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SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES SUBCOMMITTEE ACTION ON H.R. 3600, THE HEALTH SECURITY ACT OF 1993

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced that on Wednesday, March 23, 1994, the Subcommittee reported H.R. 3600, the Health Security Act of 1993, to the full Committee on Ways and Means with a favorable recommendation.

A brief summary of the provisions approved by the Subcommittee follows.

Title I. Health Care Security

I. Universal Coverage and Individual Responsibilities

A. Universal Coverage and Entitlement to Health Benefits

Each eligible individual would be entitled to health insurance that covers the guaranteed national benefit package. Every eligible individual would be entitled to a health security card. An eligible individual would be defined to include any individual who is residing in the United States, and who is a citizen or national of the United States, an alien permanently residing in the United States under color of law, or a long-term nonimmigrant.

B. Protection of Consumer Choice

An individual would be free to choose his or her own health care providers, and to purchase health care services. Employers or individuals would be free to purchase benefits in addition to the comprehensive benefit package.

C. Individual Responsibilities

All individuals would be covered under a private health plan meeting the standards specified in Title V, or in Medicare Part C. The individual responsibility requirements would be effective January 1, 1998, and would be enforced through the Internal Revenue Code.

In general, an employee in a firm that offers private health insurance would not be permitted to enroll in Medicare Part C. An exception to this rule would be permitted for any low-income employee and for any part-time, seasonal or temporary employee, who would be permitted to elect coverage under Medicare Part C. Any individual not connected to the workforce could elect to enroll in a private health insurance plan, or under Medicare Part C.

Individuals would be required to pay the premium for the guaranteed benefit package, minus the amount contributed on their behalf by employers. Individual employee contributions for their net share of the premium would be collected by the employer through payroll deductions. Low-income individuals would be eligible for a sliding-scale subsidy of the net premium amount owed, after deducting employer contributions, if any.

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II. Employer Responsibilities

A. General Employer Responsibilities

All employers would be required to contribute toward the cost of health insurance coverage for all employees. Employer contributions would cover at least 80 percent of the premium of the guaranteed national benefit package for full-time employees and their dependents.

Employer contributions for part-time, seasonal and temporary workers would be based on a pro rata share based on the ratio of the number of hours worked per week to 40 hours.

Employers with more than 100 employees would be required to meet this requirement for their workers, beginning January 1, 1996. Employers could meet this requirement through coverage under a private health plan, coverage under a self-insured plan if the employer has 1,000 or more full-time employees and elects to self-insure, or coverage under a qualified State health plan. (see Title III)

Employers with 100 or fewer employees would be required to meet this health insurance obligation for workers, beginning January 1, 1998. Medicare Part C would be available to individuals in firms with 100 or fewer employees by January 1, 1998.

Employers of children to age 18, of full-time students to age 24 would not be required to contribute on behalf of such workers -- provided such a worker is covered under a parent's health plan.

Employers would be required to offer employees a choice of a managed care plan and a plan that provides an unlimited choice of providers. Employers would be responsible for contributing at least 80 percent of the least cost of each type of plan that covers the guaranteed national benefit package.

A five-year maintenance-of-effort requirement would be imposed on employers that currently offer benefits in excess of the guaranteed national benefit package. Non-discrimination rules would prohibit employers from paying greater amounts, or from providing more generous benefits, for certain full-time employees.

B. Employer Responsibilities with Respect to Families

Employers would be required to allow family members of workers to be covered under the employer's health plan, if a private plan is offered by the employer. Employer contributions would cover at least 80 percent of the applicable premium, based on the class of family enrollment.

If a family with two workers elects to be covered under a private plan offered by one employer, the enrolling employer would contribute at least 80 percent of the cost of the premium, based on the class of family enrollment and the non-enrolling employer would contribute 80 percent of the Medicare Part C individual premium on behalf of the employee to the enrolling employer.

C. Employer Obligations for Retirees

Employers who, as of October 1, 1993, were paying a portion of the health costs for retirees ages 55 through 64, and their spouses and dependents, would be required to continue coverage. An employer could meet this obligation by paying at least 80 percent of the premium under: a private health plan; a self-insured plan, if applicable; or Medicare Part C, beginning in 1998. A maintenance-of-effort rule would require employers with contractual retiree health obligations that exceed benefits under the guaranteed national benefit package to provide such benefits to retirees, spouses and dependents, consistent with contractual obligations.

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D. Continuation of Health Benefits under COBRA Extension

Continuation of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) would be extended during the transitional period, and would terminate the earlier of (1) coverage of an employee or dependent under an employer-sponsored plan; (2) coverage of an employee or dependent under the current Medicare program, or (3) the establishment of the Medicare Part C plan, January 1, 1998.

Title II. Benefits

I. Guaranteed National Benefit Package

The guaranteed national benefit package would be covered under Medicare Part C, and would be offered by all private health insurers, and by employers with self-insured plans. Individuals and employers would be permitted to purchase supplemental policies for coverage of additional benefits and cost-sharing.

The guaranteed national benefit package would include the benefits currently covered under Medicare Parts A and B, with improvements. The benefit package would include: a single deductible of $500 per individual/$750 per family and coverage of outpatient prescription drugs, with a separate $500 deductible, 20 percent cost-sharing, and $1,000 out-of-pocket cap, which would be indexed annually. Inpatient services would be covered without co-insurance, deductibles or spell-of-illness restrictions. The Secretary would define an alternative cost-sharing schedule for managed care plans.

Also covered under the guaranteed national benefit package, would be additional services for children to age 18, with no cost-sharing. Newborn and well-baby care would be consistent with the services and periodicity schedule specified by the Secretary, in consultation with the American Academy of Pediatrics, including pediatric attendance at high-risk deliveries. Well-child services, including routine office visits, routine immunizations, routine lab tests, dental care, periodic lead screening and child abuse assessment, without cost-sharing would be covered. All pregnancy-related services would be covered. Family planning services would be covered. Additional preventive benefits would be covered, such as immunizations, mammography screening, pap smears, and colorectal screening, including colonoscopies.

A new mental health/substance abuse benefit would be established that would provide access to a continuum of services, which emphasize community and residential settings. The mental health benefit package would include intensive residential and community services and outpatient mental health services, with reduced copayments for children to age 18. Inpatient services would be covered, but limited to 90 days in general hospitals and 45 days in psychiatric hospitals, with a lifetime limit of 190 days in psychiatric hospitals. In addition, States would be given broad flexibility to establish comprehensive, managed, mental health programs for low-income adults and children with serious mental illness or emotional disturbances. The programs would allow eligible individuals to continue to receive the services defined in the guaranteed national benefit package for mental health, but without limits, and at the state option, with reduced copayments.

II. Coverage of Outpatient Prescription Drugs

Outpatient prescription drugs, biological products, insulin, and home infusion drugs would be added to the services covered under Medicare Parts B and C. In 1996, the deductible would be set at $500 and the out-of-pocket limit would be set at $1,000. Payments would be at 80% of the lesser of the actual charge for the drug or the Medicare payment limit.

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Payment limits would vary depending upon whether the drug is a single or multiple source drug with restrictive prescription, or a multiple source drug without a restrictive prescription. The limits would be updated subject to the target rate of increase for the prescription drug sector.

In order for payment to be available under Medicare, manufacturers would be required to enter into and have in effect a rebate agreement with the Secretary. As part of the rebate agreement, a manufacturer would be required to guarantee that the manufacturer would offer, to each wholesaler or retailer that purchases such drugs on substantially the same terms as any other purchaser, that same price for such drugs as is offered to such other purchaser.

There would be mandatory assignment for all covered outpatient drugs. The administrative allowance would be set at $5 per prescription. Pharmacists would be required to submit claims to Medicare carriers through a point-of-sale electronic system. The Secretary would establish a program to assure appropriate prescribing and dispensing practices under Medicare.

Only qualified home infusion drug therapy providers, who meet requirements established by the Secretary, would qualify to provide covered home infusion drug therapy services.

An 11-member Prescription Drug Payment Review Commission would be established. The Part B premium would be adjusted to finance 25 percent of the cost of the prescription drug benefit provided under Medicare Part B.

III. Other Changes in Medicare Benefits

In general, the current Medicare benefit package would be improved to include newborn services, well-baby services, well-child services, pregnancy-related services, family planning services, drugs and devices, outpatient prescription drug coverage, mental health services, and additional preventive services, consistent with the benefits covered under the guaranteed national benefit package.

Medicare would be required to make available to beneficiaries the choice of a managed care plan, if available, and an unlimited choice of providers which could involve a point-of-service option.

Title III. State Responsibilities

States would be given broad flexibility to establish their own health reform systems. The Secretary's approval would be granted for two types of authority: (1) State control solely over provider reimbursement, either as a whole or sector by sector (e.g., physician services or hospital services), and (2) State authority over all health care benefits provided in the State, including self-insured plans.

Under either system, States would be required to meet a spending target consistent with the national health spending estimates and meet other requirements for approval by the Secretary. The Federal fallback cost containment system (described in Title VI below) would not apply to providers in a State with an approved program.

With respect to State health care benefit plans, a State plan would have to provide coverage for at least the guaranteed national benefit package for all residents, other than residents covered under Medicare Parts A through C. Guarantee of coverage could be through a State single payer or public plan, an employer mandate, a combination of public and private coverage, competing health plans, managed competition, or any other system, provided that it covered all residents.

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After three years of experience with the State plan, a State could apply to integrate coverage under Medicare Parts A, B, and C into a State-based system. The Secretary could waive the three-year requirement in the case of a State which provides evidence, satisfactory to the Secretary, that all of the requirements for State benefit programs will be met, and that all benefits guaranteed to Medicare beneficiaries will be provided.

During the first three years of a State program which includes Medicare beneficiaries, the Secretary may, at the Secretary's discretion, upon thirty days notice, reduce payments on behalf of the Medicare program to a State or health care providers in a State in order to ensure that spending does not exceed the targets otherwise provided.

If the Secretary determined that a State program produced savings to the Medicare program over a period of three consecutive years, the Secretary would pay the savings attributable to the first year of that period to the State in the following year, and pay subsequent year's savings in subsequent years.

Title IV. Health Alliances

Regional Health Alliances could be established in each State, at each State's discretion, in which employer participation generally would be voluntary, although participation could be mandatory under an approved State plan as described in the preceding section.

$150 million in grants for the five year period beginning in fiscal year 1995 would be authorized to assist States in the planning, development, and initial operation of alliances. In order to be eligible for Federal grants, a State alliance program would have to meet certain requirements.

Under the grant program, an alliance could only be operated by a non-profit organization or a State agency. States could provide for division of the State into more than one area and one or more contiguous States could provide for the establishment of an inter-State alliance.

Under the grant program, regional health alliances would enter into agreements with any health plan meeting Federal standards that seeks to offer health insurance through the alliance. Alliances would offer to enter into agreements to provide services to any employer in the alliance area with fewer than 1,000 full-time employees. Regional health alliances would make similar services available to individuals and families that are not employees of participating employers but who reside in the alliance area and assist eligible individuals in enrolling in Medicare Part C.

A State could designate a regional health alliance to enforce a State capital allocation plan for the review of health-care related capital expenditures.

Title V. Health Plans

I. Establishment of Federal Standards

The Secretary of HHS would promulgate regulations to implement Federal standards for health plans sold to individuals and employers by July 1, 1995.

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States would be required to adopt the Federal standards within one year after they were issued by the Secretary, with additional time for States in which the legislature does not meet annually. The Secretary would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply. A Federal excise tax would be established for plans not in compliance with Federal standards. In addition, the Secretary could withhold Federal financial assistance in the case of a State that is not in compliance with the adoption and enforcement of Federal standards, and refer matters involving non-complying health plans to the U.S. Attorney General for further action.

The Secretary would continue to regulate financial solvency of health insurance using standards at least as stringent as model standards developed by the National Association of Insurance Commissioners.

II. Federal Standards for Health Plans Sold to Employers and Individuals

Health plans would be prohibited from denying coverage to any eligible group or individual. Plans would be required to provide for year-round open enrollment for groups and individuals. Plans sold through associations or multiple employer arrangements approved by the Secretary could restrict membership in the plan to members of the organization. Managed care plans that demonstrate they have reached capacity could apply to close enrollment.

Coverage would be guaranteed renewable, and plans could not deny or limit coverage based on a pre-existing condition. No waiting periods would be permitted.

Anti-discrimination rules would prohibit plans from engaging directly or indirectly in activities that would have the effect of discriminating against an individual.

Health plans would be required to offer the guaranteed national benefits as a separate package. Benefits would be offered using one of three cost sharing schedules: fee-for-service, managed care ,and point-of-service (combining fee-for-service and managed care cost sharing schedules).

Health plans would be required to sell the guaranteed national benefit package at community-rated premiums for all purchasers. Premiums could vary only for the four enrollment categories (individual, couple only, single parent, and two adults with children) and by geographic area. Plans would be allowed to phase in community-rated premiums over a three-year period.

Plans sold through a health alliance or approved association or multiple employer arrangement approved by the Secretary could provide an administrative discount specified by the health plan in advance. Health plans would be required to apply the administrative discount uniformly among associations or alliances.

Managed care plans, including those offering a point-of-service option would be required to meet additional requirements pertaining to arrangements with physicians and the availability and accessibility of medically necessary services. $25 million a year in Federal grants would be made available to support the development and initial operation of non-profit, community-based staff and group model HMOs in underserved areas.

Federal standards for marketing of health plans would be established. Marketing materials would be required to be approved in advance, and each State would make available to consumers information in a uniform format on approved health plans sold in the State. Materials could not be used to attract or limit enrollment of certain individuals or groups.

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The Secretary would be required to study and develop a risk adjustment and/or reinsurance methodology that could be used to reallocate premiums among insurers in a State, including a separate risk adjustment methodology based on risk factors existing solely within the pediatric health community.

Health plans would be required to offer contracts to all essential community providers in the plan's service area. Certain urban hospitals that would qualify as disproportionate share hospitals under Medicare, Federally Qualified Health Centers (FQHCs), county health departments, sole community hospitals, rural health clinics, rural Medicare-dependent hospitals and individual health providers in medically underserved areas would be designated as essential community providers. The terms of contracts could not be less favorable than those with other participating providers. Payment to FQHCs would be based on Medicare reasonable cost rates.

Plans would be required to meet standards established in Title X pertaining to grievance procedures, quality assurance and consumer protection requirements, and administrative simplification. Plans would be required to disclose utilization review requirements to consumers and the State.

III. Requirements for Supplemental Benefit Plans

Supplemental policy benefits sold to individuals and employers would be restricted to those provided in up to ten standardized supplemental benefit packages defined by the Secretary. Supplemental policies would be required to meet Federal standards for open enrollment and community rating. The sale of supplemental benefits could not be tied to the sale of the guaranteed national benefit package or any other policy, except that managed care plans would be prohibited from selling supplemental coverage to individuals other than those enrolled in the managed care plan for the guaranteed national benefit package.

In defining supplemental benefit packages, the Secretary would be directed to take into account current State laws. State laws that require health plans to offer benefits in addition to the guaranteed national benefit package would be pre-empted. Laws relating to provision of benefits by specific types of providers would also be pre-empted, and Medicare's definitions of providers would be used instead.

Standardized benefits for Medicare supplemental insurance (Medigap) policies would be conformed to changes in the benefits covered under Medicare Parts A and B. Open enrollment requirements would apply to Medigap policies.

IV. Requirements for Self-Insured Employer Plans

Limits on self-insurance would be established. Effective January 1, 1998, employers with 1,000 full-time employees or less and Multiple Employer Welfare Arrangements would be prohibited from self-insuring.

Self insured employer plans would be certified annually by the Secretary of HHS as meeting Federal standards. A Federal excise tax penalty would be established for non-compliance.

Self-insured employer plans would be required to provide the guaranteed national benefit package, and could provide additional benefits. Plans could not deny or limit coverage or vary premium contributions charge to any eligible individual based on a pre-existing condition, claims experience, or medical history. Waiting periods for coverage would be prohibited, and plans would be required to meet standards specified by the Secretary with respect to grievance procedures, quality assurance and administrative simplification.

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V. Transitional Insurance Reforms

Transitional insurance reforms would be established and effective in each State beginning on January 1, 1995, until the Federal standards described above take effect in the State. Requirements would not pre-empt any existing State law that is more stringent.

Under the transitional insurance reforms, health plans would be required to maintain coverage in force and to accept new members in a group plan without respect to health status. Pre-existing condition exclusions would be prohibited for individuals with previous coverage and would be limited to six months for newly insured individuals.

Insurers would have to apply consistent rating policies with respect to demographic characteristics and changes in benefit design across all covered individuals and groups. Premium increases for individual plans and small group plans (less than 100 employees) could not vary based on claims experience.

Health plans would be required to file a certification with the Secretary or the State indicating that they are in compliance with the transitional insurance reform requirements. Self-insured employer plans would be prohibited from reducing or limiting coverage with respect to any medical condition for which the cost of treatment is expected to exceed $5,000 a year.

Transitional insurance reform requirements would be enforced by the Secretary of HHS, subject to a civil monetary penalty up to $25,000 for each violation. The Secretary could elect to enter into agreements with States to enforce the requirements.

Title VI. Cost Containment in the Private Sector

A. Establishment of National Health Expenditure Estimates

The Secretary would estimate total national health expenditures under Medicare, and under private plans, and the baseline rates of growth for future years. The estimate of health spending in the private sector would include spending for services covered under the national guaranteed benefit package, under supplemental policies, and related cost sharing.

The national health spending estimates would be established on a per capita basis to adjust the estimates for shifts in enrollment between the public and private sectors. Target rates of growth would be set by statute for spending by private plans in each year, beginning with 1996. The target rate of growth would be set such that the rate of growth in private spending would be reduced by two percentage points in 1996, and by an additional one percentage point in each subsequent year until the rate of growth is slowed to the five-year average per capita rate of growth in the gross domestic product (GDP).

The private sector estimate for 1998 would be adjusted to reflect the effects of universal coverage and the implementation of Medicare Part C.

Beginning in 2001, the Secretary would establish estimates that would provide for a unitary national health spending estimate that combines the Medicare and private sector national health spending estimates. By 2005, the private sector estimate would be phased down to the level that would apply if Medicare payment rates were used as the maximum payment rates in the private sector.

B. Allocation of National Estimates to Classes of Services and States

The estimate of health spending in the private sector would be allocated to various classes of health services based upon the historic share and growth rates attributable to each class. The allocation to each sector within each estimate would then become an overall target attributable to each type of health service, such as hospital or physician services. Once established, these allocations could only be changed through legislation.

The estimate also would be allocated to each State to monitor State's success in controlling health care costs. The allocation would be based on the prices in each State that would apply under the maximum payment rate system and utilization patterns within each State. The State allocations would grow at the same rate as the national health spending estimate for the private sector.

Health providers would report information to the Secretary to permit monitoring of health care spending within each State.

C. Imposition of Fall-back Cost Containment System

States and health care providers would not be subject to the system of fall-back maximum payment rates for at least the initial two years (1996 and 1997) and for subsequent years, if the per capita health spending within a State remained below the target level of spending. If, in any year beginning with 1996, health care spending in the private sector in a State is greater than the private sector health spending estimate for the State for that year, then the fall-back Federal cost-containment system would become effective for all payers in that State in the second following year.

States with approved State cost-containment or health care reform systems whose spending is less than their State targets would retain control over their system

D. Maximum Payment Rates

Under the Federal fall-back cost containment system, private plans would make payments under maximum payment limits based on Medicare methodologies. These rates would be set such that spending under these rates be consistent with the private sector spending estimate. The rates would be set at the level of spending which have been achieved if the payment rates had been in effect since 1996. Annual updates in payment rates would be consistent with keeping expenditures within estimate, subject to declining growth rates over time.

Beginning in 2001, the Secretary would set the maximum payment rates that apply to the private sector such that these rates are phased down to Medicare's payment rates by the year 2005.

Title VII. Public Health Initiatives

A. Health Workforce Priorities

The Secretary would develop and implement a national health care workforce plan. The plan would establish national goals regarding both the number and specialty of physicians that are need to meet national needs. The plan would provide that, after July 1, 1998, at least 53 percent of all residents would be trained in primary care specialties and obstetrics and gynecology. In developing the plan, the Secretary would address ways to increase the number of nurse practitioners. The Secretary also would develop and implement a system that would designate residency positions as approved and consistent with the goals of the national health care workforce plan.

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After July 1, 1998, residency positions that are not consistent with and approved by the Secretary would not be used in determining adjustments to payments to hospitals relating to either the direct or indirect costs of graduate medical education. Teaching hospitals that lose residency positions would be eligible for transition payments.

B. Primary Care Incentives

The authorization for the National Health Service Corps would be increased to $200 million per year by the year 1997. In addition, the existing system of bonus payments under Medicare for services provided in underserved areas would be redirected and increased to emphasize bonuses for primary care services.

C. Academic Health Centers

The maximum payment rates for the private sector would be adjusted to reflect both the direct and indirect costs of graduate medical education. The portion of the increase in the tax on cigarettes described in Title XII would be allocated to provide direct funding for these adjustments.

In addition, adjustments would be provided in payments made to Federally Qualified Health Centers (FQHCs) to reflect the costs of training residents at FQHCs.

D. Essential Health Facilities

Medicare's Essential Access Community Hospital (EACH) program for rural health networks would be expanded from seven States to all States. Authorization for facilities would be increased from $15 million to $40 million per year, and authorization for grants to States for creation of rural health networks would be increased from $10 million to $50 million per year

An Essential Community Provider (ECP) program would be created to facilitate the organization and delivery of primary, and preventive services for medically underserved populations by fostering networks of essential community providers. The Secretary would make grants to States, local governments and eligible health care facilities. Grants could be used for the expansion of primary care sites, development of information, billing and reporting systems, recruitment and training of health professionals, or health promotion and outreach to underserved populations.

Facilities eligible for designation as essential community providers include certain hospitals that would qualify for a Medicare disproportionate share adjustment, Federally Qualified Health Centers, and nonprofit community health networks. Funding of $160 million per year for each of the fiscal years 1995 through 1999 would be available for the Essential Community Provider program.

A Capital Financing Trust Fund would be established through which the Secretary of HHS would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants. Up to $970 million would be made available annually under the Trust Fund for fiscal years 1995 through 1999. Facilities eligible for capital financing assistance include Essential Access Community Hospitals, Rural Primary Care Hospitals, and facilities eligible for assistance under the newly established Essential Community Provider program.

E. Other Public Health Related Activities

Grants would be made to local governments for lead abatement programs. A health education program would be established relating to the prevention of teenage pregnancies and smoking cessation programs.

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Title VIII. Medicare and Medicaid

1. Medicare Part C

A new Federal health insurance program would be established as of January 1, 1998, that would be called Medicare Part C.

In general, all eligible individuals, not otherwise covered under a private health plan, or entitled to benefits under the current Medicare program, would be entitled to health insurance coverage under Medicare Part C. In addition, low-income individuals with income up to 200 percent of the Federal poverty level, and part-time, seasonal and temporary workers would be permitted to enroll in Medicare Part C.

Employers with 100 or fewer employees would be permitted to enroll employees under Medicare Part C, unless the employer provided health insurance coverage to employees under a private plan that meets defined Federal standards

Medicare Part C benefits would be consistent with benefits provided under the guaranteed national benefit package. Additional benefits would be provided under Medicare Part C for eligible low-income individuals

The Secretary would establish four premium structures: individual coverage; coverage of a married couple without children; coverage of an unmarried individual and one or more children; and coverage of a married couple with one or more children. The Secretary would compute premiums for Medicare Part C on a State-by-State basis. The premium for 1998 would be set in statute, but would be modified if necessary by the Secretary, to assure that premiums cover the full actuarial cost of benefits and all administrative costs.

A new Medicare Part C Trust Fund would be established, into which all premiums and State maintenance-of-effort payments would be deposited. Additional funds would be appropriated from general revenues to assure that funds are sufficient to cover low-income subsidies and supplemental low-income benefits -- net of State maintenance-of-effort payments.

Payments for services provided under Medicare Part C would be consistent with the payment rates and methodologies specified under Medicare Parts A and B, with appropriate adjustments in payment amounts to reflect the population served by Medicare Part C.

Persons covered under Part C could elect to receive coverage through managed care organizations that contracts with Medicare, under existing Medicare policies. The Secretary would make necessary changes to the Adjusted Average Per Capita Cost (AAPCC) for payments on behalf non-aged Medicare Part C beneficiaries who elect to enroll in such plans.

II. Low-Income Coverage

A. Low-income Coverage

Low-income individuals, defined to include those with family income up to 200 percent of the Federal poverty level, would be permitted to enroll in Medicare Part C or under a private plan offered by an employer.

Premium obligations for low-income individuals would be based upon reported income, as determined by the Internal Revenue Service. The premium obligation for non-filers, and for AFDC and SSI recipients, would be deemed to be zero. For other low-income individuals, the premium obligation would increase, on a sliding-scale basis, for individuals with income up to 200 percent of the Federal poverty level.

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Premium obligations for low-income workers would be reduced by any amounts contributed by an employer. Low income individuals would be permitted to adjust their withholding to contribute to the individual's share of the premium obligation. The value of the premium would be capped at the lower of (1) the subsidy amount for enrollment under Medicare Part C, or (2) the employee obligation under the plan offered by the employer.

A wrap-around benefit package would be provided under Medicare Part C for all low-income individuals with family income up to 100 percent of the Federal poverty level. All deductibles and copayments would be waived. All EPSDT services not otherwise covered in the guaranteed national benefit package would be covered for children to age 18. Vision and hearing care, including eyeglasses and hearing aids, would be covered.

The wrap-around benefit package would also be provided under Medicare Part C for defined categories of individuals with income up to 200 percent of the Federal poverty level: pregnant women, children to age 18, and AFDC and SSI recipients.

The Secretary of HHS, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies would perform enrollment and eligibility functions necessary to administer the Medicare Part C program.

Medicaid coverage of acute care services would be repealed, effective upon the operation of the Medicare Part C program. Medicaid could continue to provide benefits not covered under the guaranteed national benefit package, or covered under the Medicare Part C wrap-around benefit package. State Medicaid payments for such services would continue to be subject to the current Federal matching payment rate. Long-term care, and other institutional services, including services for the mentally retarded and services provided in nursing facilities, would continue to be covered under Medicaid.

B. State Maintenance-of-Effort

The Secretary would be prohibited from approving any change in a State's Medicaid program that would take effect prior to the implementation of Medicare Part C.

States would make maintenance-of-effort payments to Medicare Part C to partially offset need for Federal subsidies of low-income individuals enrolled in Medicare Part C. For each State, a 1993 baseline level of Medicaid expenditures would be estimated for non-cash recipients (less Federal financial participation), for covered Medicare Part C services, including deductibles and co-insurance. In addition, States would add to this amounts paid by a State for general assistance health programs and prescription drug programs for the elderly.

States would make per capita payments to Medicare Part C for cash recipients (AFDC and SSI). This amount would be based on baseline per capita Medicaid spending for services covered under Medicare Part C made on behalf of AFDC and SSI individuals and families under current law.

These baseline amounts would be updated to 1998. In subsequent years, the non-cash recipient amount would be updated by the allowable growth in per capita spending in Medicare, and growth in the general population under age 65, and the per capita cash recipient amount would be updated by the per capita growth limit for Medicare.

The Secretary would be given broad authority to alter these computations and requirements (and the non-cash maintenance-of-effort amounts) in applying these rules to Puerto Rico and other commonwealths and territories.

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III. Cost Containment in Medicare

A. Establishment of Medicare Health Expenditure Estimates

As for the private sector, the Secretary would estimate total national health expenditures under Medicare Parts A through C, and the baseline rate of growth for future years. The estimate would include spending for all services covered under the national guaranteed benefit package, supplemental policies, low-income wrap-around benefits, and related cost sharing.

The Medicare health spending estimates would be established on a per capita basis to adjust the estimates for shifts in enrollment between the public and private sectors. Target rates of growth would be set by statute for each year, beginning with 1996. The target rate of growth would be set such that the rate of growth in Medicare spending would be reduced by two percentage points in 1996, and by an additional one percentage point in each subsequent year until the rate of growth is slowed to the five year average per capita rate of growth in the gross domestic product (GDP).

B. Allocation of National Estimates to Classes of Services and States

The Medicare estimate of health spending would be allocated to various classes of health services and States using the same methodology as used to allocate among private sector spending among classes and States. The Medicare estimate allocated to each State would be used to monitor States' success in controlling health care costs. Health providers would report information to the Secretary to permit monitoring of health care spending within each State and class of service.

C. Medicare Payment Rates

Payments for services under Part C would be set equal to the payment rates that would apply under Medicare Parts A and B. New codes and values, including separate DRG categories and weights for children, would be developed as needed such that these payment systems are appropriately adjusted for services provided to patients under the age of 65. Annual updates in Medicare payment rates would be set to be consistent with keeping expenditures within Medicare's estimate.

In the case of services that are currently paid by Medicare on a cost-related basis, rate of growth limits would be imposed until prospective payment methodologies can be developed and implemented by no later than January 1, 1997.

IV. Additional Medicare Savings

A. Indirect Medical Education

The indirect medical education adjustment paid under the Medicare prospective payment system, for both Medicare Part A and Medicare Part C would be phased down beginning with the implementation of Medicare Part C. The formula factor would be reduced from 7.7 percent to 6.8 percent for discharges occurring on or after January 1, 1998 through September 30, 1998. The formula factor would be reduced from 6.8 percent to 6.0 percent for discharges occurring on or after October 1, 1998, through September 30, 1999. The formula factor would be reduced from 6.0 percent to 5.2 percent for discharges occurring on or after October 1, 1999.

B. Disproportionate Share Adjustment

The disproportionate share adjustment paid under the Medicare prospective payment system for both Medicare Part A and Medicare Part C would be phased down beginning with the implementation of Medicare Part C.

(MORE)

Effective for discharges occurring on or after January 1, 1998, and before October 1, 1999, the Secretary would reduce payments that would otherwise be made under the disproportionate share adjustment by 25 percent. The reduction would be limited to 10 percent for urban hospitals with more than 100 beds and a disproportionate patient percentage under the existing formula that is greater than 30 percent. Effective for discharges occurring on or after October 1, 1999, the Secretary would reduce payments that would otherwise be made under the disproportionate share adjustment by 50 percent. The reduction would be limited to 25 percent for urban hospitals with more than 100 beds and a disproportionate patient percentage under the existing formula that is greater than 30 percent

The Secretary would be directed to propose a modification to definition of "disproportionate patient percentage" in order to take into account the repeal of Medicaid and the establishment of Medicare Part C.

C. Payments For Capital

Adjustments would be made to payments for inpatient hospital capital under Medicare, effective October 1, 1995. The Federal capital payment rate would be reduced by 7.31 percent. The hospital-specific capital payment rates would be reduced by 10.41 percent.

D. High Cost Medical Staffs

Limits would be established for payments for physician services relating to inpatient stays in certain hospitals, in the same manner as included in H.R. 3600.

E. Medicare Secondary Payer

Medicare secondary payer provisions scheduled to expire in 1998 would be extended. The existing data-match system, established to identify situations in which Medicare is secondary payer, would be extended. The application of Medicare secondary payer rules for disabled and ESRD beneficiaries would be extended

F. Home Health Services

A 20 percent coinsurance would be established for home health services provided under Medicare Parts A and B.

G. Additional Minor and Technical Amendments

Additional minor and technical amendments to Medicare would be made, including those provisions that were dropped from the House-passed version of the Omnibus Reconciliation Act of 1993, and included in S. 1668.

Title IX. Premium-based Financing

A. Premiums for Medicare Part C

The Secretary of HHS would determine the premium amounts to cover the guaranteed national benefit package under Medicare Part C. The premiums would be set such that, net of low-income subsidies, Medicare Part C would be fully financed by the premiums. The premiums would vary on a State-by-State basis.

The Secretary of the Treasury would calculate, and collect, the hourly contributions required to cover the guaranteed benefit package. Employers would provide for payment of the employee share of the premium through payroll withholding. Employers would pay the premiums to the IRS in the same fashion as existing payroll taxes are paid.

(MORE)

Employers providing private coverage would not collect or contribute the Medicare Part C premium for workers covered under private coverage.

B. Taxpayer Obligations

Each taxpayer would be charged for the Medicare Part C premium as part of their annual payment of personal income taxes. The amounts collected from employers and withheld from employees would be deducted from the Medicare Part C premium otherwise payable. If the individual filed proof of private coverage, the individual would not be required to pay the Medicare Part C premium.

C. Working Couples

If a working couple enrolls in Medicare Part C, they would identify one employer who would be the enrolling employer. The other employer would be a non-enrolling employer. The enrolling employer would pay 80 percent of the applicable premium category, and withhold 20 percent from the worker's pay. The non-enrolling employer would be obligation to pay 80 percent of the Medicare Part C individual premium, and would deposit this amount with the IRS.

D. Information Requirements

Individuals enrolling would be required to provide the employer with information necessary to assign all covered family members to the chosen plan.

Non-enrolling employers would be required to make minimum payments to the enrolling employer. The minimum contribution of the non-enrolling employer would be equal to 80 percent of the individual premium for Medicare Part C. The individual worker and working spouse would be required to provide their employers with information necessary to transfer the non-enrolling employer's contribution to the enrolling employer

E. Withholding Adjustments for Low-income Individuals

Low-income individuals who expect to be eligible for a subsidy of their share of their health insurance premium could adjust their tax withholding to accrue the subsidy over the course of the year. Under withholding would be subject to the same penalties as over withholding of any other tax obligation.

Title X. Quality and Consumer Protection

A. Quality Management and Improvement

The Secretary would establish standards for a National Quality Management Program and develop a set of national quality and performance measures which would apply to health plans, institutions and health care professionals. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply.

Health plans would be required to establish a grievance and appeal process and meet additional standards developed by the Secretary relating to quality assurance.

Individuals would be able to commence a civil action in an appropriate United States District Court or State court to obtain relief from anti-discriminatory activities.

Privacy of information standards would apply to the disclosure of protected health information.

(MORE)

B. Information Systems and Administrative Simplification

Claims submitted by providers would be transmitted electronically using uniform formats to be developed by the Secretary. Each provider would be required to submit claims using a unique provider identification number. Each individual would be issued a uniform health claims card.

Administrative simplification provisions would provide reporting and coordination of benefits between all health insurance plans, including supplemental policies and plans in States that opt out. The Secretary would be required to develop standards for an electronic uniform hospital clinical data set and patient care information set. As a condition of Medicare participation each hospital would be required to maintain hospital clinical data in electronic form. The Secretary may grant waivers for rural and small community hospitals.

C. Medical Malpractice

Tort reforms would include limitations on attorney fees, collateral source offset, periodic payment of awards, $350,000 non-economic damage cap and a requirement that all lawsuits include an affidavit certifying the merits of the complaint.

Grants would be available to States for the development and implementation of alternative dispute resolution systems for medical malpractice liability claims. The Secretary would establish a pilot program applying practice guidelines to medical malpractice liability actions.

D. Fraud and Abuse

The Secretary of HHS and the Attorney General would establish and coordinate an all-payer national health care fraud control program.

The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties and criminal penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system. Current civil monetary penalties would be increased from $2,000 to $10,000. New civil monetary penalties would be established for certain activities, including kickback violations. A portion of the civil money penalties, fines, and damages assessed would be deposited in a fraud and abuse account.

D. Physician Ownership and Referral

The physician ownership and referral ban would be extended beyond Medicare and Medicaid to all payers. The physician ownership and referral ban would be extended to cover home infusion therapy (excluding ambulatory infusion pumps) and any other item or service not rendered by the physician personally or by a person under the physician's direct supervision.

The exceptions in current law to the general ban on referrals would be continued with certain modifications. An exception would be provided for certain arrangements where providers are paid on an at-risk, prepaid and capitated basis.

The in-office ancillary service exception would be modified to require that solo practitioners furnish designated health services on wholly-owned equipment. The exception for group practices would be modified to require that all designated health services, other than clinical laboratory services, x-ray services, ultrasound services and other low-cost services as the Secretary may determine, be furnished in a centralized location within a given Metropolitan Statistical Area (MSA).

(MORE)

Title XI. Long-Term Care

I. Federal Long-Term Care Insurance Standards

The Secretary would promulgate regulations to implement Federal standards for private long-term care insurance policies. States would enforce the standards for all long-term care insurance policies sold to individuals or employers. The Secretary would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply. Non-compliance by an individual or entity that markets a private long-term care insurance policy would be subject to a fine of up to $10,000 per violation.

The Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), would develop standardized formats and terminology to be used in long-term care insurance policies. Requirements relating to coverage would be established to clarify appropriate terms for coverage of benefits under policies. Restrictions on eligibility for benefits would be limited, and clearly defined. Pre-existing condition exclusions could be included only looking back six months for any previous illness or episode requiring treatment, and such exclusion may only continue for six months.

Requirements for inflation protection would be established. An insurer would be required to offer the purchaser the option to obtain coverage under the policy for annual increases in benefits. The benefits under a policy would increase by not less than five percent per year compounded. Inflation protection would be excluded from the coverage only if the insured individual rejected in writing the option to obtain such coverage.

Non-forfeiture benefits would be required for all policies. The Secretary, in consultation with the NAIC, would promulgate regulations for an appropriate non-forfeiture benefit for policies that lapse. The non-forfeiture benefit would increase proportionately to the amount of premiums paid.

The issuer would provide for a procedure to determine whether threshold conditions, based upon uniform assessment standards, procedure and formats, have been met. Insurers would be required to provide an administrative procedure under which an individual may appeal any denial of a claim. In the event of a disagreement, final resolution would be provided by a State agency, or other impartial agency.

Title XII. Revenue Provisions

The following revenue provisions were retained from Title VII of H.R. 3600: (1) the limitations on contributions to cafeteria plans for health benefits; (2) the change in tax treatment of long-term care expenses; (3) accelerated death benefits under life insurance; (4) the tax credit for the disabled; (5) favorable tax treatment of purchase of long-term care insurance; (6) tax credits for professionals locating in health service shortage areas; (7) modifications of the tax treatment of certain health care organizations; (8) 100 percent deductibility of health insurance expenses for the self-employed; (9) coverage of State and local workers under the Hospital Insurance tax; and (10) the modification of the tax treatment of certain S corporation shareholders.

The assessment on corporate alliance employers included in H.R. 3600 was included, and modified to be imposed on all employers who elect to self-insure (generally employers with at least 1000 employees).

(MORE)

The increase in the tax on tobacco products from H.R. 3600 was retained, and amended to increase the tax on cigarettes to $1.49 per pack.

Revenue raised from the additional $0.50 per pack increase in the tobacco tax would be allocated to a number of initiatives. Allocations in the year 2000 would be as follows: $3.77 billion for unspecified small business subsidies; $91 million to establish a relief fund to assist tobacco farmers; $910 million for a formula grant program to assist Academic Health Centers; $460 million to fund grants to local governments for lead abatement programs; $680 million to fund the Essential Health Facilities programs in Title VII; and $91 million for health education programs administered by DHHS including those addressing teenage pregnancy prevention and smoking cessation.

(MORE)

March 25, 1994

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: MEETINGS AT CEDARS SINAI HOSPITAL

Two separate meetings, each approximately one hour in length, are being arranged. Both meetings will be held at Cedars Sinai Hospital. We have also arranged a brief tour of their Emergency Room on your way out.

The first meeting will be with a group of physicians and with a representative of Kaiser Health Care Plan. The second meeting will be made up of representatives of the area medical schools, large teaching hospitals, and Cedars Sinai.

Both groups are being told that the discussions will be informal and designed to give you the opportunity to hear their specific concerns about the health care reform proposals.

The groups will be diverse in their interests, expertise and political affiliation. I've tried to cover most of the bases.

Included in this packet are a draft list of attendees, background information on Cedars Sinai, Kaiser and some material on the President's call to the California Medical Association Convention, and finally a brief description of the California health plan.

I will prepare some brief thoughts as to questions you might ask.

DOCTORS ATTENDING MEETING IN CALIFORNIA

Leon Bender, M.D.	Los Angeles Urologist Immediate past Medical Director, Cedars Sinai
Fred Dennis, M.D.	Los Angeles Cedars Sinai Emergency Medicine Current head of California Emergency Physicians
Richard Corlin, M.D.	St. Johns Hospital, Santa Monica (collapsed during earthquake) Gastroenterology Vice Speaker, American Medical Association, House of Delegates and immediate past President of the California Medical Association
Russell Drago, M.D.	Los Angeles Kaiser Pediatrics
Vincent Gualtieri, M.D.	Sherman Oaks Urologist Officer, Los Angeles County Medical Association
Mitchell Karlan, M.D.	Beverly Hills General Surgery Former President of Los Angeles County Medical Association and American Medical Association's Scientific Panel
Marie Kuffner, M.D.	UCLA Anesthesiology Past President of Los Angeles County Medical Association First Female President -- just retired
Phil Kurzner, M.D.	Los Angeles Urologist Kaiser Department of Urology
Aliza Lifschitz, M.D.	Los Angeles Cares for AIDS patients Hispanic Does Radio Show

Charles (Chuck) McElwee, M.D.	Covina (ORS) Officer of CalPac
Jo Ellen Linder, M.D.	Pasadena Emergency Medicine
Madison Richardson, M.D.	Los Angeles Otolaryngology
William Weil, M.D.	Redondo Beach Family Practice Medical Director, MaxiCare (HMO) Head of CalPac
Richard Wigod, M.D.	Long Beach Internal Medicine Former President, Los Angeles County Medical Association Active Republican
Alan Heilpern, M.D.	Los Angeles Emergency Medicine California Hospital Medical Center
Robert Karns, M.D.	Beverly Hills Internal Medicine
Ralph Kuon, M.D.	Los Angeles General Surgery

Staff: Wade Piston, Director, Public Affairs and Government Relations
Ann Evanilla, Public Affairs Officer
Tom Thompson, Director, Communications
Collette Wright, Vice President, Programs & Policy
Brad Kuiper, Vice President, Operations

OLIVER GOLDSMITH M.D.
KAISER

BOB ERICKSON
SR. V.P.
KAISER

STEPHEN FORMAN M.D.
City of Hope

STEPHEN UMAN M.D.
CEDAR SINAI

MEETING #1 -- CALIFORNIA PHYSICIANS

Introduction

- I want to begin by thanking each of you for taking time from your schedules -- on such short notice -- to talk with me.
- I am particularly grateful to Wade Piston for all of his efforts at contacting each of you.
- As you all know, reform of our health care system is right at the top of the domestic agenda in Washington. As a result, we are all spending a great deal of time sorting through the complex issues surrounding this topic.
- Perhaps the most valuable thing we can do is talk with those of you who actually provide the care -- so, we have a clear understanding of the impact of our decisions.
- The meeting attendance list clearly shows a tremendous diversity in interests and expertise. I would hope we could engage in an informal talk that will give each of you a chance to talk about what concerns you most, and share any suggestions you have.
- Dr. Corlin perhaps you could start us off and then maybe Dr. Dennis could talk about the ER as a source of not only emergency services -- but, also primary care for those without coverage.

Other Possible Issues

1. Malpractice Reform: We are looking at alternative dispute resolution, limits on attorney's fees, and caps on non-economic damages. Whats the most important thing to them?
2. Voluntary Purchasing Pools: California put a program in place for small businesses almost one year ago -- have they had any experience with the pool? Whats their reaction?
3. Undocumented Aliens: Perhaps one of the toughest issues facing states like California are the costs of caring for non-citizens. Many of those in the room care for these patients -- what suggestions do they have?
4. Global Budgets/Premium Controls: Cost containment will be high on everyone's list of providers. The Administration proposes global budgets and price controls -- what is their view?

5. Health Manpower: Lots of interest in increasing the number of primary care physicians. Some suggest we actually limit the number of specialists we train. Others suggest we change the incentives and let the market work. What is their view?

6. Managed Care: There are a number of you here who work for managed care plans. We have heard a great deal of criticism of these arrangements as being too restrictive, or having a negative effect on quality.

   Your view?

MEETING 2

CEDARS-SINAI MEDICAL CENTER
TUESDAY, MARCH 29, 1994, 3:30-4:45 P.M.

Irving Feintech
Chairman, Board of Directors
Cedars-Sinai Medical Center
Los Angeles

MARY RAINWATER
EXEC. DIR.
LOS ANGELES FREE CLINIC

Carmen Warschaw
Chair, Government Relations Committee
Board of Directors
Cedars-Sinai Medical Center
Los Angeles

Thomas M. Priselac
President
Cedars-Sinai Medical Center
Los Angeles

Stephen J. Ryan, M.D.
Dean and Senior Vice President for Medical Affairs
University of Southern California School of Medicine
Los Angeles

Joseph P. Van Der Meulen, M.D.
Vice President for Health Affairs
University of Southern California School of Medicine
Los Angeles

Raymond G. Schultze, M.D.
Director
UCLA Medical Center
Los Angeles

Sidney H. Golub, Ph.D.
Provost for Medical Sciences and Interim Dean for Academic Affairs
University of California
Los Angeles

Robert C. Gates
Director of Health Services
Los Angeles County
Los Angeles

Reed V. Tuckson, M.D.
President of the University
Charles R. Drew University of Medicine and Science
Los Angeles

Oliver Goldsmith, M.D.
Medical Director for Southern California Permanente Medical Group
Pasadena

ROBERT ERICKSON
SR. V.P.
KAISER HEALTH PLAN
OAKLAND, CA.

Health Care in Los Angeles County: Standing on Shaky Ground

An update by the County of Los Angeles, Department of Health Services, March 3, 1994

Los Angeles County, once considered a golden, if somewhat oddball, forecaster of life in a future utopia, has run smack into a reality never in the dreams of yesterday's predictors. Unquestionably, the county remains unique. However, the fair child of the Golden State faces a future filled with dismay rather than dazzle unless important changes are made.

Even before January 17's shattering earthquake, Los Angeles County, and particularly its health care system, was on shaky ground. But the impact of those 31 seconds have left the county reeling from losses and expenses that threaten the entire health care infrastructure, as well as the lives of the residents who depend on the county's fraying safety net.

EARTHQUAKE CAUSES EXTENSIVE DAMAGE; SOCIAL AND ECONOMIC DISRUPTION

Earthquake damage to Los Angeles County Department of Health Services' six hospitals, 40 health clinics and other health services is estimated to stand at more than $1 billion. Several of the county's hospitals and clinics sustained structural and other damage and were forced to close temporarily; patients had to be transferred to other, safer facilities.

- One health clinic in the San Fernando Valley remains closed because the building has been condemned.
- The psychiatric and pediatric hospital of the Los Angeles County/USC Medical Center have been closed due to structural damage.
- Three private hospitals in the county have been closed due to structural damage and several others have been forced to curtail activities, putting additional strains on the county's health care services.

An estimated $41 million was incurred for public health emergency activities. These include assessing the threat of communicable diseases due to unsafe drinking water and lack of adequate shelter and food, and coping with injuries and illnesses related to the earthquake. Others include assessing living conditions in some 200 parks and shelters, and evaluating about 150 health care facilities, as well as assisting in evacuating patients from five nursing homes.

- Thousands of people were permanently thrown out of work overnight.
- Hundreds of families lost their homes, as well as their jobs.
- Approximately $20 billion in damage resulted from the earthquake, affecting a population largely uninsured for the damages sustained by their homes or businesses.
- The county's Department of Health Services is working with FEMA to obtain funding to rebuild or replace damaged health care facilities.

In addition to the physical disruption, the earthquake further aggravated conditions for millions of Los Angeles County residents already living "on the edge" and a county desperately trying to recover from the ravages of deep economic recession, civil unrest and recent fires and floods.

STRESS BEFORE THE EARTHQUAKE

Los Angeles is the largest county in the U.S., larger than 42 states and 162 countries. Its population is nearing 10 million. The Northridge earthquake was the latest in a series of disasters to hit the county, striking after ruinous civil unrest in 1992 and consuming wildfires and floods last year. The county remains mired in its worst recession since the 1920's and economic recovery is not expected until 1996.

With one-third of the state's population, Los Angeles County accounts for two-thirds of California's 400,000 lost jobs. The county is losing jobs at nearly twice the national average and the number of people living in poverty has increased by 33 percent in the last decade.

- One in three people live below 200 percent of poverty.
- One in five people receives public assistance.
- More than 25 percent of the county's population

is children and the majority live in poverty.

Los Angeles is the prime destination for Latin American and Asian Pacific immigrants. As these populations increase, so do their requirements for health care services.

- Ethnic diversity is increasing at a rapid rate. Today, more than half of the county's population is ethnic minorities.
- By the year 2000, three quarters of the population are expected to be ethnic minorities and 30 percent children.

IMPACT ON COUNTY HEALTH CARE SERVICES

Census data from 1990 indicate that more than 2.7 million, or 30 percent of the population, are without health insurance. This compares to 22 percent for the state and 17 percent nationally.

- One in three people have no health insurance, the highest rate of medically uninsured residents in the nation.
- Nearly one-half the population is either on Medi-Cal or without health insurance.
- Emergency room visits increased by 92 percent over the last decade as violence -- and trauma cases due to violence -- increase alarmingly.
- AIDS cases continue to surge upwards.

The county operates six public hospitals, six comprehensive health centers and 40 public health centers. Four of the hospitals have emergency rooms and three are designated as Level 1 trauma centers.

- Half of all major trauma cases in the county are transported to these three trauma centers.
- Half of the 23 hospitals participating in the trauma hospital system have withdrawn, leaving large portions of the county without services and overburdening the remaining trauma centers.

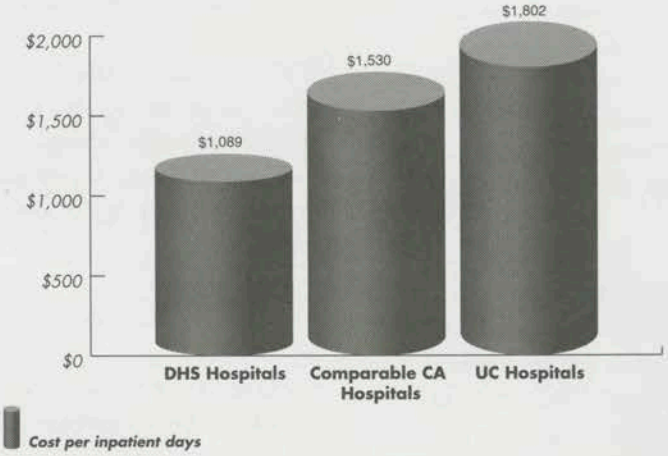
Health care for 4.3 million Medi-Cal and medically uninsured county residents is provided by a loosely constructed safety net of 24 disproportionate share hospitals, 46 county-operated health centers and 70 free and community clinics. There is a total of 146 hospitals and 112 state licensed clinics in the county.

- There has been an increase of more than 100 percent in the number of outpatient visits to county health facilities.
- Only $100 million of the $4.3 billion in taxes paid by immigrants are paid to the county, yet they use $900 million in local services.

TASK FORCE FOR HEALTH CARE ACCESS IN LOS ANGELES COUNTY

Appointed by the County Board of Supervisors, this private/public body unanimously agreed that the only definitive solution to addressing the needs of the uninsured is the adoption of comprehensive health care reform that provides universal access to care. The Task Force research indicates:

**COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
COST PER DAY COMPARISON - L.A. COUNTY VS. OTHER
CALIFORNIA HOSPITALS FISCAL YEAR 1991 -1992**



- that the 2.7 million medically uninsured in the county are currently being underserved by four to five million outpatient visits annually, roughly equivalent to the total visits provided in a year by the Department of Health Services,
- that the estimated 700,000 undocumented persons in the county are only marginally accounted for in the estimates of the uninsured population and estimates that the proportion of uninsured in this group is very high,
- that the impact on utilization of emergency room services, community clinics and public health services is far too significant to be ignored.

The Task Force unanimously recommended inclusion of undocumented persons in universal health care coverage and has recommended improving the efficiency of care for the uninsured by creating a comprehensive coordinated public and private system of care for the uninsured residents of the county, incorporating elements of managed care. The County Department of Health Services is implementing this recommendation and has suggested expanding the coordinated system to include the Medi-Cal population as well.

FALLING FINANCIAL SUPPORT THREATENS HEALTH CARE

On the state level:

California government, according to its Legislative Analyst, faces a $6.1 billion deficit for FY 94-95 and another $4.1 billion for the following year. Shortfalls of this magnitude will translate into major health and welfare cuts. The California governor's budget proposal assumes $3.8 billion will come from revenues and expenditure savings primarily from the federal government and makes no contingency plan if this assistance is not forthcoming. The proposal relies on the following:

- Increased Federal reimbursement for undocumented alien health education and correction costs ($2.3 billion)
- Increased Federal share of Medi-Cal ($.6 billion)
- Full reimbursement for 36-months of refugee services ($.1 billion)
- Reduction of AFDC grant by 10 percent ($.3 billion)
- Reduction of AFDC grant by additional 15 percent for families remaining on aid after six months ($.2 billion)
- Elimination of Medi-Cal optional benefits ($.1 billion)
- Elimination of Medi-Cal prenatal coverage for undocumented aliens ($.2 billion)

This plan shifts to counties 11.5 percent of Medi-Cal program costs, increases counties' share of AFDC costs and shifts certain programmatic responsibilities to counties, supposedly on a revenue neutral basis, offsetting with reallocated sales and property tax revenues and other funding elements.

Los Angeles County General Fund Budget
Five Year Property Tax Trend
Including Benefit from 1/2 Cent Public Safety Sales Tax

On the county level:
The county has an annual operating budget of more than $2.3 billion. More than 30 percent of financing was, or still is, in jeopardy.

Forty-five percent of statewide uncompensated care is provided in Los Angeles County and 80.5 percent of this is provided by county-operated facilities. Last year, these facilities provided more than $544 million in uncompensated care.

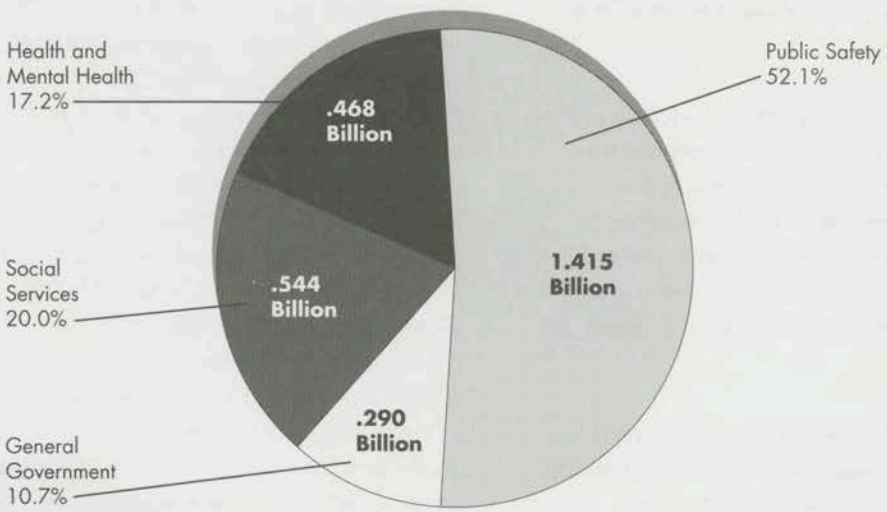
- A shortfall could result in closure of county facilities and have ongoing ramifications impacting the trauma/emergency system, mental health and the private sector.
- The county health care system employees more than 27,000 people. Loss of many of these jobs will further depress the county's economy.

THE PROSPECT OF HEALTH CARE REFORM
While county officials are generally supportive of health care reform, there appear to be few provisions for people who customarily fall through the safety net or for those facilities that provide care to these populations. The county's primary concerns are maintaining the health care safety net during a long and difficult transition period; preserving adequate financing of a safety net following implementation of health care reform for unaddressed populations. This includes undocumented and incarcerated people, and ensures adequate public health and trauma/emergency services. Key issues are:

- adequate entitlement funding to cover uncompensated costs,
- universal coverage regardless of immigration status,
- preserving disproportionate share hospital payments at current levels until reform is in place, including the delay and/or revision of the 1993 cap,
- automatically designating county hospitals and clinics and key disproportionate share hospitals as "Essential Community Providers,"
- adequate financing to defray provider costs for care to uncovered populations, and
- utilizing proposed Academic Health Centers/ Public Health Initiative provisions to gain grant

Los Angeles County General Fund Budget
1993 - 1994 Local Expenditures Base*

$2.717 Billion



Apportioning 1994 - 1995 Shortfall of $900 million

- Across-the-board allocation would result in service reductions of approximately 33%.
- Priority for public safety would result in even greater service reductions in state required health, mental health and social services expenditures.

Financed by property taxes, sales taxes, vehicle license fees, and other local revenues.

funding and interagency cooperation to reinforce the safety net and foster public-private networks built on existing "charity" hospitals and community clinics.

UNIFIED SYSTEM FOR A HEALTHY LOS ANGELES

Predicated on the findings of the Task Force on Health Care Access, the Unified System for a Healthy Los Angeles. was developed by a 39-member Managed Care Planning Council for Los Angeles County. It was formed in February 1993 to develop a plan for the most effective way to organize managed care for the Medi-Cal and medically uninsured in the county. It included representatives from nearly every segment of health care services: free and community clinics, community and public hospitals, managed care organizations, medical schools, physicians, physician groups, home health agencies, consumers, universities, pharmacists, children's services, mental health services and public health departments. Additional participants from these and other sectors were involved in consultant committees and working groups. Council members believe that preservation of safety net providers is essential for reform of the entire system.

The System aims to maintain and improve health care access for vulnerable populations through eight geographically designated public-private networks providing coordinated, culturally competent care. It contemplates independent governance under a local health authority.

Principles guiding development of the Unified System are based on a philosophy that emphasizes primary and preventive services, increases access, improves quality and contains cost. It will develop managed care services by contracting with prepaid health plans in regional areas throughout the county and all consumers of the system will have a choice of health plans.

Believing that the state's managed care objectives are better served through a single administration than by a two-track approach proposed by the state, the county's board of supervisors has encouraged state support in developing the Unified System in a letter signed by all five supervisors.

CONGRESSIONAL REPRESENTATIVES' ROLE

Start-up and transitional funding are needed to implement and carry out Unified Health System. Los Angeles County needs congressional support and is requesting that Unified Health System of Los Angeles County be funded as a designated federal demonstration project for an urban transition model to national health care reform. The health and vitality of Los Angeles County's people is key to the social and economic recovery of the region and the entire state.

The Managed Care Planning Council for Los Angeles County has endorsed the following proposed federal language:

Statutory Provision

There are authorized to be appropriated $30 million for the development of a comprehensive managed cooperative model of health care delivery for individuals eligible under Title XIX of the Social Security Act and other medically indigent individuals in the County of Los Angeles, California. The Secretary shall make such development funds available through grants or agreements which provide for payments either in advance, or by way of reimbursement, on such conditions as the Secretary finds necessary to carry out the purposes of this section.

Legislative History

The Managed Care Planning Council for Los Angeles County is an alliance of public and private health service practitioners, providers, academic institutions, consumer advocates and community representatives convened by the County of Los Angeles to develop a comprehensive, managed cooperative model of health care delivery for the Medi-Cal population and the medically indigent. The statutory provision is intended to provide funds to the Council to assist in the development of the "Unified Health System for a Healthy Los Angeles." The funds are to be expended for the costs for technical assistance, the development of information systems, the compilation and analysis of current data, and other costs that will be incurred in the development of the Unified System. It is anticipated that the development costs will be incurred over a period of at least two years.

CONGRESSIONAL DELEGATION BRIEFING PANEL MEMBERS

Areta Crowell, Ph.D.
Director, Los Angeles County Department of Mental Health; Member of Managed Care Planning Council

Randall Davis, Esq.
Los Angeles County Washington D.C. Representative; Partner, Jones, Day, Reavis and Pogue

Castulo de la Rocha, J.D.
President and CEO, Alta Med Health Services Corporation; Member of Managed Care Planning Council

Susan Fleischman, M.D.
Medical Director, Venice Family Clinic; Alternate Member of the Managed Care Planning Council

Robert C. Gates
Director, Los Angeles County Department of Health Services; Chair, Managed Care Planning Council

John Redmond
Management Analyst, Intergovernmental Relations, Los Angeles County Chief Administrative Office

Gary Wells
Assistant Director, Administrative and Financial Services, Los Angeles County Department of Health Services; Chair, Finance and Legislative Committee, Managed Care Planning Council

Mark Windisch, Esq.
Special Legal Counsel to Los Angeles County on Health Matters

Susan White
Los Angeles County Federal Representative for Health

Toni Saenz Yaffe
Assistant Director, Planning and Development Services, Los Angeles County Department of Health Services; Chief of Staff, Managed Care Planning Council

This information has been excerpted and prepared by the County of Los Angeles, Department of Health Services, 313 North Figueroa Street, Los Angeles, California 90012.

Clip and mail bottom portion for further information.

To: Robert C. Gates, Director
County of Los Angeles
Department of Health Services
313 North Figueroa Street
Los Angeles, California 90012

From: _____
_____
_____
_____
_____
(Please print and include your name, title, address and phone number.)

I am interested in receiving additional information regarding:

- ☐ Unified System for a Healthy Los Angeles
- ☐ Task Force for Health Care Access in Los Angeles County
- ☐ California Governor's Budget Proposal for FY 94-95
- ☐ Health Care Reform Impact on Los Angeles County
- ☐ Los Angeles County Department of Health Services Estimate of Earthquake Damages and Losses
- ☐ Economic Outlook for Los Angeles County
- ☐ Los Angeles County Disproportionate Share Hospitals
- ☐ Los Angeles County General and Indigent Health Care Perspectives
- ☐ Other, as indicated below

_____

_____

MEETING #2 -- HOSPITALS/MEDICAL SCHOOLS

- Thank you so much for your willingness to be here today. And a special thanks to Yoshi Honkowa who pulled you all together so quickly. And, to Mr. Feintech and the rest of you from Cedars-Sinai for being our host.

- As I suspect Yoshi explained to all of you when he called -- my interest is in listening to each of you.

- Our discussions on health care reform in Washington are still very much in the formative stages -- we are all looking for answers to the tough questions facing us.

- Perhaps among the most difficult are those related to the special circumstances of some of our large teaching facilities and public hospitals.

- Another difficult issue is the Federal role in health manpower training. Some would have us place absolute limits on the number of residents and on the mix of primary care versus specialists.

- I'm interested in hearing your views on these and any other issues of importance to you.

- Perhaps Tom Priselac could start us off and then maybe Dr. Tuckson could follow.

Other Possible Issues:

1. Indigent Care/Illegals. How do we best care for these people? How do we get them out of the emergency rooms and into primary care?

2. Managed Care. Can teaching hospitals survive? Can "centers of excellence" like Sloan Kettering, Sidney Farber and Mayo?

3. Manpower Distribution: Our problems are not only the type of physicians we train, but also where they choose to practice. How do we keep them in the inner-city or out in western Kansas?

4. Are we doing enough to encourage/support minority students in the health sciences?

KAISER PERMANENTE

Kaiser Permanente's Southern California Region

Fact Sheet

Kaiser Permanente is a prepaid group practice health plan providing comprehensive medical and hospital services to more than 6.6 million members in 12 regions nationally. Kaiser Permanente's Southern California Region was established in 1943 to serve the workers of the steel mill in Fontana. Steel from this mill was used in construction of the Liberty ships used in World War II. Today, the Southern California Region serves 2.2 million members throughout the Los Angeles area. Enrollment in Kaiser Permanente's Southern California Region comprises about 15% of the Southern California marketplace (from Bakersfield to the Border).

The Southern California Region operates 93 medical office facilities which provide day-to-day primary care for its members. Each of the medical offices serves as a satellite to the Region's 10 hospitals. The Region has an 11th hospital under construction, due to open in 1995. In addition to its medical office facilities and hospitals, Kaiser Permanente operates a 60-bed Mental Health Center in Los Angeles and a Hospice in Norwalk for terminally ill patients.

Kaiser Permanente's Southern California Region employs 33,000 people. The Southern California Permanente Medical Group, which contracts with the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, is a partnership of 3,070 doctors, the largest medical partnership in the country.

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Kaiser Foundation Health Plan, Inc.
1700 K Street, N.W., Suite 601
Washington, D.C. 20006-3817
202.296.1314 FAX 202.296.4067

CEDARS-SINAI MEDICAL CENTER

Cedars-Sinai Medical Center is the largest voluntary, nonprofit hospital in the western United States. It is internationally renowned for its diagnostic and treatment capabilities, broad spectrum of programs and services, and breakthrough biomedical research. The Cedars-Sinai reputation for the highest standards in health care and the quality of its professional staff attract patients not only from the Los Angeles area, but from around the world. For all its present magnitude, however, the origins of CSMC were modest.

In 1902, a small house in East Los Angeles opened its doors to care for patients with tuberculosis and in doing so became the Kaspare Cohn Hospital. The Boyle Heights Los Angeles Home for Incurables, established in 1921 for victims of a national influenza epidemic, had only six beds. During a growth process that involved more than one relocation, these two hospitals moved to the west side of Los Angeles, and were renamed Cedars of Lebanon and Mount Sinai.

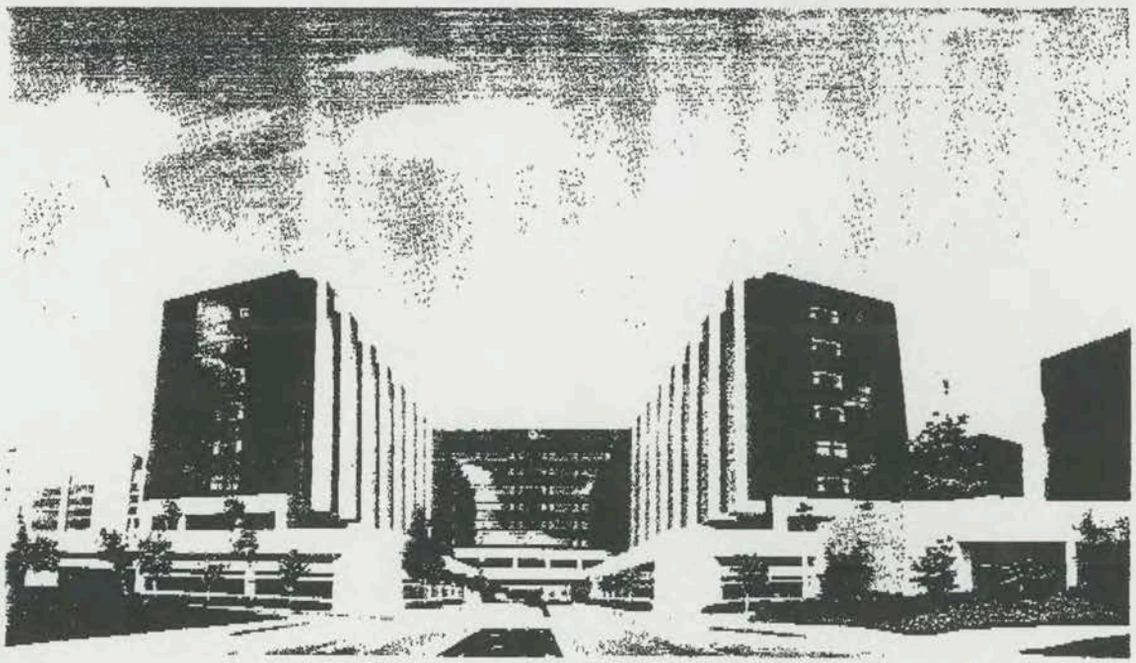
Then, in 1961, those who supported the hospitals agreed that the community would be better served by merging the two facilities. In 1973, following a decade of planning and preparation, the Thalians Mental Health Center opened and the first phase of construction on the CSMC complex was completed. The primary, eight-story structure of 1.6 million square feet, built at a cost of more than $100 million, was dedicated in 1976. Since that time, several other facilities have been added, including the off-campus, 11-story Mark Goodson Building for outpatient programs, the totally renovated structure housing the Steven Spielberg Pediatric Research Center, and the seven-story, state-of-the-art Barbara and Marvin Davis Research Building.

The goal of the community volunteers who serve on the Cedars-Sinai board of directors has been to make the medical center a world class facility in every respect, one committed to excellence in all endeavors. According to a recent consumer survey in which CSMC was compared to other Los Angeles-area medical centers, Cedars-Sinai has achieved the board's goal: it was selected first in all major categories.

Cedars-Sinai ranks among the top hospitals in the nation in voluntary biomedical and clinical research. Los Angeles' first coronary care unit was at CSMC, as was the first hospital-based blood bank. The medical center is a pioneer in fetal monitoring, and has made a major commitment to genetic research with more than 100 scientific investigators pursuing projects in this field. The Swan-Ganz catheter for monitoring the condition of cardiac patients was developed at CSMC and is now used throughout the world.

The medical center's cardiology division has gained worldwide stature for its research and applications of procedures that have become standard in the international community. For example, CSMC was the first medical facility in the world to develop a procedure in which clogged arteries could be opened without invasive surgery. A collaboration between scientists at NASA and the Jet Propulsion Laboratories with medical center physicians resulted in a space age event: blocked arteries were opened with beams of excimer laser light. Cedars-Sinai has also received national recognition for treatment of kidney disease and its neonatal intensive care unit.

As a tertiary care hospital, the medical center has many multi-speciality, critical care units. Treatment centers include the Comprehensive



Cedars-Sinai Medical Center has established a reputation for maintaining the highest standards in health care.

Far left: Surgeons in the Transplantation Center perform replacement procedures of various organs including heart, lung, and bone marrow.

Cancer Center: DOTEC (Diabetes Outpatient Training and Education Center); the Center for Reproductive Medicine; the Medical Genetics-Birth Defects Center for genetic risk information, screening, and knowledge, as well as prenatal diagnosis, an international registry for skeletal dysplasia, and diagnosis and treatment of the many birth defects afflicting children; the Bone Disorders Center; the Sleep Disorders Center; and the Ellis Eye Center. The Department of Psychiatry offers a comprehensive program at the Thalians Mental Health Center, and elsewhere on the CSMC campus, including help for addictive behavior and substance abuse.

The Transplantation Center reflects CSMC's reputation for excellence and leadership in transplantation surgery, with capabilities in the replacement of various organs, including heart, liver, lung, kidney, and bone marrow transplants. More than 22,000 surgical procedures in 14 specialties—including cardiovascular, transplantation, neurosurgery, and plastic—are performed annually.

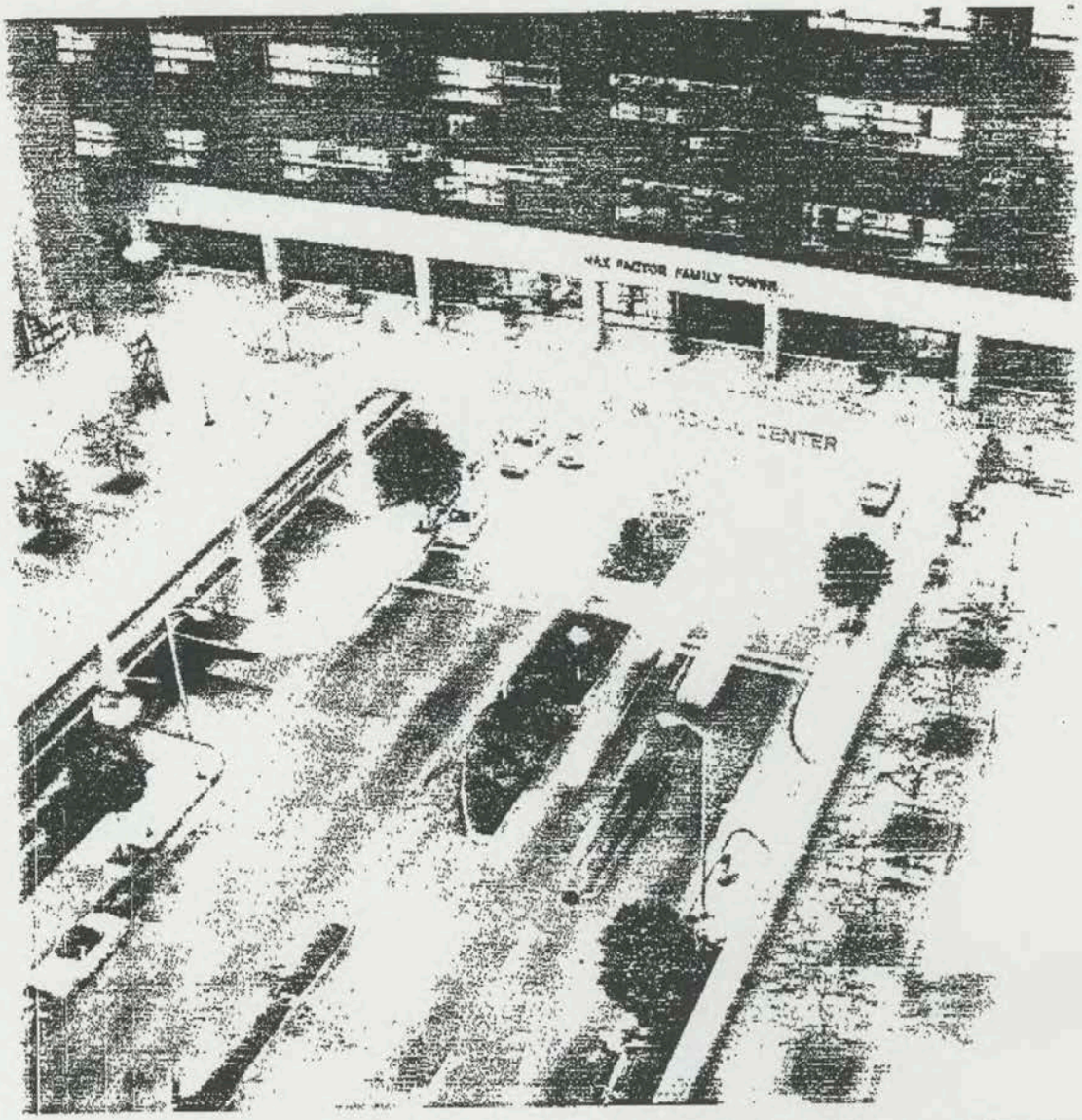
The medical center is also known for its AIDS research and treatment; pulmonary disease program; diabetes research; gastroenterology research and clinical care; endocrinology program, including thyroid function and reproductive medicine; rheumatology program (arthritis, lupus); and rehabilitative medicine program, including inpatient and outpatient care. All laboratory-based activities of the medical center are supported by the Department of Pathology & Laboratory Medicine and its state-of-the-art equipment.

The CSMC Department of Obstetrics & Gynecology functions as a comprehensive women's hospital. Some 8,000 babies are delivered annually, and high-risk maternity care and neonatology intensive care are provided. A full range of medical services for children include the Amie Karen Center for treating children suffering from cancer, leukemia, AIDS, and blood disorders; and the Medical Genetics-Birth Defects Center for diagnosis and treatment of children born with hereditary conditions and birth defects such as cystic fibrosis, mental retardation, sickle cell anemia, spina bifida, juvenile onset diabetes, and growth disturbances.

Cedars-Sinai is one of the finest teaching hospitals in the country. Residency training is offered in seven specialties, and as many as 500 physicians are in training at any one time. Training programs also are available in nursing, pharmacy, and medical technology. The medical center has an academic affiliation with the UCLA School of Medicine, and all of its medical department heads hold faculty status at the university.

Service to the community is part of the Cedars-Sinai mission, as is health care for the poor and indigent. Costs over and above donations provided by social services, such as the Jewish Federation Council and United Way, are absorbed by the medical center. The Ambulatory Care Center sees many patients who cannot pay, and Cedars-Sinai is one of the few Los Angeles-area hospitals still participating in the Los Angeles Trauma System as a Level I Unit. Other community services include physician referral, wellness education, support groups, senior citizen programs, an

The medical center's Department of Obstetrics & Gynecology offers a variety of services and treatments for children.



Thousands of dedicated people work together to ensure that patients receive the finest health care available.

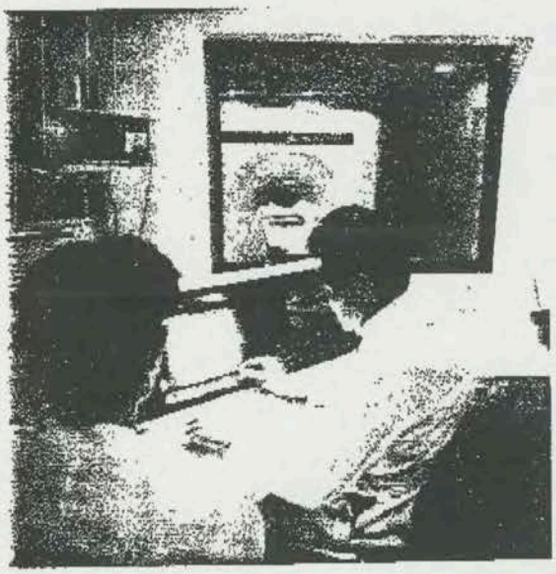
emergency response system for the elderly and disabled, a hot line for troubled teenagers, and the Adopt-a-School program.

Delivering all of these services takes the combined efforts of thousands of dedicated people. The medical staff is comprised of more than 2,200 attending physicians and 250 full-time staff physicians, supported by 2,000 nurses and nearly other employees. More than 1,400 volunteer nate about 265,000 hours annually, and 31 port groups raise funds through charitable e to benefit Cedars-Sinai.

The medical center is licensed for 1,120 and all inpatients are housed in private roo wide selection of fine food is available, and are preparation kitchens on each floor su menting the main kitchen.

For therapeutic purposes, a collection of than 8,000 art objects, such as paintings sculptures, are to be found throughout the cal center. Supervised by its own in-house tor, this is the largest collection of fine art found at any hospital in the world.

All of those who work or volunteer at Ce Sinai are proud of its reputation as one great medical centers in the world. To mai this position at the leading edge of patient medical technology, and pioneering researc forts in the future, the CSMC board of direct building a $250-million endowment fund. this type of support, the medical center can tinue to achieve its mission of providing the quality health care to be found anywhere.



Staff members use the latest technology in their research.

CEDARS-SINAI MEDICAL CENTER

INTRODUCTION AND BRIEF HISTORY

Cedars-Sinai Medical Center is a non-profit corporation, governed by an elected Board of Directors whose members serve on standing committees which formulate policy.

A comprehensive, tertiary care facility located in Los Angeles, Cedars-Sinai is not only prominent locally but serves also as a specialty referral center nationally, and even internationally, offering a complete spectrum of medical/surgical services. Along with its commitment to highest quality patient care, Cedars-Sinai offers a complete program of physician training (in affiliation with UCLA School of Medicine), nursing, medical technology, and community education. Additionally, it maintains the nationally recognized Cedars-Sinai Research Institute where many prominant physician/researchers affiliated with the Medical Center carry out research and projects often resulting in contributions to medical knowledge and practice worldwide.

Although Cedars-Sinai opened the doors of its ultra-modern, 1.6 million square foot, $100-million facility only ten years ago, it upholds a tradition of strong community service begun in 1902 with the founding of Kaspare Cohn Hospital, in a converted residential dwelling, and Mount Sinai Hospital in 1921. This tradition was reinforced by the 1961 merger of Kaspare Cohn's successor, Cedars of Lebanon Hospital and Mount Sinai Hospital -- a pooling of resources that ensured the future of a preeminent medical institution.

Thus, while Cedars-Sinai has developed into one of the world's most complex and sophisticated medical centers, it maintains a primary commitment to deliver unsurpassed care to its patients-- a commitment visible in the dedication of a highly skilled nursing staff and the corresponding satisfaction of its patients. (Cedars-Sinai's annualized turnover rate for nurses is only 1%. the lowest in the state of California. Responses to patient questionnaires distributed to patients from January-March 1986 show that 95% would recommend CSMC for patient care.) In 1985, Cedars-Sinai committed $4.6 million dollars to free care.

In the past ten years, one million patients have been treated at Cedars-Sinai; the Medical Center looks forward to cintinuing its tradition of critical, life-saving work and compassionate care.

Nurses and physicians in pediatrics are prepared to respond to the special needs of children. Visiting hours here are more flexible, and a special play therapy program helps to alleviate a child's apprehensions concerning the hospital stay. An innovative practice of Cedars-Sinai is to encourage a family member to stay with the child throughout the day and night. For this purpose, every pediatric room is furnished with a chair bed.

Cedars-Sinai is preeminent in the West for cardiovascular and thoracic surgery--from simple surgery to the most complex coronary artery bypass grafting, valve replacement/repair. There are three operating rooms for cardiovascular surgery, wtih an adjacent Cardiac Surgical Intensive Care Unit. Highly complex lung, chest and major artery surgery are performed in another three operating rooms, with adjacent recovery room.

The Department of Physical Medicine and Rehabiliation provides physical and occupational therapy, social services, and psychiatric liaison services both on inpatient and outpatient basis. Multi-disciplinary programs -- all with the aim of returning the patient to as self-sufficient and normal a lifestyle as possible -- include chronic pain management, rehabilitation for stroke, brain and spinal cord injury, multiple fractures, amputation, cardiac condition among others.

The Thalians Mental Health Center, in its own building under the Department of Psychiatry, provides a complete program of psychiatric services, and works in liaison with every department of the Medical Center. It is noted for programs dealing with divorce, child custody and family guidance. Confidential telephone counseling for parents, teens, and victims of rape is available to the community at no cost. A special Care Unit, housed in a separate facility, treats victims of alcohol and drug dependency.

Cedars-Sinai's comprehensive Ambulatory Care Center consists of a group of clinics providing ongoing outpatient care in Internal Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and numerous consultative specialties. The Same Day Outpatient Surgery Center enables patients to be admitted in the morning, have surgery performed, and be released the same day; four operating rooms, with adjacent ICU and radiology units comprise this active center. A new outpatient Comprehensive Cancer Center, offering a full range of sophisticated cancer treatment, is fully operative 24 hours daily.

The Department of Emergency Medical Services boasts one of the most extensive, highly equipped emergency centers in the country. The emergency unit contains its own CT

scanners, the most sophisticated heart monitoring equipment in the West, and complete laboratory. Its professional staff includes ten full-time Emergency physicians, and a 38-person nursing staff devoted exclusively to the emergency area. Moreover, the unit has earned the following accreditations: Level I Trauma Center designation; Heli-Pad opening; Emergency Department approved for Pediatrics/Pediatric Critical Care Center; American Heart Association Approval.

SPECIAL PROGRAMS

In recent years, multiple specialized services and facilities have added to Cedars-Sinai's capabilities in providing the most sophisticated, refined healthcare available anywhere.

These programs include:

Metabolic Support Team: This is a multi-disciplinary service of the Nutrition Center. The team combines nutritional therapy with other methods of treatment, effecting a decrease in complications of surgery. Additionally, the team provides nutritional support and medication to outpatients.

Weight Control Program: Studies show that the weight reduction program adopted by Cedars-Sinai is one of the most effective available. A medically monitored, individualized program, it begins with a fast limited to a nutritionally balanced supplement and progresses through stages of refeeding with lean basic foods.

Arthur and Eleanor Ellis Eye Center: This ultra-modern outpatient clinic uses the most technologically advanced equipment available (such as argon and Nd:YAG lasers) to treat a variety of ophthalmologic conditions, including retinal diseases and injuries, and to evaluate the sensory nervous system, both in the eye and the brain. Procedures include cryosurgery, visual field studies, electro-physiology, lens calculations, fluorescein angiography, and eye photography.

Diabetes Outpatient Training & Education Center: Through an intensive five-day program, patients learn the latest techniques in diabetes self-management, including home glucose monitoring, insulin injections, and diabetic nutrition and exercise. Special facets of the program are pre-pregnancy counseling for diabetic women and emotional support from peers and psychologists. The program's objective is to allow the patient to experience an independent, vigorous lifestyle.

Chronic Pain Management Program: This program draws from ten disciplines to use an integrated team approach in helping a patient deal with and experience alleviation of chronic pain. Patients are led through a specific series of behaviors that teach them pain-coping skills, eliminate (or decrease) their reliance on pain medication, and increase the amount of activities they can perform.
Biofeedback Therapy: This inpatient/outpatient program assists patients to recognize and subsequently regulate their own body's reactions to tensions and stress which manifest in physical disorders.
Home Care Program: This program supplies complex equipment and instruction in its use (both to patients and their families) and provides highly expert home-care nursing for those who require such services while completing their convalescence or dealing with chronic conditions at home.
Hospice Unit: This 20-bed inpatient unit, staffed by a team of specially trained volunteers and professionals, provides counselling for patients and families, and helps terminally ill patients discover how they can spend their remaining days with meaning and in all possible comfort. The staff arranges for pain control, helps plan for outpatient care, and provides liaison with community and financial services for special needs.
Geriatrics Program: Because Cedars-Sinai is located in the midst of a community densely populated with senior citizens, and because of its awareness that the over-65 population is dramatically increasing nationwide, it is inaugurating this comprehensive treatment and research program dealing with all aspects of geriatrics and gerontology. One of its initial projects has been development of a Senior Resource Center which provides members of the community with free information and referral on multiple services available to seniors and their families.
Comprehensive Cancer Center: This outpatient program provides states of the art diagnostic and therapeutic care for cancer patients. Patients receive around-the-clock service, and are offered lower costs and a better quality of life through rapid daignosis and treatment. The Amie Karen Center for Children sees patients in an environment created for the special needs of children.

Regional Arrhythmia Center: A specialty referral center for the West, the R.A.C. is unique in its ability to offer coordinated, comprehensive treatment for patients afflicted with disturbances of cardiac rhythm. The center, making expert, advanced care available for patients with unusual, complex, or previously unmanageable arrhythmias, unites a team of specialists and incorporates new and diverse techniques, antiarrhythmic devices and drugs to provide superior evaluation and treatment.
Reproductive Endocrinology Center: This developing center will employ the expertise of an interdisciplinary team -- in recognition of the fact that the field of sexual and reproductive function is a complex blend of medical and psychological factors -- to offer a comprehensive program of professional care. The reproductive and infertility aspects will include the capacity to treat all aspects of in-vitro fertilization.
Genetics Center: The hospital is developing an extensive Medical Genetics-Birth Defects Center which will provide state of the art technology toward the prevention, diagnosis, and treatment of all forms of hereditary disorders and birth defects. It houses the international skeletal dysplasia registry and clinic, a world renowned resource for the diagnosis and treatment of growth problems.

In addition to the above programs, Cedars-Sinai sponsors a no-cost, obligation-free Physician Referral Service, listing more than 600 attending physicians in 38 specialties and sub-specialties. Another valuable service sponsored by the Medical Center is Lifeline, an emergency response system for the elderly, disabled, or other vulnerable individuals.

FREE CARE

It is through the Ambulatory Care Center that Cedars-Sinai offers indigent care, making the services and capabilities of the Medical Center available to a whole spectrum of the community that would otherwise have no access to them. With the exception of donation from the Jewish Federation Council and United Way, Cedars-Sinai absorbs the costs of this care. In 1985, the Medical Center absorbed $4.6 million in caring for needy individuals.

MEDICAL EDUCATION

Cedars-Sinai is a major teaching hospital affiliated with the UCLA School of Medicine to train medical students and to offer postgraduate medical education in internal medicine, general surgery, obstetrics/gynecology, pediatrics, adult and child psychiatry, diagnostic radiology, and pathology. In 1985, there were 55 physicians receiving graduate medical training as first year residents, 139 advanced residents, and 36 fellows-- a total house staff of 230 physicians in training.

At the same time, over 2,000 practicing physicians of the CSMC medical staff, all board certified or qualified for board certification, had the opportunity to attend hundreds of educational programs. Among these are annual lectureships.

In fiscal 1984-85, the Office of Continuing Medical Education offered 31 different specialty programs, attended by 3,895 physicians, earning a total of 13,536 CME credits. Two hundred speakers, experts in various medical specialties, participate in these programs. Physicians from the surrounding community, as well as those affiliated with Cedars-Sinai, attend these programs. Nursing Research and Development provides educational and training programs for the community, patient population and nursing personnel. The department coordinates clinical educational programs for 15 affiliated universities and colleges. These include UCLA, USC, CSU Los Angeles, CSU Long Beach, Mount Saint Mary's College, L.A. Trade Tech, L.A. City College, West L..A. College, and L.A. Valley College. Many of Cedars-Sinai's nursing staff hold joint faculty appointments. An annual national symposium is conducted, bringing together leaders in the nursing and health community. Clinical nursing research and collaborative research projects are conducted by the department.

The Emergency Department provides in-service and continuing education courses to paramedics and Mobile Intensive Care Nurses.

Technical students are enrolled in our Schools of Laboratory Technology and Histopathology.Students also spend time at Cedars-Sinai training in physical therapy, radiation therapy and radiologic technology. A broad program of in-service training is conducted for professional and non-professional employees.

As a special service to the community, Cedars-Sinai makes available a program of Community Education. This includes ninne different prenatal education programs and "The Best of Health Series," which have presented topics such as CPR, parenting, first-aid, stress reduction, weight reduction, and smoking cessation.

RESEARCH

Basic biomedical and clinical research programs are an integral part of Cedars-Sinai; these programs are being conducted by renowned specialists in virtually every medical specialty and subspecialty practiced at the hospital. The Medical Center, which is steadily developing into a national medical research center, presently has more than 100 projects, which involved over 70 principal investigators and some 150 employees.

Among studies underway are diagnosis and treatment of heart disease by innovative techniques; pediatric diseases such as cancer, juvenile diabetes, and growth disorders; diabetes detection and treatment; blood apheresis treatment for arthritis; treatment of gallbladder disorders by non-invasive procedures; treatment of corneal infections; variations in the treatment of gynecological malignancies; advanced surgical techniques, for instance in spleen surgery-- and many others.

The results of research carried out at Cedars-Sinai are published in all prominent medical journals, introduced at major medical conferences, and consistently reported in local and national media.

During 1985, the Cedars-Sinai Research Institute continued to garner national acclaim, thanks to the many activities of its research program. A major facility renovation was completed to house the Ophthalmology Research Center, where research in eye surgery and disease will be conducted in cooperation with clinical activities of the Arthur and Eleanor Eye Center.

Cardiology and Surgery Research Investigators have developed the concept for the Excimer Laser, currently being built by the NASA Jet Propulsion Laboratories, which promises the potential of clearing blocked arteries without surgery. This significant scientific advancement was announced in the New York Times Science section, as well as on television. To bring these new technologies to clinical applications, the Medical Center is developing a Surgical Laser Laboratory.

The specialized Center of Research in Ischemic Heart Disease, a multi-disciplinary program now in its third consecutive grant renewal, by virtue of its size, scope, and accomplishment, constitutes a major area of cardiology research at the Medical Center.

The recent refinement at Cedars-Sinai of a miniature color TV camera in conjunction with endoscopic procedures promises to enhance dramatically the use of television endoscopy in viewing bile ducts, bloods vessels, and other body structures.

The excellence of research at Cedars-Sinai Medical Center is reflected in the large amount of research monies awarded to research specialists at the Medical Center: The Medical Center receives approximately $6 million annually in support of its research activities, from Federal, state, corporate, and foundation sources. The National Institutes of Health account for two-thirds of these monies. Additional private contributions are directed toward specific research projects, as designated by the donor(s).

Another testimony to the quality of research at Cedars-Sinai is that techniques and treatments developed here are often subsequently implemented by the medical community worldwide.

SPECIAL EQUIPMENT

As a major tertiary care and referral center, Cedars-Sinai upholds a primary objective to acquire and maintain state-of-the-art technology. Intensive Care Units in medicine, surgery, pulmonary therapy, cardiology, pediatrics, and neonatology provide highly sophisticated equipment for all possible medical situations in these area.

The development of specialized treatment centers at the Medical Center further enhances its technological capabilities. For instance, the most advanced medical equipment for treatment and surgery of eye conditions is available in the Ellis Eye Center, including the argon and Nd:Yag laser. Again, in conjunction with the opening of the Comprehensive Cancer Center, the entire Department of Radiology is being renovated and refurbished, with major equipment acquisitions; among these is an additional linear accelerator.

In cardiology and thoracic and cardiovascular surgery, Cedars-Sinai offers among the most sophisticated and extensive equipment in the nation: The increasing complexity and growth of invasive cardiology is resulting in renovation of two catheterization laboratories and purchase of single plane as well as bi-plane equipment. Completion of the renovations will provide two new laboratories as well as one existing laboratory. In the non-invasive laboratory, the addition of Doppler Echocardiology treatment module maintains a state of the art capability in Echocardiology. The opening of the Regional Arrhythmia Center ensures that the latest equipment and drugs in the treatment of disturbances of cardiac rhythms are used here.

In the Department of Surgery, application of the latest, most efficient, and precise equipment -- such as Carbon Dioxide laser and television endoscopy for a range of procedures -- goes hand in hand with basic and clinical research.

This year (1986), Cedars-Sinai will receive an Extracorporeal Shockwave Lithotriptor (commonly known as a kidney stone crusher) for noninvasive treatment of kidney stones.)

In the Department of Diagnostic Radiology procedures are performed in the following subspecialties: CT/ultrasound, neuroradiology, gastrointestinal radiology, mammography, pulmonary radiology and ultrasound, musculoskeletal radiology, pediatric radiology, uroradiology, angiography, and interventional radiology. In Nuclear medicine the most modern equipment is used for visualization of body function through use of cameras, scanners, and radioisotopes.. Cameras and scanners are used in combinations with computer analysis, making important contributions in nuclear cardiology, pulmonary medicine, endocrinology and oncology. Equipment is continually updated and the department is exceptionally active, particularly because the Nuclear Scanner and is available at only one other hospital on the West Coast. The General Electric Signa Magnetic Resonance Imaging Unit with a 1.5 Tesla magnet was installed in 1985, with the ability to carry out the most precise scanning of all body systems.

STATISTICS**

Number of licensed beds: 1201
Bassinets: 60

Average Number of Patients (Daily Basis): 658 (excluding newborns)

Patient Admissions:
Adults:
Children:
Total: 38,346 (This figure excludes newborns)

Bed Occupancy Rate: 73.41%

Ambulatory Care (Outpatient) Center Visits: 27,608

Emergency Room Visits: 106 daily average (38,859 annual)

Surgical Procedures: 18,665 annual visits

GOVERNOR PETE WILSON

PR94:296

GOVERNOR WILSON ANNOUNCES LOWER HEALTH INSURANCE RATES FOR SMALL BUSINESSES IN CALIFORNIA

FOR IMMEDIATE RELEASE
March 22, 1994

CONTACT: Sean Walsh
Paul Kranhold
(916) 445-4571
Lisa Bierer
(213) 897-0322

SACRAMENTO -- Governor Pete Wilson today announced that the nation's first voluntary health alliance has reduced its health insurance rates 6.3% for small businesses and the decrease is expected to save companies participating in the program more than $3.2 million this year.

"With HIPC, we have created a sort of "Price Club" for health care insurance," Wilson said. "We've brought small businesses together in a purchasing pool that allows them to buy better and less expensive health care."

The Health Insurance Plan of California (HIPC), which was instituted by the Wilson Administration in July of 1993, allows small businesses to pool their health insurance policies to obtain the lower rates that are typically offered to companies with large numbers of employees. Under the HIPC Alliance, businesses with between 3 and 50 employees may participate. HIPC now serves more than 44,000 employees at 2500 businesses throughout the state.

The new rates, which take effect July 1, 1994 offer health coverage from 23 of the state's best health plans, including three newcomers to the alliance: Metlife, Omni Health Plans and PacifiCare.

Wilson pointed to one small company, Cornerstone Metrology, which could not afford to offer health insurance to its seven employees at the $3000 per month it was quoted for a single policy. Under the HIPC plan, the companies rates are $789 per month.

HIPC rates have been up to 23% lower than those in the CALPERS system, which is widely considered to have among the most competitive rates in the market. CALPERS rates have decreased 1.1% this year.

-more-

"Unlike some of the plans being debated in Washington, HIPC imposes no cost on taxpayers and no job killing mandates on small businesses," Wilson said. "Once again, when it comes to helping small businesses compete and create jobs, California is leading the way."

Under the new HIPC rates released today, participating companies located in northern California will see a rate reduction of 2.72%. Companies in the central state will see rates decline 5.61%. Region 3, which includes the San Francisco Bay area will see a decrease of 6.06%. The central coast rates including Orange County will decline 7.74% and the inland empire rates will go down by 6.24%.

The largest decrease will take place in Los Angeles County, where rates will drop by 7.94%

-30-

THE HEALTH INSURANCE PLAN OF CALIFORNIA (The HIPC)
BACKGROUND INFORMATION

- The Health Insurance Plan of California (known as "the HIPC") was created as part of small group health insurance reform legislation AB 1672. The HIPC began operation on July 1, 1993, and already has 44,000 enrollees.

- The HIPC is administered by an appointed bipartisan board which establishes program rules, negotiates contracts with health plans, directs marketing efforts and monitors contractor compliance. The board contracts with a private entity, Employers Health Insurance, to administer enrollment, collect premiums and provide marketing assistance.

- The HIPC is a purchasing cooperative through which eligible small employers may purchase a basic health benefit package for their employees. Health plans have the option of selling their products through the HIPC or directly to small businesses, or both.

- Currently, employer groups of 5-50 full-time employees (at least 30 hours per week) may purchase the basic health benefit package through the HIPC if at least 70% of employees participate and the employer pays at least 50% of the premium cost of the lowest-priced plan in the area. The size requirement will drop to 4-50 on July 1, 1994 and to 3-50 on July 1, 1995.

- The average employer in the HIPC has 10 full-time employees and the average employer contribution is 80%. Over 20% of the employers enrolled in the HIPC were previously uninsured.

- The benefits package includes hospitalization, physician care, prescription drugs and medical equipment. Employees have a choice of cost-sharing -- HMO coverage with a $5 or $15 copayment or PPO coverage with a $250 or $500 deductible.

- Agents and brokers are required to provide small businesses with information on all health plan options. Agents and brokers who sell products offered through the HIPC are compensated according to a fee schedule. Over 70% of employers who purchase coverage through the HIPC utilize an agent or broker.

- Other small group health insurance market reforms contained in AB 1672 include:

  Guaranteed Issue and Renewability of All Small Group Insurance Products -- Maximum Waiting Period of 6 Months for Preexisting Condition.

  Restrictions on Premium Rate Increases and Premium Rate Disparities Between High Risk and Low Risk Groups.

CLINTON'S REMARKS
CA MEDICAL SOCIETY

Clinton Builds Bridges With Doctors

■ **Health:** Physicians at Anaheim convention quickly warm to President, who addressed group via satellite. Clinton appears to be in sync with them on key issues.

By DOUGLAS P. SHUIT
TIMES STAFF WRITER

ANAHEIM—President Clinton did some long-distance wooing of doctors Wednesday at the California Medical Assn. convention in Anaheim, asking for their support for his health reform proposals and fielding questions via a live satellite hookup from the White House.

Clinton's address began and ended with standing ovations from the crowd of 800 conventioneers—450 of them physicians—who gathered at the Disneyland Hotel to listen to the President.

Many of the physicians went to the event cool to the Clinton plan because it would place key health care decisions in the hands of large, impersonal purchasing alliances that they fear would place distance between doctor and patient.

But Clinton, whose image appeared on two movie-theater-size screens, warmed up the room quickly as he appeared to be clearly in sync with the doctors on key issues.

The physicians demonstrated their approval as the President called for limits on the power of the insurance industry, a longtime political foe of the CMA. He also told the doctors that he favors relaxing anti-trust regulations that prevent them from joining together to sell their services. Perhaps welcomed most were his repeated pledges that he believes Americans should have the maximum amount of flexibility in choosing their doctors.

The convention delegates adjourned without taking a position on the Clinton plan, but the closed-circuit television appearance seemed to accomplish some important fence-mending.

Before the speech, Dr. Max M. Stearns, a urologist from Oxnard, said he and many other physicians had felt left out when the President first unveiled his plan last year. But after listening to Clinton on Wednesday, he said, "I think the President did a very good job in addressing the different issues. We asked some tough questions and he didn't back down. . . . Best of all, he seemed to want to work with us," Stearns said.

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HEALTH: Convention

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Having a common political adversary—the health insurance industry—appeared to help build some political bridges.

During opening remarks, and later during a question-and-answer session, Clinton lashed out at the insurance industry, saying he wanted to bring an end to such industry practices as refusing insurance to people with pre-existing medical conditions or raising rates excessively high because of a person's age.

"There ought to be a clear outlawing of insurance practices which have caused so much misery and caused so many Americans to fall between the cracks [of the health system]," he said in one of several comments that won him spontaneous applause from the conventioneers.

As if the doctors had to be reminded, Clinton noted: "Insurance companies set your fees. They second-guess your clinical decisions. More and more they make you get prior approval from someone who's thousands of miles away and has never seen your patient and doesn't have a clue about what ought to be done."

Dr. David Holley, president of the CMA, told Clinton that the insurance industry spent millions to defeat Proposition 166, a CMA-backed universal health insurance initiative in 1992 that featured many of the same features of the President's health reform plan.

"We had Harry and Louise opposing us when they were only engaged," Holley cracked, referring to a yuppie married couple featured in television commercials being used by the health insurance industry to raise questions about Clinton's health plan.

Danielle Walters, a spokeswoman for the CMA, said opposition by the insurance industry to Clinton's health plan "is the same thing we went through with Proposition 166."

Walters said the state association would take no formal position on the Clinton plan until a clear version of the bill emerges from Congress.

"Everything now is in a state of flux, with a lot of the key details still to be worked out," she said.

Although Clinton clearly appeared to be close to the physicians on many issues, the President refused to back down on others. For example, he would not endorse a national cap on pain-and-suffering awards in malpractice suits similar to a cap in effect in California.

"We didn't want the whole health care plan to come a cropper on the debate over tort reform," he said.

At another point, Clinton charmed the audience when, responding to a question by Dr. Rene H. Bravo, a pediatrician from San Luis Obispo, he said, "I want to say, Bravo is a wonderful name for a pediatrician."

BC-CLINTON-MEDICAL-1
Remarks by President to California Medical Association via Satellite (1 of 5) To: National Desk, Health Care Writer
Contact: White House Office of the Press Secretary, 202-456-2100
Old Executive Office Building
11:47 A.M. EST

THE PRESIDENT: Thank you very much. Thank you, Dr. Holley for that kind introduction, and for your good work and the good work of all the physicians whom you represent now in dealing with these very difficult and complex and profoundly important issues.

I regret not being able to join you in person today, but I am glad that Ira Magaziner is able to be there with you. I'm glad I had a chance to visit with you, Dr. Holley, and your past president, Dr. Richard Corlin, in Washington recently, following another health care forum. And I'm grateful for many reasons for your continued good counsel and for this invitation to address you.

Each of you has, in the most personal way, been part of the excellence in American medicine simply by caring for the families in your communities. And I'm grateful that you understand that our health care system needs dramatic reform. You know, costs are rising too fast, that paperwork is mounting too much, that every day more constraints are placed on your patients and your ability to practice medicine the way you know it should be practiced.

But unlike so many others in the debate who will only tell us what they don't want to change, long ago you left the sidelines and became advocates for responsible, comprehensive reforms. I appreciate the early and continued support you have shown for the objectives we are trying to achieve -- providing Americans guaranteed private insurance; preserving the right of everyone to choose his or her own doctor and their own health care plans; outlawing unfair insurance practices; protecting and strengthening Medicare; and linking these health benefits to the workplace, where most people get their insurance today.

These reforms are entirely consistent with many of the things that you have tried to do in California. Your health care providers have been innovators in improving quality and controlling costs and, judging from today's headlines, the new California purchasing pool is certainly a step in the right direction --offering consumers a wide choice of plans, a comprehensive benefit package and lower rates. That kind of competition between insurers, combined with more choices for consumers is what my plan is all about.

At a national level, I think the first step we must take is clear. The best way to preserve what's right about our health care system is to guarantee private insurance to every American.

That's the foundation of our health reform plan. We'll provide every American with a health security card that will guarantee them a comprehensive package of benefits that can never be taken away. The benefits will include, for the first time for many Americans, prescription drugs and preventive care. All of you know that the best way to keep people healthy is to promote wellness in addition to treating sickness. Retaining choice of doctors and health plans is also critically important to Americans and to American medicine. And this, too, is central to our approach.

Today, only about half American employers offer their employees more than two choices of insurance plans; 90 percent of the businesses that have 25 workers or less offer no choice at all. And even for those who have some choice today, there's no guarantee they'll have it tomorrow if they change jobs or lose their job or if their employer has difficulty meeting the costs. This is a tremendous restraint on most Americans.

My proposal will guarantee the great majority of Americans far more choice of both doctors and insurance plans than they have now. Under this approach people will be able to join a traditional fee-for-service plan, a network plan, or a plan sponsored by a health maintenance organization. But in all cases it will be families, not employers or insurance companies, that make the health care choices.

The people who are telling you we don't offer enough choice, which is clearly not so on its face, are the same who for decades have been pushing you out of the way and limiting your choices. You don't believe their arguments and neither do we.

That's why among other things we're going to insist upon different insurance practices -- no more preexisting conditions, no more lifetime limits, no more higher rates for those who have had someone in their family sick or those who are older. No more overcharging of small employers or dropping them because one person in the workplace has a medical problem. No more avoiding people that might cost some money.

The fact is, increasingly insurance companies set your fees. They second-guess your clinical decisions. More and more they make you get prior approval from someone who's thousands of miles away who's never seen your patient and doesn't have a clue about what really ought to be done. They all pay according to their own fee schedules, requiring different forms for different people under different circumstances. The forms are drowning the health care system in paper.

I have a doctor friend who calls me about every three months to tell me another horror story. Recently he told me we've got all these people doing paperwork. Now we've hired somebody who doesn't even fill out forms, just spends all day on the telephone beating up on the insurance companies about the forms we've already sent in. He's told me, he said, I went to medical school to practice medicine, but I'm getting lost in the fun house instead.

Well, he's right, and I know a lot of you agree with him and identify with that story. But this year we can escape that fun house.

The fourth element of our approach is to preserve and protect Medicare. Older Americans will continue to choose their doctor and their plan; and, in addition, we want to cover prescription drugs under Medicare; and provide new options for long- term care in the home and community, which most people prefer and which will become increasingly important as our population continues to age rapidly.

Finally, let me say again, we should guarantee these health benefits at work -- that's how most people are insured now. And eight of 10 uninsured Americans have a family member who works. This is the fairest and most efficient approach to covering everyone. And so no one gets hurt by the needed reforms -- we'll provide discounts for small businesses and breaks for self-employed people and their families.

This is the proposal; it's pretty straightforward. All Americans will get a card that guarantees with it the security of private insurance and comprehensive benefits; then they can pick the doctor they want. They'll know that they're always covered by what is said to be covered, and it won't be subject to change by anyone.

Before taking your questions, now, let me again just express my deep thanks for your continued support and encouragement. After 60 years, I think this is the year we're going to provide every American health security that can't be taken away. I'm optimistic because of what's already been done. This Congress has been willing to act and to work with me to pass an economic plan that's helped to produce low interest rates and highF low F inflation and more than two million new jobs. After seven years, this Congress passed and I signed the Brady Bill and the Family and Medical Leave Bill -- things that people had given up on getting done.

The point is not that we have been able to do so much, but that is evidence that we can still do what we have to do. The American people have demanded that we make a great deal happen. They want their dreams back, and they want this problem fixed. A big part of the American Dream has always been knowing that you can care for your children or your family if they become sick -- that's what you do. You're a part of every American family's dream. I've seen the magic you perform all over the country. You care, and the American people know it. And our challenge now is to do everything possible to keep and protect the bond that you've worked a lifetime to establish. Our challenge is to provide every American health care that's always there. With your help, we can do that and we can make history.

I thank you for the leadership you've already shown. And if you have questions, I'll be glad to try to answer them. Thank you very much. (Applause.)

Q Thank you, Mr. President. I wonder if you have a contract with Coca-Cola. (Laughter.)

THE PRESIDENT: I forgot to put it in a cup. (Laughter.) There goes my Pepsi voters. (Laughter.)

Q Well, Mr. President, as you acknowledged, the California Medical Association has been deeply involved working for health system reform. You know, I think you have to realize that we had Harry and Louise opposing us when they were only engaged. (Laughter.)

The members of this house, representing 40,000 practicing California physicians are vitally concerned about what is contained in any proposal for health system reform. We will, after all, be caring for our patients within whatever structure is created by those changes. We want to be as certain as possible that it's going to work.

We have some questions for you that will address some of those physician concerns. And I'm going to take the opportunity to ask the first one.

Mr. President, in your State of the Union Address, you said that you would sign a health reform bill if it met the test of universal coverage. In addition to universal coverage, what other elements do you believe critical to a reform package, and what must be included to secure your signature?

THE PRESIDENT: Well, I want to be very careful about how I answer that because I don't want to be throwing down gauntlets that may mean more than I wish to say. But let me say, to have a system that works, you not only have to have universal coverage, but it seems to me that the benefits ought to include primary and preventive care. There ought to be a comprehensive set of benefits.

Then there ought to be a clear outlawing of insurance practices which have cost so much misery and cost so many Americans to fall between the crack. I think there should be an end to lifetime limits. (Applause.) I think there should be an end to preexisting conditions. I think there ought to be an end to discriminatory rate-setting based on age.

In order to do this I think we have to find some way of not only legislating community rating but actually having community rating. And we need a device that guarantees that small businesses and self-employed people will have access to insurance at competitive rates with people who are insured through big business and government. I think that's very, very important. So these are the things that I think are critical.

Now, if you're going to cover everybody, you have to either do it through a tax or through some device by which people pay into an insurance pool. I think the employer mandate, so-called, in the best way to do it by providing guaranteed private insurance at the workplace because that's the way most Americans get their insurance today.

I know there are some small businesses for whom this would create difficulties, so we developed a system of small business discounts paid for from tax proceeds. And the taxpayers would pay to cover those who are unemployed and uninsured. That's basically the way I think the system would have to work.

There are lots of other things I think ought to be in it, but I think it's very important for the President in the middle of a congressional process that is just not getting its sea legs and getting underway, not to be too specific in talking about vetoes.

If we can begin with a good comprehensive system of universal coverage, we can go a long way to dealing with a lot of the other problems.

As you know, my plan does deal with a number of your concerns, and I know you have more questions on that, so maybe we should get to the other questions.

Q Well, thank you very much, Mr. President. You're now going to have an opportunity to field questions from a group of pretty nervous California physicians.

Q Thank you. Good morning, Mr. President. I'm a family physician in San Bernadino. I have a unique opportunity here to ask you a question, particularly because I was a graduate from the University of Arkansas for Medical Sciences.

THE PRESIDENT: Good for you.

Q Thank you very much. (Laughter.) And I had an opportunity to campaign for you in 1982 when you made your comeback election for the governorship. So what I would like to ask you, Mr. President, is that physicians are concerned that in the current marketplace and under your proposed model, insurers and businesses are encouraged to collectively purchase health care services. However, antitrust laws prohibit physicians from collectively selling their services. It's like requiring individual autoworkers to negotiate their salaries separately with General Motors.

In light of the strong opposition of the Federal Trade Commission to any changes in antitrust laws, what would you propose to provide a more balanced and fair environment in which these negotiations can occur between physicians and insurers?

THE PRESIDENT: I think we have to change the antitrust laws to allow you to organize to provide your services and more comprehensive professional groups. (Applause). And let me say that one of the things that has concerned me most about this is that there is a development in American health care which I like, which has a consequence that I don't like.

What I like, the fact that people are getting together in competitive buying groups and trying to get a better deal and trying to squeeze some of the excess cost out of our system. I think we all agree there are some there. I don't like the fact that an inevitable consequence of that has been that so many Americans have lost the right to choose their own doctor. We try to address this -- (applause) -- we try to address this in two ways, one of which directly addresses your question. But let me try to put the two ways together so they'll fit.

Under our plan, each American consumer, once a year, would have the right to choose from at least three plans -- including a fee-for-service plan, an HMO, and hopefully some sort of provider plan that will be provided by providers who get together and who may allow all doctors in a state, for example, to participate if they agree to observe the fee schedule that the plan bargains for. So, I think you ought to be able to do that. We also think that the HMOs should have to have a fee-for-service option that would allow people who are covered under the HMO the option to choose another doctor if it seemed appropriate, and if the fee-for-service option were elected at the beginning of the year, -- (applause) -- the HMO would have to contribute to that.

So I think that this will help. But I agree that there must be some changes in the antitrust laws so that you can clearly get together without fear of legal repercussions. Otherwise, you are consigned to dealing with a middle-man that will only add to the cost of your providing your services, and undermine the choice that the consumer gets. (Applause.)

Q Thank you, Mr. President.

Q Good morning, Mr. President. I'm an oncologist practicing in Redwood City in Northern California. My question is about budgets and living within our means for health care. We recognize the need for controlling health care costs -- there's no debate about that. However, we are concerned that your proposal and others may limit the rise of health care budget to the cost of living or other artificial indexes that may have little to do with actual health care costs. Rising health care costs may be more related to human factors such as our aging population, tobacco consumption, new technologies, new diseases, such as AIDS. How can these factors be taken into account when arriving, or when developing a health care budget?

THE PRESIDENT: Well, first let me say that I basically agree with you on that. I have tried not without complete success -- or not with complete success -- but I've really tried hard since I started thinking about this issue seriously four or five years ago, when I was still a governor, to identify the elements of disparity between, let's say, the 14.5 percent of their GDP that Americans spend on health care, the 10 percent

that Canadians spend, the 9 percent or less that the Germans and the Japanese spend. There's no question that a lot of it is due to good factors like we invest more in medical research and technology, and that's good. And there's no question that some of it is due to bad factors that you can't do anything about, at least in your role as a doctor, which is higher AIDS rates, higher rates of violence which lead to enormous medical costs.

What we believe is that in the beginning, at least, there are many, many savings which can accrue from a rational system -- far, far lower administrative and bureaucratic paperwork costs; significant reductions in unnecessary costs that are in the system. That after that, in the years ahead, when we measure how much costs can increase, we're not only -- consider population growth and inflation, we will also have to consider the burdens of the American system -- if the rate of AIDS, for example, continues to go up instead of going down; if the rate of violence goes up instead of going down; if the aging population imposes greater burdens rather than fewer because we don't succeed in doing a lot of the preventive things that we're going to do.

Those things will all have to be calculated in the rate at which medical costs go up. We can't ignore real-world factors that make the CPI and health care different from the overall rate of inflation. And I think those things should be taken into account. (Applause.)

Q Thank you, Mr. President.

Q Good morning, Mr. President.

THE PRESIDENT: Good morning, sir.

Q I'm a pediatrician from San Luis Obispo. My question to you this morning relates to the power of insurance companies. Yourself, Mrs. Clinton and Mr. Magaziner have repeatedly stated that one of your goals is to return the control of medical practice back to physicians and hospitals. We obviously agree with that. Unfortunately, however, many of the current managed care plans in California are moving away from that goal.

Mr. President, does your plan contain features which would achieve that goal?

THE PRESIDENT: It does. I think there are some that would help indirectly, and one or two that would help directly. Let me just mention them.

First, giving every consumer three choices will make a big difference -- saying that every consumer has to have at least three choices and that one of those choices must always be fee-for- service. We'll put all these plans in competition with one another, and that will make a difference.

Secondly, making it easier for physicians to provide these services directly will dramatically minimize the ability of the insurance companies to add to the cost and delay and undermine the quality of health care by second-guessing everything the doctors want to do in the HMOs that they're promoting --

(gap in satellite feed)

-- in our plan that the insurance companies disclose what's in their utilization review protocol in advance so people can evaluate that and know what's going on and argue against it. And competing plans, including competing physicians groups can say, here's why this is a bad deal for you and why you shouldn't take it; and why it is going to add to the cost and undermine the quality of health care.

Now, all these are things, I think, that will really make a difference. Most doctors I know recognize that from time to time, there are certain things that ought to be subject to some kind of review. But, basically, it's gone crazy now. It's become an

instrument of denying service when it's needed. (Applause.) So what we've tried to do is strike the right balance here, and I hope we have. (Applause.)

Q Thank you, Mr. President.

THE PRESIDENT: I must say that Bravo is a wonderful name for a pediatrician to have. (Laughter.)

A lot of times you can just say that to your kids and they'll get better. (Laughter.)

Q Mr. President, I think the medical profession really believes that that issue is so important that if we win everything else but lose on that one, none of the other matters.

THE PRESIDENT: It's absolutely clear to me that the whole HMO movement has taken the utilization review to an extreme, and that it has to be backed off of. Forget about the HMO, just the whole insurance -- it's the insurance companies that are driving this. And I think the more we can put doctors into the management decisions of the HMO, and the more choice we can give to the people who themselves will be patients, who have personal contact with their doctors -- keep in mind, this is a huge deal, letting the employees themselves make this choice instead of their employers, means that somebody will be choosing; every plan will be chosen by someone who has had a personal relationship with a physician who has doubtless discussed this with him or her. I mean, that's going to make a big difference in this.

And I agree with you, it's a very important issue. (Applause.)

Q Good morning, Mr. President. I am a trauma surgeon in San Bernadino, California. Medical malpractice concerns and the practice of defensive medicine are serious issues associated with the -- (inaudible) -- of care to the trauma patient. Mr. President, we are very pleased that you believe that the tort reform should be an essential part of the health care reform, and have adopted some of -- (inaudible) -- provisions in your plan. But, sir, would you be willing to add to your plan the most essential part of the -- (inaudible) -- that is, a $250,000 cap on noneconomic damages? And, sir, if you just say yes, I would be happy. (Laughter and applause.)

THE PRESIDENT: As you might imagine, we debated that thing for a long time before we presented our plan to the Congress, because we didn't want the whole health care plan to come a cropper on a debate over tort reform. We thought there had to be some. We knew that the states were taking up this issue to some extent, but we thought we ought to do something nationally, even though tort law historically has been completely within the purview of state government, not the national government. So we agreed that there ought to be a limitation on lawyer fees -- contingency fees. And we did some other things that were recommended by you and were in the model work that was done in California.

Something else we did that I think has been insufficiently noticed is we agreed to include medical practice guidelines developed by professional groups as raising a presumption that there was no negligence on the part of doctors. This offers an enormous opportunity to dramatically reduce the number of medical malpractice suits, the number of recoveries, and therefore the malpractice rates.

My own view is that based on the research I've seen in a couple of places where this has been tried on a limited basis is it may offer the best hope of all of protecting doctors from frivolous lawsuits by simply raising a presumption that the doctor was not negligent if the practice guidelines developed by the professional groups themselves were in fact followed.

So I think that that has been not sufficiently noticed. That is a very, very big step, in addition to the other things I mentioned.

My own judgment is that we will not include the national cap because there will be so much difference among the various congressional delegations from different states about what the caps should be and whether it should change with inflation over time. And in fact you might wind up in California with a situation different from the one you have now if it were to be done. For example, if there were a debate on the national cap, then the immediate thing would be, what should the cap be; and if states have a lower one, should it be required to be raised. Because all those things were involved, we decided that we would leave the cap issue itself to state law and deal with these other matters.

I urge you to look at what we have done, because I think we've taken a long step toward trying to relieve doctors of the burden of frivolous lawsuits and trying to control the cost of malpractice insurance.

Q Thank you, sir. (Applause.)

Q Good morning, Mr. President. I'm a practicing family physician in Modesto, California. I'm also the current California Academy of Family Physicians president and past president of the Stanislaus County Medical Society.

Mr. President, when I entered medical school, I was led to believe that I would spend my career practicing health care. I find that an enormous part of my day is spent battling with health insurance clerks to get authorization for my patients to have some of the even most basic of health care.

Obviously, it would be better for me to spend that time seeing patients. What will your plan do to prevent or to limit the use of these managed health care organizations from providing these -- or throwing up these artificial barriers in the name of managed care; but in reality these things prevent us from providing that care?

THE PRESIDENT: Let me try to restate what I said before. I believe that the micromanagement of medicine by insurance companies has reached an excessive point. And what we have tried to do to reduce it, since we can't -- you don't want the federal government exactly passing laws saying what decisions can or cannot be made by physicians and others working with them. What we've tried to do is to change the whole system so that it would be much less likely.

And I will mention two things again. Number one, we make it easier for people like you to join with like-minded physicians in providing services directly or to join together and to tell people if you're going to work with them, you don't want those kinds of utilization reviews. And we require the insurance companies to disclose their utilization review protocols in advance. And they will be under much more pressure than they are now because now they won't have the same shot at Business XYZ's employees because the employees themselves will be deciding whether they want an HMO, do they want a PPO, do they want some other kind of organization; or do they want to have fee-for-service medicine. Under each case the employers liability is the same -- responsibility is the same. So I think that we are changing the environment in ways that will really permit you to cut down, working with your fellow physicians and your patients to cut down dramatically on the number of these abuses.

I also want to point out that if there is a single card which we envision which entitles a person to health care and which enables them to hook into a computer which says that they are covered and all of that, and if there is a single form related to the comprehensive benefit package which can be filled out in every doctor's office and hospital in the country and then processed by every insurance company in the country, then that is going to dramatically reduce the paperwork burden, too. I have many, many doctors complain to me that the time they have to spend and the money they have to spend in their clinics on post facto paperwork has exploded in recent years. And I think that is also very important -- cutting down on that burden, not only the time, but the money is critically important. So I believe that we will make it better.

If you have further suggestions, I'd be glad to hear them. But this is an area in which it is difficult to legislate directly and in which many physicians are reluctant to have us legislate directly. It seems to me if you change the economics and change the distribution of the power of decisionmaking in this whole process, giving more to the doctors and to patients through the workplace and less to the insurance companies, that the practices will inevitably change because the shift of decisionmaking has occurred.

Q Thank you very much. (Applause.)

Mr. President, we know that your time is very tight, if you could spare us a few minutes, we have some other questions that we would hope to be able to put before you.

THE PRESIDENT: Please do because I know we've got one or two other issues that I think should be dealt with.

Q Mr. President, I practice anesthesiology in San Diego. And I want to thank you for the opportunity to ask you a question today. Two years ago, right here in California in this state with the support of this organization, we passed a law that created voluntary health insurance purchasing cooperatives. In fact, you just alluded to them a few moments ago. And as you said they so far have been enormously successful, both in extending access and in eliminating costs.

My concern is that there are some reform proposals that would cause these purchasing pools or alliances to become so large and thus so inflexible that they would in fact limit rather than enhance the competition that you yourself state, and I agree with you, that we want to see in the marketplace. So to make these entities work the way I think we both wish them to -- the alliances and the purchasing pools -- I believe that we need to limit their size. So my question for you this morning is what would you propose to control the size of the purchasing pools and alliances so that they would fulfill their primary purpose of providing affordable, accessible care and not become a large, inflexible bureaucracy?

THE PRESIDENT: Well, let me first say that I agree that we shouldn't have them become large, inflexible bureaucracies. Under our plan, the alliances would be much larger and the membership would be mandatory. But that's because we're trying to achieve something with our plan that is beyond what the alliances do. Now this is -- I think it will all be debated in the Congress, and I'm certainly flexible on it.

But let me explain why we recommended larger alliances and offer you, not just you individually, sir, but your group there the opportunity to suggest to me -- either to Ira Magaziner who's

there or to us through a letter later -- how we could achieve the same objective. Because I know a lot of people say, well these alliances are too big or the work units -- you don't people with several thousand employees in them. And at one level, I think that's right, but at another level, I'm not sure -- and let me explain why.

The purchasing coop that you have in California which has worked real well is designed primarily to give small businesses bargaining power so that they can, in effect have the same access to health care at the same cost that people in large units like big corporations and government do. You can do that with smaller alliances -- let's say with people with a few hundred employees or 100 or whatever it is in California -- 50 and down; you can do that.

The same thing is now happening in Florida where they're seeing these results.

What we wanted to do with the alliances were three other things that it still seems have to be done somehow under the plan. First of all, through the alliances, we were going to distribute the small business discounts. We can find another way to do that, but that was going to be done.

Secondly, we were going to provide certain handling services basically for to bring together and reduce the paperwork burdens of the physicians, the employers and the insurance companies. We were going to do a lot of the paperwork there. That can probably be done some other place.

The other thing, though, which I think is very important and which all of you clapped when I mentioned earlier, is the alliances as large units were going to be used to make it financially possible for the insurance companies to observe community ratings. And I'd like to talk about that a minute.

There are two issues here on discriminatory rates. One is, how do you get small businesses and self-employed people access to the same rate structure presently available to big business and government? The other is, how do you, as a practical matter , eliminate unfair billing practices without bankrupting the insurance companies that are still in the market? That is, how do you eliminate preexisting conditions? How can you afford to do away with lifetime limits?

How can you eliminate rate discrimination against people with preexisting conditions in their families, or against workers who are older at a time when older workers are having to change jobs a lot in their life, too?

Now, you can pass a law and say, we'll have community rating. But New York did that and yet they still don't have it. And the reason is, they don't have any mechanism within which community rating can be practically made to work in a state where you have a lot of different insurance companies and the insurance companies simply cannot solvently -- can't stay solvent and do that unless people are insured in very large pools where insurance companies can make money the way grocery stores do -- a little bit of money on a lot of people.

So the fundamental difference in what California has done, which is very good, and what we are seeking to achieve is that I'm not sure that unless we have everybody below a certain substantial size in one of these alliances, we can achieve community rating. We can get better breaks within the present system for small businesses, but I am not sure we can get community rating. That's the rub. If we can solve that, I'm very flexible on the rest of this. I mean, I'm just trying to achieve an objective that we all agree is necessary. (Applause.)

Q Mr. President, I practice emergency medicine in inner-city Los Angeles. Every day I see the impact of undocumented immigrants on our health care system. Mr. President, I'm grateful to you for making health system reform a top national priority. Your proposal provides health security for all citizens and $1 billion dollars to cover noncitizens.

However, in some of California's largest counties, up to 25 percent of the population are noncitizens, both legal and undocumented. Currently, federal law and our own ethics as physicians require that we provide care. But the reality is that these costs are putting an enormous strain on our state's health care delivery system and the entire California economy. We are spending close to $1 billion dollars in Los Angeles County alone to deliver health care to undocumented immigrants. How do you feel we can better address this problem?

THE PRESIDENT: It's a difficult one, as you know. Let me make a couple of observations, and then say where I think we are practically.

Obviously, no state or local government should be required to shoulder the cost of immigration, or the lack of an immigration policy, or the inability to enforce the policy we have now at the national levels. But as a practical matter, as we all know, it happens all the time. Now, in my last two budgets, I have tried to provide more funds to California, especially in the areas of health and education for dealing with the extra costs of immigration; because I think it's not your fault.

Now, in this health care plan, we provide a billion dollars in extra money. Is it enough? Of course it's not; but it's a good step in the right direction. Let me say that if you look at the states with the big immigrant health care burden -- California, Florida, Texas, New York -- although there are five or six others with substantial burdens, as well -- our plan will save the states enormous amounts of money that they would have paid otherwise in out- of-pocket Medicaid match costs, long-term care costs and other health related costs related to running public health facilities, for example. In other words, our plan -- we estimate that California will save, if our plan goes into effect in 1996, or we begin to put it into effect in 1996, phasing it in, we estimate California will save about $6 billion or more between that year and the end of the decade -- new money that would not have been there otherwise in this budget. That will also allow the state to divert some of those resources to health care as well as to dealing with some of your long-deferred education and other problems out there.

So I believe that, between the savings that will occur from the state of California and the funds that we can put into immigrant health care -- migrant health care -- directly, I think that will make a big difference. Now, let me say, this fund will start at a billion dollars, but obviously, based on the evidence and based on our ability to secure savings in other aspects of the system, Congress will be free to supplement this fund every year from now on. That's where we're going to start.

I realize it doesn't solve the whole problem. I think it's frankly all we can afford to do at the moment. And I think the savings which will flow to the state from passing this plan, will be so great that they in turn will be able to do more and still have money left over to address other needs of Californians. So I hope they'll stick with it, because I think it's the best we can do right now.

Q Mr. President, you really need to know that over half the hospitals in California are currently operating in the red. It is an urgent problem, and I hope that the solution to the problem would not be tied to the whole health system reform.

Thank you. (Applause.)

THE PRESIDENT: I certainly agree with that.

Let me just say one other thing -- I agree that we cannot hold this problem hostage to health care. We're just trying to use the health care reform which will free up billions of dollars to put more into medical research, more into undocumented alien health care, and other things. But I agree that we have to deal with it.

Q Thank you, Mr. President. Do you time for one last question?

THE PRESIDENT: Sure.

Q Thank you very much, Mr. President. I practice internal medicine in Los Angeles. I also drink Diet Coke. And I'm delighted to be here this morning as President of the California Hispanic American Medical Association.

Mr. President, in California, our managed care system has evolved from what started as a not-for-profit market into one which today is dominated by a large for-profit publicly traded HMOs. This evolution has also caused the profits and administrative costs of these HMOs to soar, while health care services to patients has plummeted. While the CEOs of these corporations make millions, I have to argue with these same companies who insure my patients to approve immunizations, pap smears and mammograms. The CMA is sponsoring legislation in California to limit the administrative costs and profits of these companies.

How do you feel about this situation, and how would your plan protect other states from this trend?

THE PRESIDENT: In two or three ways. First of all, under our plan those plans will have to offer pap smears, mammograms and other preventive and primary services. They won't be able to cut them out.

Secondly, these companies will be under much more pressure to provide quality service and to siphon less money off to bureaucracy and profits than they are now because they won't be able to make a deal with employers which can then be enforced on employees. Every employee -- that is, every patient you see will be able to a make a new choice of plan every year. So if they get abused in year one, then in year two, the next year, they'll be able to make the same choice they made last year all over again, and choose a different plan, or fee-for-service medicine, or a group of physicians who are providing health care.

So this will fundamentally change the whole incentives of the system. They simply will not be able to use the fact that they have a preexisting relationship with an employer to undermine the delivery of quality of care between the doctor and the patient, because the patient will be a making a decision and every year can make another decision. And that will have a profound impact on it. And they will not be able to eliminate primary and preventive services from their package. That has to be involved. So that's going to change it.

Then we will make -- when we make some of the changes in the antitrust laws, which will make it even easier for physicians to get together and deliver health care directly. So these HMOs are going to be under a whole different kind of competition.

It won't be competition from somebody else providing less service at lower costs; it will be competition from somebody else providing more services and higher quality with more choices for the same costs, or sometimes less.

So I think this will really change things and put you and your patients much more in the driver's seat than you are now. That's perhaps the most critical element of my plan that has not been really noted. We are not restricting choice, we're expanding it. And we're putting the decision -- we're moving the decision from the employer to the employee about who makes the choice, which means you're moving it to the patient and that should be, I think, something that will make a profound difference -- particularly after you all get through talking to all them. (Applause.)

Q Mr. President, everyone is this room and all the people we represent would like to thank you for taking the time from your busy schedule to meet with us today. We want you to know that we're with you in this fight and we'll join with you in working with Congress in a joint effort to guarantee all Americans private health insurance that can never be taken away.

THE PRESIDENT: Thank you. And let me just say in closing if I could ask you one thing it would be to impress upon the Congress the importance of acting and acting this year. This is a very complex issue. No one has all the answers. We'll be improving on what we do from now until kingdom come. But you know more uniquely than most people do, what the consequences of not doing anything are -- and that's more restricted managed care, more people without any insurance at all, more of the headaches that you have already complained about today. So you are in a unique position to embrace the fundamental principles here -- work with me on the details and impress upon your very large congressional delegation that the time to act is now, not next year, not five years from now, but now.

Thank you very much.

Q? Thank you, Mr. President. (Applause.)

ISSUE # : THE FEDERAL ROLE IN GRADUATE MEDICAL EDUCATION

1. Federal Government's Role in Medical Education---Should it Change or Stay the Same?

   Should the government's role change from that of a financing source to a more active decision maker in:

   A. Setting the total number of residency positions available in the United States?

   B. Allocating the slots of primary care, specialty care residencies throughout the U.S.?

   C. Deciding which residency programs in different hospitals and parts of the country should be funded?

2. Should the Medicare Program Refocus Payments To Increase "Mid-Levels", Primary Care Physicians, and Non-Hospital Sites for Training?

   Should more "mid-level" training be supported by Medicare's graduate medical education dollars?

   Should Medicare's formulas for graduate medical education funding be changed to target higher payments to primary care residents versus specialty residents?

   Should non-hospital training sites be directly funded by Medicare's graduate medical education dollars?

3. Should Medicare Stay the Same, Expand or Reduce Its Expenditures on Graduate Medical Education?

   Should the Medicare dollars be reduced for graduate medical education?

   Should a new pool of private dollars be collected to fund graduate medical education? (Examples include special assessments on health plans, taxes to corporations, extra payments for health care premiums).

DRAFT

March 8, 1994

M E M O R A N D U M

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: FINANCE COMMITTEE HEARING ON GRADUATE MEDICAL EDUCATION AND THE SUPPLY OF HEALTH PROFESSIONALS ON TUESDAY, MARCH 8, 1994

Background

Today's hearing will focus specifically on the problems with graduate medical education and physician supply.

There is general agreement among medical educators and public health experts that there is an excess number of physicians overall, and a relative and absolute shortage of generalists. There is a current ratio of approximately 1:3 primary care physicians to specialists. Experts argue that this present bias towards the training and practice of specialists has led to overly expensive care, inappropriate use of costly treatment and services, and little needed attention to prevention and primary care.

The reasons for our problems are multiple and complex. But it is believed by many that at the root of the problem is the way we finance medical education, particularly graduate medical education, and the way we pay physicians.

This Committee (Finance) is particularly interested in this issue because of the large role medicare plays in providing funding.

This year medicare will spend:

$5.5 billion on Graduate Medical Education (GME)
$3.3 billion on Indirect Medical Education (IME)

Medicare GME funds have become a major source of revenue for teaching hospitals like KU. Interestingly, Federal payment policy has generally not paid for training that takes place in ambulatory settings like clinics. Many believe this is one of the reasons there is a heavy emphasis on specialty training -- because hospitals are paid for these folks but not for the family practice resident who is spending time in the community clinic.

Medicare Graduate Medical Education funding funds the direct costs of faculty salaries and student stipends. The reimbursement goes directly to the institution (hospital) and is based on their historical costs. As a result, the amount per resident varies from a low of $5,000 to a high of about $170,000 depending on where in the country they are being trained.

Medicare Indirect Medical Education money pays hospitals for the "indirect" costs they experience because of the presence of a training program. For example, more tests tend to be ordered. This payment is based on a formula and has been reduced.

The reform proposals vary dramatically in their suggestions as to how to address this issue. The Administration and McDermott are the most proscriptive -- requiring an absolute cap on the number of residencies and an absolute mix of primary care to specialty of 50/50.

The Chafee bill is the least interventionist -- and simply creates a system of voluntary demonstration programs that allow local efforts to test out solutions.

Most of the bills do provide for additional funds for the training of nurse practitioners and others. The Administration and the Breaux bills also envision creating a national medical education fund in lieu of medicare funds -- that would be made up of Federal as well as private funds to pay for medical education.

INTERESTING STATISTICS

Number of U.S. allopathic (M.D.) medical schools: 126

Number of U.S. osteopathic medical schools: 15

Number of U.S. medical school graduates this year: 17,000

Number of U.S. osteopathic school graduates: 1,700

Number of new international medical graduates in U.S.: 4,300 - 7,000

Total Number of Graduates 22,000 - 24,700

Cost of medical education est. 1993

Undergraduate: $ 5.25 billion
Graduate: $17.5 billion

Total number of residency slots: 98,000

Kansas

K.U. Medical Center

Number of residents: 342

Percentage in primary care: 34 percent (119)

Wichita

Number of residents: 246

Percentage in primary care: 50 percent (127)

SUMMARY OF REFORMS IN HEALTH PROFESSIONS EDUCATION

CURRENT SITUATION	American Health Security Act HR 1200/S 491 McDermott/Wellstone	Health Security Act HR 3600/ S1757 President Clinton/ Gephardt/Mitchell	Health Equity and Access Reform Today Act of 1993 HR 3704/ S 1770 Thomas/Chafee	Managed Competition Act of 1993 HR 3222/S 1579 Cooper/Breaux
• 50% GME paid for by Medicare, which favors tertiary care and specialization • Only 14% of current medical students are choosing primary care (1992) less than half the rate (36%) in 1982	• Mandatory reforms • Establishes target of 1:1 primary care providers to specialists five years after enactment of legislation • Establishes Advisory Committee on Health Professional Education • Reduces payments to States that fail to meet national goals for graduate medical education • Health Board will establish target number of midlevel primary care practitioners by year 2000 • Increases funding to support health professions education and nursing education, including nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants • Increases funding for NHSC	• Mandatory reforms • Provides new entitlement grant funding academic health centers for medical education • Replaces GME and IME payments for Medicare • GME payments to emphasize primary care training • Limits the number of specialty residencies • Increases the authorization for funding for training of nurse practitioners and physician assistants • Establishes National Council of GME within DHHS • Authorizes expansion of NHSC • Overrides restrictive State practice laws but health plans can still decide which providers it allows to participate in their networks	• Voluntary reforms • Creates GME demonstration projects which allows States to pool GME funds and change specialty mix • Provides tax incentives for primary care providers in underserved areas • Increases the authorization for primary care physicians • Increases the authorization for funding for training of nurse practitioners and physician assistants • Increases the authorization for funding for PHS and NHSC • Provides tax breaks for NHSC loans	• Mandatory reforms • Establishes National Medical Education Fund • Eliminates separate medical education payments under Medicare • Limits the number of specialty residencies to 110% of applicants • Differential funding for primary care; 25% higher than specialty slots • Increases the authorization for funding for training of mid-level practitioners, NHSC, and Area Health Education Centers • Overrides restrictive State practice laws but health plans can still decide which providers it allows to participate in their networks

University of California, Los Angeles, UCLA School of Medicine

10833 Le Conte Avenue
Los Angeles, California 90024
(310) 825-9111; 825-6373 (Dean's office); 206-5046 (FAX)

The medical school is in the UCLA Center for Health Sciences on the UCLA campus. The second oldest of the five medical schools in the University of California, it accepted its first class of medical students in 1951.

Type: public
1993-94 total enrollment: 715
Clinical facilities: UCLA Medical Center; UCLA Neuropsychiatric Hospital; Brentwood, Sepulveda, and Wadsworth VA medical centers; Cedars-Sinai Medical Center; Children's Hospital of L.A.; L.A. County hospitals: Charles R. Drew-Martin Luther King Jr. Medical Center; Harbor-UCLA Medical Center; Olive View Medical Center; St. Mary Medical Center; Freda Mohr Multiservice Center of the Jewish Family Service of L.A.; Jewish Home for the Aged of Los Angeles (Reseda); Kaiser Foundation hospitals: Panorama City, Sunset Boulevard, West Los Angeles; Woodland Hills; Kern (County) Medical Center; Northridge Hospital Foundation; Rand Corp.; Research and Education Institute; St. Francis Medical Center; Santa Monica Hospital Center; Shriners Hospital for Crippled Children; Valley Presbyterian Hospital Olmstead Memorial; Venice Family Clinic; Ventura County General Hospital.

Medical School Administrative Staff

Interim Dean and Provost, Medical Sciences . . . . . Sidney H. Golub, Ph.D.
Dean, Administration . . . . . Raymond L. Eden
Dean, Education . . . . . Phyllis Guze, M.D.
Dean, Research Development and Neuroscience . . . . . Jack Barchas, M.D.
Dean, Academic Affairs . . . . . William J. Dignau
Dean, Clinical Programs . . . . . Michael Zinner, M.D.
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Associate Dean, Finance and Business Affairs . . . . . Judith Rothman
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Assistant Dean, Education Administration . . . . . Joyce Fried
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Assistant Dean, Sepulveda VA Medical Center . . . . . Alan Robbins, M.D.
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Acting Assistant Dean, UCR-UCLA Biomedical Sciences Program . . . . . Mary Ann Baker, Ph.D.
Assistant Dean, WLAVAMC . . . . . Dean Norman, M.D.

Department and Division or Section Chairs

Basic Sciences

Anatomy . . . . . Richard Lolley, Ph.D.
Biological Chemistry . . . . . Elizabeth F. Neufeld, Ph.D.
Biomathematics . . . . . Kenneth L. Lange, Ph.D.
Microbiology and Immunology . . . . . Jack G. Stevens, D.V.M., Ph.D.
Pharmacology . . . . . Michael Phelps, M.D.
Physiology . . . . . Ernest Wright, D.Sc.

Clinical Science

Anesthesiology . . . . . Joseph Gabel, M.D.
Drew-King Medical Center . . . . . Daniel J. Wooten, M.D.
Harbor-UCLA Medical Center . . . . . Ching-Muh Lee, M.D.
Olive View Medical Center . . . . . Selma Calmes, M.D.
Sepulveda VA Medical Center . . . . . Peter Gesund, M.D.

University of California, Los Angeles, UCLA School of Medicine: CALIFORNIA

Wadsworth VA Medical Center	Glen Hoshizaki, M.D.
Medicine	Alan Fogelman, M.D.
Cedars-Sinai Medical Center	Glenn Braunstein, M.D.
Drew-King Medical Center	Richard Holmes, M.D.
Harbor-UCLA Medical Center	Kovuchi Tanaka (Acting)
Olive View Medical Center	Irwin Ziment, M.D.
San Fernando Valley Program	Edward Weinman, M.D.
Wadsworth VA Medical Center	Phyllis A. Guze, M.D.
Neurology	Robert C. Collins, M.D.
Harbor-UCLA Medical Center	Mark A. Goldberg, M.D.
Sepulveda VA Medical Center	Claude G. Wasterlain, M.D.
Wadsworth VA Medical Center	Wallace W. Tourtellotte, M.D.
Obstetrics and Gynecology	Roy M. Pitkin, M.D.
Cedars-Sinai Medical Center	Laurence Platt, M.D.
Drew-King Medical Center	Ezra Davidson, M.D.
Harbor-UCLA Medical Center	Charles R. Brinkman III, M.D.
Kern Medical Center	Ramchandra R. Ayyagari, M.D. (Acting)
Olive View Medical Center	George Mikhail, M.D.
Ophthalmology	Open
Drew-King Medical Center	M. Roy Wilson, M.D.
Harbor-UCLA Medical Center	Sherwin J. Isenberg, M.D.
Kern Medical Center	Roger A. Kohn, M.D.
Olive View Medical Center	Anthony C. Arnold, M.D.
Sepulveda VA Medical Center	Sherwin H. Sloan, M.D.
Wadsworth VA Medical Center	Gary N. Holland, M.D.
Pathology	Open
Cedars-Sinai Medical Center	Stephen Geller, M.D.
Drew-King Medical Center	Elias Amador, M.D.
Harbor-UCLA Medical Center	Robert Morin, M.D.
Sepulveda VA Medical Center	Woo Yung Shin, M.D.
Wadsworth VA Medical Center	Joan Howanitz, M.D.
Pediatrics	Open
Cedars-Sinai Medical Center	David L. Rimoin, M.D., Ph.D.
Drew-King Medical Center	Robert J. Schlegel, M.D.
Harbor-UCLA Medical Center	Rosemary Leake, M.D.
Kern Medical Center	Jess Diamond, M.D.
Olive View Medical Center	S. Douglas Frasier, M.D.
Psychiatry	Gary L. Tischler, M.D.
Brentwood VA Medical Center	Don E. Flinn, M.D.
Cedars-Sinai Medical Center	Milton Davis, M.D. (Acting)
Drew-King Medical Center	Claudewell Thomas, M.D.
Harbor-UCLA Medical Center	Milton H. Miller, M.D.
Neuropsychiatric Hospital	Don A. Rockwell, M.D.
Olive View Medical Center	Milton Greenblatt, M.D.
Sepulveda VA Medical Center	Arthur S. Kling, M.D.
Radiation Oncology	Robert G. Parker, M.D.
Cedars-Sinai Medical Center	Ronald W. Thompson, M.D.
Wadsworth VA Medical Center	Ahmed Sadeghi, M.D.
Radiological Sciences	Hooshang Kangarloo, M.D.
Drew-King Medical Center	Jack Eisenman, M.D.
Harbor-UCLA Medical Center	Mark Mehinger, M.D. (Acting)
Olive View Medical Center	Issa Yaghmai, M.D.
Sepulveda VA Medical Center	John H. Woodruff, Jr., M.D.
Wadsworth VA Medical Center	Edward Grant, M.D.
Surgery	Michael J. Zinner, M.D.
Cedars-Sinai Medical Center	Leonard Makowka, M.D.
Drew-King Medical Center	Arthur W. Fleming, M.D.
Harbor-UCLA Medical Center	Bruce E. Stabile, M.D.
Olive View Medical Center	Jessie E. Thompson, M.D.
Sepulveda VA Medical Center	Howard A. Reber, M.D.
Wadsworth VA Medical Center	Edward Passaro, M.D.

University of Southern California School of Medicine

1975 Zonal Avenue
Los Angeles, California 90033
(213) 342-1544 (Dean's office); 342-2722 (FAX)

The University of Southern California (USC) was founded in 1880 and is a private, nonprofit corporation. The School of Medicine became a division in 1885 and established its own campus in 1952 on 12 acres adjoining the Los Angeles County (LAC)-USC Medical Center, seven miles from the main university campus. All medical instruction has been conducted on the health sciences campus since 1960.

Type: private
1993-94 total enrollment: 590
Clinical facilities: Barlow Hospital, California Hospital Medical Center, Childrens Hospital of Los Angeles, Eisenhower Medical Center, Estelle Doheny Eye Foundation, Estelle Doheny Eye Hospital, Hollywood Presbyterian Medical Center, Hospital of the Good Samaritan, House Ear Institute, Huntington Memorial Hospital, Kenneth Norris Jr. Cancer Hospital and Research Institute, LAC-USC Medical Center, Orthopaedic Hospital, Presbyterian Intercommunity Hospital, Rancho Los Amigos Medical Center, Comprehensive Health Centers: Edward R. Roybal Comprehensive Health Center, El Monte Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center, USC University Hospital.

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Vice President for Health Affairs	Joseph P. Van Der Meulen, M.D.
Vice President and Comptroller	Fermin L. Vigil
Vice President and Executive Director, USC Physicians	Robert M. Stein, Ph.D.

Medical School Administrative Staff

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Senior Associate Dean for Academic Affairs	Dale Garell, M.D.
Associate Dean for Health Affairs, LAC-USC Medical Center	Sol Bernstein, M.D.
Associate Dean for Curriculum	Dale Garell, M.D.
Associate Dean for Admissions and Student Affairs	Ralph C. Jung, M.D.
Associate Dean for Postgraduate Medicine	Phil R. Manning, M.D.
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Assistant Dean for Administration	William P. Strippoli
Assistant Dean for Minority Affairs	Althea Alexander
Assistant Dean for Student Affairs	Mikel Snow, Ph.D.
Registrar	Frances L. Grew

University of Southern California School of Medicine: CALIFORNIA

Department and Division or Section Chairs

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Anatomy and Cell Biology ..... Richard L. Wood, Ph.D. (Acting)
Anesthesiology ..... John F. Viljoen, M.D.
Biochemistry ..... Laurence H. Kedes, M.D.
Emergency Medicine ..... Gail V. Anderson, M.D.
Family Medicine ..... Peter V. Lee, M.D.
Medical Education ..... Dianne Heestand, Ph.D. (Acting)
Medicine ..... Richard L. Tannen, M.D.
  Cardiology ..... Open
  Dermatology ..... Thomas Rea, M.D.
  Diabetes ..... Willa Hsueh, M.D.
  Endocrinology ..... Richard Horton, M.D.
  Gastro/Intestinal/Liver ..... Neil Kaplowitz, M.D.
  Geriatrics ..... Loren E. Lipson, M.D.
  Hematology ..... Donald I. Feinstein, M.D.
  Hypertension ..... Vincent DeQuattro, M.D.
  Infectious Diseases ..... John M. Leedom, M.D.
  Medical Oncology ..... Franco Muggia, M.D.
  Nephrology ..... Shaul G. Massry, M.D.
  Pulmonary Diseases ..... Edward Crandall, M.D.
  Rheumatology ..... David Horwitz, M.D.
Microbiology ..... Peter Vogt, Ph.D.
Neurological Surgery ..... Martin H. Weiss, M.D.
Neurology ..... Leslie P. Weiner, M.D.
Obstetrics-Gynecology ..... Daniel R. Mishell, Jr., M.D.
Ophthalmology ..... Ronald E. Smith, M.D. (Acting)
Orthopaedics ..... Michael J. Patzakis, M.D.
Otolaryngology ..... Dale H. Rice, M.D.
Pathology ..... Clive R. Taylor, M.D., Ph.D.
Pediatrics ..... Robert L. Baehner, M.D.
Pharmacology and Nutrition ..... Dee Warren, Ph.D. (Acting)
Physiology and Biophysics ..... Richard Bergman, Ph.D. (Acting)
Preventive Medicine ..... Malcolm Pike, Ph.D.
Psychiatry and the Behavioral Sciences ..... R. Bruce Sloane, M.D.
Radiation Oncology ..... Zbigniew Petrovich, M.D.
Radiology ..... James M. Halls, M.D.
Surgery ..... Tom R. DeMeester, M.D.
  General Surgery ..... Tom R. DeMeester, M.D.
  Cardiac Surgery* ..... Vaughn A. Starnes, M.D.
  Pediatric Surgery* ..... Open
  Plastic Surgery* ..... John F. Reinisch, M.D.
  Thoracic Surgery* ..... Open
  Oral Surgery ..... John Lytle, D.D.S., M.D.
Urology ..... Donald G. Skinner, M.D.

*Specialty without organizational autonomy.

Charles R. Drew University of Medicine and Science

1621 East 120th Street
Los Angeles, California 90059
(213) 563-4800; 563-4974 (Dean's office); 567-4854 (FAX)

The Charles R. Drew Postgraduate Medical School was incorporated as a private, nonprofit, entity in 1966. The Martin Luther King, Jr., General Hospital, a public teaching hospital was opened in 1972. In 1987 this educational institute applied for full university accreditation with the Western Association of Schools and Colleges (WASC) and changed its name accordingly to Charles Drew University of Science and Medicine. In 1989 advancement to candidacy was granted. The medical school and hospital operate jointly as a comprehensive health center. Drew departmental chairmen are concurrently chiefs of the corresponding clinical services at King Hospital. Drew signed an expanded affiliation agreement with the University of California, Los Angeles, in July 1978 for the development of undergraduate medical education at Drew for the third and fourth years of clinical instruction leading to a joint M.D. degree. The charter class of Drew/UCLA students graduated in June 1985. In 1987 the name of the medical school was changed to the Charles R. Drew University of Medicine and Science. The hospital, Martin Luther King, Jr. Hospital, also known as King/Drew Medical Center and the university are on one geographic campus.

Type: private
1993-94 total enrollment: 96
Clinical facilities: Charles R. Drew-Martin Luther King, Jr. Medical Center, Augustus F. Hawkins Mental Health Center, UCLA Hospitals and Clinics, Harbor-UCLA Medical Center.

University Officials

President of the University	Reed V. Tuckson, M.D.
Vice President for Academic Affairs	Lewis M. King, Ph.D.
Vice President for Finance and Administration	Stanette Kennebrew
Assistant Vice President for Academic Affairs	Open

Medical School Administrative Staff

Dean	Lewis M. King, Ph.D.
Associate Dean for Student Affairs	Theodore Miller, M.D.
Associate Dean for Faculty Affairs	Edward Savage, M.D.
Assistant Dean for Faculty Affairs	Ronald Edelstein, Ed.D.
Associate Dean for Graduate Medical Education	James G. Haughton, M.D.
Associate Dean for Research	Samuel Shacks, Ph.D., M.D.
Director, Vivarium	Adeleh Esfandiari, D.V.M., Ph.D.
Hospital Administrator	Edward Renford

Charles R. Drew University of Medicine and Science: CALIFORNIA

Department and Division or Section Chairs

Clinical Sciences

Anesthesiology	Daniel J. Wooten, M.D.
Emergency Medicine	William Shoemaker, M.D.
Family Medicine	Ludlow B. Creary, M.D.
Internal Medicine	Paul Kelly, M.D.
Dermatology	A. Paul Kelly, M.D.
Gastroenterology	Open
General Internal Medicine	Allen Funnye, M.D.
Hematology/Oncology	Ram K. Chillar, M.D.
Hypertension	Clarence E. Grim, M.D.
Infectious Diseases	Haragopal Thadepalli, M.D.
Neurology	Majid Molaie, M.D.
Neurosurgery	George E. Locke, M.D.
Obstetrics and Gynecology	Ezra C. Davidson, Jr., M.D.
Acute Perinatal Services	Joseph Laverne Harris, M.D.
Ambulatory Services	William Hayling, M.D.
Gynecology	Edward Savage, M.D.
Obstetrics	Teiichiro Fukushima, M.D.
Oncology	Groesbeck Parham, M.D.
Quality Assurance/Ambulatory Surgery	Alfred Forrest, M.D.
Reproductive Endocrinology	Bo Y. Suh, M.D.
Residency Program	Wilburn Durousseau, M.D.
Urogynecology	Shari Thomas, M.D.
Otorhinolaryngology	Gus Gill, M.D.
Pathology	Elias Amador, M.D.
Pediatrics	Robert J. Schlegel, M.D.
Ambulatory Pediatric Services	Alice Faye Singleton, M.D.
Child Development	Kerry English, M.D.
Inpatient and Critical Care Services	Robert O. Christiansen, M.D.
Neonatology	Xylin Bean, M.D.
Psychiatry and Human Behavior	Claudewell Thomas, M.D.
Radiology	Jack Eisenman, M.D.
Surgery	Arthur W. Fleming, M.D.
Cardiothoracic Surgery	Ashis Mandal, M.D.
General Surgery	Edward Sims, M.D.
Ophthalmology	M. Roy Wilson, M.D.
Oral and Maxillofacial Surgery	Joseph McQuirter, D.D.S.
Orthopedics	Lance Weaver, M.D.
Plastic Surgery	Ajaib Chhabra, M.D.
Urology	Nand S. Datta, M.D.

1987, 1988, AND 1989 GRADUATES ENTERING PRIMARY CARE SPECIALTIES

SCHOOL	% GRADUATES IN PRIMARY CARE	GRADUATES PRACTICING IN: FAMILY PRACTICE	GENERAL INTERNAL MEDICINE	GENERAL PEDIATRICS	PRIMARY CARE TOTAL	GRADUATES TOTAL
41 FLORIDA	27.4	36	36	19	91	332
41 SUNY– SYRACUSE	27.4	59	34	32	125	457
43 PENN STATE	27.3	30	21	19	70	256
44 M C OF PENN	27.0	44	35	15	94	348
45 ALABAMA	26.9	53	52	14	119	442
45 INDIANA	26.9	121	61	28	210	782
47 M C OF VIRGINIA	26.7	83	32	15	130	486
47 TEMPLE	26.7	67	55	17	139	521
49 NORTH CAROLINA	26.6	53	46	23	122	458
50 SOUTH ALABAMA	26.3	16	19	11	46	175
51 TEXAS A & M	26.2	23	6	8	37	141
52 SOUTHERN CALIF	26.1	46	55	19	120	460
53 MEHARRY	26.0	24	23	5	52	200
54 GEORGIA	25.9	67	46	19	132	509
55 M C OF WISCONSIN	25.8	60	51	28	139	538
55 ILLINOIS	25.8	99	100	30	229	889
57 MED U SOUTH CAROLINA	25.7	51	38	22	111	432
58 U CENTRAL DEL CARIBE	25.4	17	30	15	62	244
59 BOWMAN GRAY	25.4	28	28	22	78	307
60 PONCE–PUERTO RICO	25.2	5	22	2	29	115
61 LOUISVILLE	25.0	32	41	18	91	364
61 JEFFERSON	25.0	102	46	14	162	648
63 SOUTH FLORIDA	24.6	38	17	13	68	276
64 ARIZONA	24.3	34	16	14	64	263
65 WISCONSIN	24.2	68	26	16	110	454
66 CONNECTICUT	24.1	22	24	13	59	245
67 HOWARD	23.7	26	29	11	66	279
68 UMDNJ–R. W. JOHNSON	23.3	35	45	20	100	429
69 BROWN	23.1	17	28	10	55	238
69 OKLAHOMA	23.1	52	39	17	108	468
69 SAINT LOUIS	23.1	32	47	20	99	429
72 MARYLAND	23.0	32	53	13	98	426
72 GEORGE WASHINGTON	23.0	27	55	19	101	440
74 HAHNEMANN	22.9	36	62	13	111	485
75 SUNY – STONY BROOK	22.8	19	36	14	69	303
76 MISSOURI – KANSAS	22.1	17	33	8	58	263
77 WAYNE STATE	21.8	81	59	27	167	765
77 UMDNJ–NEW JERSEY	21.8	31	38	31	100	459
79 TEXAS GALVESTON	21.7	55	44	21	120	553
80 LOYOLA STRITCH	21.6	28	38	14	80	370

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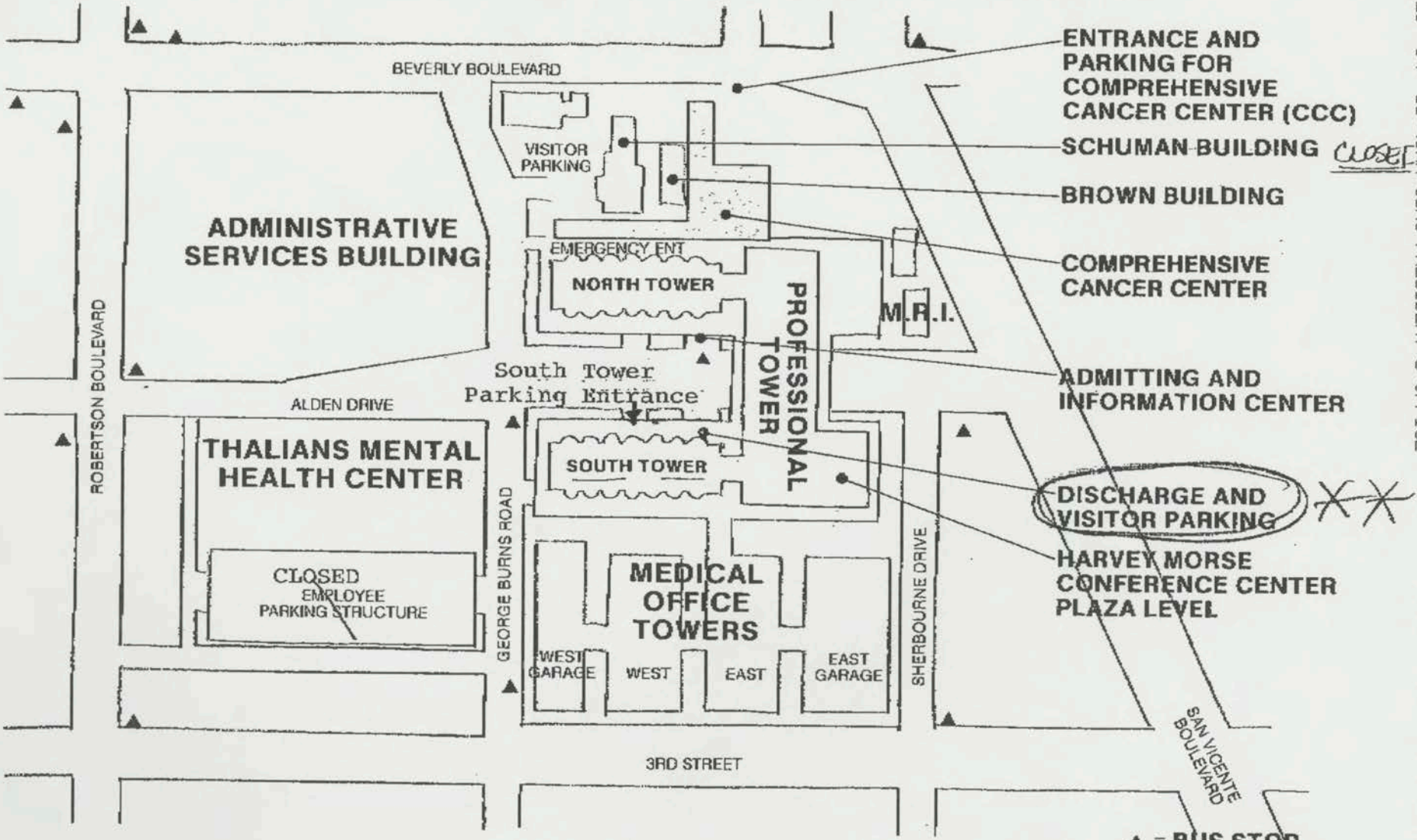
81 LOUISIANA SHREVEPORT	21.5	21	28	10	59	274
81 ALBANY	21.5	30	32	20	82	381
81 TEXAS SOUTHWESTERN	21.5	39	56	35	130	605
84 TEXAS TECH	21.4	34	18	11	63	294
84 PUERTO RICO	21.4	31	20	40	91	425
84 NORTHEASTERN OHIO	21.4	20	27	11	58	271
84 CASE WESTERN RESERVE	21.4	21	49	21	91	426
84 ROCHESTER	21.4	15	38	10	63	295
89 SUNY – BUFFALO	21.3	37	28	25	90	422
89 TUFTS	21.3	15	57	19	91	427
91 PITTSBURGH	20.8	28	35	15	78	375
92 DARTMOUTH	20.7	16	13	10	39	188
92 EINSTEIN	20.7	17	59	30	106	512
94 UTAH	20.6	34	18	9	61	296
95 U OF VIRGINIA	20.3	36	26	20	82	404
96 CHICAGO MEDICAL	19.6	32	39	17	88	448
96 WEST VIRGINIA	19.6	25	15	7	47	240
98 UNIFORMED SERVICES	19.2	49	16	22	87	454
99 DUKE	19.1	21	25	16	62	324
99 U OF PENN.	19.1	19	41	24	84	439
101 NEW YORK MED	18.8	20	69	23	112	595
101 LOUISIANA NEW ORLEANS	18.8	35	34	25	94	500
103 BOSTON	18.2	15	50	17	82	450
103 EMORY	18.2	17	30	14	61	336
105 BAYLOR	18.1	39	27	20	86	476
105 NORTHWESTERN	18.1	13	51	27	91	504
107 MIAMI	17.9	29	49	16	94	524
108 CREIGHTON	17.7	18	28	12	58	328
109 UC LOS ANGELES	17.0	57	45	22	124	729
110 WASHINGTON UNIV	16.9	14	32	16	62	367
111 NEW YORK UNIV.	16.5	3	62	13	78	473
111 U OF CHICAGO	16.5	12	24	15	51	310
113 TULANE	16.4	12	36	25	73	445
113 U OF MICHIGAN	16.4	35	34	19	88	538
115 SUNY – BROOKLYN	16.1	15	55	34	104	647
116 MAYO	15.7	13	4	0	17	108
117 HARVARD	15.5	11	40	22	73	471
118 JOHNS HOPKINS	15.0	11	24	19	54	360
119 STANFORD	14.8	3	18	15	36	244
120 GEORGETOWN	14.5	23	48	18	89	613
121 CORNELL	14.4	8	26	8	42	292
122 COLUMBIA	13.5	5	36	19	60	446
123 YALE	13.4	6	19	12	37	277
124 MT SINAI	12.3	6	28	15	47	383
125 VANDERBILT	10.0	7	14	9	30	300

CEDARS-SINAI MEDICAL CENTER

8700 BEVERLY BOULEVARD, LOS ANGELES, CALIFORNIA 90048-1869



** PLEASE PARK UNDER THE SOUTH TOWER IN THE DISCHARGE AND VISITOR LOT.

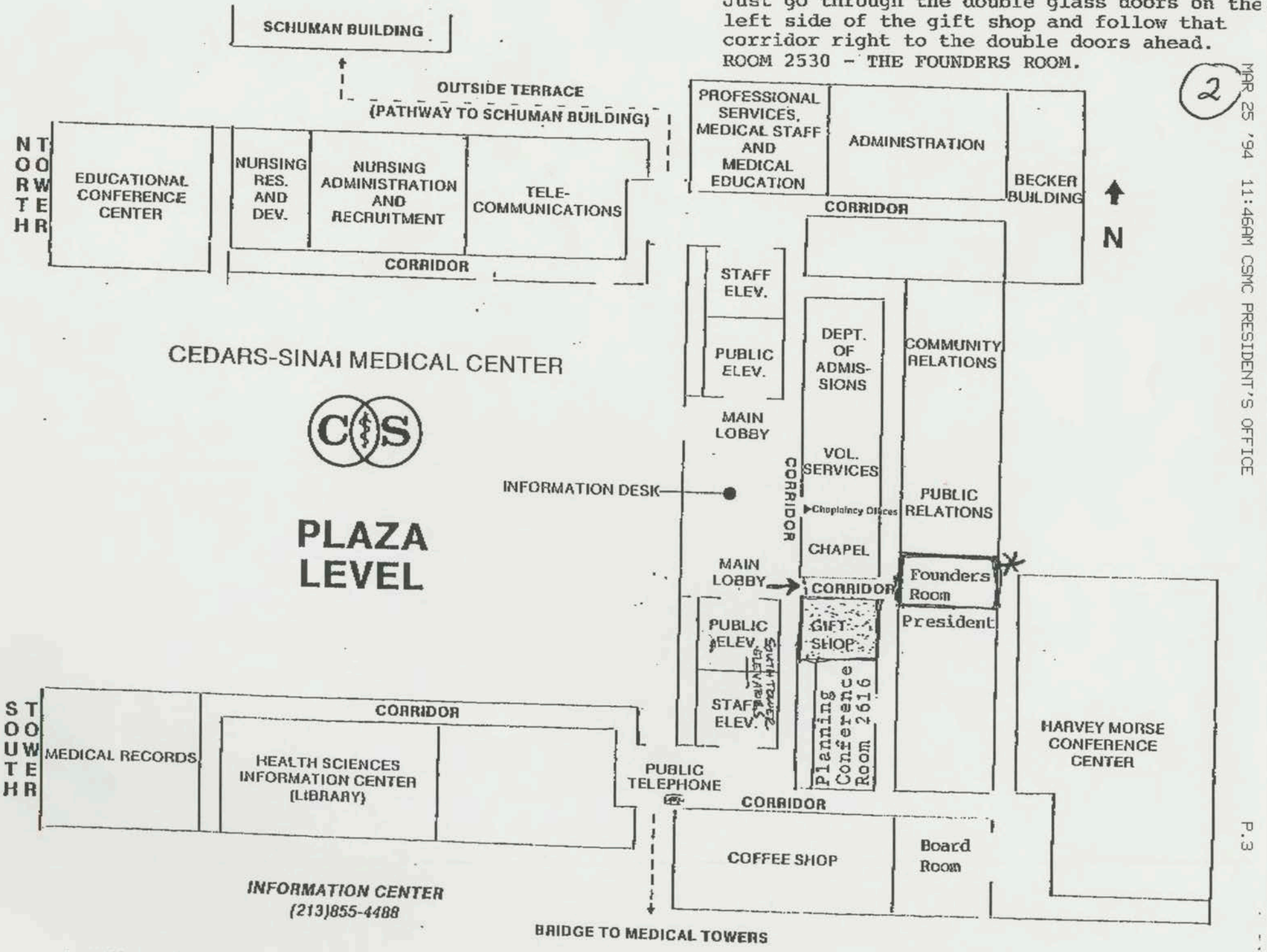
TAKE THE ELEVATORS IN THE SOUTH TOWER TO THE PLAZA LEVEL.

N

Form No. 5001-18A Rev. 7/88

The Founders Room #2530 is on the Plaza level
Just go through the double glass doors on the left side of the gift shop and follow that corridor right to the double doors ahead.
ROOM 2530 - THE FOUNDERS ROOM.

(2)



Dingell Health Plan in One Page

Dingell's "Voluntary Alliances": Are They Really Voluntary?

- States must set up at least one alliance.
- Employers & individuals may purchase insurance inside or outside of the alliance, BUT,
  - Insurers selling inside alliance do not have to sell outside of alliance, and
  - States can require insurers who sell outside of alliance to also sell inside alliance.
    - Insurers that sell both inside & outside alliance must charge the same premium, but administrative cost discount is allowed when purchasing through alliance, therefore the insurer would only be able to discount policy within the alliance.
    - The "voluntary alliances" would be, in effect, "quasi-mandatory."

Dingell Employer Mandate Costs More than Clinton

Under Clinton: If you are a firm with 12 employees and an average annual wage of $12,000, your liability is limited to 3.5% of payroll.

(3.5%) x $12,000 = $420

Employer pays $420 per employee.

Under Dingell: If you are a firm with 12 employees and an average annual wage of $12,000, your liability is 20% of the average premium.

Assuming average premium of $3,535:
(20%) x $3,535 = $707

Employer pays $707 per employee.

Comparing Clinton & Dingell

Differences between

H.R. 3600 and Dingell 3/21/94 Staff Draft

Prepared by

The Energy & Commerce Minority Staff

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- General Rule
  - States must establish at least one regional alliance to provide coverage to all residents of state.
  - ALL PERSONS REQUIRED TO PURCHASE COMPREHENSIVE HEALTH BENEFITS PACKAGE FROM ALLIANCES.
- Alliances: H.R. 3600's "Central Nervous System"
  - Premiums paid by employers and employees collected by alliance.
  - Alliances only entity to contract with individual health plans.
  - Alliances enroll all individuals, make eligibility determinations, and determine who qualifies for subsidies.
  - ALLIANCE ENFORCES NATIONAL HEALTH CARE BUDGET (CPI CAP)

Dingell: Voluntary Alliances

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- "VOLUNTARY ALLIANCES" BECOME "QUASI-MANDATORY"
  - If every employer can get a better price in the alliance, all employers would purchase within the alliance.

Clinton: Employer Responsibility

- General Rule
  - Employer pays 80% of weighted average premium.
  - Employer liability limited to 7.9% of payroll.
- Subsidies
  - For firms with < 75 employees and average wage < $24,000.
  - Employer liability limited on a sliding scale from 7.9% to 3.5%.

Dingell: Employer Responsibility

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  - Employer pays 80% of weighted average premium.
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- Small Business Carveout (Major Difference)
  - Employers with < 10 employees exempted from paying employees' health insurance.
  - If not paying premiums, employer subject to PAYROLL TAX PENALTY.
    - Minimum payroll tax of 1% for firms with < 5 employees
    - Minimum payroll tax of 2% for firms with 6 to 10 employees
  - Firms with 11 to 75 employees recieve federal subsidies based on sliding scale.
    - Small employer subsidies are greatest for small firms with low wages.

Clinton: Health Alliances

Functions under H.R. 3600

- Enforce community rating.
- Coordination of premiums in 2 worker families.
- Establish fee schedule to meet CPI premium limitations through negotiation between purchasers, providers and insurers.
- Enforce CPI premium cap: Automatic reductions in payments to providers.
- Costs of Medicaid beneficiaries & nonworkers spread among all qualified plans.

Dingell: State Functions

State Functions under 3/21/94 Staff Draft

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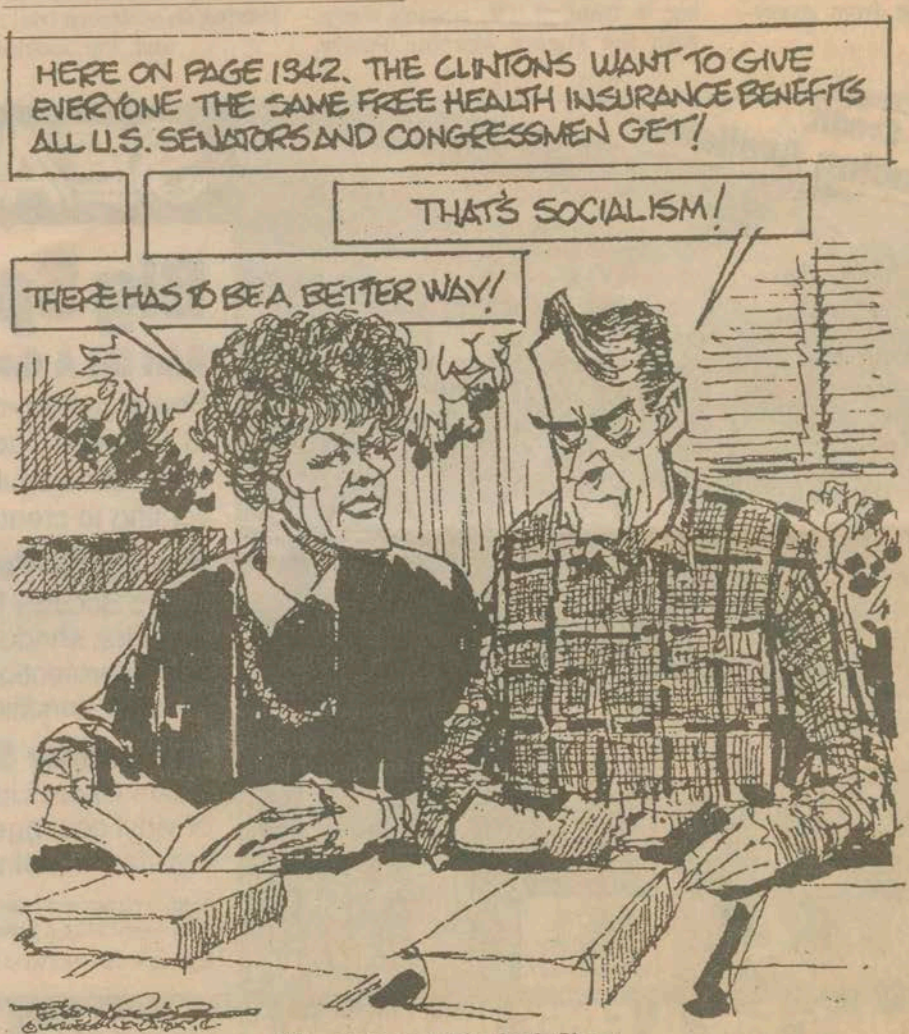
PATIENT POWER

The Free-Enterprise Alternative to the Clinton Health Plan

DRAWINGBOARD /CONRAD



The Bob and Elizabeth Show.

2:15 PM — 3:30PM

ATTENDEES: MARCH 29, 1994 MEETING WITH U.S. SENATOR ROBERT DOLE

Leon Bender, M.D. (U)
8631 W. Third Street Ste. 835 E
Los Angeles, CA 90048
(310) 657-7966

Richard F. Corlin, M.D. (GE)
1301 20th Street Ste. 330
Santa Monica, CA 90404
(310) 829-6789

Fred Dennis, M.D. (EM)
8700 Beverly Blvd.,
Los Angeles, 90048
(310) 885-6541

Russell Drago, M.D. (PD)
Kaiser
6041 Cadillac Avenue
Los Angeles, CA 90034
(213) 857-2569

Vincent Gualtieri, M.D. (U)
4955 Van Nuys Blvd., Ste. 704-710
Sherman Oaks, CA 91403
(818) 990-5020

Alan Heilpern, M.D. (EM)
California Hospital Medical Center
1401 South Grand Avenue
Emegency Dept.
Los Angeles, CA 90015

Mitchell Karlan, M.D. (GS)
416 N. Bedford Drive, Ste. 400
Beverly Hills, CA 90210
(310) 271-2177

Robert Karns, M.D. (IM)
8920 Wilshire Blvd., Ste. 321
Beverly Hills, CA 90211
(310) 652-8084

Marie Kuffner, M.D. (AN)
Dept. of Anesthesia
UCLA Medical Center
Los Angeles, CA 90024
(310) 825-6761

CEDARS-SINAI MEDICAL CENTER

MEETING WITH
U.S. SENATOR BOB DOLE
SENATE MINORITY LEADER

TUESDAY, MARCH 29, 1994
3:30 PM TO 4:45 PM
CEDARS-SINAI MEDICAL CENTER
FOUNDERS ROOM #2530

List of Participants:

Sheila P. Burke
Chief of Staff to the Senate Minority Leader

CEDARS-SINAI MEDICAL CENTER
8700 Beverly Boulevard
Los Angeles, California 90048

Irving Feintech
Chairman, Board of Directors

Carmen Warschaw
Chair, Government Relations Committee
Board of Directors

Thomas M. Priselac
President
(310) 855-5711

Stephen J. Ryan, M.D.
Dean and Senior Vice President for Medical Affairs
University of Southern California School of Medicine
2025 Zonal Avenue
KAM-500
Los Angeles, California 90033
(213) 342-1544

Joseph P. Van Der Meulen, M.D.
Vice President for Health Affairs
University of Southern California School of Medicine
1985 Zonal Avenue, Suite 100
Los Angeles, California 90033
(213) 342-2077

Raymond G. Schultze, M.D.
Director
UCLA Medical Center
Hospital Directors Office Room 17-165
10833 Le Conte Avenue
Los Angeles, California 90024
(310) 825-5041

Sidney H. Golub, Ph.D.
Provost for Medical Sciences & Interim Dean for Academic Affairs
University of California, Los Angeles
10833 Le Conte Avenue
Los Angeles, California 90024
(310) 825-5687

Robert C. Gates
Director of Health Services
County of Los Angeles
313 N. Figueroa Street, Room 912
Los Angeles, California 90012
(213) 240-8101

Reed V. Tuckson, M.D.
President of the University
Charles R. Drew University of Medicine and Science
1621 East 120th Street
Los Angeles, California 90059
(213) 563-4987

Oliver Goldsmith, M.D.
Medical Director for Southern California Permanente Medical Group
Walnut Center
393 East Walnut Street
Pasadena, California 91180
(818) 405-5000

Robert Erickson
Senior Vice President
Kaiser Foundation Health Plan
Ordway Building
Oakland, California 94816
(510) 271-2601

Mary Rainwater, LCSW
Executive Director of Los Angeles Free Clinic
8405 Beverly Boulevard
Los Angeles, California 90048
(213) 653-8622 Ext. 302

Karen Warren
Executive Vice President & Chief Operating Officer
City of Hope
1500 East Duarte Road
Duarte, California 91010
(818) 359-8111

Yoshi Honkawa
Government and Industry Relations
Cedars-Sinai Medical Center
8700 Beverly Boulevard, Room 2802
Los Angeles, California 90048
(310) 855-5701

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8700 Beverly Boulevard, Room 2802
Los Angeles, California 90048
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March 25, 1994

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: MEETINGS AT CEDARS SINAI HOSPITAL

Two separate meetings, each approximately one hour in length, are being arranged. Both meetings will be held at Cedars Sinai Hospital. We have also arranged a brief tour of their Emergency Room on your way out.

The first meeting will be with a group of physicians and with a representative of Kaiser Health Care Plan. The second meeting will be made up of representatives of the area medical schools, large teaching hospitals, and Cedars Sinai.

Both groups are being told that the discussions will be informal and designed to give you the opportunity to hear their specific concerns about the health care reform proposals.

The groups will be diverse in their interests, expertise and political affiliation. I've tried to cover most of the bases.

Included in this packet are a draft list of attendees, background information on Cedars Sinai, Kaiser and some material on the President's call to the California Medical Association Convention, and finally a brief description of the California health plan.

I will prepare some brief thoughts as to questions you might ask.

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The Los Angeles FREE Clinic

Dedicated to providing free health care and human services since 1967

March 29, 1994

The Honorable Robert Dole
Senate Minority Leader
U.S. Senate
Washington DC 20510

Dear Senator Dole,

Thank you for taking the time to meet with us about our country's desperate need for health care reform. I appreciate the opportunity to speak with you face to face about my experience providing health care to the medically underserved and indigent people of Los Angeles.

The Los Angeles Free Clinic, of which I am the executive director, is the oldest continuously operating free clinic in the nation. Founded in 1967, The Los Angeles Free Clinic has been providing health care and social services to an increasingly needy and diverse population for nearly three decades. Throughout that time, our services have always been free of charge and free of judgment to anyone who needed them.

In addition to medical and dental care, and psychological and legal counseling, The Los Angeles Free Clinic provides job training and placement for high-risk adolescents, HIV education and outreach to homeless and incarcerated youth, and adult day health care for the frail elderly and people living with AIDS.

On the average, about 40,000 people come to us for help each year. About 57 percent of them are unemployed and about 10 percent are homeless. Nearly a third of them speak a language other than English. More than 85 percent of our clients have no health insurance at all. The remaining 13 percent have inadequate insurance -- the deductible is too high, or it doesn't cover their condition, or it simply takes too long to get an appointment at their HMO. Our clients include the working poor, runaway teens, the frail elderly, immigrants, and others in need. In other words, our clients are the people falling through the cracks in our nation's current -- and grossly inadequate -- health care system.

Reply to:

☐ Seniel Ostrow Bldg., 8405 Beverly Blvd., Los Angeles, CA 90048-3476
Tel: Adm. (213) 653-8622 Appt. (213) 653-1990 Fax (213) 658-6773

☐ Partners Adult Day Health Care Center, 7362 Santa Monica Blvd.,
West Hollywood, CA 90046-6695
Tel: (213) 883-0330 Fax (213) 883-0344

☐ Hollywood Center, 6043 Hollywood Blvd., Los Angeles, CA 90028-5459
Tel: (213) 462-8632 Appt. (213) 462-4158 Fax (213) 462-6731

United Way

Anyone who doubts that there is a health care crisis need only spend a few hours in our waiting room. There they will see people who are seriously ill because they have delayed seeking medical care because they cannot afford a doctor's visit or the deductible on their insurance. Some of these people are chronically unemployed and uninsured, but many of them are recently laid-off, recently reduced to part-time or free-lance work, or full-time employees of small businesses that do not provide insurance. Our waiting room is jammed every day and our staff and volunteers work at top speed, but we are only able to accommodate a fraction of the people who need help. For every person we see, we are forced to turn away two or three.

The volunteers and staff of The Los Angeles Free Clinic welcome a national discussion of health care reform, and feel it is long overdue. We urge our elected representatives to conduct a productive non-partisan debate to develop a fair and workable plan that will provide universal access to health care. We need the commitment of both parties to implement a health care plan that will truly work.

We would like to offer ourselves, and other free and community clinics as part of the solution. We are experienced in treating clients at the lowest rung of the economic ladder -- and they are familiar with us. We are cost-effective, providing high-quality care and education at one third of the cost of government-run clinics or private practitioners. Although our capacity and services are limited, and we are no substitute for meaningful national health care reform, it seems clear to us that any workable health care plan will include free and community clinics, their volunteers, and their donors as providers of care.

It also seems clear that any workable plan must include care for everyone who needs it, regardless of their residency status. As health care providers, it is unthinkable that we would refuse care to a human being because he or she is undocumented. In addition to being antithetical to everything we stand for as caregivers, the public health consequences are grave indeed. The cost of

failing to prevent tuberculosis, birth defects, and other communicable diseases are far greater than the cost of preventing them.

In addition to providing care for the undocumented, we must also design a health care plan that accommodates other problematic populations, including the mentally ill, the homeless, runaway or "throwaway" teens, the frail elderly, and others who will have trouble navigating a complex and unfamiliar system. We cannot design a system that will require a runaway teen to return to her home state for care, or a mentally ill homeless person to cross town and carry an identification card.

We will be watching the health care debate closely, and we understand that well-meaning, reasonable people will disagree on many points. We are confident that a compromise plan can be developed that will meet most, if not all, of the nation's most urgent health care needs. We implore our elected representatives of both parties to seek that compromise in good faith, and not to hold our nation's health hostage to partisan politicking.

I appreciate the opportunity to communicate these deeply held views to you. I hope they broaden your understanding of the health care needs of our nation.

Sincerely,

Mary L. Rainwater

Mary L. Rainwater, LCSW
Executive Director

Attendees: March 29, 1994 meeting with Senator Dole
Page two

Ralph Kuon, M.D. (GS)
4065 E. Whittier Blvd., Ste. 203
Los Angeles, CA 90023
(213) 881-6550

Phillip Kurzner, M.D. (U)
Kaiser Dept. of Urology
6041 Cadillac Avenue
Los Angeles, CA 90034
(213) 857-2371

Aliza Lifshitz, M.D. (IM)
8631 W. 3rd Street, Ste. 1140 E
Los Angeles, CA 90048
(310) 659-2078

Jo Ellen Linder, M.D. (EM)
P.O. Box 265
Altadena, CA 91003
(818) 794-6838 (home)

Charles McElwee, M.D. (ORS)
219 W. Badillo Street
Covina, CA 91723
(818) 339-7325

Madison Richardson, M.D. (OTO)
6200 Wilshire Blvd., Ste. 908
Los Angeles, CA 90048
(213) 937-0068

William Weil, M.D. (FP)
1149 South Broadway, Ste. 859
Los Angeles, CA 90015
(213) 365-3457

Richard Wigod, M.D.(IM)
1703 Termino Avenue Ste. 102
Long Beach, CA 90804
(310) 498-2481

Oliver Goldsmith MD
KAISER

Bob Erickson
SR VP.
KAISER

Stephen Forman MD
City of Hope

Stephen Unger MD
CSMC-Chief Staff

Staff: Wade Piston, Director, Public Affairs & Government Relations
Ann Evanilla, Public Affairs Officer
Tom Thompson, Director, Communications
Collette Wright, Vice President, Programs & Policy
Brad Kuiper, Vice President, Operations

• Managed Competition
What about employer mandate;

drago managed care has downside too - lower quality
need level playfield

HPC - small impact on new coverage
Calpers - leaves lots of people out of their system paying higher bills

• Lifshitz
illegals - can't ignor them - they seek care - if undiag. (AIDS, TB)
they infect others

Baxter
· the HPC didn't help his employees - was more exp.
· malpractice; ? preempt states
$250,000 non econ damages

KAPLAN pressed for malpractice reform

goldsmith · concern re pt. of service requirement
- any willing provider

Kuhn malpractice ins.
OK on emp-mandate
anti trust needed
reform

linder · malpractice
· anti-trust (Blue Cross Blue Shield?)

dennis · illegal aliens
primary care physicians - concern md's may not see pt's because HMO's and others discourage them from getting care

concern economic penalties if people go to emer. rms.
- may need something to keep these units open
- ~~like~~ we need specially trained md's in ERs

Scott Kaplan
Calif. has done lots of experimentation - more state exper.
is NOT the answer
• insurance reform critical

mitchell kaplan
• medicare reimbursement too low
• can't do ↑ in benefits
• insurance companies really pushing & negotiate

Kuffner
medicare payments too low -
she is teaching physician
1/1 62.00/HR to supervise resident

guiter
concern c single payor push if managed care goes awry

uman
• manpower training - we need continued support
• what can we do to get pt. expectations modified

- medicaid - we keep promising more than we

• benefits pkg. - must be modest

Top 3 things we must do
1. ins market reform
2. catastrophic for all
- anti trust
- Malpractice reform

• pharm/benefit returns to make sure HMO's don't rape all the system

MEETING #1 -- CALIFORNIA PHYSICIANS

Introduction

- I want to begin by thanking each of you for taking time from your schedules -- on such short notice -- to talk with me.
- I am particularly grateful to Wade Piston for all of his efforts at contacting each of you.
- As you all know, reform of our health care system is right at the top of the domestic agenda in Washington. As a result, we are all spending a great deal of time sorting through the complex issues surrounding this topic.
- Perhaps the most valuable thing we can do is talk with those of you who actually provide the care -- so, we have a clear understanding of the impact of our decisions.
- The meeting attendance list clearly shows a tremendous diversity in interests and expertise. I would hope we could engage in an informal talk that will give each of you a chance to talk about what concerns you most, and share any suggestions you have.
- Dr. Corlin perhaps you could start us off and then maybe Dr. Dennis could talk about the ER as a source of not only emergency services -- but, also primary care for those without coverage.

Other Possible Issues

1. Malpractice Reform: We are looking at alternative dispute resolution, limits on attorney's fees, and caps on non-economic damages. Whats the most important thing to them?
2. Voluntary Purchasing Pools: California put a program in place for small businesses almost one year ago -- have they had any experience with the pool? Whats their reaction?
3. Undocumented Aliens: Perhaps one of the toughest issues facing states like California are the costs of caring for non-citizens. Many of those in the room care for these patients -- what suggestions do they have?
4. Global Budgets/Premium Controls: Cost containment will be high on everyone's list of providers. The Administration proposes global budgets and price controls -- what is their view?

5. Health Manpower: Lots of interest in increasing the number of primary care physicians. Some suggest we actually limit the number of specialists we train. Others suggest we change the incentives and let the market work. What is their view?

6. Managed Care: There are a number of you here who work for managed care plans. We have heard a great deal of criticism of these arrangements as being too restrictive, or having a negative effect on quality.

   Your view?

DOCTORS ATTENDING MEETING IN CALIFORNIA

✓Leon Bender, M.D.	Los Angeles Urologist Immediate past Medical Director, Cedars Sinai
✓Fred Dennis, M.D.	Los Angeles Cedars Sinai Emergency Medicine Current head of California Emergency Physicians
✓Richard Corlin, M.D.	St. Johns Hospital, Santa Monica (collapsed during earthquake) Gastroenterology Vice Speaker, American Medical Association, House of Delegates and immediate past President of the California Medical Association
✓Russell Drago, M.D.	Los Angeles Kaiser Pediatrics
✓Vincent Gualtieri, M.D.	Sherman Oaks Urologist Officer, Los Angeles County Medical Association
✓Mitchell Karlan, M.D.	Beverly Hills General Surgery Former President of Los Angeles County Medical Association and American Medical Association's Scientific Panel
✓Marie Kuffner, M.D.	UCLA Anesthesiology Past President of Los Angeles County Medical Association First Female President -- just retired
Phil Kurzner, M.D.	Los Angeles Urologist Kaiser Department of Urology
Aliza Lifschitz, M.D.	Los Angeles Cares for AIDS patients Hispanic Does Radio Show

Charles (Chuck) McElwee, M.D.	Covina (ORS) Officer of CalPac
Jo Ellen Linder, M.D.	Pasadena Emergency Medicine
Madison Richardson, M.D.	Los Angeles Otolaryngology
William Weil, M.D.	Redondo Beach Family Practice Medical Director, MaxiCare (HMO) Head of CalPac
Richard Wigod, M.D.	Long Beach Internal Medicine Former President, Los Angeles County Medical Association Active Republican
Alan Heilpern, M.D.	Los Angeles Emergency Medicine California Hospital Medical Center
Robert Karns, M.D.	Beverly Hills Internal Medicine
Ralph Kuon, M.D.	Los Angeles General Surgery

MEETING 2

MEETING #2 -- HOSPITALS/MEDICAL SCHOOLS

- Thank you so much for your willingness to be here today. And a special thanks to Yoshi Honkowa who pulled you all together so quickly. And, to Mr. Feintech and the rest of you from Cedars-Sinai for being our host.

- As I suspect Yoshi explained to all of you when he called -- my interest is in listening to each of you.

- Our discussions on health care reform in Washington are still very much in the formative stages -- we are all looking for answers to the tough questions facing us.

- Perhaps among the most difficult are those related to the special circumstances of some of our large teaching facilities and public hospitals.

- Another difficult issue is the Federal role in health manpower training. Some would have us place absolute limits on the number of residents and on the mix of primary care versus specialists.

- I'm interested in hearing your views on these and any other issues of importance to you.

- Perhaps Tom Priselac could start us off and then maybe Dr. Tuckson could follow.

Other Possible Issues:

1. Indigent Care/Illegals. How do we best care for these people? How do we get them out of the emergency rooms and into primary care?

2. Managed Care. Can teaching hospitals survive? Can "centers of excellence" like Sloan Kettering, Sidney Farber and Mayo?

3. Manpower Distribution: Our problems are not only the type of physicians we train, but also where they choose to practice. How do we keep them in the inner-city or out in western Kansas?

4. Are we doing enough to encourage/support minority students in the health sciences?

Rainwater

public providers who have been around a long time and provider free care may not survive in new environment

CONGRESSIONAL DELEGATION BRIEFING PANEL MEMBERS

Areta Crowell, Ph.D.
Director, Los Angeles County Department of Mental Health; Member of Managed Care Planning Council

Randall Davis, Esq.
Los Angeles County Washington D.C. Representative; Partner, Jones, Day, Reavis and Pogue

Castulo de la Rocha, J.D.
President and CEO, Alta Med Health Services Corporation; Member of Managed Care Planning Council

Susan Fleischman, M.D.
Medical Director, Venice Family Clinic; Alternate Member of the Managed Care Planning Council

Robert C. Gates
Director, Los Angeles County Department of Health Services; Chair, Managed Care Planning Council

John Redmond
Management Analyst, Intergovernmental Relations, Los Angeles County Chief Administrative Office

Gary Wells
Assistant Director, Administrative and Financial Services, Los Angeles County Department of Health Services; Chair, Finance and Legislative Committee, Managed Care Planning Council

Mark Windisch, Esq.
Special Legal Counsel to Los Angeles County on Health Matters

Susan White
Los Angeles County Federal Representative for Health

Toni Saenz Yaffe
Assistant Director, Planning and Development Services, Los Angeles County Department of Health Services; Chief of Staff, Managed Care Planning Council

This information has been excerpted and prepared by the County of Los Angeles, Department of Health Services, 313 North Figueroa Street, Los Angeles, California 90012.

Clip and mail bottom portion for further information.

To: Robert C. Gates, Director
County of Los Angeles
Department of Health Services
313 North Figueroa Street
Los Angeles, California 90012

From: _____
_____
_____
_____
_____
(Please print and include your name, title, address and phone number.)

I am interested in receiving additional information regarding:

- ☐ Unified System for a Healthy Los Angeles
- ☐ Task Force for Health Care Access in Los Angeles County
- ☐ California Governor's Budget Proposal for FY 94-95
- ☐ Health Care Reform Impact on Los Angeles County
- ☐ Los Angeles County Department of Health Services Estimate of Earthquake Damages and Losses
- ☐ Economic Outlook for Los Angeles County
- ☐ Los Angeles County Disproportionate Share Hospitals
- ☐ Los Angeles County General and Indigent Health Care Perspectives
- ☐ Other, as indicated below

_____
_____

On the county level:
The county has an annual operating budget of more than $2.3 billion. More than 30 percent of financing was, or still is, in jeopardy.

Forty-five percent of statewide uncompensated care is provided in Los Angeles County and 80.5 percent of this is provided by county-operated facilities. Last year, these facilities provided more than $544 million in uncompensated care.

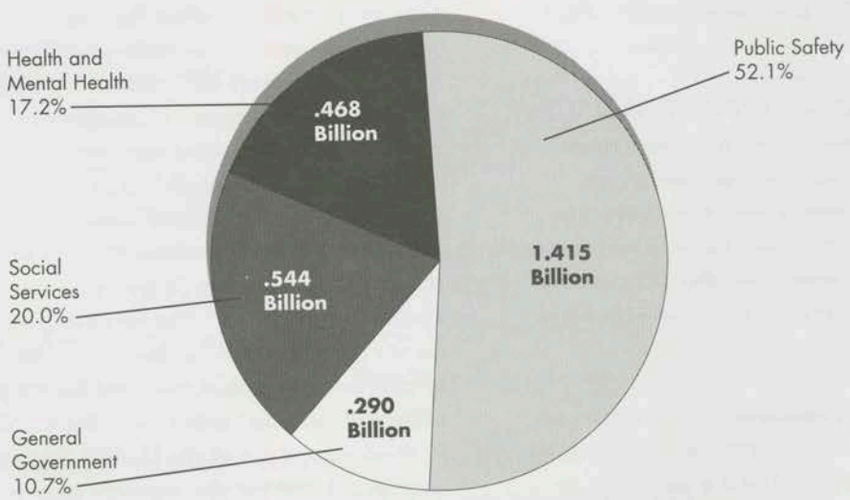
- A shortfall could result in closure of county facilities and have ongoing ramifications impacting the trauma/emergency system, mental health and the private sector.
- The county health care system employees more than 27,000 people. Loss of many of these jobs will further depress the county's economy.

THE PROSPECT OF HEALTH CARE REFORM
While county officials are generally supportive of health care reform, there appear to be few provisions for people who customarily fall through the safety net or for those facilities that provide care to these populations. The county's primary concerns are maintaining the health care safety net during a long and difficult transition period; preserving adequate financing of a safety net following implementation of health care reform for unaddressed populations. This includes undocumented and incarcerated people, and ensures adequate public health and trauma/emergency services. Key issues are:

- adequate entitlement funding to cover uncompensated costs,
- universal coverage regardless of immigration status,
- preserving disproportionate share hospital payments at current levels until reform is in place, including the delay and/or revision of the 1993 cap,
- automatically designating county hospitals and clinics and key disproportionate share hospitals as "Essential Community Providers,"
- adequate financing to defray provider costs for care to uncovered populations, and
- utilizing proposed Academic Health Centers/ Public Health Initiative provisions to gain grant

Los Angeles County General Fund Budget
1993 - 1994 Local Expenditures Base*

$2.717 Billion



Apportioning 1994 - 1995 Shortfall of $900 million

- Across-the-board allocation would result in service reductions of approximately 33%.
- Priority for public safety would result in even greater service reductions in state required health, mental health and social services expenditures.

Financed by property taxes, sales taxes, vehicle license fees, and other local revenues.

- that the 2.7 million medically uninsured in the county are currently being underserved by four to five million outpatient visits annually, roughly equivalent to the total visits provided in a year by the Department of Health Services,
- that the estimated 700,000 undocumented persons in the county are only marginally accounted for in the estimates of the uninsured population and estimates that the proportion of uninsured in this group is very high,
- that the impact on utilization of emergency room services, community clinics and public health services is far too significant to be ignored.

The Task Force unanimously recommended inclusion of undocumented persons in universal health care coverage and has recommended improving the efficiency of care for the uninsured by creating a comprehensive coordinated public and private system of care for the uninsured residents of the county, incorporating elements of managed care. The County Department of Health Services is implementing this recommendation and has suggested expanding the coordinated system to include the Medi-Cal population as well.

FALLING FINANCIAL SUPPORT THREATENS HEALTH CARE

On the state level:

California government, according to its Legislative Analyst, faces a $6.1 billion deficit for FY 94-95 and another $4.1 billion for the following year. Shortfalls of this magnitude will translate into major health and welfare cuts. The California governor's budget proposal assumes $3.8 billion will come from revenues and expenditure savings primarily from the federal government and makes no contingency plan if this assistance is not forthcoming. The proposal relies on the following:

- Increased Federal reimbursement for undocumented alien health education and correction costs ($2.3 billion)
- Increased Federal share of Medi-Cal ($.6 billion)
- Full reimbursement for 36-months of refugee services ($.1 billion)
- Reduction of AFDC grant by 10 percent ($.3 billion)
- Reduction of AFDC grant by additional 15 percent for families remaining on aid after six months ($.2 billion)
- Elimination of Medi-Cal optional benefits ($.1 billion)
- Elimination of Medi-Cal prenatal coverage for undocumented aliens ($.2 billion)

This plan shifts to counties 11.5 percent of Medi-Cal program costs, increases counties' share of AFDC costs and shifts certain programmatic responsibilities to counties, supposedly on a revenue neutral basis, offsetting with reallocated sales and property tax revenues and other funding elements.

Los Angeles County General Fund Budget

Five Year Property Tax Trend

Including Benefit from 1/2 Cent Public Safety Sales Tax

is children and the majority live in poverty.

Los Angeles is the prime destination for Latin American and Asian Pacific immigrants. As these populations increase, so do their requirements for health care services.

- Ethnic diversity is increasing at a rapid rate. Today, more than half of the county's population is ethnic minorities.
- By the year 2000, three quarters of the population are expected to be ethnic minorities and 30 percent children.

IMPACT ON COUNTY HEALTH CARE SERVICES

Census data from 1990 indicate that more than 2.7 million, or 30 percent of the population, are without health insurance. This compares to 22 percent for the state and 17 percent nationally.

- One in three people have no health insurance, the highest rate of medically uninsured residents in the nation.
- Nearly one-half the population is either on Medi-Cal or without health insurance.
- Emergency room visits increased by 92 percent over the last decade as violence -- and trauma cases due to violence -- increase alarmingly.
- AIDS cases continue to surge upwards.

The county operates six public hospitals, six comprehensive health centers and 40 public health centers. Four of the hospitals have emergency rooms and three are designated as Level 1 trauma centers.

- Half of all major trauma cases in the county are transported to these three trauma centers.
- Half of the 23 hospitals participating in the trauma hospital system have withdrawn, leaving large portions of the county without services and overburdening the remaining trauma centers.

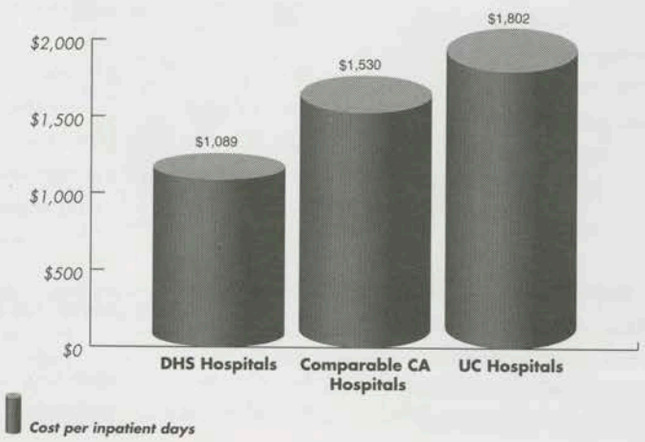
Health care for 4.3 million Medi-Cal and medically uninsured county residents is provided by a loosely constructed safety net of 24 disproportionate share hospitals, 46 county-operated health centers and 70 free and community clinics. There is a total of 146 hospitals and 112 state licensed clinics in the county.

- There has been an increase of more than 100 percent in the number of outpatient visits to county health facilities.
- Only $100 million of the $4.3 billion in taxes paid by immigrants are paid to the county, yet they use $900 million in local services.

TASK FORCE FOR HEALTH CARE ACCESS IN LOS ANGELES COUNTY

Appointed by the County Board of Supervisors, this private/public body unanimously agreed that the only definitive solution to addressing the needs of the uninsured is the adoption of comprehensive health care reform that provides universal access to care. The Task Force research indicates:

**COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
COST PER DAY COMPARISON - L.A. COUNTY VS. OTHER
CALIFORNIA HOSPITALS FISCAL YEAR 1991 -1992**



funding and interagency cooperation to reinforce the safety net and foster public-private networks built on existing "charity" hospitals and community clinics.

UNIFIED SYSTEM FOR A HEALTHY LOS ANGELES

Predicated on the findings of the Task Force on Health Care Access, the Unified System for a Healthy Los Angeles. was developed by a 39-member Managed Care Planning Council for Los Angeles County. It was formed in February 1993 to develop a plan for the most effective way to organize managed care for the Medi-Cal and medically uninsured in the county. It included representatives from nearly every segment of health care services: free and community clinics, community and public hospitals, managed care organizations, medical schools, physicians, physician groups, home health agencies, consumers, universities, pharmacists, children's services, mental health services and public health departments. Additional participants from these and other sectors were involved in consultant committees and working groups. Council members believe that preservation of safety net providers is essential for reform of the entire system.

The System aims to maintain and improve health care access for vulnerable populations through eight geographically designated public-private networks providing coordinated, culturally competent care. It contemplates independent governance under a local health authority.

Principles guiding development of the Unified System are based on a philosophy that emphasizes primary and preventive services, increases access, improves quality and contains cost. It will develop managed care services by contracting with prepaid health plans in regional areas throughout the county and all consumers of the system will have a choice of health plans.

Believing that the state's managed care objectives are better served through a single administration than by a two-track approach proposed by the state, the county's board of supervisors has encouraged state support in developing the Unified System in a letter signed by all five supervisors.

CONGRESSIONAL REPRESENTATIVES' ROLE

Start-up and transitional funding are needed to implement and carry out Unified Health System. Los Angeles County needs congressional support and is requesting that Unified Health System of Los Angeles County be funded as a designated federal demonstration project for an urban transition model to national health care reform. The health and vitality of Los Angeles County's people is key to the social and economic recovery of the region and the entire state.

The Managed Care Planning Council for Los Angeles County has endorsed the following proposed federal language:

Statutory Provision

There are authorized to be appropriated $30 million for the development of a comprehensive managed cooperative model of health care delivery for individuals eligible under Title XIX of the Social Security Act and other medically indigent individuals in the County of Los Angeles, California. The Secretary shall make such development funds available through grants or agreements which provide for payments either in advance, or by way of reimbursement, on such conditions as the Secretary finds necessary to carry out the purposes of this section.

Legislative History

The Managed Care Planning Council for Los Angeles County is an alliance of public and private health service practitioners, providers, academic institutions, consumer advocates and community representatives convened by the County of Los Angeles to develop a comprehensive, managed cooperative model of health care delivery for the Medi-Cal population and the medically indigent. The statutory provision is intended to provide funds to the Council to assist in the development of the "Unified Health System for a Healthy Los Angeles." The funds are to be expended for the costs for technical assistance, the development of information systems, the compilation and analysis of current data, and other costs that will be incurred in the development of the Unified System. It is anticipated that the development costs will be incurred over a period of at least two years.

27,000 Co. employees
6 hosp.

Health Care in Los Angeles County: Standing on Shaky Ground

An update by the County of Los Angeles, Department of Health Services, March 3, 1994

Los Angeles County, once considered a golden, if somewhat oddball, forecaster of life in a future utopia, has run smack into a reality never in the dreams of yesterday's predictors. Unquestionably, the county remains unique. However, the fair child of the Golden State faces a future filled with dismay rather than dazzle unless important changes are made.

Even before January 17's shattering earthquake, Los Angeles County, and particularly its health care system, was on shaky ground. But the impact of those 31 seconds have left the county reeling from losses and expenses that threaten the entire health care infrastructure, as well as the lives of the residents who depend on the county's fraying safety net.

EARTHQUAKE CAUSES EXTENSIVE DAMAGE; SOCIAL AND ECONOMIC DISRUPTION

Earthquake damage to Los Angeles County Department of Health Services' six hospitals, 40 health clinics and other health services is estimated to stand at more than $1 billion. Several of the county's hospitals and clinics sustained structural and other damage and were forced to close temporarily; patients had to be transferred to other, safer facilities.

- One health clinic in the San Fernando Valley remains closed because the building has been condemned.
- The psychiatric and pediatric hospital of the Los Angeles County/USC Medical Center have been closed due to structural damage.
- Three private hospitals in the county have been closed due to structural damage and several others have been forced to curtail activities, putting additional strains on the county's health care services.

An estimated $41 million was incurred for public health emergency activities. These include assessing the threat of communicable diseases due to unsafe drinking water and lack of adequate shelter and food, and coping with injuries and illnesses related to the earthquake. Others include assessing living conditions in some 200 parks and shelters, and evaluating about 150 health care facilities, as well as assisting in evacuating patients from five nursing homes.

- Thousands of people were permanently thrown out of work overnight.
- Hundreds of families lost their homes, as well as their jobs.
- Approximately $20 billion in damage resulted from the earthquake, affecting a population largely uninsured for the damages sustained by their homes or businesses.
- The county's Department of Health Services is working with FEMA to obtain funding to rebuild or replace damaged health care facilities.

In addition to the physical disruption, the earthquake further aggravated conditions for millions of Los Angeles County residents already living "on the edge" and a county desperately trying to recover from the ravages of deep economic recession, civil unrest and recent fires and floods.

STRESS BEFORE THE EARTHQUAKE

Los Angeles is the largest county in the U.S., larger than 42 states and 162 countries. Its population is nearing 10 million. The Northridge earthquake was the latest in a series of disasters to hit the county, striking after ruinous civil unrest in 1992 and consuming wildfires and floods last year. The county remains mired in its worst recession since the 1920's and economic recovery is not expected until 1996.

With one-third of the state's population, Los Angeles County accounts for two-thirds of California's 400,000 lost jobs. The county is losing jobs at nearly twice the national average and the number of people living in poverty has increased by 33 percent in the last decade.

- One in three people live below 200 percent of poverty.
- One in five people receives public assistance.
- More than 25 percent of the county's population

BACKGROUND INFORMATION

KAISER PERMANENTE

Kaiser Permanente's Southern California Region

Fact Sheet

Kaiser Permanente is a prepaid group practice health plan providing comprehensive medical and hospital services to more than 6.6 million members in 12 regions nationally. Kaiser Permanente's Southern California Region was established in 1943 to serve the workers of the steel mill in Fontana. Steel from this mill was used in construction of the Liberty ships used in World War II. Today, the Southern California Region serves 2.2 million members throughout the Los Angeles area. Enrollment in Kaiser Permanente's Southern California Region comprises about 15% of the Southern California marketplace (from Bakersfield to the Border).

The Southern California Region operates 93 medical office facilities which provide day-to-day primary care for its members. Each of the medical offices serves as a satellite to the Region's 10 hospitals. The Region has an 11th hospital under construction, due to open in 1995. In addition to its medical office facilities and hospitals, Kaiser Permanente operates a 60-bed Mental Health Center in Los Angeles and a Hospice in Norwalk for terminally ill patients.

Kaiser Permanente's Southern California Region employs 33,000 people. The Southern California Permanente Medical Group, which contracts with the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, is a partnership of 3,070 doctors, the largest medical partnership in the country.

****

Kaiser Foundation Health Plan, Inc.
1700 K Street, N.W., Suite 601
Washington, D.C. 20006-3817
202.296.1314 FAX 202.296.4067

CEDARS-SINAI MEDICAL CENTER

Cedars-Sinai Medical Center is the largest voluntary, nonprofit hospital in the western United States. It is internationally renowned for its diagnostic and treatment capabilities, broad spectrum of programs and services, and breakthrough biomedical research. The Cedars-Sinai reputation for the highest standards in health care and the quality of its professional staff attract patients not only from the Los Angeles area, but from around the world. For all its present magnitude, however, the origins of CSMC were modest.

In 1902, a small house in East Los Angeles opened its doors to care for patients with tuberculosis and in doing so became the Kaspare Cohn Hospital. The Boyle Heights Los Angeles Home for Incurables, established in 1921 for victims of a national influenza epidemic, had only six beds. During a growth process that involved more than one relocation, these two hospitals moved to the west side of Los Angeles, and were renamed Cedars of Lebanon and Mount Sinai.

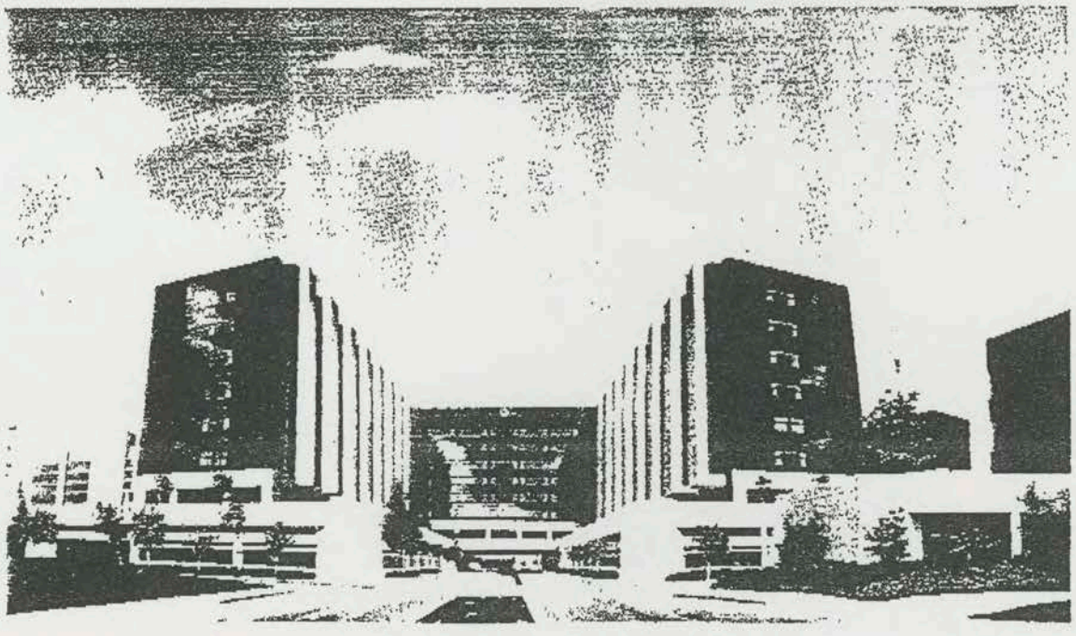
Then, in 1961, those who supported the hospitals agreed that the community would be better served by merging the two facilities. In 1973, following a decade of planning and preparation, the Thalians Mental Health Center opened and the first phase of construction on the CSMC complex was completed. The primary, eight-story structure of 1.6 million square feet, built at a cost of more than $100 million, was dedicated in 1976. Since that time, several other facilities have been added, including the off-campus, 11-story Mark Goodson Building for outpatient programs, the totally renovated structure housing the Steven Spielberg Pediatric Research Center, and the seven-story, state-of-the-art Barbara and Marvin Davis Research Building.

The goal of the community volunteers who serve on the Cedars-Sinai board of directors has been to make the medical center a world class facility in every respect, one committed to excellence in all endeavors. According to a recent consumer survey in which CSMC was compared to other Los Angeles-area medical centers, Cedars-Sinai has achieved the board's goal: it was selected first in all major categories.

Cedars-Sinai ranks among the top hospitals in the nation in voluntary biomedical and clinical research. Los Angeles' first coronary care unit was at CSMC, as was the first hospital-based blood bank. The medical center is a pioneer in fetal monitoring, and has made a major commitment to genetic research with more than 100 scientific investigators pursuing projects in this field. The Swan-Ganz catheter for monitoring the condition of cardiac patients was developed at CSMC and is now used throughout the world.

The medical center's cardiology division has gained worldwide stature for its research and applications of procedures that have become standard in the international community. For example, CSMC was the first medical facility in the world to develop a procedure in which clogged arteries could be opened without invasive surgery. A collaboration between scientists at NASA and the Jet Propulsion Laboratories with medical center physicians resulted in a space age event: blocked arteries were opened with beams of excimer laser light. Cedars-Sinai has also received national recognition for treatment of kidney disease and its neonatal intensive care unit.

As a tertiary care hospital, the medical center has many multi-speciality, critical care units. Treatment centers include the Comprehensive



Cedars-Sinai Medical Center has established a reputation for maintaining the highest standards in health care.

Far left: Surgeons in the Transplantation Center perform replacement procedures of various organs including heart, lung, and bone marrow.

Cancer Center; DOTEC (Diabetes Outpatient Training and Education Center); the Center for Reproductive Medicine; the Medical Genetics-Birth Defects Center for genetic risk information, screening, and knowledge, as well as prenatal diagnosis, an international registry for skeletal dysplasia, and diagnosis and treatment of the many birth defects afflicting children; the Bone Disorders Center; the Sleep Disorders Center; and the Ellis Eye Center. The Department of Psychiatry offers a comprehensive program at the Thalians Mental Health Center, and elsewhere on the CSMC campus, including help for addictive behavior and substance abuse.

The Transplantation Center reflects CSMC's reputation for excellence and leadership in transplantation surgery, with capabilities in the replacement of various organs, including heart, liver, lung, kidney, and bone marrow transplants. More than 22,000 surgical procedures in 14 specialties—including cardiovascular, transplantation, neurosurgery, and plastic—are performed annually.

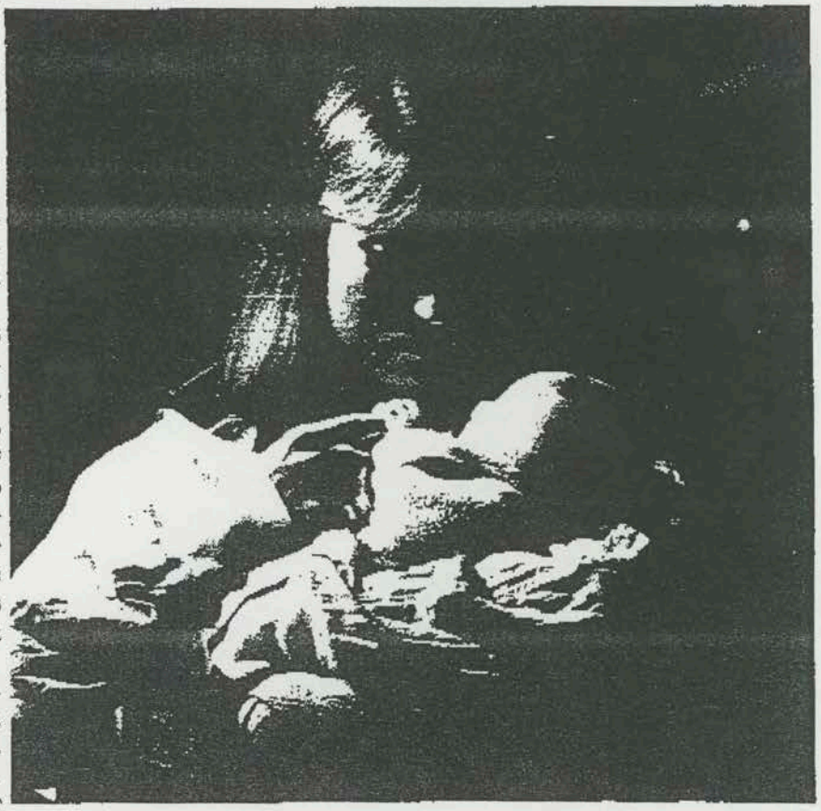
The medical center is also known for its AIDS research and treatment; pulmonary disease program; diabetes research; gastroenterology research and clinical care; endocrinology program, including thyroid function and reproductive medicine; rheumatology program (arthritis, lupus); and rehabilitative medicine program, including inpatient and outpatient care. All laboratory-based activities of the medical center are supported by the Department of Pathology & Laboratory Medicine and its state-of-the-art equipment.

The CSMC Department of Obstetrics & Gynecology functions as a comprehensive women's hospital. Some 8,000 babies are delivered annually, and high-risk maternity care and neonatology intensive care are provided. A full range of medical services for children include the Amie Karen Center for treating children suffering from cancer, leukemia, AIDS, and blood disorders; and the Medical Genetics-Birth Defects Center for diagnosis and treatment of children born with hereditary conditions and birth defects such as cystic fibrosis, mental retardation, sickle cell anemia, spina bifida, juvenile onset diabetes, and growth disturbances.

Cedars-Sinai is one of the finest teaching hospitals in the country. Residency training is offered in seven specialties, and as many as 500 physicians are in training at any one time. Training programs also are available in nursing, pharmacy, and medical technology. The medical center has an academic affiliation with the UCLA School of Medicine, and all of its medical department heads hold faculty status at the university.

Service to the community is part of the Cedars-Sinai mission, as is health care for the poor and indigent. Costs over and above donations provided by social services, such as the Jewish Federation Council and United Way, are absorbed by the medical center. The Ambulatory Care Center sees many patients who cannot pay, and Cedars-Sinai is one of the few Los Angeles-area hospitals still participating in the Los Angeles Trauma System as a Level I Unit. Other community services include physician referral, wellness education, support groups, senior citizen programs, an

The medical center's Department of Obstetrics & Gynecology offers a variety of services and treatments for children.



Thousands of dedicated people work together to ensure that patients receive the finest health care available.

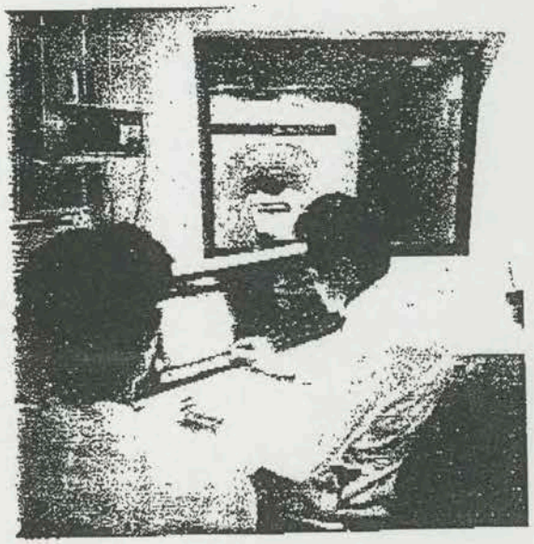
emergency response system for the elderly and disabled, a hot line for troubled teenagers, and the Adopt-a-School program.

Delivering all of these services takes the combined efforts of thousands of dedicated people. The medical staff is comprised of more than 2,200 attending physicians and 250 full-time staff physicians, supported by 2,000 nurses and nearly other employees. More than 1,400 volunteer nate about 265,000 hours annually, and 31 port groups raise funds through charitable e to benefit Cedars-Sinai.

The medical center is licensed for 1,120 and all inpatients are housed in private roo wide selection of fine food is available, and are preparation kitchens on each floor su menting the main kitchen.

For therapeutic purposes, a collection of than 8,000 art objects, such as paintings sculptures, are to be found throughout the cal center. Supervised by its own in-house tor, this is the largest collection of fine art found at any hospital in the world.

All of those who work or volunteer at Ce Sinai are proud of its reputation as one great medical centers in the world. To mai this position at the leading edge of patient medical technology, and pioneering researc forts in the future, the CSMC board of direct building a $250-million endowment fund. this type of support, the medical center can tinue to achieve its mission of providing the quality health care to be found anywhere.



Staff members use the latest technology in their research..

CEDARS-SINAI MEDICAL CENTER

INTRODUCTION AND BRIEF HISTORY

Cedars-Sinai Medical Center is a non-profit corporation, governed by an elected Board of Directors whose members serve on standing committees which formulate policy.

A comprehensive, tertiary care facility located in Los Angeles, Cedars-Sinai is not only prominent locally but serves also as a specialty referral center nationally, and even internationally, offering a complete spectrum of medical/surgical services. Along with its commitment to highest quality patient care, Cedars-Sinai offers a complete program of physician training (in affiliation with UCLA School of Medicine), nursing, medical technology, and community education. Additionally, it maintains the nationally recognized Cedars-Sinai Research Institute where many prominant physician/researchers affiliated with the Medical Center carry out research and projects often resulting in contributions to medical knowledge and practice worldwide.

Although Cedars-Sinai opened the doors of its ultra-modern, 1.6 million square foot, $100-million facility only ten years ago, it upholds a tradition of strong community service begun in 1902 with the founding of Kaspare Cohn Hospital, in a converted residential dwelling, and Mount Sinai Hospital in 1921. This tradition was reinforced by the 1961 merger of Kaspare Cohn's successor, Cedars of Lebanon Hospital and Mount Sinai Hospital -- a pooling of resources that ensured the future of a preeminent medical institution.

Thus, while Cedars-Sinai has developed into one of the world's most complex and sophisticated medical centers, it maintains a primary commitment to deliver unsurpassed care to its patients-- a commitment visible in the dedication of a highly skilled nursing staff and the corresponding satisfaction of its patients. (Cedars-Sinai's annualized turnover rate for nurses is only 1%. the lowest in the state of California. Responses to patient questionnaires distributed to patients from January-March 1986 show that 95% would recommend CSMC for patient care.) In 1985, Cedars-Sinai committed $4.6 million dollars to free care.

In the past ten years, one million patients have been treated at Cedars-Sinai; the Medical Center looks forward to cintinuing its tradition of critical, life-saving work and compassionate care.

Nurses and physicians in pediatrics are prepared to respond to the special needs of children. Visiting hours here are more flexible, and a special play therapy program helps to alleviate a child's apprehensions concerning the hospital stay. An innovative practice of Cedars-Sinai is to encourage a family member to stay with the child throughout the day and night. For this purpose, every pediatric room is furnished with a chair bed.

Cedars-Sinai is preeminent in the West for cardiovascular and thoracic surgery--from simple surgery to the most complex coronary artery bypass grafting, valve replacement/repair. There are three operating rooms for cardiovascular surgery, wtih an adjacent Cardiac Surgical Intensive Care Unit. Highly complex lung, chest and major artery surgery are performed in another three operating rooms, with adjacent recovery room.

The Department of Physical Medicine and Rehabiliation provides physical and occupational therapy, social services, and psychiatric liaison services both on inpatient and outpatient basis. Multi-disciplinary programs -- all with the aim of returning the patient to as self-sufficient and normal a lifestyle as possible -- include chronic pain management, rehabilitation for stroke, brain and spinal cord injury, multiple fractures, amputation, cardiac condition among others.

The Thalians Mental Health Center, in its own building under the Department of Psychiatry, provides a complete program of psychiatric services, and works in liaison with every department of the Medical Center. It is noted for programs dealing with divorce, child custody and family guidance. Confidential telephone counseling for parents, teens, and victims of rape is available to the community at no cost. A special Care Unit, housed in a separate facility, treats victims of alcohol and drug dependency.

Cedars-Sinai's comprehensive Ambulatory Care Center consists of a group of clinics providing ongoing outpatient care in Internal Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and numerous consultative specialties. The Same Day Outpatient Surgery Center enables patients to be admitted in the morning, have surgery performed, and be released the same day; four operating rooms, with adjacent ICU and radiology units comprise this active center. A new outpatient Comprehensive Cancer Center, offering a full range of sophisticated cancer treatment, is fully operative 24 hours daily.

The Department of Emergency Medical Services boasts one of the most extensive, highly equipped emergency centers in the country. The emergency unit contains its own CT

scanners, the most sophisticated heart monitoring equipment in the West, and complete laboratory. Its professional staff includes ten full-time Emergency physicians, and a 38-person nursing staff devoted exclusively to the emergency area. Moreover, the unit has earned the following accreditations: Level I Trauma Center designation; Heli-Pad opening; Emergency Department approved for Pediatrics/Pediatric Critical Care Center; American Heart Association Approval.

SPECIAL PROGRAMS

In recent years, multiple specialized services and facilities have added to Cedars-Sinai's capabilities in providing the most sophisticated, refined healthcare available anywhere.

These programs include:

Metabolic Support Team: This is a multi-disciplinary service of the Nutrition Center. The team combines nutritional therapy with other methods of treatment, effecting a decrease in complications of surgery. Additionally, the team provides nutritional support and medication to outpatients.

Weight Control Program: Studies show that the weight reduction program adopted by Cedars-Sinai is one of the most effective available. A medically monitored, individualized program, it begins with a fast limited to a nutritionally balanced supplement and progresses through stages of refeeding with lean basic foods.

Arthur and Eleanor Ellis Eye Center: This ultra-modern outpatient clinic uses the most technologically advanced equipment available (such as argon and Nd:YAG lasers) to treat a variety of ophthalmologic conditions, including retinal diseases and injuries, and to evaluate the sensory nervous system, both in the eye and the brain. Procedures include cryosurgery, visual field studies, electro-physiology, lens calculations, fluorescein angiography, and eye photography.

Diabetes Outpatient Training & Education Center: Through an intensive five-day program, patients learn the latest techniques in diabetes self-management, including home glucose monitoring, insulin injections, and diabetic nutrition and exercise. Special facets of the program are pre-pregnancy counseling for diabetic women and emotional support from peers and psychologists. The program's objective is to allow the patient to experience an independent, vigorous lifestyle.

Chronic Pain Management Program: This program draws from ten disciplines to use an integrated team approach in helping a patient deal with and experience alleviation of chronic pain. Patients are led through a specific series of behaviors that teach them pain-coping skills, eliminate (or decrease) their reliance on pain medication, and increase the amount of activities they can perform.
Biofeedback Therapy: This inpatient/outpatient program assists patients to recognize and subsequently regulate their own body's reactions to tensions and stress which manifest in physical disorders.
Home Care Program: This program supplies complex equipment and instruction in its use (both to patients and their families) and provides highly expert home-care nursing for those who require such services while completing their convalescence or dealing with chronic conditions at home.
Hospice Unit: This 20-bed inpatient unit, staffed by a team of specially trained volunteers and professionals, provides counselling for patients and families, and helps terminally ill patients discover how they can spend their remaining days with meaning and in all possible comfort. The staff arranges for pain control, helps plan for outpatient care, and provides liaison with community and financial services for special needs.
Geriatrics Program: Because Cedars-Sinai is located in the midst of a community densely populated with senior citizens, and because of its awareness that the over-65 population is dramatically increasing nationwide, it is inaugurating this comprehensive treatment and research program dealing with all aspects of geriatrics and gerontology. One of its initial projects has been development of a Senior Resource Center which provides members of the community with free information and referral on multiple services available to seniors and their families.
Comprehensive Cancer Center: This outpatient program provides states of the art diagnostic and therapeutic care for cancer patients. Patients receive around-the-clock service, and are offered lower costs and a better quality of life through rapid daignosis and treatment. The Amie Karen Center for Children sees patients in an environment created for the special needs of children.

Regional Arrhythmia Center: A specialty referral center for the West, the R.A.C. is unique in its ability to offer coordinated, comprehensive treatment for patients afflicted with disturbances of cardiac rhythm. The center, making expert, advanced care available for patients with unusual, complex, or previously unmanageable arrhythmias, unites a team of specialists and incorporates new and diverse techniques, antiarrhythmic devices and drugs to provide superior evaluation and treatment.
Reproductive Endocrinology Center: This developing center will employ the expertise of an interdisciplinary team -- in recognition of the fact that the field of sexual and reproductive function is a complex blend of medical and psychological factors -- to offer a comprehensive program of professional care. The reproductive and infertility aspects will include the capacity to treat all aspects of in-vitro fertilization.
Genetics Center: The hospital is developing an extensive Medical Genetics-Birth Defects Center which will provide state of the art technology toward the prevention, diagnosis, and treatment of all forms of hereditary disorders and birth defects. It houses the international skeletal dysplasia registry and clinic, a world renowned resource for the diagnosis and treatment of growth problems.

In addition to the above programs, Cedars-Sinai sponsors a no-cost, obligation-free Physician Referral Service, listing more than 600 attending physicians in 38 specialties and sub-specialties. Another valuable service sponsored by the Medical Center is Lifeline, an emergency response system for the elderly, disabled, or other vulnerable individuals.

FREE CARE

It is through the Ambulatory Care Center that Cedars-Sinai offers indigent care, making the services and capabilities of the Medical Center available to a whole spectrum of the community that would otherwise have no access to them. With the exception of donation from the Jewish Federation Council and United Way, Cedars-Sinai absorbs the costs of this care. In 1985, the Medical Center absorbed $4.6 million in caring for needy individuals.

MEDICAL EDUCATION

Cedars-Sinai is a major teaching hospital affiliated with the UCLA School of Medicine to train medical students and to offer postgraduate medical education in internal medicine, general surgery, obstetrics/gynecology, pediatrics, adult and child psychiatry, diagnostic radiology, and pathology. In 1985, there were 55 physicians receiving graduate medical training as first year residents, 139 advanced residents, and 36 fellows-- a total house staff of 230 physicians in training.

At the same time, over 2,000 practicing physicians of the CSMC medical staff, all board certified or qualified for board certification, had the opportunity to attend hundreds of educational programs. Among these are annual lectureships.

In fiscal 1984-85, the Office of Continuing Medical Education offered 31 different specialty programs, attended by 3,895 physicians, earning a total of 13,536 CME credits. Two hundred speakers, experts in various medical specialties, participate in these programs. Physicians from the surrounding community, as well as those affiliated with Cedars-Sinai, attend these programs. Nursing Research and De velopment provides educational and training programs for the community, patient population and nursing personnel. The department coordinates clinical educational programs for 15 affiliated universities and colleges. These include UCLA, USC, CSU Los Angeles, CSU Long Beach, Mount Saint Mary's College, L.A. Trade Tech, L.A. City College, West L..A. College, and L.A. Valley College. Many of Cedars-Sinai's nursing staff hold joint faculty appointments. An annual national symposium is conducted, bringing together leaders in the nursing and health community. Clinical nursing research and collaborative research projects are conducted by the department.

The Emergency Department provides in-service and continuing education courses to paramedics and Mobile Intensive Care Nurses.

Technical students are enrolled in our Schools of Laboratory Technology and Histopathology.Students also spend time at Cedars-Sinai training in physical therapy, radiation therapy and radiologic technology. A broad program of in-service training is conducted for professional and non-professional employees.

As a special service to the community, Cedars-Sinai makes available a program of Community Education. This includes ninne different prenatal education programs and "The Best of Health Series," which have presented topics such as CPR, parenting, first-aid, stress reduction, weight reduction, and smoking cessation.

RESEARCH

Basic biomedical and clinical research programs are an integral part of Cedars-Sinai; these programs are being conducted by renowned specialists in virtually every medical specialty and subspecialty practiced at the hospital. The Medical Center, which is steadily developing into a national medical research center, presently has more than 100 projects, which involved over 70 principal investigators and some 150 employees.

Among studies underway are diagnosis and treatment of heart disease by innovative techniques; pediatric diseases such as cancer, juvenile diabetes, and growth disorders; diabetes detection and treatment; blood apheresis treatment for arthritis; treatment of gallbladder disorders by non-invasive procedures; treatment of corneal infections; variations in the treatment of gynecological malignancies; advanced surgical techniques, for instance in spleen surgery-- and many others.

The results of research carried out at Cedars-Sinai are published in all prominent medical journals, introduced at major medical conferences, and consistently reported in local and national media.

During 1985, the Cedars-Sinai Research Institute continued to garner national acclaim, thanks to the many activities of its research program. A major facility renovation was completed to house the Ophthalmology Research Center, where research in eye surgery and disease will be conducted in cooperation with clinical activities of the Arthur and Eleanor Eye Center.

Cardiology and Surgery Research Investigators have developed the concept for the Excimer Laser, currently being built by the NASA Jet Propulsion Laboratories, which promises the potential of clearing blocked arteries without surgery. This significant scientific advancement was announced in the New York Times Science section, as well as on television. To bring these new technologies to clinical applications, the Medical Center is developing a Surgical Laser Laboratory.

The specialized Center of Research in Ischemic Heart Disease, a multi-disciplinary program now in its third consecutive grant renewal, by virtue of its size, scope, and accomplishment, constitutes a major area of cardiology research at the Medical Center.

The recent refinement at Cedars-Sinai of a miniature color TV camera in conjunction with endoscopic procedures promises to enhance dramatically the use of television endoscopy in viewing bile ducts, bloods vessels, and other body structures.

The excellence of research at Cedars-Sinai Medical Center is reflected in the large amount of research monies awarded to research specialists at the Medical Center: The Medical Center receives approximately $6 million annually in support of its research activities, from Federal, state, corporate, and foundation sources. The National Institutes of Health account for two-thirds of these monies. Additional private contributions are directed toward specific research projects, as designated by the donor(s).

Another testimony to the quality of research at Cedars-Sinai is that techniques and treatments developed here are often subsequently implemented by the medical community worldwide.

SPECIAL EQUIPMENT

As a major tertiary care and referral center, Cedars-Sinai upholds a primary objective to acquire and maintain state-of-the-art technology. Intensive Care Units in medicine, surgery, pulmonary therapy, cardiology, pediatrics, and neonatology provide highly sophisticated equipment for all possible medical situations in these area.

The development of specialized treatment centers at the Medical Center further enhances its technological capabilities. For instance, the most advanced medical equipment for treatment and surgery of eye conditions is available in the Ellis Eye Center, including the argon and Nd:Yag laser. Again, in conjunction with the opening of the Comprehensive Cancer Center, the entire Department of Radiology is being renovated and refurbished, with major equipment acquisitions; among these is an additional linear accelerator.

In cardiology and thoracic and cardiovascular surgery, Cedars-Sinai offers among the most sophisticated and extensive equipment in the nation: The increasing complexity and growth of invasive cardiology is resulting in renovation of two catheterization laboratories and purchase of single plane as well as bi-plane equipment. Completion of the renovations will provide two new laboratories as well as one existing laboratory. In the non-invasive laboratory, the addition of Doppler Echocardiology treatment module maintains a state of the art capability in Echocardiology. The opening of the Regional Arrhythmia Center ensures that the latest equipment and drugs in the treatment of disturbances of cardiac rhythms are used here.

In the Department of Surgery, application of the latest, most efficient, and precise equipment -- such as Carbon Dioxide laser and television endoscopy for a range of procedures -- goes hand in hand with basic and clinical research.

This year (1986), Cedars-Sinai will receive an Extracorporeal Shockwave Lithotriptor (commonly known as a kidney stone crusher) for noninvasive treatment of kidney stones.)

In the Department of Diagnostic Radiology procedures are performed in the following subspecialties: CT/ultrasound, neuroradiology, gastrointestinal radiology, mammography, pulmonary radiology and ultrasound, musculoskeletal radiology, pediatric radiology, uroradiology, angiography, and interventional radiology. In Nuclear medicine the most modern equipment is used for visualization of body function through use of cameras, scanners, and radioisotopes.. Cameras and scanners are used in combinations with computer analysis, making important contributions in nuclear cardiology, pulmonary medicine, endocrinology and oncology. Equipment is continually updated and the department is exceptionally active, particularly because the Nuclear Scanner and is available at only one other hospital on the West Coast. The General Electric Signa Magnetic Resonance Imaging Unit with a 1.5 Tesla magnet was installed in 1985, with the ability to carry out the most precise scanning of all body systems.

STATISTICS**

Number of licensed beds: 1201
Bassinets: 60

Average Number of Patients (Daily Basis): 658 (excluding newborns)

Patient Admissions:
Adults:
Children:
Total: 38,346 (This figure excludes newborns)

Bed Occupancy Rate: 73.41%

Ambulatory Care (Outpatient) Center Visits: 27,608

Emergency Room Visits: 106 daily average (38,859 annual)

Surgical Procedures: 18,665 annual visits

GOVERNOR PETE WILSON

PR94:296

GOVERNOR WILSON ANNOUNCES LOWER HEALTH INSURANCE RATES FOR SMALL BUSINESSES IN CALIFORNIA

FOR IMMEDIATE RELEASE
March 22, 1994

CONTACT: Sean Walsh
Paul Kranhold
(916) 445-4571
Lisa Bierer
(213) 897-0322

SACRAMENTO -- Governor Pete Wilson today announced that the nation's first voluntary health alliance has reduced its health insurance rates 6.3% for small businesses and the decrease is expected to save companies participating in the program more than $3.2 million this year.

"With HIPC, we have created a sort of "Price Club" for health care insurance," Wilson said. "We've brought small businesses together in a purchasing pool that allows them to buy better and less expensive health care."

The Health Insurance Plan of California (HIPC), which was instituted by the Wilson Administration in July of 1993, allows small businesses to pool their health insurance policies to obtain the lower rates that are typically offered to companies with large numbers of employees. Under the HIPC Alliance, businesses with between 3 and 50 employees may participate. HIPC now serves more than 44,000 employees at 2500 businesses throughout the state.

The new rates, which take effect July 1, 1994 offer health coverage from 23 of the state's best health plans, including three newcomers to the alliance: Metlife, Omni Health Plans and PacifiCare.

Wilson pointed to one small company, Cornerstone Metrology, which could not afford to offer health insurance to its seven employees at the $3000 per month it was quoted for a single policy. Under the HIPC plan, the companies rates are $789 per month.

HIPC rates have been up to 23% lower than those in the CALPERS system, which is widely considered to have among the most competitive rates in the market. CALPERS rates have decreased 1.1% this year.

-more-

"Unlike some of the plans being debated in Washington, HIPC imposes no cost on taxpayers and no job killing mandates on small businesses," Wilson said. "Once again, when it comes to helping small businesses compete and create jobs, California is leading the way."

Under the new HIPC rates released today, participating companies located in northern California will see a rate reduction of 2.72%. Companies in the central state will see rates decline 5.61%. Region 3, which includes the San Francisco Bay area will see a decrease of 6.06%. The central coast rates including Orange County will decline 7.74% and the inland empire rates will go down by 6.24%.

The largest decrease will take place in Los Angeles County, where rates will drop by 7.94%

-30-

THE HEALTH INSURANCE PLAN OF CALIFORNIA (The HIPC)
BACKGROUND INFORMATION

- The Health Insurance Plan of California (known as "the HIPC") was created as part of small group health insurance reform legislation AB 1672. The HIPC began operation on July 1, 1993, and already has 44,000 enrollees.

- The HIPC is administered by an appointed bipartisan board which establishes program rules, negotiates contracts with health plans, directs marketing efforts and monitors contractor compliance. The board contracts with a private entity, Employers Health Insurance, to administer enrollment, collect premiums and provide marketing assistance.

- The HIPC is a purchasing cooperative through which eligible small employers may purchase a basic health benefit package for their employees. Health plans have the option of selling their products through the HIPC or directly to small businesses, or both.

- Currently, employer groups of 5-50 full-time employees (at least 30 hours per week) may purchase the basic health benefit package through the HIPC if at least 70% of employees participate and the employer pays at least 50% of the premium cost of the lowest-priced plan in the area. The size requirement will drop to 4-50 on July 1, 1994 and to 3-50 on July 1, 1995.

- The average employer in the HIPC has 10 full-time employees and the average employer contribution is 80%. Over 20% of the employers enrolled in the HIPC were previously uninsured.

- The benefits package includes hospitalization, physician care, prescription drugs and medical equipment. Employees have a choice of cost-sharing -- HMO coverage with a $5 or $15 copayment or PPO coverage with a $250 or $500 deductible.

- Agents and brokers are required to provide small businesses with information on all health plan options. Agents and brokers who sell products offered through the HIPC are compensated according to a fee schedule. Over 70% of employers who purchase coverage through the HIPC utilize an agent or broker.

- Other small group health insurance market reforms contained in AB 1672 include:

  Guaranteed Issue and Renewability of All Small Group Insurance Products -- Maximum Waiting Period of 6 Months for Preexisting Condition.

  Restrictions on Premium Rate Increases and Premium Rate Disparities Between High Risk and Low Risk Groups.

CLINTON'S REMARKS
CA MEDICAL SOCIETY

LA Times 3-25-94

Clinton Builds Bridges With Doctors

■ **Health:** Physicians at Anaheim convention quickly warm to President, who addressed group via satellite. Clinton appears to be in sync with them on key issues.

By DOUGLAS P. SHUIT
TIMES STAFF WRITER

ANAHEIM—President Clinton did some long-distance wooing of doctors Wednesday at the California Medical Assn. convention in Anaheim, asking for their support for his health reform proposals and fielding questions via a live satellite hookup from the White House.

Clinton's address began and ended with standing ovations from the crowd of 800 conventioneers—450 of them physicians—who gathered at the Disneyland Hotel to listen to the President.

Many of the physicians went to the event cool to the Clinton plan because it would place key health care decisions in the hands of large, impersonal purchasing alliances that they fear would place distance between doctor and patient.

But Clinton, whose image appeared on two movie-theater-size screens, warmed up the room quickly as he appeared to be clearly in sync with the doctors on key issues.

The physicians demonstrated their approval as the President called for limits on the power of the insurance industry, a longtime political foe of the CMA. He also told the doctors that he favors relaxing anti-trust regulations that prevent them from joining together to sell their services. Perhaps welcomed most were his repeated pledges that he believes Americans should have the maximum amount of flexibility in choosing their doctors.

The convention delegates adjourned without taking a position on the Clinton plan, but the closed-circuit television appearance seemed to accomplish some important fence-mending.

Before the speech, Dr. Max M. Stearns, a urologist from Oxnard, said he and many other physicians had felt left out when the President first unveiled his plan last year. But after listening to Clinton on Wednesday, he said, "I think the President did a very good job in addressing the different issues. We asked some tough questions and he didn't back down. . . . Best of all, he seemed to want to work with us," Stearns said.

Please see HEALTH, B5

HEALTH: Convention

Continued from B1

Having a common political adversary—the health insurance industry—appeared to help build some political bridges.

During opening remarks, and later during a question-and-answer session, Clinton lashed out at the insurance industry, saying he wanted to bring an end to such industry practices as refusing insurance to people with pre-existing medical conditions or raising rates excessively high because of a person's age.

"There ought to be a clear outlawing of insurance practices which have caused so much misery and caused so many Americans to fall between the cracks [of the health system]," he said in one of several comments that won him spontaneous applause from the conventioneers.

As if the doctors had to be reminded, Clinton noted: "Insurance companies set your fees. They second-guess your clinical decisions. More and more they make you get prior approval from someone who's thousands of miles away and has never seen your patient and doesn't have a clue about what ought to be done."

Dr. David Holley, president of the CMA, told Clinton that the insurance industry spent millions to defeat Proposition 166, a CMA-backed universal health insurance initiative in 1992 that featured many of the same features of the President's health reform plan.

"We had Harry and Louise opposing us when they were only engaged," Holley cracked, referring to a yuppie married couple featured in television commercials being used by the health insurance industry to raise questions about Clinton's health plan.

Danielle Walters, a spokeswoman for the CMA, said opposition by the insurance industry to Clinton's health plan "is the same thing we went through with Proposition 166."

Walters said the state association would take no formal position on the Clinton plan until a clear version of the bill emerges from Congress.

"Everything now is in a state of flux, with a lot of the key details still to be worked out," she said.

Although Clinton clearly appeared to be close to the physicians on many issues, the President refused to back down on others. For example, he would not endorse a national cap on pain-and-suffering awards in malpractice suits similar to a cap in effect in California.

"We didn't want the whole health care plan to come a cropper on the debate over tort reform," he said.

At another point, Clinton charmed the audience when, responding to a question by Dr. Rene H. Bravo, a pediatrician from San Luis Obispo, he said, "I want to say, Bravo is a wonderful name for a pediatrician."

BC-CLINTON-MEDICAL-1
Remarks by President to California Medical Association via Satellite (1 of 5) To: National Desk, Health Care Writer
Contact: White House Office of the Press Secretary, 202-456-2100
Old Executive Office Building
11:47 A.M. EST

THE PRESIDENT: Thank you very much. Thank you, Dr. Holley for that kind introduction, and for your good work and the good work of all the physicians whom you represent now in dealing with these very difficult and complex and profoundly important issues.

I regret not being able to join you in person today, but I am glad that Ira Magaziner is able to be there with you. I'm glad I had a chance to visit with you, Dr. Holley, and your past president, Dr. Richard Corlin, in Washington recently, following another health care forum. And I'm grateful for many reasons for your continued good counsel and for this invitation to address you.

Each of you has, in the most personal way, been part of the excellence in American medicine simply by caring for the families in your communities. And I'm grateful that you understand that our health care system needs dramatic reform. You know, costs are rising too fast, that paperwork is mounting too much, that every day more constraints are placed on your patients and your ability to practice medicine the way you know it should be practiced.

But unlike so many others in the debate who will only tell us what they don't want to change, long ago you left the sidelines and became advocates for responsible, comprehensive reforms. I appreciate the early and continued support you have shown for the objectives we are trying to achieve -- providing Americans guaranteed private insurance; preserving the right of everyone to choose his or her own doctor and their own health care plans; outlawing unfair insurance practices; protecting and strengthening Medicare; and linking these health benefits to the workplace, where most people get their insurance today.

These reforms are entirely consistent with many of the things that you have tried to do in California. Your health care providers have been innovators in improving quality and controlling costs and, judging from today's headlines, the new California purchasing pool is certainly a step in the right direction --offering consumers a wide choice of plans, a comprehensive benefit package and lower rates. That kind of competition between insurers, combined with more choices for consumers is what my plan is all about.

At a national level, I think the first step we must take is clear. The best way to preserve what's right about our health care system is to guarantee private insurance to every American.

That's the foundation of our health reform plan. We'll provide every American with a health security card that will guarantee them a comprehensive package of benefits that can never be taken away. The benefits will include, for the first time for many Americans, prescription drugs and preventive care. All of you know that the best way to keep people healthy is to promote wellness in addition to treating sickness. Retaining choice of doctors and health plans is also critically important to Americans and to American medicine. And this, too, is central to our approach.

Today, only about half American employers offer their employees more than two choices of insurance plans; 90 percent of the businesses that have 25 workers or less offer no choice at all. And even for those who have some choice today, there's no guarantee they'll have it tomorrow if they change jobs or lose their job or if their employer has difficulty meeting the costs. This is a tremendous restraint on most Americans.

My proposal will guarantee the great majority of Americans far more choice of both doctors and insurance plans than they have now. Under this approach people will be able to join a traditional fee-for-service plan, a network plan, or a plan sponsored by a health maintenance organization. But in all cases it will be families, not employers or insurance companies, that make the health care choices.

The people who are telling you we don't offer enough choice, which is clearly not so on its face, are the same who for decades have been pushing you out of the way and limiting your choices. You don't believe their arguments and neither do we.

That's why among other things we're going to insist upon different insurance practices -- no more preexisting conditions, no more lifetime limits, no more higher rates for those who have had someone in their family sick or those who are older. No more overcharging of small employers or dropping them because one person in the workplace has a medical problem. No more avoiding people that might cost some money.

The fact is, increasingly insurance companies set your fees. They second-guess your clinical decisions. More and more they make you get prior approval from someone who's thousands of miles away who's never seen your patient and doesn't have a clue about what really ought to be done. They all pay according to their own fee schedules, requiring different forms for different people under different circumstances. The forms are drowning the health care system in paper.

I have a doctor friend who calls me about every three months to tell me another horror story. Recently he told me we've got all these people doing paperwork. Now we've hired somebody who doesn't even fill out forms, just spends all day on the telephone beating up on the insurance companies about the forms we've already sent in. He's told me, he said, I went to medical school to practice medicine, but I'm getting lost in the fun house instead.

Well, he's right, and I know a lot of you agree with him and identify with that story. But this year we can escape that fun house.

The fourth element of our approach is to preserve and protect Medicare. Older Americans will continue to choose their doctor and their plan; and, in addition, we want to cover prescription drugs under Medicare; and provide new options for long- term care in the home and community, which most people prefer and which will become increasingly important as our population continues to age rapidly.

Finally, let me say again, we should guarantee these health benefits at work -- that's how most people are insured now. And eight of 10 uninsured Americans have a family member who works. This is the fairest and most efficient approach to covering everyone. And so no one gets hurt by the needed reforms -- we'll provide discounts for small businesses and breaks for self-employed people and their families.

This is the proposal; it's pretty straightforward. All Americans will get a card that guarantees with it the security of private insurance and comprehensive benefits; then they can pick the doctor they want. They'll know that they're always covered by what is said to be covered, and it won't be subject to change by anyone.

Before taking your questions, now, let me again just express my deep thanks for your continued support and encouragement. After 60 years, I think this is the year we're going to provide every American health security that can't be taken away. I'm optimistic because of what's already been done. This Congress has been willing to act and to work with me to pass an economic plan that's helped to produce low interest rates and highF low F inflation and more than two million new jobs. After seven years, this Congress passed and I signed the Brady Bill and the Family and Medical Leave Bill -- things that people had given up on getting done.

The point is not that we have been able to do so much, but that is evidence that we can still do what we have to do. The American people have demanded that we make a great deal happen. They want their dreams back, and they want this problem fixed. A big part of the American Dream has always been knowing that you can care for your children or your family if they become sick -- that's what you do. You're a part of every American family's dream. I've seen the magic you perform all over the country. You care, and the American people know it. And our challenge now is to do everything possible to keep and protect the bond that you've worked a lifetime to establish. Our challenge is to provide every American health care that's always there. With your help, we can do that and we can make history.

I thank you for the leadership you've already shown. And if you have questions, I'll be glad to try to answer them. Thank you very much. (Applause.)

Q Thank you, Mr. President. I wonder if you have a contract with Coca-Cola. (Laughter.)

THE PRESIDENT: I forgot to put it in a cup. (Laughter.) There goes my Pepsi voters. (Laughter.)

Q Well, Mr. President, as you acknowledged, the California Medical Association has been deeply involved working for health system reform. You know, I think you have to realize that we had Harry and Louise opposing us when they were only engaged. (Laughter.)

The members of this house, representing 40,000 practicing California physicians are vitally concerned about what is contained in any proposal for health system reform. We will, after all, be caring for our patients within whatever structure is created by those changes. We want to be as certain as possible that it's going to work.

We have some questions for you that will address some of those physician concerns. And I'm going to take the opportunity to ask the first one.

Mr. President, in your State of the Union Address, you said that you would sign a health reform bill if it met the test of universal coverage. In addition to universal coverage, what other elements do you believe critical to a reform package, and what must be included to secure your signature?

THE PRESIDENT: Well, I want to be very careful about how I answer that because I don't want to be throwing down gauntlets that may mean more than I wish to say. But let me say, to have a system that works, you not only have to have universal coverage, but it seems to me that the benefits ought to include primary and preventive care. There ought to be a comprehensive set of benefits.

Then there ought to be a clear outlawing of insurance practices which have cost so much misery and cost so many Americans to fall between the crack. I think there should be an end to lifetime limits. (Applause.) I think there should be an end to preexisting conditions. I think there ought to be an end to discriminatory rate-setting based on age.

In order to do this I think we have to find some way of not only legislating community rating but actually having community rating. And we need a device that guarantees that small businesses and self-employed people will have access to insurance at competitive rates with people who are insured through big business and government. I think that's very, very important. So these are the things that I think are critical.

Now, if you're going to cover everybody, you have to either do it through a tax or through some device by which people pay into an insurance pool. I think the employer mandate, so-called, in the best way to do it by providing guaranteed private insurance at the workplace because that's the way most Americans get their insurance today.

I know there are some small businesses for whom this would create difficulties, so we developed a system of small business discounts paid for from tax proceeds. And the taxpayers would pay to cover those who are unemployed and uninsured. That's basically the way I think the system would have to work.

There are lots of other things I think ought to be in it, but I think it's very important for the President in the middle of a congressional process that is just not getting its sea legs and getting underway, not to be too specific in talking about vetoes.

If we can begin with a good comprehensive system of universal coverage, we can go a long way to dealing with a lot of the other problems.

As you know, my plan does deal with a number of your concerns, and I know you have more questions on that, so maybe we should get to the other questions.

Q Well, thank you very much, Mr. President. You're now going to have an opportunity to field questions from a group of pretty nervous California physicians.

Q Thank you. Good morning, Mr. President. I'm a family physician in San Bernadino. I have a unique opportunity here to ask you a question, particularly because I was a graduate from the University of Arkansas for Medical Sciences.

THE PRESIDENT: Good for you.

Q Thank you very much. (Laughter.) And I had an opportunity to campaign for you in 1982 when you made your comeback election for the governorship. So what I would like to ask you, Mr. President, is that physicians are concerned that in the current marketplace and under your proposed model, insurers and businesses are encouraged to collectively purchase health care services. However, antitrust laws prohibit physicians from collectively selling their services. It's like requiring individual autoworkers to negotiate their salaries separately with General Motors.

In light of the strong opposition of the Federal Trade Commission to any changes in antitrust laws, what would you propose to provide a more balanced and fair environment in which these negotiations can occur between physicians and insurers?

THE PRESIDENT: I think we have to change the antitrust laws to allow you to organize to provide your services and more comprehensive professional groups. (Applause). And let me say that one of the things that has concerned me most about this is that there is a development in American health care which I like, which has a consequence that I don't like.

What I like, the fact that people are getting together in competitive buying groups and trying to get a better deal and trying to squeeze some of the excess cost out of our system. I think we all agree there are some there. I don't like the fact that an inevitable consequence of that has been that so many Americans have lost the right to choose their own doctor. We try to address this -- (applause) -- we try to address this in two ways, one of which directly addresses your question. But let me try to put the two ways together so they'll fit.

Under our plan, each American consumer, once a year, would have the right to choose from at least three plans -- including a fee-for-service plan, an HMO, and hopefully some sort of provider plan that will be provided by providers who get together and who may allow all doctors in a state, for example, to participate if they agree to observe the fee schedule that the plan bargains for. So, I think you ought to be able to do that. We also think that the HMOs should have to have a fee-for-service option that would allow people who are covered under the HMO the option to choose another doctor if it seemed appropriate, and if the fee-for-service option were elected at the beginning of the year, -- (applause) -- the HMO would have to contribute to that.

So I think that this will help. But I agree that there must be some changes in the antitrust laws so that you can clearly get together without fear of legal repercussions. Otherwise, you are consigned to dealing with a middle-man that will only add to the cost of your providing your services, and undermine the choice that the consumer gets. (Applause.)

Q Thank you, Mr. President.

Q Good morning, Mr. President. I'm an oncologist practicing in Redwood City in Northern California. My question is about budgets and living within our means for health care. We recognize the need for controlling health care costs -- there's no debate about that. However, we are concerned that your proposal and others may limit the rise of health care budget to the cost of living or other artificial indexes that may have little to do with actual health care costs. Rising health care costs may be more related to human factors such as our aging population, tobacco consumption, new technologies, new diseases, such as AIDS. How can these factors be taken into account when arriving, or when developing a health care budget?

THE PRESIDENT: Well, first let me say that I basically agree with you on that. I have tried not without complete success -- or not with complete success -- but I've really tried hard since I started thinking about this issue seriously four or five years ago, when I was still a governor, to identify the elements of disparity between, let's say, the 14.5 percent of their GDP that Americans spend on health care, the 10 percent

that Canadians spend, the 9 percent or less that the Germans and the Japanese spend. There's no question that a lot of it is due to good factors like we invest more in medical research and technology, and that's good. And there's no question that some of it is due to bad factors that you can't do anything about, at least in your role as a doctor, which is higher AIDS rates, higher rates of violence which lead to enormous medical costs.

What we believe is that in the beginning, at least, there are many, many savings which can accrue from a rational system -- far, far lower administrative and bureaucratic paperwork costs; significant reductions in unnecessary costs that are in the system. That after that, in the years ahead, when we measure how much costs can increase, we're not only -- consider population growth and inflation, we will also have to consider the burdens of the American system -- if the rate of AIDS, for example, continues to go up instead of going down; if the rate of violence goes up instead of going down; if the aging population imposes greater burdens rather than fewer because we don't succeed in doing a lot of the preventive things that we're going to do.

Those things will all have to be calculated in the rate at which medical costs go up. We can't ignore real-world factors that make the CPI and health care different from the overall rate of inflation. And I think those things should be taken into account. (Applause.)

Q Thank you, Mr. President.

Q Good morning, Mr. President.

THE PRESIDENT: Good morning, sir.

Q I'm a pediatrician from San Luis Obispo. My question to you this morning relates to the power of insurance companies. Yourself, Mrs. Clinton and Mr. Magaziner have repeatedly stated that one of your goals is to return the control of medical practice back to physicians and hospitals. We obviously agree with that. Unfortunately, however, many of the current managed care plans in California are moving away from that goal.

Mr. President, does your plan contain features which would achieve that goal?

THE PRESIDENT: It does. I think there are some that would help indirectly, and one or two that would help directly. Let me just mention them.

First, giving every consumer three choices will make a big difference -- saying that every consumer has to have at least three choices and that one of those choices must always be fee-for- service. We'll put all these plans in competition with one another, and that will make a difference.

Secondly, making it easier for physicians to provide these services directly will dramatically minimize the ability of the insurance companies to add to the cost and delay and undermine the quality of health care by second-guessing everything the doctors want to do in the HMOs that they're promoting --

(gap in satellite feed)

-- in our plan that the insurance companies disclose what's in their utilization review protocol in advance so people can evaluate that and know what's going on and argue against it. And competing plans, including competing physicians groups can say, here's why this is a bad deal for you and why you shouldn't take it; and why it is going to add to the cost and undermine the quality of health care.

Now, all these are things, I think, that will really make a difference. Most doctors I know recognize that from time to time, there are certain things that ought to be subject to some kind of review. But, basically, it's gone crazy now. It's become an

instrument of denying service when it's needed. (Applause.) So what we've tried to do is strike the right balance here, and I hope we have. (Applause.)

Q Thank you, Mr. President.

THE PRESIDENT: I must say that Bravo is a wonderful name for a pediatrician to have. (Laughter.)

A lot of times you can just say that to your kids and they'll get better. (Laughter.)

Q Mr. President, I think the medical profession really believes that that issue is so important that if we win everything else but lose on that one, none of the other matters.

THE PRESIDENT: It's absolutely clear to me that the whole HMO movement has taken the utilization review to an extreme, and that it has to be backed off of. Forget about the HMO, just the whole insurance -- it's the insurance companies that are driving this. And I think the more we can put doctors into the management decisions of the HMO, and the more choice we can give to the people who themselves will be patients, who have personal contact with their doctors -- keep in mind, this is a huge deal, letting the employees themselves make this choice instead of their employers, means that somebody will be choosing; every plan will be chosen by someone who has had a personal relationship with a physician who has doubtless discussed this with him or her. I mean, that's going to make a big difference in this.

And I agree with you, it's a very important issue. (Applause.)

Q Good morning, Mr. President. I am a trauma surgeon in San Bernadino, California. Medical malpractice concerns and the practice of defensive medicine are serious issues associated with the -- (inaudible) -- of care to the trauma patient. Mr. President, we are very pleased that you believe that the tort reform should be an essential part of the health care reform, and have adopted some of -- (inaudible) -- provisions in your plan. But, sir, would you be willing to add to your plan the most essential part of the -- (inaudible) -- that is, a $250,000 cap on noneconomic damages? And, sir, if you just say yes, I would be happy. (Laughter and applause.)

THE PRESIDENT: As you might imagine, we debated that thing for a long time before we presented our plan to the Congress, because we didn't want the whole health care plan to come a cropper on a debate over tort reform. We thought there had to be some. We knew that the states were taking up this issue to some extent, but we thought we ought to do something nationally, even though tort law historically has been completely within the purview of state government, not the national government. So we agreed that there ought to be a limitation on lawyer fees -- contingency fees. And we did some other things that were recommended by you and were in the model work that was done in California.

Something else we did that I think has been insufficiently noticed is we agreed to include medical practice guidelines developed by professional groups as raising a presumption that there was no negligence on the part of doctors. This offers an enormous opportunity to dramatically reduce the number of medical malpractice suits, the number of recoveries, and therefore the malpractice rates.

My own view is that based on the research I've seen in a couple of places where this has been tried on a limited basis is it may offer the best hope of all of protecting doctors from frivolous lawsuits by simply raising a presumption that the doctor was not negligent if the practice guidelines developed by the professional groups themselves were in fact followed.

So I think that that has been not sufficiently noticed. That is a very, very big step, in addition to the other things I mentioned.

My own judgment is that we will not include the national cap because there will be so much difference among the various congressional delegations from different states about what the caps should be and whether it should change with inflation over time. And in fact you might wind up in California with a situation different from the one you have now if it were to be done. For example, if there were a debate on the national cap, then the immediate thing would be, what should the cap be; and if states have a lower one, should it be required to be raised. Because all those things were involved, we decided that we would leave the cap issue itself to state law and deal with these other matters.

I urge you to look at what we have done, because I think we've taken a long step toward trying to relieve doctors of the burden of frivolous lawsuits and trying to control the cost of malpractice insurance.

Q Thank you, sir. (Applause.)

Q Good morning, Mr. President. I'm a practicing family physician in Modesto, California. I'm also the current California Academy of Family Physicians president and past president of the Stanislaus County Medical Society.

Mr. President, when I entered medical school, I was led to believe that I would spend my career practicing health care. I find that an enormous part of my day is spent battling with health insurance clerks to get authorization for my patients to have some of the even most basic of health care.

Obviously, it would be better for me to spend that time seeing patients. What will your plan do to prevent or to limit the use of these managed health care organizations from providing these -- or throwing up these artificial barriers in the name of managed care; but in reality these things prevent us from providing that care?

THE PRESIDENT: Let me try to restate what I said before. I believe that the micromanagement of medicine by insurance companies has reached an excessive point. And what we have tried to do to reduce it, since we can't -- you don't want the federal government exactly passing laws saying what decisions can or cannot be made by physicians and others working with them. What we've tried to do is to change the whole system so that it would be much less likely.

And I will mention two things again. Number one, we make it easier for people like you to join with like-minded physicians in providing services directly or to join together and to tell people if you're going to work with them, you don't want those kinds of utilization reviews. And we require the insurance companies to disclose their utilization review protocols in advance. And they will be under much more pressure than they are now because now they won't have the same shot at Business XYZ's employees because the employees themselves will be deciding whether they want an HMO, do they want a PPO, do they want some other kind of organization; or do they want to have fee-for-service medicine. Under each case the employers liability is the same -- responsibility is the same. So I think that we are changing the environment in ways that will really permit you to cut down, working with your fellow physicians and your patients to cut down dramatically on the number of these abuses.

I also want to point out that if there is a single card which we envision which entitles a person to health care and which enables them to hook into a computer which says that they are covered and all of that, and if there is a single form related to the comprehensive benefit package which can be filled out in every doctor's office and hospital in the country and then processed by every insurance company in the country, then that is going to dramatically reduce the paperwork burden, too. I have many, many doctors complain to me that the time they have to spend and the money they have to spend in their clinics on post facto paperwork has exploded in recent years. And I think that is also very important -- cutting down on that burden, not only the time, but the money is critically important. So I believe that we will make it better.

If you have further suggestions, I'd be glad to hear them. But this is an area in which it is difficult to legislate directly and in which many physicians are reluctant to have us legislate directly. It seems to me if you change the economics and change the distribution of the power of decisionmaking in this whole process, giving more to the doctors and to patients through the workplace and less to the insurance companies, that the practices will inevitably change because the shift of decisionmaking has occurred.

Q Thank you very much. (Applause.)

Mr. President, we know that your time is very tight, if you could spare us a few minutes, we have some other questions that we would hope to be able to put before you.

THE PRESIDENT: Please do because I know we've got one or two other issues that I think should be dealt with.

Q Mr. President, I practice anesthesiology in San Diego. And I want to thank you for the opportunity to ask you a question today. Two years ago, right here in California in this state with the support of this organization, we passed a law that created voluntary health insurance purchasing cooperatives. In fact, you just alluded to them a few moments ago. And as you said they so far have been enormously successful, both in extending access and in eliminating costs.

My concern is that there are some reform proposals that would cause these purchasing pools or alliances to become so large and thus so inflexible that they would in fact limit rather than enhance the competition that you yourself state, and I agree with you, that we want to see in the marketplace. So to make these entities work the way I think we both wish them to -- the alliances and the purchasing pools -- I believe that we need to limit their size. So my question for you this morning is what would you propose to control the size of the purchasing pools and alliances so that they would fulfill their primary purpose of providing affordable, accessible care and not become a large, inflexible bureaucracy?

THE PRESIDENT: Well, let me first say that I agree that we shouldn't have them become large, inflexible bureaucracies. Under our plan, the alliances would be much larger and the membership would be mandatory. But that's because we're trying to achieve something with our plan that is beyond what the alliances do. Now this is -- I think it will all be debated in the Congress, and I'm certainly flexible on it.

But let me explain why we recommended larger alliances and offer you, not just you individually, sir, but your group there the opportunity to suggest to me -- either to Ira Magaziner who's

there or to us through a letter later -- how we could achieve the same objective. Because I know a lot of people say, well these alliances are too big or the work units -- you don't people with several thousand employees in them. And at one level, I think that's right, but at another level, I'm not sure -- and let me explain why.

The purchasing coop that you have in California which has worked real well is designed primarily to give small businesses bargaining power so that they can, in effect have the same access to health care at the same cost that people in large units like big corporations and government do. You can do that with smaller alliances -- let's say with people with a few hundred employees or 100 or whatever it is in California -- 50 and down; you can do that.

The same thing is now happening in Florida where they're seeing these results.

What we wanted to do with the alliances were three other things that it still seems have to be done somehow under the plan. First of all, through the alliances, we were going to distribute the small business discounts. We can find another way to do that, but that was going to be done.

Secondly, we were going to provide certain handling services basically for to bring together and reduce the paperwork burdens of the physicians, the employers and the insurance companies. We were going to do a lot of the paperwork there. That can probably be done some other place.

The other thing, though, which I think is very important and which all of you clapped when I mentioned earlier, is the alliances as large units were going to be used to make it financially possible for the insurance companies to observe community ratings. And I'd like to talk about that a minute.

There are two issues here on discriminatory rates. One is, how do you get small businesses and self-employed people access to the same rate structure presently available to big business and government? The other is, how do you, as a practical matter , eliminate unfair billing practices without bankrupting the insurance companies that are still in the market? That is, how do you eliminate preexisting conditions? How can you afford to do away with lifetime limits?

How can you eliminate rate discrimination against people with preexisting conditions in their families, or against workers who are older at a time when older workers are having to change jobs a lot in their life, too?

Now, you can pass a law and say, we'll have community rating. But New York did that and yet they still don't have it. And the reason is, they don't have any mechanism within which community rating can be practically made to work in a state where you have a lot of different insurance companies and the insurance companies simply cannot solvently -- can't stay solvent and do that unless people are insured in very large pools where insurance companies can make money the way grocery stores do -- a little bit of money on a lot of people.

So the fundamental difference in what California has done, which is very good, and what we are seeking to achieve is that I'm not sure that unless we have everybody below a certain substantial size in one of these alliances, we can achieve community rating. We can get better breaks within the present system for small businesses, but I am not sure we can get community rating. That's the rub. If we can solve that, I'm very flexible on the rest of this. I mean, I'm just trying to achieve an objective that we all agree is necessary. (Applause.)

Q Mr. President, I practice emergency medicine in inner-city Los Angeles. Every day I see the impact of undocumented immigrants on our health care system. Mr. President, I'm grateful to you for making health system reform a top national priority. Your proposal provides health security for all citizens and $1 billion dollars to cover noncitizens.

However, in some of California's largest counties, up to 25 percent of the population are noncitizens, both legal and undocumented. Currently, federal law and our own ethics as physicians require that we provide care. But the reality is that these costs are putting an enormous strain on our state's health care delivery system and the entire California economy. We are spending close to $1 billion dollars in Los Angeles County alone to deliver health care to undocumented immigrants. How do you feel we can better address this problem?

THE PRESIDENT: It's a difficult one, as you know. Let me make a couple of observations, and then say where I think we are practically.

Obviously, no state or local government should be required to shoulder the cost of immigration, or the lack of an immigration policy, or the inability to enforce the policy we have now at the national levels. But as a practical matter, as we all know, it happens all the time. Now, in my last two budgets, I have tried to provide more funds to California, especially in the areas of health and education for dealing with the extra costs of immigration; because I think it's not your fault.

Now, in this health care plan, we provide a billion dollars in extra money. Is it enough? Of course it's not; but it's a good step in the right direction. Let me say that if you look at the states with the big immigrant health care burden -- California, Florida, Texas, New York -- although there are five or six others with substantial burdens, as well -- our plan will save the states enormous amounts of money that they would have paid otherwise in out- of-pocket Medicaid match costs, long-term care costs and other health related costs related to running public health facilities, for example. In other words, our plan -- we estimate that California will save, if our plan goes into effect in 1996, or we begin to put it into effect in 1996, phasing it in, we estimate California will save about $6 billion or more between that year and the end of the decade -- new money that would not have been there otherwise in this budget. That will also allow the state to divert some of those resources to health care as well as to dealing with some of your long-deferred education and other problems out there.

So I believe that, between the savings that will occur from the state of California and the funds that we can put into immigrant health care -- migrant health care -- directly, I think that will make a big difference. Now, let me say, this fund will start at a billion dollars, but obviously, based on the evidence and based on our ability to secure savings in other aspects of the system, Congress will be free to supplement this fund every year from now on. That's where we're going to start.

I realize it doesn't solve the whole problem. I think it's frankly all we can afford to do at the moment. And I think the savings which will flow to the state from passing this plan, will be so great that they in turn will be able to do more and still have money left over to address other needs of Californians. So I hope they'll stick with it, because I think it's the best we can do right now.

Q Mr. President, you really need to know that over half the hospitals in California are currently operating in the red. It is an urgent problem, and I hope that the solution to the problem would not be tied to the whole health system reform.

Thank you. (Applause.)

THE PRESIDENT: I certainly agree with that.

Let me just say one other thing -- I agree that we cannot hold this problem hostage to health care. We're just trying to use the health care reform which will free up billions of dollars to put more into medical research, more into undocumented alien health care, and other things. But I agree that we have to deal with it.

Q Thank you, Mr. President. Do you time for one last question?

THE PRESIDENT: Sure.

Q Thank you very much, Mr. President. I practice internal medicine in Los Angeles. I also drink Diet Coke. And I'm delighted to be here this morning as President of the California Hispanic American Medical Association.

Mr. President, in California, our managed care system has evolved from what started as a not-for-profit market into one which today is dominated by a large for-profit publicly traded HMOs. This evolution has also caused the profits and administrative costs of these HMOs to soar, while health care services to patients has plummeted. While the CEOs of these corporations make millions, I have to argue with these same companies who insure my patients to approve immunizations, pap smears and mammograms. The CMA is sponsoring legislation in California to limit the administrative costs and profits of these companies.

How do you feel about this situation, and how would your plan protect other states from this trend?

THE PRESIDENT: In two or three ways. First of all, under our plan those plans will have to offer pap smears, mammograms and other preventive and primary services. They won't be able to cut them out.

Secondly, these companies will be under much more pressure to provide quality service and to siphon less money off to bureaucracy and profits than they are now because they won't be able to make a deal with employers which can then be enforced on employees. Every employee -- that is, every patient you see will be able to a make a new choice of plan every year. So if they get abused in year one, then in year two, the next year, they'll be able to make the same choice they made last year all over again, and choose a different plan, or fee-for-service medicine, or a group of physicians who are providing health care.

So this will fundamentally change the whole incentives of the system. They simply will not be able to use the fact that they have a preexisting relationship with an employer to undermine the delivery of quality of care between the doctor and the patient, because the patient will be a making a decision and every year can make another decision. And that will have a profound impact on it. And they will not be able to eliminate primary and preventive services from their package. That has to be involved. So that's going to change it.

Then we will make -- when we make some of the changes in the antitrust laws, which will make it even easier for physicians to get together and deliver health care directly. So these HMOs are going to be under a whole different kind of competition.

It won't be competition from somebody else providing less service at lower costs; it will be competition from somebody else providing more services and higher quality with more choices for the same costs, or sometimes less.

So I think this will really change things and put you and your patients much more in the driver's seat than you are now. That's perhaps the most critical element of my plan that has not been really noted. We are not restricting choice, we're expanding it. And we're putting the decision -- we're moving the decision from the employer to the employee about who makes the choice, which means you're moving it to the patient and that should be, I think, something that will make a profound difference -- particularly after you all get through talking to all them. (Applause.)

Q Mr. President, everyone is this room and all the people we represent would like to thank you for taking the time from your busy schedule to meet with us today. We want you to know that we're with you in this fight and we'll join with you in working with Congress in a joint effort to guarantee all Americans private health insurance that can never be taken away.

THE PRESIDENT: Thank you. And let me just say in closing if I could ask you one thing it would be to impress upon the Congress the importance of acting and acting this year. This is a very complex issue. No one has all the answers. We'll be improving on what we do from now until kingdom come. But you know more uniquely than most people do, what the consequences of not doing anything are -- and that's more restricted managed care, more people without any insurance at all, more of the headaches that you have already complained about today. So you are in a unique position to embrace the fundamental principles here -- work with me on the details and impress upon your very large congressional delegation that the time to act is now, not next year, not five years from now, but now.

Thank you very much.

Q? Thank you, Mr. President. (Applause.)

ISSUE # : THE FEDERAL ROLE IN GRADUATE MEDICAL EDUCATION

1. Federal Government's Role in Medical Education---Should it Change or Stay the Same?

   Should the government's role change from that of a financing source to a more active decision maker in:

   A. Setting the total number of residency positions available in the United States?

   B. Allocating the slots of primary care, specialty care residencies throughout the U.S.?

   C. Deciding which residency programs in different hospitals and parts of the country should be funded?

2. Should the Medicare Program Refocus Payments To Increase "Mid-Levels", Primary Care Physicians, and Non-Hospital Sites for Training?

   Should more "mid-level" training be supported by Medicare's graduate medical education dollars?

   Should Medicare's formulas for graduate medical education funding be changed to target higher payments to primary care residents versus specialty residents?

   Should non-hospital training sites be directly funded by Medicare's graduate medical education dollars?

3. Should Medicare Stay the Same, Expand or Reduce Its Expenditures on Graduate Medical Education?

   Should the Medicare dollars be reduced for graduate medical education?

   Should a new pool of private dollars be collected to fund graduate medical education? (Examples include special assessments on health plans, taxes to corporations, extra payments for health care premiums).

DRAFT

March 8, 1994

M E M O R A N D U M

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: FINANCE COMMITTEE HEARING ON GRADUATE MEDICAL EDUCATION AND THE SUPPLY OF HEALTH PROFESSIONALS ON TUESDAY, MARCH 8, 1994

Background

Today's hearing will focus specifically on the problems with graduate medical education and physician supply.

There is general agreement among medical educators and public health experts that there is an excess number of physicians overall, and a relative and absolute shortage of generalists. There is a current ratio of approximately 1:3 primary care physicians to specialists. Experts argue that this present bias towards the training and practice of specialists has led to overly expensive care, inappropriate use of costly treatment and services, and little needed attention to prevention and primary care.

The reasons for our problems are multiple and complex. But it is believed by many that at the root of the problem is the way we finance medical education, particularly graduate medical education, and the way we pay physicians.

This Committee (Finance) is particularly interested in this issue because of the large role medicare plays in providing funding.

This year medicare will spend:

$5.5 billion on Graduate Medical Education (GME)
$3.3 billion on Indirect Medical Education (IME)

Medicare GME funds have become a major source of revenue for teaching hospitals like KU. Interestingly, Federal payment policy has generally not paid for training that takes place in ambulatory settings like clinics. Many believe this is one of the reasons there is a heavy emphasis on specialty training -- because hospitals are paid for these folks but not for the family practice resident who is spending time in the community clinic.

Medicare Graduate Medical Education funding funds the direct costs of faculty salaries and student stipends. The reimbursement goes directly to the institution (hospital) and is based on their historical costs. As a result, the amount per resident varies from a low of $5,000 to a high of about $170,000 depending on where in the country they are being trained.

Medicare Indirect Medical Education money pays hospitals for the "indirect" costs they experience because of the presence of a training program. For example, more tests tend to be ordered. This payment is based on a formula and has been reduced.

The reform proposals vary dramatically in their suggestions as to how to address this issue. The Administration and McDermott are the most proscriptive -- requiring an absolute cap on the number of residencies and an absolute mix of primary care to specialty of 50/50.

The Chafee bill is the least interventionist -- and simply creates a system of voluntary demonstration programs that allow local efforts to test out solutions.

Most of the bills do provide for additional funds for the training of nurse practitioners and others. The Administration and the Breaux bills also envision creating a national medical education fund in lieu of medicare funds -- that would be made up of Federal as well as private funds to pay for medical education.

INTERESTING STATISTICS

Number of U.S. allopathic (M.D.) medical schools: 126

Number of U.S. osteopathic medical schools: 15

Number of U.S. medical school graduates this year: 17,000

Number of U.S. osteopathic school graduates: 1,700

Number of new international medical graduates in U.S.: 4,300 - 7,000

Total Number of Graduates 22,000 - 24,700

Cost of medical education est. 1993

Undergraduate: $ 5.25 billion
Graduate: $17.5 billion

Total number of residency slots: 98,000

Kansas

K.U. Medical Center

Number of residents: 342

Percentage in primary care: 34 percent (119)

Wichita

Number of residents: 246

Percentage in primary care: 50 percent (127)

University of California, Los Angeles, UCLA School of Medicine

10833 Le Conte Avenue
Los Angeles, California 90024
(310) 825-9111; 825-6373 (Dean's office); 206-5046 (FAX)

The medical school is in the UCLA Center for Health Sciences on the UCLA campus. The second oldest of the five medical schools in the University of California, it accepted its first class of medical students in 1951.

Type: public
1993-94 total enrollment: 715
Clinical facilities: UCLA Medical Center; UCLA Neuropsychiatric Hospital; Brentwood, Sepulveda, and Wadsworth VA medical centers; Cedars-Sinai Medical Center; Children's Hospital of L.A.; L.A. County hospitals: Charles R. Drew-Martin Luther King Jr. Medical Center; Harbor-UCLA Medical Center; Olive View Medical Center; St. Mary Medical Center; Freda Mohr Multiservice Center of the Jewish Family Service of L.A.; Jewish Home for the Aged of Los Angeles (Reseda); Kaiser Foundation hospitals: Panorama City, Sunset Boulevard, West Los Angeles; Woodland Hills; Kern (County) Medical Center; Northridge Hospital Foundation; Rand Corp.; Research and Education Institute; St. Francis Medical Center; Santa Monica Hospital Center; Shriners Hospital for Crippled Children; Valley Presbyterian Hospital Olmstead Memorial; Venice Family Clinic; Ventura County General Hospital.

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University of California, Los Angeles, UCLA School of Medicine: CALIFORNIA

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Wadsworth VA Medical Center

University of Southern California School of Medicine

1975 Zonal Avenue
Los Angeles, California 90033
(213) 342-1544 (Dean's office); 342-2722 (FAX)

The University of Southern California (USC) was founded in 1880 and is a private, nonprofit corporation. The School of Medicine became a division in 1885 and established its own campus in 1952 on 12 acres adjoining the Los Angeles County (LAC)-USC Medical Center, seven miles from the main university campus. All medical instruction has been conducted on the health sciences campus since 1960.

Type: private
1993-94 total enrollment: 590
Clinical facilities: Barlow Hospital, California Hospital Medical Center, Childrens Hospital of Los Angeles, Eisenhower Medical Center, Estelle Doheny Eye Foundation, Estelle Doheny Eye Hospital, Hollywood Presbyterian Medical Center, Hospital of the Good Samaritan, House Ear Institute, Huntington Memorial Hospital, Kenneth Norris Jr. Cancer Hospital and Research Institute, LAC-USC Medical Center, Orthopaedic Hospital, Presbyterian Intercommunity Hospital, Rancho Los Amigos Medical Center, Comprehensive Health Centers: Edward R. Roybal Comprehensive Health Center, El Monte Comprehensive Health Center, H. Claude Hudson Comprehensive Health Center, USC University Hospital.

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    Cardiac Surgery* . . . . . Vaughn A. Starnes, M.D.
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  Oral Surgery . . . . . John Lytle, D.D.S., M.D.
Urology . . . . . Donald G. Skinner, M.D.

*Specialty without organizational autonomy.

Charles R. Drew University of Medicine and Science

1621 East 120th Street
Los Angeles, California 90059
(213) 563-4800; 563-4974 (Dean's office); 567-4854 (FAX)

The Charles R. Drew Postgraduate Medical School was incorporated as a private, nonprofit, entity in 1966. The Martin Luther King, Jr., General Hospital, a public teaching hospital was opened in 1972. In 1987 this educational institute applied for full university accreditation with the Western Association of Schools and Colleges (WASC) and changed its name accordingly to Charles Drew University of Science and Medicine. In 1989 advancement to candidacy was granted. The medical school and hospital operate jointly as a comprehensive health center. Drew departmental chairmen are concurrently chiefs of the corresponding clinical services at King Hospital. Drew signed an expanded affiliation agreement with the University of California, Los Angeles, in July 1978 for the development of undergraduate medical education at Drew for the third and fourth years of clinical instruction leading to a joint M.D. degree. The charter class of Drew/UCLA students graduated in June 1985. In 1987 the name of the medical school was changed to the Charles R. Drew University of Medicine and Science. The hospital, Martin Luther King, Jr. Hospital, also known as King/Drew Medical Center and the university are on one geographic campus.

Type: private
1993-94 total enrollment: 96
Clinical facilities: Charles R. Drew-Martin Luther King, Jr. Medical Center, Augustus F. Hawkins Mental Health Center, UCLA Hospitals and Clinics, Harbor-UCLA Medical Center.

University Officials

President of the University	Reed V. Tuckson, M.D.
Vice President for Academic Affairs	Lewis M. King, Ph.D.
Vice President for Finance and Administration	Stanette Kennebrew
Assistant Vice President for Academic Affairs	Open

Medical School Administrative Staff

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Assistant Dean for Faculty Affairs	Ronald Edelstein, Ed.D.
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Director, Vivarium	Adeleh Esfandiari, D.V.M., Ph.D.
Hospital Administrator	Edward Renford

Charles R. Drew University of Medicine and Science: CALIFORNIA

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Emergency Medicine . . . . . William Shoemaker, M.D.
Family Medicine . . . . . Ludlow B. Creary, M.D.
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- Dermatology . . . . . A. Paul Kelly, M.D.
- Gastroenterology . . . . . Open
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- Gynecology . . . . . Edward Savage, M.D.
- Obstetrics . . . . . Teiichiro Fukushima, M.D.
- Oncology . . . . . Groesbeck Parham, M.D.
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- Reproductive Endocrinology . . . . . Bo Y. Suh, M.D.
- Residency Program . . . . . Wilburn Durousseau, M.D.
- Urogynecology . . . . . Shari Thomas, M.D.

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- Inpatient and Critical Care Services . . . . . Robert O. Christiansen, M.D.
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- Urology . . . . . Nand S. Datta, M.D.

Los Angeles County Medical Association

ANN EVANILLA
LACMA Public Affairs Officer

W. Bradford Gary
Vice President,
Government Affairs Worldwide

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2300 N Street, N.W.
Suite 600
Washington, D.C. 20037
Telephone: (202) 663-9012
FAX: (202) 663-9054
Voice Mail: (800) 669-6890
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DR. ALIZA LIFSHITZ

CALIF. HISPANIC AMERICAN
MEDICAL ASSOCIATION

Health Reporter (appears 1 time/week)
on
KMEX
UNIVISION
(largest hispanic media (TV) market
in Southern California

BULLETIN

LENO

ERATION OF HISPANIC
N MEDICAL ASSOCIATIONS

YEAR 1

ter

Facing these statistically - and alarming - proven facts, as physicians that bridge two cultures our mission and responsibility is not only to deal with their illnesses per se, but to became advocates of their plea. We must devote to raise awareness of our own people, as well

Highlighting Achievements of March Meeting of The Confederation in Los Angeles

APPOINTMENTS:

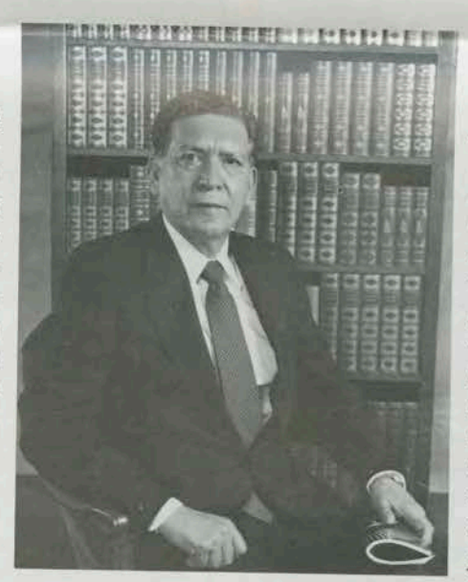
Aliza Lifshitz, MD., was appointed our representative to the A.M.A. Committee on Intemational Mcdical Graduates. Dr. Rene Rodriguez is our appointed representative for Government Affairs and he will work out of Washington DC, Mr. Louis Piccoli has the task of being our representative and liaison with the private sector, specially the

A BULLETIN
GALENO
CONFEDERATION OF HISPANIC
AMERICAN MEDICAL ASSOCIATIONS

VOLUME 2 YEAR 1

President's Letter

DEAR COLLEAGUE:



In these changing times when the reform of the Health system has brought confusion and uncertainty, it is imperative for us Hispanic physicians to unify our efforts as we are an intrinsic part of our Hispanic community in U.S.A.. A community that has not fared that well, by many measurements, in achieving the American dream. This, in spite of the preponderance of our culture in many geographical areas of the country, specially in the Southwest. Hispanics now living in U.S.A. number more than twenty million, with a projection of forty million by the year 2030.

Hispanics certainly are a heterogeneous population, however linked by strong bonds of language, customs and strong family and moral
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high incidence of undetected and untreated diabetes, hypertension, certain types of cancer, tuberculosis and other communicable diseases with their catastrophic consequences.

Facing these statistically - and alarming - proven facts, as physicians that bridge two cultures our mission and responsibility is not only to deal with their illnesses per se, but to became advocates of their plea. We must devote to raise awareness of our own people, as well as public and government agencies, private sector and academic world and all those who are directly or indirectly entrusted with planning, teaching and delivering health services to our Hispanic Community.

As the National Health Reform Task Force is in the planning stages of the new Health System for the nation, we trust the expertise and experience of those who have fielded the calls of our patients shall be appreciated and accepted as a valuable
formulation of any
a position paper with the hope that the voice of Hispanic physicians will be taken into consideration.

Adrian F. Ortega, President.

Highlighting Achievements of March Meeting of The Confederation in Los Angeles

APPOINTMENTS:

Aliza Lifshitz, MD., was appointed our representative to the A.M.A. Committee on Intemational Medical Graduates. Dr. Rene Rodriguez is our appointed representative for Government Affairs and he will work out of Washington DC, Mr. Louis Piccoli has the task of being our representative and liaison with the private sector, specially the Pharmaceutical Industry.

The Youth Initiative program will have two sessions this summer. This successful program brings talented Hispanic high school students as scholars for an introduction to the structures that deal with Health Issues in DC. to stimulate them to pursue health care professions and promote better understanding of their roles as future leaders of our community.

The assembly of national representatives approved the final version of the new Bylaws of the Confederation.

Dunkelman, L.A. and Publications and Communications, Dr. Ralph G. Kuon, Califonia.

A BULLETIN
GALENO
CONFEDERATION OF HISPANIC
AMERICAN MEDICAL ASSOCIATIONS

VOLUME 2 YEAR 1

President's Letter

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EMBASSY SUITES℠

Mtg w/ Sousa

Principal financial group —

insurance upon —

can you do ↗ 5 universal mandate

"they support mandates"?

① guarantee issue ; ② pre existing conditions — What if they delay coverage till they get sick —

• guarantee issue will work for small employers — they have sugg. risk sharing arrangements unclear for individuals

Paul M. Pietzsch
President

Healthy Iowans

HEALTH POLICY CORPORATION OF IOWA

Two Ruan Center
601 Locust • Suite 330
Des Moines, Iowa 50309-3774

(515) 244-1211
FAX (515) 288-9143

BUSINESS HEALTH CARE ACTION GROUP
STEVE WETZELL, Executive Director
(612) ~~888-7888~~ 854-7066
(612) 858-9675 (FAX)

3639 Elmo Road
Minnetonka, MN
55305

Ætna

David L. Chew
Vice President
Corporate Issues, RC2C

151 Farmington Avenue
Hartford, CT 06156-3700

203-273-6034 Fax: 203-273-7397

CALACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
STATE CHAPTER OF CALIFORNIA, INC.

FREDERICK DENNIS, M.D., FACEP
President 1993-1994

505 N. Sepulveda Blvd.
Suite 12
Manhattan Beach, CA 90266

(310) 374-4039
Fax (310) 374-5851
Hm. Ph. & Fax (818) 591-1846