P. Bechard

BRIEFING BOOK

FOR

THE TRIP OF THE PRESIDENT

TO

ALBUQUERQUE, NEW MEXICO

December 3, 1993

Staff Copy

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Friday, December 3, 1993

Albuquerque, New Mexico

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SCHEDULE OF THE PRESIDENT

FOR

FRIDAY, DECEMBER 3, 1993

FINAL

SCHEDULER:	**LEE SATTERFIELD**	
	HOME:	**202-588-0606**
	OFFICE:	**202-456-7560**
	WHCA PAGER:	**4382**

PRESS DESK:	**ANNE EDWARDS**	
	HOME:	**301-565-3101**
	OFFICE:	**202-456-7560**
	WHCA PAGER:	**4208**

PRINCIPAL EVENTS:

* **DLC Speech** - Washington, DC
* **Public Event** - Albuquerque, NM

WEATHER:

Washington, DC
Cloudy with rain; minimum temperature 36 to 41; maximum temperature 52 to 57; wind west at 5 to 10 knots

Albuquerque, NM
Partly cloudy; minimum temperature 20 to 25; maximum temperature 49 to 54; wind northwest at 5 to 10 knots

as of 12/02/93 7:26pm

Albuquerque Advance Team:

Team Member	Team Assignment	WHCA Pager	Cell #	SKYPAGE pin
Kirk Hanlin	lead		202-494-9805	895-3399
Tanya Sergey	site			
Amy Stewart	site			
David Neslen	press lead		202-494-9943	
Julie Staroba	press			
Ernie Gibble	press			
David Montoya	motorcade			

Albuquerque Contact Numbers:

Contact Number	Direct Dial	From White House *96+
Staff Advance Phone		35220
Staff Advance Fax	505-243-8427	
Staff Hotel Phone	505-842-1234	
Staff Hotel Fax		
Press Advance Phone		35224
Press Advance Fax	505-243-8608	
Signal Operator		35000
Meet Me Conference	202-757-2104	

SCHEDULE OF THE PRESIDENT
FOR
FRIDAY, DECEMBER 3, 1993
FINAL

NOTE:	**Staff travelling to Albuquerque, NM, with the President should assemble in the West Basement at 11:00 am for an 11:15 am departure via staff vans en route Andrews Air Force Base. Staff driving themselves should arrive at Andrews no later than 11:30 am.** **Baggage call is at 9:00 am in OEOB 89 1/2.**

tba — **JOG**

8:45 am-
9:45 am

PHONE CALLS
OVAL OFFICE
Staff Contact: Tony Lake

- Prime Minister Balladur of France
- President Mitterrand of France

NOTE: Usual morning briefings will be given to **the President** on paper.

9:50 am

THE PRESIDENT departs White House via motorcade en route Sheraton Washington Hotel
[drive time: 10 minutes]

10:00 am

THE PRESIDENT arrives Sheraton Washington Hotel

10:00 am-
11:00 am

DLC SPEECH
SHERATON WASHINGTON HOTEL
Remarks: David Kusnet
Staff Contact: Linda Moore
OPEN PRESS

10:10 am	Sen. Breaux makes brief remarks and introduces the **President**
10:15 am- 10:45 am	**The President** makes remarks
10:45 am	**The President** works ropeline on departure

11:10 am		**THE PRESIDENT** departs Sheraton Washington Hotel via motorcade en route White House [drive time: 10 minutes]
11:20 am		**THE PRESIDENT** arrives White House
11:20 am- 11:35 am		**MEETING** OVAL OFFICE Staff Contact: Carol Rasco
11:35 am- 11:45 am		**OFFICIAL PHOTOGRAPH** OVAL OFFICE Staff Contact: Howard Paster
11:50 am		**THE PRESIDENT** proceeds to South Lawn to work ropeline
12:05 pm		**THE PRESIDENT** departs White House via Marine 1 en route Andrews Air Force Base [flight time: 10 minutes]
12:15 pm		**THE PRESIDENT** arrives Andrews Air Force Base
12:25 pm	EST	**THE PRESIDENT** departs Andrews Air Force Base via Air Force 1 en route Albuquerque International Airport, Albuquerque, NM [flight time: 3 hours, 50 minutes]
2:15 pm	MST	**THE PRESIDENT** arrives Albuquerque International Airport, Hangar H, Albuquerque, NM
2:30 pm		**THE PRESIDENT** departs Albuquerque International Airport, Hangar H, via motorcade en route El Pueblo Health Services, Inc. [drive time: 30 minutes]
3:00 pm		**THE PRESIDENT** arrives El Pueblo Health Services, Inc.
3:00 pm- 4:30 pm		**RURAL HEALTH CARE EVENT** EL PUEBLO HEALTH SERVICES, INC. Bernalillo, NM Remarks: Carolyn Curiel Staff Contact: Julia Moffett **OPEN PRESS**

3:00 pm- 3:30 pm	Tour of clinic EL PUEBLO HEALTH SERVICES, INC.
3:30 pm	**The President** proceeds outside to tent area

	3:45 pm- 4:30 pm	Program TENT

-- Dr. Allan Firestone introduces **the President**

-- **The President** makes brief opening remarks and participates in group discussion with participants and families

-- **The President** ends discussion

-- Dr. Firestone closes program

-- **The President** shakes hands and departs

4:30 pm- 5:00 pm	**REGIONAL PRESS INTERVIEWS** OUTSIDE TENT AREA El Pueblo Health Services, Inc. Bernalillo, NM Staff Contact: Jeff Eller -- Denver press -- Phoenix press
5:15 pm	**THE PRESIDENT** departs El Pueblo Health Services, Inc., via motorcade en route Albuquerque Convention Center East [drive time: 30 minutes]
5:45 pm	**THE PRESIDENT** arrives Albuquerque Convention Center East and proceeds to hold
5:45 pm 6:15 pm	**HOLD** SUITE H Albuquerque Convention Center East
6:15 pm- 7:00 pm	**RECEPTION** PECOS ROOM Albuquerque Convention Center East Remarks: Carter Wilkie Staff Contact: Linda Moore **OPEN PRESS** during **the President**'s remarks 6:15 pm — Off-stage introduction of Rep. and Mrs. Bill Richardson, Sen. and Mrs. Jeff Bingaman, Gov. and Mrs. Bruce King, and **the President**

		6:20 pm	Rep. Richardson makes welcoming remarks and introduces Sen. Jeff Bingaman
		6:23 pm	Sen. Bingaman makes brief remarks and introduces Gov. King
		6:26 pm	Gov. King makes brief remarks and introduces **the President**
		6:29 pm	**The President** makes remarks
		6:45 pm	**The President** works ropeline and departs

7:00 pm — **THE PRESIDENT** departs Albuquerque Convention Center East via motorcade en route Albuquerque Convention Center West
[drive time: 5 minutes]

7:05 pm — **THE PRESIDENT** arrives Albuquerque Convention Center West

7:15 pm-
8:15 pm — **DINNER**
TAOS ROOM
Albuquerque Convention Center West
Staff Contact: Linda Moore
POOL SPRAY

NOTE: Meet and greet only; no remarks.

8:30 pm — **THE PRESIDENT** departs Albuquerque Convention Center West via motorcade en route Albuquerque International Airport, Hangar H
[drive time: 15 minutes]

8:45 pm — **THE PRESIDENT** arrives Albuquerque International Airport, Hangar H, Albuquerque, NM

9:00 pm MST — **THE PRESIDENT** departs Albuquerque International Airport, Hangar H, Albuquerque, NM, via Air Force 1 en route Los Angeles International Airport, Los Angeles, CA
[flight time: 1 hour, 45 minutes]

9:45 pm PST — **THE PRESIDENT** arrives Los Angeles International Airport, Remote Pad, Los Angeles, CA

10:00 pm — **THE PRESIDENT** departs Los Angeles International Airport, Remote Pad, via motorcade en route Beverly Hilton Hotel
[drive time: 25 minutes]

10:25 pm	**THE PRESIDENT** arrives Beverly Hilton Hotel
BC AND STAFF RON	**BEVERLY HILTON HOTEL** **9876 WILSHIRE BOULEVARD** **LOS ANGELES, CA**

THE WHITE HOUSE

WASHINGTON

December 2, 1993

VISIT TO THE EL PUEBLO HEALTH SERVICES CLINIC TO DISCUSS RURAL HEALTH CARE ISSUES

DATE: **December 3, 1993**
LOCATION: **El Pueblo Health Services Clinic, Bernalillo, NM**
TIME: **3:00 pm MST**
FROM: **Julia Moffett**

I. PURPOSE

This event gives you the opportunity to tour a rural health care facility, to hear from a doctor on the front lines of rural health care, to have a discussion with both patients and providers regarding their problems and concerns and to further educate them about how the Health Security Act of 1993 addresses rural health care problems.

The patients and providers who have come togther for this event are, for the most part, not experts in rural health care. They come to this discussion with their own problems and circumstances--security, access, shortage of doctors and facilities, inability to get specialty treatment--which are representative of many of the typical health care problems experienced in rural areas. The doctors and other rural health care administrators in the audience bring many more personal stories with them in addition to a more macro-understanding of the problems these areas are facing.

II. BACKGROUND

Message

This event is essentially a regional event due to its time and subject matter. However, no regional health care event which will resonate more than one which focuses on rural health care issues. The Health Security Act of 1993 does a lot to address the needs of rural communities: By providing universal coverage, the plan creates affordable insurance even if you farm, own a small business or work in a small business; the plan encourages more doctors and nurses to serve rural America; the plan guarantees access to the services rural Americans need with funding for additional transportation services as an example; the single-claim form will dramatically reduce red tape, both for doctors and consumers; choice will be improved; and networks of rural doctors and leading medical centers will improve the quality of rural medical care.

The El Pueblo Health Services Clinic, Bernalillo and the state of rural health care services

The El Pueblo Health Services Clinic has been in operation for 17 years. The staff includes Dr. Alan Firestone and Dr. Carmen Rodriguez, 1 full-time medical assistant, 1 office manager, 1 full-time billing clerk, and 1 full-time insurance billing person. This staff has grown from 1 front desk receptionist when the clinic opened. Additionally, the administrative space at the clinic has grown by 500%. The clinic sees 35-45 patients per day. Approximately 15-20% of the patients are Medicaid recipients, 30-35% are uninsured. Atypical for rural areas, this clinic serves a small Native American and Migrant population.

Bernalillo is in Sandoval County, one of 30 of the 33 New Mexico counties considered underserved by federal standards. Although it is a low to middle-income, rural area, agriculture is not as predominant as it is in many other counties. It is, however, plagued with many of the problems indicative to New Mexico as a whole: more than 25% of the New Mexico population is uninsured, more than one-third of the uninsured are children, nearly 40% of them are under 100% of the federal poverty level, one-third of them are employees of businesses with under 25 employees, and nearly two-thirds are not working. New Mexico ranks 47th in the country for lack of access to primary care--21% of the New Mexico population does not have access to primary care.

Dr. Alan Firestone

Born in Youngstown, Ohio, Dr. Firestone came to Bernalillo as a National Health Service Corps member after earning his medical degree from UCLA. After spending 11 years in the Corps, the federal government attempted to reduce the size of the Corps and Dr. Firestone was told to shut down his clinic. Instead, Dr. Firestone chose to leave the Corps but to keep the El Pueblo Health Services Clinic open.

III. PARTICIPANTS

Tour
The President
Dr. Alan Firestone, Director, El Pueblo Health Services Clinic

Discussion
There are twelve people whom you will have the primary discussion with. In addition to Dr. Firestone, they are patients from the area as well as other rural health care providers. Their biographies are attached.

The larger audience of 50 people is comprised of additional patients and providers ranging from Bernalillo to Albuquerque to other surrounding rural towns and counties. You may wish to include these people if you choose to expand the discussion as they are all involved with rural health care in some fashion. A list of these people is attached.

VIPs
The VIPS attending the event will be seated in a special section of the audience and are not

expecting to participate in the primary conversation. You may choose to ask them to say a few words if you open the discussion up to the larger group. They are:

Mayor Ernie Aguilar and Mrs. Mary Kay Aguilar
Senator Jeff Bingaman and Mrs. Anne Bingaman
Senator Pete Domenici
Governor Bruce King and Mrs. Alice King
Congressman Bill Richardson and Mrs. Barbara Richardson
Congressman Steven Schiff
Congressman Joe Skeen

*Chris and Donna Key and Jimmy Kidd have been invited.

IV. PRESS PLAN

The press will be prepositioned during the clinic tour both inside and outside. The discussion outside is open press. Several local television stations may go live during the outside discussion.

V. SEQUENCE OF EVENTS

* You will arrive at the El Pueblo Health Services Clinic and will be met by Dr. Alan Firestone.

* You and Dr. Firestone will proceed into the clinic for a brief tour of the facility. (The elected officials traveling with you will proceed directly to the tent.)

* You will first walk through the waiting room to greet patients on your way to Examination Room #1.

* In Examination Room #1, you will meet Dr. Carmen Rodriguez and the patient she is examining.

* You will then proceed to the Children's Examination Room as well as Examination Room #2. You may have an opportunity to greet patients in both areas.

* You then proceed to Dr. Firestone's office to hold while the press positions for the discussion outside.

* Once the press is positioned, you and Dr. Firestone proceed to the tent area. You will be greeted by Mayor Ernie Aguilar and his wife, Mary Kay.

* Once in the tent, you may greet the 12 participants in the discussion.

* Dr. Firestone will then introduce you.

* You will then make brief opening remarks.

* Dr. Firestone will then briefly introduce each of the twelve participants and they will tell you a little about their history and experiences with rural health care.

* You may follow up with the participants with individual questions or further information about the plan.

* You may also choose to open the discussion up to the wider audience or to initiate a Q & A period.

* When the conversation is through, you should make brief closing remarks.

* Dr. Firestone will then thank everyone for joining you today.

* You may meet and greet with the audience upon departure.

VI. REMARKS

Cards are enclosed which include brief opening and closing remarks as well as an outline to use when leading the discussion on rural health care and how the Health Security Act of 1993 addresses rural health care issues.

PROFILES OF DISCUSSION PARTICIPANTS

Harriett Pacheco Brandstetter

Ms. Brandstetter is the Executive Director of La Clinica de Familia, a privately and federally funded community/migrant health center. She has 27 years of community health experience. Her clinic is part of a 17 year old clinic system which includes four medical clinics and one dental clinic. Her patients primarily consist of the underserved populations of New Mexicans and Central American border residents. Her clinics are operating at full capacity with long, active waiting lists.

Christina Campos

Ms. Campos is a trained community encourager for Guadalupe County. Her role is to activate the community to design a healthcare system which is affordable and acceptable to the citizens of this county. The community is a single-provider town of 2,100 residents. There are other part-time providers in the County of 4,200 citizens, but not enough to meet the healthcare needs of the County. Ms. Campos also serves as the financial officer of a small hospital in Santa Rosa, and is able to articulate the problems of this ranching community from many different perspectives.

Blanche Ekdahl

Ms. Ekdahl is 86 years old and lives in a trailer park in Abiquiu. She has severe arthritis and walks with a cane. Her doctor has told her she must have surgery to replace her knee and he has scheduled it to occur in the next few months. Since Abiquiu is a tiny, remote village far from nursing care, Ms. Ekdahl will be forced to move to either Los Alamos or Sante Fe where she will have access to consistent care.

Dr. Alan Mark Firestone

Born in Youngstown, Ohio, Dr. Firestone came to Bernalillo as a National Health Service Corps member after receiving his medical degree from UCLA. After spending 11 years in the Corps, measures were taken to decrease the Corps numbers and he was told to close down his clinic. Instead, Dr. Firestone chose to leave the Corps but to keep the El Pueblo Health Services Clinic open. It is currently in its 17th year of operation.

Celestin "Cel" Gachupin

Cel Gachupin, the former Governor of the Zia Pueblo (40 miles north of Albuquerque), had a son, Robert, who came down with asthma at age 2, and Cel became asthmatic at the same time. Robert was in and out of the hospital and shifted back and forth to specialists many times. Robert's life nearly ended at the Zia Pueblo ranch several times. He would stop breathing and Cel would have to pound him on the back to start breathing again, then drive to where they could call an ambulance. Ond day, when Robert was 8, Cel took him fishing and Robert said it was the best day of his life. That night, Robert woke up in the middle of the night, as he often did, and called for his mother to bring him a nebulizer. As his mother and father were holding him in their arms, he went limp. They had to call an ambulance from Placitas, about 30 miles away, which proved to be too long a wait before Robert died.

Karen Lewis

Ms. Lewis is a patient of the El Pueblo Health Services Clinic. Though currently uninsured, she was insured until her premiums doubled following surgery six years ago. She, like so many rural residents, has to drive a long distance for care. Additionally, her grown children face many health care problems, with her son and daughter-in-law most recently being told to quit one of their jobs in order for the couple to qualify for children's health care assistance for their young child.

Forrest William Mason

Mr. Mason has had diabetes for 40 years and has high-blood pressure. He was born in Estancia 75 years ago. He is a success story in that his care is currently very good (his doctor, Linda Stogner is in the audience) but, without it, his situation would be disastrous. He lives 54 miles from Albuquerque. In the past, Mr. Mason has had a gall-bladder attack and had to travel to Albuquerque for treatment.

Lynn Mathes

Ms. Mathes is a patient at the El Pueblo Health Services Clinic. She is an uninsured, single mother with three grown children. Her employment history has consisted of many short-lived rural jobs which typically have no infrastructure, no insurance and no security. Following an accident at the stable where she was working, Ms. Mathes has incurred tremendous bills which remain unpaid and has been unable to hold a permanent job. She currently finds herself bartering jewelry for the therapy care her injury requires. Due to her limited budget, she can only afford to pay each of her doctors $5 per month.

Neddy Ogaldez

Mr. Ogaldez is a patient at the El Pueblo Health Services Clinic. He has been uninsured, but has recently obtained a job at a paint and body shop which may offer insurance at some point. Previously, he has been out of work with an infection he contracted from working with cattle. He has two children and piles of unpaid medical bills.

Miranda Sapien

Mrs. and Mr. Sapien live 2 miles west of the doctor. Her mother was living with them for 12 years. She had Parkinsons disease and was totally blind. The closest home care that they knew about was in Albuquerque. In order to get someone to their home, they would have to pay their transportation plus $7 an hour--which has taken a toll on their limited budget. Once their mother became bed-ridden, Dr. Firestone would make housecalls, but when he could not or when they felt as if they were burdening him by calling, their mother went without care.

Angela Sosa

Ms. Sosa will talk about the story of her mother who died of a brain tumor at 62 years old. At 62, she was ineligible for Medicare. Ms. Sosa mother's case was one of many in which people have little documentable income from their various rural jobs and, therefore, do not qualify for Medicaid. Ms. Sosa belives her mother's condition could have been exacerbated by her lack of access to doctors and her mother's difficulty in understanding the complexity of the system.

Jack Vick, M.D.

Dr. Vick is a resident physician at the Department of Family and Community Medicine at the University of New Mexico University Hospital. He intends to pursue a rural health care practice upon completion of his residency. In the past, he served as the sole provider for a small rural hospital and clinic when the only physician abondoned the center.

AUDIENCE MEMBERS

(This list includes audience members with direct relationships to rural health care issues only)

Francisco Crespin, Jr., M.D., New Mexico Department of Health District Health Officer
John Ekdahl, son of patient in discussion
Genevieve Gachupin, wife of person in discussion
Pamela Galbraith, Administrator, Medical Services, University Hospital, UNM
George Stephen Goldstein, Director, New Mexico Health Care Initiative
Petal Gordon, patient
Joaquin and Lala Gurule, patients
Kay Elene Handleigh, nurse who witnesses lack of quality rural health care services
Ben and Les Harrison-Inglis, patients
Arthur Kaufman, M.D., Chairman, Department of Family and Community Medicine, UNM
James Kolb, Administrator, Catron County Medical Clinic
Patricia Lavine and Dale Patrick Lavine (son), patients, University Hospital, UNM
Murray Lewis, husband of patient in discussion
Wanda Lizar, mother of patient in discussion
Nora and Brian Lucero, patients
Eugenio Lujan, County Extension Agent, Guadalupe County, organized county to provide care
Alice Luna, patient
Bill Sapien, husband of patient in discussion
Charles Stearns, patient
Jessica Sosa Stewart, sister of patient in discussion
Linda Stogner, M.D., Director of Hope Medical Center; former National Health Service Corps
Priscilla Taylor, patient
Vincentita and Miquel Toledo, patients
Chris Urbina, M.D., Department of Family and Community Medicine, UNM

OUTLINE FOR DISCUSSION

Acknowledgments:

Before we begin, I would like to acknowledge some people who are here. First, Mayor Aguilar and his wife, Mary Kay, were nice enough to be with us today. I am also delighted to recognize Governor King and his wife, Alice, Senator Bingaman and his wife, Anne, Senator Domenici, Congressman Bill Richardson and his wife, Barbara, and Congressmen Schiff and Skeen.

Introduction:

- I'm happy to be here today to talk with you about the challenges rural areas face in trying to access high quality, affordable health care. Having been born and raised in a rural state, I've experienced first hand the problems of communities with too few doctors, and no hospital for miles.

- I've visited communities filled with self-employed farmers who struggle to scrape together enough to buy health insurance in a market stacked against the little guy.

- And I've talked to doctors and nurses (like yourselves) who feel that making a commitment to rural practice is an impossible proposition -- lower reimbursement, little or no peer support, and a high number of patients with no insurance and no ability to pay doctor's bills.

The promise of health care security for all Americans must mean access to high quality care for all America-- our cities and suburbs, but also our rural towns and farm communities.

Rural Communities and Universal Coverage

The biggest problem rural areas face is insecurity-- there are too many people with out coverage. And too many that are with coverage find that insurance means little because there are no doctors or hospitals available.

- Twenty-one million rural residents are without access to consistent primary care providers, and new, younger physicians setting up rural practices have not kept pace with those who retire-- leaving many communities with no doctor at all. Rural communities worry that the current shortage of physicians will continue, and limit their access to care even further.

- Americans living in rural areas also have a harder time getting to the services they need. More than half of the rural poor do not own a car, and nearly 60 percent of the older Americans in rural areas have no driver's license.

The Health Security Act:

- The Health Security Act guarantees you comprehensive health benefits, no matter you live. Since rural areas have more than their share of uninsured, underinsured and Medicaid recipients, providing universal coverage will channel new resources into rural health care systems.

- 14 million Americans in rural areas will receive improved health care services, since the Health Security plan targets rural areas in which more than half of all residents earning low incomes.

- As we phase-in health reform, current grants will continue to pay for clinical services for the uninsured, as well as to supplement services for low-income individuals.

- After universal coverage is achieved, money that in the past was used for health services to the uninsured will be redirected and combined with new grants to pay for support services that improve access to care. These services include outreach, follow-up, home visits, transportation, and child care during office visits.

Rural Health Care and Access to Providers

I also know the promise of security presents different challenges in rural areas-- a health security card means little to the person with no doctor that can see him, no hospital for a hundred miles. Right now, two-thirds of rural counties do not have enough doctors.

Rural doctors provide more charity care than any doctors in the country, and when doctors and hospitals do get paid, they often get paid late. In the most extreme cases, rural doctors are so strapped, there is one doctor trying to fulfill the needs of 2,000 people.

The Health Security Act:

- We have new ways to increase doctors and nurses in rural areas: tax incentives, increased reimbursement, retraining, scholarships, and loan forgiveness programs.

- The Health Security Act expands the National Health Service Corps, placing more than 3,000 primary care providers in rural areas by the year

2004.

- Under the Health Security Act, technical and financial assistance will be provided to help rural communities establish links with larger referral centers and academic health centers.

- The Health Security plan includes grants to support the development of telecommunications links between rural providers and other providers, health care centers, and institutions. This will help facilitate "group practices without walls," allowing easier consultation and coordination among rural providers and with urban providers.

- Rural health care centers will receive special protection. These "essential providers" will be offered contracts with plans, or receive reimbursement on a fee-for-service basis to ensure access to care and continuity of care for rural residents.

The Health Security Plan

RURAL COMMUNITIES

America's rural communities pose special challenges in health care-- both for those who need services and those who provide them. A total of 34 million people--half of them with incomes under 200 percent of poverty--live in rural areas with inadequate health care.

The fragile economies of rural areas often mean that many residents have little or no insurance, making it difficult for rural communities to attract and keep doctors and maintain local hospitals. Twenty-one million rural residents are without consistent access to primary care providers, and the population of younger rural physicians has not expanded to replace those who retire. Rural communities worry that the current shortage of physicians will continue, and limit their access to care even further.

Americans living in rural areas also have a harder time getting to the services they need. More than half of the rural poor do not own a car, and nearly 60 percent of the rural elderly are not licensed to drive.

The Health Security plan will create a system that meets the unique needs of rural communities. The plan will develop strategies for delivering and financing health care in rural areas, making care more easily available, and attracting doctors and nurses to and keeping them in rural areas.

Guarantees Universal Coverage

- The Health Security plan will guarantee comprehensive health benefits for all Americans, no matter who they are or where they live. Since rural areas have a disproportionate number of uninsured, underinsured and Medicaid recipients, providing universal coverage will help channel significant new resources into rural health care systems.

- The plan will encourage cooperative relationships among rural and urban providers such as developing information sharing capabilities and referral mechanisms to link academic health centers and rural health providers.

- Under the plan, regional alliances may provide incentives to urban health plans to serve rural areas in their region. They may also be required to serve underserved rural areas as a condition of participation.

Increases Access to Providers

- The Health Security plan will develop an infrastructure and provide support for primary care capacity to help serve rural citizens and providers. An additional 14 million Americans will receive improved health care services as the Health Security plan targets rural areas in which more than half of all residents earn incomes 200 percent or less of the poverty level.

- New workforce initiatives, including tax incentives, increased reimbursement, retraining, scholarships, and loan forgiveness programs, will encourage health care providers to practice in rural underserved areas.

- The Health Security plan will expand the National Health Service Corps, placing at least 3,000 primary care practitioners in rural areas by the year 2000.

Encourages Health Networks

- Under the Health Security plan, technical and financial assistance will be provided to develop networks. This will help the rural communities that need outside expertise to establish links with larger referral centers and academic health centers.

- The Health Security plan includes grants to support the development of telecommunications links between underserved providers and other providers, health care centers, and institutions. This will help facilitate "group practices without walls," allowing easier consultation and coordination among rural providers and with urban providers.

- New grants will be provided to academic health centers to help build information and referral infrastructure needed to support rural health networks.

- Investment in currently successful programs, such as community and migrant health centers, will be increased to help them establish and enhance contacts with other providers.

Assures Participation of Essential Community Providers

- For the first five years after implementation, the Health Security plan will designate as "essential providers" qualified practitioners and facilities in underserved areas.

- These providers will either be offered contracts with plans, or receive reimbursement on a fee-for-service basis to ensure access to care and continuity of care for rural and other vulnerable populations.

- Federal grants and loans will help essential providers establish links with local practitioners, community hospitals, and academic centers, and form integrated practice networks or community-based plans.

Coordination of Programs

- During the phase-in of health reform, current block grants will continue to pay for clinical services for the uninsured as well as supplemental services for all low-income individuals.

- After universal coverage is achieved, funds which had been used to provide health services to the uninsured will be redirected and combined with new grants to pay for support services to ensure access to care. These services include outreach, follow-up, home visits, transportation, and child care during office visits.

December 2, 1993

NEW MEXICO RURAL HEALTH CARE REFORM ISSUES

Although we have limited our discussion to rural issues, we would expect the President to receive questions about the basic benefit package and other general issues related to guaranteeing universal coverage.

1. In our area, non-profit clinics like this are the linchpin of the community's health care system and serve those whom no one else will serve. How can we be assured that clinics like this will be included in the plans?

The Health Security Act provides a 5-year protection to certain types of providers that are essential for ensuring access to health care in underserved rural areas. This provision requires health plans to contract with and pay essential providers for the services they provide under the benefit package. Some specific providers are included as automatically designated essential community providers:

- CHCs and MHCs
- Rural Health Clinics
- Federally-Qualified Health Centers
- Indian Health System facilities (including tribal units and 638 contractors)
- Other federal grantees serving special populations, such as MCH, family planning, Ryan White, and school-based providers.

In addition, independent health professionals and facilities (such as public hospitals, sole community hospitals, and local health departments) may apply to the Secretary for designation as an essential community provider. These providers must demonstrate that, in their absence, people would lack access to services guaranteed under the comprehensive benefit package.

2. What happens after 5 years?

In general, we expect that most essential providers will be integrated into health plans in their areas by the end of the 5-year transition period and will not require continuation of the essential provider protections.

However, we are concerned that five years may not be adequate in some communities. Therefore, the Secretary is charged with conducting a study and making recommendations to Congress, by no later than March 2001, as to whether, and to what extent, the essential provider protections should continue for some or all essential community providers beyond the five year transition period.

3. What incentives does the plan have to encourage health care providers to locate in rural areas?

Changes in funding policies for health professions education will increase the supply of primary care providers, the type of provider most needed in rural communities. Funding will be doubled for nurse practitioner, certified nurse-midwife, and physician assistant training programs. The National Health Service Corps (NHSC) will be expanded from its current field strength of about 1,600 to about 7,700 by 2004. About 55 percent of NHSC providers locate in rural areas. Primary care providers in underserved areas may receive a tax credit of up to $1,000 for physicians and $500 for non-physician providers for up to 5 years of service. The allowable depreciation expense for medical equipment is increased for doctors practicing in underserved areas. Physicians serving in underserved areas will receive a 20 percent bonus payment for services provided to Medicare beneficiaries. In addition, development of rural health care networks and improvements in the health care system will make rural practice more attractive.

4. OK. So the plan has incentives for doctors to go to rural areas, but what will benefit the doctors already there and make them want to stay?

The 20% bonus and the tax benefits for medical equipment apply to both new and existing physicians in health professional shortage areas. In addition, the plan will help reduce the isolation of rural practitioners by improving linkages with academic and regional medical centers, partly through improved telecommunications. The plan also will encourage the development of rural training sites for health care professionals. Involving rural practitioners in training health professionals promotes their interaction with colleagues and fosters their own continuing education.

Health plans will be required to assure adequate access in the areas they serve. Therefore, health plans will have an interest in establishing locum tenens programs and other services for rural physicians to maintain adequate access in rural areas.

5. Right now, I contract with several HMOs to provide health care to local residents. Each HMO has its own administrative procedures and requires me to use a particular laboratory and hospital. How will health care reform affect this?

Administrative procedures will be streamlined under the Health Security Act. Each health plan will use the same forms for documenting the health care you provide.

Your patients work for many different employers, each of whom is likely to offer only a few health plans to their employees. Because each employer may offer a different choice of plans than other employers in the area, you may feel it is necessary to contract with numerous health plans so your patients can continue to choose you for their physician. Under health care reform, everyone in your community who is enrolled in the health alliance will have the same choice of plans. You may then find it advantageous to contract with only a few HMOs because all your patients would have the option to select one of the plans in which you participate.

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

The reform offers Americans choices of different types of insurance -- all providing the comprehensive benefit package. A traditional Blue Cross-type plan will be available to everyone, whether or not there is an HMO. The plan also will foster development of managed care plans where there currently are none.

7. With all the copayments, I don't think the health plan is going to be affordable for a lot of rural people.

Subsidies for premiums and cost-sharing (e.g. copayments and deductibles) will be available for low income people. This is a big improvement over the way things are now. The plan also makes health care more affordable by providing everyone with the advantages of purchasing health insurance as part of a large group and by restructuring the health care system.

8. The plan does not cover undocumented persons. How will they get health care? Will hospitals and practitioners be required to provide care to undocumented persons? How will they get paid for the care they provide to undocumented persons?

The plan continues the current financing of care for undocumented persons. Federal funds will continue to be available to help hospitals and clinics that care for a large number of undocumented people.

If undocumented persons are employed, their employers will be required to contribute toward their health insurance premiums. Undocumented persons could then pay the remainder of their premium themselves. However, they will not be eligible to receive federal subsidies to pay for their premiums.

9. The plan is not adequately portable for migrant workers.

The health care choices of migrant workers will be improved in several ways. Migrant workers who are American citizens or legal residents will receive a health security card that entitles them to the same health care coverage as every other

American. Migrants will be members of the health alliance in their home area. Transfers between health alliances allow them to use their health security card for care wherever they are. Outside their home area, migrants can receive emergency services at no additional cost. Routine care is available through the point of service option, but higher copayments would apply to those in HMOs and PPOs. In addition, additional funding will be available to migrant health centers, which provide health care services along the migrant streams.

10. The Indian Health Service is a big provider here, but I understand it's off limits to non-Indians.

An Indian Health Service Center may serve non-Indians on a contract basis. The plan fosters greater cooperation between the IHS and other health care providers in rural areas.

11. It's not fair that American Indians don't get subsidies if they use IHS facilities.

This was corrected in a technical amendment. American Indians now can receive subsidies for care provided at an IHS center.

12. Won't the Medicare cuts force our rural hospitals to close?

Savings in the Medicare program will come about from the restructuring of certain aspects of the Medicare program and a lower rate of increase in Medicare spending as health care costs come under control. Let me explain. Currently, Medicare expenditures are growing at 3 times the rate of general inflation. Projections for Medicare expenditures are based on this rate. Under our proposal, the rate of increase will initially slow to 2 times the general rate of inflation. Medicare will save money when health care costs are controlled and the rate of increase in health care expenditures is reduced.

Another major source of Medicare savings is through changes in the way teaching hospitals are paid. Few rural hospitals receive payments for training physicians. Therefore, few rural hospitals will be hurt by this change. In fact, changes in the way the federal government finances health professions education will make it easier for rural hospitals to participate in training programs and receive financial support for their role in educating health care professionals. In addition, grant programs will be available to build rural health care networks that could help rural hospitals expand local capacity.

Finally, under the Health Security Act, everyone will have health insurance. Rural hospitals will no longer be providing health care to large numbers of people who cannot pay for their care.

13. Aren't rural areas hurt by the budget targets because our costs are already low?

In rural areas, like the rest of the country, health care costs are increasing much more rapidly than people's wages. The budget targets try to bring the rate of increase of health care expenditures down to the same rate of increase as people's wages. Then we can have money for education, roads, vacations, and the other things we want.

The plan works over time to even out the differences in the amount rural and urban states spend per person.

14. The Health Security Card does not do any good if transportation is not covered.

Grants are available for states to cover transportation to ensure access in rural areas. Controlling health care costs will also mean that rural counties have more money left over for transportation.

15. Wouldn't it be simpler to have a single-payer system?

We believe it is important for the states to be involved in the health care system and to have the flexibility to develop the health care system that will work best for them, within the parameters established by the federal government. States may opt to develop a single payer system if they assure that federal requirements under health care reform are met. However, we do not believe that a single-payer system is the preferred choice by all Americans. Moreover, we view this as an opportunity to preserve the good parts of our health care system and improve upon that which doesn't work, without creating a totally new system.

Have you heard that a hospital down the road is closing its doors today?

The Presbytarian Hospital system is not closing-- what they ARE doing is restructuring their hospitals to respond to the increasing trends toward cost-effective outpatient care and shorter hospital stays.

Presbytarian's Northside facility is being transformed from an in-patient/out-patient hospital to a strictly outpatient facility-- continuing the practices of day surgery, X-ray and lab services. This is in response to the advances in technology that allow for more and more procedures to be done in the oupatient setting-- and is the kind of market-driven change we'll see more of as we bring market power and cost-consciousness to health care.

THE NEW MEXICO AND HEALTH SECURITY
ACT BACKGROUND PAPER WILL BE FORWARDED

THE WHITE HOUSE

WASHINGTON

December 2, 1993

INTERVIEW WITH DENVER TELEVISION STATIONS

DATE: December 3, 1993
TIME: 4:30-4:45 PM RAT
LOCATION: Big Tent at El Pueblo Health Services, Berna Lillo, NM
FROM: Ethan Zindler
Office of Media Affairs

I. PURPOSE

You will be meeting with reporters from the four Denver television affiliates for the purpose of highlighting your health care initiative. KCNC (NBC), KUSA (ABC), KMGH (CBS), and KUBD (Telemundo) are traveling from Denver to Albuquerque to cover your health care event and to participate in the interview.

II. EVENT BACKGROUND

The last time you were in Denver was for your meeting with the Pope. This will be your first chance to address people in Denver directly through t.v. about health care.

II. HEALTH CARE REVIEW BACKGROUND

See attached prepared by Intergovernmental Affairs.

III. COLORADO ISSUES BACKGROUND

According to the Colorado Department of Labor unemployment in the state fell %.6 in October to %5.1, the lowest mark in two years. The issues of grazing and mining discussed in your Phoenix briefing are prevalent here as well. Other issues of interest to Denver:

Teen Gang Violence/Gun Control

This past summer a number of high profile acts of random violence committed by Denver area teenagers shocked and outraged many Coloradans. Several of these were "drive-by" killings committed by teens simply seeking to prove themselves tough enough to be part of local gangs.

In response, Governor Romer called the state's legislature back into session at the end of July. Within an extraordinarily short period time legislation barring minors from carrying firearms (except in very specific, hunting situations) was passed and signed. This action was all the more extraordinary considering the large number of Coloradans who own guns. In addition, there was said to have been little visible opposition to the recent passage and signing of the Brady Law.

In the final vote on Brady, Colorado's Congressional delegation split along party lines: Reps. Schroeder and Skaggs voted for it, all GOP members against.

Amendment 2

Passed by voter referendum in 1992, Amendment 2 was to create a state constitutional amendment to prohibit any local ordinances or state statutes that allowed protection from discrimination based on sexual orientation. Immediately following its passage, gay and civil rights groups announced their intention to fight Amendment 2 in court. Not long after, federal Judge Jeff Bayless granted an injunction preventing Amendment 2 from taking effect until the resolution of the constitutional issues it raises.

Judge Bayless recently concluded hearing the case for and against Amendment 2. Now, the Christian Right and gay and civil rights activists nationwide await his decision. Anti-2 forces, however, were encouraged by the clarity with which Judge Bayless wrote his original injunction and are cautiously optimistic about what the Judge will soon decide.

Governor Romer, who opposed Amendment 2 in 1992, finds himself in a tough position. As the governor of the state he is required to uphold the laws of Colorado. He, therefore, must support the efforts of the Republican attorney general to uphold Amendment 2.

Romer speculation

Due to his high profile among governors and his frequent trips to Washington on behalf of administration initiatives, there has been some speculation that Governor Romer will leave Colorado for a Cabinet post. This is a particularly sticky issue because in light of his announced candidacy for re-election in 1994. Some have accused him of simply biding time until something in Washington opens up. To end the speculation, Romer pledged Wednesday to serve the full term if, in fact, he is re-elected.

Proposed Changes in the Ski-Fee System

Assistant Secretary of Agriculture Jim Lyons Tuesday said that the formula used to calculate leases for ski areas on public lands is unfair and that the Administration plans to overhaul it by next winter. A recent Forest Service study, which reviewed 13 ski resorts across the country, concluded that major ski resorts pay too little and smaller ski areas pay too much under the current system. The plan under consideration at Agriculture would increase costs for mega-resorts such as Steamboat Springs and decrease costs at day-ski areas.

NAFTA

With the exception of Senator Campbell, all the members of Colorado's Congressional delegation voted in favor of NAFTA.

IV. SEQUENCE OF EVENTS

4:20-4:30 PM	Briefing/Makeup
4:30-4:45 PM	Denver television interviews
4:45-5:00 PM	Phoenix television interviews

V. PARTICIPANTS

David Crabtree, KCNC (NBC) -- Morning anchor and specialty reporter, good friend of Jeff Eller and Lisa Caputo.
Ed Sardella, KUSA (ABC) -- Evening anchor.
Jane Hampden, KMGH (CBS) -- Station's lead health reporter.
Rodolofo Cardines (Telemundo) -- Evening anchor.
Jeff Eller
Ernie Gibble, Media Affairs

You have not been interviewed by any of these reporters previously.

VI.PRESS PLAN

Closed to press other than participants.

V.REMARKS

None necessary.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM TO PRESIDENT CLINTON

FR: **JOHN HART**
DT: **NOVEMBER 30, 1993**
RE: **HEALTH CARE REFORM IN THE STATE OF COLORADO**

I. Summary and Background

Colorado can best be described as a middle of the road state on health care reform. While there is a bold reform proposal ready to be introduced, no significant health care reform legislation has been passed. The major reform proposal in health care in Colorado is ColoradoCare, a proposal that is a result of a study funded by the Robert Wood Johnson Foundation. ColoradoCare is a proposed statewide insurance program that would be managed by a newly established Health Authority. The proposal includes universal coverage through private plans, health insurance purchasing pools, and financing through either a payroll or per person tax. In September 1993, Colorado released the ColoradoCare Preliminary Feasibility Study. The main finding of this study was that it would be feasible to provide all Coloradans with an affordable, comprehensive health benefits package.

ColoradoCare dovetails with the Administration's Health Security Plan in many aspects. It is a managed competition proposal which drives down costs by eventually driving down business for health-care companies with high overhead costs. This legislation was unveiled in July 1993 and should be introduced in the Colorado legislature (controlled by a Republican majority) in 1994. What is actually introduced in the 1994 General Assembly will probably be a scaled back version of ColoradoCare, with further reform pending what happens nationally.

Around 80% of the state's population lives in "the front range" of the state in the urban or suburban areas that include Denver and Boulder. The urban areas of the state (particularly Denver) have a fairly sophisticated health care infrastructure and are accessible to a large portion of the population. The rural areas of the state however face problems with access to adequate health care which is magnified in the winter by the rugged terrain and frequent snow and ice. The state also has a measurable Native American population and a large number of undocumented workers.

II. Health Care Reform Efforts

There is bi-partisan support for some kind of health care reform in the state. There is controversy over which approach to take. There is a strong single payer movement. When Governor Romer held extensive regional hearings throughout the state, he found that the single payer advocates were very vocal in their opposition to ColoradoCare's system of managed competition. However, he believes that the likelihood of a single-payer system passing the Republican-controlled Colorado legislature is slim. Republicans and business leaders have also expressed significant concerns about the of the prospects of financing ColoradoCare, mandates and small business.

A. Current Health Reform Climate

Governor Romer faces the challenge of getting health care reform legislation passed by a Republican-controlled state legislature in an election year. In addition, all new taxes in Colorado must be approved by a referendum of the people, and the state also has several government spending limitation laws.

As referred above, there are also a significant number of single payer advocates in the state.

While the state is predominately urban, rural interests are disproportionately influential in the state legislature. There is a prevalent Western frontier mentality in place in Colorado politics, which is well represented through the ranching and mining community in the state. As such, rural health care issues are an important factor in the state's health care reform debate.

B. Major Legislation

The Health Care Reform Initiative Advisory Committee has responsibility for overseeing the work of five study committees and drafting recommendations for ColoradoCare for consideration by the legislature in 1994.

1. In 1993, legislation was passed granting immunity from civil and criminal antitrust actions to hospitals attempting to form or negotiate cooperative agreements.

2. In 1992, the General Assembly enacted and Governor Romer signed legislation calling for a study of the feasibility of ColoradoCare. The following provisions on health care were also enacted:

   - **Cost Containment Strategy** - attempts to decrease health care inflation rate through collaborative efforts of all players in health care. A Cost Containment and Guaranteed Access Commission created to recommend measures to make health care more affordable and to study guaranteed access to health insurance for small employer groups.

- **Guaranteed Access** - establishes procedures for small employer carriers to opt to participate in pooling excessive risks or risk-assuming carriers. Reinsurance Board created to develop an operational plan for reinsurance mechanism, including methodology for setting reinsurece premiums and assessments. Establishes an advisory committee of small business, insurance industry, and health care provider representatives to recommend health coverage suitable for a guaranteed access program.
- **Certification Process** - streamlines the current system of approving insurance policy contracts by implementing a certification system which reduced the burden of unnecessary paperwork. Maintains effective enforcement by making it an unfair trade practice to sell policies not complying with Colorado insurance law.
- **Continuation of Coverage** - expands the period of time Colorado residents can continue group coverage after termination from employment up to six months or until they become eligible for another group insurance. Allows insureds to maintain previous group coverage for pre-existing conditions which are excluded form new coverage.

3. Group Health Insurance Reform was enacted in 1991. This reform required the following:

- **Health Insurance for Small Employers** (25 or fewer employees): Small employer plans must comply with Colorado's mandated benefits package; requires small employer health insurers to renew all groups and individuals in a small group; requires small employer health insurers to renew all groups and individuals in a small group; requires small employer health insures to disclose their rating practices, frequency with which premium rates may be changed, class of business into which employer will be placed and provision of renewability. Prohibits small employer insurers from asking for or using medical information that is more than 5 years old in setting rates for or underwriting employer groups; and annual increase in small employers premium is capped at an amount equal; to the sum of the percentage increase in the best new business rate for that policy, plus 15% , and adjustments necessary to reflect changes in case characteristics.
- **Health Insurance for all groups** - When a group policy is replaced: the succeeding carrier must cover everyone covered under the prior policy;

pre-existing condition limitation periods must be the lesser of the succeeding or prior plan's period; and credit must be given under the succeeding plan for deductibles and waiting periods satisfied under the prior plan. The Commissioner of Insurance has authority to regulate multiple employer trusts and most other insurance-type arrangements. Group plans are subject to all of Colorado's group health insurance status, unless the employer covers only one company and that company is located in another state, or the plan is a fully self-insured, single employer plan, or a Taft-Hartly union trust plan, or is a "valid multi-state association." This requires all health policies and plans that re not fully insured by a licensed insurer to disclose that fact. Amends existing law to change the maximum pre-existing exclusion period from 2 years to 1 year.

ColoradoCare was developed in 1989 by a private, not-for-profit citizens group known as the Colorado Coalition for Health Care Access.

C. Key figures in Reform

Governor Roy Romer - Governor Romer was one of the four governors designated by the National Governors Association (NGA) to represent the governors on the Health Care Task Force. In the past year, he has held over 30 regional health care hearings around the state. He is a formidable politician with national stature who has been a friend to the Administration. As a leader in health care reform at the state level, he is an articulate and credible speaker on the need for national reform.

Alan Weil - Governor Romer's Health Care Advisor

Patricia Nolan, M.D., Executive Director, Department of Health

David R. West, Manager, Department of Health and Medical Services

State Insurance Commissioner Joanne Hill

Senator Sally Hopper (R) - was a co-sponsor of legislation passed in 1992.

Representative Mike Coffman (R) - was a co-sponsor of legislation passed in 1992.

Senator Jim Rizzuto (D)

Representative Peggy Kerns (D)

III. General Comparison

A. Similarities

Security - ColoradoCare guarantees health insurance for all Coloradans. The plan provides an affordable, comprehensive health benefits package to all citizens of the state. ColoradoCare prevents insurers from denying coverage to sick people or to people who live in high risk neighborhoods.

Savings - Both The Health Security Act and ColoradoCare call for workers to pay 20% of the premium and employers to pay 80%. Employers have the option of paying more than 80% if they choose. Both plans rely on competition among insurers and slowing the rate of growth of health care costs for savings. Employers keep costs down by joining huge alliances and shopping for the best per-worker deals from among the insurers vying for customers. Government mandates what is to be covered and sets a cap on overall costs.

Quality - Both plans rely on a private delivery system and competition among insurers.

Choice - Governor Romer has publicly stated that choice is one of the essential elements that must be protected under ColoradoCare. Some people would choose to pay higher premiums to get a wide choice of physicians and little or no deductible. Others would choose to spend less and have a narrower choice of physicians. ColoradoCare provides all residents with a choice of private health plans.

Responsibility - As with the Health Security Act, under ColoradoCare, every individual, family and business with adequate resources will be expected to pay some of the cost of health care coverage.

Simplicity - ColoradoCare will streamline the health care system and reduce administrative costs by requiring uniform billing systems and electronic data exchange.

B. Differences

Cost - Colorado's population is generally younger and healthier than the national average, so the cost of providing care to the uninsured in Colorado could be less.

Financing - Colorado's financing of health care reform is hampered by a state constitutional requirement for a referendum to raise taxes. ColoradoCare derives a portion of its funding from increases in taxes on alcoholic beverages, as well as tobacco.

IV. Key Elements of Reform

ColoradoCare is a universal health insurance proposal for Colorado. Its key elements are as follows:

- ColoradoCare will guarantee uninterrupted health insurance coverage for all Coloradans. All residents of the state will be provided a comprehensive set of health care benefits, including preventive health care services.

- ColoradoCare will provide all residents with a choice of private health plans, including indemnity plans, preferred provider organizations (PPOs), health maintenance organizations (HMOs), and other plan configurations, such as exclusive provider organizations (EPOs) and point-of-service plans (POSs). The choice of the plan will be made by the individual - employers will no longer select plans for their employees.

- Under ColoradoCare, every individual, family and business with adequate resources will be expected to pay some of the cost of health care coverage. Health insurance would be financed in much the same way it is now - through a combination of employer, employee, and tax-funded (government) contributions.

- ColoradoCare will create one or more regional health purchasing pools that will be responsible for negotiating the best health insurance deals for all Coloradans. Once the premiums are negotiated, the pool will pay health plans based upon the number of people who enroll in each plan.

- Under ColoradoCare, health plans will not be permitted to exclude anyone from coverage on the basis of that person's health status or income. Once ColoradoCare is in place, no Coloradan will ever face a waiting period during which certain conditions are not covered.

- Government's role will be limited to qualifying health plans that wish to participate in the ColoradoCare program, performing basic administrative functions, and regulating the market. Every Coloradan will be served by a specific health plan, much as they are now.

- While ColoradoCare will not limit the number of health plans that could participate, the number of plans that remain in the Colorado health insurance market may decline, due to the effects of market competition.

- Employers and individuals will be free to purchase supplemental health insurance packages if they feel that the benefits offered under ColoradoCare are not sufficient.

- ColoradoCare will control costs by changing how people think about and pay for health care coverage - making individuals more responsible. ColoradoCare will reduce costs by forcing health plans to squeeze out inefficiencies. ColoradoCare will control costs by changing the incentives that health care providers currently face to increase the amount of care they provide, rather than hold costs down. ColoradoCare will streamline the health care system and reduce administrative costs by requiring uniform billing systems and electronic data exchange.

VI. Status of Waiver Requests

Colorado waiver request 0268 is a freedom of choice waiver request submitted by the state in response to a court order which mandates that the state serve mentally ill persons under a home and community based services waiver. HCFA has requested additional information form the state.

Colorado waiver request 0006.90.R2 Renewal to provide case management, homemaker, personal care, adult day care, respite and transportation to aged and disabled. Additional information request sent to regional office on 6/10/93; therefore , 90 day clock has stopped. Awaiting state's response.

Colorado waiver request 0006.90.R1.05 modification to add chronically mentally ill adults to the targeted group of recipients. Additional information request sent to regional office on 7/19/93; therefore, 90 day clock has stopped. awaiting state's response.

Colorado waiver request 40157.90 Renewal -- to provide services to children who are institutionalized or ar risk of institutionalization is pending in HCFA. 90th day is 12/27/93.

Colorado waiver request 40179 to provide services to children with developmental disabilities. This is pending in HCFA. 90th day is 12/19/93.

Colorado freedom of choice waiver 03 was approved on 10/14/93. This waiver is unique in that it represents the state's initial effort in managing mental health care on a prepaid basis. HCFA reviewed the request in draft form, and had two teleconferences with the state.

VII. Demographics

1991 Total state population: 3,377,000
1990 Population below poverty: 13.7%
1990 Rural population: 17.6%

1991 Health Insurance Coverage
Population covered by Medicaid: 9.6%
Population covered by Medicare: 11.5%
Population covered by Private Payers: 77.6%

Population uninsured: 10.1%

Non-Elderly with Selected Source of Health Insurance
1992 Population with employer coverage: 69.8%
1992 Population with other private insurance: 7.4%
1992 Total population with private insurance: 77.3%

Public Health System
PHS public health expenditures (FY 1992): $222,200,000
State public health expenditures (FY 1989): $121,411,000
Local public health expenditures (FY 1989): $29,082,000
Community & Migrant Health Center: 15
Population undeserved: 10.1% (around 500,00)

Health Indicators
Infant mortality rate per 1000 live births (1991): 8.4
Two year olds appropriately immunized (1989): 61.7%
Prenatal care stated in first trimester (1991): 78.6%

Medicaid
Medicaid Recipient in 1992: 259,000
Percentage of Population covered by Medicaid (1991): 9.6%
Medicaid Payments in 1992: $814,000,000
Medicaid Payment per Recipient in 1992: $3,145
Medicaid Expenditures as % of state expenditures (1992): 16.3%
FY 1993 FMAP: 54.42%
Approximately 50% of Colorado's Medicaid recipients are enrolled in managed care plans.

AFDC Payment Levels Based on Percentage of Poverty
Threshold for an AFDC family of three as a percentage of the 1992 national poverty level of $11,570: 43.7%
Threshold for Pregnant Women family of three as a percentage of the 1992 national poverty level of $11,500: 133%

Managed Care
HMO's in 1992: 15
Percent of Population in HMOs in 1992: 22.2%
Operational PPOs in 1990: 35

VIII. Sources

"2 Health Plans Appear Compatible," Rocky Mountain News, October 4, 1993.

Colorado Health Care Reform Initiative Executive Summary.

Assistant Secretary of Planning and Evaluation, Department of Health and Human Services, Colorado Overview.

Health Care Financing Administration Waiver Status (as of 11/29/93).

Phone conversations with Governor Romer's office.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM TO THE PRESIDENT

FR: JOHN HART
DT: DECEMBER 2, 1993
RE: DENVER, COLORADO AND HEALTH CARE REFORM

I. Overview

Mayor of Denver: Wellington Webb
Population of city: 467,610

The Denver Health and Hospitals (DHH) provides health care for the city and county of Denver and is one of the most completely integrated health care systems in the country. It is comprised of a network of Public Health, Community Health (neighborhood provider stations in areas of greatest need) and Denver General Hospital. It provides universal access with an emphasis on preventative care. The system includes an ambulance and 911 system run by the hospital; an acute care hospital and trauma center; community health centers; school-based clinics; public health; substance treatment services; employees clinic and HMO; poison center; and a coroners office. It has one administration entity, one set of health care providers; one medical record; and one system of ancillary services. This network prevents ambulance gridlock, provides timely primary and preventive service (500,000 outpatient visits/yr.), prevents inappropriate use of emergency rooms; promotes wellness; and provides for the treatment of disease.

The DHH serves about 20% of Denver's population (approx. 100,000). Under this program, 95% of pregnant women have had some prenatal care; 88% of 2 year old children are immunized; 90% of patients with hypertension are treated for this disorder; 80% of women over 18 have had pap smears at appropriate intervals; and 70% of women over 50 have had mammography at appropriate intervals. The DHH relies extensively on midlevel providers such as nurse practioners, child health associates, physician assistants and certified registered nurse anesthetists.

AIDS has now reached an epidemic level in Denver. Mayor Webb announced on National Aids Awareness Day the opening of the Mayor's HIV Resources Coordination Office.

Cost Containment under DHH - DHH requires one of the lowest city/county subsidy rates (15%) as of 1991. It is 85% self-financed. The expenses have increased less than 6% per year from 1981 through 1991. The public health costs are 50 - 100% less than other cities of comparable size. Charges for a hospital service are 30% less than other providers. There is a lower cost per AIDS patient than nationally.

II. Sources

Denver Health and Hospitals Executive Summary from the office of Mayor Wellington Webb of Denver.
Phone conversations with Donna Good (Mayor Webb's office), Frank Judson (Director of Denver Public Health Department)

THE WHITE HOUSE

WASHINGTON

December 2, 1993

INTERVIEW WITH PHOENIX TELEVISION STATIONS

DATE: December 3, 1993
TIME: 4:45-5:00 PM RMT
LOCATION: Big Tent at El Pueblo Health Services, Berna Lillo, NM
FROM: Ethan Zindler
Office of Media Affairs

I. PURPOSE

You will be meeting with reporters from the four Phoenix television affiliates for the purpose of highlighting your health care initiative in an important media market. KPNX-TV (NBC), KTSP-TV (CBS), KTVK-TV (ABC) and KPHO-TV (independent) are travelling from Phoenix to Albuquerque to cover your health care event and to participate in the interview.

II. EVENT BACKGROUND

You have not been interviewed exclusively by reporters from these stations during your Presidency, however, each station participated in the July 30th satellite press conference on the budget that you held for Arizona print, radio and television reporters. KTVK-TV served as the host for the satellite press conference.

II. HEALTH CARE REVIEW BACKGROUND

See attached briefing prepared by Intergovernmental Affairs.

III. ARIZONA ISSUES BACKGROUND

Crime

Many Arizonans were shocked when it was revealed several months ago that their state's crime rate is the 4th highest in the nation. Arizona is a state in which it is estimated over half of all households owns a firearm. Yet when the Brady Bill passed and was signed last week, opposition was muted. (In fact, there is said to be a move afoot to propose legislation banning minors from possessing guns, similar to that recently passed by the Colorado state legislature.)

On the final Brady vote, the Arizona Congressional delegation split along party lines: Reps. Coppersmith, English, and Pastor voted in favor, all GOP members against.

Grazing Fees

Several western senators (including Colorado's Ben Nighthorse-Campbell) led a filibuster that effectively blocked the legislative attempt to raise grazing fees on public lands. Left with no other option, the Department of Interior will now raise fees through direct administrative action. The Department's proposal leaves the federal fees lower than private lease rates and lower than state rangeland leasing rates. Federal grazing land will continue to be the best deal available for ranchers. The fees proposed by the Department of Interior represent a fair value return to taxpayers for the use of their land and resources while keeping ranching a vital part of the economy of the West.

In recent weeks, Secretary Babbitt has conducted a series of meetings with governors, local officials, ranchers, and environmentalists on the issue of grazing. The point of these ongoing meetings has been to build consensus for reform and make local folks understand why this is so important to the administration. The point of these meetings is not to negotiate the fee increases, merely to help explain them.

Mining

Recently, more than 2/3 of the House of Representatives weighed in in favor of mining reform. Americans clearly want the 1872 Mining Act updated and are tired of subsidizing mining companies that do not take adequate responsibility for environmental cleanup. The administration is working with the mining industry to ensure that the Senate compromise is fair to all parties involved. (The House version of the Mining Act would charge royalties for mineral extraction on public lands and require mine operators clean up whatever environmental damage caused. The Senate version is expected to be somewhat less aggressive.)

Repayment of Central Arizona Project to Federal Government

The Administration's budget requires the Central Arizona Project to honor its full federal repayment in 1994, a requirement that previous Administrations have let slide and that some in the state claim will create a real hardship for rural water districts next year. The Department of the Interior is committed to working with the State of Arizona and its water contractors to honor the State's commitment to this project. The Department's information is that there are funds available to meet the State's payment terms. (However, you should be aware that there is considerable discrepancy between the $2.8 billion the federal government claims to be owed and the $1.8 billion the state claims to owe.)

NAFTA

Legislators from Arizona and the neighboring state of Sonora, Mexico recently held an extraordinary joint session to discuss how the two states could work together after the passage of NAFTA. The wide-ranging day-long session included discussion of such issues as economic development, health, free trade, agriculture and the environment. Senator Deconcini and Rep. Jim Kolbe (R) also addressed the meeting. Among other things, the legislators called for a feasibility study on the creation of a deep-water port at Guaymas, Mexico and for creation of a free-trade corridor along U.S. Route 93.

Every member of Arizona's Congressional delegation voted in favor of NAFTA.

Clean Air Act

The Arizona state legislature recently mandated new, more stringent auto emission testing in order to comply with the Clean Air Act. Frustrated by this and other federal mandates, Governor Symington, along with other western Republican governors, is said to be looking to sue the federal government over issues of state/federal jurisdiction. (Word is he's looking for a particularly silly federal law to use as an example before the Supreme Court.)

IV. SEQUENCE OF EVENTS

4:20-4:30 PM	Briefing/Makeup
4:30-4:45 PM	Denver television interviews
4:45-5:00 PM	Phoenix television interviews

V. PARTICIPANTS

Cameron Harper -- Hosted your satellite press conference in July.
Dave Patterson -- Participated in satellite press conference.
Bruce Kirk -- Never interviewed you before, early evening anchor.
Karen Carns -- Never interviewed you, evening anchor.
Jeff Eller
Ernie Gibble, Media Affairs

VI. PRESS PLAN

Closed to press other than participants.

V. REMARKS

None necessary.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR THE PRESIDENT

FROM: **John Hart, Deputy Assistant to the President for Intergovernmental Affairs**

DATE: **December 3, 1993**

SUBJECT: **Arizona and the Health Security Act**

I. Background and Summary

Arizona is behind most states in enacting comprehensive health reform. Arizona has large rural areas that are severely underserved for primary care. Arizona also has a large concentration of small businesses that are generally adverse to reform.

Arizona has taken an innovative approach to providing care for the poorest segment of the state's population through a managed competition plan. The success of Arizona's Medicaid managed competition system is a good example of how managed competition cuts costs and retains quality.

II. Health Care Reform Efforts

A. Arizona Health Care Cost Containment System

Until 1982, Arizona was the only state that did not have a Medicaid program. In October of 1982, the Republicans proposed Arizona Health Care Cost Containment System (AHCCCS) to Governor Babbit as a 1115 demonstration project.

Arizona was the first of three states to implement a Medicaid managed care program -- almost 90% of AHCCCS recipients are now enrolled in HMOs, with preventive care and gatekeepers as a centerpiece. Although there are no categories of citizens that are excluded form the program, unlike Medicaid, the AHCCCS eligibility level is far below the federal poverty level.

While Medicaid is traditionally a fee-for-service system, AHCCCS is the only system in the country to be run on a prepaid care basis. This system has had a surprisingly high rate of success among the doctors in the state -- 70% participate in the program.

AHCCCS covered only acute care services between 1982 to 1988. In November 1988, Arizona enacted a capitated long term care program for the elderly, physically disabled, and the mentally retarded/developmentally disabled populations.

An evaluation of the acute care portion of AHCCCS between 1983 and 1988 indicated: 1) AHCCCS averaged 6% less than the comparable Medicaid programs; and 2) access, enrollee satisfaction, and quality were comparable to traditional Medicaid programs.

B. Political Climate

Health care reform is not a pressing issue in Arizona. One of the biggest problems for the Health Security Act in this conservative state is the mandates on small business. About 80% of all businesses in Arizona are small businesses -- only 40% provide health insurance, down from 56% two years ago.

Next years legislative calendar may include a bill to shift more Medicaid recipients onto the federal payroll. In 1990 and 1991, bills were introduced that would establish a high risk pool for the medically uninsurable population. These bills failed to pass primarily due to concerns about the losses experienced in other states and the budget constraints of the state.

It is important to note that AHCCCS was a Republican proposal that brought about bi-partisan consensus in the state.

In April of 1992, a poll showed that 90% of Arizonans wanted change in the system, 54% believed the federal government should take the lead in reform, and 54% were willing to pay higher taxes to provide universal coverage.

C. Key Players

Democrats Senator Cindy Resnick, Chair of National Conference of State Legislatures health committee, and a member of the Clinton Task Force and Representative Art Hamilton, Minority Leader in the House have been active in reform in Arizona. Republican Representative Susan Girard, new Chair of the House Committee on Health looks to be an active moderate in health care reform. Since reform in 1982, which was forced by the economy, those who where active in reform have left.

III. General Comparisons to the Health Security Act

A. Similarities

Savings
Like the Health Security Act, the Arizona Health Cost Containment system uses a managed care as an instrument to control costs in the health care system.

Choice
Because over 70% of doctors in the state accept participants in the Arizona Health Cost Containment System, high levels of quality are maintained -- proving that managed care does not limit choice.

B. Differences

Though AHCCCS has been successful, it does not provide coverage for all of the state's uninsured.

IV. Key Elements of Reform

A. Arizona Health Care Cost Containment System, AHCCCS

Delivery System
All eligible recipients must select among available health options for services. Fourteen health plans are now participating and are selected through a competitive bidding process. Virtually all eligible recipients receive care through one of these plans. The health plans are paid on a prepaid capitated basis and subcontract with providers to deliver services.

Eligibility
Two major groups are in the AHCCCS system, categoricals and state-funded-only members, made up of the Medically Needy/Medically Indigent. Categoricals are those for whom the state receives federal matching funds. The eligibility is far below the federal poverty level -- 34.6%. Pregnant women and children are eligible at 140% of the federal poverty level.

Cost Containment
AHCCCS controls costs as follows:
- all eligible enrollees participate in a prepaid capitated plan
- plans are competitively bid
- primary care physicians act as "gatekeepers"
- copayments are nominal

Funding
Funding for AHCCCS comes from federal, state, and county monies. The county's contribution is fixed, but it varies for long term care.

Emergency Services Program
In a major shift in services, AHCCCS has begun limiting care for undocumented individuals to only emergency health care, as mandated by the Arizona Legislature in July 1993. Previously, undocumented individuals were able to receive services in the Medically Needy/Medically Indigent category, because only proof of residency was required for these state-funded-only populations. Savings are estimated at $30 million.

Health Care Group
The Health Care Group, administered by the AHCCCS is a subdivision of Medicaid that addresses the needs of small business. The program enables employers wit 40 or fewer employees to obtain coverage under an AHCCCS managed care plan which protects them from medical underwriting and limits pre-existing conditions to 12 months for inpatient care. Funds are from the state budget. No industries are excluded from coverage. Under the Accountable Health Care Bill, Accountable Health Plans must offer insurance to all small employers regardless of size.

Waivers
Waivers for AHCCCS will expire September 30, 1994.

B. Arizona Long Term Care System

The Arizona Long Term Care System (ALTCS) is a program of institutional and home based care services for the indigent elderly, started in 1988. ALTCS offers less costly alternatives to institutionalization in the form of Home and Community Based Services (HCBS) to the full extent agreed by the federal government.

As of October 1992, the federal government has limited the availability of HCBS to 30 percent of the total population served by ALTCS. The Governor has recommended even higher percentages of HCBS availability to increase savings.

In addition to cost containment through HCBS, ALTCS uses a rigorous screening process to ensure that only the individuals that are in need of the level of care will be needed. Eligibility for the program is based on SSI and AFDC eligibility requirements.

Laguna Research Associates is conducting an evaluation of the long term care (LTC) program. Preliminary results indicate the cost of the LTC program was about the same as the cost of a traditional program in 1989, but in 1990 it was 6% lower, and by 1991, it was 13% lower.

C. Bill 2027

In 1991, legislation was passed to prohibit employers from cancelling or not renewing coverage except in the event of nonpayment of premiums, fraud or mismanagement and establish new criteria for "bare bones" packages, to include maternity and well-child benefits. As of March 1993, no insurers were offering "bare bones" packages to small groups.

D. Accountable Health Plans, (AHP)

In May 1993, legislation was passed to establish the Health Benefit Plan Committee and require the certification of all health plans offered by insurers in Arizona.

The Health Benefit Committee, appointed by the governor, will:

- develop a Basic Health Benefit Plan (BHBP)
- recommend benefit and cost-sharing levels and any exclusions and limitations
- determining the list of licensed health providers who would be eligible for reimbursement under the Basic Health Benefit Plan

AHPs would operate under the following guidelines:

- AHPs must offer the BHBP to small employers of 25 to 40 employees -- by July 1996, there will be no limits
- AHPs must guarantee issue
- AHPs must guarantee renewability
  AHPs may vary the premium rate by 60% from the prescribed community rating due to the presence of high risk circumstances
- Pre-existing condition exclusion is at maximum 12 months prior to the effective date of the plan
- AHPs must use standard formats for billing and data collection
- Quality Assurance and Utilization Reviews will be filed with the Department of Insurance

E. Health Care Service Organizations

Arizona has none health care service organizations (HCSOs) ranging in size from 2,000 to over 300,000 enrollees. HCSOs account for about 25% of the health care market in Arizona, not including their administrative only (ASO) contacts with self-insured employers.

V. Statistics

Rank of Arizona

3rd -- Percent of Population enrolled in HMOs -- 30.3%
11th -- Percent of Population Uninsured -- 16.9%
28th -- Infant Mortality Rate per 1000 Live Births -- 8.6
33rd -- Medicaid Expenditures as a Percent of State Expenditures -- 12.4%
36th -- Percent of Population covered by Medicaid -- 8.3%
43rd -- Percent of Population Underserved -- 9.2%
50th -- Medicaid Payments per Recipient -- $520

Demographics

3,750,000 -- Total Population (1991)
14,000 - 18,000 -- Undocumented Individuals (1993)
470,100 -- Participants in AHCCCS (1993)
18,052 -- Participants in ALTCS (1993)
13.7% -- Population below Poverty (1990)
12.5% -- Rural Population (1990)
16% -- Hispanic (1993)
6% -- Native American (1993)

1993 Health Insurance Coverage

13% -- Covered by AHCCCS
13% -- Covered by Medicare
58% -- Covered by Private Payers
16% -- Uninsured

Total Health Payments Per Family in Arizona

$2,091 -- in 1980
$7,069 -- in 1993
$14,648 -- in 2000
238% -- Percent increase 1980 to 1993
601% -- Percent increase 1980 to 2000

Nonelderly Population with Selected Sources of Health Insurance, 1992

60.1% -- With Employer Coverage
7.6% -- With other Private Insurance
67.6% -- Total with Private Insurance

Public Health System

$196,100,000 -- PHS public health expenditures (FY1992)
$169,355,000 -- State public health expenditures (FY1989)
$229,948,000 -- Local public health expenditures (FY1989)
11 -- Community and Migrant Health Centers
9.2% -- Population Underserved

Health Indicators

8.6 -- Infant mortality rate per 1000 live births (1991)
58.1% -- Two year olds appropriately immunized (1989)
68.7% -- Prenatal care started in first trimester (1991)

Medicaid, 1992
402,000 -- Medicaid recipients
$209,000,000 -- Medicaid expenditures
$520 -- Medicaid payment per recipient
12.4% -- Medicaid expenditures as a percent of state expenditures

Managed Care
19 -- HMOs (1992)
30.3% -- Percent of population enrolled in HMOs (1992)
24 -- Operational PPOs (1990)

VII. Sources

ASPE, HHS, Arizona Overview, November 1993.
Arizona Health Cost Containment System, Frank Lopez
David Azevedo, "No kidding -- there's a state where the doctor's like Medicaid", December 21,1992.
Department of Insurance, Survey of March 15, 1993.
Families USA Foundation, Skyrocketing Health Inflation -- 1980-1993-2000 -- The Burden on Families and Businesses, November 22, 1993.
The Finn Foundation News Release, "Study Shows Arizonans Want Increased Government Control of Health Care System", April 8, 1992.
Guy Webster, "Walkout over Health Care", Arizona Republic, March 4, 1993.

THE WHITE HOUSE

WASHINGTON

MEMORANDUM TO THE PRESIDENT

FR: JOHN HART
DT: DECEMBER 2, 1993
RE: PHOENIX/MARICOPA COUNTY, ARIZONA AND HEALTH CARE

I. Overview
Mayor: Paul Johnson
Population: 983,000
County: 2,233,700
Uninsured in County (as of 1992): 16% (357,392)
19% of all employed adults in county lack insurance (of that 19% -- 15% Work Full Time and 33% Part-time)
Vaccination rate for 2 yr olds in county: 47%
Unemployment rate (October 1993): 4.9% for Maricopa County (6.1% for state)

75% of the residents of Arizona either live in Pima County (Tucson) or Maricopa County (Phoenix and Scottsdale). Phoenix is the Maricopa county seat and comprises one of five districts in the Maricopa Human Services Planning Districts. The county faces a number of health care problems. The primary provider of public health services in the city and county is the state Arizona Health Care Cost Containment System (AHCCS), a managed care system. There are 15 AHCCS providers in the state and 7 in Maricopa County. Since 1957, the city of Phoenix has had an agreement with the county, that the county would take the lead in providing health care services. With such a large terrain and diverse constituency, Maricopa County faces a cross-section of health care challenges from serving a urban population, such as Phoenix, to providing access for the rural areas in the county. With the lack of a comprehensive public transit system in the county, transportation to health service facilities has come up at every public hearing and focus group held on the subject. Like many places, a large portion of the uninsured are the working poor.

The Salt River and Fort McDowell Indian reservations are also located within Maricopa County, but they receive their own allocation of Social Services Block Grant funds through Indian Health Services. 28.1% of the population of Phoenix is comprised of minorities.

Like many communities in border states, Maricopa County has the problem of providing care to a large population of undocumented workers. There are many cases of families where the parents are illegal aliens and have no health care but the children have been born in the United States and are therefore eligible for federal programs. Many in the county and state hope that NAFTA and national health care reform will address this problem.

II. Women and Children

Between 1985 and 1990, there was a 38% increase in the number of pregnant women receiving late or no health services. In 1990, 3 of every 10 pregnant women in the county received inadequate prenatal care. On the positive side, the infant mortality rate decreased 5% dropping from 9.4 per every 1000 live births in 1985 to 8.9 in 1990. The number of low birth weight births however, rose from 2,094 in 1985 to 2,615 in 1990. Many mothers and children in Maricopa County continue to be in need of government-sponsored nutrition programs. Current estimates suggest there are 50,701 women and children eligible for WIC services in Maricopa County who are not being served. Births to teens under 15 years old increased 21% between 1985 and 1990.

II. Sources

1992 Flinn Foundation Study

Maricopa Association of Governments

Phone Conversations with Dr. Steve Englander and Heidi Hutchins, Maricopa County Department of Public Health

Kids Count FactBook: Arizona's Children 1992, Morrison Institute for Public Policy, Arizona State University School of Public Affairs.

THE WHITE HOUSE

WASHINGTON

December 2, 1993

FUNDRAISING RECEPTION FOR GOVERNOR KING, SENATOR BINGAMAN AND CONGRESSMAN RICHARDSON

DATE:	Friday, December 3, 1993
LOCATION:	Pecos Room, Albuquerque Convention Center
TIME:	6:15 P.M. M.S.T.
FROM:	Linda Moore, Political Affairs Lee Satterfield, Scheduling and Advance

I. PURPOSE AND BACKGROUND

This event is a joint fundraiser for Governor Bruce King, Senator Jeff Bingaman and Representative Bill Richardson. All three are up for re-election next year. Proceeds will be divided as follows: 37.5% for the Bingaman campaign, 37.5% for the King campaign and 25% for the Richardson campaign.

II. PARTICIPANTS

Between 400-500 people are expected to attend, each paying $250.

Some labor unions have opted not to purchase tickets to this event to protest your campaign for NAFTA and the three beneficiaries' support of the treaty.

III. PRESS PLAN

Open press during remarks only. Closed press for the remainder of the event.

IV. SEQUENCE OF EVENTS

* Prior to the beginning of the program, Raymond Sanchez (D), Speaker of the state House of Representatives and the Master of Ceremonies for the event, will introduce various elected officials in the crowd. Three bands will have already performed.

* At 5:45 you will proceed to the holding room.

* At 6:15, Sanchez will introduce (in the following order) Congressman and Mrs. Richardson, Senator and Mrs. Bingaman, Governor and Mrs. King and then you. Each will enter the room when their names are announced and remain on stage throughout the program.

* At 6:20, Congressman Richardson will speak and then introduce Senator Bingaman.

* Senator Bingaman will speak and then introduce Governor King.

* Governor King will speak and then introduce you.

* You will deliver your remarks.

* You will then exit stage right working the crowd as you go. The three couples and the Speaker will follow you off stage right and continue with you as you work the rope line.

* You will exit the reception and proceed to the photo-op.

V. REMARKS

Remarks provided by Carter Wilkie.

The President of the United States
"Celebration '94" Reception
Albuquerque, New Mexico
December 3, 1993

- You know, when you're President, you can't eat a thing without the press writing all about it. I mean, Reagan had his jelly beans. George Bush hated broccoli. And the other day, there it was in the *Wall Street Journal*: Hillary and I love salsa. (The only reason why I agreed to do this fundraiser was that I figured you would serve me some.)

- I'm happy to be back here in New Mexico with my old friend, Gov. Bruce King (who is missing the start of the annual Lobo Classic basketball tournament so he can host me here tonight), along with my partners in Washington, Sen. Jeff Bingaman and Rep. Bill Richardson, and all of the early members of our "Adelante con Clinton" campaign.

- Together, and especially because of Bill's leadership in the house, we passed NAFTA.

- Together we're securing a place in the new global economy for our workers in defense industries, in the national labs and in America's research centers. And I want to thank Gov. King on this, too.

- Today, we announced the third round of grants in our Technology Reinvestment Project. And, in case you haven't heard, New Mexico won big.

- TRP helps small defense firms make the transition to commercial markets. It takes military technology and puts it to use in the civilian economy. All of this is just part of a national defense conversion plan that totals $20 billion dollars over five years.

- Jeff is too modest to tell you, but he's really the national architect of TRP. It's the product of years of effort on his part. And for a while he had to go up against a hostile GOP administration in the White House.

- But thanks to New Mexico sending me to Washington, we've been able to give Jeff's TRP all the support it deserves: to form partnerships between government and industry; to build investment in R&D; to boost performance in American manufacturing; and to prepare America for the 21st century economy.

- Jeff fought to keep TRP a merit-based program because he knew that New Mexico would do well on the merits. And it has. Sandia is a participant in a number of winning teams, and several state-sponsored projects have been selected for matching grants. It's more than defense conversion, it's a model for how government and industry can work together to get America moving.

- I came out here tonight because I wanted Jeff and Bill and Bruce to get all the credit on these things they deserve.

THE WHITE HOUSE

WASHINGTON

December 2, 1993

**FUNDRAISING DINNER FOR GOVERNOR KING,
SENATOR BINGAMAN AND CONGRESSMAN RICHARDSON**

DATE:	Friday, December 3, 1993
LOCATION:	Taos Room, Albuquerque Convention Center
TIME:	7:05 P.M. M.S.T.
FROM:	Linda Moore, Political Affairs Lee Satterfield, Scheduling and Advance

I. PURPOSE

This event is a joint fundraiser for Governor Bruce King, Senator Jeff Bingaman and Representative Bill Richardson. All three are up for re-election next year. Proceeds will be divided as follows: 37.5% for the Bingaman campaign, 37.5% for the King campaign and 25% for the Richardson campaign.

II. PARTICIPANTS

Two hundred people will attend the dinner, paying $1,000 each.

You may notice that a table of Native American leaders is seated near the front. You should know that the Native American community is very angry with King because of his opposition to gambling on Indian lands. They are also angry at Senator Bingaman for successfully opposing a nuclear waste site -- which they viewed as an opportunity for economic development on one of their reservations. The group is earmarking their contributions to Richardson.

Jeep Gilliland, chairman of the New Mexico AFL-CIO, will attend the dinner. Gilliland opposed NAFTA but some pro-NAFTA observers have commented that he was statesmanlike in his opposition and kept the debate on the issues, acknowledging that the topic was one on which reasonable people could differ.

Representatives of the Sikh community in New Mexico have purchased a table. The head of the Sikh community in the state is Siri Singh Sahib Ji and he will be in attendance. (Because of his difficult name, he is often referred to as "Yodi G.") You may recognize him immediately because of his religious garb. He is the chief religious and administrative authority for the Sikh religion in the Western Hemisphere.

Kate Stetson, national co-chair of Native Americans for Clinton-Gore, will be in attendance. The fundraiser is being held on her birthday. She is turning 45.

Kevin Gover, another national co-chair of Native Americans for Clinton-Gore, was recently chosen to be one of only a handful of recipients of the DNC's O'Brien Democratic Award. Hundreds of nominees competed for the award.

III. PRESS PLAN

Press pool spray only.

IV. SEQUENCE OF EVENTS

* At 7:10, you will proceed to hold in the Santa Domingo room.

* At 7:15, you will enter the dinner and work the room around the tables. Governor King, Senator Bingaman and Representative Richardson will take turns introducing you to the attendees.

* You will exit at 8:00.

V. REMARKS

No remarks necessary at this event.

THE WHITE HOUSE

WASHINGTON

December 2, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: Paul Deegan
National Economic Council

SUBJECT: Background Information on the New Mexico Economy

This memorandum presents background information about current conditions and issues in New Mexico. It addresses (i) issues of major concern in the state, and (ii) Administration programs that will help the state.

I. PRESSING ISSUES IN NEW MEXICO

- *Technology Reinvestment Project (TRP)* -- On October 22, November 24, and December 3, you announced a number of TRP award selections. Lead participant winners in New Mexico include:

  - The $20 million project* led by New Mexico State University was selected on December 3. This project will create a cross-disciplinary center by building learning bridges between industry, colleges and the National Labs. Other New Mexico partners include DOE/Sandia and Los Alamos National Laboratories.

  - The $4.5 million project* led by the University of New Mexico was selected on December 3. This technology deployment pilot project will help small businesses. Other New Mexico partners include Sandia National Labs and Laguna Industries.

  - The $4.1 million project* led by the University of New Mexico was selected on December 3. This project will focus on improving apprenticeships for students and small vendors in the Albuquerque area. **Extensive efforts will be made to reach out to rural communities and Native Americans.** Other New Mexico partners include Digital Equipment and BDM International.

  - The $1.2 million project* led by the University of New Mexico was selected on December 3. This project will focus on modern manufacturing techniques and design while emphasizing the management of people and businesses. Other New Mexico partners include Motorola and Intel.

- The $13.2 million project* led by the *New Mexico Industry Network Corporation* of Albuquerque was selected on November 24. This manufacturing extension program had roughly 60 partners in New Mexico, including General Electric, Hewlett-Packard, Intel, Motorola, the State of New Mexico, and the University of New Mexico.

- The $2.8 million project* led by *Rio Grande Medical Technologies* of Albuquerque was selected on October 22. The other New Mexico partners in this system for noninvasive arterial blood gas measurement are DOE/Sandia National Laboratories and the University of New Mexico.

*Total project cost; federal share to be negotiated - about half. (Total value of the projects listed above is $45.8 million.)

FYI: In your October 22 award selection announcement you said a special word of thanks to Senator Bingaman for the work he has done on the TRP.

- ***Intel Investing $1 Billion in Rio Rancho*** -- Intel is expanding its Rio Rancho microprocessor manufacturing plant by 1.3 million square feet. This $1 billion expansion will add up to 1,000 new jobs to the current workforce of 2,400. It is the most expensive project in Intel company history. (Source: Intel Corporation)

- ***Motorola Investing $35 million in Albuquerque*** -- Motorola is currently expanding its Albuquerque ceramic filter components (for cellular phones and pagers) manufacturing facility by 80,000 square feet. This $35 million expansion will add 500 new jobs to the current workforce of 1,500. (Source: Motorola Inc.)

- ***Service Sector Has Seen Steady Job Growth*** -- Employment in services grew from 133,000 in 1981 to over 225,000 in 1992. In fact, employment in services grew by at least 5,400 jobs during every single year in that period. (Source: DoC)

- ***Retail Sector Optimistic*** -- Merchants have a very optimistic outlook for the holiday season, especially in the Albuquerque area. Merchants expect sales to be up 10% over last year. (Source: New Mexico Retail Merchants Association)

- ***Job Losses in Manufacturing*** -- Almost 1 in 9 manufacturing jobs in New Mexico were lost from 1989 to 1992. Employment in manufacturing fell 44,900 in 1989 to 42,600 in 1992 -- a net loss of 4,700 jobs. (Source: DoC)

  Net decline in total employment in manufacturing (New Mexico, 1989-1992):

- Motor Vehicles and Equipment	(-1,100 jobs)
- Machinery and Computer Equipment	(-600 jobs)
- Instruments and Related Products	(-500 jobs)
- Lumber and Wood Products	(-400 jobs)

- *NAFTA* -- New Mexico's exports to Mexico and Canada reached $71 million in 1992, and supported almost 4,000 jobs. (Source: USTR)

NM's Exports to Mexico, 1987-1992 -- Thousand $ (Source: DoC)

	1987	1992	% Change
Total Exports to Mexico	**9,100**	**31,700**	**249%**
Chemical Products	3,900	12,200	214%
Lumber and Wood Products	5	3,200	64,547%
Indus. Machinery & Computers	1,250	2,600	110%
Agriculture - crops	146	2,400	1,532%

- ***Bright Economic Outlook*** -- In 1994, the New Mexico economy is expected to continue to expand at a rapid pace, led by construction, manufacturing, services, and state and local government. Employment in construction in Albuquerque is expected to grow by 7.9%. (Source: Bureau of Business and Economic Research, University of New Mexico)

III. ADMINISTRATION PROGRAMS THAT WILL BENEFIT NEW MEXICO

According to Treasury estimates, based on a variety of demographic and economic data, your economic growth plan for New Mexico (1993-1998) includes the following:

- $145 million investment in worker training and higher education;
- $89 million investment in schools and children;
- $132 million investment in housing and communities;
- $86 million investment in health and AIDS research;
- $317 million investment in highways, mass transit and environmental infrastructure;
- $68 million investment in technology (including defense conversion);
- $35 million in tax incentives for business investment; and
- $226 million in tax credits for the working poor (Expanded EITC, fully-phased).

Rep.	EITC Benefits	$ (millions)	% Families	Higher Taxes
Richardson	44,000 families	74.4	34.0	1,358 families
Schiff	42,100 families	71.2	31.7	1,885 families
Skeen	47,800 families	80.8	36.0	893 families
STATE	**133,800 families**	**226.4**	**33.9**	**4,136 families**

- *Your Economic Growth Plan Will Create Jobs in New Mexico* -- Treasury estimates your economic growth plan will create over 65,000 new jobs from 1993-1996 -- 75% more than were created from 1989-1992.

THE WHITE HOUSE

WASHINGTON

December 2, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: Ann Walker, Felton Newell
RE: Local Issues Briefing: Albuquerque, N.M.

Population Demographics:

Total:	385,000
Ethnic Breakdown:	
White	78%
Hispanic Origin	35%
Black	3%

Economy
Scientists at the Los Alamos and Sandia laboratories are concerned about the effect of GATT provisions which allow tariffs for government subsidized industrial research. The clean car initiative would be affected by this provision. Senator Jeff Bingaman and Rep. George Brown recently expressed concern about the agreement in a letter to the administration.

Technology
The Federal Government awarded a $3.2 million matching grant to a New Mexico consortium to help bring new technology to the State's manufacturers. The grant, authorized under the Technology Reinvestment Project, will help pay field agents to work with manufacturers in New Mexico and El Paso County, Texas. The agents will provide advice on new technology, as well as basic business guidance on management and finance.

Homelessness
The State Fair Commission recently decided against using the state fairgrounds as the site for a 400-bed overflow shelter. The decision has spawned a controversy over whether the city, state or private sector should take care of Albuquerque's homeless population. Mayor Chavez has criticized the Governor for the Commission's decision, while King has said it is an "Albuquerque problem". Chavez pledged to address the problem once he takes office.

THE WHITE HOUSE

WASHINGTON

2 26:57

December 2, 1993

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: MARCIA HALE
KEITH MASON KM

SUBJECT: DEPARTMENT OF INTERIOR/ OUTREACH TO WESTERN GOVERNORS

I. SUMMARY

Attached is a memo from Stephanie Solien updating us on Sec. Babbitt's outreach to western governors as it relates to grazing fees, mining reform laws and other general issues.

II. DISCUSSION

Since you will be seeing Governor King tomorrow, we feel that you should be made aware of Secretary Babbitt's attempt to have a collaborative consultation effort on these issues with Governor King. At the present time, Governor King does not want Secretary Babbitt to pursue this process within the state of New Mexico. He would like to wait for the prevailing political attitudes on these issues to subside before he decides to participate in collaborative discussion with Secretary Babbitt, environmentalists and ranchers.

Enclosure

December 1, 1993

MEMORANDUM

TO: Marcia Hale
Keith Mason

FROM: Stephanie Solien

SUBJECT: Western Governors Outreach

I wanted to update you on Secretary Babbitt's outreach efforts with the Western Governors on grazing, mining law reform and other general issues.

The Secretary is working hard to fulfill his commitment to the Western Governors to be more accessible on the grazing and mining issues. Since my last report, the Secretary has been to Colorado twice to meet with a coalition of environmentalists and ranchers at the request of Governor Romer, and has pledged to go to Colorado and meet with them six more times. He has also recently spent a day in Nevada, meeting with Governor Bob Miller. On these trips, he has spoken to the Governors about the grazing issue and has also consulted with them on the Congressional movements on mining law reform. He has also spoken with them on water issues and on state-specific issues of priority concern to the Governors.

In addition to his meetings with Governors Romer and Miller, the Secretary has spoken with Governors Sullivan of Wyoming, King of New Mexico and Leavitt of Utah. He discussed with those Governors arranging trips to their states soon: Governors Sullivan and Leavitt have been enthusiastic, while Governor King has suggested waiting.

Secretary Babbitt will be attending the Western Governors Association dinner on Thursday, Dec. 2, with Assistant Secretary Bob Armstrong. At the request of the Western Governors Association, we are setting up two working groups of gubernatorial and Departmental staff--one to work on grazing, the other on mining--and will have scheduled meetings of those two groups before Christmas.

Separately, we are considering a trip to Arizona for an event with Rep. Karen English, but the Secretary does not feel a meeting with Governor Symington is advisable. We are also trying to schedule a trip to Montana at the request of Rep. Pat Williams, and will advise as to discussions with the Montana Governor's office.

In summary, the Secretary is planning to spend an average of two days per week in the West over the coming weeks. While in the West, he will visit editorial boards and have press availability.

My office will update you as we move forward. Thanks for your help and your interest.

THE WHITE HOUSE

WASHINGTON

P6:55

December 2, 1993

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: MARCIA HALE
KEITH MASON KM

SUBJECT: GOV. BRUCE KING/ GATT

I. SUMMARY

Governor King wrote you on Tuesday expressing concerns about the current GATT negotiations as they pertain to intellectual property provisions in the current draft. Intel Corp., the largest industrial employer in New Mexico, believes that the "compulsory licensing" provisions in the current draft would jeopardize its patents and copyrights. Attached is a copy of Governor King's letter and a memorandum from USTR to the Chief of Staff responding to Governor King's concerns.

OFFICE OF THE GOVERNOR
STATE CAPITOL
SANTA FE, NEW MEXICO 87503

BRUCE KING
GOVERNOR

(505) 827-3000

November 30, 1993

The Honorable Bill Clinton
President of the United States
1600 Pennsylvania NW
Washington DC 20500

Dear Mr. President:

As you may know, Intel Corp. is the largest industrial employer in New Mexico. They have brought to my attention serious concerns about the current GATT negotiations as they pertain to intellectual property.

Intel believes the "compulsory licensing" provisions in the current draft would jeopardize its patents and copyrights, which are fundamental business rights protected by the U.S. Constitution. Intel believes compulsory licensing should be limited to military and national emergency uses.

My understanding is that Intel's concerns are shared by other firms in the semiconductor and electronics industries. I believe these firms will support GATT if their concerns on intellectual property are addressed.

Thank you for your consideration. Alice and I are looking forward to seeing you in Albuquerque on December 3.

Sincerely,

Bruce King

Bruce King
Governor

BK:jmc

OFFICE OF THE UNITED STATES
TRADE REPRESENTATIVE
EXECUTIVE OFFICE OF THE PRESIDENT
WASHINGTON
20506

December 2, 1993

MEMORANDUM TO MACK MCLARTY, CHIEF OF STAFF

FROM: Charlene Barshefsky, Acting U.S. Trade Representative CB

SUBJECT: Semiconductor Industry's Concerns With TRIPs Text

ISSUE:

In your meeting tomorrow, Governor King may raise a constituent (Intel Corporation) concern with the compulsory licensing provisions of the draft Uruguay Round text on intellectual property protection. U.S. negotiators are extremely concerned about pressing for the semiconductor industry's proposed changes, for the reasons listed below.

TALKING POINTS:

- Our negotiators in Geneva understand the concerns of the U.S. semiconductor industry with respect to the compulsory licensing provisions in the draft Uruguay Round text on intellectual property protection.

- Our negotiators have addressed these concerns by significantly limiting the instances in which compulsory licenses would be permitted. Given that a flat prohibition on compulsory licenses was simply impossible to achieve, they believe they have ensured the highest level of protection possible.

- The text in its present formulation puts a series of 11 conditions on the grant of compulsory licenses. These limitations should significantly restrict the grant of compulsory licenses for patents and semiconductor layout designs.

- Our negotiators have considered very carefully the proposals put forth by the semiconductor industry. Their judgement was that opening up that portion of the text would result in developing country demands for further weakening of the disciplines achieved to date. Any weakening of the text would damage U.S. industry interests.

- Semiconductor industry requests could also require changes in U.S. law, including the uranium enrichment program, which would be problematic.

- The U.S. semiconductor industry can rest assured that if it has problems with the way any of our trading partners are implementing the compulsory licensing provisions, the U.S. government will make every effort to resolve the problem bilaterally.

Background

On November 30, Governor Bruce King by letter (attached) notified you of the concerns the U.S. semiconductor industry has with the compulsory licensing provisions in the Uruguay Round text concerning intellectual property (known as the "TRIPs Agreement").

The semiconductor industry has expressed extreme concern about the TRIPs text compulsory licensing provisions that apply to patents and layout designs for integrated circuits. They believe that other countries will grant compulsory licenses especially for use of their patents on integrated circuits.

Article 31 of the draft TRIPs text contains the relevant provisions and covers both government use of patents with out the express authorization of the patent owner and forms of compulsory licenses. The text takes the approach of requiring Members to meet certain procedural and substantive requirements before granting a compulsory license.

U.S. law contains both government use provisions and compulsory licenses. The government use provisions in 28 U.S.C. 1498 are extremely broad and frequently used by many U.S. agencies, including DOD, NASA, and DOE. All federal agencies, however, can have recourse to this provision.

During the negotiations on the TRIPs text, we met several times with representatives of the agencies that use Section 1498 in their contracting and procurement programs. After considerable effort, we persuaded them to accept a limitation on the waiver of one of the requirements to the situation of "public non-commercial use." Further changes to U.S. practice were not accepted.

With respect to compulsory licenses, U.S. law contains three such licenses. They are in the Clean Air Act, the Atomic Energy Act, and the Energy Policy Act. Although the first two licenses have not been invoked, Congress only recently enacted the uranium enrichment compulsory licensing provisions of the Energy Policy Act in preparation for the future privatization of the commercial aspects of the U.S. uranium enrichment program. These compulsory licensing provisions are intended to replace the Department of Energy's current use of Section 1498 to obtain access to patented technology in this area.

The proposal put forth by the industry would require major changes in U.S. law that are very likely to be opposed by USG agencies and other parts of the private sector that rely on government use licenses to conduct their business. For example, the uranium enrichment compulsory license is for "commercial exploitation" needs.

Moreover, Federal agencies do not want to attempt to negotiate a voluntary license for every patent that might be infringed in the context of a massive procurement project. For some projects, hundreds of patents may be involved. The industry proposal would require the Government to conduct an expensive patent search to determine which patents might be used, contact the patent owners and then attempt to negotiate licenses. The cost in money and time would be enormous and it would be impossible to have any confidence that all relevant patents could be identified.

With respect to limiting the scope of the license to products for consumption in the domestic market, the U.S. Government sells some of the products manufactured pursuant to a government use contract. This does not represent a significant portion of production under USG procurement contracts, so we can accept the "predominantly for the supply of the domestic market" limitation, but not a total ban on foreign sales.

Compulsory licensing provisions for layout designs of integrated circuits is clearly a secondary issue. As a practical matter, the technology is outpacing the legal protection that is available. Although the United States does not have compulsory licensing provisions in its law, we permit reverse engineering. Several EC member state integrated circuit laws provide for compulsory licensing. These provisions have never been used and the industry has never objected to these countries' laws.