

THE WHITE HOUSE

WASHINGTON

January 26, 2010

The Honorable Michael C. Burgess, M.D.
United States House of Representatives
229 Cannon House Office Building
Washington DC 20515

Dear Representative Burgess:

I am writing in response to your letter to President Obama dated September 30, 2009. In the letter, you ask the White House to disclose “all meetings with health care stakeholders” related to “securing an agreement on health reform legislation.” As you know, the President is firmly committed to increasing transparency in government. As part of fulfilling that commitment, the President announced on September 4, 2009, a groundbreaking voluntary disclosure policy governing White House visitor records. With limited exceptions, the policy requires the public release of all visitor records created after September 15—the first time in history that any Administration has disclosed this information on an ongoing basis. The policy also provides for the release of records created before September 15, in response to specific requests.

Shortly after the announcement of the new policy, we received a request for all healthcare-related meetings attended by certain senior White House staff members. Although visitor records usually do not identify the subject matter of particular meetings, we made a good faith effort to identify healthcare-related records. On November 25, we released the results of our search, by posting online records related to 575 individual appointments and/or visits to the White House. According to the *Associated Press*, the “records show a broad cross-section of the people most heavily involved in the health care debate.” I have enclosed with this letter a summary of those records. The full data set (which is too large to print) remains available online. Of course, if there are additional searches for specific individuals that you or other Members of the Committee would like us to conduct, we would be happy to do so.

Your letter also requests information relating to any supposed agreements between the White House and healthcare reform stakeholders. The White House has regularly provided to the public information about its discussions and meetings with stakeholders. Much of this information has been available on the White House website, and I have enclosed it and other additional relevant materials with this letter.

Finally, your letter requests information relating to any groups or individuals who asked to meet with the White House regarding healthcare and were denied. The White House receives millions of letters, emails, and telephone calls regarding high-profile policy issues such as healthcare, and we greatly value the public’s ability to participate in this historic dialogue.

Therefore, we are willing to work with you to identify any particular groups or individuals that you or other Members believe were unable to communicate their views.

Thank you for your letter. We look forward to working with you and the other Members of the Committee on these important issues.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Bauer', with a long horizontal flourish extending to the right.

Robert F. Bauer
Counsel to the President

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

May 12, 2009

THE WHITE HOUSE
WASHINGTON

May 12, 2009

Mr. Stephen J. Uhl
President & CEO
Advanced Medical Technology Association

Dr. J. James Rohack, M.D.
President-elect
American Medical Association

Ms. Karen Ignagni
President & CEO
America's Health Insurance Plans

Mr. Rich Umbdenstock
President & CEO
American Hospital Association

Mr. Billy Tauzin
President & CEO
Pharmaceutical Research and Manufacturers of America

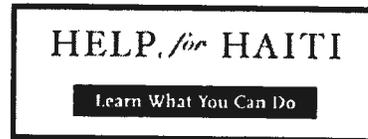
Mr. Dennis Rivera
Chair, SEIU Healthcare
Service Employees International Union

Dear Mr. Uhl, Dr. Rohack, Ms. Ignagni, Mr. Umbdenstock, Mr. Tauzin, and Mr. Rivera:

It was a pleasure to meet with all of you yesterday. As I said yesterday, health care reform will require all of us working together—from drug and insurance companies to labor unions and business executives, from doctors to hospitals and Members of Congress. I appreciate the commitment you have made to health care reform by pledging to do your part to reduce our Nation's annual health care spending growth rate by 1.5 percentage points. Coupled with comprehensive health care reform, your efforts could save the Nation more than \$2 trillion over the next ten years and save hardworking families \$2,500 in health care costs in the coming years.

Getting spiraling health care costs under control is essential to providing all Americans with affordable, quality care, making our businesses more competitive, and closing our budget deficits. I will hold you to your pledge to get this done. As we discussed in our meeting yesterday, I would like you to update my Administration by early June on the progress you have made toward fulfilling this important commitment.

Sincerely,
Barack Obama



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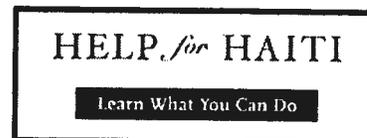
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THE WHITE HOUSE
Office of the Press Secretary

FOR IMMEDIATE RELEASE

July 8, 2009

**BACKGROUND ON TODAY'S HEALTH CARE ANNOUNCEMENT**

- As families, businesses and governments struggle with the increasing burden of health care costs, hospital leaders are joining with the Administration to say the status quo is no longer sustainable. Like others in the health care industry, hospitals have seen firsthand that Americans with health insurance are struggling to pay their health care bills because they are under-insured and their out of pocket expenses are rising. Often those without insurance – because they have lost a job or someone in their family suffers from a pre-existing condition – are forced to throw themselves on the mercy of America's hospitals. Hospitals absorb some of the cost of caring for Americans without insurance – while the remainder is passed on to taxpayers or Americans with insurance. The hospital industry agrees with the President that the time to enact health reform that lowers costs and assures quality and affordable coverage for all Americans is now. It cannot wait.
- Last month, the hospital industry acknowledged that significant health care savings can be achieved by improving efficiencies and realigning incentives to emphasize quality of care instead of quantity of procedures. Now they have worked with Senate Finance Committee Chairman Max Baucus to develop proposals that will produce \$155 billion of savings in federal health care spending over the next 10 years—savings that will be used to finance health care reform, in keeping with the President's firm goal of enacting legislation that is deficit neutral.
- As part of this agreement, hospitals have committed to support policies that will help pay for health reform and reduce overall costs to the Medicare program. These reductions will be achieved through a combination of payment reforms, including additional reductions in hospital's annual inflationary updates. They will be more than offset as health reform takes hold and hospitals bear less of the financial burden of caring for the uninsured or underinsured.
- In addition, in the area of delivery system reform, hospitals are reaffirming their long-standing commitment to improve quality and reduce costs in the health care system by supporting initiatives such as value-based purchasing; testing ways to better integrate care; and taking steps to reduce unnecessary hospital readmissions.
- The savings the industry has agreed to achieve are consistent with the policy goals set forth by the President and the Congress to expand coverage, reduce health care costs and transform the health care delivery system.

Attendees and participants at today's announcement included:

- Vice President Biden
- HHS Secretary Kathleen Sebelius
- Richard Bracken - President & CEO, Hospital Corporation of America
- Wayne Smith - President & CEO, Community Health Systems
- Sister Carol Keehan - President and CEO, Catholic Health Association of the United States (CHA)
- Rich Umbdenstock - President and CEO, American Hospital Association

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The Consensus Grows: Hospitals for Health Reform

Posted by [Jesse Lee](#) on July 08, 2009 at 12:45 PM EST

This morning marked another major milestone for health reform, as Vice President Biden, HHS Secretary Kathleen Sebelius and representatives of the hospital industry came together to announce a major investment from hospitals in the effort. The contribution is yet another step towards ensuring reform will be deficit-neutral and a key to long-term fiscal sustainability.

"As part of this agreement," the [Vice President explained](#), "hospitals are committing to contributing \$155 billion -- \$155 billion -- in Medicare and Medicaid savings over the 10 years to cover health care cost reform -- over the next 10 years." He further explained how the agreement is another example of how reform is in everybody's interest: "As more people are insured, hospitals will bear less of the financial burden of caring for the uninsured and the underinsured, and we'll reduce payments to cover those costs, in tandem with that reduction."

• [Read the White House background](#)

Having warmly welcomed the hospital CEOs and representatives, Vice President Biden honed in on the significance of this latest step towards consensus:

Folks, reform is coming. It is on track; it is coming. We have tried for decades -- for decades -- to fix a broken system, and we have never, in my entire tenure in public life, been this close. We have never been as close as we are today, and things remain on track.

We have these hospitals working with us, and we have the pharmaceutical industry working with us; we have doctors and nurses and health care providers with us; we have the American public behind us. And everyone sees that we need change. And in my view, we're going to get that change, and we're going to get it this year.

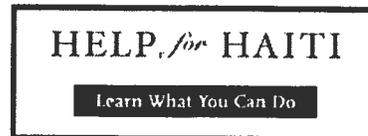


Vice President Joe Biden announces that the nation's hospitals will give up \$155 billion in future Medicare and Medicaid to help defray the cost of President Obama's health care plan, in room 350 of the EEOB, Wednesday, July 8, 2009. Official White House Photo by David Lienemann

And he explained how the agreement came about:

The hospital industry knows, and the people with me here today know, and the President knows, that the status quo is simply unacceptable. Let me say that again -- the status quo is simply unacceptable. Rising costs are crushing us. They're crushing families, crushing businesses, crushing state budgets - and they are crushing the health care industry itself.

Hospitals have acknowledged that significant health care savings can be achieved by improving efficiencies, realigning incentives to emphasize quality care instead of quantity of procedures. And in the last several weeks, they've been working with Chairman Baucus and are coming forward with a



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proposal that produces real savings in federal health care spending – savings that will be applied toward the President’s firm goal -- firm goal of enacting health care reform that is deficit-neutral -- health care reform that is deficit-neutral.

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THE WHITE HOUSE
Office of the Vice President

For Immediate Release July 8, 2009

REMARKS BY THE VICE PRESIDENT AT HEALTH CARE ANNOUNCEMENT
Dwight D. Eisenhower Executive Office Building

10:50 A.M. EDT

THE VICE PRESIDENT: Good morning, folks. How are you? I want to thank you all -- I apologize for being late. I was at a meeting with Senator Baucus and Senator Reid, and Senator Baucus was on his way over here with me for this announcement and he -- there was a vote called in the Senate. So, again, I apologize to our participants here.

I want to thank everyone for joining me here today. And as you know, we have with us today a constellation of people who have been able to put together a great, great proposal with Senator Baucus and the President: Richard Bracken, the president and CEO of the Hospital Corporation of America; Wayne Smith, President and CEO of Community Health Systems; Sister Carol Keenan who -- I told her that I was a good kid in school. (Laughter.) And she is the CEO of Catholic Health Association of the United States. And Richard Umbdenstock -- am I pronouncing it correctly, Richard? Rich, actually -- and president and CEO of the American Hospital Association.

I was going to introduce Max Baucus, but you got to go up to the Hill and see him -- he's voting now. And obviously, our Secretary -- Secretary Sebellus.

Look, I want to warmly welcome the hospital CEOs here with us today. You know, every day you see firsthand the impact the skyrocketing health care costs have had on American families. And today, they've come together to do something about those health care costs.

Folks, reform is coming. It is on track; it is coming. We have tried for decades -- for decades -- to fix a broken system, and we have never, in my entire tenure in public life, been this close. We have never been as close as we are today, and things remain on track.

We have these hospitals working with us, and we have the pharmaceutical industry working with us; we have doctors and nurses and health care providers with us; we have the American public behind us. And everyone sees that we need change. And in my view, we're going to get that change, and we're going to get it this year.

The poet Virgil said, the greatest wealth is health. Well, we're here today to make our health care system healthy again. A strong commitment from these hospitals represented here and others will be a big part of making that happen.

All around the country, the people who have health insurance still are struggling to pay their bills because they are underinsured or they're out-of-pocket expenses are rising so rapidly they have trouble keeping up. And those who don't have insurance because they've lost their jobs or have been denied coverage because someone in their family has a preexisting condition are throwing themselves at the mercy of the people who represent the major hospitals in this -- in the United States of America today. And as a result, our hospitals are cracking under the weight of providing quality health care for Americans who lack insurance.

The hospital industry knows, and the people with me here today know, and the President knows, that the status quo is simply unacceptable. Let me say that again -- the status quo is simply unacceptable. Rising costs are crushing us. They're crushing families, crushing businesses, crushing state budgets -- and they are crushing the health care industry itself.

Hospitals have acknowledged that significant health care savings can be achieved by improving efficiencies, realigning incentives to emphasize quality care instead of quantity of procedures. And in the last several weeks, they've been working with Chairman Baucus and are coming forward with a proposal that produces real savings in federal health care spending -- savings that will be applied toward the President's firm goal -- firm goal of enacting health care reform that is deficit-neutral -- health care reform that is deficit-neutral.

As part of this agreement, hospitals are committing to contributing \$155 billion -- \$155 billion -- in Medicare and Medicaid savings over the 10 years to cover health care cost reform -- over the next 10 years. These reductions will be achieved through a combination of delivery system reforms, additional reductions in hospital -- and additional reductions in the hospital's annual inflationary updates. All of these savings are based on the policies the administration proposed in its budget to fund health care reform.

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As our system becomes more efficient -- thanks to innovation, technology and electronic records -- we'll show increases -- we'll slow, I should say, increases in Medicare and Medicaid payments to hospitals. As more people are insured, hospitals will bear less of the financial burden of caring for the uninsured and the underinsured, and we'll reduce payments to cover those costs, in tandem with that reduction.

Today's announcement I believe represents the essential role hospitals play in making reform a reality. And a reality it will be. We must enact this reform this year. We must -- and we will -- enact reform by the end of August. And we can't wait. I know that; the leaders that are up here know that; the President knows that; my colleagues who I just spoke to know that; and the entire Congress knows it. And I look forward to hearing how their hospitals are going to be helping and bringing about this reform. That's why they're here today.

So I thank you again for being here. I thank the press for being here, and our colleagues. And I'd like now to introduce Sister Keenan -- or as we say, "Yester, it's your podium." (Laughter.)

END 10:57 A.M. EDT

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PHRMA STATEMENT ON MEDICARE PART D COVERAGE GAP

**PhRMA Statement on Medicare Part D Coverage Gap**

Washington, D.C. (June 20, 2009) — Pharmaceutical Research and Manufacturers of America (PhRMA) President and CEO [Billy Tauzin](#) and PhRMA Board Chairman [David Brennan](#), Chief Executive Officer, AstraZeneca, issued the following statement regarding today's commitment, as part of health care reform, to help close the coverage gap in the [Medicare prescription drug program](#) (Part D):

"PhRMA ([about](#)) is committed to working with the Administration and Congress to help enact comprehensive health care reform this year. We share a common goal: every American should have access to affordable, high-quality health care coverage and services.

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"As part of that reform, one thing that we have agreed to do is support legislation that will help seniors affected by the coverage gap in the Medicare prescription drug benefit. Although the program has been a tremendous success for the vast majority of seniors, the coverage gap has posed a challenge to some seniors and our companies have been exploring ways to address this issue for several years.

"Under this proposed new legislative program – which represents the first important step in health care reform – America's pharmaceutical research and biotechnology companies have agreed to help close the gap in coverage. Specifically, companies will provide a 50 percent discount to most beneficiaries on brand-name medicines covered by a patient's Part D plan when purchased in the coverage gap.

"In addition, the entire negotiated price of the Part D covered medicine purchased in the coverage gap would count toward the beneficiary's out-of-pocket costs, thus lowering their total out-of-pocket spending. Importantly, the proposal would not require any additional paperwork on the part of the beneficiary nor would an asset test be used for eligibility.

“Since its inception, strong competition among drug plans participating in the Medicare drug benefit has led to significant savings for seniors. On average, beneficiaries are saving \$1,200 annually on their medicines, and the average low-income beneficiary saves \$3,900, according to the Centers for Medicare and Medicaid Services. This agreement will help to provide additional savings to even more seniors across the nation.

“Even though Medicare beneficiaries are satisfied with their prescription drug coverage – as evidenced by a recent Medicare Today survey showing overall satisfaction has grown from 78 percent at the start of the program in 2006 to 84 percent in 2009 – we have constantly explored ways to improve the benefit.

“This commitment to support legislation that will help close the coverage gap reflects our ongoing work with Congress and the Administration to make comprehensive health care reform a reality this year.”

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country’s leading pharmaceutical research and biotechnology companies, which are devoted to inventing medicines that allow patients to live longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for new cures. PhRMA members alone invested an estimated \$50.3 billion in 2008 in discovering and developing new medicines. Industry-wide research and investment reached a record \$65.2 billion in 2008.

PhRMA Internet Address: www.phrma.org

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May 12, 2009

REMARKS BY THE PRESIDENT
AFTER ROUNDTABLE WITH BUSINESS LEADERS TO
DISCUSS EMPLOYER HEALTH CARE COSTS

Roosevelt Room

12:23 P.M. EDT

THE PRESIDENT: Hello, everybody. We just had a wonderful conversation that is a corollary to the discussion that I had yesterday. And you may be seeing a theme, this was -- we're doing some stuff on health care because I think the country is geared up, businesses are geared up, families are geared up, to go ahead and start solving some of our extraordinary health care system problems.

Yesterday we focused a lot on cost. One element of cost is that where companies are able to take initiatives to make their employees healthier, to give them incentives and mechanisms to improve their wellness and to prevent disease, companies see their bottom lines improve.

And so what we've done is to gather together a group today -- some of the best practitioners of prevention and wellness, wellness programs -- in the private sector. You have companies like Safeway that have been able to hold their costs flat for their employees at a time when other companies are seeing double-digit inflation in their health care.

You've got terrific innovations at companies like Microsoft, where they actually have used home visits of doctors to reduce the utilization of emergency room care and are saving themselves millions of dollars.

We've got the Hotel Employees Union that has been taking data and working individually with providers as well as their membership, working with the employer and the employee as well as the providers, and seeing huge reductions in some of the costs related to chronic illnesses.

Johnson & Johnson has been a leader in this area since 1978. Pitney Bowes has been taking similar approaches and seeing millions of dollars in savings to their bottom line. The Ohio Department of Public Health has been doing terrific work with respect to their state employees as well as spreading the message across the state.

And then REI, which has to be fit since they're a fitness company -- (laughter) -- has been doing work that allows them to provide health care coverage, health insurance, not only to their full-time employees but also their part-time employees. Every single employee is covered, but part of the reason they're able to do it is because they put a big emphasis on prevention and wellness.

So what we've done here today is to gather together some of these stories and best practices to make sure that they are going to be informing the health care reform discussions that take place here in Washington. There's no quick fix, there's no silver bullet. When you hear what Safeway or Johnson & Johnson or any of these other companies have done, what you've seen is sustained experimentation over many years and a shift in incentive structures so that employees see concrete benefits as a consequence of them stopping smoking or losing weight or getting exercise, working with providers -- the provider incentives are aligned with the employee incentives as well, and changing the culture of a company.

Now, if we can do that in individual companies, there's no reason why we can't do that for a country as a whole. Part of what we want to do here, starting here today is to lift up these best practices so other companies can identify and potentially implement them; but also to make sure that when we think about how we're going to reform the health care system as a whole, when we think about things like Medicare and Medicaid reimbursements, when we think about how we can make the system more efficient, that we're not just doing this in the abstract, but we're actually taking proven measures that have been applied in the private sector and seeing how we can apply those, for example, to federal employees and our employee health care system. All this designed to save taxpayers money, save businesses money and ultimately make the American people healthier and happier and make sure that we're getting a better bang for our health care dollar.

So it's been a terrific conversation. This will be a part of the ongoing process that we're developing over the next several months and I appreciate all of you for participating in a wonderful conversation.



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All right. Thank you, guys.

END
12:29 P.M. EDT

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THE WHITE HOUSE
Office of the Press Secretary

EMBARGOED UNTIL 6:00 AM ET, SATURDAY, May 16, 2009
WEEKLY ADDRESS: President Obama Says Progress on Clean Energy and Healthcare Reform Will Lay
New Foundation

WASHINGTON – This week, President Barack Obama praised individuals representing different perspectives for coming together to address the challenges of building a clean energy economy, reforming the healthcare system and laying a new foundation for the long-term strength of our economy. Utility companies and corporate leaders are working with environmental advocates and labor leaders to find a way to reduce dependence on foreign oil, to fight climate change, and to create millions of new jobs in America. Recently, past critics and advocates of healthcare reform sat down with the President to work on reducing the healthcare costs by \$2 trillion in the next decade and saving families \$2,500 in the coming years. The full audio of the address is [HERE](#). The video can be viewed online at www.whitehouse.gov.

Remarks of President Barack Obama
Weekly Address
Saturday, May 16, 2009

Good morning. Over the past few months, as we have put in place a plan to speed our economic recovery, I have spoken repeatedly of the need to lay a new foundation for lasting prosperity; a foundation that will support good jobs and rising incomes: a foundation for economic growth where we no longer rely on excessive debt and reckless risk – but instead on skilled workers and sound investments to lead the world in the industries of the 21st century. Two pillars of this new foundation are clean energy and health care. And while there remains a great deal of difficult work ahead, I am heartened by what we have seen these past few days: a willingness of those with different points of view and disparate interests to come together around common goals – to embrace a shared sense of responsibility and make historic progress.

Chairman Henry Waxman and members of the Energy and Commerce Committee brought together stakeholders from all corners of the country – and every sector of our economy – to reach an historic agreement on comprehensive energy legislation. It's another promising sign of progress, as longtime opponents are sitting together, at the same table, to help solve one of America's most serious challenges.

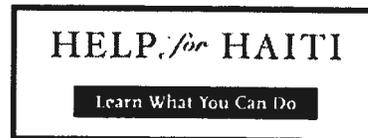
For the first time, utility companies and corporate leaders are joining, not opposing, environmental advocates and labor leaders to create a new system of clean energy initiatives that will help unleash a new era of growth and prosperity.

It's a plan that will finally reduce our dangerous dependence on foreign oil and cap the carbon pollution that threatens our health and our climate. Most important, it's a plan that will trigger the creation of millions of new jobs for Americans, who will produce the wind turbines and solar panels and develop the alternative fuels to power the future. Because this we know: the nation that leads in 21st century clean energy is the nation that will lead the 21st century global economy. America can and must be that nation – and this agreement is a major step toward this goal.

But we know that our families, our economy, and our nation itself will not succeed in the 21st century if we continue to be held down by the weight of rapidly rising health care costs and a broken health care system. That's why I met with representatives of insurance and drug companies, doctors and hospitals, and labor unions who are pledging to do their part to reduce health care costs. These are some of the groups who have been among the fiercest critics of past comprehensive health care reform plans. But today they too are recognizing that we must act. Our businesses will not be able to compete; our families will not be able to save or spend; our budgets will remain unsustainable unless we get health care costs under control.

These groups have pledged to do their part to reduce the annual health care spending growth rate by 1.5 percentage points. Coupled with comprehensive reform, their efforts could help to save our nation more than \$2 trillion in the next ten years – and save hardworking families \$2,500 each in the coming years.

This week, I also invited Speaker of House Nancy Pelosi, Majority Leader Steny Hoyer, and other congressional leaders to the White House to discuss comprehensive health reform legislation. The House is working to pass a bill by the end of July – before they head out for their August recess. That's the kind of urgency and determination we



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need to achieve comprehensive reform by the end of this year. And the reductions in spending the health care community has pledged will help make this reform possible.

I have always believed that it is better to talk than not to talk; that it is far more productive to reach over a divide than to shake your fist across it. This has been an alien notion in Washington for far too long, but we are seeing that the ways of Washington are beginning to change. For the calling of this moment is too loud and too urgent to ignore. Our success as a nation – the future of our children and grandchildren – depends upon our willingness to cast aside old arguments, overcome stubborn divisions, and march forward as one people and one nation.

This is how progress has always been made. This is how a new foundation will be built. We cannot assume that interests will always align, or that fragile partnerships will not fray. There will be setbacks. There will be difficult days. But we are off to a good start. And I am confident that we will – in the weeks, months, and years ahead – build on what we have already achieved and lay this foundation which will not only bring about prosperity for this generation, but for generations to come.

Thanks so much.

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Office of the Press Secretary

For Immediate Release

June 22, 2009

REMARKS BY THE PRESIDENT
ON THE MEDICARE PART D "DOUGHNUT HOLE"
AND AARP ENDORSEMENT
Diplomatic Reception Room

11:58 A.M. EDT

THE PRESIDENT: Thank you. Well, first of all, I want to thank Bary Rand for the introduction, but also AARP, the organization he so ably represents, for coming together with us on this critical issue today.

Last week, in my address to the American Medical Association, I spoke about the urgent need for health care reform and what will be required to achieve it. And one of the things that will be required, I said, was that everyone in our health care community is going to have to come together and do their part.

In recent days, Chairman Baucus, who has been doing an outstanding job leading the finance committee on this issue, as well as members of my administration, have been in discussions with the pharmaceutical industry to find a way to bring down costs of prescription drugs for America's seniors. And I'm pleased to report that over the weekend we reached an understanding that will help close the notorious "doughnut hole" in Medicare Part D. This is a significant breakthrough on the road to health care reform -- one that will make the difference in the lives of many older Americans.

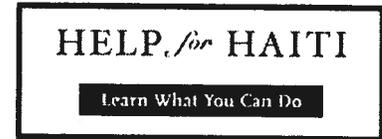
I think many of you in the press are familiar with the issue. The "doughnut hole" refers to a gap in prescription drug coverage that makes it harder for millions of Medicare beneficiaries to pay for the medication they need. The way the program is structured, Medicare covers up to \$2,700 in yearly prescription costs and then stops, and the coverage starts back up when the costs exceed \$6,100. Which means between \$2,700 and \$6,100 folks are out of luck. And this gap in coverage has placing a crushing burden on many older Americans who live on fixed incomes and can't afford thousands of dollars in out-of-pocket expenses.

Chris Dodd, who has been an outstanding leader on a whole host of health care issues throughout his career and who is helping to lead the HELP Committee while Senator Kennedy is undergoing his treatment for his illness -- Chris, I think, will tell you that as we travel around the country, seniors would constantly be coming up to us and saying, how do we deal with this extraordinary burden? And as a consequence, you'd have seniors who would be taking half their medication, even though the doctor said that is not going to be as effective; you are putting your life at risk. They had no other choice.

So as part of the health care reform I expect Congress to enact this year, Medicare beneficiaries whose spending falls within this gap will now receive a discount on prescription drugs of at least 50 percent from the negotiated price their plan pays. It's a reform that will make prescription drugs more affordable for millions of seniors, and restore a measure of fairness to Medicare Part D. It's a reflection of the importance of this single step for America's seniors that it has earned the support of AARP, which has been fighting for years to address this anomaly in the system on behalf of older Americans. AARP is committed, as I am, to achieving health care reform by the end of this year. And I'm committed to continuing to work with AARP to ensure that any reforms we pursue are carried out in a way that protects America's seniors, who know as well as anyone what's wrong with our health care system and why it's badly in need of reform.

Our goal -- our imperative -- is to reduce the punishing inflation in health care costs while improving patient care. And to do that we're going to have to work together to root out waste and inefficiencies that may pad the bottom line of the insurance industry, but add nothing to the health of our nation. To that end, the pharmaceutical industry has committed to reduce its draw on the health care system by \$80 billion over the next 10 years as part of overall health care reform.

Real health care reform that reduces the spiraling costs of health services and extends quality, affordable health coverage to all Americans will require these kinds of commitments throughout the system. And drug and insurance companies stand to benefit when tens of millions more Americans have coverage. So we're asking them, in exchange, to make essential concessions to reform the system and help reduce costs. It's only fair. Today marks a major step forward. But it will only be meaningful if we complete the journey.



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So I want to commend the House for coming together last week to produce a health care reform bill -- a bill, I might note, that protects seniors and has received the support of the AARP. I will continue to work closely with the relevant chairs in the House and the Senate, and leaders like Senator Dodd and Senator Baucus, and with members of both parties who are willing to commit themselves to this critical task. Our families, our businesses, and our long-term fiscal health demands that we act and act now. Today, we are. And I'm grateful to all those who helped make this day possible. And to those who, here in Washington; who've grown accustomed to "sky is falling" prognoses and the certainties that we cannot get this done, I have to repeat -- revive an old saying we had from the campaign: Yes, we can. We are going to get this done.

Thank you very much, everybody.

END
12:04 P.M. EDT

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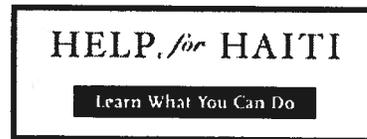
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Office of the Press Secretary

For Immediate Release

June 20, 2009



Statement from the President Obama on Agreement to Bring Down Drug Prices for Americans Seniors

"I am pleased to announce that an agreement has been reached between Senator Max Baucus and the nation's pharmaceutical companies that will bring down health care costs and reduce the price of prescription drugs for millions of America's seniors. As part of the health reform legislation that I expect Congress to enact this year, pharmaceutical companies will extend discounts on prescription drugs to millions of seniors who currently are subjected to crushing out-of-pocket expenses when the yearly amounts they pay for medication fall within the doughnut hole any payments by seniors not covered by Medicare that fall between \$2700 and \$6153.75 per year. The existence of this gap in coverage has been a continuing injustice that has placed a great burden on many seniors. This deal will provide significant relief from that burden for millions of American seniors".

"The agreement by pharmaceutical companies to contribute to the health reform effort comes on the heels of the landmark pledge many health industry leaders made to me last month, when they offered to do their part to reduce health spending \$2 trillion over the next decade. We are at a turning point in America's journey toward health care reform. Key sectors of the health care industry acknowledge what American families and businesses already know - that the status quo is no longer sustainable. The agreement reached today to lower prescription drug costs for seniors will be an important part of the legislation I expect to sign into law in October. I want to commend House chairmen Henry Waxman, George Miller and Charles Rangel for addressing this issue in the health reform legislation they unveiled this week. This is a tangible example of the type of reform that will lower costs while assuring quality health care for every American".

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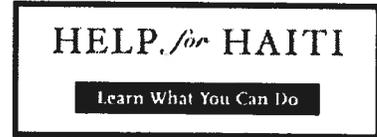
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Office of the Press Secretary

For Immediate Release
May 11, 2009



Below is a list of health care reform stakeholders who will meet with the President and administration officials today. Please find attached a [full fact sheet](#) and the [groups' letter to President Obama](#) concerning reducing the growth rate of health care costs.

Meeting Participants:

Stakeholders:

Insurers

George Halvorson, Chairman and CEO of Kaiser Foundation Health Plan
Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP)
Jay Geilert, President and CEO of Health Net Inc.

Hospitals

Thomas Priselac--President & CEO, Cedars-Sinai Health System
Rich Umbdenstock-- President & CEO, American Hospital Association (AHA)
Ken Raske--President, Greater New York Hospital Association

Physicians

J. James Rohack, M.D.-- President-Elect, American Medical Association (AMA)
Rebecca Patchin, M.D.-- Chair-Elect of the AMA
Rich Deem-- Senior Vice President of the AMA

Medical Device Companies

Michael Mussallem--Chairman & CEO, Edwards Lifesciences
Steve Ubl-- President & CEO, AdvaMed
David Nexon-- Senior Executive Vice President, AdvaMed

Pharmaceutical Companies

Richard Clark--Chairman, President & CEO, Merck
Billy Tauzin--President & CEO, PhRMA
Rick Smith--Senior Vice President, PhRMA

Labor

Andy Stern, SEIU
Dennis Rivera, SEIU Health

Administration Officials:

Nancy-Ann DeParle, Director of the Office of Health Reform
Peter Orszag, Director of the Office of Management and Budget
Larry Summers, Director of the National Economic Council
Kathleen Sebelius, HHS Secretary

After the meeting, the following stakeholders will join President Obama for his remarks:

- George Halvorson, Chairman and CEO of Kaiser Foundation Health Plan

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- J. James Rohack, M.D., President-Elect, American Medical Association
- Richard Clark, Chairman, President & CEO, Merck
- Michael Mussallem, Chairman & CEO, Edwards Lifesciences
- Dennis Rivera, SEIU
- Tom Priselac, President and CEO of Cedars- Sinai Health System

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release
May 11, 2009

REMARKS BY THE PRESIDENT
ON REFORMING THE HEALTH CARE SYSTEM
TO REDUCE COSTS

State Dining Room

12:35 P.M. EDT

THE PRESIDENT: Hello, everyone. All right. Well, I just concluded a extraordinarily productive meeting with organizations and associations that are going to be essential to the work of health care reform in this country – groups that represent everyone from union members to insurance companies, from doctors and hospitals to pharmaceutical companies. It was a meeting that focused largely on one of the central challenges that we must confront as we seek to achieve comprehensive reform and lay a new foundation for our economy – and that is, the spiraling cost of health care in this country.

They're here because they recognize one clear, indisputable fact: When it comes to health care spending, we are on an unsustainable course that threatens the financial stability of families, businesses and government itself.

This is not news to the American people, who, over the last decade, have seen their out-of-pocket expenses soar, health care costs rise, and premiums double at a rate four times faster than their wages.

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What is a growing crisis for the American people is also becoming an untenable burden for America's businesses. Rising health care costs are commanding more and more of the money that our companies could be using to innovate and to grow, making it harder for them to compete around the world. These costs are leading the small businesses that are responsible for half of all private sector jobs to drop coverage for their workers at an alarming rate.

And, finally, the explosion in health care costs has put our federal budget on a disastrous path. This is largely due to what we're spending on Medicare and Medicaid – entitlement programs whose costs are expected to continue climbing in the years ahead as baby boomers grow older and come to rely more and more on our health care system. That's why I've said repeatedly that getting health care costs under control is essential to reducing budget deficits, restoring fiscal discipline, and putting our economy on a path towards sustainable growth and shared prosperity.

We, as a nation, are now spending a far larger share of our national wealth on health care than we were a generation ago. At the rate we're going, we are expected to spend one fifth of our economy on health care within a decade. And yet we're getting less for our money. In fact, we're spending more on health care than any other nation on Earth, even though millions of Americans don't have the affordable, quality care they deserve, and nearly 46 million Americans don't have any health insurance at all.

This problem didn't just appear overnight. For decades, Washington has debated what to do about this. For decades, we've talked about reducing costs, improving care, and providing coverage to uninsured Americans. But all too often, efforts at reform have fallen victim to special interest lobbying aimed at keeping things the way they are; to political point-scoring that sees health care not as a moral issue or an economic issue, but as a wedge issue; and to a failure on all sides to come together on behalf of the American people.

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Their efforts will help us take the next and most important step -- comprehensive health care reform -- so that we can do what I pledged to do as a candidate and save a typical family an average of \$2,500 on their health care costs in the coming years. Let me repeat that point. What they're doing is complementary to and is going to be completely compatible with a strong, aggressive effort to move health care reform through here in Washington with an ultimate result of saving health care costs for families, businesses and the government. That's how we can finally make health care affordable, while putting more money into the pockets of hardworking families each month. These savings can be achieved by standardizing quality care, incentivizing efficiency, investing in proven ways not only to treat illness but to prevent them.

This is a historic day, a watershed event in the long and elusive quest for health care reform. And as these groups take the steps they are outlining, and as we work with Congress on health care reform legislation, my administration will continue working to reduce health care costs to achieve similar savings. By curbing waste, fraud, and abuse and preventing avoidable hospital re-admissions and taking a whole host of other cost-saving steps, we can save billions of dollars, while delivering better care to the American people.

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But there's so much more to do. In the coming weeks and months, Congress will be engaged in the difficult issue of how best to reform health care in America. I'm committed to building a transparent process where all views are welcome. But I'm also committed to ensuring that whatever plan we design upholds three basic principles: First, the rising cost of health care must be brought down; second, Americans must have the freedom to keep whatever doctor and health care plan they have, or to choose a new doctor or health care plan if they want it; and third, all Americans must have quality, affordable health care.

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Ultimately, the debate about reducing costs -- and the larger debate about health care reform itself -- is not just about numbers; it's not just about forms or systems; it's about our own lives and the lives of our loved ones. And I understand that. As I've mentioned before during the course of the campaign, my mother passed away from ovarian cancer a little over a decade ago. And in the last weeks of her life, when she was coming to grips with her own mortality and showing extraordinary courage just to get through each day, she was spending too much time worrying about whether her health insurance would cover her bills. So I know what it's like to see a loved one who is suffering, but also having to deal with a broken health care system. I know that pain is shared by millions of Americans all across this country.

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END
12:46 P.M. EDT

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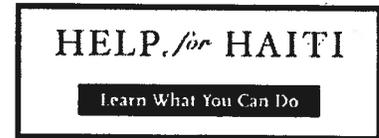
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AdvaMed
Advanced Medical Technology Association



**American Hospital
Association**

PHARMA



AHIP
America's Health
Insurance Plans



June 1, 2009

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

Four weeks ago we came together, representing six different sectors of the health care industry, and pledged: *As restructuring takes hold and the population's health improves over the coming decade, we will do our part to achieve your Administration's goal of decreasing by 1.5 percentage points the annual health care spending growth rate – saving \$2 trillion or more.*

Since then, we have been working hard on how to help achieve that goal. We have convened seven all-day meetings and multiple conference calls to discuss what we can contribute, both individually and collectively, to help achieve that challenging goal.

We have made solid progress. Individually and together, our organizations have developed initiatives that will help move the nation toward achieving the Administration's goal and we intend to keep working. Our organizations will now pursue these initiatives which, together, will help transform the U.S. health care system.

The attached documents describe each sector's commitments, which will have significant and lasting financial impact over time. Each group has identified changes in its sector that will reduce costs, strengthen quality and improve access to care through the following key areas:

- **Utilization of care:** Providing clinicians and other providers with the tools to address utilization and to improve quality and safety will help ensure that patients receive the right care at the right time in the right setting and will lower costs.
- **Cost of doing business:** Innovative approaches to reducing the growing costs of providing health care services are essential and will benefit all stakeholders in the health care system.
- **Administrative simplification:** Streamlining the claims processing system will allow clinicians and other personnel to spend less time and fewer resources on paperwork, lowering costs for everyone.
- **Chronic care:** We are identifying significant opportunities to better manage chronic disease, which accounts for 75% of overall health care spending. We are also looking at more effective approaches to health promotion and disease prevention, with a special focus on obesity.

Some of these proposals can be achieved under current law. The success of others will depend upon good public policy.

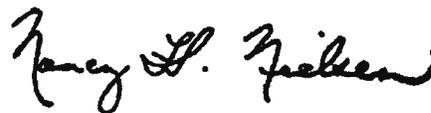
We are committed to doing our part to make the system more affordable and effective for the nation. Our initiatives demonstrate that commitment, and we will work very hard to see them implemented. We can and will work together, and with other key sectors of the health care community, to identify further reform opportunities.

We will continue to work with you, the Congress and other stakeholders to make reform a reality.

Sincerely,



Stephen J. Ubl
President and CEO
Advanced Medical Technology Association



Nancy H. Nielsen, MD
President
American Medical Association



Karen Ignagni
President and CEO
America's Health Insurance Plans



Billy Tauzin
President and CEO
Pharmaceutical Research and Manufacturers of America



Rich Umbdenstock
President and CEO
American Hospital Association



Dennis Rivera
Chair, SEIU Healthcare
Service Employees International Union

Cost Savings Estimates

The literature provides estimates of the potential savings for some, but not all of the proposed initiatives. Based on the literature, the potential savings could be:

- **Utilization of Care:** \$150 - \$180 billion
- **Chronic Care:** \$350 - \$850 billion
- **Administrative Simplification and Cost of Doing Business:** \$500 - \$700 billion

Achieving these system-wide cost reductions will require collaboration and good public policy.

The sources for the above estimates are included in the attachments to the June 1st letter.



AdvaMed

Advanced Medical Technology Association

Medical Technology Industry Initiatives

The Advanced Medical Technology Association represents manufacturers of medical devices and diagnostics. Our members account for 90 percent of the devices and diagnostics sold in the U.S. and 50 percent of the products sold worldwide. Our industry is highly competitive. Over the last 18 years, medical device and diagnostic prices have increased only one-quarter as fast, on average, as other medical prices and one-half as fast as the general consumer price index (CPI).

While the direct cost of these products is a relatively small and stable proportion of national health expenditures (approximately 6 percent), devices and diagnostics are an integral part of medical practice and utilization of health care services and play a key role in preventing, treating and curing disease. Since the key decisions about the use of devices and diagnostics are ultimately made by health care providers, changes in medical practice, in the incentives in the health care system, and in the management and prevention of disease will all have significant effects on utilization of our products.

In addition to the initiatives described below, we also support a number of broader structural changes in the reimbursement and delivery system designed to encourage quality and efficiency that will affect our industry and that we anticipate will substantially reduce health care costs. Among these are a substantially expanded federally supported comparative effectiveness research effort as embodied in the Baucus-Conrad bill and establishment of payment systems that reward providers for the quality and efficiency of care provided.

AdvaMed also is committed to supporting an expanded national commitment to health promotion and disease prevention and to fundamentally restructuring our health care system to provide improved management and treatment of chronic disease. The Milken Foundation has estimated that the difference between our current national trajectory on chronic disease and an alternative path that combines better management with enhanced prevention and technological progress could save the nation more than \$1 trillion annually by 2023.

Finally, the products our industry creates meet clinical needs and extend and enhance lives. Many of them also reduce costs by making it possible to diagnose disease promptly and to cure it more efficiently and effectively.

For example, new diagnostic tests can correctly identify diseases in minutes that once took hours or days to correctly diagnose and are the key to more efficient drug development and targeting. New imaging techniques also can lead to earlier and more accurate diagnosis and replace more invasive procedures. Implantable orthopedic products give the gift of mobility and result not only in better quality of life, but in greater productivity and reduced institutionalization. Device driven innovations in cardiology have contributed to a 50 percent reduction in deaths from heart disease over the period 1980-2000 and kept people active and contributing members of society who would otherwise be dead or disabled. Continued medical progress depends to a significant degree on continued innovation in medical devices and diagnostics.

Initiative #1: Assist in development of quality metrics to improve the role that AdvaMed member companies' technologies play in treating and managing disease.

The AMA convened Physician Consortium for Performance Improvement (PCPI) has identified priorities for targeted measure development to assure appropriateness of care, focusing on areas where there is particular concern about overuse. The device industry believes that the goal of health care delivery must be the right care for the right patient at the right time. Both failure to provide appropriate treatment and provision of inappropriate treatment raise costs and lower quality. The industry commits to working cooperatively with the AMA and the PCPI to contribute its expertise to development of these measures.

To achieve this objective, we will:

- o Encourage physicians who have expert knowledge of medical devices to participate in the PCPI and its workgroups;
- o Organize our industry sectors to assure full input of our scientific and medical knowledge and expertise in measurement development for device-intensive procedures.

Initiative #2: Reduce medical errors and avoidable injuries

The Institute of Medicine's landmark 1999 study found that as many as 100,000 patients may die annually as a result of in-hospital medical errors and that these errors cost \$38 billion annually. At today's medical costs, the financial toll of medical errors would be \$75 billion. Errors in the outpatient setting add additional costs.

While the proportion is unknown, it is reasonable to assume that some portion of medical errors involves improper use of medical devices and that application of technology to the processes of care could reduce other errors. The device industry commits to launching a three-pronged initiative to reduce medical errors and enhance patient safety.

(1) Human factors and devices. Dr. Peter Pronovost of Johns Hopkins is spearheading a public-private partnership to reduce medical errors. This effort is modeled on the CAST work in the aircraft industry. CAST brought stakeholders together in an effort to reduce the frequency of airplane crashes. Thus far, they have been extremely successful, using a combination of procedural and technological fixes. Dr. Pronovost has successfully reduced the frequency of errors in ICUs through a checklist approach to reducing human errors modeled on procedures used in the airline industry.

A similar approach to other areas of health care with all parties participating can produce significant improvements in patient safety, which leads not only to lower costs but to better care. The medical device industry will engage with Dr. Pronovost's or similar efforts in several ways. We will bring the expertise and experience of our companies to bear in advancing research in identifying medical devices for which modified design or design consistency can reduce human errors and we will encourage companies to make appropriate changes.

An example of this approach occurred years ago in the design of anesthesiology equipment where a simple change in design of all products that assured that the hose to deliver oxygen could only attach to the outlet for oxygen and the hose for anesthesia

could only attach to outlet for anesthesia had an important impact in reducing fatal errors. In addition, device companies can design products that produce software controlled monitoring systems to supplement checklist procedures designed to reduce human error.

(2) Education and awareness. AdvaMed will launch an intensive education and awareness program to encourage our member companies to accelerate and intensify their risk management and human factors programs in product design. We will especially focus these efforts on smaller companies that may lack internal expertise in this specialized area.

(3) Joint Commission. The Joint Commission (TJC) has embarked on an effort to improve safety and quality of care that goes beyond its traditional role of setting of standards for care and monitoring compliance with these standards. The Joint Commission is investing in a new initiative (1) to identify areas where significant quality and safety issues exist in the delivery of health care, and (2) to recommend solutions, strategies, and interventions that will improve safety and quality and at the same time yield savings in health care spending. AdvaMed will work with the Joint Commission in both of these efforts, engaging its companies' medical directors and technology design scientists in the process. Solutions will involve finding efficiencies for health care organizations that will be both reliable and sustainable over time. The first area the Joint Commission has identified for action is hand hygiene. Another area under consideration for future initiatives where device companies have special expertise is infection control more broadly defined.



AHIP's Submission on Behalf of the Health Insurance Industry

AHIP members, in conjunction with the Blue Cross Blue Shield Association, are fully engaged in broad, long-term efforts to improve quality, simplify the process of obtaining and delivering care, and improving value for all those who purchase it.

The initiatives outlined below will help our nation transition to a fully integrated, 21st century health care system that utilizes the benefits of health information technology, rewards quality and value, and empowers patients to more effectively engage in the health care system. These efforts, combined with the work being done by other stakeholders, can help put our health care system on a sustainable path.

ADMINISTRATIVE SIMPLIFICATION

Current situation:

There is currently a lack of uniformity for providers who face administrative challenges created by having business contracts with multiple health insurance plans, each with different telephone numbers, codes, fax numbers, and varying forms and administrative processes.

Proposed reforms:

The health insurance industry is proposing a comprehensive overhaul of administrative processes to standardize and automate five key functions—claims submissions, eligibility, claims status, payment, and remittance. The move to fully automating and standardizing administrative transactions will be a watershed event, allowing physicians, hospitals, and other health care providers to reduce their administrative costs substantially. The effect throughout the health care industry will be similar to the effect of ATMs being introduced throughout the banking system.¹

¹ Third party sources that provide insight into the range of savings that could be achieved if these proposals are implemented across the health care system, including: L.P. Caslino, S. Nicholson, D.N. Gans et al., "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs Web Exclusive*, May 14, 2009, w533-w543. James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals" *Health Affairs Web*, 2005. 24 (6), 1629-1639. Andis Robeznieks, "Adding up the costs" *Modern Healthcare*. May 18, 2009, <http://www.modernhealthcare.com/apps/pbcs.dll/search?Category=Search> Retrieved June 1, 2009.

We are *not* recommending a voluntary effort, but rather that HHS require the adoption of the CAQH Committee on Operating Rules for Information Exchange (CORE). CORE has been developed as part of a multi-stakeholder effort comprised of plans, providers, and suppliers. The goal is to eliminate costly variation and promote uniformity and clarity in the way that information is exchanged between health plans, doctors, and hospitals.

The administrative simplification provisions of HIPAA should be updated and expanded to:

- Direct the Secretary of HHS to utilize and coordinate the work of existing entities, both private and public, including ONCHIT, OESS, NCVHS and CAQH, and adopt a set of comprehensive and robust standards for codes and implementation specifications.
- Require the Secretary to establish a collaborative process to develop common operating rules for all administrative transactions, including the standards in HIPAA that will address: requirements for data content using available and established national standards; infrastructure requirements for streamlining data flow; and policies pertaining to the rights and responsibilities of the entities transmitting data.
- Establish a multi-stakeholder national task force to develop a process similar to the national Correct Coding Initiative (NCCI) to address correct coding for all populations and health care services covered by public programs and private insurers; make recommendations regarding timely adoption of claims coding updates, i.e. ICD, CPT, HCPCS; and recommend uniform prompt pay requirements across all states.

As part of health reform, we are supporting comprehensive reform of market rules. We support uniform federal guidelines operationalized at the state level and the creation of portals to make it easier for individuals and small businesses to evaluate and purchase coverage. This will simplify the system and reduce administrative costs.

We have advocated that each state provide a list of all insurance plans available to individuals and small employers. There would be comparative information in a common format on benefits, price, and quality features to enable individuals and small businesses to comparatively shop for coverage and determine whether they are eligible for subsidies.

BRINGING SIMPLIFICATION SOLUTIONS TO PHYSICIANS NOW THROUGH THE LAUNCH OF COMMON WEB PORTALS

Current situation:

Physicians typically care for patients covered by multiple health insurers in any geographic area. There is a wide variation in the processes used to carry out common office tasks, such as verifying a patient's insurance and submitting/receiving payment, and in the way insurers and physicians exchange the information needed to run medical practices on a day-to-day basis.

Health plan initiative:

The health insurance industry is preparing to launch a major effort that will make common administrative tasks in physician offices simpler, more efficient, and less expensive. Beginning with pilot tests in Ohio and New Jersey that will inform a national strategy, our community is establishing web portals that will allow physicians to conduct business with insurers throughout a region or state at one website, reducing the need to visit multiple websites and/or spend hours on the phone. Common web portals will virtually eliminate paperwork, improve efficiency through the system, and yield significant savings.

Expansion to include government programs:

AHIP is recommending that the Department of Health and Human Services work with the private sector to implement these demonstration projects across all payers, private and public, to test advanced administrative connectivity to providers through web portals and other business-to-business technology for both the electronic transaction of administrative data in phase I and clinical data exchange in phase II.

AGGREGATING PHYSICIAN PERFORMANCE DATA

Current situation:

Stakeholders from across the health care system support the principle that measuring and reporting on quality are fundamental building blocks for achieving the goals of reform – improved quality, improved access, and improved value. Physicians have raised concerns about that lack of uniformity and consistency in how their performance is evaluated. Currently, physician performance is measured by individual health plans and public programs that utilize different sets of measures and look at only a subset of patients.

Health plan initiative:

Public sector and private sector data will be combined using common measures and common methods to arrive at a more complete and accurate picture of the quality of care providers deliver. Using consistent measures endorsed by the National Quality Forum, and in conjunction with local physicians, this project will compile data for 12 important measures of physician performance, and give physicians the ability to evaluate and comment on the data and communicate results to consumers. This approach will be tested

in two pilot communities in 2009 to advance a nationally-consistent data aggregation strategy.

IMPROVING HEALTH LITERACY

Current situation:

Health literacy is the ability to understand and act on the medical information and instructions we are given. Almost half of all Americans lack the skills needed to navigate the health care system and engage meaningfully in their own health care. A 2007 study from the School of Business at the University of Connecticut estimates that low health literacy costs the health care system between \$106 and \$238 billion annually.

Health plan initiative:

Working with researchers at Emory University, our community has launched a groundbreaking effort, now in pilot testing, that will allow health plans to assess their health literacy across their organizations and to build targeted health literacy programs. This will be the first such tool that makes it possible for a health care organization to conduct such a company-wide assessment.

EMPOWERING CONSUMERS THROUGH THE USE OF PERSONAL HEALTH RECORDS

Current situation:

About half of all Americans live with at least one chronic medical condition, and chronic disease accounts for more than 75% of the nation's health care costs. In addition, personal health information needed for clinical decision making is often dispersed piecemeal among a number of physicians, hospitals, pharmacies, and other health care providers. This lack of coordination within the health care system results in preventable medical errors, duplication of tests and procedures, and the delivery of inefficient and inappropriate care.

Health plan initiative:

Consumers, especially those with chronic conditions, will have greater access to the information they need to optimize their health and health care as the result of the personal health record (PHR) model developed by AHIP and BCBSA in a coordinated effort. Our community has identified common elements that should be included in PHRs and has tested mechanisms to transfer PHRs when consumers change coverage and plans of care.

The Center for Information Technology Leadership estimates that the adoption of health plan PHRs could save as much as \$11 billion annually.

American Hospital Association



The American Hospital Association (AHA) is working to fulfill the hospital field's commitment to develop concrete ideas to achieve the Administration's cost containment goals. The following document presents specific actions that can be taken in the immediate term, as well as longer-term initiatives, to bend the cost curve. It also includes actions that can be taken to collaborate with other stakeholders. Some of these initiatives would be further enabled by public policy changes, changes that the AHA will continue to pursue on Capitol Hill.

The document is divided as follows:

- I. Immediate Cost Savings Initiatives
- II. Longer-Term Initiatives
- III. Cross-Stakeholder Initiatives

I. Immediate Cost Savings Initiatives

Containing health care costs is a complex undertaking that will require the cooperation of various stakeholders, and broad-based action across both the private and public sectors.

The nation's hospitals firmly believe that ensuring access to quality, affordable coverage for every American is a key first step. As the Commonwealth Fund noted in its 2007 Annual Report, "If everyone in the U.S. had health insurance coverage, the possible cumulative health system savings could amount to more than \$1.5 trillion over 10 years. Rather than national health expenditures rising from 16% of GDP to 20% by 2017 – as is currently projected – spending could be held to 18.5% of GDP."

While America's hospitals continue to advocate for coverage for all, paid for by all – a key pillar of our *Health for Life: Better Health. Better Health Care.* framework for overall health system reform – there are immediate steps hospitals are taking to contain costs. Many of these steps have been tested and adopted by hospitals and health systems in partnership with their national, state, regional and metropolitan hospital associations and have shown great promise for improving quality and reducing costs across the board. Other strategies flow from our recent work with strategic partners such as the Agency for Healthcare Research and Quality (AHRQ).

On behalf of America's hospitals, the AHA will work in conjunction with our hospital association partners, as well as other stakeholders such as the Institute for Healthcare Improvement (IHI), to design and implement the *Hospitals in Pursuit of Excellence* campaign. The goals of this campaign will be to:

- Facilitate hospital and health system performance improvements that have meaningful quality improvement and associated cost savings;
- Further the use of known best practices, initially in the areas of infection prevention and patient safety and expanding over time into other areas;

American Hospital Association



- Facilitate the sharing of best practices among hospitals, health systems and national, state, regional and metropolitan hospital associations; and
- Demonstrate the commitment of the hospital field to achieve these improvements.

Hospitals in Pursuit of Excellence Campaign	
1. Reduce surgical infections and complications ⁱⁱ	Promote adoption of the World Health Organization (WHO) Surgical Safety Checklist to enable teams to implement critical safety steps. AHA has co-sponsored with IHI a webinar to encourage hospitals to test an adaption of the checklist and will accelerate sharing and learning among hospitals.
2. Reduce central line-associated blood stream infections (CLABSI) ⁱⁱⁱ	Promote best practice strategies to reduce central line-associated blood stream infections through reliable implementation of infection prevention and monitoring strategies. In conjunction with AHRQ, AHA has been working with multiple states and hospitals to spread best practices in implementing a culture of safety and teamwork and accelerating the elimination of CLABSI.
3. Reduce methicillin-resistant Staphylococcus aureus (MRSA) ^{iv}	Promote best practices in screening, hand hygiene and contact precautions to prevent the spread of MRSA. AHA and several health systems are collaborating with The Joint Commission on a broad ranging, new initiative to improve patient safety and reduce preventable complications, starting with an effort on hand hygiene.
4. Reduce clostridium difficile infections (c diff) ^v	Promote best practices in screening, hand hygiene and contact precautions to prevent the spread of c diff. AHA and several health systems are collaborating with The Joint Commission on a broad ranging, new initiative to improve patient safety and reduce preventable complications, starting with an effort on hand hygiene.
5. Reduce ventilator-associated pneumonia (VAP) ^{vi}	Promote the spread of reliably tested best practices for patients receiving mechanical ventilation.
6. Reduce catheter-associated urinary tract infections ^{vii}	Promote best practices in the appropriate use, insertion and care of catheters to minimize urinary tract infections.
7. Reduce adverse drug events from high-hazard medications (e.g., anticoagulants, narcotics, opiates, insulin, sedatives) ^{viii}	Promote best practices in the prevention of adverse drug events focused on high-hazard medications by using standardized protocols, adequate monitoring and increased patient and family education.
8. Reduce pressure ulcers ^{ix}	Promote best practices in helping hospitals assess the risk of a hospital-acquired pressure ulcer, daily skin inspection and optimizing prevention.

II. Longer-Term Hospital Initiatives

In addition to the aforementioned immediate opportunities, hospitals will continue to increase their engagement in a number of longer-term initiatives. The *Hospitals in Pursuit of Excellence*

American Hospital Association



campaign will help promote these initiatives as the evidence, tools and nationally endorsed measures for these opportunities develop:

- Improving Care Coordination – Focus in particular on the discharge process and care transitions.
- Implementing Health Information Technology (HIT) – Focus on leadership and clinical strategies to effectively implement HIT.
- Promoting Efficient Resource Utilization – Promote palliative and hospice care through the use of advanced directives and best practices.
- Preventing Patient Falls – Further the implementation of effective fall prevention programs and use of fall risk assessment tools.
- Improving Perinatal Care – Promote best practices to improve perinatal care and reduce birth trauma and complications.
- Reducing Supply Costs – Create a more efficient and transparent purchasing environment, including greater alignment of hospital and physician incentives, greater product standardization and other measures.

III. Cross-Stakeholder Initiatives

The hospital field is committed to continuing its work with health plans, physicians and other stakeholders to achieve a more efficient, effective and coordinated health care system. The future vision of such a system includes simplified and standardized public and commercial insurance processing systems, reducing the need to practice defensive medicine and enhancing the ability of practitioners and providers to integrate clinically to improve quality of care.

i The Commonwealth Fund. Annual Report. 2007.

ii http://www.commonwealthfund.org/usr_doc/site_docs/annualreports/2007/AR2007.pdf.

iii Centers for Disease Control and Prevention. Scott, DR, The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.

iv *ibid*

v <http://www.infectioncontrolday.com/hotnews/55h168584264313.html>.

vi Centers for Disease Control and Prevention. Scott, DR, The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.

vii *ibid*

viii *ibid*

ix Committee on Identifying and Preventing Medication Errors. Aspden P, Wolcott J, Bootman JL, Cronenwett LR, Editors. *Preventing Medication Errors: Quality Chasm Series*. Washington, DC: National Academies Press; July 2006.

x Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA*. 2006;296:974-984.



Medicine's Efforts to Address Utilization of Care

Background

The AMA-convened Physician Consortium for Performance Improvement (PCPI) develops evidence based measures that capture variations in care and inform efforts to improve the quality of care and the appropriate utilization of health care services and treatments. The measures are developed by expert work groups including practicing physicians, health care professionals, patients, representatives of health plans, and others. All measures are reviewed by the PCPI membership, which includes more than 100 national specialty societies, state medical associations, ABMS and member boards, Council on Medical Specialty Societies, and 13 health care professional organizations, as well as CMS, AHRQ, a Consumer/Purchaser Advisory Panel, private health plans, and other organizations.

Improve Care Transitions to Avoid Hospital Readmissions

To reduce hospital readmissions within 30 days of initial discharge, the PCPI, the American Board of Internal Medicine Foundation, the American College of Physicians and the Society of Hospital Medicine has developed a set of measures to improve care transitions from hospitals to other settings. These measures focus on medication guidance for patients prior to discharge, care transition records for patients prior to hospital discharge and timely transmission of medical information to physicians serving the patient following hospital discharge. The Care Transitions measures have been submitted to the National Quality Forum for review.

Simultaneously, the AMA is undertaking development of an electronic care transition tool that will facilitate the transfer of information between hospitals and primary care doctors, emergency departments and primary care doctors. We are currently in discussions with HIT entities and healthcare systems to adopt the format. We are also developing a strategy to partner with other entities in a campaign to improve care transitions in order to improve quality, reduce redundant testing, and improve the efficiency of care processes to be rolled out in 2010.

Significance: Studies project substantial savings from reducing hospital readmissions.

Efforts to Reduce Unnecessary Utilization

The PCPI initiated work in 2009 to address concerns about the overuse of certain services or procedures. Topics were selected based on priorities established by the Institute of Medicine, the National Quality Forum, the National Priority Partners and the PCPI. Selection criteria include high variation, high volume and high cost, availability of relevant guidelines, and the potential for improving quality and efficiency of care.

The PCPI selected the following topics for development of overuse measures this year:

- Surgical and non-surgical management of back pain

Significance: A major health plan reported that nearly 20% of plan members' spine surgery occurred within the first 6 weeks of symptoms, which is not consistent with guidelines. The volume of spinal fusion surgery has increased significantly. Eliminating unwarranted variations in treatment will produce substantial savings.

- Percutaneous Coronary Intervention (PCI) (encompasses a variety of procedures) for Chronic Stable Coronary Artery Disease

Significance: Studies project large potential savings from adhering to evidence based guidelines for coronary artery disease.

- Maternity Care: Induction of labor/Caesarean Sections

Significance: There has been a substantial increase in the rate of elective induction of labor. Practice patterns are not always consistent with ACOG guidelines. Expenses related to c-section births account for 45% of the more than \$79 billion in annual hospital charges attributed to childbirth in the U.S. annually.

- Sinusitis: Antibiotic prescriptions and sinus radiography

Significance: Antibiotics for sinusitis account for 21 percent of all antibiotic prescriptions for adults and 9 percent for children. More than 1 in 5 antibiotic courses for adults are for sinusitis. Sinusitis is the fifth most common diagnosis for which an antibiotic is prescribed. Overuse of antibiotics for respiratory and sinus infections is an increasing problem, with potential savings of \$525 million to \$1.1 billion (New England Healthcare Institute).

PCPI will develop measures for diagnostic imaging, examples include:

- CT angiography for pulmonary embolism
- MRI of the knee
- MRI of the shoulder
- CT or MRI of the head
- Stress Echocardiography
- SPECT MPI

Significance: Although their growth has moderated significantly since implementation of the Deficit Reduction Act of 2005, Medicare payments for physician imaging services increased from \$7 billion to \$14 billion between 2000 and 2006. This represented a 13 percent annual increase in spending for these services, versus an 8 percent increase in all Medicare physician-billed services over the 2000 to 2006 time period. For a 10 year period from 1997 to 2006, a large private insurer saw CT utilization per enrollee increase 14 percent per year, and MRI increase 26 percent per year. Specialty societies, PCPI members, health plans and government agencies have identified diagnostic imaging as an important area for developing measures of overuse given the rising costs, increased volume and numerous published articles on the topic.

Note: A significant portion of higher level imaging is driven by the fear of potential lawsuits, commonly referred to as defensive medicine. There is extensive literature indicating that defensive medicine adds tens of billions of dollars in health care spending. Physicians who adhere to evidenced based best practice guidelines are not protected from lawsuits in our current

liability system. Congress needs to enact liability protections for physicians who adhere to best practice guidelines and fund state demonstration projects to test alternative reforms such as health courts, administrative compensation systems and early offer initiatives.

Medication Reconciliation

The AMA has initiated a multi-pronged effort to reconcile multiple prescriptions for individual patients treated by different physicians. This program of medication reconciliation is designed to avoid potential adverse events and inappropriate prescriptions. A prototype electronic version of the medication reconciliation card is undergoing beta-testing. A second version will be tested in early July. The AMA is completing a strategy to make the electronic version available to employers, health systems and physicians available by the end of 2010.

Significance: Literature reviews project potential annual savings of \$3 billion.

The initiatives by physician groups outlined above represent current activities. This portfolio will be expanded in the years ahead to reduce the rate of growth in total health care spending.



Biopharmaceutical Sector and Bending the Cost Curve

Medicines have already begun to play a key role in bending the cost curve in the U.S. For example, IMS Health reports that in 2008, spending for prescription medicines grew by just 1.3% over 2007 – the lowest rate since 1961. In 2009, IMS projects that the U.S. market for prescription medicines will contract, declining 1-2% *below* 2008 levels. Going forward till 2014, IMS projects annual growth rate for prescription medicines to remain essentially flat.¹ Between 2008 and 2009, CMS’s Office of the Actuary reduced its 10-year forecast of total drug spending by 14% or \$515 billion.² Declining cost trends have been driven by several factors. For example, generic use rate in the U.S. is now at 72 percent – up from 43 percent in 1996 – and is expected to further increase over the next several years as additional brand prescriptions come off patent. Since 2007, over 130,000 global biopharmaceutical job losses have been announced.

Investments in Public Health and Reforming the Delivery System

As recognized in the coalition’s May 11 letter, “Billions in savings can be achieved through a large-scale national effort of health promotion and disease prevention to reduce the prevalence of chronic disease and poor health status, which leads to unnecessary sickness and higher health health costs.” PhRMA supports moving forward with significant public health initiatives to reduce the need for health services, including medicines. The importance of substantial public health and primary prevention initiatives to bending the cost curve is evident in the projection by David Cutler and colleagues finding that reducing obesity to levels seen in the 1980s would achieve savings of over \$1 trillion in Medicare alone over the next 25 years.³ Likewise, the importance of public health and primary prevention initiatives to bending the cost curve is evident in the doubling of the number of new diabetes cases in the U.S. over the last decade. Individuals with diabetes have average health spending that is about 4 times the level of individuals without diabetes, indicating the impact increasing incidence has on health costs. It is also evident in the impact diabetes has on other conditions. For example, according to research, “Cardiovascular disease in the setting of diabetes is more premature, relentless and recurrent, despite aggressive therapies and interventions...Chronic kidney disease is also accelerated by diabetes, which, in turn, hastens the pace of hypertension, atherosclerosis, and heart failure.”⁴

To help achieve savings, PhRMA also supports a series of policy changes that will support delivery of less fragmented, better coordinated, more efficient and higher quality care. As stated in the coalition’s May 11 letter, encouraging coordinated care, adherence to evidence-based best practices, implementing proven clinical prevention strategies, and aligning quality and efficiency incentives are key to achieving a more sustainable and stable health system. How medicines are used is determined by our health care system; the array of changes to improve the delivery system will significantly affect use of medicines, reducing overuse, underuse and misuse and allowing patients and society to achieve their full therapeutic value.

1 IMS Press Release, “IMS Health Reports U.S. Prescription Sales Grew 1.3 Percent in 2008 to \$291 Billion,” March 19, 2009.

2 A. Sisko et al., “Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook,” Health Affairs, February 2009.

3 D. Goldman et al., “The Value of Elderly Disease Prevention, 2006, available at: http://www.bepress.com/fhep/biomedical_research/1.

4 M.L. Weisfeldt and S. J. Zieman, “Advances in the Prevention and Treatment of Cardiovascular Disease,” Health Affairs, January/February 2007.

Better use of medicines driven by delivery system changes can have a central role in further bending the cost curve, as well as helping achieve better health outcomes.⁵ For example, better use of medicines can save lives, decrease utilization of other health care services, enhance productivity and save money. A large and growing body of data shows that proper use of medicines can keep patients with chronic illnesses healthy, slow disease progression and minimize costly hospitalizations. Although medicines play a central role in effective treatment, in today's health care system they often are not used well – meaning foregone opportunities for better health and cost savings. For instance, David Cutler and colleagues have reported that use of antihypertensive medicines prevented 833,000 hospitalizations in 2002 alone.⁶ Cutler notes that we have achieved only half the health gains available against hypertension. He projects that if all untreated patients with Stage I or II hypertension had been treated and achieved normal blood pressure, an additional 89,000 excess premature deaths from major cardiovascular disease could have been avoided in 2001 and 420,000 hospitalizations for stroke and myocardial infarction avoided in 2002. University of Maryland School of Pharmacy researcher Bruce Stuart reports that each additional prescription used nets Medicare a savings of \$57 in reduced hospital stays.⁷ A recent Agency for Health care Research and Quality (AHRQ)-sponsored study found that a discharge nurse and pharmacist working to coordinate hospital discharges and educate patients on the use of discharge medications significantly reduced unnecessary and costly hospital readmissions relative to the usual standard of care.⁸

Use of prescription medicines is often determined by incentives that drive the health care delivery system. Realigning incentives to consistently deliver high quality care will therefore significantly affect use of medicines, reducing overuse, misuse and underuse. Therefore, PhRMA supports:

- **Development and use of performance measures to drive quality and promote better, more efficient care.** PhRMA supports public reporting of performance measures to aid in decision-making by patients and payers, and the need to move toward performance-based payment for providers based on sound clinical, evidence-based quality measures that are developed and endorsed by professional consensus. These programs should reward health care practitioners for delivering and improving care consistent with consensus-based quality standards while recognizing the need to individualize treatment. For example, measurement of appropriate evidence-based processes (e.g., hemoglobin A1c test administered to patients with diabetes) and expected outcomes (e.g., control of blood glucose as demonstrated by hemoglobin A1c<8% in patients with diabetes) are typical means or measures of evaluating the effectiveness of a quality improvement initiative. Adoption of well-designed performance measures can help to ensure that patients are receiving the right types of

5 Full a full description of studies concerning cost-offsets related to medication use and the importance of adherence in improving health and lowering cost, see: "Just What the Doctor Ordered: Taking Medicines as Prescribed Can Improve Health and Lower Costs," and "Medicines Play a Key Role in Improving Health While Reducing Avoidable Costs," available at www.phrma.org.

6 D. Cutler et al., "The Value of Antihypertensive Drugs: A Perspective on Medical Innovation," *Health Affairs*, January/February 2007.

7 B. Stuart et al., "Assessing the Impact of Drug Use on Hospital Costs," *Health Services Research*, February 2009.

8 B.W. Jack et al, "A Reengineered Hospital Discharge Program to Decrease Rehospitalization," *Annals of Internal Medicine*, February 2009.

treatment, including pharmacotherapy, for a given condition and that patients are actually following the treatment regimens to achieve desired health outcomes.

The importance of bending the curve of creating a system that better supports quality, efficient care is evident in current treatment patterns for diabetes, hypertension and high cholesterol. Of the 24 million Americans with diabetes, 6 million are undiagnosed, 3 million are untreated and 9 million are treated, but not well controlled.⁹ According to research by David Cutler, among those with hypertension, 24% are unaware, 11% are aware but not treated, 34% are treated but not controlled and 31% are controlled. Further, Cutler's research finds that of those Americans with high cholesterol, 37% are unaware, 22% are aware but not treated, 16% are treated and not controlled and 25% are controlled.¹⁰

One important aspect of performance measurement development is improving adherence to physician-directed treatment. Poor adherence to needed medicines is one of the central reasons that patients with chronic illnesses often do not achieve optimal outcomes and suffer illnesses and costs that could have been avoided. Research estimates the cost of non-adherence at \$100 billion to \$300 billion annually, including costs from avoidable hospitalizations, nursing home admissions, and premature deaths.¹¹ Many of the human and economic costs associated with non-adherence can be avoided, making improving patient adherence one of the best opportunities to get better results and greater value from our health care system. For example, one study reports that people with diabetes who took their diabetes medicines less than 60 percent of the time were 3.6 times more likely to be hospitalized than those who followed their prescribed treatment.¹² Another study found that better adherence to medicines among patients with diabetes, high cholesterol, and high blood pressure has been shown to reduce total health care costs by \$4 to \$7 for every additional dollar spent on medicines.¹³ Even if performance measurement only addresses a small portion of non-adherence, there are significant opportunities to save tens of billions of dollars in the health care system.

- **Expanded use of medication therapy management (MTM) to address polypharmacy, reduce medication errors and inappropriate use, and achieve better clinical outcomes at lower cost.** MTM is an important mechanism for evaluating a beneficiary's multiple conditions and prescribed medicines to ensure that their treatment and care are appropriately coordinated and managed. The pharmaceutical sector and other partners in the health care system have been supporting development of MTM models to identify models that can work to improve care and lower costs. A program originated in Asheville, North Carolina (the Asheville Project) has since been expanded based upon its success. The expanded program, known as the Diabetes Ten City Challenge (DTCC), is sponsored by the APhA Foundation

9 See, "Pitfalls & Opportunities in Diabetes Prevention & Care," PhRMA.

10 D. Cutler, "Improving Chronic Care Management," Presentation at Alliance for Health Reform Briefing, March 28, 2008.

11 L. Osterberg and T. Blaschke, "Adherence to Medication," *New England Journal of Medicine* 2005;353:487-97 and M.R. DiMatteo, "Variation in Patients' Adherence to Medical Recommendations: A Quantitative Review of 50 Years of Research," *Medical Care*, March 2004.

12 D.T. Lau and D.P. Nau, "Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization Among Individuals with Type 2 Diabetes," *Diabetes Care* 2004;27(9):2149-53.

13 M.C. Sokol, et al., "Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost," *Medical Care*, June 2005.

with support from GlaxoSmithKline, and is a voluntary health benefit involving waiver of co-pays for diabetes medications and supplies. The program also involves helping people better manage their diabetes on a day to day basis with the help of a specially-trained pharmacist "coach".

Today, 30 employers and hundreds of local pharmacists in ten cities are working together to help people manage their diabetes. In addition, as a result of a partnership with Mirixa Corporation announced in 2009, the DTCC model of collaborative care is now available to employers nationwide through HealthMapRx. The program has established a proven track record in improving care and lowering costs. A report published in the May/June 2009 issue of the *Journal of the American Pharmacists Association* (JAPhA) documents the economic and clinical benefits for employers and participants. According to the research, employers realized an average annual savings of almost \$1,100 in total health care costs per patient when compared to projected costs if the DTCC had not been implemented and participants saved an average of almost \$600 per year. Participants also improved in all of the recognized standards for diabetes care, including decreases in A1c, LDL cholesterol and blood pressure; and increases in current flu vaccinations and foot and eye exams. Given the significant economic and societal impact of diabetes, the DTCC represents a promising model in designing a patient-centered health benefit, one that improves outcomes for patients and manages costs for everyone involved. Another program, also part of the original Asheville program, focused on managing of cardiovascular disease. The program decreased cardiovascular-related medical costs from 31 percent of total health care costs to 19 percent during a six-year study period while increasing the use of cardiovascular medicines nearly threefold. The program also resulted in a 50 percent decrease in the risk of a hospitalization or an emergency room visit due to a cardiovascular event.¹⁴ Both the DTCC and cardiovascular model are illustrative of the types of models that can help reform our system.

In addition to the models being sponsored by the pharmaceutical industry and APhA, the Medicare Modernization Act required that Part D plans have MTM programs that ensure that covered Part D drugs prescribed to targeted beneficiaries¹⁵ are appropriately utilized to optimize health outcomes and reduce the risk of adverse events. Many targeted beneficiaries have complex medication regimens, which makes MTM important to ensure that their chronic conditions are managed appropriately and that optimal health outcomes are achieved. While CMS has taken helpful steps to improve consistency and performance among MTM programs, additional changes could further enhance results. PhRMA supports establishment of clear requirements, development of a quality-based payment program that recognizes achievement of performance targets, targeting beneficiaries for MTM services based on total Medicare costs (rather than just drug costs), and testing of approaches, including financial incentives, to improve active patient engagement in MTM programs. Continued efforts to establish clear, rigorous requirements and a quality-based payment program that recognizes achievement of performance targets will help improve health outcomes, particularly for beneficiaries with chronic conditions, and also presents opportunities to save the health care system money by ensuring appropriate use of medicines.

¹⁴ B. Bunting et al., "The Asheville Project: Clinical and Economic Outcomes of a Community-based Long-term Medication Therapy Management Program for Hypertension and Dyslipidemia," *Journal of the American Pharmaceutical Association*, January/February 2008.

¹⁵ Targeted beneficiaries are those patients who have multiple chronic diseases, take multiple medications, or reach an established spending threshold.

- **Development of an abbreviated regulatory approval pathway for biosimilars that assures patient safety, increases competition, and provides responsible incentives for the R&D investment needed** (including patent protection and at least 14 years of data protection). Biologics are revolutionizing health care with effective, targeted therapies for many devastating diseases such as cancer, Alzheimer's, and Parkinson's and will be critical in achieving the President's goal of retiring words like 'terminal' and 'incurable' from our vocabulary. As of 2008, more than 300 biologics have been approved by the FDA and 633 biotechnology medicines were in development, including more than 250 for various cancers.¹⁶

Strengthening the Evidence Base

- **Well-designed comparative clinical effectiveness research (CER) as an important tool to support good decision-making in health care.** The Baucus-Conrad bill introduced in the last Congress is a good basis from which to establish policy in this area. Strengthening the evidence base for clinical decisions and decisions about how care can be organized so that patients receive the best possible care should be an important element of health care reform. CER can help inform the policy- and population-level decisions already being made in the health care system through existing processes. CER efforts at all levels should help inform and support decisions made by patients and providers. Empowering patients and physicians with high quality information on the full range of available treatment options and health services will help ensure that our health system efficiently delivers the best possible results for all patients.
- **Support the release of Part D data to facilitate research on effective care.** PhRMA supports release of additional Part D data, including plan identifiers, plan-level benefit design and formulary data (while, as CMS recognizes, protecting proprietary information, such as rebates, important to the competitiveness of the market). This would be useful to support research on patterns of care (especially when linked with Medicare A and B data), the impact of alternative benefit designs on adherence and clinical outcomes, and can help improve care for dual eligible beneficiaries. CMS should also make available an expanded number of performance measures developed and endorsed by a multi-stakeholder consensus process.

Drug Development

As stated in the coalition's May 11 letter, "the proper approach to achieve and sustain reduced cost growth is one that will ... encourage the advancement of medical treatments, approaches and science", among other factors. An example of innovation's importance in achieving this goal is found in Alzheimer's Disease. Today, Medicare beneficiaries with Alzheimer's disease account for 34% of Medicare spending, even though they constitute only 12.8% of the

¹⁶ Biotechnology Research Continues to Bolster Arsenal Against Disease with 633 Medicines in Development." Accessed at: <http://www.phrma.org/images/110308%20biotech%202008.pdf> on May 8, 2009.

population age 65 and older. According to a study by the Lewin Group¹⁷, commissioned by the Alzheimer's Association, Medicare and Medicaid costs can be reduced by slowing the onset and progression of Alzheimer's disease. This could achieve annual Medicare savings of \$51 billion by 2015, \$126 billion by 2025, and \$444 billion by 2050. Annual savings in Medicaid spending on nursing home care would also be significant – \$10 billion in 2015, \$23 billion by 2025, and \$70 billion by 2050. Today, biopharmaceutical companies have 67 medicines in development for the treatment of Alzheimer's.

➤ **Initiatives to improve the efficiency of drug development.**

The cost and challenges of new drug development continue to increase as the disease areas targeted for new drugs are more complicated, our understanding of them is less complete, and as clinical trial and post-approval requirements increase.¹⁸ The biopharmaceutical research sector is continually retooling to seek more efficient drug development and to exploit new scientific opportunities. Companies' efforts to improve the development process have been especially intensive in recent years. There are a number of initiatives that can complement this ongoing intensive work throughout the sector. These initiatives, many of them broadly collected under FDA's Critical Path Initiative, include:

- Expanding the development and utilization of biomarkers through public-private partnerships, such as the Biomarkers Consortium;
- Encouraging the development and use of new trial designs (such as adaptive designs and designs for targeted populations and sub-populations based on genetic markers or specifically defined and measured disease states);
- Encouraging incorporation of standard of care real world data for illustrating novel treatment benefit; and
- Fostering better utilization of post-approval methods for further elucidation of benefit and risk.

➤ **Acceleration of the development and adoption of personalized medicine.** Incorporating personalized medicine into the fabric of the healthcare system can help resolve embedded inefficiencies, such as trial-and-error dosing, poor adherence to therapy, avoidable hospitalizations, late diagnoses, and care that is reactive rather than proactive preventative therapy. Moreover, personalized medicine offers better targeting of therapies to those who can benefit from their use by allowing the best matching of a patient and a medicine. For example, economists at the FDA have estimated that the use of a genetic test to properly dose the blood thinner warfarin could prevent 17,000 strokes and 85,000 “serious bleeding events” each year and avoid as much as 43,000 visits to the emergency room.¹⁹ If the 2 million people that start taking warfarin each year were to be tested at a cost of \$125 to \$500 per patient, the overall cost savings to the healthcare system would be \$1.1 billion

17 “Saving Lives. Saving Money. Dividends for Americans Investing in Alzheimer's Research,” The Lewin Group, March 2005, Prepared for the Alzheimer's Association.

18 Tufts University Center for the Study of Drug Development, Growing Protocol Design Complexity Stresses Investigators, Volunteers, Tufts Impact Report (Jan./Feb. 2008), available at http://csdd.tufts.edu/_documents/www/Doc_309_65_893.pdf.

19 McWilliam A, Lutter R, Nardinelli C. Health Care Savings from Personalizing Medicine Using Genetic Testing: The Case of Warfarin. 2006 AEI-Brookings Joint Center; (Available online at: <http://aei-brookings.org/publications/abstract.php?pid=1127>)

annually. In addition, studies have found that hundreds of millions of dollars can be saved by targeting cancer therapies based on specific genetic mutations. Through public-private partnership efforts such as the Biomarkers Consortium and C-PATH Institute, industry, academia and government can facilitate the evolution of the regulatory framework needed to support the full development of personalized medicine.

Companies are working intensively to advance personalized medicine. This work's potential for improved patient outcomes and health care value can be supported by taking additional steps, such as including consideration of personalized medicine in the HIT infrastructure and codifying the HHS Personalized Health Care Initiative.

Expanding Access to Comprehensive and Competitive Prescription Drug Coverage

- **Assuring all Americans access to good prescription drug coverage – resulting in negotiated savings for 47 million more Americans.** Approximately 47 million Americans are wholly uninsured - these individuals typically pay undiscounted retail prices at the pharmacy counter. We support each and every one of these 47 million individuals gaining insurance coverage that will include negotiation of savings on prescription drug prices. The largest U.S. purchasers, such as PBMs, each negotiate for over 700 million prescriptions on behalf of tens of millions of individuals. This allows them to achieve significant savings off retail prices for the people they cover.



SEIU's Submission: Proposals to Bend the Cost Curve
June 1, 2009

SEIU recognizes that bending the cost curve will involve major changes in the operations of healthcare institutions and these changes will have a major impact on our more than one million healthcare members. Reducing unnecessary procedures, replacing paperwork with electronic medical records, using health IT to improve work flow and shifting the emphasis to prevention will allow our members to spend more time with their patients providing the right care at the right time in the right setting. We understand that creating a more efficient healthcare delivery system requires a strong partnership among organized labor, hospitals, and physicians.

We also understand that a more efficient delivery system requires realignment of the workforce—and in some cases, a reduced workforce. Fewer workers handling charts, but more workers engaged in prevention. Less time spent on redundant tests and imaging but more time on educating patients on wellness. The dislocation will be difficult; change always is. While we must create pathways for our healthcare workforce to retrain and upgrade for the new jobs and new opportunities, we cannot be afraid of the new face of healthcare. SEIU stands ready to help our provider partners in developing the best trained and prepared workforce.

Our readiness to move forward is best judged by steps we have already taken in major restructurings of the delivery system. SEIU actively supported the efforts of New York State's Berger Commission to "right size" the acute and long term care sectors. The Commission made 57 mandatory recommendations, affecting 81 acute care and long-term care facilities. The acute care recommendations reconfigured 57 hospitals or one-quarter of all hospitals in the State—with nine facilities being closed. Collectively, the Commission sought to reduce inpatient capacity by almost 4,200 beds.

In addition, the Commission's long-term care recommendations called for downsizing or closing nursing homes targeting nursing bed reductions of approximately 3,000. In addition, the long-term care recommendations contemplated creating more than 1,000 new non-institutional slots. It is estimated that the capacity reduction outlined by Berger Commission would cut 23,400 hospital and nursing home jobs in New York State.

Our twelve-year long engagement in the Kaiser Labor Management Partnership helped Kaiser to move from a \$250 million dollar loss in 1996 to a position of market leadership. The 55,000 union members within the Kaiser system have supported and implemented the host of work process and technological changes that has moved Kaiser into a position of being recognized as one of the premier healthcare delivery system in the country. SEIU has been Kaiser's strongest partner in this process.

Today, SEIU is involved in a host of pilots and demonstrations around the country on cost reductions. For example, our public employee members in California receive their health benefits through CalPERS. CalPERS has undertaken a pilot program designed to improve health care quality, enhance service, and reduce costs. CalPERS will partner with Blue Shield of California, Catholic Healthcare West (CHW), and Hill Physicians Medical Group to implement the pilot starting January 2010. SEIU also represents most of the healthcare workers at Catholic Healthcare West. The program will create an integrated health care model that aligns incentives among our public employee members, the health plan, hospital system, and medical group. The providers have also agreed to be at financial risk should the pilot's cost reduction goals fall short of expectations. All SEIU/CalPERS members who live or work in Sacramento, Placer, and El Dorado counties are eligible for the pilot program, even if they are currently enrolled in one of the other CalPERS health plans. Blue Shield anticipates that the 12-month pilot will succeed in keeping the 2010 total cost of health care trend flat (or negative) as compared to the 2009 projected cost of health care in the targeted three county region.

SEIU was an aggressive supporter of President Obama's \$30 billion healthcare information technology commitment in the American Recovery and Reinvestment Act. We understood its importance as a down payment on healthcare reform and we understood that without significant modernization of the delivery system we could not afford to expand coverage. We also understand that any modernization will change the way our members deliver care and will dislocate many workers from their current jobs. The 2005 Rand study estimated a \$70 billion savings from full implementation of health IT. Most of the savings comes from re-engineered work flow leading to a 10% reduction in average length of stay. Building on the Rand study, SEIU calculates the job loss from full implementation of health IT to be roughly 630,000.

SEIU's specific initiatives (see below) are directed at the primary and long term care sectors. We believe these initiatives can make a significant impact on shifting America on to a path of affordable healthcare. We are also firmly committed to working with our hospital and physician partners to create the most flexible, responsive and efficient healthcare workforce in the world.

Initiative A. - Expanding Home and Community Based Services

Definition/description: Our long-term care system provides the most expensive care in the least desirable setting – not occasionally, but as a matter of default. While long-term services and supports are not the driver of Medicaid spending, the demographic changes over the next two decades present a challenge for state budgets that demands our attention. Resetting our long-term care system is also crucial if we are to have the infrastructure necessary for truly integrated Medicare and Medicaid covered services.

We know that consumers strongly prefer home and community based services (HCBS) over care in an institution. We also know that the average total public expenditure on a recipient of HCBS waiver services who is nursing home eligible is approximately \$44,000/year less than for a person receiving institutional services. State Medicaid programs can support approximately three adults with physical disabilities in the community for every one person in a nursing facility.

While it is clear that a well-developed HCBS program can limit institutional costs and help states moderate the cost of Medicaid spending overall, most states need additional federal resources to pursue such a strategy. The theory behind this proposal is to provide states with temporarily increased federal matching payments for HCBS expenditures, based on the degree of system imbalance. Our initial thoughts are that the proposal would be structured as follows:

- States where less than 25% of LTC spending is devoted to HCBS would receive a five percentage point boost in federal matching rates for HCBS; and
- States where HCBS spending makes up between 25% and 49.9% of LTC spending would receive a two percentage point boost in federal matching rates for HCBS.

In exchange, for the higher FMAP, states would agree to adopt certain structural reforms in the administration of their Medicaid program. State level experience shows that success on containing costs depends on nursing home diversion, which in turn depends on whether a state has adopted the programmatic and structural changes needed for this more person-centered approach. The federal government can use the Real Choices Systems Change Grants or the Medicaid Transformation Grants to obtain both technical and financial assistance in implementing the structural changes that reinforce a program of diversion and increased consumer choice:

- Mission statement of a community based long term care system that allows beneficiaries to receive services in a setting of their own choosing.
- Consolidated program administration/budget authority.
- Presumptive eligibility.
- Case management.
- Uniform assessment.
- Single entry point.
- Nursing home conversion programs.
- Collection of encounter and other data needed for more accurate budgeting and for development of quality standards.
- Adoption of federal quality measures.

At the same time, states would develop and implement more aggressive nursing home diversion program. States would be free to increase diversion through either waivers or state plan amendments permitted under the new 1915(i) waiver, amended to increase income eligibility and expand the scope of services.

There are possible variations to this proposal. States that are balanced could receive an FMAP increase as well, perhaps the one percentage point suggested by Senate Finance Committee (this adds costs). The increased FMAP can be applied to new HCBS cases (this reduces costs significantly in the early years, but is difficult to administer, especially in the out-years).

Estimated Impact: Our model demonstrates that an across the board FMAP increase combined with an ambitious yet realistic goal of increasing nursing home diversion by 3 percentage points annually yields net savings for the health care system of \$43 billion (\$26 billion in net federal savings and \$16 billion in net state savings) over ten years. These savings are calculated based on current population growth, utilization and disability rates.

Initiative B – Medicare and Medicaid Chronic Care and Prevention

Definition/description: Medicare and Medicaid Chronic Care and Prevention using community health teams. This initiative would develop coordinated care within the traditional fee-for-service Medicare program. Community health teams—are comprised of care coordinators, nurse practitioners, social and mental health workers, nutritionist among other providers. The CHTs would work closely with primary care physicians to manage and execute care plans developed by the physician. Each patient would receive a care plan—those that are healthy, at risk (overweight, pre-diabetic, and those with chronic disease). The CHTs would work with these patients to provide primary preventive services (diet, exercise, nutrition counseling) and coordinate care for chronically ill patients. These teams would provide transitional care for patients (as they enter a hospital, nursing home) and work closely with patients at home and in the community. The initiative would allow other payers such as Medicaid, CHIP, private health plans and self-insured employers to contract with the teams to prevent disease and manage patients with chronic health care conditions.

Estimated Impact: Likely substantial. The functions performed by the CHTs incorporate the functions (transitional care, close integration of care coordination and the physicians' office) that have been shown empirically to reduce costs—on net on the order of 4 to 8 percent.

Initiative C - Post Acute Care Payment Reform

Definition/description: In the summer of 2009, 200 nursing homes across four states will begin participating in a three-year Medicare Nursing Home Value Based Purchasing Demonstration that will provide incentive payments to high-performing and rapidly-improving nursing homes. Facilities will receive quality scores based on their staffing levels, staff turnover rates, rates of potentially avoidable rehospitalizations, quality measure outcomes and performance on state inspection surveys. The Demonstration will allocate 80% of any Medicare savings above a 2.3%

savings threshold to qualifying skilled nursing facilities. (Incentive payments are capped at 5% of total Medicare expenditures.) Medicare retains any savings below the 2.3% threshold and a portion of the savings beyond the 2.3% threshold. This option proposes to expand the program nationwide beginning in Fiscal Year 2013.

Estimated Impact: SEIU's estimate assumes savings of 2.3% of total annual Medicare nursing home spending or \$6 billion. Most of the savings to come from reduced rehospitalizations.



America's Health
Insurance Plans

American Hospital
Association



May 15, 2009

Contact: See Below

Joint Statement

Washington, DC — “We are committed to working together to bend the health care cost curve. Health care reform will not be sustainable unless the nation brings down the rate of growth of health care spending. We are committed to doing our part to make reform sustainable and to make the system more affordable and effective for patients and purchasers.

“Our organizations are currently engaged in an intensive process to develop proposals to reduce the rate of increase in future health care costs. And to be successful, we must take action in public-private partnership. We look forward to offering cost-savings recommendations in the weeks ahead.”

The participating organizations reaffirm their commitment as outlined in the May 11 letter pledging to do our part to bring down health care costs: http://www.whitehouse.gov/assets/documents/05-11-09_Health_Costs_Letter_to_the_President.pdf.

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Coming Together to Bring Down the Cost of Health Care Fact Sheet

RISING HEALTH CARE COSTS ARE BURDENING FAMILIES, BUSINESSES, GOVERNMENTS, AND THE ECONOMY: For years, rising health care costs have been a burden on families, businesses, and the entire economy. Since 2000, health insurance premiums have almost doubled and health care premiums have grown three times faster than wages. These rising costs have eroded the financial stability of all Americans as families have had to pay more for insurance coverage; have been exposed to a greater risk of personal bankruptcy as deductibles and co-payments increase; and have seen their actual benefits decrease as employers search for ways to rein in escalating health care costs. As families and businesses have struggled with these rising costs, states have also been forced to cut back on investments in areas that are critical to long-term prosperity such as higher education and infrastructure. Overall, health care is consuming an ever-increasing amount of our nation's resources: at the current rate, health care will eat up more than 20 percent of GDP in 2018. Reforming health care is the key to restoring financial stability for American families and businesses and for securing our fiscal future.

THE TIME TO ACT IS NOW: For too long, politics and point-scoring have prevented our country from tackling this growing crisis. As we work our way out of an economic and financial crisis of historic proportions, the American people are eager to put the old Washington ways behind them and put us on a steady path toward a patient-centered health care system that reduces costs, preserves an individual's choice of doctor and plan and assures quality, affordable health care for every American.

HEALTH CARE INDUSTRY LEADERS ARE NOW PLEDGING TO MAKE A MAJOR REDUCTION IN COST GROWTH AS PART OF COMPREHENSIVE HEALTH REFORM: Today, we are seeing the beginning of a change for the future as a wide array of leaders in the health care field – insurance companies, hospitals, pharmaceutical companies, medical device manufacturers, and providers – have come forward with a proposal that could save the country \$2 trillion over the next 10 years. They are proposing to take aggressive steps to cut health care costs that, if done in the context of comprehensive health reform, will reduce the annual health care spending growth rate by 1.5 percentage points for the next 10 years.

As they take the steps they have outlined and as we work with Congress on health reform legislation, our Administration will continue its commitment to reducing costs so we can achieve similar savings. Working together, these initial steps, combined with enactment of comprehensive health reform, could result in savings of roughly \$2,500 for American families – savings consistent with the President's statements on the campaign trail. These are savings every American family will see - and that will benefit our country for years to come.

These are important steps toward comprehensive health care reform both for the savings identified and the improvements these efforts will make to health care delivery in our country. Moreover, if groups as disparate as – AHIP, AMA, AHA, PhRMA, SEIU, and AdvaMed – can come together around the cause of cost-cutting and greater affordability, the possibility for fundamental reform in the weeks ahead is great.

HEALTH CARE INDUSTRY LEADERS ARE JOINING WITH THE ADMINISTRATION TO IMPROVE EFFICIENCY AND QUALITY. Controlling spending is about more than just saving money, it must be about ensuring that we provide the best patient-centered health care system that promotes health and prevents illness. As we do this, we need to reform our payment system to promote efficiency and accountability while we eliminate waste and cost shifting; align incentives toward quality care and healthy outcomes; encourage shared responsibility; reduce fraud and abuse; build the base of information to undertake future program modernization; address the underlying causes of unnecessary health care spending; and encourage care coordination, prevention, and other services that are found to promote high quality, efficient health care.

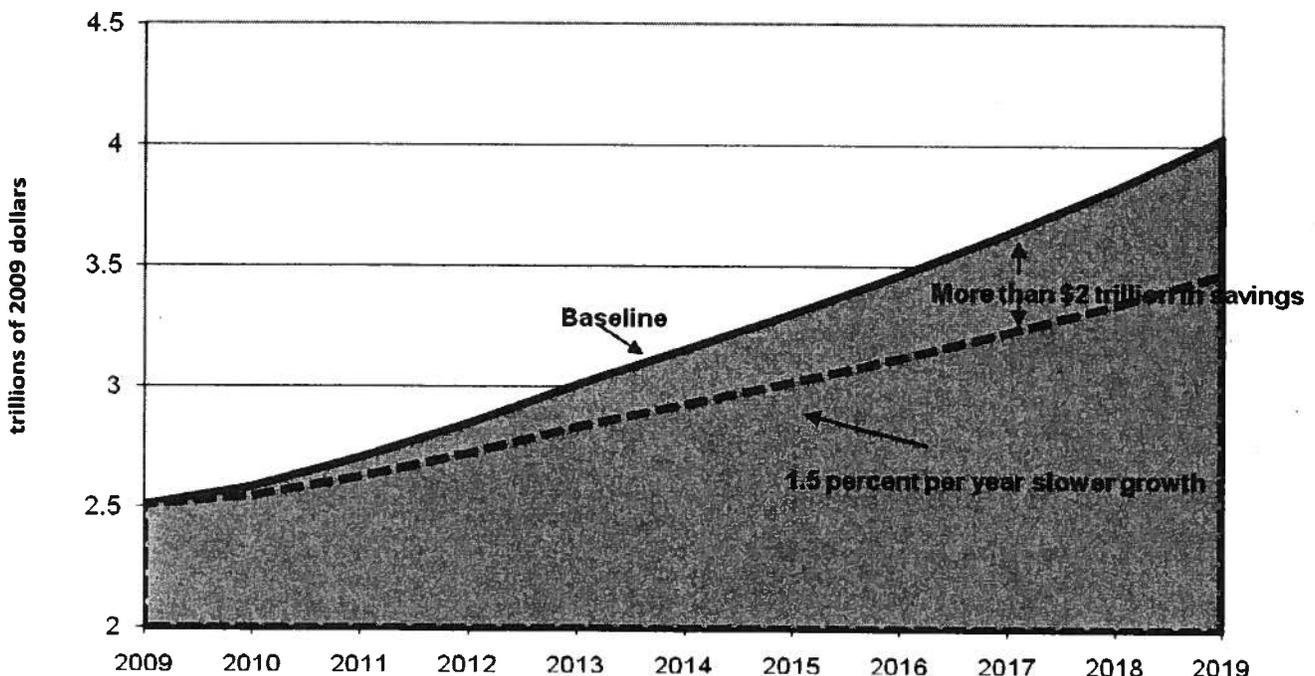
THE ADMINISTRATION WILL BUILD UPON ITS BUDGET PROPOSALS TO ACHIEVE SAVINGS IN MEDICARE AND MEDICAID. In the President's FY 2010 Budget and the Recovery Act, there are policy proposals that will improve the efficiency and quality of the Medicare and Medicaid programs while reducing average annual spending growth and extending the life of the Medicare Trust Fund. The Budget proposals aim to align incentives toward quality, promote efficiency and accountability, and encourage shared responsibility. These proposals include:

- **Improving Care after Hospitalizations and Reduce Hospital Readmission Rates.** Nearly 18 percent of hospitalizations of Medicare beneficiaries are the result of the readmission of patients who had been discharged from the hospital within the previous 30 days. Sometimes the readmission could not have been prevented, but many of these readmissions are avoidable with better discharge planning and follow-up care. To improve this situation, hospitals will receive bundled payments that cover not just the hospitalization, but care for the 30 days after the hospitalization. Hospitals with high rates of readmission will be paid less if patients are re-admitted to the hospital within the same 30-day period. This combination of incentives and penalties should lead to better care after a hospital stay and result in fewer readmissions – saving roughly \$25 billion of wasted money over 10 years.
- **Reducing Medicare Overpayments to Private Insurers through Competitive Payments.** Under current law, Medicare overpays Medicare Advantage plans by 14 percent more on average than what Medicare spends for beneficiaries enrolled in the traditional fee-for-service program. The Budget proposes to replace the current mechanism to establish payments with a competitive system in which payments would be based upon an average of plans' bids submitted to Medicare. This would allow the market, not Medicare, to set the reimbursement limits, and save taxpayers more than \$177 billion over 10 years, as well as reduce Part B premiums.
- **Reducing Drug Prices.** The Administration proposed accelerating access to make affordable biologic drugs available through the establishment of a regulatory, scientific, and legal pathway for FDA approval of generic versions of biologic drugs. The Budget also proposed bringing down the drug costs of Medicaid by increasing the Medicaid drug rebate for brand-name drugs from 15.1 percent to 22.1 percent of the Average Manufacturer Price, applying the additional rebate to new drug formulations, and allowing States to collect rebates on drugs provided through Medicaid managed care organizations.

- Improving Medicare and Medicaid Payment Accuracy.** The Government Accountability Office (GAO) has labeled Medicare as “high risk” due to billions of dollars lost to overpayments and fraud each year. The Centers for Medicare and Medicaid Services (CMS) will address vulnerabilities presented by Medicare and Medicaid, including Medicare Advantage and the prescription drug benefit (Part D). CMS will be able to respond more rapidly to emerging program integrity vulnerabilities across these programs through an increased capacity to identify excessive payments and new processes for identifying and correcting problems.
- Expanding the Hospital Quality Improvement Program.** The health care system tends to pay for quantity of services not quality. Experts have recommended that hospitals and doctors be paid based on delivering high quality care, or what is called “pay for performance.” The President’s Budget will link a portion of Medicare payments for acute in-patient hospital services to hospitals’ performance on specific quality measures. This program will improve the quality of care delivered to Medicare beneficiaries, and save over \$12 billion over 10 years.

THE ADMINISTRATION LOOKS FORWARD TO HEARING UPDATES ON THE GROUPS’ PROGRESS

National Health Expenditures Under Two Scenarios





AdvaMed
Advanced Medical Technology Association



**American Hospital
Association**

PhRMA



AHIP
America's Health
Insurance Plans



AMA
AMERICAN
MEDICAL
ASSOCIATION



May 11, 2009

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

We believe that all Americans should have access to affordable, high quality health care services. Thus, we applaud your strong commitment to reforming our nation's health care system. The times demand and the nation expects that we, as health care leaders, work with you to reform the health care system.

The annual growth in national health expenditures—including public and private spending—is projected by government actuaries to average 6.2% through the next decade. At that rate, the percent of gross domestic product spent on health care would increase from 17.6% this year to 20.3% in 2018—higher than any other country in the world.

We are determined to work together to provide quality, affordable coverage and access for every American. It is critical, however, that health reform also enhance quality, improve the overall health of the population, and reduce cost growth. We believe that the proper approach to achieve and sustain reduced cost growth is one that will: improve the population's health; continuously improve quality; encourage the advancement of medical treatments, approaches, and science; streamline administration; and encourage efficient care delivery based on evidence and best practice.

To achieve all of these goals, we have joined together in an unprecedented effort, as private sector stakeholders—physicians, hospitals, other health care workers, payors, suppliers, manufacturers, and organized labor—to offer concrete initiatives that will transform the health care system. As restructuring takes hold and the population's health improves over the coming decade, we will do our part to achieve your Administration's goal of decreasing by 1.5 percentage points the annual health care spending growth rate—saving \$2 trillion or more. This represents more than a 20% reduction in the projected rate of growth. We believe this approach can be highly successful and can help the nation to achieve the reform goals we all share.

To respond to this challenge, we are developing consensus proposals to reduce the rate of increase in future health and insurance costs through changes made in all sectors of the health care system. We are committed to taking action in public-private partnership to create a more stable and sustainable health care system that will achieve billions in savings through:

- Implementing proposals in all sectors of the health care system, focusing on administrative simplification, standardization, and transparency that supports effective markets;

- Reducing over-use and under-use of health care by aligning quality and efficiency incentives among providers across the continuum of care so that physicians, hospitals, and other health care providers are encouraged and enabled to work together towards the highest standards of quality and efficiency;
- Encouraging coordinated care, both in the public and private sectors, and adherence to evidence-based best practices and therapies that reduce hospitalization, manage chronic disease more efficiently and effectively, and implement proven clinical prevention strategies; and,
- Reducing the cost of doing business by addressing cost drivers in each sector and through common sense improvements in care delivery models, health information technology, workforce deployment and development, and regulatory reforms.

These and other reforms will make our health care system stronger and more sustainable. However, there are many important factors driving health care costs that are beyond the control of the delivery system alone. Billions in savings can be achieved through a large-scale national effort of health promotion and disease prevention to reduce the prevalence of chronic disease and poor health status, which leads to unnecessary sickness and higher health costs. Reform should include a specific focus on obesity prevention commensurate with the scale of the problem. These initiatives are crucial to transform health care in America and to achieve our goal of reducing the rate of growth in health costs.

We, as stakeholder representatives, are committed to doing our part to make reform a reality in order to make the system more affordable and effective for patients and purchasers. We stand ready to work with you to accomplish this goal.

Sincerely,



Stephen J. Ubl
President and CEO
Advanced Medical Technology Association



J. James Rohack, MD
President-elect
American Medical Association



Karen Ignagni
President and CEO
America's Health Insurance Plans



Billy Tauzin
President and CEO
Pharmaceutical Research and Manufacturers of America



Rich Umbdenstock
President and CEO
American Hospital Association



Dennis Rivera
Chair, SEIU Healthcare
Service Employees International Union

White House Visitors Records

Released Publicly on November 25, 2009

	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
1	SPERLING	GENE	B	1/24/2009 8:31:06AM	1/24/2009 4:26:29PM	1/24/2009 8:00:00AM	1	EMANUEL	RAHM	WH	WW
2	DASCHLE	THOMAS	A	1/25/2009 1:43:11PM		1/25/2009 1:30:00PM	1	EMANUEL	RAHM	WH	WW
3	CHILDRESS	MARK	B			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
4	CHU	STEVEN				1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
5	DEBOER	JOAN	M			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
6	DEVALANCE	BRIAN	L			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
7	DONOVAN	SHAUN				1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
8	DUNCAN	ARNE	F			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
9	GEITHNER	TIMOTHY				1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
10	GINGRICH	JOHN				1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
11	HOLDER	ERIC		1/28/2009 2:40:57PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
12	JACKSON	LISA	H			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
13	JETT	CAROLE	P			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
14	JOHNSTON	DAVID	E			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
15	KATZ	BRUCE	M			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
16	KENNEDY	BRIAN	J			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
17	LAHOOD	RAYMOND	V	1/28/2009 2:51:57PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
18	LEW	JACOB	L			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
19	MCCORD	MICHAEL	J	1/28/2009 2:55:25PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
20	NAPOLITANO	JANET	J	1/28/2009 2:55:10PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
21	OHLSON	KEVIN	A			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
22	PATTERSON	MARK	A			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
23	SALAZAR	KENNETH	A			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
24	SHINSEKI	ERIC	K			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
25	SMOOT	JULIANA	S	1/28/2009 2:46:03PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
26	SOLIS	HILDA	L			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
27	STRICKLAND	THOMAS	L			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
28	TANDEN	NEERA				1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
29	TIERNEY	SUSAN	F			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
30	UZZELL	MEGAN	J			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
31	VILSACK	THOMAS	J			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
32	WACHTER	ERIC	E			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
33	WADE	RICKY	C	1/28/2009 2:55:08PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350

White House Visitors Records

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Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
34 WEBSTER	MERIDITH	A	1/28/2009 2:59:03PM		1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
35 YALE	MATTHEW	A			1/28/2009 3:00:00PM	34	EMANUEL	RAHM	OEOB	350
36 SPERLING	GENE				1/29/2009 9:00:00AM	1	AXELROD	DAVID	WH	WW
37 BACKUS	JENNIFER		2/13/2009 3:38:32PM	2/13/2009 4:37:38PM	2/13/2009 3:00:00PM	1	EMANUEL	EZEKIEL	OEOB	263
38 DACEY	AMY	K	2/18/2009 2:22:08PM	2/18/2009 5:12:19PM	2/18/2009 2:15:00PM	2	EMANUEL	RAHM	WH	WW
39 ATKINS	EARNEST	C	2/20/2009 10:33:45AM	2/20/2009 12:04:30PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
40 BARNETT	PHILIP	S	2/20/2009 10:24:54AM	2/20/2009 11:51:19AM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
41 BURNES	AUSTIN	W	2/20/2009 10:58:51AM	2/20/2009 5:30:16PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
42 CAPRON	MARGARET				2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
43 COVEYBRANDT	ALEXIS	A	2/20/2009 10:58:31AM	2/20/2009 1:23:48PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
44 HARTZ	JERRY		2/20/2009 10:51:07AM	2/20/2009 12:03:45PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
45 HEALY	RICHARD	J	2/20/2009 10:47:50AM	2/20/2009 12:05:03PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
46 HEYMSFELD	DAVID	A	2/20/2009 10:53:21AM	2/20/2009 12:04:17PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
47 HOWELL	CHARLES	T	2/20/2009 10:53:46AM	2/20/2009 12:04:43PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
48 JONES	ARANTHAN				2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
49 KAHN	TOM		2/20/2009 10:52:28AM	2/20/2009 12:04:10PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
50 KESSLER	RICHARD	J	2/20/2009 10:47:43AM	2/20/2009 12:05:16PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
51 LAREW	ROBERT	L	2/20/2009 10:47:59AM	2/20/2009 12:03:07PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
52 PARKER	WYNDEE	R	2/20/2009 10:58:18AM	2/20/2009 12:04:37PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
53 ROSLANOWICK	JEANNE		2/20/2009 10:47:35AM	2/20/2009 12:05:59PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
54 STROMAN	RONALD	A	2/20/2009 9:55:36AM	2/20/2009 11:47:32AM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
55 TUCKER	DAVID	M	2/20/2009 10:48:40AM	2/20/2009 12:03:34PM	2/20/2009 10:45:00AM	18	TURTON	DANIEL	WH	RESIDENCE
56 ZUCKERMAN	MARK		2/20/2009 10:52:42AM	2/20/2009 12:03:24PM	2/22/2009 3:00:00PM	6	AXELROD	DAVID	WH	WW
57 MARTINO	BETHANY	R			2/22/2009 3:00:00PM	6	AXELROD	DAVID	WH	WW
58 PUPJAK	MICHAEL	F			2/22/2009 3:00:00PM	6	AXELROD	DAVID	WH	WW
59 SAUER	ERIC	D			2/22/2009 3:00:00PM	6	AXELROD	DAVID	WH	WW
60 SEBELIUS	KATHLEEN				2/22/2009 3:00:00PM	6	AXELROD	DAVID	WH	WW
61 WOLFF	KATHRYN				2/22/2009 3:00:00PM	6	AXELROD	DAVID	WH	WW
62 WOLFFSTAFF	KATHLEEN				2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW
63 MARTINO	BETHANY	R			2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW
64 PUPJAK	MICHAEL	F			2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW
65 SAUER	ERIC	D			2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW
66 SEBELIUS	KATHLEEN				2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
67	WOLFF	KATHRYN				2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW
68	WOLFFSTAFF	KATHLEEN				2/22/2009 5:00:00PM	5	AXELROD	DAVID	WH	WW
69	BRONFMAN	EDGAR	M			2/24/2009 12:45:00PM	3	EMANUEL	RAHM	WH	WESTWING
70	BROPHY	SUSAN	A			2/24/2009 12:45:00PM	3	EMANUEL	RAHM	WH	WESTWING
71	BROWN	JAMES	E			2/24/2009 12:45:00PM	3	EMANUEL	RAHM	WH	WESTWING
72	BIXBY	ROBERT		2/25/2009 2:43:29PM	2/25/2009 4:51:43PM	2/25/2009 2:30:00PM	6	ORSZAG	PETER	OEOB	252
73	GREENSTEIN	ROBERT	M	2/25/2009 3:09:27PM	2/25/2009 4:12:34PM	2/25/2009 2:30:00PM	6	ORSZAG	PETER	OEOB	252
74	MACGUINEAS	MAYA	C	2/25/2009 2:47:15PM	2/25/2009 4:57:18PM	2/25/2009 2:30:00PM	6	ORSZAG	PETER	OEOB	252
75	MINARIK	JOSEPH	J	2/25/2009 2:59:18PM	2/25/2009 4:09:00PM	2/25/2009 2:30:00PM	6	ORSZAG	PETER	OEOB	252
76	REISCHAUER	ROBERT		2/25/2009 2:58:52PM		2/25/2009 2:30:00PM	6	ORSZAG	PETER	OEOB	252
77	RIVLIN	ALICE		2/25/2009 2:49:24PM	2/25/2009 4:08:50PM	2/25/2009 2:30:00PM	6	ORSZAG	PETER	OEOB	252
78	BEGANS	PETER				2/26/2009 10:00:00AM	5	EMANUEL	ZEKE	OEOB	263
79	DRISCOLL	JOHN				2/26/2009 10:00:00AM	5	EMANUEL	ZEKE	OEOB	263
80	EISENBERG	WOODY				2/26/2009 10:00:00AM	5	EMANUEL	ZEKE	OEOB	263
81	SNOW	DAVID				2/26/2009 10:00:00AM	5	EMANUEL	ZEKE	OEOB	263
82	TEAGARDEN	RUSSELL				2/26/2009 10:00:00AM	5	EMANUEL	ZEKE	OEOB	263
83	SELIB	JONATHAN	G	2/26/2009 12:55:15PM	2/26/2009 2:22:04PM	2/26/2009 12:30:00PM	1	ROUSE	PETE	WH	WW
84	BLAND	JEFFREY		2/27/2009 3:10:05PM	2/27/2009 4:50:31PM	2/27/2009 3:30:00PM	3	EMANUEL	ZEKE	OEOB	263
85	HYMAN	MARK		2/27/2009 3:09:46PM	2/27/2009 4:49:54PM	2/27/2009 3:30:00PM	3	EMANUEL	ZEKE	OEOB	263
86	ORNISH	DEAN		2/27/2009 3:04:19PM	2/27/2009 3:57:29PM	2/27/2009 3:30:00PM	3	EMANUEL	ZEKE	OEOB	263
87	BOCCHINO	CARMIELLA	A	3/10/2009 8:45:53AM	3/10/2009 10:10:20AM	3/10/2009 9:00:00AM	6	EMANUEL	EZEKIEL	OEOB	260
88	BURNETT	LAIRD	D	3/10/2009 8:31:41AM	3/10/2009 10:11:17AM	3/10/2009 9:00:00AM	1	EMANUEL	EZEKIEL	OEOB	260
89	FISCHER	DONALD	R	3/10/2009 8:46:10AM	3/10/2009 10:11:06AM	3/10/2009 9:00:00AM	6	EMANUEL	EZEKIEL	OEOB	260
90	KANG	JEFFREY	L	3/10/2009 8:46:52AM	3/10/2009 10:48:29AM	3/10/2009 9:00:00AM	6	EMANUEL	EZEKIEL	OEOB	260
91	POIEL	RICHARD	G	3/10/2009 8:46:37AM	3/10/2009 10:11:00AM	3/10/2009 9:00:00AM	6	EMANUEL	EZEKIEL	OEOB	260
92	SANDY	LEWIS	G	3/10/2009 8:46:23AM	3/10/2009 10:10:49AM	3/10/2009 9:00:00AM	6	EMANUEL	EZEKIEL	OEOB	260
93	WEISSBERG	JED	I	3/10/2009 8:47:08AM	3/10/2009 10:11:11AM	3/10/2009 9:00:00AM	6	EMANUEL	EZEKIEL	OEOB	260
94	JENSEN	JULIE	A	3/11/2009 2:44:06PM		3/11/2009 3:00:00PM	5	JARRETT	VALERIE	OEOB	146
95	ROSEN	HILARY	B	3/11/2009 2:43:40PM		3/11/2009 3:00:00PM	5	JARRETT	VALERIE	OEOB	146
96	SMITH	ERIK	J	3/11/2009 2:51:35PM	3/11/2009 10:52:53PM	3/11/2009 3:00:00PM	5	JARRETT	VALERIE	OEOB	146
97	SUTPHEN	DAVID	A	3/11/2009 2:44:18PM	3/11/2009 10:52:47PM	3/11/2009 3:00:00PM	5	JARRETT	VALERIE	OEOB	146
98	CLAYPOOL	FORREST	E			3/12/2009 12:00:00PM	1	AXELROD	DAVID	WH	WW
99	KRUEGER	ALAN		3/13/2009 10:05:48AM	3/13/2009 11:19:33AM	3/13/2009 10:00:00AM	1	EMANUEL	EZEKIEL	OEOB	263

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
100	BINGEL	KELLY	R	3/13/2009 10:19:22AM	3/13/2009 12:25:41PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
101	CARDONA	MARIA	T	3/13/2009 10:18:19AM	3/13/2009 12:24:43PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
102	ELLEITHEE	MOHAMAD	A	3/13/2009 10:19:35AM	3/13/2009 12:23:52PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
103	EPSTIEN	JULIAN		3/13/2009 10:27:32AM	3/13/2009 6:23:08PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
104	FELDMAN	MICHAEL	B	3/13/2009 10:18:01AM	3/13/2009 12:44:55PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
105	FENN	PETER	H	3/13/2009 10:12:44AM	3/13/2009 12:24:55PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
106	FINNEY	KAREN	E	3/13/2009 10:29:33AM	3/13/2009 12:08:11PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
107	GOODFRIEND	DAVID	R	3/13/2009 10:24:37AM	3/13/2009 12:06:50PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
108	KOFINIS	CHRISTOPHER		3/13/2009 10:13:25AM	3/13/2009 12:23:59PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
109	MASTERS	RICHARD	W	3/13/2009 10:08:46AM	3/13/2009 12:25:04PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
110	MCMAHON	STEVE	H	3/13/2009 10:20:21AM	3/13/2009 12:24:12PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
111	MYERS	MARGARET	J	3/13/2009 10:17:20AM	3/13/2009 12:24:21PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
112	OMERO	MARGARET		3/13/2009 10:14:17AM	3/13/2009 12:24:06PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
113	PALMERI	JENNIFER	B	3/13/2009 10:21:54AM	3/13/2009 12:08:42PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
114	ROSEN	HILARY	B	3/13/2009 10:09:17AM	3/13/2009 12:24:33PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
115	ROSENBERG	SIMON	B	3/13/2009 10:18:09AM	3/13/2009 12:12:33PM	3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
116	WOODHOUSE	WILSON	B			3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
117	OKONGWU	ADAZE	Y			3/13/2009 10:30:00AM	18	AXELROD	DAVID	WH	WW
118	PAYNE	MARY	E	3/16/2009 12:01:18PM	3/16/2009 5:07:39PM	3/16/2009 12:15:00PM	2	EMANUEL	EZEKIEL	OEOB	263
119	TERSIGNI	ANTHONY		3/16/2009 12:01:29PM	3/16/2009 12:36:01PM	3/16/2009 12:15:00PM	2	EMANUEL	EZEKIEL	OEOB	263
120	CARLTON	DAMON				3/16/2009 6:45:00PM	3	DEPARLE	NANCY	OEOB	196
121	PUPJAK	MICHAEL	F			3/16/2009 6:45:00PM	3	DEPARLE	NANCY	OEOB	196
122	SEBELIUS	KATHLEEN	G			3/16/2009 6:45:00PM	3	DEPARLE	NANCY	OEOB	196
123	CONLON	PAUL	F	3/19/2009 12:48:31PM	3/19/2009 2:44:23PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
124	ECKELS	TIMOTHY	J	3/19/2009 12:48:46PM	3/19/2009 1:48:03PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
125	HALE	DANIEL	G	3/19/2009 12:48:15PM	3/19/2009 5:25:17PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
126	HILLER	ELINOR	A	3/19/2009 12:49:31PM	3/19/2009 3:37:08PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
127	NOTTMEIER	TONYA	W	3/19/2009 12:47:47PM	3/19/2009 1:49:03PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
128	SWEDISH	JOSEPH	R	3/19/2009 12:47:59PM	3/19/2009 1:47:49PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
129	YAGER	MARILYN	K	3/19/2009 12:47:28PM	3/19/2009 1:50:19PM	3/19/2009 1:00:00PM	7	EMANUEL	EZEKIEL	OEOB	260
130	SAMUEL	WILLIAM	H	3/19/2009 4:19:46PM	3/19/2009 5:04:16PM	3/19/2009 4:30:00PM	2	EMANUEL	RAHM	WH	WESTWING
131	SWEENEY	JOHN	J	3/19/2009 4:19:54PM	3/19/2009 5:53:09PM	3/19/2009 4:30:00PM	2	EMANUEL	RAHM	WH	WESTWING
132	CLARK	RICHARD	T	3/24/2009 2:15:20PM	3/24/2009 2:55:32PM	3/24/2009 2:30:00PM	4	EMANUEL	EZEKIEL	OEOB	263

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
133	HOGANSON	JONATHAN		3/24/2009 2:15:29PM	3/24/2009 2:56:51PM	3/24/2009 2:30:00PM	4	EMANUEL	EZEKIEL	OEOB	263
134	HORVATH	JANE	C	3/24/2009 2:15:08PM	3/24/2009 2:55:20PM	3/24/2009 2:30:00PM	4	EMANUEL	EZEKIEL	OEOB	263
135	PASTERNAK	RICHARD	C	3/24/2009 2:15:42PM	3/24/2009 2:55:38PM	3/24/2009 2:30:00PM	4	EMANUEL	EZEKIEL	OEOB	263
136	ABRAHAMSON	MARTIN		3/25/2009 9:13:34AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
137	AKHTER	MOHAMMAD		3/25/2009 9:34:36AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
138	ALTSCHULER	STEVEN	M	3/25/2009 9:45:33AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
139	BACH	PETER		3/25/2009 9:12:37AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
140	BEAN	JAMES	R	3/25/2009 9:23:51AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
141	BORENSTEIN	DAVID		3/25/2009 9:34:24AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
142	CORWIN	STEVEN		3/25/2009 9:05:18AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
143	COSGROVE	DELOS	M			3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
144	CROSBY	JOHN	B	3/25/2009 9:20:49AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
145	CURTIS	JARED	R	3/25/2009 9:29:17AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
146	DALEY	JENNIFER				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
147	DZAU	VICTOR	J			3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
148	FISHER	ELIOT		3/25/2009 9:30:32AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
149	GOLDMAN	LEE		3/25/2009 9:35:18AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
150	GOLDSCHMIDT	PASCAL	J			3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
151	HARRIS	JEFFREY	P	3/25/2009 9:31:54AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
152	HIMMELSTEIN	DAVID		3/25/2009 9:22:54AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
153	HUGHES	DORA				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
154	JOSEPH	GERALD	F	3/25/2009 9:22:36AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
155	KRUMHOLZ	HARLAN		3/25/2009 9:20:36AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
156	LEWIN	JOHN	C	3/25/2009 9:08:33AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
157	LICHTER	ALLEN				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
158	MADARA	JAMES				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
159	MILLER	EDWARD				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
160	MOORE	ROGER				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
161	NIEMAN	HARVEY	A	3/25/2009 9:28:48AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
162	OPELKA	FRANK		3/25/2009 9:33:55AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
163	PIZZO	PHILIP	A	3/25/2009 9:30:45AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
164	REDBERG	RITA	F	3/25/2009 9:29:02AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
165	RIOS	ELENA		3/25/2009 9:54:00AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
				3/25/2009 10:06:02AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
166	ROHACK	JAMES		3/25/2009 9:33:19AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
167	RUBERNSTEIN	LISA		3/25/2009 9:07:34AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
168	RUBINSTEIN	ARTHUR		3/25/2009 9:29:39AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
169	RUSSELL	THOMAS				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
170	SANDLER	ROBERT	S	3/25/2009 9:36:15AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
171	SCULLY	JAMES		3/25/2009 9:35:55AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
172	SWEENEY	ROSEMARIE		3/25/2009 9:20:17AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
173	VICK	PAUL				3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
174	WEAVER	WAYNE	D			3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
175	WITTES	ROBERT	E	3/25/2009 9:36:27AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
176	ZUCKERMAN	JOSEPH		3/25/2009 9:12:25AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
177	ALTMAN	STUART	H	3/25/2009 11:42:51AM		3/25/2009 10:00:00AM	41	EMANUEL	EZEKIEL	OEOB	474
178	SACHS	JEFFREY		3/26/2009 11:28:31AM	3/25/2009 3:13:26PM	3/25/2009 12:00:00PM	1	EMANUEL	EZEKIEL	OEOB	263
179	GRUBER	JONATHAN		3/26/2009 12:53:38PM	3/26/2009 1:30:04PM	3/26/2009 12:00:00PM	1	AXELROD	DAVID	WH	VVV
180	GRUBER	SAMUEL		3/26/2009 12:53:47PM	3/26/2009 2:22:04PM	3/26/2009 12:30:00PM	2	ORSZAG	PETER	OEOB	252
181	KRUEGER	ALAN			3/26/2009 10:34:06PM	3/26/2009 12:30:00PM	2	ORSZAG	PETER	OEOB	252
182	ROSEN	HILARY	B			3/27/2009 3:45:00PM	1	AXELROD	DAVID	WH	WESTWING
183	SUTPHEN	DAVID	A			3/30/2009 11:00:00AM	3	GASPARD	PATRICK	WH	VVV
184	FISHMAN	LINDA	E	3/30/2009 8:47:45AM		3/30/2009 11:00:00AM	3	GASPARD	PATRICK	WH	VVV
185	UMBENSTOCK	RICHARD	J	3/30/2009 8:48:04AM		3/30/2009 9:00:00AM	2	EMANUEL	EZEKIEL	OEOB	263
186	FOX	ALISSA		3/31/2009 4:00:34PM		3/30/2009 9:00:00AM	2	EMANUEL	EZEKIEL	OEOB	263
187	HALTMEYER	KRIS		3/31/2009 4:00:18PM		3/31/2009 3:30:00PM	4	ORSZAG	PETER	OEOB	252
188	KIES	KENNETH		3/31/2009 3:56:08PM		3/31/2009 3:30:00PM	4	ORSZAG	PETER	OEOB	252
189	SEROTA	SCOTT		3/31/2009 4:00:49PM		3/31/2009 3:30:00PM	4	ORSZAG	PETER	OEOB	252
190	BROWN	JASON		3/4/2009 12:58:26PM		3/31/2009 3:30:00PM	4	ORSZAG	PETER	OEOB	252
191	KIMBELL	DEBORAH	G	3/4/2009 10:03:34AM		3/4/2009 2:24:20PM	1	EMANUEL	EZEKIEL	OEOB	263
192	WEINSTEIN	JAMES	N	3/4/2009 10:03:22AM		3/4/2009 12:56:25PM	2	EMANUEL	EZEKIEL	OEOB	263
193	REDLENER	IRWIN	E	3/5/2009 12:33:16PM		3/4/2009 10:46:50AM	2	EMANUEL	EZEKIEL	OEOB	263
194	BLUM	JONATHAN	D	3/6/2009 12:58:00PM		3/5/2009 6:02:48PM	1	GASPARD	PATRICK	WH	VVV
195	BROWN	JASON		3/6/2009 11:02:46AM		3/6/2009 2:10:19PM	1	EMANUEL	EZEKIEL	OEOB	260
196	KAHN	CHARLES	N	3/6/2009 9:27:48AM		3/6/2009 12:02:03PM	1	EMANUEL	EZEKIEL	OEOB	260
197	LEE	PETER	V	3/6/2009 8:55:43AM		3/6/2009 10:32:24AM	1	EMANUEL	EZEKIEL	OEOB	263
198	BOCCHINO	CARMELLA	A	3/6/2009 9:28:40AM		3/6/2009 10:32:12AM	1	EMANUEL	EZEKIEL	OEOB	263
						3/6/2009 10:44:02AM	1	EMANUEL	EZEKIEL	OEOB	263

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
199	HOFFMAN	CHRISTY	L	4/13/2009 1:53:43PM	4/13/2009 2:45:17PM	4/13/2009 2:00:00PM	4	ORSZAG	PETER	OEOB	252
200	MADLAND	DAVID	L	4/13/2009 1:53:51PM	4/13/2009 2:45:37PM	4/13/2009 2:00:00PM	4	ORSZAG	PETER	OEOB	252
201	PODESTA	JOHN	D	4/13/2009 1:53:29PM	4/13/2009 2:45:29PM	4/13/2009 2:00:00PM	4	ORSZAG	PETER	OEOB	252
202	COHEN	BRIAN	A	4/17/2009 4:08:07PM	4/17/2009 5:54:54PM	4/17/2009 4:20:00PM	1	SCHILIRO	PHIL	WH	WESTWING
203	VAUGHAN	THERESE	M	4/21/2009 1:21:45PM	4/21/2009 5:24:02PM	4/21/2009 1:30:00PM	2	DEPARLE	NANCY	OEOB	196
204	WEBB	BRIAN	R	4/21/2009 1:21:54PM	4/21/2009 2:30:52PM	4/21/2009 1:30:00PM	2	DEPARLE	NANCY	OEOB	196
205	LEVITIS	JASON	A	4/21/2009 10:23:12AM	4/21/2009 1:57:35PM	4/21/2009 11:00:00AM	1	DEPARLE	NANCY	OEOB	180
206	PETROU	LAURA	A	4/21/2009 3:30:43PM	4/21/2009 5:13:45PM	4/21/2009 3:15:00PM	1	DEPARLE	NANCY	OEOB	476
207	LEVITIS	JASON	A			4/21/2009 3:30:00PM	1	DEPARLE	NANCY	OEOB	476
208	BURD	STEVEN	A	4/21/2009 6:30:00PM	4/21/2009 7:37:54PM	4/21/2009 6:30:00PM	1	EMANUEL	EZEKIEL	OEOB	263
209	DOUGLASS	LINDA	A	4/21/2009 8:02:06AM	4/21/2009 7:52:09PM	4/21/2009 8:00:00AM	2	DEPARLE	NANCY	OEOB	196
210	HASH	MICHAEL	M	4/21/2009 8:09:55AM	4/21/2009 7:04:35PM	4/21/2009 8:00:00AM	2	DEPARLE	NANCY	OEOB	196
211	CLAYPOOL	FORREST				4/23/2009 1:15:00PM	1	AXELROD	DAVID	WH	WW
212	PETROU	LAURA		4/23/2009 4:17:09PM	4/24/2009 1:21:35AM	4/23/2009 4:15:00PM	1	DEPARLE	NANCY	WH	WW
213	HASH	MICHAEL		4/28/2009 1:24:41PM	4/28/2009 8:35:46PM	4/28/2009 1:15:00PM	1	DEPARLE	NANCY	OEOB	196
214	LAMBREW	JEANNE		4/28/2009 3:56:11PM	4/28/2009 6:58:48PM	4/28/2009 4:00:00PM	4	DEPARLE	NANCY	WH	WW
215	PETROU	LAURA				4/28/2009 4:00:00PM	4	DEPARLE	NANCY	WH	WW
216	SESHAMANI	MEBA		4/28/2009 3:54:08PM	4/28/2009 6:58:54PM	4/28/2009 4:00:00PM	4	DEPARLE	NANCY	WH	WW
217	TANDEN	NEERA		4/28/2009 3:54:17PM	4/28/2009 7:48:11PM	4/28/2009 4:00:00PM	4	DEPARLE	NANCY	WH	WW
218	LEVITIS	JASON	A	4/29/2009 11:03:38AM	4/29/2009 12:12:59PM	4/29/2009 11:00:00AM	3	DEPARLE	NANCY	OEOB	196
219	SESHAMANI	MEENA		4/29/2009 11:05:02AM	4/29/2009 12:22:07PM	4/29/2009 11:00:00AM	3	DEPARLE	NANCY	OEOB	196
220	TANDEN	NEERA		4/29/2009 11:04:00AM	4/29/2009 1:06:48PM	4/29/2009 11:00:00AM	3	DEPARLE	NANCY	OEOB	196
221	HASH	MICHAEL		4/29/2009 8:47:33AM	4/29/2009 9:54:15AM	4/29/2009 8:00:00AM	2	DEPARLE	NANCY	OEOB	196
222	BERND	DAVID	L	4/3/2009 8:19:01AM	4/3/2009 9:41:53AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
223	DEAN	LLOYD	H			4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
224	DEMETRIOU	ACHILLES	A	4/3/2009 8:17:19AM	4/3/2009 9:41:38AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
225	DOWLING	MICHAEL	J			4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
226	DRISCOLL	JOHN	H	4/3/2009 8:18:50AM	4/3/2009 9:42:28AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
227	FINE	PETER	S			4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
228	HALL	MELVIN	F	4/3/2009 8:16:08AM	4/3/2009 9:43:17AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
229	JERNIGAN	DONALD	L	4/3/2009 8:15:21AM	4/3/2009 10:42:56AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
230	LAUER	CHARLES	S	4/3/2009 8:18:38AM	4/3/2009 10:43:02AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
231	LIPSTEIN	STEVEN	H	4/3/2009 8:18:27AM	4/3/2009 9:43:30AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
232	LOFTON	KEVIN	E	4/3/2009 8:16:32AM	4/3/2009 9:42:17AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
233	PRISELAC	THOMAS	M	4/3/2009 8:16:57AM	4/3/2009 9:42:41AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
234	RYAN	MARY	J	4/3/2009 8:15:53AM	4/3/2009 9:42:10AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
235	SWEDISH	JOSEPH	R	4/3/2009 8:17:36AM	4/3/2009 9:42:49AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
236	TARWATER	MICHAEL	C	4/3/2009 8:16:44AM	4/3/2009 9:41:50AM	4/3/2009 8:30:00AM	16	EMANUEL	EZEKIEL	OEOB	263
237	TERSIGNI	ANTHONY	R	4/3/2009 1:15:44PM	4/3/2009 4:17:26PM	4/3/2009 1:15:00PM	1	AXELROD	DAVID	WH	WW
238	CLAYPOOL	PHILIP	G	4/30/2009 1:27:23PM	4/30/2009 5:42:00PM	4/30/2009 2:00:00PM	18	JARRETT	VALERIE	OEOB	248
239	LAMARCHE	FORREST		4/30/2009 6:55:30PM	4/30/2009 6:45:00PM	4/30/2009 6:45:00PM	1	AXELROD	DAVID	WH	WW
240	CLAYPOOL	FORREST		4/30/2009 6:55:30PM	4/30/2009 6:45:00PM	4/30/2009 6:45:00PM	1	GASPARD	PATRICK	WH	WW
241	KIRSCH	RICHARD	J	4/6/2009 12:24:26PM	4/6/2009 1:19:04PM	4/6/2009 12:30:00PM	1	ORSZAG	PETER	OEOB	252
242	WILLIAMS	RONALD	A	4/6/2009 1:59:32PM	4/6/2009 2:31:55PM	4/6/2009 2:00:00PM	1	EMANUEL	RAHM	WH	WESTWING
243	CUTTER	STEPHANIE		4/8/2009 9:26:02AM	4/8/2009 10:40:20AM	4/8/2009 9:30:00AM	3	EMANUEL	RAHM	WH	WESTWING
244	PATTERSON	MARK	A	4/8/2009 9:26:18AM	4/8/2009 10:28:01AM	4/8/2009 9:30:00AM	3	EMANUEL	RAHM	WH	WESTWING
245	FEDER	JUDITH	M	4/9/2009 3:36:34PM	4/9/2009 5:57:03PM	4/9/2009 12:00:00PM	1	DEPARLE	NANCY	OEOB	196
246	CHILDRESS	MARK	B	4/9/2009 3:36:34PM	4/9/2009 5:57:03PM	4/9/2009 3:45:00PM	2	ROUSE	PETE	WH	WW
247	PETROU	LAURA		4/9/2009 3:39:20PM	4/9/2009 6:07:19PM	4/9/2009 3:45:00PM	2	ROUSE	PETE	WH	WW
248	BAICKER	KATHERINE		5/11/2009 3:44:50PM	5/11/2009 5:49:45PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
249	BERTKO	JOHN	M	5/11/2009 3:45:26PM	5/11/2009 5:44:54PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
250	CASALINO	LAWRENCE	P	5/11/2009 3:43:20PM	5/11/2009 5:57:03PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
251	CUTLER	DAVID		5/11/2009 3:37:38PM	5/11/2009 5:46:19PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
252	EPSTEIN	ARNOLD		5/11/2009 3:28:14PM	5/11/2009 5:46:19PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
253	FELDMAN	ROGER	D	5/11/2009 3:28:14PM	5/11/2009 5:46:19PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
254	FORMAN	HOWARD		5/11/2009 3:45:41PM	5/11/2009 5:46:19PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
255	GARBER	ALAN	M	5/11/2009 3:45:41PM	5/11/2009 5:46:19PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
256	KRUMHOLZ	HARLAN		5/11/2009 3:49:25PM	5/11/2009 5:49:27PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
257	LEWIN	JOHN	C	5/11/2009 3:47:00PM	5/11/2009 5:49:27PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
258	LUFT	HAROLD	S	5/11/2009 3:42:24PM	5/11/2009 5:49:27PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
259	MCGLYNN	ELIZABETH	A	5/11/2009 3:45:06PM	5/11/2009 5:42:18PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
260	MELTZER	DAVID	O	5/11/2009 3:22:17PM	5/11/2009 5:49:57PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
261	MILSTEIN	ARNOLD	S	5/11/2009 3:44:03PM	5/11/2009 5:49:57PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
262	NEWHOUSE	JOSEPH	P	5/11/2009 3:38:00PM	5/11/2009 5:40:44PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
263	SCHAEFFER	LEONARD	D	5/11/2009 3:41:52PM	5/11/2009 5:40:44PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263
264	SHORTELL	STEPHEN	M	5/11/2009 3:41:52PM	5/11/2009 5:40:44PM	5/11/2009 4:00:00PM	19	EMANUEL	EZEKIEL	OEOB	263

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
265	CROSSON	FRANCIS	J	5/11/2009 3:47:59PM		5/11/2009 00:00:00PM	19	EMANUEL	EZEKIEL	OE0B	263
266	PETROU	LAURA				5/15/2009 11:30:00AM	1	ORSZAG	PETER	WH	WESTWING
267	GELLIN	BRUCE				5/19/2009 12:00:00PM	4	ORSZAG	PETER	OE0B	WW
268	PETROU	LAURA				5/19/2009 12:00:00PM	4	ORSZAG	PETER	OE0B	WW
269	ROBINSON	ROBIN				5/19/2009 12:00:00PM	4	ORSZAG	PETER	OE0B	WW
270	TRUMAN	RICHARD				5/19/2009 12:00:00PM	4	ORSZAG	PETER	OE0B	WW
271	COHEN	JONATHAN		5/19/2009 4:35:11PM	5/19/2009 5:23:04PM	5/19/2009 4:40:00PM	1	SCHILIRO	PHIL	WH	WW
272	HELMSLEY	STEPHEN	J	5/22/2009 2:11:57PM	5/22/2009 3:29:30PM	5/22/2009 2:30:00PM	4	ORSZAG	PETER	OE0B	252
273	PATTERSON	MARVIN		5/22/2009 2:11:49PM	5/22/2009 3:28:55PM	5/22/2009 2:30:00PM	4	ORSZAG	PETER	OE0B	252
274	STEVENS	SIMON	L	5/22/2009 2:11:40PM	5/22/2009 3:29:12PM	5/22/2009 2:30:00PM	4	ORSZAG	PETER	OE0B	252
275	WELTERS	ANTHONY		5/22/2009 2:12:05PM	5/22/2009 3:29:03PM	5/22/2009 2:30:00PM	4	ORSZAG	PETER	OE0B	252
276	LAMBREW	JEANNE				5/27/2009 3:00:00PM	1	AXELROD	DAVID	WH	WW
277	BJORKLUND	CYBELE		5/28/2009 11:56:41AM	5/28/2009 2:03:29PM	5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
278	CURTIS	DEBRA	S	5/28/2009 11:56:51AM	5/28/2009 2:05:46PM	5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
279	EBELER	JACK	C	5/28/2009 12:05:12PM	5/28/2009 2:04:36PM	5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
280	FRIEDMAN	JENNIFER	L	5/28/2009 11:57:16AM		5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
281	LAMBREW	JEANNE	M			5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
282	NELSON	KAREN	F	5/28/2009 12:05:03PM	5/28/2009 2:04:43PM	5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
283	OREILLY	MEGAN	E	5/28/2009 12:04:46PM	5/28/2009 2:05:55PM	5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
284	VARNHAGEN	MICHELE	L	5/28/2009 12:04:55PM		5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
285	WHITE	CHIQUITA		5/28/2009 11:58:33AM	5/28/2009 7:49:17PM	5/28/2009 12:00:00PM	9	DEPARLE	NANCY	WH	WW
286	SMITH	THOMAS				5/6/2009 5:00:00PM	2	ORSZAG	PETER	WH	WW
287	ASOMUGHA	CHISARAOKWU	N	5/7/2009 2:01:09PM	5/7/2009 5:12:07PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	252
288	BARRON	JILL				5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
289	BIRNBAUM	IRWIN	M	5/7/2009 2:00:37PM	5/7/2009 4:22:12PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
290	CHEN	PEGGY				5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
291	FORMAN	HOWARD	P	5/7/2009 2:00:23PM	5/7/2009 4:22:04PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
292	GOODRICH	KATHERINE	H	5/7/2009 2:04:12PM	5/7/2009 5:12:21PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
293	HANSEN	LUKE	O	5/7/2009 2:03:53PM	5/7/2009 5:12:58PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
294	JOHNSON	LARA	W	5/7/2009 2:04:45PM	5/7/2009 5:12:44PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
295	KUY	SREYRAM		5/7/2009 1:59:14PM	5/7/2009 5:12:36PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
296	LANDMAN	ADAM	B	5/7/2009 1:59:27PM	5/7/2009 5:12:30PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430
297	MAKAROV	DANIL	V	5/7/2009 1:59:58PM	5/7/2009 5:12:51PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OE0B	430

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
298	MANDE	JEROLD	R	5/7/2009 1:59:04PM	5/7/2009 5:07:07PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OEOB	430
299	PHIPPS	MICHAEL		5/7/2009 1:59:43PM	5/7/2009 5:11:49PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OEOB	430
300	RAO	MITESH	B	5/7/2009 2:00:11PM	5/7/2009 5:11:58PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OEOB	430
301	SPATZ	ERICA	S	5/7/2009 2:00:52PM	5/7/2009 5:12:14PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OEOB	430
302	VIOLA	KATE	V	5/7/2009 2:04:28PM	5/7/2009 5:11:34PM	5/7/2009 2:00:00PM	16	EMANUEL	EZEKIEL	OEOB	430
303	JOHNSON	JOEL	P			5/8/2009 12:15:00PM	1	EMANUEL	RAHM	WH	WW
304	AGRAST	MARK				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
305	APPELBAUM	JUDITH	C			6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
306	BOYD	APRIL				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
307	GANESAN	ARAVINTH				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
308	GOMEZ	GABRIELLA		6/12/2009 5:00:28PM	6/12/2009 11:18:13PM	6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
309	GRESHAM	DANA				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
310	HARDEN	KRYSTA				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
311	KENNEDY	BRIAN				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
312	KING	ELIZABETH		6/12/2009 4:52:08PM	6/12/2009 9:11:03PM	6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
313	KOVAR	PETER				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
314	LETTENEY	ROBERT	A			6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
315	LEVY	JONATHAN				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
316	MANSOUR	CHRISTOPHER				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
317	PALM	ANDREA				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
318	PEACOCK	NELSON				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
319	SATCHER	DARAKA				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
320	SHAND	TANIA	E			6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
321	TURNER	KATHLEEN				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
322	VANDIVIER	DAVID		6/12/2009 4:32:22PM	6/12/2009 5:17:46PM	6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
323	VERMA	RICHARD				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
324	WEICH	RONALD				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
325	WIGGINS	CHANI				6/12/2009 4:30:00PM	22	SCHILIRO	PHIL	OEOB	276
326	LAMBREW	JEANNE		6/15/2009 4:39:59PM	6/15/2009 5:49:06PM	6/15/2009 4:20:00PM	1	SCHILIRO	PHIL	WH	WESTWING
327	SACHS	JEFFREY		6/16/2009 3:49:29PM	6/16/2009 4:42:29PM	6/16/2009 4:00:00PM	1	AXELROD	DAVID	WH	WW
328	MALKOVICH	NICHOLAS	X			6/17/2009 5:45:00PM	5	EMANUEL	RAHM	WH	WW
329	RAND	ADDISON	B	6/17/2009 5:32:35PM		6/17/2009 5:45:00PM	5	EMANUEL	RAHM	WH	WW
330	SELIB	JON				6/17/2009 5:45:00PM	5	EMANUEL	RAHM	WH	WW

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
331	SHIELDS	ERIN	E			6/17/2009 5:45:00PM	5	EMANUEL	RAHM	WH	WW
332	LAMBREW	JEANNE		6/18/2009 3:08:07PM	6/18/2009 5:34:48PM	6/18/2009 3:00:00PM	1	SCHILIRO	PHIL	WH	WW
333	AGRAST	MARK				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
334	BOYD	APRIL				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
335	DIONNE	GARY	A			6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
336	GANESAN	ARAVINTH				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
337	GOMEZ	GABRIELLA		6/19/2009 5:02:41PM	6/19/2009 6:08:42PM	6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
338	GRESHAM	DANA				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
339	HARDEN	KRYSTA				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
340	KENNEDY	BRIAN		6/19/2009 4:58:00PM	6/19/2009 6:02:17PM	6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
341	KING	ELIZABETH				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
342	KOVAR	PETER				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
343	LETTRE	MARCEL				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
344	LEVY	JONATHAN				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
345	MANSOUR	CHRISTOPHER				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
346	PALM	ANDREA				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
347	SATCHER	DARAKA				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
348	SHAND	TANIA				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
349	TURNER	KATHLEEN				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
350	VANDIVIER	DAVID				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
351	VERMA	RICHARD				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
352	WEICH	RONALD				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
353	WIGGINS	CHANI				6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
354	WOLF	HARRY	A			6/19/2009 4:45:00PM	22	SCHILIRO	PHIL	OEOB	276
355	LEAMOND	NANCY	A			6/22/2009 11:30:00AM	3	JARRETT	VALERIE	WH	WW
356	RAND	ADDISON	B			6/22/2009 11:30:00AM	3	JARRETT	VALERIE	WH	WW
357	ROTHER	JOHN				6/22/2009 11:30:00AM	3	JARRETT	VALERIE	WH	WW
358	ADAMS	KIRK		6/30/2009 12:26:14PM	6/30/2009 1:02:53PM	6/30/2009 12:30:00PM	6	EMANUEL	RAHM	WH	WESTWING
359	DACH	LESLIE	A	6/30/2009 12:26:26PM	6/30/2009 1:03:01PM	6/30/2009 12:30:00PM	6	EMANUEL	RAHM	WH	WESTWING
360	FEDER	JUDITH		6/30/2009 12:26:34PM	6/30/2009 1:02:30PM	6/30/2009 12:30:00PM	6	EMANUEL	RAHM	WH	WESTWING
361	NAWAR	MICHELLE		6/30/2009 12:26:47PM	6/30/2009 1:02:39PM	6/30/2009 12:30:00PM	6	EMANUEL	RAHM	WH	WESTWING
362	PODESTA	JOHN	D	6/30/2009 12:26:54PM	6/30/2009 1:02:16PM	6/30/2009 12:30:00PM	6	EMANUEL	RAHM	WH	WESTWING
363	RIVERA	DENNIS				6/30/2009 12:30:00PM	6	EMANUEL	RAHM	WH	WESTWING

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
364	HALVORSON	GEORGE		6/5/2009 1:51:27PM	6/5/2009 2:23:16PM	6/5/2009 2:00:00PM	1	ORSZAG	PETER	OEOB	252
365	BOYD	APRIL		6/5/2009 4:33:27PM	6/5/2009 5:33:38PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
366	GANESAN	ARAVINTH	R	6/5/2009 4:32:36PM	6/5/2009 5:31:49PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
367	GOMEZ	GABRIELLA		6/5/2009 4:39:47PM	6/5/2009 5:43:16PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
368	GRESHAM	DANA		6/5/2009 4:48:40PM	6/5/2009 5:47:54PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
369	HARDEN	KRYSTA		6/5/2009 4:37:10PM	6/5/2009 5:25:24PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
370	KENNEDY	BRIAN		6/5/2009 4:28:04PM	6/5/2009 5:43:07PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
371	KING	ELIZABETH		6/5/2009 4:38:25PM	6/5/2009 6:07:46PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
372	KOVAR	PETER		6/5/2009 4:38:41PM	6/5/2009 5:44:03PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
373	LEVY	JONATHAN	M	6/5/2009 4:30:39PM	6/5/2009 5:36:25PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
374	MANSOUR	CHRISTOPHER		6/5/2009 4:21:19PM	6/5/2009 5:48:00PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
375	PALM	ANDREA		6/5/2009 4:27:37PM	6/5/2009 5:31:43PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
376	SHAND	TANIA		6/5/2009 4:33:04PM	6/5/2009 5:34:16PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
377	TURNER	KATHLEEN				6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
378	VANDIVIER	DAVID		6/5/2009 4:31:09PM	6/5/2009 7:08:24PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
379	VERMA	RICHARD		6/5/2009 4:44:16PM	6/5/2009 5:50:40PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
380	WEICH	RONALD				6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
381	WIGGINS	CHANI		6/5/2009 4:36:25PM	6/5/2009 5:50:19PM	6/5/2009 4:30:00PM	17	SCHILIRO	PHIL	OEOB	276
382	NICKELS	THOMAS				7/10/2009 1:30:00PM	3	MESSINA	JIM	WH	WW
383	POLLACK	RICHARD		7/10/2009 1:27:30PM	7/10/2009 5:09:35PM	7/10/2009 1:30:00PM	3	MESSINA	JIM	WH	WW
384	GONZALEZ	ROSE	I	7/10/2009 4:37:05PM	7/10/2009 5:36:05PM	7/10/2009 4:45:00PM	3	MESSINA	JIM	WH	WW
385	HANEY	CYNTHIA	L	7/10/2009 4:36:55PM	7/10/2009 5:36:19PM	7/10/2009 4:45:00PM	3	MESSINA	JIM	WH	WW
386	PATTON	REBECCA	M	7/10/2009 4:36:40PM	7/10/2009 5:35:55PM	7/10/2009 4:45:00PM	3	MESSINA	JIM	WH	WW
387	LAMBREW	JEANNE		7/10/2009 5:26:23PM	7/10/2009 9:01:39PM	7/10/2009 5:30:00PM	1	SCHILIRO	PHILIP	WH	WW
388	LAMBREW	JEANNE				7/13/2009 12:00:00PM	1	SCHILIRO	PHIL	WH	WW
389	LAMBREW	JEANNE		7/14/2009 6:06:41PM	7/14/2009 7:28:55PM	7/14/2009 6:30:00PM	1	SCHILIRO	PHIL	WH	WW
390	LAMBREW	JEANNE		7/15/2009 5:23:31PM		7/15/2009 5:30:00PM	1	SCHILIRO	PHIL	WH	WW
391	LAMBREW	JEANNE				7/16/2009 5:30:00PM	1	SCHILIRO	PHIL	WH	WW
392	BELCHER	KIM	C	7/17/2009 4:34:30PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
393	BENENSON	JOEL		7/17/2009 4:18:32PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
394	BINDER	DAVID	B	7/17/2009 4:33:59PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
395	BRODNITZ	PETER	D	7/17/2009 4:30:13PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
396	BURTON	JENNIFER	L	7/17/2009 4:30:03PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
397	CAHILL	MARY	E	7/17/2009 4:19:23PM	7/17/2009 6:05:42PM	7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
398	DAVIS	RICHARD	F			7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
399	FENTON	DAVID	S			7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
400	GIANGRECO	PETER	A	7/17/2009 4:20:12PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
401	GREENBERG	STANLEY	B			7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
402	HALLORAN	CHARLES	P	7/17/2009 4:41:06PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
403	HORTSMEYER	SETH	C			7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
404	JONES	ROBERT	P	7/17/2009 4:07:48PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
405	LAGUENS	DAWN	E	7/17/2009 4:32:19PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
406	LAKE	CELINDA	C	7/17/2009 4:06:16PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
407	LEDERER	LISA	E	7/17/2009 4:34:58PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
408	LIGHTBODY	LAURA	B	7/17/2009 4:24:42PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
409	MANATT	DANIEL	C	7/17/2009 4:21:14PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
410	MAXFIELD	ANDREW	M	7/17/2009 4:16:38PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
411	OLICK	KAREN		7/17/2009 4:26:36PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
412	ROSENTHAL	STEVEN	S			7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
413	ROWLEY	JOHN	P	7/17/2009 4:40:45PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
414	SHEPARDSON	ROBERT	T	7/17/2009 4:25:53PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
415	TEWES	PAUL	E			7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
416	BELCHER	KIM	C			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
417	BENENSON	JOEL				7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
418	DAVIS	RICHARD	F			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
419	BINDER	DAVID	B			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
420	BRODNITZ	PETER	D			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
421	BURTON	JENNIFER	L			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
422	CAHILL	MARY	E			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
423	CROW	ALLAN	B			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
424	DIXON	DAVID	M			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
425	FENTON	DAVID	S	7/17/2009 4:55:03PM		7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
426	GIANGRECO	PETER	A			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
427	GREENBERG	STANLEY	B	7/17/2009 5:18:07PM		7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
428	HALLORAN	CHARLES	P			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
429	HORTSMEYER	SETH	C	7/17/2009 4:54:31PM		7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
430	JONES	ROBERT	P			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
431	LAGUENS	DAWN	E			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
432	LAKE	CELINDA	C			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
433	LEDERER	LISA	E			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
434	LIGHTBODY	LAURA	B			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
435	MANATT	DANIEL	C			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
436	MAXFIELD	ANDREW	M			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
437	OLICK	KAREN				7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
438	PALMIERI	JENNIFER		7/17/2009 5:03:37PM		7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
439	ROSENTHAL	STEVEN	S			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
440	ROWLEY	JOHN	P			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
441	SHEPARDSON	ROBERT	T			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
442	CROW	ALLAN	B	7/17/2009 4:05:12PM		7/17/2009 4:30:00PM	0	MESSINA	JIM	OEOB	248
443	TEWES	PAUL	E			7/17/2009 4:30:00PM	27	MESSINA	JIM	OEOB	248
444	LEAMOND	NANCY				7/20/2009 6:00:00PM	3	ORSZAG	PETER	OEOB	208
445	ROTHER	JOHN		7/20/2009 5:54:24PM	7/20/2009 6:50:14PM	7/20/2009 6:00:00PM	3	ORSZAG	PETER	OEOB	208
446	SLOANE	DAVID		7/20/2009 5:54:10PM	7/20/2009 6:49:52PM	7/20/2009 6:00:00PM	3	ORSZAG	PETER	OEOB	208
447	CLAYPOOL	FORREST		7/21/2009 12:20:33PM	7/21/2009 2:52:35PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
448	CUNNINGHAM	JOSEPH		7/21/2009 12:20:18PM	7/21/2009 5:10:16PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
449	DICKEY	NANCY		7/21/2009 12:21:27PM	7/21/2009 1:44:10PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
450	FRENCH	DOUGLAS		7/21/2009 12:21:19PM	7/21/2009 1:44:22PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
451	GOTTLIEB	GARY		7/21/2009 12:20:59PM	7/21/2009 5:10:42PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
452	LANGSHUR	ERIC		7/21/2009 12:20:49PM	7/21/2009 2:52:43PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
453	TENACE	GINO		7/21/2009 12:21:37PM	7/21/2009 2:52:43PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
454	TERSIGNI	ANTHONY		7/21/2009 12:20:08PM	7/21/2009 1:44:03PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
455	TUCKSON	REED		7/21/2009 12:21:11PM	7/21/2009 3:16:39PM	7/21/2009 12:30:00PM	9	AXELROD	DAVID	WH	WW
456	LAMBREW	JEANNE		7/21/2009 3:17:15PM	7/21/2009 6:23:05PM	7/21/2009 2:50:00PM	1	SCHILIRO	PHIL	WH	WW
457	LAMBREW	JEANNE				7/22/2009 4:00:00PM	1	SCHILIRO	PHIL	WH	WW
458	CASTELLANI	JOHN	J	7/23/2009 11:30:39AM	7/23/2009 12:30:55PM	7/23/2009 11:30:00AM	5	DEPARLE	NANCY	OEOB	197
459	CICCONI	STEPHEN		7/23/2009 11:30:18AM	7/23/2009 12:31:10PM	7/23/2009 11:30:00AM	5	DEPARLE	NANCY	OEOB	197
460	GHAZAL	MARIA		7/23/2009 11:30:06AM	7/23/2009 12:31:03PM	7/23/2009 11:30:00AM	5	DEPARLE	NANCY	OEOB	197
461	PEREZ	ANTONIO		7/23/2009 11:29:53AM	7/23/2009 12:30:50PM	7/23/2009 11:30:00AM	5	DEPARLE	NANCY	OEOB	197
462	TAYLOR	NANCY	E	7/23/2009 11:30:31AM	7/23/2009 12:31:17PM	7/23/2009 11:30:00AM	5	DEPARLE	NANCY	OEOB	197

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
463	LAMBREW	JEANNE		7/27/2009 5:59:57PM	7/27/2009 7:56:06PM	7/27/2009 6:00:00PM	1	SCHILIRO	PHIL	WH	WW
464	CHILDRESS	KATHERINE		7/30/2009 12:42:47PM	7/30/2009 1:59:42PM	7/30/2009 12:00:00PM	5	ROUSE	PETE	WH	WESTWING
465	CHILDRESS	MARK		7/30/2009 12:42:58PM	7/30/2009 2:53:39PM	7/30/2009 12:00:00PM	5	ROUSE	PETE	WH	WESTWING
466	HAYNES	WARREN		7/30/2009 12:43:54PM	7/30/2009 2:41:44PM	7/30/2009 12:00:00PM	5	ROUSE	PETE	WH	WESTWING
467	SCAMARDOHAYNES	STEFANI		7/30/2009 12:43:31PM	7/30/2009 2:41:30PM	7/30/2009 12:00:00PM	5	ROUSE	PETE	WH	WESTWING
468	LAMBREW	JEANNE		7/30/2009 4:28:42PM		7/30/2009 4:30:00PM	1	SCHILIRO	PHIL	WH	WW
469	LEWIS	CAYA	B	7/31/2009 2:34:20PM	7/31/2009 4:14:59PM	7/31/2009 2:30:00PM	1	ORSZAG	PETER	WH	WW
470	LAMBREW	JEANNE		7/6/2009 2:52:34PM	7/6/2009 8:17:08PM	7/6/2009 3:00:00PM	1	SCHILIRO	PHILLIP	WH	WW
471	LOVELESS	CHARLIES	M	7/7/2009 1:05:47PM	7/7/2009 2:26:50PM	7/7/2009 1:00:00PM	4	EMANUEL	RAHM	WH	WW
472	MCENTEE	GERALD	W	7/7/2009 1:05:56PM	7/7/2009 1:57:36PM	7/7/2009 1:00:00PM	4	EMANUEL	RAHM	WH	WW
473	SAMUEL	WILLIAM	H	7/7/2009 12:52:17PM	7/7/2009 1:57:55PM	7/7/2009 1:00:00PM	4	EMANUEL	RAHM	WH	WW
474	SWEENEY	JOHN	J			7/7/2009 1:00:00PM	4	EMANUEL	RAHM	WH	WW
475	BISHOP	SHAWN				7/7/2009 2:30:00PM	5	EMANUEL	RAHM	WH	WW
476	FOWLER	ELIZABETH				7/7/2009 2:30:00PM	5	EMANUEL	RAHM	WH	WW
477	MALKOVICH	NICHOLAS				7/7/2009 2:30:00PM	5	EMANUEL	RAHM	WH	WW
478	SELIB	JON				7/7/2009 2:30:00PM	5	EMANUEL	RAHM	WH	WW
479	SULLIVAN	RUSSELL	W	7/7/2009 2:30:00PM	7/7/2009 8:13:53PM	7/7/2009 2:30:00PM	5	EMANUEL	RAHM	WH	WW
480	TAUZIN	WILBERT	J	7/7/2009 2:20:43PM	7/7/2009 3:26:48PM	7/7/2009 2:30:00PM	8	MESSINA	JIM	WH	WW
481	LAMBREW	JEANNE		7/7/2009 3:59:59PM	7/7/2009 10:30:04PM	7/7/2009 4:00:00PM	1	SCHILIRO	PHIL	WH	WW
482	LAMBREW	JEANNE		7/8/2009 6:27:56PM	7/8/2009 6:56:26PM	7/8/2009 6:30:00PM	1	SCHILIRO	PHIL	WH	WW
483	MULHAUSER	SCOTT				7/8/2009 9:38:00AM	3	MESSINA	JIM	WH	WW
484	SELIB	JONATHAN				7/8/2009 9:38:00AM	3	MESSINA	JIM	WH	WW
485	SULLIVAN	RUSSELL				7/8/2009 9:38:00AM	3	MESSINA	JIM	WH	WW
486	LAMBREW	JEANNE				7/9/2009 5:30:00PM	1	SCHILIRO	PHIL	WH	WW
487	AVANT	ISSAC	L	7/9/2009 7:02:22PM	7/9/2009 7:06:44PM	7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
488	BELAND	MICHAEL	A	7/9/2009 7:02:26PM	7/9/2009 7:07:14PM	7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
489	BRANSON	CHERRI		7/9/2009 7:02:30PM	7/9/2009 7:06:58PM	7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
490	GRAZIANO	DENA				7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
491	NORTHROP	ALISON		7/9/2009 7:04:30PM	7/9/2009 7:07:01PM	7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
492	OLCOTT	JACOB				7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
493	RYE	ANGELA		7/9/2009 7:02:40PM		7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
494	SCOTT	TAMLA		7/9/2009 7:04:07PM		7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
495	STROUD	DENIS		7/9/2009 7:02:49PM		7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitor Last Name	Visitor First Name	Meeting Location	Meeting Room
496	TURBYFILL	BRIAN		7/9/2009 7:05:20PM		7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
497	VINA	STEVEN		7/9/2009 7:04:18PM	7/9/2009 7:44:28PM	7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
498	WIGGINS	CHANI				7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
499	ZAMUDIODOLAN	CARLA				7/9/2009 7:00:00PM	13	TURTON	DAN	WH	EW
500	BLAIR	COURTNEY		7/9/2009 7:02:55PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
501	BRANDON	TYLER		7/9/2009 8:14:02PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
502	DUNMIRE	BRYAN		7/9/2009 8:13:53PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
503	GOULD	JONATHAN		7/9/2009 8:16:21PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
504	GRABER	ELIZABETH		7/9/2009 8:14:13PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
505	HAWLEY	JONATHAN		7/9/2009 8:12:24PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
506	LAM	JULIA		7/9/2009 8:12:00PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
507	LOGAN	KRISTEN		7/9/2009 8:16:16PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
508	LOUIS	STEPHANIE		7/9/2009 8:12:12PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
509	MICHEL	ERIC		7/9/2009 8:12:20PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
510	PAULL	MORGAN		7/9/2009 8:14:26PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
511	ROSE	BILL		7/9/2009 8:14:08PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
512	SIKORA	ALLISON		7/9/2009 8:16:32PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
513	SOLNET	JEFFREY		7/9/2009 8:11:54PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
514	URBINA	LUIS		7/9/2009 8:16:27PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
515	WANG	AIXIN		7/9/2009 8:13:58PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
516	YANG	DAVID		7/9/2009 8:14:19PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
517	ZHANG	HAN		7/9/2009 8:12:07PM		7/9/2009 8:00:00PM	18	AXELROD	DAVID	WH	WESTWING
518	LEWIN	JOHN	C	8/10/2009 12:05:02PM	8/10/2009 1:31:05PM	8/10/2009 12:00:00PM	1	DEPARLE	NANCY	WH	WW
519	LAMBREW	JEANNE				8/10/2009 9:30:00AM	1	DEPARLE	NANCY	OEOB	82
520	DEEM	RICHARD	A	8/11/2009 1:15:30PM	8/11/2009 2:35:35PM	8/11/2009 1:15:00PM	1	DEPARLE	NANCY	WH	WW
521	EPERLY	TED	D	8/11/2009 11:56:37AM	8/11/2009 1:10:46PM	8/11/2009 12:15:00PM	5	DEPARLE	NANCY	OEOB	82
522	SWEENEY	ROSEMARIE		8/11/2009 11:56:57AM	8/11/2009 1:10:42PM	8/11/2009 12:15:00PM	5	DEPARLE	NANCY	OEOB	82
523	TOOKER	JOHN	P	8/11/2009 12:02:30PM	8/11/2009 1:10:33PM	8/11/2009 12:15:00PM	5	DEPARLE	NANCY	OEOB	82
524	TRACHTMAN	RICHARD	L	8/11/2009 12:02:17PM	8/11/2009 1:10:52PM	8/11/2009 12:15:00PM	5	DEPARLE	NANCY	OEOB	82
525	ALDEN	ERROL		8/11/2009 5:28:13PM		8/11/2009 5:30:00PM	6	DEPARLE	NANCY	OEOB	82
526	HALL	ROBERT	T	8/11/2009 5:27:20PM		8/11/2009 5:30:00PM	6	DEPARLE	NANCY	OEOB	82
527	JENKINS	RENEE	R	8/11/2009 5:27:01PM		8/11/2009 5:30:00PM	6	DEPARLE	NANCY	OEOB	82
528	NOYES	ELIZABETH	J			8/11/2009 5:30:00PM	6	DEPARLE	NANCY	OEOB	82

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
529	PALFREY	JUDITH		8/11/2009 5:27:59PM		8/11/2009 5:30:00PM	6	DEPARLE	NANCY	OEOB	82
530	TAYLOE	DAVID	T	8/11/2009 5:27:36PM	8/11/2009 6:29:24PM	8/11/2009 5:30:00PM	6	DEPARLE	NANCY	OEOB	82
531	LAMBREW	JEANNE	M	8/13/2009 6:06:23PM		8/13/2009 5:50:00PM	1	DEPARLE	NANCY	WH	WW
532	LEVITIS	JASON				8/14/2009 10:30:00AM	4	DEPARLE	NANCY	OEOB	82
533	LEWIS	CAYA	B			8/14/2009 10:30:00AM	4	DEPARLE	NANCY	OEOB	82
534	SESHAMANI	MEENA				8/14/2009 10:30:00AM	4	DEPARLE	NANCY	OEOB	82
535	TANDEN	NEERA				8/14/2009 10:30:00AM	4	DEPARLE	NANCY	OEOB	82
536	LEWIS	CAYA	B	8/14/2009 5:28:33PM	8/14/2009 6:29:13PM	8/14/2009 5:11:00PM	1	DEPARLE	NANCY	OEOB	450
537	LAMBREW	JEANNE	M			8/14/2009 9:07:00AM	1	DEPARLE	NANCY	OEOB	82
538	AYRES	MERRIBEL		8/18/2009 10:04:34AM		8/18/2009 10:15:00AM	5	SCHILIRO	PHIL	WH	WW
539	HANRAHAN	PAUL	T	8/18/2009 10:03:57AM		8/18/2009 10:15:00AM	5	SCHILIRO	PHIL	WH	WW
540	IMMELT	JEFFREY				8/18/2009 10:15:00AM	5	SCHILIRO	PHIL	WH	WW
541	LASH	JONATHAN	W	8/18/2009 10:04:22AM		8/18/2009 10:15:00AM	5	SCHILIRO	PHIL	WH	WW
542	ROGERS	JAMES		8/18/2009 10:04:12AM		8/18/2009 10:15:00AM	5	SCHILIRO	PHIL	WH	WW
543	ACKIL	JOSHUA	J	8/21/2009 2:46:09PM	8/21/2009 4:56:26PM	8/21/2009 3:00:00PM	5	SCHILIRO	PHIL	WH	WW
544	AGUILLEN	AMADOR	D	8/21/2009 3:10:05PM		8/21/2009 3:00:00PM	7	TURTON	DAN	WH	EW
545	COGORNO	ROBERT	A	8/21/2009 3:01:45PM	8/21/2009 4:56:18PM	8/21/2009 3:00:00PM	7	TURTON	DAN	WH	EW
546	HOGANSON	JONATHAN	R	8/21/2009 3:10:43PM	8/21/2009 4:56:42PM	8/21/2009 3:00:00PM	7	TURTON	DAN	WH	EW
547	MULLEN	MICHAEL	P	8/21/2009 3:05:31PM	8/21/2009 10:55:46PM	8/21/2009 3:00:00PM	7	TURTON	DAN	WH	EW
548	TATEJR	DANIEL	C	8/21/2009 3:43:46PM	8/21/2009 4:56:50PM	8/21/2009 3:00:00PM	7	TURTON	DAN	WH	EW
549	THOMAS	DAVID	R	8/21/2009 3:10:20PM		8/21/2009 3:00:00PM	7	TURTON	DAN	WH	EW
550	LAMBREW	JEANNE	M	8/26/2009 8:56:24AM	8/26/2009 10:18:27AM	8/26/2009 9:00:00AM	1	DEPARLE	NANCY	OEOB	82
551	LAMBREW	JEANNE	M			8/26/2009 9:00:00AM	1	DEPARLE	NANCY	WH	WW
552	BURKE	SHEILA	P	8/27/2009 12:12:36PM	8/27/2009 1:40:40PM	8/27/2009 12:00:00PM	1	DEPARLE	NANCY	WH	WW
553	LAMBREW	JEANNE	M			8/28/2009 10:00:00AM	1	DEPARLE	NANCY	OEOB	82
554	DEPARLE	JASON	P	8/29/2009 7:31:42PM		8/29/2009 7:15:00PM	5	DEPARLE	NANCY	WH	WW
555	FORSTHOEFEL	ANDREW	J	8/29/2009 7:31:45PM		8/29/2009 7:15:00PM	5	DEPARLE	NANCY	WH	WW
556	FORSTHOEFEL	CAITLIN	M	8/29/2009 7:31:46PM		8/29/2009 7:15:00PM	5	DEPARLE	NANCY	WH	WW
557	FORSTHOEFEL	LUKE	F	8/29/2009 7:31:48PM		8/29/2009 7:15:00PM	5	DEPARLE	NANCY	WH	WW
558	JORNLIN	THERESE	M	8/29/2009 7:31:49PM		8/29/2009 7:15:00PM	5	DEPARLE	NANCY	WH	WW
559	LAMBREW	JEANNE	M	8/31/2009 11:50:53AM		8/31/2009 9:20:00PM	2	DEPARLE	NANCY	WH	WW
560	PEWEN	WILLIAM	F	8/31/2009 12:02:14PM		8/31/2009 12:00:00PM	2	DEPARLE	NANCY	WH	WW
561	LAMBREW	JEANNE		8/31/2009 5:05:23PM	8/31/2009 8:38:58PM	8/31/2009 5:00:00PM	1	SCHILIRO	PHIL	WH	WW

White House Visitors Records

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	Last Name	First Name	M.I.	Time of Arrival	Time of Departure	Appointment Date	Total People	Visitee Last Name	Visitee First Name	Meeting Location	Meeting Room
562	DEAN	LLOYD	H	8/4/2009 2:27:29PM		8/4/2009 2:00:00PM	5	GASPARD	PATRICK	WH	WW
563	FRANCIS	CHARLES	P			8/4/2009 2:00:00PM	5	GASPARD	PATRICK	WH	WW
564	OQUINN	MARVIN	R			8/4/2009 2:00:00PM	5	GASPARD	PATRICK	WH	WW
565	RANDLETT	THOMAS	W	8/4/2009 2:26:30PM	8/4/2009 4:30:40PM	8/4/2009 2:00:00PM	5	GASPARD	PATRICK	WH	WW
566	WIEBE	ROBERT	L	8/4/2009 2:28:10PM		8/4/2009 2:00:00PM	5	GASPARD	PATRICK	WH	WW
567	BACKUS	JENNIFER				8/4/2009 4:45:00PM	1	AXELROD	DAVID	WH	WW
568	LAMBREW	JEANNE	M	8/5/2009 9:50:53AM	8/5/2009 12:45:19PM	8/5/2009 9:34:00AM	1	DEPARLE	NANCY	OEOB	82
569	CAMPBELL	KATHERINE	M	8/7/2009 12:33:29PM	8/7/2009 5:37:27PM	8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW
570	CLARK	ROBERT	J	8/7/2009 12:32:16PM	8/7/2009 5:38:13PM	8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW
571	GRONNIGER	TIM		8/7/2009 12:32:38PM	8/7/2009 4:22:22PM	8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW
572	KEMPF	PURVEE	P	8/7/2009 12:32:07PM	8/7/2009 2:06:52PM	8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW
573	MILLER	VIRGIL	A	8/7/2009 12:32:28PM		8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW
574	NELSON	KAREN		8/7/2009 12:33:16PM	8/7/2009 4:27:52PM	8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW
575	SCHNEIDER	ANDY		8/7/2009 12:33:36PM	8/7/2009 5:37:49PM	8/7/2009 12:15:00PM	7	DEPARLE	NANCY	WH	WW