April 23, 1993

TO: Senator Dole

FROM: Vicki

RE: Speech to American Society of Anesthesiologists

You are scheduled to give the keynote speech to the American Society of Anesthesiologists on Sunday, April 25 at 2:15 at the J.W. Marriott Hotel. Adrienne Lang, Director of Government Affairs will meet you at the hotel entrance.

Dr. Peter McDermott, a physician in private practice in southern California, will introduce you.

About 450 anesthesiologists will be in attendance. The following doctors are from Kansas:

| | |
|---|---|
| Dr. Greg Unruh | Kansas City |
| Dr. James Kindscher | Kansas City |
| Dr. Katherine Latimer | Wichita |
| Dr. Kirk Benson | Kansas City |

Of course, their concern is health care reform and how specific measures i.e. price controls, will affect their practices. They would like you to speak for twenty to thirty minutes. No question and answer period is scheduled.

Senator Mitchell will address the group on Monday.

SPEAK Sun, April 25
J.W. Marriott
Hdw. 6:30-8:00 pm
(will be returning from Delaw
- Republican Conf Mtg)
$2,000
(Mrs Dole will be with you.)

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Office of Governmental Affairs
1101 Vermont Avenue, N.W.
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Washington, DC 20005
(202) 289-2222
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March 4, 1993

The Honorable Robert Dole
United States Senate
Hart 141
Washington, DC 20510

Dear Senator Dole:

On behalf of the American Society of Anesthesiologists (ASA), representing more than 30,000 physicians nationwide, I am pleased to invite you to address our 1993 Legislative Conference, which is being held in Washington, D.C. at the J.W. Marriott hotel.

We would be honored if you could present keynote remarks as part of our dinner on Sunday evening, April 25th. We can easily accommodate your schedule for any time between about 6:30 and 8 p.m.

This conference is attended by the ASA leadership, PAC Board, Committee on Governmental Affairs and more than 400 anesthesiologists from across the country, including a contingent from Kansas. Your leadership role, both within the Senate and on health care issues, is well-known to our membership and I know you could anticipate an informed and appreciative audience.

Please contact me if I can provide any additional information, and I look forward to a favorable reply.

Sincerely,

Adrienne Lang

Adrienne C. Lang
Director

Spoke w/ Drake 8 29

ASA AMERICAN SOCIETY OF ANESTHESIOLOGISTS

April 1993

Issue: Bundling payments for the services of radiologists, anesthesiologists and pathologists into the hospital DRG (per discharge) payment system.

Position: The American Society of Anesthesiologists, American College of Radiology, College of American Pathologists and the American Medical Association strongly oppose this budget proposal.

Background:

The Reagan Administration proposed RAP DRGs in 1987. At that time, RAP DRGS was opposed by: The Ways and Means Committee, the Energy and Commerce Committee, the Finance Committee, 325+ Members of Congress who signed a House resolution of opposition, the Physician Payment Review Commission and the hospitals.

Problems:

1. Implementation of a physician DRG system would too closely align the incentives of physicians with hospitals. "This might well result in the physician not continuing to be as strong an advocate for needed medical services... "(Congressional Research Service, paper for the Senate Finance Committee, 1986)

2. These specialists are not different than other physicians who treat inpatients. To single them out as a facility service is totally inappropriate.

3. DRGs do not describe physician services and the complexity of anesthesiology, radiology or pathology services within any given DRG vary drastically. Unlike hospitals, these physicians do not have the volume of cases, nor control of case mix, to mitigate distortions.

4. Anesthesiology is a consultant service; anesthesiologists do not bring patients into the system or control volume. The budget proposal states RAP DRGs would encourage efficiencies and eliminate "marginal services". What part of an anesthetic can be called "marginal"?

5 The Medicare Fee Schedule (MFS) was legislated by the Congress two years after RAP DRGs were discussed and defeated. The Congress had specific MFS provisions for these specialties, thus indicating the intent of Congress that radiology, anesthesiology and pathology be treated as all other physician services and reimbursed under the MFS.

6. The MFS imposed severe cuts in anesthesiology payments. There is absolutely no justification for further targeted assaults on this critical medical specialty.

7 If the Congress and the Administration wants to move towards managed competition under health care reform, then a RAP DRG proposal is counter to that goal. These three specialities, representing about 70,000 physicians, would be completely removed from the managed competition game and the negotiations which are its heart.

520 N. NORTHWEST HIGHWAY • PARK RIDGE, IL 60068-2573 • TELEPHONE 708/825-5586 • FAX 708/825-1692

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

April 1993

Issue: The Congress is considering a Physician Payment Review Commission (PPRC) budget proposal that payments to the anesthesia care team be capped at 120 percent of the personally provided rate; that the payment be divided 50 percent to the CRNA and 50 percent to the anesthesiologist; that the 120 percent cap decrease to 100 percent over four years.

Position: The American Society of Anesthesiologists can support a cap set permanently at 120 percent, with the payment divided equally between the anesthesiologist and nurse; the existing base and time unit reductions for concurrent cases (OBRA '87) would be repealed. The ASA cannot support a decrease in the cap or any dilution of existing regulations (TEFRA) regarding the requirements for medical direction.

Background:

Several federal budget cycles have proposed capping payments to the anesthesia care team at 100 percent of the personally performed rate; current law would divide that payment 70 percent to the nurse anesthetist and only 30 percent to the anesthesiologist. The Congress has not supported such a proposal because it would mean the end of the anesthesia care team. The PPRC, however, has convened a technical advisory panel and independent researcher from the Center for Health Economics Research (CHER) to seek a solution to this issue.

The research report reviewed options based on these criteria: 1) preservation of incentives to maintain the care team and to avoid significant disruption of current employment arrangements; 2) preservation of quality and access; 3) administrative feasibility; and 4) political acceptability. Extensive simulations were prepared and reviewed by a panel of anesthesiologists and nurse anesthetists.

CHER concluded "Capping payments at 100 percent of the solo rate would lead to disincentives for anesthesiologists to medically direct CRNAs and/or for hospitals to employ CRNAs. It appears to be impossible to balance both objectives within a capped solo rate."

CHER recommended to the PPRC a cap at 120 percent of the solo rate, divided 50/50 between the anesthesiologist and CRNA; further study should be conducted before moving to any lower cap.

The PPRC is recommending to the Congress that a 120 percent cap apply only in the first year, and decrease by 5 percent per year over four years.

The ASA cannot support any cap lower than 120 percent of the solo rate, or any split providing less than 50 percent to the anesthesiologist, who bears the medical and legal responsibility for the patient's care. A 120 percent cap will provide federal budget savings, yet maintain an incentive for the much needed care team.

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# SENATOR DOLE SPEECH TO AMERICAN SOCIETY OF ANESTHESIOLOGISTS SUNDAY, APRIL 25

THANK YOU VERY MUCH. IT IS A PRIVILEGE TO BE HERE.

YOUR PRESENCE HERE IN WASHINGTON COMES AT A CRITICAL TIME. IT IS A TIME WHEN SOME SO-CALLED HEALTH CARE REFORMERS SEEM TO BE IN SEARCH OF AN

ENEMY, RATHER THAN A SOLUTION. THEY'RE LOOKING FOR SOMEONE TO BLAME FOR ALL THE COMPLEX PROBLEMS CONFRONTING OUR HEALTH CARE DELIVERY SYSTEM. UNFORTUNATELY THESE SAME REFORMERS, WHILE CRYING FOR CHANGE ARE TELLING GROUPS LIKE YOURS THAT YOU

ARE SIMPLY A "SPECIAL INTEREST", AND THEREFORE SHOULD HAVE NO VOICE IN THE DEBATE. THEY APPARENTLY FEEL THE SAME WAY ABOUT REPUBLICANS -- WE'VE ALSO BEEN EXCLUDED FROM HAVING ANY INPUT INTO THE WHITE HOUSE TASK FORCE.

WELL, I'M HERE TO TELL YOU THAT THE ONLY SPECIAL INTEREST I CARE ABOUT IS THE AMERICAN PEOPLE. THEY ARE THE ONES WHO WILL SUFFER IF THE WHITE HOUSE AND CONGRESS DO THE WRONG THING.

AS MANY OF YOU KNOW,

SENATE REPUBLICANS HAVE BEEN DEEPLY IMMERSED IN THE ISSUE. WE'VE HAD A HEALTH TASK FORCE HARD AT WORK FOR THE PAST TWO YEARS, AND I SAY WITH PRIDE THAT SOME OF MY REPUBLICAN COLLEAGUES TAKE A BACKSEAT TO NO ONE WHEN IT COMES TO HEALTH CARE EXPERTISE AND

COMPASSION.

THOSE OF US WHO HAVE BEEN ON THE FRONTLINES OF THIS ISSUE KNOW FIRSTHAND THAT THE HEALTH CARE CHALLENGE IS BIGGER THAN ANY ONE GROUP -- BIGGER THAN THE REPUBLICAN TASK FORCE, BIGGER THAN THE

DEMOCRATIC TASK FORCE AND BIGGER THAN THE WHITE HOUSE -- AND THE SOONER WE ALL GET INVOLVED THE BETTER.

NO DOUBT ABOUT IT, HEALTH CARE IS AN ISSUE THAT CRIES OUT FOR BIPARTISAN COOPERATION. IT WILL BE NEARLY IMPOSSIBLE TO PASS

ANY MAJOR REFORM WITHOUT IT. AND BIPARTISAN DOESN'T MEAN SIMPLY PICKING OFF THREE REPUBLICANS SO THAT THE DEMOCRAT MAJORITY CAN RAM A FLAWED PLAN THROUGH CONGRESS AND CLAIM VICTORY.

IT IS HARDLY NEWS THAT HEALTH CARE COSTS HAVE

SPIRALED OUT OF CONTROL --

WE ARE RAPIDLY APPROACHING

THE ONE TRILLION DOLLAR

MARK FOR HEALTH CARE

SPENDING. AND, AS YOU KNOW,

THIS SPENDING IS ONE OF THE

MAJOR FACTORS IN THE

RECORD-SETTING FEDERAL

DEFICIT, WITH ENTITLEMENT

PROGRAMS GROWING AND

GROWING EACH YEAR, ALONG WITH THE NUMBER OF UNINSURED.

EVERYONE WANTS TO KNOW WHY HEALTH CARE COSTS KEEP GOING UP. FOR LEADERS AND EXPERTS, THE ANSWER IS THAT THE COST ISSUE IS A COMPLEX ONE. THEY

REFER TO FACTORS SUCH AS DUPLICATION OF TECHNOLOGY AND SERVICES, DEFENSIVE MEDICINE, TOO MANY REGULATIONS, MOUNTAINS OF PAPERWORK, HEALTH COSTS ASSOCIATED WITH CRIME AND DRUG ABUSE, AND AN AGING POPULATION.

BUT, AS I POINTED OUT TO SOME OF YOUR COLLEAGUES WHEN I ADDRESSED THE A.M.A. LAST MONTH, ACCORDING TO A RECENT SURVEY FROM GALLUP, THE AMERICAN PEOPLE CAN SUM UP THE COST ISSUE IN ONE SIMPLE WORD: "GREED". THE SURVEY SHOWS THAT AMERICANS BLAME THE HIGH

COSTS ON UNNECESSARY TESTS, WASTEFUL HOSPITALS, OVERPAID DOCTORS, AMBULANCE-CHASING MALPRACTICE LAWYERS, AND OVERPRICED PHARMACEUTICALS. FROM THE PUBLIC'S PERSPECTIVE, WE DON'T HAVE A COST PROBLEM, WE HAVE A "PROFITS" PROBLEM.

THE AMERICAN PEOPLE BELIEVE THAT OUR HEALTH CARE SYSTEM IS RIDDLED WITH WASTE AND GREED.

THEREFORE, NO ONE IS EAGER TO TALK ABOUT HARD CHOICES.

NO ONE WANTS TO GIVE UP ANYTHING. AND NOT MANY WANT TO CONSIDER CHOICES THAT RAISE THEIR OWN COSTS

OR REDUCE THE SERVICES THEY GET. THE HARD FACTS ARE, IF WE ARE GOING TO IMPROVE THE LOT OF SOME -- OTHERS WILL HAVE TO DO WITH CHANGES IN WHAT THEY GET TODAY. BUT THAT IS NOT AN EASY PLAN TO SELL. IT'S MUCH EASIER TO SIMPLY MAKE YOU THE ENEMY -- TO PUT PRICE CONTROLS AND

GLOBAL BUDGETS IN PLACE. IN THE VIEW OF THIS SENATOR -- AND IN THE VIEW OF MANY OTHERS IN OUR TASK FORCE -- THAT'S NOT THE ANSWER.

THE CATASTROPHIC HEALTH CARE LEGISLATION THAT CONGRESS PASSED IN 1988 IS A GOOD EXAMPLE OF

GOOD INTENTIONS GONE BAD.

WE THOUGHT IT WAS A PRETTY

GOOD IDEA. WE SAID TO THE

PEOPLE WHO WERE BETTER OFF

THAN OTHERS, THAT THEY

OUGHT TO PAY A LITTLE MORE.

I THOUGHT IT MADE A LOT OF

SENSE, AND WAS GOOD

LEGISLATIVE POLICY. IT WAS A

TOUGH DECISION, BUT IT

PASSED CONGRESS BY AN OVERWHELMING MAJORITY. LESS THAN A YEAR LATER, IT WAS REPEALED BECAUSE THE PEOPLE WHO WERE GOING TO HAVE TO PAY MORE HAD A VERY EFFECTIVE LOBBY. THEY TOLD US HOW THEY EARNED THESE BENEFITS, AND HOW EVEN THOUGH THEY MIGHT BE

BETTER OFF, THEY SHOULDN'T HAVE TO PAY ONE MORE CENT. AND LET'S FACE IT, WHEN THE SENIOR CITIZENS SPEAK UP, CONGRESS LISTENS -- AND WHEY THEY SPOKE, CONGRESS CHANGED ITS VOTE. WHAT LOOKED LIKE COMMON SENSE REFORM WAS QUICKLY REPEALED.

SO THE LESSON WE LEARNED THEN, AND WHAT WE ARE LEARNING NOW, IS THAT AMERICANS STILL WANT MORE CARE, MORE QUALITY, MORE ACCESS, BUT AT LOWER COSTS.

SO, WHAT DO WE DO?

I BELIEVE WE ALL SHARE THE SAME GOALS -- UNIVERSAL

ACCESS FOR ALL, IN A SYSTEM THAT CONTAINS COSTS WHILE PRESERVING CHOICE AND THE HIGH QUALITY OF CARE.

WE ALL WANT TO SEE HEALTH CARE REFORM -- WE ALL KNOW THAT WE CANNOT SUSTAIN OUR CURRENT RATE OF SPENDING -- AND WE ALL

KNOW THAT WE MUST FIND A WAY TO BRING EVERYONE INTO THE SYSTEM.

THE AMERICAN PUBLIC SHOULD EXPECT US, THEIR ELECTED REPRESENTATIVES, TO SEEK SOLUTIONS THAT MAINTAIN THE FOLLOWING SIX PRINCIPLES. THESE PRINCIPLES

SHOULD BE USED TO EVALUATE ANY PLAN PUT FORWARD BY THE ADMINISTRATION OR BY REPUBLICANS WHEN THEY INTRODUCE THEIR OWN ALTERNATIVE.

1. PROTECT QUALITY -- THERE IS A REASON OUR HEALTH SYSTEM IS THE ENVY OF

THE WORLD -- WHY PEOPLE FROM EVERY COUNTRY IN THE WORLD SEND THEIR YOUNG PEOPLE HERE TO BE TRAINED, TO DO RESEARCH; WHY THEY FLOCK HERE TO YOUR HOSPITALS FOR CARE -- THE REASON IS QUALITY. THANKS TO OUR SEARCH

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FOR QUALITY AND EXCELLENCE, WE HAVE DEFEATED PLAGUES, MADE SPARE PARTS FOR NEARLY EVERY BODY ORGAN, AND OUR INTENSIVE CARE NURSERIES CAN SAVE THE LIFE OF THE SMALLEST, FRAILEST NEWBORN. IN OUR WISH TO LOWER

COSTS AND BETTER

MANAGE OUR RESOURCES,

LET'S NOT THROW AWAY

OUR MEDICAL MIRACLES.

2. INCREASE ACCESS,

PRESERVE CHOICE, AND

FLEXIBILITY -- CONSUMERS,

NOT THE GOVERNMENT,

SHOULD BE THE ONES TO

MAKE CHOICES ABOUT WHERE THEY GET THEIR CARE AND FROM WHOM. AT THE HEART OF OUR FREE MARKET SYSTEM, IS OUR ABILITY TO CHOOSE. IN HEALTH CARE, AS IN NO OTHER INDUSTRY, THAT CHOICE IS CRITICAL TO MAINTAINING QUALITY

HEALTH CARE FOR YOU AND YOUR FAMILY. AND CRITICAL TO MAINTAINING CHOICE IS FLEXIBILITY IN ANY SYSTEM. WHETHER IT'S THE ABILITY TO CHOOSE BETWEEN HOSPITAL BASED CARE OR HOME BASED CARE -- OR THE ABILITY TO DESIGN A

SYSTEM SPECIFICALLY GEARED TO THOSE IN RURAL AMERICA -- WE MUST ALLOW THOSE CHOICES AND THAT TARGETING OF RESOURCES.

3. PRESERVE JOBS -- THIS MAY BE ONE OF OUR

TOUGHEST CHALLENGES.

WE ALL AGREE THAT WE HAVE TO INCREASE THE NUMBER OF PEOPLE IN THE COUNTRY WHO HAVE ACCESS TO HEALTH CARE AND HEALTH INSURANCE.

SOME WILL ARGUE THAT MANDATES ON EMPLOYERS IS THE ONLY OPTION. BUT

WHAT WE CAN'T AFFORD TO DO IS PUT OUR PEOPLE OUT OF WORK BY MANDATING AND TAXING SMALL BUSINESS OUT OF BUSINESS. EVERY SMALL EMPLOYER I TALK TO DESCRIBES THE PRECARIOUS FINANCIAL SITUATION THEY ARE IN --

ANOTHER PAYROLL TAX --

ANOTHER MANDATE COULD

PUT THEM OVER THE EDGE.

KEEPING PEOPLE AT WORK

AND KEEPING OUR

ECONOMY GROWING IS THE

BEST PRESCRIPTION FOR

BETTER HEALTH CARE

BENEFITS.

4. NO GOVERNMENT CONTROLLED CARE -- IT'S A SHAME THAT SOME CRITICS HAVE TO BE REMINDED, BUT WE ARE NOT SWEDEN OR GERMANY OR EVEN CANADA -- AND WE DON'T WANT TO BE. YES, WE'VE GOT REAL PROBLEMS. BUT THEY REQUIRE AMERICAN

SOLUTIONS. MANAGED COMPETITION -- AS IT HAS BEEN DESCRIBED TO ME -- BUILDS ON THE PRIVATE SECTOR AND HELPS PEOPLE MAKE BETTER CHOICES ABOUT THEIR FAMILIES AND WHAT THEY NEED. THE GOVERNMENT SHOULD BE THERE TO HELP

THOSE WHO NEED IT AND HAVE NO OTHER RESOURCES -- IT'S NOT THERE TO CONTROL OUR LIVES. YES, PEOPLE WANT THE SECURITY THAT AN ILLNESS WON'T BANKRUPT THEM. BUT, AMERICANS DON'T WANT SOCIALISM WHICH SOME ARE TRYING

MIGHTILY TO INSTITUTE WHENEVER THEY CAN.

5. CONTROL COSTS NOT CARE -- GLOBAL BUDGETS AND PRICE CONTROLS TRANSLATE INTO REDUCED QUALITY AND RATIONED CARE. CONTROLS ON THE PRICES OF HEALTH CARE

ONLY POSTPONES THE

NECESSARY

CONFRONTATION WITH THE

UNDERLYING DEMAND THAT

HAVE PRODUCED THEIR

INCREASE.

UNFORTUNATELY,

CONTROLS ARE INEVITABLY

TARGETED AT THE

SYMPTOMS NOT THE

CAUSES. LET'S CREATE AN ENVIRONMENT TO REDUCE COSTS AND UTILIZATION THROUGH A BETTER, MORE APPROPRIATE USE OF SERVICES. LET'S PUT RESPONSIBILITY ON NOT ONLY PROVIDERS, BUT ALSO ON EMPLOYERS AND EMPLOYEES TO USE CARE

WISELY. LET'S ENCOURAGE PREVENTION -- LETS ENCOURAGE BETTER MANAGEMENT OF CARE AND RESOURCES. LETS CHANGE FINANCIAL INCENTIVES NOT SHUT THEM DOWN.

6. <u>REAL TORT REFORM</u> -- IN

NO OTHER INDUSTRIALIZED COUNTRY DO HEALTH CARE PROVIDERS CONFRONT THE DAY-TO-DAY THREAT OF LITIGATION. IT'S NO WONDER PHYSICIANS AND NURSES AND OTHERS FIND IT HARD TO SAY, "NO" WHEN A PATIENT DEMANDS ANOTHER TEST, OR ORDER

A TEST SO AS TO AVOID THE CHARGE THEY DIDN'T DO ENOUGH. THAT'S NO WAY TO DO BUSINESS.

NOW, LET ME BE CLEAR -- NO DOUBT THAT MISTAKES ARE SOMETIMES MADE AND SOME PATIENTS ARE FULLY DESERVING OF PROTECTION

UNDER THE LAW, AND ARE DUE PROPER COMPENSATION. BUT AT SOME POINT, REASON MUST RULE. IT'S LONG PAST TIME FOR THE DEMOCRAT MAJORITY ON CAPITOL HILL TO STAND UP TO THE TRIAL LAWYERS ASSOCIATION AND SAY, ENOUGH IS ENOUGH! IT'S ALSO TIME FOR US TO CREATE A

LEGAL ENVIRONMENT THAT ENCOURAGES HOSPITALS AND OTHER INSTITUTIONAL PROVIDERS TO USE THEIR RESOURCES IN WAYS THAT REDUCE COSTS, MAXIMIZE ACCESS AND REWARD INNOVATION.

THIS YEAR, AS YOU KNOW,

WE ARE DISCUSSING "MANAGED COMPETITION", WHICH SOME SAY WILL CONTROL COSTS WHILE BRINGING EVERY AMERICAN INTO THE SYSTEM. I HAVE TO BELIEVE THAT MANY AMERICANS -- INCLUDING SOME IN GOVERNMENT -- ARE UNCERTAIN OF WHAT MANAGED COMPETITION IS, OR HOW IT

REALLY WORKS. I, FOR ONE, HAVE QUESTIONED HOW MANAGED COMPETITION WILL WORK IN RUSSELL, KANSAS, OR ANY RURAL AREA, OR INNER CITY, WHERE THERE ARE ONLY ONE OR TWO DOCTORS.

AND, THERE IS CONCERN BY MANY THAT MANAGED

COMPETITION WILL REDUCE THE ABILITY OF AMERICANS TO CHOOSE THEIR PROVIDERS, OR WILL LEAD TO RATIONING OF CARE. THESE ARE ISSUES THAT WILL HAVE TO BE ADDRESSED.

THE CHALLENGE NOW IS TO DEVELOP A FAIR AND EQUITABLE HEALTH CARE

# STRATEGY TO MAKE HEALTH CARE AVAILABLE TO ALL AMERICANS THROUGH A COMPETITIVE PRIVATE SECTOR HEALTH CARE SYSTEM.

PERHAPS THE REAL CHALLENGE IS TO ACCOMPLISH THIS WITHOUT RAVAGING THE ECONOMY -- WITHOUT HURTING

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BUSINESS -- AND WITHOUT FURTHER STRAINING OUR BANKRUPT ECONOMY. IT'S PRETTY EASY TO PROMISE EVERYBODY EVERYTHING, BUT THAT KIND OF PROPAGANDA WILL ONLY HELP MAKE THE CRISIS A PERMANENT ONE.

THIS DEBATE CAN NOT

DISINTEGRATE INTO A POLITICAL CONTEST. IF IT DOES, THE AMERICAN PEOPLE WILL BE THE LOSERS. THE AMERICAN PEOPLE WANT ANSWERS AND SOLUTIONS, AND THEY DON'T CARE WHICH PARTY TAKES CREDIT. CLEARLY, WE HAVE TO WORK TOGETHER -- PROVIDERS, BUSINESS, INSURERS,

CONSUMERS, AND THE GOVERNMENT.

I AM CONVINCED THAT REFORM CAN TAKE PLACE -- AND I AM CONVINCED THAT IT CAN BE DONE WITHOUT CREATING MORE REGULATIONS OR ANOTHER GOVERNMENT PROGRAM.

NO DOUBT ABOUT IT, THE ADMINISTRATION AND CONGRESS MUST WORK TOGETHER ON REFORMING OUR NATION'S HEALTH CARE SYSTEM. AND REPUBLICANS ARE READY TO ROLL UP OUR SLEEVES AND FACE THE DIFFICULT DECISIONS THAT MUST BE MADE.

THE PRESIDENT HAS DONE THE RIGHT THING BY MAKING HEALTH CARE A TOP PRIORITY. NOW COMES THE HARD PART: LEADERSHIP. FOR THE NEXT FEW MONTHS, THE HEALTH CARE CHALLENGE WILL BECOME A REAL TEST OF HIS LEADERSHIP ABILITIES. THE PRESIDENT CAN TRY TO GO IT

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ALONE. HE CAN SHUT OUT THE EXPERTS. HE CAN WELCOME ONLY HIS DEMOCRAT ALLIES TO THE OVAL OFFICE, BUT THAT'S NOT LEADERSHIP. THE AMERICAN PEOPLE WANT ACTION, THEY WANT RESULTS. IF THE PRESIDENT LISTENS TO THE PEOPLE, HE'LL GET THE MESSAGE. IF HE DOES, WE'LL

ALL BE PLAYERS. IF NOT, WE'LL ALL BE THE LOSERS. THAT WOULD BE A DISASTER.

I CAN ASSURE YOU THAT REPUBLICANS CONTINUE TO BE FULLY COMMITTED TO REFORMING OUR HEALTH CARE DELIVERY SYSTEM. WE CONTINUE TO MEET ON A

WEEKLY BASIS AND WILL REMAIN COMMITTED UNTIL HEALTH CARE COSTS ARE CONTAINED AND ALL AMERICANS HAVE ACCESS TO THE SYSTEM. WE MAY BE LOCKED OUT OF THE WHITE HOUSE, BUT WE REFUSE TO BE LOCKED OUT OF THE DEBATE. IF THE WHITE HOUSE THINKS

THAT THEY CAN REFORM FOURTEEN PERCENT OF THE AMERICAN ECONOMY ALONE -- AND THAT GROUPS SUCH AS THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AND EVERY OTHER GROUP OF PROFESSIONALS SHOULD ONLY HAVE SEASON TICKETS TO THE OBSERVATION DECK, THEN IT'S

TIME TO TELL THE WHITE HOUSE IT NEEDS A CHECK-UP.

AGAIN I THANK YOU FOR YOUR EFFORTS, AND LOOK FORWARD TO WORKING WITH YOU.

#

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