August 20, 1993

MEMORANDUM FOR CAROL RASCO

FROM: Christine Heenan

SUBJECT: American Physicians Service Group, Inc. address

Carol:

From what I can tell, this group is a contract organization that provides administrative, utilization, and billing assistance to physician group practices.

They have in their client base physician groups ranging from small to quite large. They service physicians organized in a variety of ways, by affiliation (with teaching institutions or based on "admitting privileges" at academic medical centers), and by specialty.

I think this group will have three main interests:

1. Overall constructs of reform

2. What role will there be for service contractors like them who have built a market by off-loading the more "business-like" functions from physicians, like billing and administration?

3. What will be the future of the organized physician group practices that make up their client base?

1. Overall construct of reform

I would, at the beginning, walk through the goals of reform-- what it is we think is wrong that we want to fix, what we think is right that we want to preserve and protect. As you go through the overview, I would stress uncontrolled costs and lack of coverage for millions as the problems we want to fix. **(I know we aren't supposed to talk about the uninsured, and are instead supposed to talk about "never losing security", but I would make an exception here because it will be a real plus to know that everyone seen by a doctor will have coverage to pay for that visit.)** As far as the things we want to preserve, I would focus on physician-oriented issues: 1) guaranteeing choice of provider, 2) preserving and bolstering the doctor-patient relationship 3) high quality health care.

(I would also stress that while there is no question that reform will drive a wholesale reduction in paperwork, administrative efficiency, attention to costs, and accurate and accessible patient information will remain critical components of a good health care system, and health plans will need help performing those functions.) In fact, it has been the case that in recent years, physician practices and hospitals best able to operate efficiently are those that manage their books and manage their paper flow. Health plans competing on cost, quality, and efficiency will need to pay a lot of attention to administration, management, and financial functions in order to succeed in this environment.

3. The role of physician group practices under reform

Issue: Since one of the main changes reform will drive is the organization of comprehensive health plans, this group could be concerned that all physicians will have to affiliate with different plans, and there will not be a role for physician group practices as there has been in the past. This is not the case. Groups of physicians who have organized themselves together through common ties, either practice privileges or specialty mix, will be able to stay organized as a group, and may well have an advantage under reform.

First, groups of doctors may want to negotiate with plans collectively, as a group, rather than as individual providers. That could mean better rates and also a continued sharing of practice responsibilities, overhead, etc.

Second, physician groups, particularly larger groups, may choose to organize their own health plans. **The President's health reform proposal will include specific provisions to help physician group practices organize into health plans, because we believe it is important that doctors remain central to the organization and operation of these plans.** First, there will be start-up loan funds available to group practices looking to capitalize their own plans. Secondly, the solvency requirements for health plans will be less stringent on doctor-organized plans.

And just as physician groups increasingly contract with outside groups for the administration and management functions of a large group practice, they will no doubt still look to contract for these functions if they operate as health plans. Since, as health plans, these groups will now bear greater financial risk for the care and management of their patient load, these functions may actually prove more important.

Two last points:

Many group practice clinics function in traditionally underserved areas. As part of the initiative to bolster the availability of care in those areas, there will be greater incentives for physicians to practice in these settings, and greater financial assistance for these care settings.

Also, a few of the clinics represented are in rural settings, and you may want to mention increased funding and incentives to extend care to rural settings as one of the goals of reform.

With most audiences, elimination of paperwork and streamlining of billing is also a major point to hit on. I think this is a bit tricky with this group, since, if we are perceiving their role correctly, their whole industry basically built up because the paperwork and sheer complexity of administrative tasks were too much for most physicians (bringing us to # 2..)

2. The role for administrative and billing contractors under reform

I would start by acknowledging how bad things have gotten for physicians offices with rules, regulations, paperwork requirements, billing forms, etc. **This group knows the enormity of paperwork requirements better than most, and knows that too many of the rules and paperwork requirements don't make sense.**

One of the most important goals of reform will be to help ease the burden of complex and confusing bills and insurance rules from consumers, and the burden of time-consuming and frustrating paperwork from doctors, nurses, and hospitals.

This will be a major thrust of reform, but will not all happen over night, and will need to happen with the guidance and technical assistance of experts in the field.

As we look to:

1) develop a standard, uniform billing form

2) take a critical look at HCFA and private insurance regulations to determine which work well and which should be revisited

3) develop data and information systems to create national practice guidelines and quality outcomes reporting

4) develop information networks and technical capacity to use "smart card" technology, and to disseminate the guidelines and outcomes that are developed

5) insure that patient record confidentiality is protected even in an age of more sophisticated information sharing in health care,

organizations like theirs are in a unique position to help guide those kinds of changes.

Many of the clinics represented at your talk are affiliated to academic institutions, you may want to restate the commitment to academic health centers that you talked about wit NACHRI.

Hope this helps. Please let me know if you need more.

When I accepted we felt we perhaps would have announced plan — So, specifics are still not to be discussed & that is awkward for me - on the other hand it gives me another learning opportunity to be w/ indiv. like yourself.

Dom Policy
(split from Eco.) + NSC

21 staff inc Support
5 posit —
DPC - only 1 w/ prayers in all
① Eco (Children / fam. inc Ed
② Health Care
③ Welf. Reform
④ Campaign Finance / Lobby
⑤ Nat Service

Add Immigration
Pesticides
Forest Summit
Violence

No sharing
Ed
HHS
Justice
Interior
OMB
Labor
Treasury
AIDS
Drug
Agri
Commerce
Trans
HUD
EPA
Energy

Health care reform —

~~Because~~ what we are embarked upon and what we are partners in is nothing less than trying to deliver on the promise ~~that this organization and~~ the President ~~have~~ made to deliver health care in a way that is affordable, maintain quality and providing it to every citizen of our country.

To that end, I'm particularly pleased to be joined here with Governor Chiles. Those of you from Florida must know how closely the rest of us have watched what you have achieved already in organizing a delivery system to provide quality health care. And I want to applaud not only the Governor, who is with us, but all of you from Florida, the hospitals and the medical community, who are going to make this program in Florida a model for the rest of the country.

I mentioned earlier we delayed-budget process tough vote.

I'm also pleased to be here with Congressman Bacchus. ~~There was a very tough vote last week. It was a vote~~ to try to move this economy forward. It was a vote that was controversial, but which ~~he~~ voted in the favor of ending gridlock and getting us a budget and an economic program that began to put our house in order in this country. And we hope that our constituents ~~and this state~~ know how difficult it sometimes is in ~~the other magic kingdom~~ DC to stand up to what you believe is right for the country at the time.

And I particularly want to thank this association because all during the very difficult days leading up to that vote

MORE

last week, the American Hospital Association played a very constructive and productive role. It is a role that I have come to expect from Dick Davidson and the people who represent you in Washington. It is a role that I have come to depend upon. They're always straight, they always tell us what your thinking and what's at stake, but they do it in a productive and constructive way. There's too little of that in Washington sometimes. And I'm very pleased that this association is represented so well by your board and by your staff that they can play that kind of positive role in reaching difficult decisions that this country faces.

If we are on the brink of health care reform, it is only because of the work of dedicated indivs like yours and all of you represented here. It is only because for a number of years, you have been sounding the alarm about what is happening on the front lines of health care. It is only because you see every day what comes in the emergency room, what comes in the front door, what comes in the out-patient clinics that you run. It is only because you understand, being on the front lines, that we cannot continue doing what we do in health care in this country and fulfill either our human mission or meet our economic demands.

So let us move forward together in trying to fashion a health care system that represents the best about what each of us believe, and do every day. It is not going to be easy, just as the budget reconciliation was not easy. It did not satisfy all the goals of the President. It did not satisfy all the goals of the American Hospital Association.

I know many of you are distressed about the level of the Medicare cuts that emerged from the House-Senate conference. But even so, you understood how imperative it was that the budget be passed not only to put our house in order and our country on the right track, but so that we could get to the second stage of the important business facing this country -- and that is health care reform.

When I joined the board of the Arkansas Children's Hospital, I thought I had something of a working knowledge of the challenges hospitals faced, the changing role of physicians, nurses, other health care professionals. I learned all about the dish payments and the DRGs, the utilization reviews. I figured out what PROs and PPOs and HMOs were. But I also learned a lot more. I learned about what you face every day. I have taken that knowledge with me into this assignment of the last six months.

I can't even pretend to understand the day-to-day complexities, but I fully understand how dedicated hospital administrators and medical personnel are to meeting those challenges

MORE

If it has not been for the many hundreds and even thousands of you and your colleagues around the country who have participated in the efforts of the last six months, we would not be where we are today -- on the brink of having the President present a plan to the country and to the Congress.

But then the plan that the President is going to be presenting will very much resemble what this association has been saying all along. I was telling Dick as we were waiting to come in that I picked up the Conventional Daily, and the American Hospital Association and health care reform article which appears on the second page outlines what health care reform has to consist of. You know it better than I, but it is a message that comes from you to the American people and will be a part of what the President presents as he takes the concepts that you have worked on and are implementing and presents them to the entire nation.

Now, I do not want to be overly optimistic about the challenge that confronts us. Taking ~~this article~~ our principles and going down point by point and looking at how access to health care must be universal, it must provide health services delivered by networks of providers, we must contain costs -- all of those things ~~which you agreed on and that we agreed on~~ will not come easily. There will continue to be opposition based on fear -- the fear of change, the fear of losing some advantage -- opposition based on ideological concerns about how we should or should not reform our system. But we have to take each of those fears or concerns and deal with them honestly. Because if we can present a plan that corresponds to what you know will work, we ought to be able to convince the Congress and the country, because there is so much at stake.

When we began this effort there wasn't any preconceived plan waiting in any closet for someone to pick up and present. The plan that is being developed has rested on the advice of people representing hospitals, of physicians, of businesspeople, of nurses, of everyone who has a stake in the health care system. We looked at every model that we could find anywhere in the world. We looked to see what worked and what didn't work. We looked to understand how we could draw from different approaches to create an American solution to an American problem.

We looked here within our own country. ~~I know that earlier you honored Jack Lewin, who has been an integral part in helping us to think through and design a system that would work for the country based on Hawaii's experience.~~ We visited hospitals all over the country that are doing creative and entrepreneurial ways of approaching specific issues, because we wanted to be sure that what we presented bore the mark of reality and experience.

MORE

And so, as we move forward, that has been our hallmark. We have wanted to be able to say to any American, we believe this will work and here is the evidence to back us up. We also wanted to start from the very simple premise that at the bottom, health care reform is about individual opportunity and responsibility. As the President has said all during the last six months, we must ground our country's course in our most enduring values. And that is the belief that America can extend all of us an opportunity if we assume responsibility for ourselves, our communities, and our country.

In other words, you have to eliminate the all too prevalent state of mind that there is a free lunch, that there can be a free ride, that there is something for nothing, and get back to what I was raised to believe and, I would venture, most of you, that the American Dream depended upon our willingness to work hard and to be responsible.

But we also have to be sure that that American Dream is out there to be seized. And one of the most corroding aspects of the last years has been the way our health care system has eaten away at our economic potential, at our human potential. So if we agree that we have to ground what we are doing in experience and reality, and if we believe we have to restore opportunity and responsibility, then the health care reform debate is something beyond just the specifics. And we may not agree on all of the specifics, but if we can agree on the direction we are going and how we should get there, we will make enormous progress together, because we are united by common concerns and common goals.

We've already made great strides in putting together a plan that will represent those common concerns and common goals. And I want to share some of those features with all of you today.

~~Let me start with your~~ Our #1 goal. We must achieve universal coverage. Every American should have the security of knowing that no matter where he or she works, whether he or she has ever been sick before, where he or she lives, because that person is an American, he or she will be entitled to a package of benefits that will give them health security. We cannot achieve cost containment in a system in which nearly 40 million of our citizens now do not have coverage for their health care needs.

We also need a delivery system that integrates the delivery of care, ~~along the lines that you have advocated. You were among the first~~ We were to promote community care networks -- a concept that lies at the very heart of revitalizing our health care system. That, combined with the universal coverage, gives us the tools at the local level to be creative in providing services to meet the needs of local populations. ~~You also~~ We have understood from the very beginning that

integrating delivery and providing networks of care is the surest and most efficient way to provide for contained costs because when providers are paid as a group, whether it's in a fee-for-service network, or a PPO, or a HMO, or some as yet unnamed form for delivery care, there is then a sentence built into the system to be careful about the allocation of resources; to look to other people to learn how better to deliver the care that we have to; to understand what the trade-offs are. It is very important that we organize our health care system so that it is better able to deliver health care to all of our citizens.

We have also understood how we have to cut the costs in the current system by simplifying administration and paperwork. You are living, breathing examples every day of what is wrong with our health care system. You know as hospital administrators, as directors of nursing, as people who are in the back offices that are filled with paperwork, that if we do not simplify the burdens on our health care system we can never provide health care to every American at an affordable cost.

In order to do that we need to move toward a single form system. We need to do all that we can to implement more efficient means of electronic and computerized billing. We need to understand clearly that it is no longer acceptable for the paperwork hospital to be growing at four times the rate of the care-giving hospital when you have, as I have talked with hospital administrators all over this country, the difficult choices of having to hire more bookkeepers and clerical people while you are laying off nurses and technicians, that is an unacceptable choice for any hospital and needs to be eliminated as soon as possible. (Applause.)

Because what the current ratio is that hospitals must hire four new administrators for every new doctor -- four to one -- simply to handle the avalanche of insurance forms and paperwork. I will never forget talking to a nurse a few months ago who summed it up for me. She said she went into nursing to care for people. If she had wanted to be an accountant she would have gone through an accounting course and worked for an accounting firm. And yet she spent nearly 50 percent of her time filling out forms.

I want to see nurses like the ones who took care of my father in his last days in that hospital, St. Vincent's in Little Rock, taking care of people, not filling out unnecessary forms in a duplicative system that doesn't deliver one more ounce of compassion, care, and help. (Applause.) And if we have anything to do with it, in this reform effort, it is to free our doctors and our nurses from those kinds of burdens.

MORE

We also have to be aware of how the interaction between the legal system and the health care system have often interfered with ~~your~~ that capacity to make good decisions. One of the issues that ~~your association~~ brought to ~~us~~ was one that I heard all over the country: How can we try to move forward to this new world that we're outlining if we cannot even collaborate among ourselves? How can we try to be more efficient in our communities if we're afraid that we might be sued for antitrust violations? ~~You told us and~~ we heard ~~you~~, and is was something that I have never known before I got into this, that the kind of positive arrangements that ~~you~~ would want to pursue with ~~your~~ neighbors and even ~~your~~ competitors were being either chilled or in some way eliminated from consideration because of the fear of the antitrust laws. Hospitals ~~such as yours~~ have come to believe that expensive legal opinions would be required any time they wanted to merge or share high-technology equipment or form a purchasing cooperative or integrated network for delivering services.

~~You also told us~~ that ~~hospitals~~ were frustrated over the last years because they couldn't get quick and reliable advise from the enforcers of the antitrust laws in the federal government. Well, we not only heard ~~you~~, we're going to do something about that. (Applause.) At the request of the task force and the White House, the Justice Department right now is exploring guidelines for mergers, networks, joint ventures, purchasing cooperatives, and information exchanges so that hospitals do not have to file hundreds of more forms and wait years and years to share an MRI or pool advanced ultrasound equipment or do some of the other things you would like to do to give better service to your community. So we intend to move on that. It will part of the President's health care reform package. (Applause.)

We intend for that package to result in a health security card for every American that will be the key to a package of benefits that will, again, do something ~~you~~ have urged us to do: a package of benefits that will stress primary and preventive health care. Because we believe that if we have funding streams for primary and preventive health care we will save money, not just in the long run but in the medium run. That if you know that there is reimbursements standing in the wings for immunizing children, for providing mammograms for every woman, for providing well child care for young children, the services will be there. And all of us will benefit from those services.

We cannot have a healthy health care system without stressing primary and preventive health care. And we have to do that by changing the incentives that have grown up in our insurance industry that only pay for something once it was a problem. If you will stand with us on primary and preventive health care we will make a huge difference. (Applause.)

MORE

Even though universal coverage is one of our keys, and ~~something we share in common with you~~, I want to make clear that health care reform is not ~~any longer~~, from my view, driven just by the needs of those who are uninsured. It is driven by the fears and concerns of those who are already insured. Two million Americans a month lose their health insurance. Some may only lose it for a month, some may lose it for more than a year or two. But the fear of losing it, the increasing costs of acquiring it, the problems employers face in a market where they have so little purchasing power has made the fact of insurance, once taken for granted by many millions of Americans, no longer a source of personal security.

So in the community from which you come, the debate is not just about taking care of those who have no coverage, it is about taking care of all of us. And part of that debate has to be explained by you because you see it every day. Until all Americans are insured for health care we can never control costs because of the phenomenon you know so well, known as cost-shifting.

Many Americans in ~~my~~ our conversations over the last month who do have insurance are desperate to hold on to it and want it to mean something again. They often don't make the link that you make every day between the people who do get care in our country -- because we do take care of people who come through those ~~hospital~~ your doors, but it is often at the most expensive, latest point. And they come without any reimbursement stream, or an inadequate one. And that is what leads to the $25 Tylenols, the latex gloves that are so expensive, ~~that Governor Chiles has tried to use to educate the people of Florida.~~

Because you know that the money has to come from somewhere. All those who are currently insured will be better off financially and in terms of the services they will have access to if everybody is insured, because you will then ~~have~~ self the kind of compensation ~~your~~ deserved ~~to have~~ when you take care of everybody. That is a message ~~local hospitals~~ you will have to help us deliver to educate Americans, so that the linkage between the benefits to be obtained from insuring those who are not insured and the security that all Americans, including those who are insured, will receive can be made clearly at the grass roots level.

Because until Americans fully appreciate what you go through every day they will not understand that right now those of us who have insurance are paying not only for ourselves, we're paying for the shortfalls in the public system and we're paying for the uncompensated care. We can do better than that if we get everybody in the system and make everybody responsible for some part of their

MORE

own care. That has to be a hallmark of the message that we send in the next several months.

Because when all Americans have a comprehensive package of benefits, then the ~~hospitals~~ clinics that I have visited, ~~like King Drew in Los Angeles or St. Agnes in Philadelphia~~, which treat large populations of indigent patients, will be able to serve the needy people in their own communities because they know they will be compensated for the care that they give. So that is a key issue that we have to have your help in explaining to our fellow citizens.

We also know that hospitals that reach out clinics/programs ~~like the one honored today from Cambridge, Massachusetts~~, to get into the community and provide services that are beyond what is traditionally thought of as conventional hospital services, will enable their communities to get ahead of the curve. Community care networks, like ~~the ones that you have honored or the~~ ones that are exemplary ~~like~~ in Wellsboro, Pennsylvania, or rural southwest Georgia, are examples of the approaches I'm talking about.

If you go to Georgia in that 10-county region where this network is operating, you will see people who have all of the problems that are exacerbated by poverty, often afflicted by chronic disease, often without the resources adequately to take care of themselves until they end up in ~~your~~ the emergency rooms. But if we have an organized approach with a package of benefits that has a reimbursement stream behind it, then networks like that one in Georgia or ones that many of you are running will be able to provide primary care in underserved urban and rural areas. You'll be able to have mobile care going out into those communities. And the net result will be our costs will actually begin to decrease, because we will have reached out to people where they live to provide the services that they need.

Making it possible for you to do what you know needs to be done in your communities is one of the keys to a successful health care reform. We also have to change the mix of health care professionals. We have to provide incentives for the National Health Service Corps to encourage doctors and nurses to practice in remote and challenging parts of our country. We need to change the way Medicare has funded graduate medical education. That is the primary reason we have the mix of specialist to primary care physicians today -- a ratio that is 70 percent in favor of those who are specialists.

We need specialists. We have to have specialists. But the reason we have so many is not just because every young man and woman -- seven out of 10 going to medical school in the last 20 years has decided they would rather be a specialist, it's because we as taxpayers subsidize the subspecialties. We need to change those

Rural Urban Academic Health Centers

MORE

incentives so that we can begin to give the pool of primary and preventive health care professionals back to the country. We cannot have universal coverage and health care reform unless we have more primary care physicians and nurses, and that starts at the top with the way the federal government funds the programs. (Applause.)

We also need to be sure that we make the very best possible use of our doctors and our nurses. We need to encourage physician assistants. We need to encourage advanced practice nurses, nurse midwives, and others who can provide the kinds of services that will be needed in a broad-based system that emphasizes primary and preventive health care. And we need to be sure that where there is an underserved area, a network of care is there to provide those services.

You know, in Washington DC -- the other magic kingdom -- there is a hospital in the poorest ward of that city. That hospital is in a place called Ward 8. It has only six percent of the city's pediatricians and only one of 15 city-run clinics. But it has 25 percent of the city's children, the highest proportion of premature babies the city, the most children with AIDS, and the largest number of infants who die before their first birthday.

Now, the Greater Southeast Community Hospital is there in that community, and it could be wringing its hands, it could be trying to keep its head above water, it could be folding its doors and going elsewhere. But instead, it has taken the challenge that its community provides and risen to it. It couldn't afford to keep giving away the kind of care that it was giving as people were brought in like some warehouse receiving sick people at their emergency room dock. It had to break out of conventional thinking about health care and devise inventive ways of dealing with the problems that were destroying the hospital as well as the community.

So Greater Southeast opened a school-based clinic, launched ambulatory care program, organized volunteers to perform blood pressure screenings at Sunday church service, made judicious investments in the kind of technology that would serve the most people in their area -- opting, for example, for a state-of-the-art kidney dialysis machine rather than even pretending it could perform open-heart surgery.

The net result is that costs are beginning to be somewhat put into balance, because so many people are treated at an earlier stage. Yes, they still show up in great numbers at the emergency room, but many more are treated in the much more cost-effective way of providing primary care in the community.

Those are the kinds of unconventional thinking that we need to make conventional -- ~~that all of you know so well~~. If we do, then we will not only provide health care for all Americans, we will begin to see results in terms of cost savings. We make a promise to you. Not only will we deal with the problems that you have brought to us, like antitrust, with the intrusive micromanagement that just boggles my mind.

I once met a hospital administrator who told me that two of the departments in their hospital were now under 100 percent utilization review without any noticeable increase in quality. We want to get back to doctors and nurses making sound judgments about their patients. We also intend to simplify the well-intentioned regulations that often burden you like CLIA, so that it can be a reasonable approach to a problem.

We will make these promises to you, because we believe we can deliver them. We believe we can change what is currently going on in the federal government when it comes to health care. We also will make promises to our citizens -- not only those who will be insured and those who will have security, but to older Americans, ~~many of whom now come to seek treatment in your facilities.~~ We will increase the options for home and community-based care services and greater protections for nursing home residents. There will be a new federal home care program for disabled citizens, regardless of income. We want to end the travesty of people spending themselves into poverty to qualify for meager government aid, which only paid for nursing home care. (Applause)

We want people to be able to be treated with dignity and respect in their home and in their community. We want hospitals, ~~like many of yours~~, to start getting reimbursement for adult day care or for Alzheimer patient care. We want ~~you~~ to be able to serve your communities in a creative, unconventional way that we want to become the standard of practice.

We also intend to provide a prescription drug benefits, because one of the things I learned in the many hours I've spent in ~~St. Vincent's~~ talking with my friends who were doctors and nurses and hospital administrators is that you know very often when someone is discharged with that prescription in hand, either they can't afford to refill it, or they self-medicate because they want the pills to go longer. So if it says take four a day for three weeks, they'll take one a day and try to stretch it out. And then all too often they end up back in ~~your~~ acute care.

We want to provide a prescription drug benefit that will save us money by keeping people out of ~~your~~ hospitals who don't need to be there because they can be treated well by medication. You

will have to help us with that because it is something that has to be done carefully and cannot be permitted to get out of control in terms of cost. But it is a need that we want to see included in the benefits package. Malpractice - Practice guidelines - you can help.

Now, there are several ways of paying for this system. And really, if you cut through all of the arguments that will come from all directions, there are really three general approaches that the President could have pursued. There is a publicly financed approach where we would substitute for all of the existing private sector funding -- federally mandated tax money to go into financing the health care system. That's often referred to as a single payor system, and many of the countries with whom we compete provide such a system and do it at far less of a cost than the system we have.

For a number of reasons, that will not be the approach that the President proposes, although there are many strong -- (applause) -- there are many strong advocates who believe it is the right way to go. The President, ever since he was a governor and studied this issue at the National Governors Association meetings and all through the campaign, has believed that the strength of that system, like cutting administrative costs and reaching universal coverage, could be achieved without some of the problems that would come with it.

A second approach that will be advocated strongly is putting the responsibility for being insured on the individual, much as what states do now with auto insurance. If you want to drive, you have to have auto insurance. I guess the analogy would be if you want to get sick, you have to have health care insurance. It's a very difficult approach -- for health care needs.

It would also be difficult to predict how many employers who now provide health insurance would cease doing so because of the existence of an individual mandate. But, again, it has some strengths that we want to be very aware of. The emphasis on individual responsibility is absolutely key. We have to make consumers better informed consumers as they make health care choices.

And the third approach, which is the one the President has always thought would be most promising, is to build on the system we currently have -- an employer-employee system that has given us the best quality of health care in the world, that has placed us at the head of the pack when it comes to research and development and technological breakthroughs, but which, unfortunately, hasn't fulfilled its promise because of the problems of cost-shifting and inability to actually organize the delivery of care.

But most employers in this country currently do provide some health insurance for their employees. They have been paying the price for the increases in Medicaid and Medicare and for those who are without insurance. And it is appropriate to ask that if some have borne all the burden, shouldn't all of us bear some of the burden? Why should any employer or employee who does not take on the responsibility for health insurance coverage any longer get what amounts to a free ride? Because you and I could go down the main street ~~in Orlando~~ Anchorage or any street in America and we could point to a store that does provide insurance and a store that doesn't. But when the people who are employed by and work in the store that doesn't get really sick, they ~~go to your hospital~~ get care, don't they? They're there. Maybe they have some coverage, maybe they have some savings they can use. But, by and large, they don't pay the full freight.

So the next year when it comes time to renew insurance, that first store that's trying to provide health care for its owners and its employees has to pay a higher premium to cover the costs of his neighbor's employee. At some point, America once again has to be willing to believe that all of us are in this together, because health care reform is not just about eliminating paperwork and bureaucracy or making the antitrust laws make sense, or reaching universal coverage on paper. Health care reform is about reinstituting a sense of compassion and caring into our society. It is about making common sense, practical judgments about our economic priorities. It is about putting our national house in order.

So we must establish new priorities, new incentives, and new partnerships. We must all take responsibility and we must all contribute. This will not be easy, but we don't have a choice.

Too many times in the past, individuals and interest groups and the government have marched to the edge of health care reform only to cower in fear and shrink away. And our problems have only gotten worse. Too many times we have held meetings and drafted brochures and plans and walked away. Too many times we have watched as one political party blamed the other for a system that had awry. And while they were all pointing fingers, the problems got worse, the pressures on you got harder, and yet we all walked away once again.

Now, after having walked away from this problem like so many others, how many more meetings do we need? How many more plans shall we draft? How many more dollars shall we pile up on the national debt, on more uncompensated care ledgers, on the backs of the people who are really paying the freight?

We need your help. ~~We need you help at the Association.~~ We need your help in your communities ~~as the primary care givers.~~ This is an opportunity that doesn't come often in the life of either

MORE

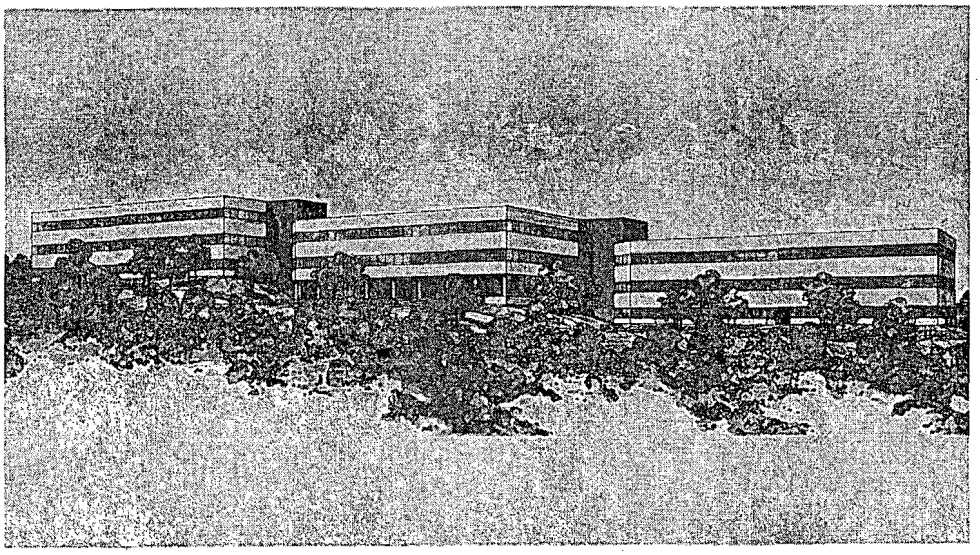
individuals and institutions or in country. This is an opportunity to make a bold stand, to fix a problem, to do it in a way that will work and to move our country forward.

If we are bold enough, and wise enough to meet this challenge now, we can join together not as Democrats or Republicans or liberals or conservatives, or any of those other categories that for too long have not only divided us, but have obscured the real debate about what is at stake. Let us come together as Americans -- as people committed to safeguarding our nation's future health and well-being. Let us join hands in knowing that if we move forward in ~~the direction so many of you have urged for so long,~~ we can be proud of the contributions we have made to fulfilling the American Dream of putting our nation back on the right course, of dealing with its human and economic challenges, and of once again, having a society that truly is a community.

That is what is at stake. That is our opportunity. That is our responsibility.

Thank you all very much.

END



The headquarters of American Physicians Service Group, Inc. is located in Austin, Texas.

For additional information contact:

Director, Financial Communications
American Physicians Service Group, Inc.
1301 Capital of Texas Hwy., S., B220
Austin, Texas 78746

(512) 328-0888

American Physicians Service Group, Inc.

June 21, 1993

Ms. Carol Rasco
Domestic Policy Advisor
The White House
West Wing
Washington, D.C. 20500

(704) 252-2711
800-438-5800

Dear Ms. Rasco,

I was very pleased to hear you had accepted the invitation to be Keynote Speaker at our sixth annual user conference in Asheville, North Carolina. I am enclosing information on the conference, the general area and the agenda. An annual report for our company is also included. APS Systems, Inc. will be happy to reimburse you for all travel, lodging and miscellaneous expenses related to this trip. We have guaranteed your reservation for late arrival at the Grove Park Inn on Sunday, August 22, 1993.

We are requesting your speech address the administration's healthcare reform plans. We are providing an hour for you (30 minutes for your presentation, then 30 minutes for a question and answer session). If this is not a sufficient amount of time, please let us know and we will be happy to adjust the schedule.

Approximately 55 people will be attending the conference. Some of the academic organizations represented are: Yale Faculty Practice Plan, New Haven, Connecticut; Nebraska Clinicians Group, affiliated with the University of Nebraska, Omaha, Nebraska; Medical College Physicians Group, affiliated with the University of Arkansas, Little Rock, Arkansas; Physicians Practice Group, affiliated with the Medical College of Georgia, Augusta, Georgia. The multi-specialty clinics list includes: Kent Medical Center, Kent, Washington; Billings Clinic, Billings, Montana; North Mississippi Health Services, Tupelo, Mississippi. Two single specialty clinics will be represented: Noran Neurological Clinic, Minneapolis, Minnesota; TME, Inc. (MRI specialty), Houston, Texas; providing services in approximately 12 states.

Our client base ranges from a 20 physician group to over 500 physicians at our largest client site. Each of our sites will be sending staff from various departments. Your audience will include Executive Directors, Administrators, Business Office Managers, Chief Financial Officers and Information System Managers.

Again, I look forward to meeting you and hearing firsthand about the exciting and necessary changes in healthcare administration. If you have any questions or comments, please feel free to contact me at (800) 252-3628.

Sincerely,

APS SYSTEMS, INC.

Roger T. Scaggs

Penny (wife)

Roger T. Scaggs
President

Group Practice Managed Healthcare News®

Reprinted from *Group Practice Managed Healthcare News*, August 1992, Vol. 8, No. 8

Computerized Management Systems

APS Releases New Scheduling Module to Complement Bullet/3000

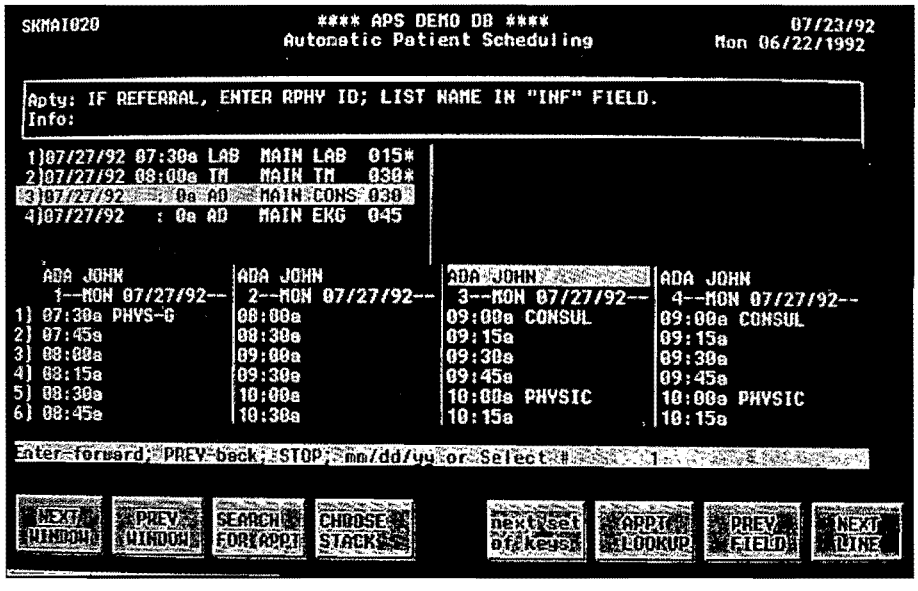
by Betsy Rudowski

Contrary to what some may believe, all integrated management information systems are not the same. When a number of systems are compared, many of the same modules are offered as part of the overall system package. The inimitable capabilities of these modules (which are identical in name only) are the distinguishing features that set them apart. Since 1985, American Physicians Service Group, Inc. (APS) has simplified operations for medium-sized to large group practices and university academia with their Bullet/3000 accounts receivable management system. In September 1992, the company will enhance the Bullet/3000 with the general release of a new module called the Multi-Resource Management System (MRMS).

About the Company

Founded in 1974, APS is headquartered in Austin, Tex., with regional offices located in San Antonio and Dallas, Tex. and in Little Rock, Ark. The company employs a staff of approximately 150, comprising programmers, customer support representatives and marketing personnel. APS bills itself as a financial services firm, where over 95% of its revenues are derived from healthcare organizations. The company went public in 1983 and, in 1991, had revenues of over $17 million.

The Bullet/3000 is a system specifically designed for clinics and medical school practice plans. It is installed presently in 29 sites—from Augusta, Ga. to Tacoma, Wash. The largest user of the Bullet/3000 is Arkansas' academic practice plan, with 400 healthcare providers. The smallest user is a neurologic specialty clinic in Minnesota, with 20 physicians.



System Platform

The Bullet/3000 runs exclusively on Hewlett-Packard (HP) equipment. APS is an HP value-added reseller (VAR) and, as such, markets the software as well as the hardware. Specifically, the system runs on HP 3000 Series computers that are connected to personal computers or terminals. Selection of the appropriate model should be based on the number of providers on staff and of patients treated, existing data base size and anticipated transactions. A case study provided by APS described the hardware configuration for the Physician Practice Group (PPG), a billing and collection agency serving the Medical College of Georgia in Augusta. About 300,000 patients annually are treated by the college's 310-member, multi-spe-

cialty staff. In 1987, PPG installed the Bullet/3000 system to run on an HP 3000 Series 70 computer. By July 1990, PPG exceeded the maximum number of transactions manageable with that system and upgraded to an HP 3000 Series 960.

"PPG now has over 8 gigabytes (GB) of disk storage on-line, two tape drives and two system printers," PPG reported. With this configuration, over 5 to 6 million transactions currently reside on the system installed at PPG.

System Modules

The Bullet/3000 uses a relational data base, the HP TurboIMAGE data base management system, which serves as the backbone of its integration capability. The system can draw from patient and physician financial, demographic and medical information for on-line inquiry and manipulation of data on command.

Currently, 13 modules comprise the Bullet/3000. In September, that number rises to 14 with APS' latest add-on module, the MRMS. This module is different from conventional scheduling applications because it allows for overall time management of a healthcare facility. MRMS will interactively coordinate appointments to include a combination of patients, physicians, locations, rooms, equipment or other resources as determined by the practice. A total of 12 different schedules can be arranged. To date, the module has been field-tested at one site—an 85-physician, multispecialty clinic serving Montana, Wyoming, North Dakota and South Dakota. Based on their comments, it appears that MRMS is especially helpful for clinics treating patients traveling from rural communities. According to a clinic spokesperson, on any given day entire families travel hundreds of miles to be seen at their clinic. The MRMS module enables administrative staff to schedule each family member so that all their medical needs are satisfied during that visit. When the module is fully implemented, the clinic expects to schedule over 2,000 appointments per day.

The other modules, which are not meant to be undervalued in this evaluation, include: the core or base module, Patient Registration; and add-on modules, Transactions, Patient Billing, Insurance Processing, Collection Follow-up, Management Reporting, Equity Allocation, Table Management, Appointment Scheduling, Medical Records/Chart Tracking, Alternative Delivery Tracking, Recall and Ad Hoc Reporting.

System Features

Flexibility is a primary component of the Bullet/3000 system. APS designed the system to enable the user to customize it based on the organization's specific needs. This flexibility pertains to many different aspects of the system, including customized fields, tables, reports and operator-definable defaults.

A few of the many other features include:

- Accommodation of Multiple Clinics/Companies: Bullet/3000 allows the operator to extract data from other data bases to establish multiple accounts receivables, ledgers and payables.
- Context-Sensitive Help: Windows containing information specific to the system—i.e., module or field—provide concise explanations of where the user is, what he or she is doing and how to proceed.
- Free-form Text: This feature enables the user to enter notations into each patient record, each account attached to the patient and each insurance record attached to the account.
- High-speed or Interactive Data Entry: The high-speed option allows the operator to enter large volumes of data rapidly. The data are entered in an off-line key-to-disk system. Data then are transferred to the Bullet/3000 system on tape or through telecommunication. An accuracy check is done while the system is in the batch-processing mode. Any errors that are found may then be corrected on-line. Interactive Data Entry edits and validates the data as they are entered. Any errors that are brought to the user's attention during the entry process may be corrected on the spot. The latest data-entry option developed by APS is the use of optical scanners that read charge slips, which eliminate keying of data.

Customer Support

The company offers what has become a standard support program. Both on-site training and remote support are provided, as well as a 24-hour, toll-free hotline. There is a 6- to 8-month, on-site implementation process for a medium-sized practice. In addition, APS can be contracted for other support programs, such as outsourcing arrangements.

Price

The company quoted a price of about $250,000 for a complete system (hardware and software) designed for a 50-physician practice. This amount will buy the Bullet/3000 base system, the HP 3000 Series computer, necessary peripherals and customer support.

Summary

The APS Bullet/3000 system is a complete, fully integrated management system that should meet the needs of managed care organizations now and in the future. A comprehensive review of the system is recommended. More information may be obtained by contacting Mr. Ron Castleberry, vice president, sales and marketing, APS Service Group, Inc., 1301 Capital of Texas Highway, Suite B-220, Austin, TX 78746, or by calling (800) 252-3628.

Betsy Rudowski is a freelance writer specializing in healthcare issues. She is based in New Jersey.

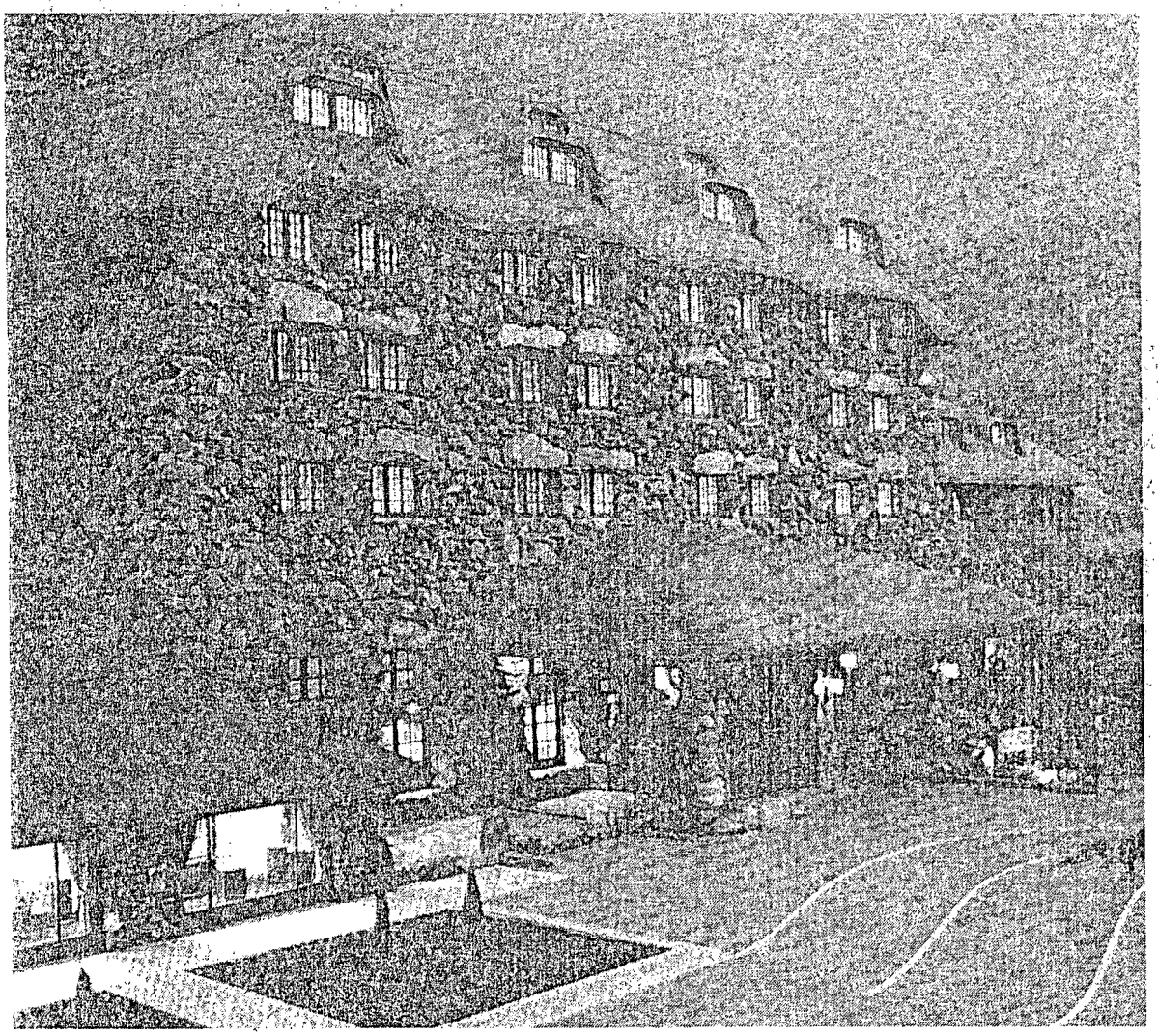
APS BULLET

USER CONFERENCE

VI

August 22-24, 1993

EXPERIENCE THE LEGEND!



ASHEVILLE, NORTH CAROLINA

Plan now to join us in beautiful Asheville, North Carolina for an important, educational conference. The sixth annual Bullet User's Conference promises to be an event filled with informative issues and sessions that include healthcare reform, a managed care round table, miscellaneous open forums and idea swapping.

To balance out the seminars and working sessions, Asheville offers many adventures. You may find yourself wandering through a magnificent European Chateau, hiking up a twisting mountain trail, enjoying a whitewater rafting trip, golfing on tree-lined fairways with spectacular views of the famous Blue Ridge Mountains, or relaxing outdoors, overlooking a spectacular mountain sunset.

THE BILTMORE ESTATE

This carefully preserved, 255-room mansion, filled with treasures such as paintings by Renoir, rests in Asheville. Visit the splendor and beauty of the Biltmore estate, touring the house, gardens and winery. Be sure to stop in the Tasting Room for a sample of the winery's products!

BLACK MOUNTAIN

The Cherokees named it Grey Eagle and the pioneers named it Dark Mountain. Today, Black Mountain, located in the heart of the Blue Ridge Mountains, offers Lake Lure, Chimney Rock, Maggie Valley and a breathtaking drive along the spectacular Blue Ridge Parkway.

THE GROVE PARK INN MOUNTAIN RESORT

Listed on the National Register of Historic Places, the Grove Park Inn is the location for this year's conference. A contemporary resort complex with rustic charm, the Inn sits atop Sunset Mountain. The Inn boasts 510 rooms, four restaurants, two ballrooms, a country club, and an 18-hole golf course.

The list of recreational programs is long. The Inn has been voted one of the "50 best tennis resorts" by Tennis Magazine (6 outdoor and 3 indoor courts). Also available are the outdoor pool, racquetball and squash courts, indoor pool with a windowed patio and ceiling for a splendid view of the mountains, and of course, the championship golf course that will challenge players at every level. The Inn provides day camp for children ages 3-11.

BULLET/3000
USER CONFERENCE VI
AGENDA

Sunday

10:00 a.m. - 4:00 p.m.	Golf
6:00 p.m. - 8:00 p.m.	Cocktail Reception, Guests and Spouses

Monday

8:00 a.m. - 8:30 a.m.	Continental Breakfast
8:30 a.m. - 8:45 a.m.	Introduction - Roger T. Scaggs, President, APS Systems, Inc.
8:45 a.m. - 9:45 a.m.	Healthcare Reform - Carol Rasco, Domestic Policy Advisor (invited)
9:45 a.m. - 10.00 a.m.	Break
10:00 a.m. - 10:45 a.m.	Staff and Programming Updates - Patty Bluhm, Vice President Support and Development, APS Systems, Inc.
10:45 a.m. - 11:45 a.m.	Balance After Insurance...Preparing for Implementation, Judy Kragness, Client Service Representative, APS Systems, Inc.
11:45 a.m. - 1:15 p.m.	Lunch
1:15 p.m. - 2:00 p.m.	Family Bill Collections - Dave Grissom, Systems Analyst, APS Systems, Inc.
3:00 p.m. - 8:30 p.m.	Depart for The Biltmore Estates tour and dinner

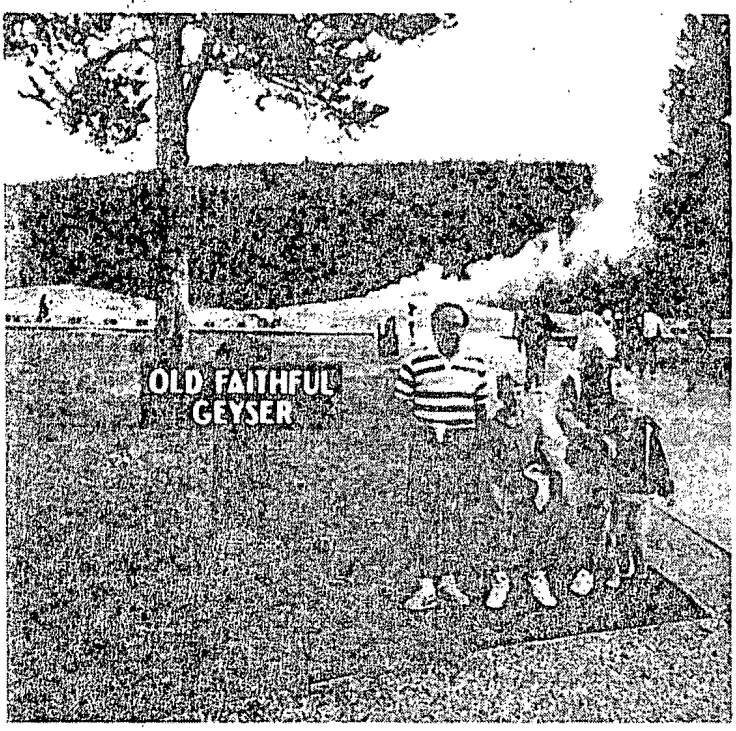
---

Tuesday

7:45 a.m. - 8:15 a.m.	Continental Breakfast
8:15 a.m. - 9:45 a.m.	Misc. Forum • Remit Tape Formats • Line Item Reporting • Diagnosis Claim Grouping • Managed Care Phase I
9:45 a.m. - 10:30 a.m.	Executive Information System, Deborah Draper, Systems Analyst, APS Systems, Inc.
10:15 a.m. - 10:30 a.m.	Break
10:30 a.m. - 11:30 a.m.	Managed Care Round Table - Led by a Representative from Yale Faculty Practice Plan and Judy Kragness

---

REMEMBER...



DON'T FORGET...

RESERVATIONS DEADLINE FOR
THE QUALITY INN
IS MAY 21, 1993

RESERVATIONS DEADLINE FOR
THE GROVE PARK INN
IS JUNE 30, 1993

HEWLETT PACKARD

Physicians Practice Group Positions for the Future with On-line Information Management

Application Note

American Physicians Services Group

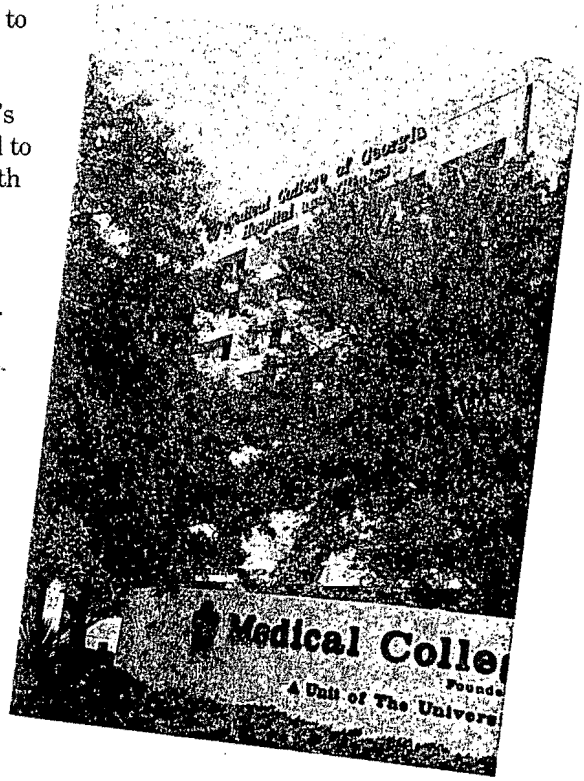
Health Care Information Systems

Since 1958, the Physicians Practice Group (PPG) has provided billing and professional fee collection for the academic faculty of the Medical College of Georgia in Augusta. Presently, there are 310 faculty members in more than sixty specialties serving almost 300,000 patients each year. Robert Colligan, Executive Director, Charles May, Associate Director for Operations, and Richard Marshall, Associate Director for Institutional Relations talk about their APS/HP information system and how it will affect PPG's future.

Seven years ago, PPG was using an in-house batch system running on an IBM computer and using an outside service bureau for technical support. No one had a terminal or computer and all documentation was coming from the batch system in paper format. All account service representatives had volumes of paper at their desks pertaining to patient claims.

"We felt like we were using 70's technology and that we wanted to get away from using folders with claims in them," says Richard Marshall. "Everything was done in batch mode - in paper, microfilm or microfiche format. That meant that our data was typically a week to two weeks old."

PPG management realized that a batch system was not the most efficient billing system for its doctors and began the search for an on-line system that could carry them into the 90's. With an on-line system, patient data would be hours, not weeks old.



The Medical College of Georgia, Augusta, GA

aps Systems, Inc.

HEWLETT PACKARD

Richard Marshall and Charles May review the month-end report.

At this same time, APS Systems, Inc. of Austin, Texas purchased the outside service bureau that PPG was using for technical assistance. Subsequently, PPG joined the APS users' group where they helped to develop the current software package – the APS Bullet/3000. According to PPG, the users group is still an important component in the ongoing development of the software product.

Installation Goes Smoothly

In March of 1987, PPG purchased the APS Bullet/3000 Accounts Receivable Management System running on an HP 3000 Series 70 computer from Hewlett-Packard. Moving from the batch system to the APS electronic system was a major change in the environment at PPG.

When told that the paper would disappear, the employees were shocked. "There was fear initially," says Charles May. "Would jobs be eliminated when we went to the on-line system?"

"The computer system hasn't replaced the people though," adds Robert Colligan. "The same people have acquired new skills and responsibilities."

The installation of the computer system and the APS Accounts Receivable, Equity Allocation and Collection Follow-up modules in November went very quickly. In one weekend, old balances were converted over to the new system as a line-item transaction. Prior to implementation, PPG met with APS on a regular basis to establish a checklist, convert files and build tables. "APS was fantastic. They were available 24 hours a day," says May.

Upgrading to the Series 960 Allows for More Users

In July 1990, PPG exceeded the maximum number of transactions manageable with the HP 3000 Series 70 and upgraded to an HP 3000 Series 960. PPG now has over 8 gigabytes of disk storage on line, two tape drives, and two system printers. And the system is interfaced to PPG's general ledger and accounts payable software.

"It was the smoothest conversion I have been involved with in 23 years of computer conversions," says May. "APS and HP came in on Friday evening and we were up and running 'live' Saturday afternoon. I credit both HP and APS for making it so smooth."

Another reason for the upgrade was PPG's long-term desire to expand the system to provide on-line, up-to-date information to more users. Over the next couple of years, PPG anticipates increasing the number of terminals from 95 to 150-175.

PPG has also been able to reallocate personnel, eliminate unnecessary positions and cut the number of overtime hours, representing a significant cost savings. On the Series 70, month end processing took almost 4 to 5 days of continuous processing and man-hours. On the Series 960, the process takes only 12 to 18 hours. At the time of conversion in 1987, there were 350,000 transactions on the system. Today, there are 5 to 6 million.

APS Systems, Inc.

Increasing Reimbursement

The Medical College of Georgia hospital in-patient facility and 18 outpatient clinics are generating charges that are sent to PPG through different modes. APS has provided an interface that allows these charges to be input electronically, saving hundreds of data entry hours each month.

In the past year, PPG brought several hospital departments on line which are now entering charges directly into the PPG system through personal computers (PCs). These departments can toggle (hot key) between local departmental PC applications and PPG data on the HP 3000, maximizing the versatility of the PCs. To encourage departments to come on line, PPG ran a pilot program with one department. The program worked so well that PPG recently received a request from one department for 12 more PCs.

Because academic institutions are traditionally multi-specialty organizations, claims processing can be very complex as each specialty has its own kinds of diagnoses, procedures and codes.

"One of the things that the system helps us do is gather data over time, such as what kinds of codes are being used," says Marshall. "This assists us in our physician billing practices. By ensuring that we are using the appropriate billing code, we can ensure the appropriate reimbursement for services rendered."

The new system has also freed personnel to do more claims tracking and monitoring. Using the software's claims tracking features, PPG's efforts are now focused on tracking a claim, rather than merely getting the claim out the door.

"The doctors are looking at how much money we're collecting for them each month and we have to watch accounts receivables very, very closely," says Marshall. "The system has allowed us to get a much better handle on our accounts and the delinquency criteria."

Saving Time with Up-To-Date Information

Each month, the system averages 200,000 to 220,000 transactions and generates about 45,000 patient statements and 32,000 insurance claims. PPG transmits claims to insurance carriers weekly while generating the professional bill for each patient. When a patient is seen in 2 or 3 clinics in the same day, the system compiles the data, gathering all charges for statements and claim filing.

Patients are distributed among multiple cycles which allows statements to be generated weekly, although each patient receives only one statement each month. This evens out PPG's workload because patients often have questions as soon as they receive the statement.

"This was a major problem with the batch system" says May. "For the next two weeks our people responded to patient calls. And oftentimes, because of the monthly batch processing of claims, we did not have the up-to-date information. Today with the on-line system we're looking at charges that may have been created only hours ago."

PPG sees a wide variety of patients from indigent to full paying. Because the APS Bullet/3000 paper-less collection system is driven by tables, a specific type of follow-up letter can be generated based on the patient mix category.

Using the system's reporting capability, PPG can determine the indigent patient mix and do automatic write-offs. By setting up parameters that generate a review list, PPG can easily write-off charges from a patient account, saving time and controlling receivables for the practice.

Robert Colligan, Executive Director

HEWLETT PACKARD

Generating More Than 250 Reports A Month

In addition to 100+ standard system-provided reports, PPG has developed about 175 monthly ad-hoc reports from the accounts receivable database. After working closely with the chairman, department managers, and doctors at the college to determine their criteria, PPG is able to provide detailed, customized reports within two or three days.

"A doctor may tell us he thought he billed out more in a certain month," says Marshall. "We can show him the total picture – what he billed, the patient mix and the income results."

The physician response has been very positive. "Our physicians are very demanding and they now feel they are getting the information they need," says Colligan. "I get compliments all the time regarding the kinds of information and data we're giving them."

Preparing for the Future

"The backbone of this whole operation is the computer system," says May. "How effective that system is, is how effective PPG can be. That's what this computer has given us, the information to make us more effective."

"Although I've used competing systems in other groups that were certainly adequate, we've found Hewlett-Packard to be a superior hardware platform," said Colligan.

Computer operator Barbara McCord and the heart of the system - the HP 3000 Model 960

"The APS Bullet/3000 is a more flexible system with significant attention given to the needs of running the practice," adds Colligan.

In the future, PPG will be investigating scanning capabilities utilizing optical character readers. Patient encounter forms can be scanned rather than keyed into the system, allowing PPG to direct personnel resources elsewhere. PPG also plans to investigate better ways to store and access medical records.

"I see nothing but growth for PPG and the healthcare industry," says Colligan. "Technology is changing in health care and procedures are changing all the time. How we do our business is going to change dramatically."

"As an academic institution, the Medical College of Georgia wants to be, and needs to be, on the leading edge. Physicians Practice Group, as a provider of billing and collection activity for these physicians, is now on the leading edge on the computer side," adds Colligan. "With HP and APS, we can offer the best management information possible now and in the future."

Health Care Information Systems
Hewlett-Packard Company
3000 Minuteman Road
Andover, MA 01810
(508) 687-1501

APS Systems, Inc.
1301 Capital of Texas Highway, Suite B220
Austin, TX 78746
(800) 252-3628

5091-1683E
Printed in the U.S.A. 5/91

aps Systems, Inc.

Clinton Presidential Records
Digital Records Marker

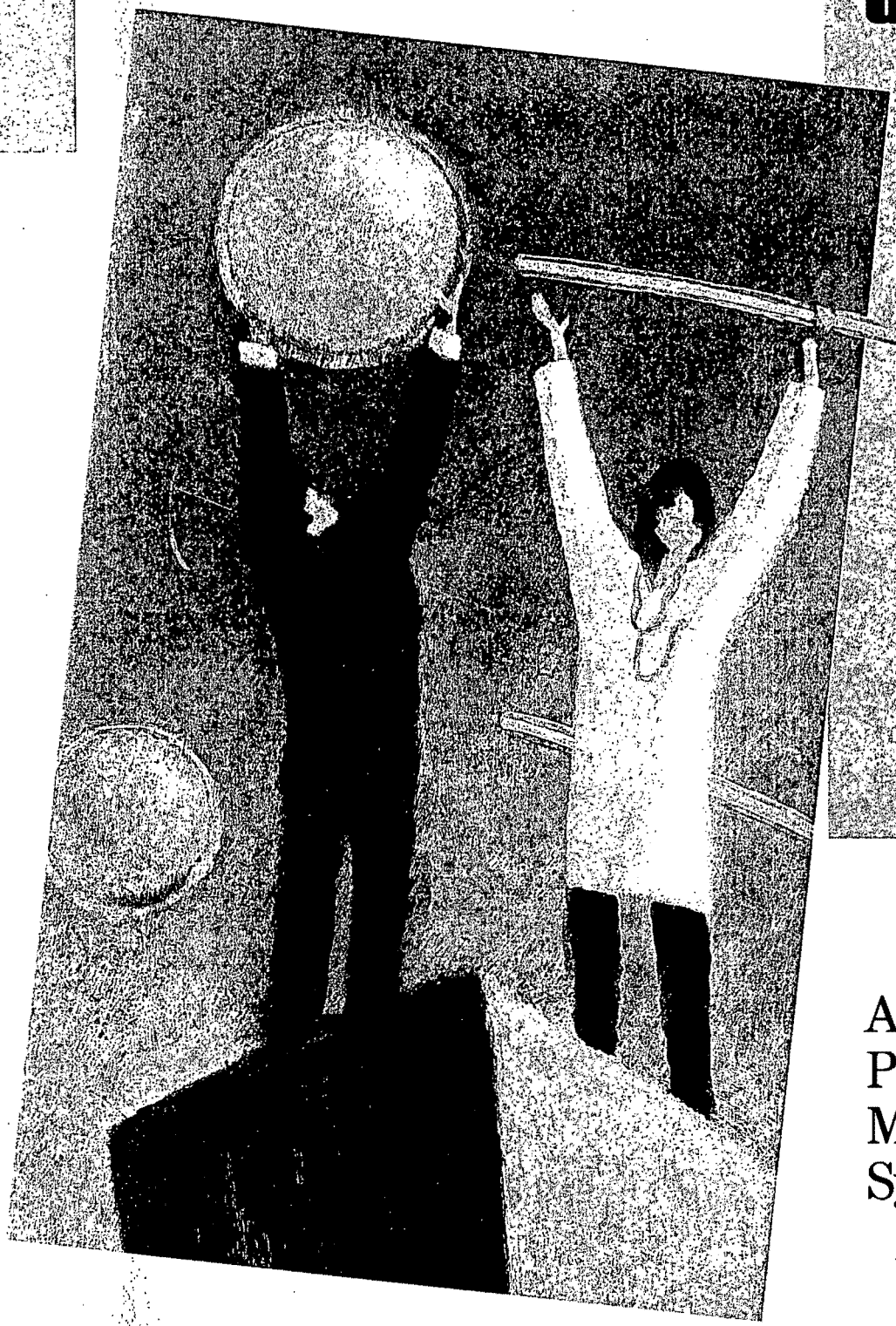
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

HEWLETT PACKARD

aps Systems, Inc.



APS BULLET/3000 Practice Management System

aps Systems, Inc.

APS/BULLET 3000

Software for Large Group Practices and Medical Schools

A product of
American Physicians Service Group, Inc.

HealthCare Information Systems

Features

- Client-definable flexibility
- Full range of applications
- Complete help system
- Menu- or command-driven
- Operator-definable defaults
- Free form text
- Handles multiple clinics/companies
- Complete user documentation
- Multiple reporting methods
- High speed or interactive data entry
- Single stroke function keys
- Runs on HP 3000 business computers from Hewlett-Packard

Functional Description

The APS BULLET/3000 is one of the finest accounts receivable management systems available today for large group practices. The heart of the APS BULLET/3000 is the HP TurboIMAGE database management system. Integrating patient and physician financial, demographic and medical information, this database makes information from varied sources available for on-line inquiry throughout your organization.

The flexibility of the APS BULLET/3000 will allow you to respond quickly to the demands of the medical market. The APS BULLET/3000 is a system for today, with the capability to grow with your needs of tomorrow.

Application Software

APS BULLET/3000 is composed of 13 major software modules.

Registration
The system handles Registration and Pre-Registration through the same programs and screens, and allows the user to elect Family, Patient or Industrial billing on a patient-by-patient basis. Input is available in either an on-line or off-line mode, and the system allows for user-definable data elements. Inquiry and LOOK-UP are available by name, social security number, birthdate or subscriber number. Patients may have multiple account balances and responsible parties without re-registration of the patient.

Transactions
Transactions may be entered on-line, through on-line batch or by off-line tape. Automatic pricing of services may be done by either Fee Schedules (up to 9999 different schedules) or by Conversion Factor/Relative Value. Diagnosis information may be captured at Registration, or on Charge Entry or Diagnosis Entry screens.

Patient Billing
This module allows and tracks both Open Item Insurance Balances and Accounts Receivable Balance Forwards. It accommodates patient, family and institutional bills and allows for cycle billing by one of five methods of selection or monthly billing. The system accommodates Finance Charges, Monthly Payment Plans, Dunning Messages by Account Type and Payment History, and allows entry of prepayments separate from the patient's normal balance.

aps Systems, Inc.

Functional Description cont.

Insurance Processing
The system allows the choice of Sequential or Simultaneous Claim form generation, and generates claims for any account with unfiled charges that has insurance coverage records on file. The software includes claims tracking, maintains claims information and current filings, and allows for manual insurance requests.

Collection Follow-up
This module tailors collection follow-up processes and delinquency criteria for each account type. Collection reports and letters are produced automatically. History records are produced for any system-generated activity.

Management Reporting
APS BULLET/3000 generates a number of reports, including: Referring Physician; Diagnosis Frequency; Projected Change in Fees Impact; and Detail and Summary for Provider Productivity.

Equity Allocation
Equity Allocation maintains separate receivables for each provider in the system, and balances Equity and A/R with each equity run. Reporting is extremely flexible to assist in tailoring the output to the individual department, section or provider's needs.

Table Management
Tables interact with, direct and specify the logic used by the application software. Tables are flexible, user maintainable, and allow the user to enter frequently used information once for entry elsewhere.

Appointment Scheduling
Appointment Scheduling allows the user to schedule both physician time and patient appointments. Appointments can be booked indefinitely into the future and can be made according to different parameters such as: physician; specialty; day of the week; and clinic.

Medical Records/Chart Tracking
The system provides a secure record of each patient's medical record, and organizes and reports medical histories, medications, notes, orders, therapies, vital signs and lab results on line and interactively.

Alternative Delivery Tracking
This module captures HMO and other prepaid insurance plan variables by employer group and plan, maintaining enrollment information by subscribers and members. Other features include: income calculation; billing; online benefits inquiry; and complete reporting.

Recall
Recall provides appointment reminder notices, table-driven recall reasons and an audit trail for patient management.

Ad Hoc Reporting
Reports may be created based on the entire database, and can be displayed on the screen or printed. The system can extract files in Lotus 1-2-3, DIF or ASCII format.

Configuration and Price

APS BULLET/3000 was specifically designed for HP 3000 business computers. The system utilizes the HP TurboIMAGE database to access all data elements. Complete systems start at $250,000 and range to $1,000,000+, depending on requirements.

Customer Information

Profile
APS BULLET/3000 meets the needs of medical university and teaching hospital practice plans, as well as medical group practices requiring at least 20 terminals.

Benefits
- Allows maximum flexibility
- Meets current and long range financial management needs
- Improved control over accounts receivable and collections for better cash flow, insurance processing and follow-up to maximize the third party payment structure
- More efficient management through improved patient and physician scheduling

Support
American Physicians Service Group offers on-site training and remote support, as well as a toll-free hotline for immediate response.

For more information, contact:
Roger T. Scaggs
President
American Physicians Service Group, Inc.
1301 Capital of Texas Hwy.
Suite B-220
Austin, Texas 78746
1-800-252-3628

HEWLETT PACKARD
Premier Solution Provider

5954-6540
Printed in U.S.A. 04/90

AMERICAN PHYSICIANS SERVICE GROUP, INC.

Asheville, NC
August 22-23, 1993

Roger Scaggs, President of APS, will greet you at the airport upon arrival in Asheville. Patti Adams, Marketing Support Representative for APS, will coordinate your return to the airport on Monday.

Your hotel accommodations were confirmed by APS at:

The Grove Park Inn Mountain Resort
phone: (704)252-2711

A car has been requested for your departure from the WH on Sunday at 5:00 pm. A WH driver will meet you at the USAir terminal for return to the WH on Monday at 1:30 pm.

*NOTE: There will be no meal service on either of your flights.

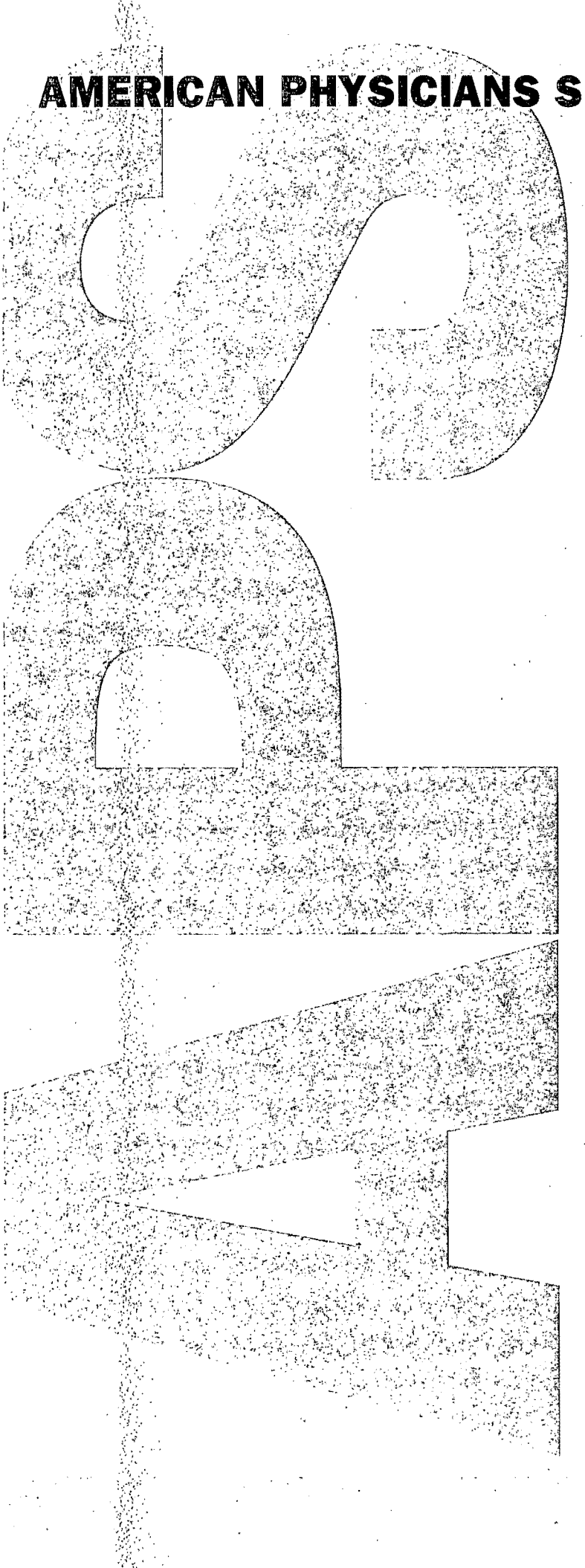
Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

AMERICAN PHYSICIANS SERVICE GROUP, INC.



Annual Report **1992**