates (from your state agency) each get a $25 discount off the normal registration fee. To qualify for the discount, you must mail or fax your registration forms **together**. Substitutions will be allowed; however, there must be a minimum of two registrants from your state agency for the discount to apply.

Conference Audio Taping

Most conference sessions will be audio taped for purchase before, during or after the conference. Tuesday's Conference Intensive will also be available on tape. (Sorry–the Pre-Conferences, special interest luncheon discussions and roundtables will not be taped). The complete two-day package (contents are subject to change) may be ordered with your conference registration, during the conference or by mail after the conference. They will be shipped directly to you immediately after the conference. The special price of $125 includes a free storage case and shipping. Individual session tapes may be purchased; order forms will be available during the conference.

The sessions to be taped are subject to change.

REGISTRATION INFORMATION

How To Register

- Complete the Registration Form on the back page
- One form per registrant – photocopies OK
- Government purchase orders accepted
- Registration fees are non-refundable after July 28, 1999
- Substitutions are acceptable
- Call NASHP at 207-874-6524 for more information
- Payment in full in advance will help shorten the conference check-in process

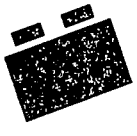
Registration Fees and Logistics

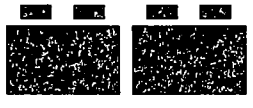
Register before July 9 for the best prices! Fees for the conference include admission to *conference* sessions, **Sunday** evening reception and dinner and continental breakfast, lunch and breaks on **Monday** and **Tuesday**. Conference materials – including a program guide, applicable notebooks and other resources – are also included in the fee. **The conference officially begins with the Opening Reception and Dinner on Sunday, August 1, at 5:00pm.**

The Conference Registration Desk will be open on Saturday afternoon from 3:00 p.m. to 5:00 p.m. for your convenience.

The three Pre-Conferences on Sunday, August 1, from 9:00 a.m. to 4:00 p.m. include continental breakfast and lunch, and resource materials. The Conference Intensive, *"Medicaid Managed Care: Are We Getting What We Pay For?"* on Tuesday, August 3, from 8:45 a.m. to 5:15 p.m., includes continental breakfast, lunch and breaks, and resource materials.

In an effort to speed-up the check-in process, please pay registration fees in full, in advance of the conference.





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and more great speakers to come!

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Register by fax: 207-874-6527 or by mail: NASHP, 50 Monument Square, Suite 502, Portland, Maine 04101

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Name _____ Title _____

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Address _____ City _____ State _____ Zip Code _____

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Please check one: ❑ Federal ❑ State ❑ Private ❑ Academic/Consultant ❑ Other

SECTION TWO: Registration

Please review carefully, *circle the package you want and check selections as needed*

Packages	**Government Employees**		**Private Sector**	
A. Pre-conference ONLY, Check ONE:	Before 7/9	After 7/9	Before 7/9	After 7/9
❑ CHIP* ❑ LTC ❑ GME	$150	$250	$400	$600
B. Conference Intensive ONLY	$75	$175	$200	$400
"Medicaid Managed Care: Are We Getting What We Pay For?"				
C. Conference ONLY	$325	$425	$800	$1,000
D. Conference and Pre-conference	$425	$525	$1,000	$1,200
Check ONE Pre-conference:				
❑ CHIP* ❑ LTC ❑ GME				
❑ I would like to attend the dinner cruise	$36	$36	$36	$36
❑ **Discount** for two or more attendees (state government agency staff, only)	**- $25**	**- $25**	(refer to pg. 5 for eligibility & conditions)	
TOTAL DUE	$_____	**$** _____	**$** _____	**$** _____

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❑ Check or money order enclosed (make check payable to Center for Health Policy Development, EIN # 52-1576801

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❑ Visa/MasterCard/American Express _____ Exp. Date _____ Corp Code _____

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Special Diet? Please specify _____. Please contact us in advance at 207-874-6524 with any special needs. The NASHP shall comply with Section 504, Title IX and the ADA, and, upon request, will provide reasonable accommodations to qualified individuals with disabilities.

SECTION FOUR: Extras

An added benefit of attendance...

❑ Please check here if you would like to receive the six-month complimentary subscription to *Health Affairs* - the bimonthly journal of health policy!

❑ Please reserve a complete set of Conference audiotapes for me right now. You may include the $125 payment in the total above or pay at the conference.

❑ I am interested in receiving sponsor/exhibitor information

***Limited to Executive Branch officials responsible for CHIP implementation**

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ASSISTANT TO THE PRESIDENT
FOR STATE HEALTH POLICY DEVELOPMENT
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10 Fun Things to Do & See in Cincinnati!

- Visit the Cincinnati Zoo & Botanical Garden (513-281-4700). Cincinnati's zoo boasts the most gorilla births of any zoo and is home to such colorful (and large) creatures as the BlackRhino, White Bengal Tiger, and Red Panda.
- Catch the Cincinnati Reds (513-421-4510)
  ...against the Giants on Sunday, August 1, at 1:15 p.m.
  ...against the Rockies on Tuesday, August 3, at 7:05 p.m.
- Experience the Sunday Brunch voted best in Cincinnati at the Omni Netherland (conference central): 513-564-6465.
- For those of you who can't get enough of WKRP on Nick-at Nite, take a walk to Fountain Square and pay homage to the show as you stand at the foot of the Tyler Davidson Fountain.
- Cruise the Ohio River aboard the Queen City Clipper on Monday night.
- Have a pulled pork sandwich and celebrate Cincinnati's historic pork industry.
- Pay a visit to the Cincinnati Art Museum and its world-renowned collection of art from ancient to modern times (including Cincinnati's famous Rookwood Pottery): 513-721-5204.
- Have a hypersensory experience at the OMNIMAX theater, located at the Cincinnati Museum Center (513-287-7000).
- For those of you interested in heading off the beaten track, explore some of the most intriguing museums in the country: The American Museum of Brewing History and Arts (in Fort Mitchell), The Trapshooting Hall of Fame and Museum (in Vandalia), and the United States Playing Card Museum (in Norwood).
- Join colleagues from across the country and make the most of NASHP's 12th annual (and best-ever) State Health Policy Conference!

Monday, June 28, 1999
11:30am

To: Chris Jennings
Dan Mendelson

From: Chuck Konigsberg

Re: Medicare Briefing

I would appreciative if one or both of you would brief the health LAs of our Finance Committee Democrats on the President's Medicare proposal. Late Tuesday or Wednesday before 5pm would be good for us. Please let me know asap at 224-0701. Thanks.

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510–6200

FAX COVER SHEET

# of pages (excluding cover sheet): 1 **Date:** 6/28/99

✓ **URGENT** **Time:** 11:45 am

From: **Chuck Konigsberg**
Chief Health Counsel & General Counsel
Democratic Staff
U.S. Senate Committee on Finance
203 Hart Senate Office Bldg.
Washington, DC 20510
phone: 202-224-5315
fax: 202-228-3904
e- mail: Chuck_Konigsberg@finance-min.senate.gov

To: Chris Jennings

Dan Mendelson

Comments:

Please join the members of

National Transplant Action Committee
Minority Organ and Tissue Transplant Education Program
Transplant Recipients International Organization

in honoring

Representative Pete Stark
Sponsor of the Gift of Life Congressional Medal Act

Wednesday, June 23, 1999

Reception 6:00 pm
Dinner 7:30 pm
J. W. Marriott
1331 Pennsylvania Avenue, NW
Washington, D.C.

RSVP by June 17, 1999
1-888-700-8812

National Transplant Action Committee
1750 SW Skyline Blvd., Suite 12
Portland, OR 97221

Reply Card

Yes, I will be able to attend the event honoring Representative Pete Stark. Enclosed is my contribution of $_____.

$3,000 VIP reception and dinner
Table of 10 x _____ tables = $_____
_____ Individual tickets $300 per person = $_____
$1,500 Cash bar and dinner
Table of 10 x _____ tables = $_____
_____ Individual tickets $150 per person = $_____

Members of NTAC, TRIO and MOTTEP

$1,500 VIP reception and dinner
Table of 10 x _____ tables = $_____
_____ Individual tickets $150 per person = $_____
$ 750 Cash bar and dinner
Table of 10 x _____ tables = $_____
_____ Individual tickets $150 per person = $_____

No, I cannot attend, but I would like to make a contribution of $_____.

Name _____
(As you would like it to appear on your name tag)

_____
(Affiliation, if any)

Address _____

_____
This is a ___ home or ___ business address.

Phone: _____
This is a ___ home or ___ business address.

To RSVP, or for more information,
please call David Rohrer at 1-888-700-8812.

National Partnership
for Women & Families

FAX TRANSMISSION

MS/ Tell them I'd love to come but schedule conflicts & work-load preclude me from attending. Thanks
CJ

TO: Chris Jennings

COMPANY:

FAX #: 456-5557

FROM: Joanne Hustead

DATE: 6/4/99 **PROGRAM CHARGED:**

SUBJECT: **NO. OF PAGES:** 3 **INCLUDING COVER**

COMMENTS: Please be our guest at our annual luncheon next Thursday, June 10th.

Please call 986-2600 to RSVP + ask to speak with me or Ileana Fuller.

IF YOU HAVE PROBLEMS RECEIVING THIS FAX, PLEASE CALL 202-986-2600

...nnecticut Avenue, NW / Suite 710 / Washington, DC 20009 / 202.986.2600 / Fax: 202.986.2539 / Web Site: http //www.nationalpartnership.org

The National Partnership for Women & Families

Making History

Annual Luncheon

Thursday, June 10, 1999

Making History

The National Partnership for Women & Families

A voice for fairness
A source for solutions
A force for change

Just a year ago, the Women's Legal Defense Fund launched a revitalized organization, the National Partnership for Women & Families. Since then, we have broken new ground on health care and work/family issues – two of the issues that matter most to Americans today. During the past year, we led an extraordinary coalition that is promoting real patient protections. And, while a few years ago we were the driving force behind enactment of the Family & Medical Leave Act, today we are creating a new national movement that will make family leave affordable for more working families.

For nearly 30 years, the National Partnership has been making life better for women and families. Making history. Making progress. Making change.

As we approach the new millennium, we celebrate women's remarkable advances in this century and our role in those victories. The National Partnership's 1999 honoree is uniquely qualified to help us do that. One of the nation's pre-eminent historians, Doris Kearns Goodwin is a commentator, an analyst, a Pulitzer Prize winning author, and a role model for women and girls throughout the world. Her insightful commentary and keen observations help put into perspective women's changing role in society, and the history that is being made every day.

National Partnership for Women & Families

Luncheon Chair
ROBERT A. ESSNER
Executive Vice President, American Home Products

Chair Emeritus John F. Smith
Chairman, CEO & President, General Motors Corporation

invite you to join us for

MAKING HISTORY

our Annual Luncheon
honoring

DORIS KEARNS GOODWIN
noted historian, author and commentator

Thursday, June 10, 1999, 11:30 am
The Washington Hilton Hotel
1919 Connecticut Avenue, NW
Washington, DC

♦♦♦♦

$150 per person

No. 742

ISSUE BRIEF

NATIONAL HEALTH POLICY FORUM

Canada's Generalist Training: Are There Lessons for the United States?

Friday, June 25, 1999
12:30 pm - Refreshments available
1:00 to 4:30 pm - Discussion
Holiday Inn on the Hill
415 New Jersey Avenue, N.W.
Federal Ballroom South

A discussion featuring

Norman Kahn, M.D.
Vice President for Education and Scientific Affairs
American Academy of Family Physicians

Nadia Mikhael, M.D., F.R.C.P.C., F.A.C.P.
Director of Education
Royal College of Physicians and Surgeons of Canada

Mamoru Watanabe, M.D.
Emeritus Professor of Medicine
University of Calgary
Canada

Stephen Gray, M.D.
Medical Policy Consultant
Legislation and Professional Regulation
Ministry of Health
Canada

Registration: Please call **Dagny Wolf at 202/872-1392** as soon as possible.

The George Washington University
WASHINGTON DC

Canada's Generalist Training

A stubborn specialist-to-generalist imbalance in the U.S. health workforce continues to concern policymakers looking at its import for a reconfiguring health marketplace. With the imbalance persisting as health care moves from fee-for-service to managed care, largely in ambulatory settings, policymakers are considering various ways of addressing it. Whether they tinker with current Medicare graduate medical education (GME) policy or take an entirely new approach, such as having an "incentivized" all-payer fund, they are struggling with designing, enacting, and implementing change in a fairly entrenched system.

Seven years ago, the Council on Graduate Medical Education set a national goal for at least half of all medical school graduates to begin careers in primary care fields: family medicine, general internal medicine, and general pediatrics. At the time, only 27 percent did. Since then, the proportion of generalists has gradually inched up, so that 37 percent of medical school graduates entered a generalist career in 1997. Even in the midst of an overall physician surplus, however, the primary care fields remain far from saturated.

The United States government and medical experts have expressed concern about physicians' apparent preference for careers in the congested specialty fields. Between 1965 and 1992, the proportion of physicians in general practice declined from 51 percent to 35 percent. Despite repeated expressions of concern by government agencies and health care experts, this imbalance in physician preference persists.

The Medicare Payment Advisory Commission (MedPAC) is seeking methods to rectify this disparity. MedPAC is currently addressing what Medicare's policy should be regarding medical education payments as it prepares GME funding policy recommendations for its report to the Congress in August 1999. The report will outline how and whether medical payments to hospitals for Medicare GME, as well as other federal policies on GME, should be changed.

Policymakers in the United States, striving to alter federal incentives to shift U.S. GME from a specialty-oriented to a generalist model, have only to look across their northern border to see a system that produces the balance of physicians the United States is seeking. Medical educators in both countries generally acknowledge that, although the two systems are differently organized and financed (Table 1), the quality of Canadian GME is comparable to that of the United States. The relative output of nonspecialist physicians, however, is much higher. While Canada has a physician-to-patient ratio similar to that of the United States, its proportion of generalists to specialist physicians is 50-50. As a result, the U.S. primary care physician workforce pales in comparison to Canada's generalist population.

Addressing the premise that the U.S. medical education system is inappropriately skewed toward specialty medicine, this Forum session is intended to compare and contrast the U.S. and Canadian GME systems, including how each system is organized and financed. While the United States is unlikely to adopt the Canadian GME System (just as this country has not embraced the Canadian health delivery and payment approach), the model provides various lessons. One is full integration of primary care and GME. Another is the use of incentives to achieve desired policy goals.

BACKGROUND

The United States and Canada both are concerned with disparities in access to health care services for some segments of their populations. However, in Canada this is largely a problem of attracting physicians

ISSUE BRIEF/No. 742

Analyst/Writer:
Lee A. Hawkins, W. K. Kellogg Foundation–Robert Wood Johnson Foundation Fellow

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Michele Black, Publications Director

NHPF is a nonpartisan education and information exchange for federal health policymakers.

Table 1
Organization and Financing of GME in Canada and the United States

	Canada	United States
Decision Regarding GME Specialty Mix and Program Size	Medical school deans	Hospital CEOs, program directors, department chairs
Accreditation	RCPSC and CFPC, medical school programs	ACGME (RRCs), hospital programs
Certification	RCPSC and CFPC	Specialty boards
Licensure	Provincial authorities	State medical boards
Funding Source:		
Resident Salaries	Ministries of health	Hospital patient care revenues
Faculty Salaries	Ministries of education, practice plan	University funds, hospital funds, practice plan
Hospital Overhead	Ministries of health, global hospital budgets	Hospital patient care revenues, Medicare IME

Source: Michael Whitcomb, "Organization and Financing of Graduate Medical Education in Canada," Journal of the American Medical Association, *268, no. 9 (September 12, 1992): 1107.*

Note: Only the predominant ways of organizing and financing GME are compared. CEO indicates chief executive officer; RCPSC, Royal College of Physicians and Surgeons of Canada; CFPC, College of Family Physicians of Canada; ACGME, Accreditation Council for Graduate Medical Education; RRC, Residency Review Committee; and IME, indirect medical education adjustment.

to locate in geographically remote, rural, or climatically inhospitable areas. It is not a problem of availability of generalist physicians. In the United States, in addition to issues relating to geographical maldistribution of physicians, the undersupply of primary care physicians comes into play.

From a historical perspective, there are some similarities between the medical education system in Canada and the United States. For example, in undergraduate training, Canada's 16 medical schools and the United States' 125 medical schools are accredited by both the Liaison Committee on Medical Education (LCME) and the Canadian Accreditation Committee, which sits jointly with the LCME. In addition, by the time most Canadians finish medical school, they will have sat through at least part one of the U.S. national boards and perhaps through parts two and three as well. As a result, it appears that the end product at graduation is almost indistinguishable, from one country to another, as far as knowledge and skills are concerned.

However, obvious differences appear in postgraduate training, both in structure and funding. The Canadian system has a primary care orientation from beginning to end; the American system does not. Furthermore, the accepted structure of seeking care in Canada is for the patient to go to a primary care physician first, while, in America, many patients think first of self-referral to a non-primary care specialist. This formalized, first-line care and referral role gives primary care physicians in Canada a balance of power in the physician community.

In addition, the Canadian reimbursement system strongly reinforces the generalist system by paying only a nonspecialist fee to a specialist for providing a primary care service. This primary care orientation is reinforced by the primary care emphasis of Canadian medical education. And finally, unlike the case in the United States, all the provinces in Canada are able, through direct budgeting of GME, to influence the specialty mix in GME training programs.

REGULATORY CAPACITY AND CONSOLIDATION

The number of players in every aspect of medical education and workforce planning is far smaller, both absolutely and relatively, in Canada than in the United States (Table 2). The main difference, however, is that the structure of medical education in Canada seems to reinforce the primary care paradigm. This is particularly evidenced by the presence of a prominent department of family medicine in every Canadian medical school, the resulting strong appeal of this specialty to Canadian medical students, more equitable incomes of family physicians compared to specialists, and a higher regard for the profession of generalist medicine. Furthermore, through their direct budgetary influence over the specialty mix in GME training programs, the Canadian provinces appear to have fostered a greater emphasis on education that, unlike the situation in the United States, gives Canada's medical schools a greater role in GME than teaching hospitals.

Another area of significant difference is the organizational unification in Canada of training program accreditation and specialist certification into single bodies (that is, the Royal College of Physicians and Surgeons of Canada [RCPSC] for all specialties and the College of Family Physicians of Canada [CFPC] for family physicians). In this regard, the United States could hardly provide a greater contrast. In the United States, the 24 specialty boards that set specialty certification requirements, which the training programs are obliged to meet, are autonomous. In addition, the American Board of Medical Specialties (ABMS) is primarily a coordinating organization, while the accreditation function is under an entirely separate organization, the Accreditation Council on Graduate Medical Education (ACGME).

Another key difference between the two countries is the existence of a national health insurance system in Canada. Canada has a predominantly publicly financed, privately delivered health care system that is best

Table 2
Medical Education Organizational Structures in Canada and the United States

Canada	United States
16 medical schools	125 medical schools
10 provinces and 2 territories	50 states + D.C. and Puerto Rico
All post-M.D. programs under control of university	Nearly all post-M.D. programs hospital-based but not under control of university with which program is affiliated
RCPSC accredits/certifies all specialties and CFPC accredits/certifies all family medicine training/ specialists	Numerous specialty boards plus separate accrediting bodies
Family medicine the only primary care specialty; all others, including internal medicine and pediatrics, consultant specialties	Family medicine a relatively small field and not the only route to primary care
Post-M.D. training funded via university with provincial government approval	Each program funded separately
ACMC-coordinated, centralized database for all post-M.D. trainees—system can track career/specialty choice location	No one centralized database; difficult to link training to practice

described as an interlocking set of ten provincial and two territorial health insurance plans. This system, known to Canadians as "Medicare," provides access to universal, comprehensive coverage for medically necessary hospital inpatient and outpatient physician services. The single-payer attribute of Canada's public insurance has enabled the provinces and territories to control the growth of health expenditures in the public sector more successfully than in the private sector. In addition, the comprehensive funding of both ambulatory and inpatient care may contribute to the greater ease of teaching in ambulatory settings in Canada. The absence of apparent problems with ambulatory teaching in Canada is just one more contrast with the U.S. system, in terms of logistics and the financing of ambulatory medical education.

QUALITY CONTROL

It is important to distinguish between accreditation, which refers to the analysis and evaluation of programs, and certification, which applies to the documentation and appraisal of individuals. In Canada, responsibility for both the accreditation of GME programs and the certification of individuals is assumed by a single organization. The CFPC accredits family medicine programs and certifies individuals as family physicians. The RCPSC accredits specialty programs and certifies individuals as specialists. Currently, there are 55 specialty and subspecialty qualifications available in Canada, in addition to certification in family medicine by the CFPC. In addition, the RCPSC Accreditation Committee has developed a comprehensive set of regulations outlining the general policies of accreditation. The RCPSC has also relied on the various specialty committees, of which there is one for every specialty and subspecialty recognized by the college, to develop supplementary requirements for the approval of hospitals relating to programs in the individual specialties. While policy issues are considered by the specialty committee as a whole, the "core committee" acts as the consulting body to the accreditation committee in matters concerning the accreditation of programs in the specialty.

In the United States, the ACGME has the responsibility for accrediting programs in all specialties, while the task of certifying individuals is the responsibility of the 24 specialty boards which comprise the ABMS. In the United States, the ABMS is presently the umbrella organization for its 24-member boards offering more than 100 specialty and sub-specialty qualifications. The ACGME has developed a coherent program of policies and standards for GME and oversees the accreditation of residency programs in 26 recognized specialties and 74 related subspecialties. Authority to review and accredit residency programs is delegated by the ACGME to the Residency Review Committees (RRC), of which each recognized specialty has its own. The essential components for programs in each specialty are outlined by the RRCs in the United States and by the Specialty Committees in Canada that cover all aspects of a residency program. The systems for accrediting postgraduate medical education programs in the United States and Canada, while similar in purpose, differ in both philosophy and practice. While these differences do exist, it is clear that the educational principles underlying the two systems continue to be held in common.[1]

Given the much larger size of the accreditation system in the United States, the cost of the U.S. system is predictably much greater. In comparing the two systems, on a cost-per-program basis, the ACGME's 1998 budget was $12 million and the two Canadian colleges' 1998 budget was $600,000. The financing of the two systems is quite different, however. The ACGME finances its operations primarily through two sources: a yearly capitation assessment on each accredited program, based on the number of residents enrolled, and a fee for survey visits, which is paid by the program or by its sponsoring institution. The five sponsoring organizations also pay an annual contribution. In Canada, the cost of accreditation is born by the two colleges and is paid out of general revenues, which are primarily membership fees paid by individual physicians.

SOURCES OF GME FINANCING

There are major differences in the GME financing systems in Canada and the United States. In Canada, all university education is highly subsidized by the provincial governments. Education, like health, is a provincial jurisdiction. The Canadian government likes to point out that 37 percent of educational payments come from the federal government, but the other 63 percent come from the provincial governments. In addition, in Canada, tuition fees are fixed by the government and are the same for any Canadian. Consequently, there is virtually no student indebtedness, and the average debt of a graduating Canadian medical student is not a high profile subject as it is in the United States. In the United States, tuition is relatively low in state-supported schools, but living expenses force many students in U.S. public schools to incur significant debt. Furthermore, GME financing in Canada is through explicit provincial budget lines, rather than being commingled with clinical services and clinical research, as in the United States. The provincial ministries of health fund

the majority of GME positions. Furthermore, the number and distribution of GME positions by postgraduate year is a matter of negotiation between the government and the medical school. Moreover, in Canada, house-staff salaries and benefits are determined by negotiation between the government and the provincial house staff association. A small number of GME positions (approximately 15 percent of total positions) are funded from sources other than the Ministry of Health.

The arrangements that govern non–ministry-funded positions vary among provinces. In some, no restrictions apply to the use of nongovernment funds. In others, only government sources may fund GME positions and nongovernment funds may be used to support specific specialty positions, subject to government approval. Government funds for the salaries of university faculty, including medical school faculty who teach house staff, are provided by the Ministry of Education. Although the GME budget provided by the Ministry of Health generally does not include funds to support the salaries of faculty who supervise and teach house staff, in some provinces the Ministry of Health provides funds to pay family physicians who teach in community family medicine training sites. Revenue from providing patient care has become a main source for paying the salaries of clinical faculty. Clinical faculty members submit bills for patient care services to the government, just as they would in private practice. Because of the global financing of hospitals and universities, medical schools find it financially as easy to train in ambulatory settings as in inpatient locales. This contrasts with the constant cries of U.S. medical schools about the financial and administrative difficulties of shifting training out of the inpatient hospital settings prevalent in the United States.

In the United States, the majority of GME funding comes from inpatient revenue and faculty physician billing. About 30 percent of funding comes from the federal government, largely through Medicare; inpatient revenues from a variety of payers and sources cover the rest. Medicare, however, pays set payments for services, regardless of the hospital. Medicare then makes explicit payments to teaching hospitals to cover its "share" of the cost of training residents. Medicare pays for its share in two ways: (*a*) the direct medical education (DME) payment and (*b*) the indirect medical education (IME) adjustment. DME represents those costs directly attributable to the education of residents, including salary, fringe benefits, office space, administrative and clerical support, a share of the cost of faculty, and allocated overhead. MedPAC figures for 1997 indicate that DME expenditures were about $2.2 billion. The amount of DME varies from institution to institution, and national standardization of DME payments is a component of many reforms. The IME adjustment is meant to reimburse teaching hospitals for their higher inherent operation costs, such as more indigent care, more complex and severe cases, and increased diagnostic testing. The IME adjustment allows teaching hospitals to support their broader mission. In fiscal year 1997, according to MedPAC figures, this was about $4.6 billion. The federal government, mainly through the two Medicare payments, IME and DME, is the only explicit payer of graduate medical education.

The role of state government in supporting medical education is well-established. Since the late 1940s, states have subsidized loan and scholarship programs as financial incentives for medical students and physicians in training, and most states have provided some level of institutional support for medical education. Most states also elect to provide some level of support for GME. Second to Medicare, Medicaid is the largest payer of GME, providing teaching hospitals close to $2 billion annually. Although Medicare has a statutory requirement to support GME, state Medicaid programs have no such formal obligation. On average, Medicaid GME payments represent less than 10 percent of a state's total Medicaid fee-for-service inpatient hospital payments.[2]

PHYSICIAN WORKFORCE

The health care workforce theme in the United States is particularly significant, given the current health reform debate about the need for increased numbers of primary care providers, the maldistribution of physicians, and the appropriate balance between generalists and specialists in the physician ranks. While federal policymakers have focused on only limited aspects of the health care workforce, the list of issues that most concern analysts looking at the health care work force is very broad. The list includes but is not limited to (*a*) the adequacy of supply of various health professionals, (*b*) the geographic distribution of health professionals, (*c*) potential oversupply and poor distribution of specialty physicians, (*d*) the costs associated with educating health professionals, (*e*) the impact that changes in the health care delivery system may have on the financing of health professionals education, and (*f*) the competency testing of health care professionals.[3]

Workforce concerns in the United States are complicated by the fact that the responsibility for determining and legislating policy on these issues is not vested

in a single body but is distributed among many parties and levels of government (that is, federal, state, county, and local governments; third-party payers, such as insurance companies and managed care organizations; professional associations; and educational institutions, such as academic health centers that train the health care workforce and determine the educational foundation of practitioners).

The supply and character of the health care workforce available to meet the demand for health services at any given time are also determined by many factors. These include the geographic location of practitioners, the number and type of students in health professions education programs, the number and capacity of educational facilities in both the United States and abroad, the number of foreign-trained practitioners that have immigrated to the United States, the retention rates for health care professionals, the degree of labor force participation, the average age of retirement, and the level of productivity of professionals.

In the mid-1960s, the government determined that there was a shortage of physicians in the United States. Largely as a result of subsequent policy and program innovations, the number of medical schools in the country increased by 50 percent and the number of students doubled between 1961 and 1995. By 1981, the Graduate Medical Education National Advisory Commission was predicting an oversupply of physicians. And, in fact, the number of physicians in this country more than doubled between 1965 and 1994, increasing from under 300,000 to nearly 700,000 in that period, while the population increased by only 45 percent. The resulting ratio of 261 physicians per 100,000 population is significantly greater than that in other industrial countries. Since the advisory commission's 1981 warning, the number of medical school graduates has remained relatively stable (16,000 graduates of allopathic medical schools and 1,700 graduates of osteopathic medical schools per year). The number of residency positions, however, has increased dramatically.[4]

As Canada has developed its generalist-based GME system, the United States has struggled to convert its specialty-oriented GME model. As care has moved from inpatient to outpatient settings, GME in the United States has retained its inpatient teaching hospital focus, reinforced by Medicare GME. Within the last decade, a number of studies and reports have called for the production of more primary care physicians in the United States, and various academic health centers (such as the University of New Mexico and the University of Washington) have responded. Indeed, in recent years, the primary care residency match has reflected increased interest on the part of medical students in entering primary care careers. Nonetheless, the flow of medical school graduates into specialties in the United States continues to predominate.

Various questions have arisen on the road to primary care-specialist parity, some of them related to the trend toward managed care. One concerns the efficacy of the "gatekeeper" model—whether the use of a primary care physician as a decision maker serves the best interests of the patient and provides the best-quality health care. Another relates to the expansion in the scope of practice of other health care providers—whether physician assistants, nurse practitioners, and other such nonphysician providers may be able to provide primary care services more efficiently and cost effectively than physicians.

Comparing U.S. and Canadian GME is somewhat analogous to evaluating apples and oranges, because the two countries have different health systems (or, more accurately, Canada has a defined health system and the United States has a pluralistic structure). However, analysts do reach several conclusions when they make the comparison. Canada produces a physician workforce that reflects a 50-50 mix of generalists to specialists. The unit costs per physician are much less than in the United States. The locales in which the workforce are trained correlate closely with the ambulatory sites in which Canadian physicians provide care to the population. While there are some problems with maldistribution because Canadian physicians—like their U.S. counterparts—tend to prefer metropolitan areas over rural and frontier areas, the workforce seems to be a better fit with the health care needs of Canadian people than is the case in the United States. These assumptions lead to intriguing questions for federal policymakers attempting to improve or reform Medicare GME provisions.

THE FORUM SESSION

This session will compare and contrast the U.S. and Canadian GME systems and provide insight into policies affecting the organization and financing of the U.S. GME system. The meeting will explore how the Canadian GME system produces family physicians and specialists who are considered to be as well-trained and as highly qualified as their counterparts in the United States. It will also feature commentary on the minor problem of specialty physician imbalance in Canada

and the relevancy of the Canadian experience with GME to the debate on GME reform in the United States.

Norman B. Kahn, Jr., M.D., was recently appointed vice president of education and scientific affairs, American Academy of Family Physicians (AAFP). Previously, Dr. Kahn served as the director of the AAFP's Division of Education. After an internship and residency in family practice at San Francisco General Hospital, he had a rural practice in California for four years. He also directed both a community- and university-based family practice residency program, as well as a network of university-affiliated programs. A prolific writer and presenter, he will discuss both the training and service aspects of the U.S. GME system.

Nadia Mikhael, M.D., F.R.C.P.C., this spring became the director of education at the Royal College of Physicians and Surgeons of Canada. In her new role, she is responsible for the accreditation process of the 55 specialty training programs in the 16 Canadian medical schools, the credentialing of all candidates for specialty certification in Canada, the 43 specialty examination processes in both English and French, and the educational research and development activities of the Royal College. A fellow of the College of American Pathologists and the American Association of Pathologists, she most recently was chair of and a professor in the Department of Pathology, University of Ottawa. She will discuss the administration of GME in Canada, including the training requirements of the RCPSC, general standards of accreditation, regulations on residency requirements, and certification.

Mamoru Watanabe, M.D., emeritus professor and faculty dean of medicine at the University of Calgary, will discuss Canada's physician workforce planning and polices and the current state of physician supply in Canada. Dr. Watanabe's work involves analysis of workforce data that permit forecasting and exploring trends as well as exploration of the issues and factors that influence physician needs and supply.

Stephen Gray, M.D., is a medical policy consultant with the British Columbia Ministry of Health. His responsibilities include policy and planning functions for national, regional, and provincial health and human resources. He is a member of the Federal Provincial Territorial Advisory Committee on Health Human Resources and the National Advisory Committee on Postgraduate Medical Training. Dr. Gray will discuss the relationship between government and physicians in Canada (focusing on topics such as methods of payment and organization of care) as well as GME funding and levers to affect change.

This briefing, followed by a roundtable discussion between participants and presenters, will address the following questions:

- Do the two systems require fundamentally different numbers and proportions of primary care physicians, or are the Canadian requirements only superficially greater because of Canada's more structured generalist model?
- Why did Canada adopt generalist medicine as its model? Is it the difference in terms of its pipeline of general practitioners?
- Should the United States consider further movement towards a consortium or system of medical education built upon one or more medical schools and affiliated teaching hospitals, health maintenance organizations, and other ambulatory training sites involved in GME?
- Should there be more direct U.S. accountability of the financing of GME so that all parties (for example, medical schools, training program directors, and the public) clearly know what funds are being provided for GME?
- Are medical educational institutions in the United States and Canada producing the health professionals needed for an effective and productive workforce in the 21st century?
- Why is half of Canada's physician population in a clearly defined specialty of generalist care? Which Canadian variations or similar structures and themes could be adopted in the United States and which could not?
- How closely are the independent actions of 125 medical schools and more than 7,000 residency programs in the United States coordinated to produce a national physician supply that is aligned with health care needs and decisions about national expenditures for health care?
- What proportion of Canadian medical school graduates cross into the United States for their postgraduate medical education, and vice versa?
- Do the provincial governments in Canada determine the numbers of residencies that they will fund in any province, and do they do so in each specialty? In other words, do they determine the numbers of, for example, dermatology, internal medicine, or pediatrics residencies that they will fund?

- There are two elements in the environment that seem particularly important distinctions in the United States and Canada: the medical malpractice environment and the greater heterogeneity of the U.S. population. How do these two factors affect what the United States would be able to do?

ENDNOTES

1. Josephine M. Cassie, Judith S. Armbruster, Ian M. Bowmer, and David C. Leach, "Accreditation of Postgraduate Medical Education in the United States and Canada: A Comparison of Two Systems," paper presented at the 1998 Annual Conference of the Association for Medical Education in Europe, August 30–September 2, 1998.

2. Tim Henderson, "Financing Medical Education by the States," Forum for State Health Policy Leadership, National Conference of State Legislatures, August 1998.

3. Association of Academic Health Centers, *Health Workforce Issues for the 21st Century*, ed. Paul F. Larson, Marian Osterweis, Elaine R. Rubin (Washington, D.C.: Association of Academic Health Centers, 1994).

4. Forum on the Future of Academic Medicine, Association of American Medical Colleges, "The Physician Workforce," issue paper; accessed at http://www.aamc.org/about/progemph/forum/issues.htm, March 1, 1999.

No. 741

ISSUE BRIEF

NATIONAL HEALTH POLICY FORUM

Confidentiality of Health Information: What Can We Learn from State Partnerships?

Monday, June 21, 1999
1:00 pm - Light Refreshments
1:30 to 3:30 pm - Discussion
Holiday Inn on the Hill
415 New Jersey Avenue, N.W.
Federal Ballroom North

A roundtable discussion featuring

A. G. Breitenstein
Chair
Massachusetts Confidentiality Working Group

John Colmers
Executive Director
Health Care Access and Cost Commission
State of Maryland

Peter Hayes
Senior Consultant
J & H Marsh & McLennan
Scarborough, Maine

Meg O'Donnell
Director of Quality Assurance and Consumer Protection
Division of Health Care Administration
State of Vermont

Michael Stapley
President and Chief Executive Officer
Deseret Mutual Benefit Administrators
Salt Lake City

Registration: Please call **Dagny Wolf at 202/872-1392** as soon as possible.

The George Washington University
WASHINGTON DC

Confidentiality of Health Information

Devising protections for confidentiality of health care information that will satisfy all concerned is a major challenge for policymakers: multiple agendas, each meritorious but not readily reconciled, grapple for primacy. At the heart of the contention are two basic goals. The first is to keep individuals' health records safe from inappropriate use and disclosure. The second is to improve health care delivery and outcomes at both the personal and population level. Striking a balance between the two is the critical task.

This need for balance plays through many decisions that must be made in order to achieve equilibrium overall. There are questions of individual as opposed to societal goals, privacy versus optimal health care, and federal versus state control. If tracking a group of patients with a particular disease may lead to a cure, should researchers be barred from using records that would identify the target group? If a primary care physician discusses a perplexing case with a specialist without the patient's knowledge, has confidentiality been breached? If a state chooses to address medical privacy issues in a way different from what Congress decides to do, whose will should prevail?

Opinions tend to be sharply divided according to vantage point. Multistate employers favor strict federal preemption. Insurance regulators would prefer that a federal standard serve as a floor, permitting states to build on it if they so choose.[1] Patients want assurance that unauthorized disclosure of their personal information will not put their employment or insurability in jeopardy. Researchers fear they will be unable to conduct studies that use personally identifiable information to link specific treatments with actual outcomes. Some physicians have suggested that confidentiality concerns could be alleviated if providers retained all clinical information and, subject to audit, simply billed insurers on the basis of case complexity. Managed care plans assert that they are uniquely able to influence provider performance improvement.

This Forum session will explore state-level health data initiatives undertaken by public-private partnerships representing a variety of data needs and concerns. In planning and implementing data networks and quality measurement programs, confidentiality has been a key consideration.

BACKGROUND

Bills introduced this year in the Senate include S. 573, sponsored by Patrick J. Leahy (D-Vt.) and Edward M. Kennedy (D-Mass.); S.578, sponsored by James M. Jeffords (R-Vt.) and Christopher J. Dodd (D-Conn.); and S. 881, introduced by Robert F. Bennett (R-Utah). These bills made varying trade-offs among the various interests as they addressed the disclosure of personal health information. Reconciliation among their areas of significant difference was attempted by Health, Education, Labor and Pensions Committee chair Jeffords for a mark-up scheduled for May 26, which was canceled and rescheduled for June 9 as this announcement went to press. Action in the House has yet to take definite shape, although several members are pursuing it, including Ways and Means Health Subcommittee chair Bill Thomas (R-Calif.). Commerce Committee Health and Environment Subcommittee chair Michael Bilirakis (R-Fla.) held a hearing on the topic May 27. Reps. Edward J. Markey (D-Mass.) and Gary A. Condit (D-Calif.) have introduced bills.

Demand for action is fueled in part by an August deadline imposed by the Health Insurance Portability and Accountability Act of 1996 and in part by pressure from the European Union (EU). The EU's own privacy directive (effective October 1998) sets up personal data privacy protections within the EU and also bans the transfer of personal information to countries not deemed to have adequate data protections.

ISSUE BRIEF/No. 741

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Discussions in preparation for the Health, Education, Labor and Pensions Committee mark-up focused on several areas of possible compromise. These included the definition of personally identifiable health information, use of a single "consolidated" authorization by the patient (as opposed to a separate authorization for each proposed disclosure of protected information), and new restrictions on access to protected health information by law enforcement agents and privately funded researchers.

Less amenable to compromise has been the question of federal preemption. State officials and privacy advocates want to preserve states' ability to take stronger measures and respond to new situations not anticipated by federal proposals. In recent congressional testimony, Kansas Insurance Commissioner Kathleen Sibelius expressed concern that preemption would wipe out existing privacy protections, including those applied to other lines of insurance, such as life and property and casualty. She asked that states retain their ability to move more quickly to identify and respond to both technological changes and unintended consequences of federal law.[2] Insurance and employer representatives, by contrast, have insisted that they need full preemption of state confidentiality laws for effective administration and data collection.[3]

Attempts at middle ground solutions included a provision in the original S.578 that would have grandfathered state laws enacted before the federal law's effective date, in effect providing an 18-month window for states to act before preemption took effect (with ongoing exceptions for state public health and mental health laws). A revised version released in preparation for mark-up would allow state laws enacted prior to the enactment of the federal law to remain in place if they are more protective than the federal standards. How and by whom "more protective" would be determined, other than through litigation, is not specified. Since so much of this disagreement is philosophical-cum-political, it is perhaps not surprising that consensus has been elusive.

THE FORUM SESSION

While Congress has been struggling with the ramifications of privacy protection, many states have moved forward, some with legislation and some with health data initiatives in which confidentiality was one of a range of issues to address. Among the most interesting are a series of public-private collaborations in health information policy, recently highlighted in a report that is included with this meeting announcement. Published by the Milbank Memorial Fund and the Reforming States Group (RSG), the report describes projects in ten states. This session is presented in conjunction with RSG, a voluntary association of leaders in health policy in the legislative and executive branches of more than 40 states.

Representatives from several of these collaborative efforts will describe the climates that gave rise to their efforts, the process that allowed them to accommodate divergent viewpoints, and the channels and obstacles to agreement on confidentiality of personal health information. **John Colmers,** executive director of Maryland's Health Care Access and Cost Commission and chair of the Reforming States Group, will describe the group's ongoing efforts to address information policy issues and provide a forum for states to share experiences in this area. He will also talk about Maryland's statewide HMO performance report cards. **A. G. Breitenstein,** chair of the Massachusetts Confidentiality Working Group and a speaker at the Forum's September 1998 session on confidentiality, will review the working group's considerable progress toward legislation to be introduced in this session. **Peter Hayes,** senior consultant with J & H Marsh & McLennan, will address the uses of health data for which the Maine Health Management Coalition was created. (Maine, it should be noted, is the state where privacy legislation passed in 1998 was suspended by the governor within two weeks of its effective date.) **Michael Stapley,** president and chief executive officer of Deseret Mutual Benefit Administrators and chair of the Utah health information network, will describe how the latter organization standardizes and generates administrative data. **Meg O'Donnell,** director of quality assurance and consumer protection in Vermont's Division of Health Care Administration, will talk about that state's ongoing efforts to reach consensus on a legislative proposal. Representatives of the National Association of Insurance Commissioners and the National Conference of State Legislatures will also be on hand.

Among policy questions to be addressed are the following:

- How would federal preemption affect state-level collaborative health information projects?
- How are quality improvement and health system accountability served by such projects?
- How should "personally identifiable health information" be defined? To what extent do intended use and format as well as specific data elements enter into a definition?

- What participants and processes have proved conducive to reaching consensus on health information issues, including confidentiality?

A. G. Breitenstein is an attorney and has recently completed a master's program in public health, with a concentration in health policy and management, at the Harvard School of Public Health. Before returning to school, she was the founding director of the Health Law Institute in Boston. Ms. Breitenstein has drafted several legislative proposals, including H. 1738, "An Act Protecting the Privacy of Medical Records," currently pending in the Massachusetts legislature.

John Colmers has served as executive director of Maryland's Health Care Access and Cost Commission since being appointed to the post, with the governor's approval, in 1993. The agency was created that year by the legislature to implement health care reform in the state. Its charges include developing a health care database, implementing a provider payment system, and creating report cards for HMOs. Previously, Mr. Colmers was executive director of the Health Services Cost Review Commission, which oversees Maryland's unique all-payer hospital rate-setting system.

Peter Hayes is a senior consultant with J & H Marsh & McLennan. He served nearly two decades with the Hannaford Brothers Company in a series of financial and analytical positions and then for seven years as manager, employment benefits. He is co-founder and past president of the Maine Health Management Coalition and serves on the board of Community Health Services, the largest provider of home health care services in Maine.

Meg O'Donnell is the director of quality assurance and consumer protection for the Division of Health Care Administration in Vermont's Department of Banking, Insurance, Securities and Health Care Administration. She is responsible for implementing the state's regulatory oversight program for managed care plans. Ms. O'Donnell served as the Division's general counsel for five years before accepting her present position.

Michael Stapley has been president and chief executive officer of Deseret Mutual Benefit Administrators since 1996, having joined the company as vice president in 1984. Before that, he was deputy director and for a period acting executive director of the Utah Department of Health. He is a member of the Department of Labor's ERISA Advisory Council and chairman of the board of the Utah Health Information Network.

ENDNOTES

1. Kathleen Sibelius, testimony before the Senate Committee on Health, Education, Labor and Pensions on behalf of the National Association of Insurance Commissioners, April 27, 1999.

2. Sibelius, Senate testimony.

3. Washington Business Group on Health, testimony submitted for the record to the Senate Committee on Health, Education, Labor and Pensions, April 27, 1999.

EMPLOYER-SPONSORED COVERAGE

Changes In The Wind?

June 1999

KEY DATA

Less than 10% of Americans had private health insurance in 1940. By 1977, 71% of the non-elderly were covered by private insurance — 90% of them through employers.

One-third of workers had health coverage fully paid for by their employers in 1995, down from 62% in 1984.

89% of workers accepted coverage offered by their employers in 1996 versus 93% in 1987. One reason: employees have to pay more of the cost.

$58 billion more in federal income taxes would be collected this year if workers paid tax on the cash value of employer-based coverage.

4 of 5 uninsured Americans in 1995 came from a family with a full-time worker.

5 of 6 employers offering coverage offered only one choice in 1996.

Only 18% of employers offered their workers a traditional indemnity plan in 1998.

For six decades, working Americans have been relying on their employers to arrange and help pay for their health coverage. Most people with employer-sponsored coverage are satisfied with the system. But increasingly, questions are being raised about whether employer coverage might erode slowly — perhaps even precipitously — over the next few years. This raises concerns among policy makers and analysts looking to address the 43 million Americans who already lack health coverage.

Despite record employment levels, the proportion of under-65 Americans in employer plans is lower than it was a decade ago (see figure 2). One likely factor in the drop-off is that employers had been requiring employees to pay more of their own premiums. In medium and large firms, for example, 62% of workers paid nothing for their own coverage in 1984. By 1995, only 33% had fully paid coverage. Contributions for family coverage have dropped even more sharply, as many firms seek to limit expenses by limiting their payment for covering dependents. Employers are beginning to face rising premiums after several years of stability, which may further erode coverage.

Also, the nature of employment is changing. Part-time, temporary and small firm workers are less likely to have coverage through their jobs. Any economic slowdown might induce further erosion.

Despite remarkable economic prosperity in recent years, employer coverage levels have not markedly improved. There is little reason to hope that it will expand significantly in the future. So there is renewed interest in other options for reaching the millions of workers and dependents without coverage — options such as tax preferences or other subsidies that would help families get coverage in the individual or "nongroup" market. These proposals could represent a historic turn away from reliance on employers for coverage for most Americans under age 65.

HOW WE GOT HERE

The US system of voluntary, employer-provided coverage through private plans — unique among major industrial nations — evolved by quirk of history. During World War II, wage controls prevented unions from negotiating higher pay; instead they negotiated for more benefits, such as health insurance.

Continued growth in employer-based coverage in the following decades was promoted by the federal tax treatment of health benefits. Employers can deduct the cost of health benefits as a business expense. For the employee, the employer's contributions are not counted as taxable income. So a dollar of health coverage is worth more than a dollar of wages. The federal government extended coverage to its workers in the late 1950s. By the 1960s, health benefits were widely available among medium and large employers, public and private, and increasingly common even in smaller firms.

The 1970s and early 1980s saw explosive

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ALLIANCE FOR HEALTH REFORM

Did Managed Care Buy Time?

MANAGED CARE, BY HELPING HOLD DOWN COST INCREASES, has helped in turn shore up employers' willingness to offer health coverage, particularly small employers. Short-term savings from managed care have been dramatic: As most firms moved to managed care for their workers, average employer premium growth was only about 1% in 1996, and average premiums actually dropped in 1997. But can it continue? One respected survey estimates that employers' premiums rose about 4% in 1998 and will rise 8.5% in 1999, despite managed care.

growth in general inflation and in health costs. Spending for private insurance more than quadrupled between 1974 and 1984. In turn, these rapidly rising costs caused major reactions by employers and insurers.

SMALL EMPLOYERS' DIFFICULTIES

One consequence of rising employer costs for coverage has been fragmentation of the so-called risk pool, and small firms' resulting difficulties in getting affordable coverage for their employees. Early on, employers tended to buy coverage from carriers, such as the nonprofit Blue Cross and Blue Shield plans, who accepted all applicants and charged a uniform rate to everyone in the community. With this large pool of insured people, the risk of any individual having an expensive medical problem was balanced by the many people at lower risk. Gradually, however, other commercial insurers began offering better prices to employers with healthier workers; many Blues plans had little choice in a competitive market but to follow suit. So instead of one large community-wide risk pool, many smaller pools were formed.

Larger employers found that they could save money as well as avoid state taxes and regulation by "self-insuring" — carrying the financial risk for their own employees' health care costs, rather than paying the insurance company to bear that risk. Over time this meant that, while large employers could easily get coverage for their workers at reasonable cost, small employers had greater difficulty — especially if one of their workers presented a high risk. Insurers might charge them higher rates or refuse to cover the high-risk worker or even the entire firm.

Concerns about access to insurance by small employers have led to reforms at the federal and state level. Under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, health insurers may not refuse any small employer, and there are limits on the restrictions they may place on coverage of any individual worker. Many states have moved to restrict the range of rates insurers can quote to different employers because of the health status of their workers, but HIPAA does not regulate insurance prices.

Opponents of these rules contend that they may backfire: While they reduce costs for high-risk firms, they raise costs for low-risk firms and could lead some to drop coverage. Whether this has actually occurred is uncertain, largely because of difficulties in separating the effects of reforms from other trends.

WHAT'S GOOD ABOUT EMPLOYER COVERAGE?

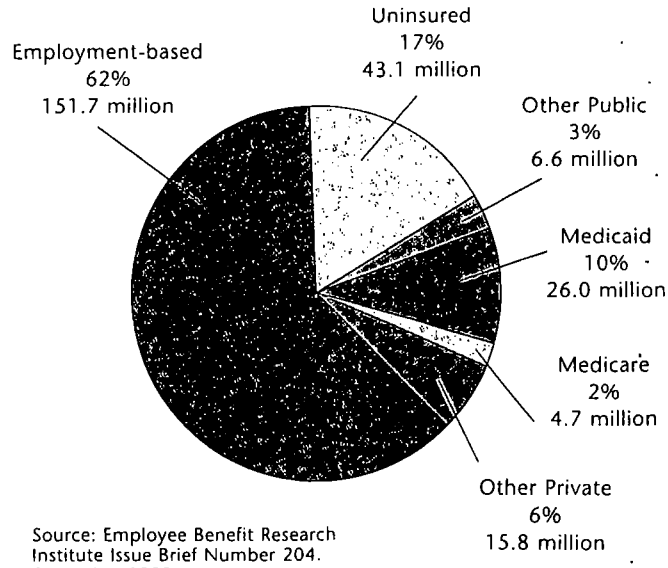
While tax treatment makes employer-sponsored coverage the insurance method of choice for most Americans, group coverage has other advantages as well.

Employer coverage costs less for equivalent benefits than coverage purchased in the individual or "non-group" market. Grouping offers economies of scale and administrative efficiencies. Administrative expenses can make up 40 percent or more of individual premiums, compared to 15 percent or less for employer plans, where marketing costs are much lower. Also, employers have more leverage than individuals. Those with many workers can get a better price from insurers. And many of the largest firms have been leaders in value-oriented purchasing, pushing for quality and consumer satisfaction data from health plans.

As mentioned earlier, group coverage allows for the pooling of risks — spreading expenses for high-cost individuals across a number of participants. This is especially true of larger employers, and of joint labor-management plans, known as Taft-Hartley plans, that cover millions in industries like construction and trucking. In a smaller firm, one sick individual can

Figure 1

Sources of Health Insurance Coverage for Non-Elderly Americans



Source: Employee Benefit Research Institute Issue Brief Number 204. December 1998

Note: Total exceeds 100% due to some overlap in coverage

raise costs for the entire group. States have tried to counteract this by passing laws helping multiple small employers to group together for insurance purposes and by limiting rate variations offered to such groups.

Finally, people are more likely to participate in employer plans than to obtain coverage on their own. Economists say that workers who receive employer-subsidized health benefits are forgoing higher wages. But the cost is largely invisible, and as premiums rise, workers would be unlikely (in some cases, unable) to spend as much buying nongroup coverage. Plus, signing up for coverage at work is simpler and more convenient than hunting for it on one's own.

WHAT'S WRONG WITH EMPLOYER COVERAGE?

The major objection to the employer-based system is that there is no clear reason why the availability, benefits, and cost of health insurance should depend on where somebody works.

Perhaps employee groups were a convenient way of organizing coverage when most families had one worker who often had a long-term connection with one employer and one health plan. Today, families have multiple earners (not always married to each other) and people change jobs often. People often have to change doctors if they change employers.

Moreover, employers aren't necessarily equipped to be astute purchasers of health coverage. Buying health care is a sideline to employers. And many workers get no choice of health plans at all, especially in small firms. Even among firms with 200 or more employees, 47 percent offered no choice of plan in 1996.

Finally, employer coverage provides greater economic benefits to higher-income workers than to lower-income workers. Workers in higher tax brackets receive a greater tax benefit from having employer contributions not counted in their taxable income.

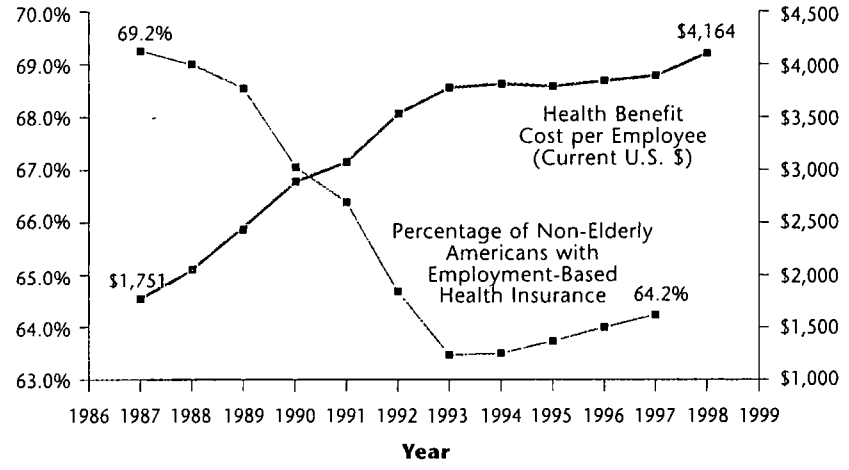
HOW COULD WE STRENGTHEN EMPLOYER COVERAGE?

Several measures have been proposed to promote expansion of employer coverage, or at least help prevent further erosion.

- **Give employers direct financial incentives** to offer coverage. Some states already do this, and President Clinton's FY 2000 budget proposal calls for a partial tax credit for small firms not previously offering coverage.
- **Reduce the number of state-mandated benefits** and other insurance regulation, to reduce price increases.
- **Help employers with high-cost workers** (at least partly at the expense of employers with low-cost workers) by further reforms in the small group market. Some would couple this with changes to keep small employers in the small group pool.

Figure 2

TRENDS IN EMPLOYMENT-BASED HEALTH INSURANCE AND HEALTH BENEFIT COST PER EMPLOYEE



Source: Mercer/Foster-Higgins; Employee Benefit Research Institute (EBRI)

- **Use Medicaid or the new children's insurance program** to help pay for employer family coverage for those eligible.
- **Promote cooperative health purchasing groups,** through elimination of legal barriers or provision of start-up funding.
- **Finally, we could once again consider proposals to require employers to subsidize coverage.** While this was a feature of the failed Clinton health plan, proponents still argue that it is the only way of approaching universal coverage without restructuring our entire system.

WHAT IF WE ELIMINATED THE SPECIAL TAX TREATMENT OF EMPLOYER COVERAGE?

Except for advocates of a totally public insurance system, not many people are talking about eliminating employer coverage. But there is considerable discussion of proposals that would change the tax code in ways that would reduce the current advantages of employer plans. Proponents of change argue that the current system is —

- **bad tax policy,** distributing scores of billions of dollars in tax breaks each year disproportionately to higher-wage workers;
- **bad employment policy,** effectively raising the cost of labor, and raising it the highest percentage for the lowest-wage workers; and
- **bad health policy,** offering precious little incentive for extending coverage to many more of the uninsured.

Some proposals would more or less equalize the tax treatment of employer-provided insurance and coverage purchased individually, by allowing an income tax deduction for the purchase of coverage in the individual market. Other proposals would limit or eliminate the "employee exclusion," under which employer contributions for coverage are not treated as taxable income to employees. The savings to the government could fund an alternative subsidy system, such as a tax credit that a worker could use to buy coverage either in the nongroup market or through an employer group.

Changes in the system could improve equity by helping workers whose employers do not offer coverage. Some proposals would also better target the current tax subsidy — an estimated $58 billion in fiscal 1999, more than the cost of the mortgage interest deduction or reduced rates on capital gains[1] — which now disproportionately helps higher income workers.

But eliminating the preferential tax treatment of employer coverage might also diminish its other advantages. Employers might offer wages instead of benefits — reasoning that workers would be just as well off with a tax break for nongroup coverage, and reducing their own exposure to future cost increases or legal liability for care denials.

However, workers would then face the higher costs of nongroup coverage, as well as the discriminatory underwriting and rating practices still permissible in most states. Some workers would enroll in less comprehensive plans, while many more might forgo coverage altogether. Even if an employer continued to offer a plan, healthier workers might find that they could get better rates by leaving their group. Higher-risk workers would be left behind in a steadily deteriorating risk pool. As premium prices rose, employers would face greater incentives to drop coverage.

Tax code changes might need to be accompanied by other steps to prevent declines in overall coverage. These could include:

- **stronger regulation of the individual market,** to promote pooling and make coverage more accessible to older and higher-risk purchasers;
- **development of cooperatives** or other measures to reduce excess administrative costs;
- **individual credits or other subsidies** set at levels sufficient to assure that lower-risk and modest-income individuals will still participate.

Some say that even these measures would be insufficient, and that the nongroup market can be made workable only if all individuals are required to participate, through some form of individual coverage mandate.

CONCLUSION

Policy makers, advocates and analysts are looking aggressively for ways to fill the gaps in our coverage system, and to correct its inequities. Could some proposed changes actually hasten the erosion of job-based coverage? And should we worry about that?

Many proponents of change say there's no reason to prefer job-based to individual coverage, and that we ought to design the tax system so that the two are treated equally.

Others worry that we may take steps that endanger the employer system — like it or not, the base of coverage in America — without having anything ready to replace it. They say that while there are holes in the employer system, we are unlikely to adopt a universal coverage plan any time soon. Meanwhile, in this view, we ought to be doing what we can to shore up the existing system and achieve some modest expansion.

Policy makers must weigh these competing considerations as changes in our current coverage system are put forward and discussed.

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Kenneth Thorpe, *Tulane University*	**504-588-5171**

1 Joint Committee on Taxation. Lost Social Security taxes are omitted from these tax expenditure estimates, because collecting these taxes now would lead to higher benefit payouts in the future. Including these other tax preferences, some analysts put the 1998 federal subsidy at $111 billion.

ACKNOWLEDGMENTS

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The Alliance also thanks health policy analyst and writer Mark Merlis, who contributed most of the research and drafting for this paper.

The Alliance is a bipartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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JOB-BASED HEALTH CARE: HOW SOLID A FOUNDATION?

A Briefing on What's at Stake If We Alter the Way Most Americans Get Coverage

For six decades, working Americans have relied on their employers to arrange and help pay for their health coverage. More than 150 million Americans get their coverage in this way -- almost four times as many as Medicare covers, by comparison. But increasingly, questions are being raised about how solid a foundation employer coverage provides as we try to solve the major problems of access to and cost of care.

There is some reason for skepticism. The proportion of under-65 Americans in employer-sponsored health plans is lower than a decade ago (though stable since 1993). Affordability is a major cause — workers are having to pay more of their total health premium, so fewer are accepting coverage. Also, the growth of part-time and contract work means large numbers of workers who are not offered health benefits. Despite scores of billions of dollars in tax preferences, there is little reason to hope that coverage through employers will expand greatly anytime soon.

If the goal is to insure more Americans, are the current tax and subsidy incentives the right ones? Should premiums for individual coverage be fully tax-deductible? How about tax credits to offset all or part of the premium cost, financed by taxing as wages all employer contributions for health coverage? If we did, would employers continue paying for coverage at today's levels? Would the result be more people with coverage, or fewer?

To address such questions, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, will hold a June 11 luncheon briefing. Speakers include **Paul Fronstin**, senior research associate with the Employee Benefit Research Institute; Princeton economist **Uwe Reinhardt**; **Deborah Chollet,** associate director of the Alpha Center; and others. Alliance Chairman **Sen. Jay Rockefeller** will moderate. As background for the meeting, the Alliance has produced the enclosed issue brief, *Employer-Sponsored Coverage: Changes in the Wind*?

WHEN: **Friday, June 11, 12:15-2 p.m. (Lunch available at noon)**

WHERE: **Room 216, Hart Senate Office Building**

RSVP: *By 5 p.m. on Wednesday, June 9.* Fax the form on the reverse side of this notice to 202/466-6525, phone 202/466-5626 or register on-line at **www.allhealth.org.** *Seating is limited.*

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JOB-BASED HEALTH CARE: HOW SOLID A FOUNDATION?
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ASK YOUR QUESTION IN ADVANCE

If you have a specific question, and want to allow our panelists the chance to provide a considered response, just write your question in the space below. Be sure to note if you want particular panelists to answer. We will address as many of these questions as time permits.

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June 7, 1999

Christopher C. Jennings
Deputy Assistant to the President for Health
Policy Development
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. Jennings:

We invite you or a member of your staff to join colleagues from government and the health professions for a one day meeting in Washington, DC, on July 7-8, 1999, to discuss policy for preventing and treating dental pain among children who obtain health coverage through Medicaid and the Children's Health Insurance Program. Recurrent and severe pain is often a marker for limitations on the access of these children to appropriate preventive and treatment services. The meeting will explore the possibility that enhanced perception of dental pain by parents, school and social service professionals, and health care providers, as well as children themselves, could lead to earlier access to dental care and better utilization of available resources.

This meeting is the result of previous work by the two foundations that are convening it. Mayday is dedicated to reducing the incidence of physical pain. The Milbank Memorial Fund and the Reforming States Group (RSG), an organization of leaders of the legislative and executive branches from more than 40 states, recently devised a plan by which states could pay for appropriate dental care for children eligible for Medicaid and CHIP. Bert Edelstein provided technical assistance to the Fund and the RSG in developing this plan. He is writing a background paper on dental pain as a marker for problems of access to care that will be distributed before the meeting.

The meeting will be held at the One Washington Circle Hotel. It will begin with dinner on the evening of Wednesday, July 7th, reconvene the next morning and adjourn by 3:30 p.m. The foundations will arrange travel and accommodations for persons attending the meeting.

Sincerely

Burt Edelstein
Director
Children's Dental Health Project

Daniel M. Fox
President
Milbank Memorial Fund

Fenella Rouse
Executive Director
The Mayday Fund

Encl.

645 Madison Avenue, 15th Floor
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Tel: (212) 355-8400
Fax: (212) 355-8599
E-mail: dmfox@milbank.org

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Facsimile

To:	Christopher Jennings	**From:**	Daniel M. Fox
Fax:	202-456-5557	**Pages:**	2
Tel:	202-456-5560	**Date:**	June 7, 1999
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Chris Jennings (Meetings, Trips, Events)
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Speaking Engagements (April, May, June 1999) [4]

2011-0747-S
rc422

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P1 National Security Classified Information [(a)(1) of the PRA]
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Economic Policy Institute

1660 L STREET, NW • SUITE 1200 • WASHINGTON, DC 20036 • 202/775-8810 • FAX 202/775-0819

You are invited to attend

BALANCING ACTS:
Easing the Burdens and Improving the Options for Working Families

A Symposium Sponsored By

Economic Policy Institute
Alfred P. Sloan Foundation
Program On Working Families
U.S. Department of Labor
Workforce/Workplace of the Future Project

June 15, 1999
9:00 a.m. – 4:00 p.m.
Dirksen Senate Office Building, Room 138
1st & C Streets, NE, Washington DC

This conference will bring together key experts from the research, labor and business communities, who will detail the latest findings, trends, and policy options in the area of work and family life. The panels – highlighting the most innovative new practices that unions and companies are adopting – will engage policymakers in a lively discussion of the issues.

Space is limited. Please fill out the following registration form and fax it back by **June 9**. If you have questions about the conference, please call Stephanie Steptoe at 202-775-8810.

Fax to EPI at 202-775-0819, Attention: Stephanie Steptoe

___ **I will be attending the June 15, 1999 conference.**

Name: _____ Phone: _____

Affiliation: _____ Fax: _____

Address: _____ E-mail: _____

___ **I cannot attend the conference, but would like copies of the materials when they are available.**

BALANCING ACTS:
Easing the Burdens and Improving the Options for Working Families

AGENDA

9:00am	Breakfast
9:15 - 9:30am	**Welcome and Introduction** Dr. Kathleen Christensen, Program Director, Alfred P. Sloan Foundation Jeff Faux, President, Economic Policy Institute Susan Green, Acting Assistant Secretary for Policy, Department of Labor
9:30 - 11:00am	**The New Realities For Working Families** Moderator: Eileen Appelbaum, Economic Policy Institute Suzanne Bianchi, University of Maryland *Setting the Stage: Changes in Work and Family Lives of Americans* Marin Clarkberg, Cornell University *A New Look at the Time Squeeze: Work Hours and Work Preferences* Tom Fricke, University of Michigan *Unanswered Questions: An Ethnography of the Everyday Lives of Middle-Class Working Families* Marlene Kim, Rutgers University *The Limited Resources Available to the Working Poor and the Demands These Families Face*
11:00 - 11:15am	Break
11:15am - 12:45pm	**What Helps Working Families Juggle Competing Demands?** Moderator: Heidi Hartmann, Institute for Women's Policy Research Phyllis Moen, Cornell University *Couples and Careers: What Happens When Both Partners Have a Career?* Katherine Newman, John F. Kennedy School, Harvard University *What Are the Key Issues Facing Low-Wage Families?* Ellen Galinsky, Families and Work Institute *Family-Friendly Policies: Can Companies' Human Resource Practices Help?* Eileen Appelbaum, Economic Policy Institute and Arne L. Kalleberg, University of North Carolina, Chapel Hill

High Commitment Workplaces and Workers' Perceptions That Their Companies Help Them Balance Work and Family Demands

12:45 - 2:00pm **Lunch**
Speaker: Sen. Paul Wellstone (D-MN)

2:30 - 3:45pm **Workplace Models That Increase the Options for Working Families**
Moderator: Rick Belous, George Washington University and EPI

Labor and Business Experiences

Netsy Firestein, Executive Director, Labor Project for Working Families

Sherri Chiesa, Vice President, HERE (Invited)

Marcie Pitt Catsouphes, Boston College
Insights From the Business Week Survey of Companies

Dana Friedman, Senior Vice President, Bright Horizons – Family Solutions

Susan Hofman, Director of Workforce Diversity, Allied Signal (Invited)

3:45 – 4:00pm Closing Remarks

Nancy Reagan

The Alzheimer's Association

invites you to a reception to celebrate the announcement of

The Congressional Task Force on Alzheimer's Disease

The Honorable Edward J. Markey, Chair ◆ *The Honorable Christopher H. Smith, Co-Chair*

June 8, 1999

5:30 until 7:00 p.m.

United States Capitol, Room HC-6

special guest

David Hyde-Pierce (co-star of *Frasier*)

r.s.v.p. (202) 393–7737

Institute for Health Policy
Brandeis University

May 12, 1999

Mr. Christopher Jennings, Health Policy Advisor
The White House
212 Old Executive Office Building
17th & Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Jennings:

Thank you very much for your willingness to attend the meeting of the State Legislative Health & Human Services Chairs Summit. This meeting, sponsored by the National Conference of State Legislatures and the Institute for Health Policy at Brandeis University, will bring together key health and human service legislative chairs to discuss important developments in health and social services.

Your session is scheduled for Friday, June 4, 1999 from 3:15 to 4:15pm. The session will be held at the Park Hyatt Washington, 1201 24th St NW, Washington, DC 20037, (202-789-1234).

Your session is titled a "*Briefing on Major Health Issues before the 106th Congress.*" Paul Harrington, Majority Health Policy Director for the Senate Labor and Human Resources Committee, will also participate. We would be appreciative if you could plan to speak for about 15 minutes, and then participate in Q&A with the chairs. We would invite you to comment on the Executive Branch position on any major health policy matters, including:

- tax credit proposals for the uninsured
- the status of the Children's Health Insurance Program
- managed care regulatory reform
- the continuing impact of the Balanced Budget Act
- medical records confidentiality

Thank you for your willingness to participate. Please contact me if you need further information. My number is 781-736-3904, email: jmcdonough@brandeis.edu

Sincerely,

John E. McDonough

The Heller School • Brandeis University
415 South Street, MS035 • Waltham, MA 02454-9110
VOICE: 781.736.3900 • TTY/TDD: 781.736.3009 • www.brandeis.edu/heller/ihp/ihp.html

#601

6/4 – 3:15–4:15 pm

Institute for Health Policy
Brandeis University

March 30, 1999

Mr. Chris Jennings
The White House
212 Old Executive Office Building
17th and Pennsylvania Avenue, NW
Washington, DC 20201

Dear Mr. Jennings:

Earlier this year, you indicated an interest in attending a session of the State Legislative Health Committee Chairs Project. The earlier session that we discussed had to be postponed because of unanticipated scheduling conflicts.

I am writing again to invite you to attend a Summit of State Legislative Health and Human Services Chairs that will be held from *June 4 to 6 in Washington DC at the Park Hyatt Hotel.* In particular, we would be most appreciative if you would be willing to provide a briefing on major health policy issues currently before the 106th Congress.

The session is being organized by the Health Chairs Project, a collaboration of the National Conference of State Legislatures and the Institute for Health Policy at Brandeis University. The Project is supported by the Henry Kaiser Family Foundation.

The session at which you would speak is tentatively scheduled for *Friday June 4, from 3:15 to 4:15pm.* However, if you would need another time to be able to brief the health and human services chairs, you would be happy to arrange that with you.

Please let me know if you would be available and interested. My telephone is 781-736-3904; my fax is 781-736-3985; and my e-mail is jmcdonough@brandeis.edu

The state legislative health and human services chairs are an active and important group of policy makers who would benefit enormously from your participation. Thank you very much for your consideration. We know that the chairs would appreciate meeting you and learning from you.

Sincerely,

John E. McDonough
Senior Associate

The Heller School • Brandeis University
415 South Street, MS035 • Waltham, MA 02454-9110
VOICE: 781.736.3900 • TTY/TDD: 781.736.3009 • www.brandeis.edu/heller/ihp/ihp.html

NOTES from TERESA

REQUEST #1601

Date Received _____

Meeting ____ Conference Call ____ Speaking Engagement ✓

Requestor John F. McDonough

Organization Brandeis University

Requested Date 6/4 3:15-4:15 pm

Contact Game

Telephone No. 781-736-3904 - Fax 781-736-3985

Request Received:

Correspondence ✓ Telephone Call _____

COMMENTS: CC Dovora
- 4/15/99 called John. He's away from the office until 4/23.
- He left forwarding # Michele 781-736-3979
- Called her & left message to call me.

#601

Institute for Health Policy
Brandeis University

March 30, 1999

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Washington, DC 20201

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John E. McDonough
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EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE®

CIEBA
THE COMMITTEE ON INVESTMENT OF EMPLOYEE BENEFIT ASSETS

May 21, 1999

Re: June 25th CIEBA/EBRI Symposium

Dear Policymaker:

On behalf of the Committee on Investment of Employee Benefit Assets (CIEBA) of the Financial Executives Institute and the Employee Benefit Research Institute ("EBRI"), we would like to cordially invite you to join us at our upcoming symposium entitled *ERISA at 25: Applying the Experience to Social Security Reform.*

The symposium will be held on Friday, June 25 from 9:00 a.m. to 3:15 p.m. at the Westin Fairfax Hotel, Washington, D.C. Attached is a copy of our agenda and RSVP form. We expect an attendance between 100-150 members of CIEBA, FEI and EBRI, as well as policymakers.

By way of background, CIEBA is an organization composed of over 150 of the largest corporate pension funds in the U.S. with over $1 trillion of plan assets under management. EBRI is a nonprofit, nonpartisan organization whose overall mission is to contribute to, encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education.

Since Congress enacted ERISA in 1974, the assets of employee benefit trusts have exploded, the management of funds has moved to high levels of sophistication, and returns have been substantial. At the same time, the dramatic post-ERISA growth of individual account plans has driven administrative system developments and education delivery to new heights. As the nation considers Social Security reform and significant changes in the rules governing employment-based retirement plans, there are at least two areas of where the ERISA experience can provide insight. First, in evaluating the proposals to invest trust fund assets in the equity markets; and, secondly, in evaluating the feasibility of establishing individual accounts that are broadly available.

We believe that this symposium will provide valuable information to Members of Congress and their staff, agency representatives and the public-at-large as the subject of Social Security reform continues to be debated. We hope that you will be able to attend. Because space is limited, I ask that you return the enclosed response form by Wednesday, June 2. If you have any questions, please contact Jacque Johnson, Executive Director, CIEBA, who will be happy to work with you and your office. She may be reached at (202) 457-6205 or jjohnson@feidc.org.

We look forward to having you join us.

Sincerely,

W. Allen Reed
President
General Motors Investment Management Co.
Chairman, CIEBA

Dallas L. Salisbury
President
EBRI

Enclosures

ERISA at 25: APPLYING THE EXPERIENCE TO SOCIAL SECURITY REFORM

SPONSORED BY

COMMITTEE ON INVESTMENT OF EMPLOYEE BENEFIT ASSETS (CIEBA)

AND

EMPLOYEE BENEFIT RESEARCH INSTITUTE (EBRI)

Westin Fairfax
2100 Massachusetts Avenue, N.W.
Washington, D.C.
June 25, 1999

Agenda

Friday, June 25, 1999

9:00-9:10 a.m. — **Welcome and Introductory Remarks**
W. Allen Reed
President, General Motors Investment Management Corporation
Chairman, CIEBA

9:10-9:45 a.m. — **ERISA at 25 years – Is it a success story?**

Keynote Speaker:
Dallas L. Salisbury
President & CEO, Employee Benefit Research Institute

**Hear about the key components of the private retirement system and how they have changed under ERISA. Where are we today?*

9:45-10:30 a.m. — **ERISA and the next 25 years.**

9:45 to 10:00 a.m. — **Speaker:**
The Honorable Earl Pomeroy (D/ND) (invited)

**Representative Pomeroy will provide a picture of what may lie ahead for public policy.*

10:00 to 10:30 a.m. — **Speaker:**
J. Randall MacDonald
Executive Vice President, Human Resources & Admin., GTE Corporation

**Mr. MacDonald will look into the future of employer decision making, the changing employment contract and its implications.*

10:30-10:45 a.m. — **Break**

10:45 a.m.-12:00 noon — **Assessment of the potential implications of investing a portion of Social Security funds into the financial markets**

**CIEBA has sponsored four proprietary studies which will be presented for the first time during the conference. Each study will address the Fund's long-term expected return, the liquidity implications, benchmarking issues, effect on interest rates, influence on corporate America.*

T. Britton Harris, Moderator
President
GTE Investment Management Corp.

Panelists:
William A. Brown
Managing Director and Chief Economist
J.P. Morgan & Co., Incorporated

William C. Dudley
Managing Director and Director of U.S. Economic Research
Goldman Sachs & Co.

John Rogers
President and CEO
INVESCO Global

Stephen Roach
Chief Economist and Director of Global Economic Analysis
Morgan Stanley Dean Witter

12:00-1:30 p.m. **Keynote Luncheon Speaker**
The Honorable Robert E. Rubin (invited)
Secretary of the Treasury

1:45-3:00 p.m. **Administering Universal Personal Accounts**

1:45 to 2:00 p.m. **Speaker:**
The Honorable Judd Gregg (R/NH) (invited)

** Senator Gregg will share his views on the feasibility of establishing individual accounts.*

2:00 to 3:00 p.m. **Panelists:**
**The panelists will offer their experience and best practices in the delivery of a defined contribution program.*

Bill Quinn, Moderator
President
AMR Investment Services, Inc.

Sharon Kinsman
Vice President, Pension Investments
Warner-Lambert Company

Don Butt
Vice President
USWEST Investment Management Co.

Jim Bayne
Manager, Benefits Finance & Investment
Exxon Corporation

3:00-3:15 p.m. **Wrap-up and Concluding Remarks**
Allen Reed and Dallas Salisbury

ERISA at 25: APPLYING THE EXPERIENCE TO SOCIAL SECURITY REFORM

REGISTRATION FORM

LOCATION: Westin Fairfax
2100 Massachusetts Avenue, NW
Washington, DC 20008

DATE: June 25, 1999

TIME: 9:00am – 3:15pm

RETURN THIS PORTION BY JUNE 2, 1999 TO:

CIEBA
C/O Financial Executives Institute
1615 L Street NW, Suite 1320
Washington, DC 20036
Fax: 202-857-0230
E-mail: sthomas@feidc.org

☐ Will attend the June 25th policy forum only

☐ Will attend the policy forum/luncheon

☐ Will not attend the June 25th policy forum

Name: _____

Title: _____

Organization: _____

Address: _____

City, State, Zip Code: _____

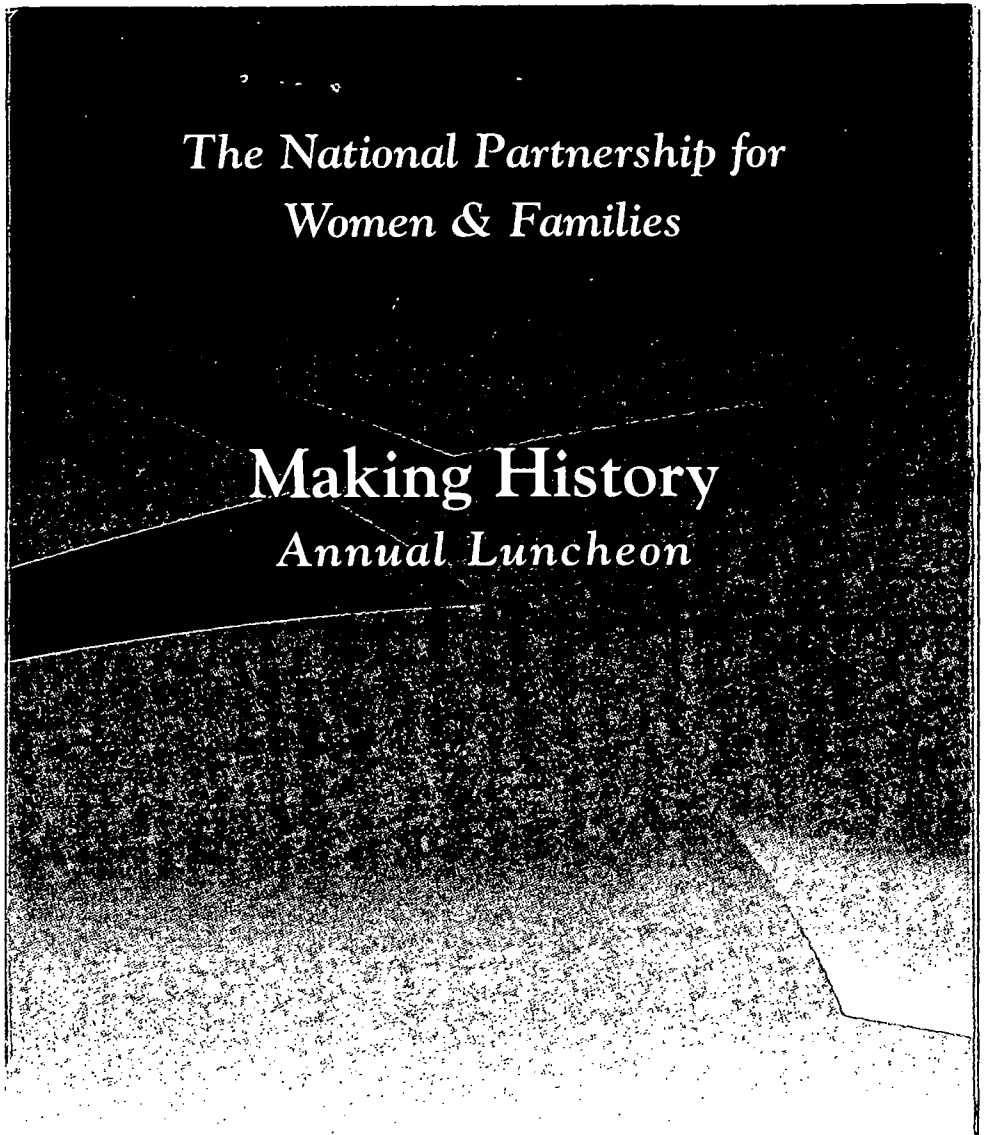
Phone: _____ Fax _____

E-mail: _____

The National Partnership for Women & Families

Making History

Annual Luncheon



Thursday, June 10, 1999

Making History

The National Partnership for Women & Families

A voice for fairness
A source for solutions
A force for change

Just a year ago, the Women's Legal Defense Fund launched a revitalized organization, the National Partnership for Women & Families. Since then, we have broken new ground on health care and work/family issues – two of the issues that matter most to Americans today. During the past year, we led an extraordinary coalition that is promoting real patient protections. And, while a few years ago we were the driving force behind enactment of the Family & Medical Leave Act, today we are creating a new national movement that will make family leave affordable for more working families.

For nearly 30 years, the National Partnership has been making life better for women and families. Making history. Making progress. Making change.

As we approach the new millennium, we celebrate women's remarkable advances in this century and our role in those victories. The National Partnership's 1999 honoree is uniquely qualified to help us do that. One of the nation's pre-eminent historians, Doris Kearns Goodwin is a commentator, an analyst, a Pulitzer Prize winning author, and a role model for women and girls throughout the world. Her insightful commentary and keen observations help put into perspective women's changing role in society, and the history that is being made every day.

National Partnership for Women & Families

Luncheon Chair
ROBERT A. ESSNER
Executive Vice President, American Home Products

Chair Emeritus John F. Smith
Chairman, CEO & President, General Motors Corporation

invite you to join us for

MAKING HISTORY

our Annual Luncheon
honoring

DORIS KEARNS GOODWIN
noted historian, author and commentator

Thursday, June 10, 1999, 11:30 am
The Washington Hilton Hotel
1919 Connecticut Avenue, NW
Washington, DC

◆◆◆◆

$150 per person

Annual Luncheon

Annual Luncheon Committee

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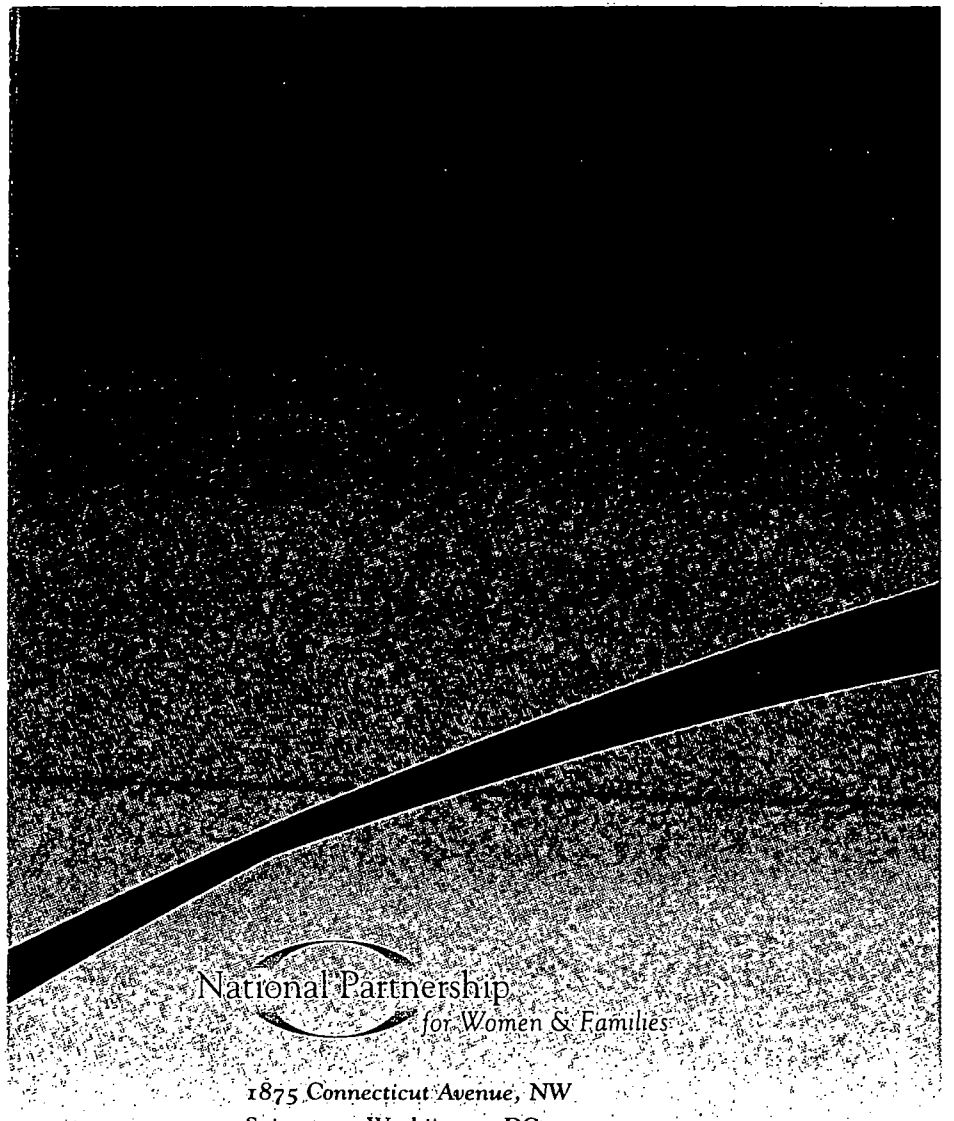

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Please indicate the number of Luncheon tickets you will be using _____.

- ❑ ***Enclosed is my check.*** Please make your check payable to the National Partnership and return it with this card to: 1875 Connecticut Avenue, NW, Suite 710, Washington, DC 20009.
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For additional information call 202.986.2600

Please respond as soon as possible. Space is limited.

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- ❑ ***Please reserve _____ Luncheon ticket(s) at $150 each.***

I want to be listed in the program as a special contributor:

- ❑ ***Sponsor*** — $350 *(2 Luncheon tickets and a listing in Luncheon program)*
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- ❑ ***Host*** — $1,500 *(Table of 8, 2 VIP Reception* passes and a listing in Luncheon program)*
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**The VIP Reception, preceding the Luncheon, begins at 11:00 am at the Washington Hilton Hotel.*

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APHSA
American Public Human Services Association

Marva Livingston Hammons, *President*

William Waldman, *Executive Director*

Regrets. Sundays are practically impossible for me. CJ

May 18, 1999

Christopher Jennings
Deputy Assistant to the President for Health Policy Development
Domestic Policy Council, Office of Policy Development
216 OEOB
Executive Office of the President
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Mr. Jennings:

The American Public Human Services Association (APHSA), a non-profit, bi-partisan association representing the public human service agencies in the 50 states, is holding its summer meeting on "Aging America: Implications for Public Human Services" in Washington, DC from July 18-20. The three-day conference will focus on the implications of an increasing elderly American population for human services programs and policy.

APHSA would like to invite you join us as a plenary speaker during our opening session on Sunday, July 18, which will be held from 1:00 p.m. - 4:00 p.m. We would like you to give a 20-30 minute presentation from 2:30 p.m. - 3:30 p.m. for our discussion on "Medicare Reform: If not now, when?" Specifically, we would like to hear your thoughts on the current Medicare reform debate and what the future might hold for these policy discussions. We are expecting between 400 and 500 participants from the federal, state, and local government and national advocacy organizations.

The conference will begin on Sunday with an overview of demographic changes in our population, and the resulting affects this will have on the federal budget and major entitlement programs such as Medicare and Medicaid. Monday's theme will center around "Human Services Today and Tomorrow," through discussions on current and future challenges for recipients of all ages, the human services field, and national policy and legislation that stem from an aging population. The final session on Tuesday will

explore intergenerational issues such as kinship care, grandparent child support, and intergenerational child care.

I have included a brochure about our organization for your information. Thank you for your consideration. We are very excited about this policy conference and hope you will be willing to share your expertise with us. Please call at your earliest convenience (202-682-0100) to let us know if you will be able to join us. If you have any questions, please contact Anna Lovejoy, Policy Analyst in the Government Affairs Department at the number above, x260.

Sincerely,

William Waldman
Executive Director

Enclosure

WW/er/al

Wall Street Comes to Washington:

Analysts' Perspectives on the Changing Health Care System

Wednesday, June 9, 1999
9:00 A.M.-12 Noon
Continental Breakfast at 8:30 A.M.

Grand Hyatt Hotel at Metro Center
Constitution B

Roundtable Participants

Karen M. Boezi
Venture Partner
Coral Ventures

Norman M. Fidel
Senior Vice President
Alliance Capital Management, LP

Geoffrey E. Harris
Global Head of Corporate Finance
Health Care Division
Warburg Dillon & Read

Patricia F. Widner
Managing Director
Warburg Pincus Asset Management

Moderators

Paul B. Ginsburg
President
Center for Studying Health System Change

Joy M. Grossman
Health Researcher
Center for Studying Health System Change

At this fourth annual roundtable hosted by the Center for Studying Health System Change (HSC), Wall Street analysts will offer their perspectives on current trends in health care, including how long they expect premiums to continue rising, the benefits and risks that accrue from the continued consolidation of plans and hospitals, how markets, regulators and doctors themselves have responded to the recent high-profile physician practice management company (PPMC) failures and, finally, the impact of the Balanced Budget Act (BBA) on providers, plans and Medicare beneficiaries.

Roundtable participants are drawn from different backgrounds—they include analysts who advise health care investors and portfolio managers who invest in health care companies—and have complementary expertise. Each of the participants will offer varying perspectives about how business, medicine and policy interact and will speculate on what the future might hold for the nation's health care system. There will be adequate time for audience questions.

Topics to Be Covered Include:

- How long and to what extent will premiums rise, and how will purchasers respond? To what extent have pharmaceutical cost increases been brought under control? Will proposed patient protection legislation provoke a surge in costs and, consequently, in premiums?

In this section, analysts will also discuss whether we can expect a return to double-digit premium increases in the 21st century, and why or why not.

- What have been the benefits and lessons learned to date from recent plan consolidations? Will these mergers enable plans to gain leverage in particular markets, and what might the impact be on providers, employers and consumers?

Analysts will also contrast the plan consolidation experience with that of hospitals. Is there any empirical evidence that hospitals are gaining ground vis-a-vis plans?

- What has been the immediate fallout from the PPMC failures? How have physicians associated with PPMCs fared? How are the remaining PPMCs and others, such as hospital-owned physician organizations, revamping their strategies? How will physicians organize themselves, and where will they go for new sources of capital to finance their growth?

In this section, analysts will also discuss how regulators are responding to PPMC and plan bankruptcies, and how these responses influence market dynamics.

- What is and will be the impact of the BBA on provider payments, and what are the implications for hospitals and other acute care providers? What has been the effect of this legislation on Medicare risk plans?

Analysts will also discuss how the BBA has affected plan entries and exits, changes in benefits and beneficiary premiums and plan profits. The effect of all of these changes on consumers will be considered.

What You Can Expect from This Conference:

Hear the views of analysts who track the fortunes of varying health care companies and investors who have direct influence over the strategic direction of these organizations.

Learn how Wall Street perceives recent legislation and regulation, and what effect analysts think these actions have on market behavior and costs.

Ask questions about current trends and new developments to better understand how the health care system is evolving, and what these changes mean for the industry, purchasers and consumers.

About HSC

The Center for Studying Health System Change—a research organization funded exclusively by The Robert Wood Johnson Foundation—provides objective, timely analyses about changes in the nation's health care system and their impact on consumers and private and public decision makers. HSC, based in Washington, D.C., is affiliated with Mathematica Policy Research, Inc.

Regis[illegible]on Form

Please respond by completing a registration form on HSC's web site—www.hschange.com— **by June 3, 1999.**

WALL STREET CONFERENCE
WEDNESDAY, JUNE 9, 1999
9:00 A.M.-12 NOON
SESSION REGISTRATION AND CONTINENTAL BREAKFAST 8:30 A.M.
GRAND HYATT HOTEL at METRO CENTER
CONSTITUTION B

If you do not have Internet access, please complete and fax the registration form below to: (202) 484-9258.

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❑ **Special Needs**

Space Limitations: Space is limited, and registrations will be accepted on a first-come, first-served basis. Please be sure to respond by completing a registration form on HSC's web site or by fax by Thursday, June 3, 1999.

Address and Directions to the Hotel: Grand Hyatt Hotel, 1000 H Street, NW, Washington, DC 20001. Tel: (202) 637-4776. The hotel is located at the Metro Center stop on the Red, Orange and Blue lines. Use the 11th Street exit when leaving Metro Center. You will see the underground entrance to the Grand Hyatt leading directly from the Metro.

Questions: For questions concerning conference logistics, please contact Roland Edwards, Conference Coordinator, at (202) 484-4514.

Mr. Chris Jennings
The White House
Old Executive Office Building
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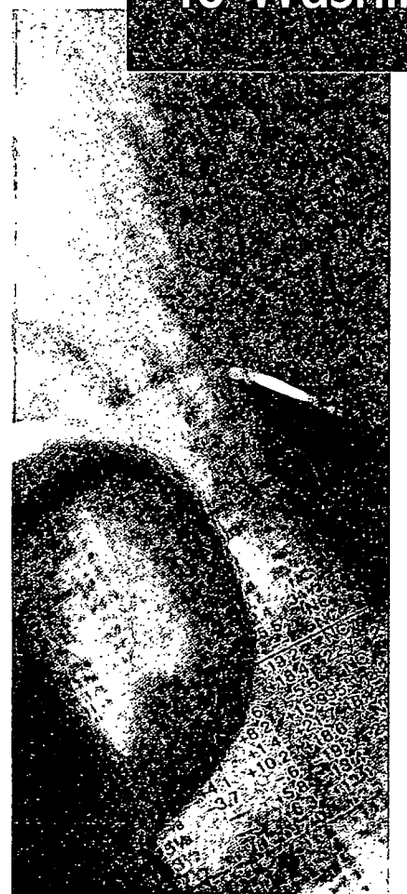

Analysts' Perspectives on the Changing Health Care System

Wednesday,
June 9, 1999
9:00 A.M.-12 Noon
Washington, D.C.

Wall Street Comes to Washington:

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Registration Form

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HSC's Fourth Annual

Wall Street Comes to Washington:

Analysts' Perspectives on the Changing Health Care System

Wednesday,
June 9, 1999
9:00 A.M.-12 Noon
Washington, D.C.

FOR IMMEDIATE RELEASE
MAY 19, 1999

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FOR MORE INFORMATION
Ann Greiner or Gina Rule (202) 484-5261
www.hschange.com

MEDIA ADVISORY

WALL STREET DIAGNOSES HEALTH CARE INDUSTRY WOES

Top Health Care Analysts Debate Industry's Well-Being
At Center for Studying Health System Change Roundtable

WHAT:	Policy roundtable, "Wall Street Comes To Washington: Analysts' Perspectives on the Changing Health Care System."
WHEN:	Wednesday, June 9; 9:00 a.m. to Noon, Continental Breakfast at 8:30 a.m.
WHERE:	Grand Hyatt Hotel at Metro Center (Constitution B), 1000 H Street, NW Washington, DC 20001.
WHO:	Health care industry analysts and Center for Studying Health System Change (HSC) researchers plus attendees from government, academia, and industry.

- The fourth annual Wall Street Comes to Washington conference will feature roundtable discussions with top health care industry analysts from some of the nation's most prestigious investment firms:
  - **Karen M. Boezi** of Coral Ventures
  - **Norman M. Fidel** of Alliance Capital Management, LP
  - **Geoffrey E. Harris** of Warburg Dillon & Read
  - **Patricia F. Widner** of Warburg, Pincus Counselors, Inc.
- Participants will focus on recent events affecting the U.S. health system including the continuing rise in premiums, plan consolidations, physician practice management company failures, and implementation of the Balanced Budget Act.
- **Paul Ginsburg, Ph.D.** and **Joy Grossman, Ph.D.**, both of the Center for Studying Health System Change, will moderate the discussions.
- For information or to register, visit HSC's web site at www.hschange.com or contact Gina Rule at (202) 484-3291.

Health System Change – an independent research organization funded exclusively by The Robert Wood Johnson Foundation – provides objective, timely analyses about changes in the nation's health care system and their impact on consumers to private and public decision makers. Health System Change, based in Washington, D.C., is affiliated with Mathematica Policy Research.

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The Diabetes Research Foundation

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Mr. Michael Woicekowski

District of Columbia
Miss Lucy Gibson

Florida
Mr. Josh Levy

Georgia
Mr. Charles Bennett, Jr.

Hawaii
Miss Natalie Benjamin

Idaho
Miss Emily Hawkins

Illinois
Mr. Adam Kerbis
Miss Jackie Wisz

Indiana
Mr. Zachary Henke

Iowa
Miss Tyler Karsten

Kansas
Miss Megan Connor

Kentucky
Miss Lauren Hensen

Louisiana
Mr. Ryan Wilson

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Miss Jamie Langbein
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Miss Rebecca Guiterman

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Mr. Sam Melton
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Mr. Tom Solo

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Minnesota
Miss Dana Heser

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Mr. Land Smathers

Missouri
Mr. Gregory Spartz

Montana
Miss Shelby Roberson

Nebraska
Miss Elizabeth Osterman

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Miss Jackie Singer
Miss Mollie Singer
Miss Anna Zucker

New Hampshire
Mr. Jordan Hoekstra

New Jersey
Mr. Anthony Eaton
Miss Lia LaRocca
Miss Haylee Lenkey

New Mexico
Miss Lydia Pollard

New York
Mr. Ben Goldberger
Miss Samantha Mandel
Miss Ashley Schreiner
Mr. Will Smith
Mr. Robbie Sorrell

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Miss Ruth Hendren

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Miss Lisa Zaring

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Oregon
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Mr. Stockton Morris

Rhode Island
Mr. Scott Fischer

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Miss Devin Jackson

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Miss Nancy Stockton

West Virginia
Mr. Jamie Mitchell

Wisconsin
Miss LaNisha Patterson
Mr. Kevin Swatek

Wyoming
Miss Anna Reid
Miss Katrina Rikard

CHILDREN'S CONGRESS DELEGATES FROM ALL 50 STATES WILL BE IN ATTENDANCE.

The President of the United States and Mrs. Clinton, *Honorary Patrons*

The Honorable Arlen Specter, *Honorary Co-Chair*
The Honorable Harry Reid, *Honorary Co-Chair*
The Honorable George R. Nethercutt, Jr., *Honorary Co-Chair*
The Honorable Diana DeGette, *Honorary Co-Chair*

Mary Tyler Moore, *JDF International Chairman*
The Silvestri Family, *Chair Family, JDF Children's Congress*
and The Juvenile Diabetes Foundation International

CORDIALLY INVITE YOU TO ATTEND

The JDF Children's Congress Hearing and Luncheon

TUESDAY, JUNE 22, 1999

Hearing
9:30 a.m.
Senate Room
Senate Office Building

Luncheon
12:00 noon
Cannon Caucus Room 345
Cannon House Office Building

RSVP 703.556.4245

THE JDF Children's Congress

"Promise to remember me..." Children with diabetes, advocates for a cure

The first Juvenile Diabetes Foundation Children's Congress is being held in Washington, DC from June 20, 1999 to June 22, 1999. Over 100 children with diabetes representing all 50 states are making a pilgrimage to Capitol Hill to bring their heartfelt plea for help to fund a cure for a disease they endure every day—diabetes.

The children are asking their lawmakers to "Promise to remember me..." as they vote for funds to find a cure for this debilitating disease which afflicts 16 million Americans; over one million of whom have juvenile, or Type 1, diabetes—the most severe form.

The child delegates, researchers, and celebrities will offer testimony at the hearing. A song specially composed for the occasion will be sung on the steps of the U. S. Capitol. The Honorable Strom Thurmond will be honored at the luncheon.

I am pleased to attend the JDF Children's Congress Hearing

Hearing 9:30 A.M. Senate Room, Senate Office Building

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I am pleased to attend the JDF Children's Congress Luncheon

Luncheon 12:00 NOON Cannon Caucus Room, Cannon House Office Building

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

IF YOU HAVE ANY QUESTIONS,
PLEASE CALL CRISTIE ADAMS AT 703.556.4245

Juvenile Diabetes Foundation International
The Diabetes Research Foundation

The JDF Children's Congress™
1320 Old Chain Bridge Road, Suite 330
McLean, VA 22101

COLUMBIA JOURNALISM REVIEW
a publication of the
Columbia University Graduate School of Journalism

The Public Interest Stake in the Digital News Era

Wednesday, May 26, 1999
5:30 to 7:30 p.m.

Library of Congress
Washington, DC

Underwritten by AT&T

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Joan Konner, Publisher
Marshall Loeb, Editor

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Is there a role for government and what is the responsibility of the industry in the digital news era?

Wednesday, May 26, 1999
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Keynote Speaker

Representative Edward J. Markey
(D-MA)
U.S. House of Representatives

Panelists

Robert W. Decherd
Chairman, President, & CEO
A. H. Belo Corporation

Lawrence K. Grossman
Columnist, *Columbia Journalism Review*
Former President, NBC News

Julia Johnson
Commissioner
Florida Public Service Commission

Newton N. Minow
Counsel, Sidley & Austin
Former Chairman, Federal Communications Commission

Representative W.J. "Billy" Tauzin
(R-LA)
U.S. House of Representatives

Moderator

JUDY WOODRUFF
Prime Anchor & Senior Correspondent
CNN

COLUMBIA JOURNALISM REVIEW

"The Public Interest Stake in the Digital News Era"

Wednesday, May 26, 1999 ◆ 5:30 to 7:30 p.m.

☐ I will attend ☐ I will NOT attend

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Title _____

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