TREASURY NEWS

Department of the Treasury Washington, D.C. Telephone 566-2041

EMBARGOED UNTIL 9:00 PM EST
January 28, 1992

These seven examples are hypothetical illustrations of how President Bush's package could affect individuals and families.

Example A:	Additional Tax Allowance for Children and $5,000 First-Time Homebuyers Tax Credit
Example B:	Additional Tax Allowance for Children, $5,000 First-Time Homebuyers Tax Credit, Penalty-Free IRA Withdrawals for First-Time Homebuyers, and Deduction of Interest on Student Loans
Example C:	Additional Tax Allowance for Children
Example D:	$5,000 First-Time Homebuyers Tax Credit
Example E:	Capital Gains
Example F:	Deduction of Interest on Student Loans and Penalty-Free IRA Withdrawals for Educational Expenses
Example G:	Buying a Home for a Growing Family

Example A: **Additional Tax Allowance for Children and $5,000 First-Time Homebuyers Tax Credit**

Family A consists of a husband and wife and two young children. The family's income consists of combined earnings of $44,000 and interest income of $500. At the end of 1992, the family buys a condominium for $60,000; it is their first home purchase. The family does not itemize deductions and, under current law, pays Federal income taxes of $4,395. Under the President's proposals, the family would benefit from a $500 increase in the personal exemption for each child which begins on October 1, 1992, and from the tax credit for first-time home buyers. The larger personal exemption would decrease their tax by $37.50, and the home-buyer credit would reduce their tax by $2,500 in 1992 and by an additional $2,500 in 1993. Including these benefits, Family A's 1992 Federal income taxes would be $1,857.50, which is 58 percent less than under current law.

In 1993, Family B has its taxes reduced by $2,500 by the second half of the credit for first time home buyers and by $150 from the full year effect of the $500 increase in the personal exemption for each child. Thus, in 1993, the proposal would reduce Family B's Federal income taxes by $2,650.

Office of Tax Analysis
January 28, 1992

Example B: **Additional Tax Allowance for Children, $5,000 First-Time Homebuyers Tax Credit, Penalty-Free IRA Withdrawals for First-Time Homebuyers, and Deduction of Interest on Student Loans**

Family B consists of a husband and wife and two young children. The family's income consists of combined earnings of $44,000 and interest income of $500. During 1992, the family buys a condominium for $60,000; it is their first home purchase. Family B obtains the funds for the downpayment on the new house by withdrawing $5,000 from an IRA account. During the second half of the year, they pay interest of $1,000 on loans which they incurred to pay their college tuition. Under current law, Family B has itemized deductions of $7,000 and pays Federal income taxes of $5,495, including a $500 penalty (10 percent of the amount taken out) for making an early withdrawal from an IRA. Under the President's proposals, the family would benefit from: the $500 increase in the personal exemption for each child which begins on October 1, 1992; the elimination of the IRA penalty for IRA withdrawals used to purchase a home; the tax credit for first-time home buyers; and the deductibility of interest on education loans. The larger personal exemption would decrease their tax by $37.50; eliminating the IRA penalty would reduce their taxes by $500; the home-buyer credit would reduce their tax by $2,500 in 1992 and by an additional $2,500 in 1993; and the deductibility of interest on education loans would lower their taxes by $150. Including these benefits, Family A's 1992 Federal income taxes would be $2,307.50, which is 58 percent less than under current law.

In 1993, Family B has its taxes reduced by $2,500 by the second half of the credit for first time home buyers, by $150 from the full year effect of the $500 increase in the personal exemption for each child, and by $150 by the deductibility of interest on its education loans. Thus, in 1993, the proposal would reduce Family B's Federal income taxes by $2,800.

Office of Tax Analysis
January 28, 1992

Example C: Additional Tax Allowance for Children

Family C consists of a husband and wife and three children, all under age 18. The family's only income is from wages of $40,000. The family does not itemize deductions and, under current law, pays Federal income taxes of $3,720. The larger personal exemption for children which begins on October 1, 1992 would reduce the family's tax by $56.25, or 1 percent, to $3,663.75. In 1993, with the larger personal exemption for children being in effect for the full year, the tax reduction would be $225.

Office of Tax Analysis
January 28, 1992

Example D: $5,000 First-Time Homebuyers Tax Credit

Newly-married couple D has combined earnings of $48,000 and interest income of $2,000. At the end of 1992, they purchase a house for $120,000. It is the first home purchase for either spouse. The family does not itemize deductions and, under current law, pays Federal income taxes of $6,368. Under the President's proposals, the family would benefit from the tax credit for first-time home buyers. Their Federal taxes would be reduced by $2,500 in 1992 and by an additional $2,500 in 1993. Including the credit, their 1992 tax would be $3,868, or 39 percent less than under current law.

Office of Tax Analysis
January 28, 1992

Example E: Capital Gains

Taxpayer E has been self-employed, and in 1992 he sells his business and retires. Taxpayer E and his wife file a joint income tax return and do not have any dependent children. They have $60,000 of income from operating their business, $10,000 of interest and dividend income, and a long-term capital gain of $100,000 from the sale of the business. They have itemized deductions of $10,400. Under current law, their 1992 Federal income tax would be $41,546. Under the President's proposed reduction in capital gains taxes, their Federal income tax would be $32,400, a reduction of 22 percent.

Office of Tax Analysis
January 28, 1992

Example F: Deduction of Interest on Student Loans and Penalty-Free IRA Withdrawals for Educational Expenses

Family F has two children, both over age 18 and both attending college. Both children are claimed as dependents on their parent's Federal income tax return. Both parents work, earning combined salaries of $60,000. In addition, in order to pay college tuition, during 1992 Family F withdraws $5,000 from the father's IRA account. The family has taken loans to pay college tuition, and during the second half of 1992, the interest paid on those loans is $2,000. Family F does not own its home, but it has itemized deductions of $6,400, apart from the interest on the loans for college expenses.

Under current law, Family F's 1992 Federal income tax is $9,566, including a $500 penalty because of the early withdrawal from the IRA account. Under the President's proposals, the early IRA withdrawal to pay college expenses would no longer be subject to a penalty. In addition, the interest on the loans for college expenses would be deductible. As a result, Family F's Federal income taxes would be $8,506, a reduction of $1,066, or 11 percent.

Office of Tax Analysis
January 28, 1992

Example G: "Buying a home for a growing family"

"Susan and Ward", 28 and 30, have lived in rented apartments since they were married six years ago. Their combined income of $44,500 has allowed them to live comfortably in their Colorado community, but they have not managed to accumulate savings sufficient for the down payment they need to purchase a $60,000 3-bedroom townhouse condominium in their neighborhood. With one small child and another on its way, they know that they will soon need more space.

The President's tax proposals would make it possible for Sue and Ward to buy their own home. Under the President's plan, the couple would be entitled to a $5000 tax credit for first-time home buyers. Permitted to withdraw accumulated savings from their IRA accounts without penalty, they could raise enough money for the down payment. Furthermore, with the additional $1000 tax exemption for their two children, the deductibility of interest on Susan's outstanding student loans permitted under the President's program, and the lowest mortgage interest rates in years, servicing their mortgage would be much less of a burden on their incomes than it otherwise would be.

Tax Benefits for "Sue and Ward" in 1992

1992 Federal taxes under current law:	$5,495	(includes $500 penalty for early IRA withdrawal)
1992 Federal taxes with President's proposals:	$2,307.50	

		1992 Savings:	
First-time homebuyer's credit	=	$2,500	($2,500 in 1993 as well)
IRA withdrawals for home purchases	=	$ 500	(assumes $5,000 withdrawal)
Additional tax allowance for children	=	$37.50	(1/4 benefit for 1992; for 1993)
Deduction of interest on student loans	=	$ 150	(assumes $1,000 interest)
		$3,187.50	

w/GRW

re: Communications / Health / ...

- GRW
- ARGolen
- Jamie Crown
- Jeff Vogt
- Dan Cassa

GRW Let me share my assignment w/ you.

Assumptions: A block of time to be devoted to health care reform.

- last time: expanded figuring to venture.

- what GRW says would make sense: MINIBLOCKS.

- need to fit this with: GROWTH
  FAMILY
  PEACE.

need to ~~figure~~ insinuate ourselves into this debate

helpful both for reminding public and POTUS about what this means, getting POTUS comfortable w/ arguments.

- bringing POTUS up to speed
  ARG - talk him to read the "white paper"

- How to make news.

MAY 11: SMALL BUSINESS WEEK.

Cassa's theory: Problem -- POTUS has given one speech. Can't worry about talking not making news until ...

ARG - press will write whatever GR said. GIVE THEM A LEAD.

- another way... get health care pts of light.

FOR INSTANCES ... EVERYONE in this group will come up w/ anecdotes.

Grow to sum

- Periodic health speech
- Look for examples → STAY WITH SUCCESS STORIES.
  - Medicaid HMOs.
  - technology / simplification.

local group for every speech

- minorities I.V.s

THE WHITE HOUSE
WASHINGTON

DATE: 3/24/92

TO: Hans

FROM: DAVID J. BEIGHTOL
Special Assistant to the President for
Intergovernmental Affairs
Room 160, OEOB, x7170

- ☐ FYI
- ☐ Appropriate Action
- ☑ Let's Discuss
- ☐ Per Our Conversation
- ☐ Per Your Request
- ☐ Please Return

COMMENTS:

Is the attached
Accurate?

Southern Governors' Association

Memorandum

To: Washington Directors/Staff Advisory Committee
From: Candy Penn
Re: Preemption of State Premium Taxes
Date: February 28, 1992

Attached in information on legislation that would preempt state legislation and potentially preempt state premium taxes on health insurance. The legislation, S. 1872, would establish minimum standards for small group health insurance and is scheduled for mark up by the Senate Finance Committee within the next week.

I understand this is a significant issue for states and one that Finance Committee members are hearing little about. Also attached are two charts (national and the Southern region) that identify state revenues, premium and retaliatory taxes, feed and assessments, and fines and penalties. Please let me know if you want us to follow up on it.

784-1380
Tina Carol Roberts

Hall of the States Mandate Monitor

Mandate Watch List

Health care reform measures lead the March Watch List

The Better Access to Affordable Health Care Act of 1991 S 1872, sponsored by Senator Bentsen (D-Texas) Marked up March 3 Senate Finance

Sets minimum standards for health insurance sold to businesses with less than 50 employees. Establishes two basic benefit packages and requires states to choose among several options for guaranteeing availability of insurance to all small employers; pre-empts state mandated benefits not covered in the basic benefit packages; calls for the development of a federal certification program for managed care plans and utilization review programs; and, pre-empts existing state legislation regulating managed care and utilization review. A similar bill was introduced last fall in the House (HR 3626, Rostenkowski).

The President's Comprehensive Health Reform Proposal February 6, 1992

The President proposes to federally certify small group purchasing arrangements or Health Insurance Networks (HINs), extending protections, currently limited to self-insured companies under the Employee Retirement Income Security Act of 1974 (ERISA), to these purchasing groups. This would effectively exempt these plans from state premium taxes and assessments. Total premium taxes provide $6.6 billion in revenue to states, much of this is from the health insurance business. Currently, there is no Congressional sponsor for this proposal.

Other Actions

Amendments to the Fair Labor Standards Act S 600, sponsored by Senator Metzenbaum (D-Ohio) Scheduled for Markup March 11 - Senate Labor and Human Resources Committee.

Among other provisions, the bill establishes standards for a work permit system for teens that states would be required to administer without federal funding. It should be noted that most states operate similar work permit programs on their own initiative. For such states, it is unclear, at this point, how much additional administrative cost would be involved.

Under the terms of S 600, employers are barred from employing a minor unless the minor holds a valid "certificate of employment," issued by the state agency designated by the governor to administer the program. If the minor is under 16, the agency must secure a written statement of consent from a parent and a written verification from the minor's school that the student meets attendance requirements. No provision is made in the bill to compensate either states or school districts.

Watch List continues on reverse side...

The Hall of the States Mandate Monitor is a database that records the changing status of legislation containing federal mandates on state and local government. The Mandate Watch List alerts readers to particularly threatening legislation under active consideration.

The Monitor and the Watch List are maintained by NCSL and are issued 10 to 12 times a year depending upon federal action. Inquiries should be directed to:

Christine Wnuk
National Conference of State Legislatures
444 North Capitol St., NW
Suite 500
Washington, D.C. 20001
(202) 624-8695

Subscriptions to the Monitor and Watch List can be purchased for $35 a year by calling the Marketing Department at 303/830-2200.
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ACTION ALERT

National Conference of State Legislatures

William T. Pound
Executive Director

444 North Capitol Street, N.W.
Washington, D.C. 20001
(202) 624-5400

February 27, 1992

State Preemption in Small Group Health Insurance Reform in Tax and Economic Stimulus Bill Mark-up on March 3, 1992

Senator Lloyd Bentsen (D-Texas), Chairman of the Senate Finance Committee will mark-up his small group health insurance reform bill (S. 1872), during consideration of tax and economic stimulus proposals next week. This legislation would set minimum standards for health insurance sold to businesses with less than 50 employees. Insurers would be prohibited from: (1) excluding individuals in a group; (2) cancelling policies due to claims experience or health status; (3) raising premiums beyond a certain range; and (4) imposing a preexisting condition exclusion on an individual who changes jobs without a lapse in coverage of more than three months when the individual seeks health insurance coverage with a new employer. All group health insurance, including self-insured plans would be prohibited from excluding coverage for pre-existing conditions for more than a 6 month period. The bill establishes two basic benefit packages and requires states to choose among several options for guaranteeing availability of insurance to all small employers. **The bill preempts state mandated benefits not covered in the basic benefit packages.** The bill calls for the development of a federal certification program for managed care plans and utilization review programs, and **preempts existing state legislation regulating managed care and utilization review.**

President Bush is seeking a sponsor to add provisions to this bill that would preempt state premium taxes. The Bentsen proposal would establish up to 15 state demonstration projects to test the feasibility of small employer group purchasing arrangements and would provide up to $10 million to fund the project. The President proposes to federally certify these small group purchasing arrangements or Health Insurance Networks (HINs), extending protections, currently limited to self-insured companies under the Employee Retirement Income Security Act of 1974 (ERISA), to these purchasing groups. This would effectively exempt these plans from state premium taxes and assessments. **Total premium taxes provides $6.6 billion in revenues to states, much of this is from health insurance business (See Attachment A).**

ACTION: Call your member on the Senate Finance Committee and express your concerns about the level of state preemption in the legislation and your particular concerns regarding the premium tax exemption.

Senate Finance Committee

Lloyd Bentsen, Texas, Chair
Daniel P. Moynihan, New York
Max Baucus, Montana
David L. Boren, Oklahoma
Bill Bradley, New Jersey
George Mitchell, Maine
David Pryor, Arkansas
John D. Rockefeller, IV, West Virginia
Thomas Daschle, South Dakota
John Breaux, Louisiana

Bob Packwood, Oregon Ranking Minority Member
Bob Dole, Kansas
William V. Roth, Jr., Delaware
John C. Danforth, Jr., Missouri
John H. Chafee, Rhode Island
Dave Durenberger, Minnesota
Steve Symms, Idaho
Charles Grassley, Iowa

Orrin Hatch, Utah

NCSL Staff Contacts: Joy Johnson Wilson, Michael Bird, Bill Waren

"Action Alert" is a publication of the NCSL Office of State-Federal Relations requesting lobbying assistance from state legislators

TABLE 10
REVENUES IN 1990

STATE	TOTAL REVENUES	PREMIUM AND RETALIATORY TAXES	FEES AND ASSESSMENTS	FINES AND PENALTIES
ALABAMA	148,871,607	$147,626,706	$1,188,401	$56,500
ALASKA	24,950,897	22,791,111	2,030,699	129,087
AMERICAN SAMOA	-	-	-	-
ARIZONA	104,286,436	101,256,870	1,931,692	1,097,874
ARKANSAS	61,075,316	61,075,316	N/A	N/A
CALIFORNIA	1,284,608,755	1,232,000,000	52,000,000	608,755
COLORADO	83,261,348	81,493,149	1,686,531	81,668
CONNECTICUT	183,161,316	167,700,000	15,250,417	210,899
DELAWARE	27,470,102	25,553,402	1,905,300	11,400
DISTRICT OF COLUMBIA	34,430,767	33,816,312	614,455	0
FLORIDA	325,312,086	293,700,000	31,606,576	5,510
GEORGIA	169,454,182	164,258,642	4,605,554	589,986
GUAM	5,119,919	5,076,000	43,919	0
HAWAII	57,164,075	56,760,489	357,064	46,522
IDAHO	33,037,197	30,371,107	2,618,800	47,290
ILLINOIS	199,664,955	162,701,603	36,158,630	804,722
INDIANA	108,859,050	106,290,003	2,504,397	64,650
IOWA	98,572,185	93,714,573	4,792,500	65,112
KANSAS	89,197,115	70,684,767	17,979,986	532,362
KENTUCKY	74,632,756	59,235,943	15,213,620	183,193
LOUISIANA	134,025,921	126,318,557	7,564,613	142,751
MAINE	47,711,168	44,451,697	3,246,471	13,000
MARYLAND	143,282,701	138,686,065	4,419,651	176,985
MASSACHUSETTS	23,559,545	7,560,715 a	15,979,120	19,710
MICHIGAN	78,337,502	71,347,895	6,937,067	52,540
MINNESOTA	125,297,000	120,638,000 b	4,531,000	128,000
MISSISSIPPI	92,767,574	87,740,450	4,982,219	44,905
MISSOURI	122,951,805	118,573,571	4,128,457	249,777
MONTANA	24,799,227	23,372,013	1,328,145	99,069
NEBRASKA	41,923,856	38,038,600	3,816,960	68,296
NEVADA	60,310,930	54,659,204	5,479,691	172,035
NEW HAMPSHIRE	38,461,034	36,450,004	2,007,030	4,000
NEW JERSEY	381,770,000	167,443,000	214,006,000	321,000
NEW MEXICO	51,670,000	49,271,000	2,399,000	- c
NEW YORK	602,550,150	536,600,000	62,466,286	3,483,864
NORTH CAROLINA	191,671,588	186,440,045	5,212,543	19,000
NORTH DAKOTA	25,955,499	18,186,845	7,703,654	65,000
OHIO	287,550,512	270,274,667	17,242,845	33,000
OKLAHOMA	85,297,510	83,401,179	1,798,388	97,943
OREGON	61,847,922	57,482,260	4,329,741	35,921
PENNSYLVANIA	212,927,000	197,548,000	14,853,000	426,000
PUERTO RICO	16,516,839	15,141,514	1,188,619	186,706
RHODE ISLAND	48,429,857	47,415,481	1,008,859	5,517
SOUTH CAROLINA	85,197,432	83,794,109	1,299,623	103,700
SOUTH DAKOTA	28,241,721	26,656,609	1,567,922	17,190
TENNESSEE	160,686,000	158,618,200	1,600,000	467,800
TEXAS	545,970,273	525,763,143	19,806,239	400,891
UTAH	43,802,394	41,048,795	2,711,849	41,750
VERMONT	23,857,624	22,167,209	1,562,765	127,650
VIRGINIA	171,123,787	157,918,333	12,683,904	521,550
WASHINGTON	105,283,486	102,310,961	2,807,791	164,734
WEST VIRGINIA	55,351,647	52,813,432	2,537,115	1,100
WISCONSIN	74,217,518	69,445,177	4,713,161	59,180
WYOMING	12,836,554	11,814,402	1,011,925	10,227
TOTAL	$7,319,313,640	$6,665,597,125	$641,420,194	$12,296,321
AVERAGE	$138,100,257	$125,765,983	$12,335,004	$241,104

a Retaliatory taxes only.
b Source: Insurance Information Institute, 1989 data.
c Included in fees and assessments.

SOUTHERN STATES' REVENUES IN 1990

		Total Revenues	Premium and Retaliatory Taxes	Fees and Assessments	Fines and Penalties
SGA States	AL	148,871,607	$147,626,706	$1,188,401	$56,500
	AR	61,075,316	61,075,316	N/A	N/A
	DE	27,470,102	25,553,402	1,905,300	11,400
	FL	325,312,086	293,700,000	31,606,576	5,510
	GA	169,454,182	164,258,642	4,605,554	589,986
	KY	74,632,756	59,235,943	15,213,620	183,193
	LA	134,025,921	126,318,557	7,564,613	142,751
	MD	143,282,701	138,686,065	4,419,651	176,985
	MS	92,767,574	87,840,450	4,982,219	44,905
	MO	122,951,805	118,573,571	4,128,457	249,777
	NC	191,671,588	186,440,045	5,212,543	19,000
	OK	85,297,510	83,401,179	1,798,388	97,943
	PR	16,516,839	15,141,514	1,188,619	186,706
	SC	85,197,432	83,794,109	1,299,623	103,700
	TN	160,686,000	158,618,200	1,600,000	467,800
	TX	545,970,273	525,763,143	19,806,239	400,891
	VA	171,123,787	157,918,333	12,683,904	521,550
	WV	55,351,647	52,813,432	2,537,115	1,100
Regional Total:		$2,611,659,126	$2,486,758,607	$121,740,822	$3,259,697
Regional Average:		$145,092,174	$138,153,256	$7,161,225	$191,747
National Total:		$7,319,313,640	$6,665,597,125	$641,420,194	$12,296,321
National Average:		$138,100,257	$125,765,983	$12,335,004	$241,104
Southern Regional % of National Total		35.68%	37.31%	18.98%	26.51%

SOURCE: NCSL Action Alert

THE WHITE HOUSE

WASHINGTON

SCHEDULE PROPOSAL FEBRUARY 28, 1992

TO: KATHY SUPER
DEPUTY ASSISTANT TO THE PRESIDENT
FOR APPOINTMENTS AND SCHEDULING

THROUGH: SHERRIE ROLLINS
ASSISTANT TO THE PRESIDENT FOR PUBLIC LIAISON
AND INTERGOVERNMENTAL AFFAIRS

FROM: BOBBIE KILBERG BK
DEPUTY ASSISTANT TO THE PRESIDENT
FOR PUBLIC LIAISON

KATHY JEAVONS KJ
ASSOCIATE DIRECTOR FOR PUBLIC LIAISON

REQUEST: "TOWN MEETING" ON HEALTH CARE REFORM

PURPOSE: For the President to promote his comprehensive health reform program.

BACKGROUND: In order to win broader approval of his comprehensive health reform program, it is important for the President to continue to meet with individuals and groups around the country who are in favor and/or would be helped by the various innovative reform measures in the proposal.

One venue for such an event could be a "town meeting" or roundtable discussion with a variety of individuals -- small business owners, minority health care workers, community health center representatives, farmers, etc. -- each of whom will be helped by the President's proposal and are supportive.

This meeting (or meetings) should take place outside of Washington. Since Congress will be holding hearings on health care reform throughout March, it would be appropriate for the President to participate in such a meeting during the second or third week of March.

DATE AND TIME:	March or April, 1992 Time: flexible (45 minutes)
LOCATION:	Possibilities include: Chicago, IL Milwaukee, WI
PARTICIPANTS:	The President selected individuals from the health care community and those who benefit from the President's reform program (100 people)
MEDIA:	Press Pool

3/9/22

HEAL's 8 cities

Orlando
Houston
Nashville
Rochester, MN
Topeka
Waterloo/Cedar Rapids — Nogle
Sacramento — tazio
[Pa / Ohio]

MODEL: Louisville -- turned out 650 businesses.

Talking Points on Health Care Reform: Small Businesses

- The American people are ready for action on health care reform.
- The President and House Republicans have both announced comprehensive health reform programs that will ensure access to health care services for all Americans and will take significant steps in controlling the cost of health care services.
- Legislation has been introduced that will dramatically reform our current health care system in a way that builds on our current system -- a system that provides the highest quality health care services anywhere in the world.
- It is time that we quit playing election-year politics with the health of the American people.
- The health of American people is too important for us to wait any longer.
- There is wide support for reform now.
- We should act on legislation now that will ensure access to quality, affordable health care.
- We must have policies that focus on the cost drivers in the system -- not some new Federal bureaucracy that will sap precious resources from the system.
- Both the President's plan and the House Republic plan will provide significant benefit to individuals and small businesses.
- For the self-employed, the cost of health insurance premiums will become fully tax deductible -- making health insurance more affordable for them and their families.
- Small businesses will be protected against dramatic increases in insurance premiums that often occur just when the insurance is needed the most -- namely when someone in the group incurs high medical bills.
- No longer can insurance companies cancel coverage or excluded individuals or families based on previous claims experience or the health status of any member of the group.
- This legislation also protects individuals with pre-existing conditions. In the past, health insurance plans for these individuals would exclude coverage for the pre-existing condition.

- With passage of this bill, significant limits will be placed on insurer's ability to exclude coverage for pre-existing conditions.
- Employees will no longer have to worry about losing coverage or not being able to get new coverage when they change jobs.
- This legislation will directly address the concerns of small businesses in this country.
- The Congress must carefully examine these proposals and act on them now.
- They are well thought out and will work.
- And they will not lead to massive tax increases that a government-run health system would require.

re Health Public Affairs

3/11/92

→ GWilenstein, K Seavons, P Lutminger, A Glenn,

Primary Care Conf → coming up at Long Range today, KJ says

HIAA --> Quayle ?

~~SBA~~, Comm mailing lists done + p.p.s.

Phase III

- Gail. · Plays well outside Washington.
· Need to have POTUS talking more about it.
· Members w/ constituents -- does well.

AG: We have people power -- need M.C.s to do it.

Working with business groups

-

Speeches to major media groups

3/19 – Newspaper editors

3/26 – Cosson

4/9 – Am Soc Newspaper Editors

∴ 1. POTUS more involved. { 1. POTUS, 2. MCs, 3. through GOP structure.

2. Town meetings

3. POTUS on issues.

Ideas: – Room 450 events

– target cities.

– getting Veep out there

– adding many to photos for dinner Groups // 24th – March of Dimes

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MEMORANDUM

FEB 19 1992

TO: The Secretary
Through: DS _____
COS _____
ES _____

FROM: Alixe R. Glen ARG
Assistant Secretary for Public Affairs

SUBJECT: Health Care Reform Strategy -- Phase II--**ACTION**

Action Requested By: Monday, February 24, 1992

BACKGROUND

While the President's Health Care Plan has been warmly embraced by many credible experts and organizations (see Tab A), the public remains confused by and unconvinced that its concerns are addressed in any meaningful way. Furthermore, the press reports have been superficial at best, and the critics have been predictable but shallow. Our effort to sell the Plan must be grassroots, tenacious and target the constituencies that benefit from the various elements of the Plan, e.g. the self-employed, small business employers, low income, average family, etc.

RECOMMENDATION

Accordingly, pending your approval, OPA will pursue the following:

1. Satellite Media Tours: On a weekly basis, the Secretary should participate in 4-6 local t.v. interviews from the HHS studio in media markets throughout the Super Tuesday states and other major media markets. This requires 30 minute time blocks, between 10:00 - 11:00 a.m. or 1:00 - 2:00 p.m.

   Approved_____ Disapproved_____

2. Editorial Boards: The Secretary should participate in editorial boards in every city he visits in the coming months. In addition, we will arrange board meetings with the Washington Post & Times, the Wall Street Journal and the New York Times.

   Approved_____ Disapproved_____

3. Radio: This extremely effective medium offers the opportunity for a thoughtful, more lengthy discussion of the plan's substance. OPA will pro-actively seek out radio talk, health, and consumer shows for the Secretary and Deputy Secretary.

Approved_____ Disapproved_____

4. Health Core Group: The Secretary should again invite the "Core Group" participants to a meeting to reassess where we are and brainstorm on further communications strategies.

Approved_____ Disapproved_____

5. Town Meeting: Recommend the President host a Town Meeting on Health Care. This pre-super Tuesday event could occur in any southern city, with an audience of enthusiastic supporters of the President's Plan and credible opponents of pay-or-play. Discussion highlights could include success stories in the following areas: coordinated care, electronic billing, prevention, etc.

Approved_____ Disapproved_____

6. Stonehenge Summit: If a Town Meeting is not possible, a meeting similar to the AIDS Briefing could take place at the Department, with presentations that vindicate each aspect of our reform proposal.

Approved_____ Disapproved_____

7. Targeted Mailings and OP-ED's: With support from HHS OPDIVs, USDA, Commerce, SBA, and others, OPA will target each interest group or constituency through mailings, op-ed's in specialty trade press, and newsletters, highlighting specific aspects of the plan as relevant to the narrow audience. (See Tab B).

Approved_____ Disapproved_____

A more detailed memo will follow with precise lists of target audiences and information dissemination vehicles.

Attachments:

TAB A - Association Endorsements
TAB B - Targeted Audience Mailing Examples

MEMORANDUM FOR DAN CASSE

FROM: Alixe Glen

SUBJECT: Upcoming opportunities for POTUS

The following HHS programs and suggested events will provide the President with forums to highlight the Health Care Reform Plan.

National Primary Care Conference (March 29-31)

This national conference will promote a common understanding of what primary care means to today's health system and future reforms. Co-sponsored by the Kellogg, Kaiser and Robert Wood Johnson Foundations, national leaders in the health services financing, education and research communities will review public health and financing problems. A Presidential address to the plenary session could highlight the Health Care Reform Proposal.

Immunization (mid-late March)

As a follow-up to the six-city site visits, a Presidential event in the East Room would allow the Administration's initiative to be highlighted. Representatives from each of the six-cities could be invited to present the President with their achievements.

Healthy Start (early May - Mother's Day)

The Ad Council campaign will be ready for prime time television, radio and consumer magazines just in time for Mother's Day. We envision a Rose Garden campaign unveiling ceremony with Healthy Mothers and Babies who have received the appropriate pre-natal care. Healthy Start is a major Bush initiative and highlights this administration's commitment to prevention, children and minority health.

National Health Service Corps - 20th Anniversary (Immediate and June)

1992 marks the 20th anniversary of the National Health Service Corps (NHSC), recently revitalized by the Administration to address the severe shortage of primary care professionals in America's rural and inner-city areas. A national media campaign is ready to be unveiled, focusing on recruitment of new Corp professionals. An immediate event with the President, on location, with Corps members would be excellent. In addition, the NHSC 20th Anniversary National Meeting is scheduled for June 24-26 in Washington. Expansion of the Corps and community health centers is a major element of health care reform.

Health Insurance Association of America (April 26 - 29)

The HIAA annual meeting will take place at the Grand Hyatt in Washington, attended by over 700 Executives whose companies cover 95 million Americans. This year's meeting theme is "Working to Insure All Americans."

National Managed Health Care Congress (March 29 - April 1)

Sponsored by Business Week, this unique meeting combines 3,000 managed care experts representing purchasers, providers, payors and suppliers from throughout the country. This would be a friendly audience. The Convention takes place in Washington, D.C. at the Sheraton Washington.

Annual Health Care Seminar (May 4 - 6)

Sponsored by Alex Brown, in Baltimore, the meeting attracts 1,000 CEO and CFO level executives interested in managed care and health care delivery. Another friendly audience to articulate the President's Plan.

World Summit for Children Report (late March-early April

HHS has taken the lead in preparing a report to UNICEF on the U.S. national plan of action and strategy in follow-up to the World Summit on Children. This report, which will have input from agencies throughout the Federal government, will discuss U.S. goals and objectives.

The President could present the United States World Summit Report to UNICEF representatives in an East Room event. The report is in process, will be complete mid-April.

Business Responds to AIDS (late March)

As part of the America Responds to AIDS campaign at the Centers for Disease Control, a national conference is planned for late March with corporate leaders to discuss what role employers can play in AIDS awareness and prevention efforts. The President made a public commitment through the Magic Johnson meeting to play a more visible leadership role in the AIDS fight. This would be a relatively friendly audience to deliver the AIDS message.

Corporate Summit for Children (April 29 - 30)

The National Commission to Prevent Infant Mortality will hold a Washington, D.C. Corporate Summit, where leaders from small and large business, educators, policymakers and health care professionals will discuss issues of importance to mothers and children. A Presidential address on Healthy Start and access would be appropriate.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D C 20201

SCHEDULE PROPOSAL

Date: 2/26/92

TO: EDE HOLIDAY

FROM: ALIXE R. GLEN
DEPUTY ASSISTANT SECRETARY
FOR PUBLIC AFFAIRS

REQUEST: EAST ROOM EVENT TO ANNOUNCE INFANT IMMUNIZATION INITIATIVE

BACKGROUND: In a June 1991 Rose Garden event, President Bush met with public and private sector leaders in immunization to accelerate the Administration's efforts to have 90 percent of all two year olds immunized by the year 2000. The President called on HHS Secretary Sullivan to develop local preschool immunization action plans in six cities across the nation to serve as a model for other communities.

The Secretary traveled to each city with Dr. James Mason, head of the U.S. Public Health Service, Dr. Antonia Novello, U.S. Surgeon General and Dr. Bill Roper, Director of the Centers for Disease Control. And, as you are aware, the President traveled with the Secretary to personally participate in the San Diego site visit.

The site visits were a tremendous boost to the program in two ways. First, action plans were developed that were truly unique in the cooperative efforts they created between the public and private sectors and, secondly, the media generated by each visit served to raise public awareness of the problem.

The President's budget requests for immunization exemplify the Administration's commitment to eliminating this public health problem. In the FY 93 budget proposal, for example, immunization funding will increase 18 percent over 1992, an increase of 148 percent since 1989.

In order to raise awareness of the Administration's efforts within the medical and public health community as well as in the general public, we recommend an event in the East Room with President Bush. The President's speech could include the following announcements:

NATIONAL LEVEL ACTIONS

- Official unveiling and presentation of the National Immunization Action Plan, developed by the Interagency Committee on Immunization

- Announcement of the launching of a new national public education campaign in collaboration with the AD Council

- Description of and announcement of the availability of the new National Standards for Immunization Practices which all public and private sector doctors and nurses can adopt to improve delivery of vaccines

STATE AND LOCAL LEVEL ACTIONS

- Presentation of the lessons learned from the immunization site visits to six U.S. cities, such as how public and private partnerships can be forged

- Description of the Administration's plans to distribute $46 million in FY 1992 to support the development and implementation of approximately 90 long-term state and city plans based on the six-city models

- Release of a schedule to revisit the six cities and monitor the implementation of their plans with the intention of sharing the information about what works with the other states and cities developing plans later this year

Presidential action on these initiatives would include a letter to the National Governor's Association, National League of Cities and other inter-governmental groups announcing plans for these initiatives. A letter to all national medical associations from Dr. Sullivan outlining specifics of the Standards for Immunization Practice. A memorandum from the President to all members of the Cabinet commending them for their cooperation in this interagency effort and asking for their continued support. A White House Fact Sheet would outline specifics of the initiatives.

DATE AND TIME: Mid/Late April
Mid-morning

LOCATION: THE WHITE HOUSE EAST ROOM

PARTICIPANTS:
- Secretary Sullivan
- Dr. James Mason
- Dr. Antonia Novello
- Dr. Bill Roper
- Representatives from the public and private sector involved in the each of the six-city plans
- Representatives from national service organizations involved in immunizations efforts such as the PTA, Junior League, Kiwanis, etc.
- Representatives from the entertainment industry involved in immunization efforts, such as Henry Winkler and Steven Spielberg
- Representatives from private industry and national foundations involved in the issue such as Kaiser Permanente and the Aetna Foundation
- Representatives from inter-governmental groups
- Representatives from the Ad Council
- Immunized Two Year Olds

OUTLINE OF EVENTS:
- Introduction by Secretary Sullivan
- President Delivers Remarks
- Possible Secretarial Achievement Award presented to representatives for outstanding efforts

REMARKS: See Background Section for details; HHS speechwriters will work with White House speechwriters

MEDIA COVERAGE: Open press with public and private sector representatives available at the stake-out area

PROJECT OFFICER:
- Alixe Glen
- Debbie Messick

cc:
- Robin Carle
- Dr. James Mason
- Dr. Bill Roper

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MEMORANDUM

MAR 2 - 1992

TO: Dave Carney
Bush/Quayle Campaign

FROM: Alixe Glen ARG
Assistant Secretary for Public Affairs

SUBJECT: Health Care Town Meeting

We all know that the President's health care reform proposal is right for America. The problem is many Americans don't yet know that the President's plan is right for them.

We know it fixes just about everything that needs fixing. (Tab A) And it does it in a way that most Americans prefer -- i.e. through the current private-public partnership. Yet, at the same time, many are having a difficult time assimilating this rather complex issue. Their understanding hasn't been enhanced much by the media, which has tended to address the plan in superficial terms, and by the extensive coverage of the presidential primary campaigns with their daily muggings of the President's policies and proposals.

How do we cut through the clutter and give the President's plan a fair public hearing? I suggest a Town Meeting, hosted by the President, in which "invited" guests and experts promote the plan's central concepts by providing successful illustrations and examples. The President is the best spokesperson for the plan, and this event will give him a unique opportunity to explain it in compassionate yet realistic terms, as well as dispel the perception of weakness on this issue.

We propose that the meeting take place March 11 in Springfield, Illinois. Illinois is well suited for such an event, because of its diverse industry, large and small business mix, helpful Governor, and Labor Secretary Lynn Martin's valuable input.

The audience would include a mix of health care providers, insurers, employers, employees and concerned citizens, who would give the President positive feedback. Through their various perspectives, they will validate each aspect of the President's plan with real life examples that are working for real people, clearly demonstrating that experimentation and "states as laboratories" is innovative and effective. Inevitably, the perils of "pay-or-play" would be discussed as well.

For example, the meeting could highlight managed care programs like Allied Signals, where savings over three years exceed $90 million; Health Insurance Networks like COSE in Cleveland, where 10,000 employees have pooled together to negotiate affordable health care; or the 12-employee National Car branch in Des Moines, where employees have reduced their health care expenditures by a third. Other managed care examples are attached at Tab B.

The Health Care Equity Action League (HEAL) has had great success with similar meetings, hosting several around the country in recent weeks. (Tab C)

THE SITE

The town meeting could be held in the rotunda of the State Capitol Building. Two hundred guests could be theatre style on the ground floor and in the balcony. Secretary Sullivan could emcee the meeting, calling on pre-identified speakers to describe how they are delivering care efficiently.

THe AHA and the AMA are both based in Chicago, so a hospital site could also be easily arranged.

As opposed to the Democrats town meetings, we would take a glass half full approach, highlighting what IS working, not what is failing. (Tab D)

If the President's plan is to succeed, we must create opportunities to get the message out. Once explained -- in simple, concrete terms -- our plan becomes the only logical and realistic solution.

Tab A

How the President's plan addresses America's major health care concerns:

It helps those who can't afford insurance through a tax credit or tax deduction.

It helps employers -- large and small -- provide employee health care through reforms that make insurance affordable, accessible, and guaranteed.

It helps the self-employed, by increasing their deductibility to 100 percent.

It helps eliminate denial of coverage to those with pre-existing conditions.

It helps control out-of-pocket cost hikes through coordinated care with low deductibles.

It helps eliminate: crowded emergency rooms, uncompensated care, duplicative and unnecessary procedures, malpractice insurance costs.

It helps people evaluate the cost and quality of medical care through better information and prevention.

It helps reduce the hassle factor to patients by simplifying administrative procedures.

It helps unemployed poor through expansion of Community Health Centers and National Health Service Corps professionals.

USDA Backgrounder

Roger Runningen (202) 720-4623

Issued: Feb. 14, 1992

News Division, Office of Public Affairs, Room 404-A, U.S. Department of Agriculture, Washington, D.C. 20250

HOW THE PRESIDENT'S HEALTH CARE PLAN HELPS FARMERS

FARM FAMILIES WILL GET broader health insurance coverage at less cost under the President's health care plan announced Feb. 6. Self-employed farmers who have no employer-sponsored health insurance and who buy their own health insurance can currently deduct 25 percent of their health insurance costs from their reported income. A farm family with $35,000 income in net farm income paying $6,000 a year for health insurance can save $420 in taxes. Under the President's plan, they can deduct all the $6,000 and save $1,680 in taxes.

PART-TIME FARMERS who are covered by health insurance where they work will be eligible for a deduction of up to $3,750 (for a family of three). The deduction is reduced by the employer's contribution to the cost of the health insurance. For example, if the employer pays $3,000 for insurance coverage at the workplace, employees can deduct $750 of their own insurance cost. If the employer's cost for their insurance is $2,000, employees can deduct up to $1,750 of the cost of their own insurance.

LOW INCOME FARMERS who are below the threshold for paying income taxes--and who are not covered by a federal health insurance program or by an employer-sponsored plan--will receive a transferable tax credit certificate worth $3,750 (for a family of three) that they can use to buy health insurance. As incomes rise above the tax threshold, the value of the certificate is reduced. At incomes of 150 percent of the tax threshold, the value of the certificate drops to 10 percent ($375 for a family of three). As farmers move up the income scale, they reach a point where deducting the cost of their health insurance on their income tax returns has more value to them than the value of the certificate.

FARM EMPLOYERS will be able to get more affordable health insurance for their employees under the President's plan. One way is to enter a network pool with small businesses and individuals for broader risk sharing and lower administrative costs. Currently, administrative costs for health insurance for a small number of employees can reach 40 percent of the premium, compared with 10 percent for a large number of employees. The President's plan will allow farm organizations to offer health insurance to their members nationwide.

FARM EMPLOYEES may benefit because the farm employer can get more coverage for them at less cost. Or they can take their tax credit certificate and supplement the farm employer's insurance with their own. Or, if it's to their advantage, they can deduct up to $3,750 (for a family of three) from reported income minus anything the employer pays.

ANOTHER VALUABLE FEATURE of the Presidents' health care plan is that people can't be denied group coverage because of their health conditions. Insurers must offer coverage to any group, regardless of the health of those in the plan. They can also change jobs and join the health insurance plan of a new employer, regardless of their health status.

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THE PRESIDENT'S HEALTH CARE REFORM PLAN

How It Will Help Small Business Owners, Employees and Their Families

The President, in shaping his health reform plan, has been especially concerned about assuring health insurance affordability, security and choice for small business owners, employees and their dependents.

Today, in small businesses, an estimated 19 million workers and dependents have no insurance (comprising about one-half of all uninsured); many others who are insured are concerned about losing coverage if they change jobs or lose employment; and employers have difficulty obtaining information about insurance or even finding an insurer willing to sell them coverage.

The President's plan would respond to those problems.

- **Small business employees and their families** would receive, through the tax system, insurance credit certificates or tax deductions of up to $1,250 for individuals, $2,500 for 2-person families, and $3,750 for larger families. This would make insurance much more affordable.

- **Self-employed persons** would be permitted to deduct 100% of their insurance costs as a regular business expense.

- **Affordable health plans** would be developed by every state; small business employers, employees and their families could purchase those plans.

- **Managed care programs** would become more broadly available; families choosing managed care would share in the savings those programs achieve through efficient operation and guided use of services.

- **Limits on insurance premiums** would prevent sudden, large increases in insurance costs.

- **Health insurance networks** (HINs) would help those small business employers who join to find health insurance information; they would reduce members' costs by obtaining discounts; and they would pass on savings obtained from HIN members' exemption from excessive state-mandated benefits and taxes.

- **Insurance access and security** would be strengthened by prohibiting insurers from rejecting small groups (or their individual members) applying for coverage (even if they have existing medical problems); by limiting waiting periods; and by the availability of states' affordable health plans. College students would receive transitional coverage for 6 months after graduation. People would not lose insurance if their health status changes.

- **Clear information on quality, cost and effectiveness** of local health care providers, medical services, and prudent lifestyle choices will help people maintain good health, and when they need to buy services, to obtain them from doctors and hospitals that emphasize both high quality and cost containment.

The President's plan will:

- Make health care more accessible by making health insurance more affordable;
- Reduce the runaway costs of health care by making the health care system more efficient;
- Cut waste and excess in the present system; and
- Get the growth in government health programs under control.

The President's plan does not:

- Include governmental price regulation or rationing of health care;
- Burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans;
- Require massive tax increases like "play or pay" and national health insurance; or
- Threaten poor, older Americans with benefit reductions or premium increases.

HHS HIGHLIGHTS

FEBRUARY 1992

THE BUSH - SULLIVAN RECORD

Under the leadership of President George Bush and Secretary Louis W. Sullivan, M.D., the Department of Health and Human Services (HHS) has moved aggressively to address our nation's most pressing health and social problems.

With some 250 domestic programs, HHS has the federal government's largest budget -- accounting for almost 40 percent of all federal spending. The two largest federal programs, for example -- Social Security and Medicare -- are part of HHS.

The period since President Bush took office has been among the most dynamic in HHS's history. Among the highlights:

- A comprehensive program for reform of the nation's health care system that will provide all Americans access to affordable health care, reduce the rapid growth of health care spending, and assure the security and continuity of Americans' health care coverage.

- Major new initiatives addressing the problems of infant mortality, immunization, lead poisoning, tobacco use, child abuse and neglect, alcohol and drug abuse, minority males, and women's health.

- A revitalized Food and Drug Administration, the most sweeping overhaul of its food labeling regulations in over fifty years, and major reforms in its drug approval process.

- A major focus on health promotion and disease prevention via development and release of "Healthy People 2000," a targeted, comprehensive health promotion and disease prevention strategy for America, and an increase in funding of more than 56 percent since 1989.

- A new priority on America's children, with funding for children's programs nearly doubled, and creation of the Administration for Children and Families, which combines HHS's wide array of programs for children and families within a single operating division.

- o Increased support for biomedical and behavioral research, with an increase in funding of 35 percent supporting a record number of research projects.

- o Greatly intensified efforts on HIV/AIDS prevention, on educating the public about HIV/AIDS, and on speeding the availability of drugs and services to the HIV/AIDS affected.

The following pages offer a capsule summary of many, but by no means all, of the outstanding accomplishments achieved by the Department of Health and Human Services under the Bush/Sullivan stewardship.

CONTENTS

COMPREHENSIVE HEALTH CARE REFORM

President Bush's program for comprehensive reform of America's health care system, announced February 6, 1992, uses market forces and incentives to forge a less costly, more efficient system and provides access to affordable health insurance for all Americans.

Guaranteed Access to Health Insurance for the Poor -- The President's plan guarantees access to health insurance for all poor families through a transferable health insurance tax credit (certificate) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package ($3,750 for a family).

Insurance Security for All Americans -- The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.

Reduced Cost of Health Insurance -- Smaller businesses and individuals will be pooled into larger groups -- so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now cannot find affordable insurance will be helped.

New Help for the Middle Class -- Up to $3,750 in health insurance costs can be deducted from the federal income tax by families with incomes less than $80,000. Over 90 million Americans will receive new assistance for health costs.

Growth of Coordinated Care -- Laws limiting coordinated care will be eliminated -- as would costly state-mandated benefit laws. The president's plan encourages individuals, employers, and health providers to use coordinated care systems.

Informed Consumers -- The President's plan will use the power of an informed marketplace to help control costs by providing consumers the information they need to choose the coverage that best meets their needs.

Reduced Administrative Costs -- Regulatory reforms will streamline the current paperwork maze and market reforms will allow small employers to share -- and thereby substantially reduce -- administrative costs.

Major Malpractice Reform -- A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.

Expanded Services in Underserved Areas -- Many inner-city and rural areas have acute shortages of clinics and doctors. The President's FY 1993 budget proposes an increase of $105 million to support 126 additional Community and Migrant Health Center sites, 20 more homeless health care grantees, and 6 more health grantees near public housing. An increase of $20 million is proposed to expand the National Health Service Corps to increase the pool of health professionals serving in shortage areas.

The President's Plan Will Not:

-- Include governmental price regulation or rationing of health care;
-- Burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes;
-- Require massive tax increases like "play or pay" or national health insurance proposals;
-- Threaten poor older Americans with benefit reductions or premium increases.

HEALTH PROMOTION/DISEASE PREVENTION

Health promotion and disease prevention efforts offer our best opportunity to reduce preventable disease, disability, and premature death in America. It has been estimated that upwards of 900,000 of the 2.2 million deaths that occur each year are avoidable. Under President Bush and Secretary Sullivan, health promotion and disease prevention activities have become major priorities -- the $8.7 billion proposed for FY 1993 represents an increase of 56 percent since 1989.

Healthy People 2000 -- A targeted, comprehensive health promotion and disease prevention strategy for the United States was completed in September 1990. "Healthy People 2000," a 672-page document offering specific goals, will serve as a guide for policies to improve the health of the American people for the remainder of this century.

Infant Mortality -- The Bush Administration's "Healthy Start" initiative represents a major new effort to reduce the intolerably high infant mortality rate in the United States. Demonstration grants targeted to 15 cities and rural areas with excessive infant deaths are intended to develop techniques for reducing infant mortality rates in these areas by up to one-half in five years. Proposed funding of $143 million for "Healthy Start" in FY 1993 more than doubles the FY 1992 level.

"Healthy Start" builds on the already substantial resources -- some $5 billion -- HHS is spending under President Bush on programs to decrease infant mortality and improve maternal and infant health. They include Maternal and Child Health block grants, support to Community Health Centers and Migrant Health Centers, and the Centers for Disease Control's pregnancy risk assessment monitoring system.

Immunization -- In a far-reaching Immunization Initiative to address low immunization rates among certain populations of pre-school children, the Bush Administration is actively supporting innovative, comprehensive approaches at the state and local levels with the goal of ensuring that 90 percent of our children under age 2 are fully immunized by the year 2000.

HHS's budget for immunization activities has risen from $98.2 million in 1988 to a proposed $349 million for FY 1993 -- an increase of 148 percent. Among the new approaches already being undertaken by the Centers for Disease Control are "express lanes" for vaccinations in public clinics, making vaccinations available in hospital emergency rooms, and making vaccinations available through the Women, Infants, and Children (WIC) and Aid to Families with Dependent Children (AFDC) programs.

Lead Poisoning -- The Bush Administration developed a "Strategic Plan to Eliminate Childhood Lead Poisoning," describing actions that can be taken at all levels to help eliminate this disease within 20 years. New CDC guidelines call for less than half of the blood level of lead than previously advised. And new efforts are being initiated to screen children and remove lead from homes, neighborhoods, water supplies, and the air. The Administration has requested an increase of 88 percent in funding for lead poisoning screening and public education activities for FY 1993.

HIV/AIDS -- The widely acclaimed "AIDS Prevention Guide," designed to help parents and other adults give our young people the information they need to protect themselves against the HIV virus, was first released in 1989. It is only one part of a comprehensive program of HIV and AIDS prevention efforts which also include the National AIDS Hotline, the National AIDS Clearinghouse, public service advertisements, and assistance to state AIDS programs.

Total HIV/AIDS spending will increase to $4.9 billion under the President's FY 1993 budget proposal -- an increase of 118 percent since 1989.

The appointment by President Bush of the widely admired basketball great "Magic" Johnson to the National Commission on AIDS presents a broad new opportunity to educate Americans, young and old alike, on methods of preventing HIV infection and on developing sorely needed compassion and respect for those afflicted with HIV and AIDS.

Tobacco Use -- Secretary Sullivan has become the nation's leader in the battle against tobacco use -- the number one preventable cause of disease and death in America. ASSIST, the largest-ever national program to combat smoking, was launched in October 1991. Its goal is to help more than 4.5 million adults to stop smoking and 2 million more young people never to start. And a model bill for states to use for restricting minors' access to tobacco was developed and released in May 1990. With the President's FY 1993 budget proposal, funding for smoking cessation activities will have increased 42 percent under the Bush Administration.

CHILDREN AND FAMILIES

The Bush Administration is guided by the firm conviction that America's children are our most precious resource and that strong, self-sufficient families represent the basic building blocks of our society. Accordingly, the Administration has committed itself to a greater emphasis on the needs of the nation's children and families. And it is fulfilling that commitment.

Administration for Children and Families -- In a major reorganization designed to fulfill the Administration's commitment to strengthening families, the Administration for Children and Families (ACF) was created in April 1991. It combined HHS's wide array of programs for children and families within a single operating division with a staff of over 2,000 and a proposed budget of $28.3 billion for FY 1993.

Head Start -- President Bush's number one National Education Goal is to have every child in America start school ready to learn. During the Bush Administration, Head Start, the early childhood development program for low-income children, has witnessed the largest expansion in its history. For FY 1993, the President has proposed the largest increase ever -- $600 million. Total support will increase to over $2.8 billion -- up 125 percent since 1989 -- and enrollment will reach 779,000, allowing every eligible 4-year-old child whose parents want them to participate to receive the Head Start experience.

JOBS Program -- The Job Opportunities and Basic Skills Training (JOBS) program, which assists welfare recipients to become self-sufficient, has now been implemented in all 50 states. JOBS requires states to provide education, training and work activities to welfare recipients. For example, teenage mothers who have not completed high school must go to school on a full-time basis and child care is provided for their children while they attend school. About 523,000 people are now participating in JOBS each month.

Expanded Medicaid Eligibility -- Beginning in April 1990, Medicaid coverage was required for pregnant women, and children up to age 6, with incomes below 133 percent of the federal poverty level. Coverage of children up to age 19 with incomes below 100 percent of poverty is being phased in. And Medicaid demonstration projects are testing expanded coverage for pregnant substance abusing women and coverage for low income families not otherwise eligible.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program has been greatly enhanced -- states are now required to provide children with treatments for conditions discovered during a screening visit, regardless of whether such conditions are ordinarily covered by the state program. And EPSDT providers are now required to perform lead blood level assessments appropriate to age and risk as part of the routine screening. If blood poisoning is detected, Medicaid must cover the cost of treatment.

Child Support Enforcement -- A record-high $6 billion was collected from absent parents on behalf of their children through the Child Support Enforcement program in 1990, the last year for which final statistics are available. And paternity was established for over 393,000 children born out of wedlock, an increase of more than 54,000 over the previous year. In an effort to achieve even greater progress, the Bush Administration is proposing legislation to further expand the effectiveness and efficiency of the Child Support Enforcement program.

Child Care and Development Block Grants -- This new program, begun in September 1991, provides financial assistance to low-income families with a parent who is working or attending a training or educational program. The parent is given a variety of options in addressing child care needs. The purpose of the program is to increase the availability, affordability, and quality of child care.

At-Risk Child Care Program -- Established in October 1990, this program provides child care assistance to families who are at risk of going on welfare if they do not receive employment-related child care assistance.

Child Abuse and Neglect -- Under an initiative launched in 1990, HHS is pursuing aggressive activities to enhance public awareness of the problem, to identify knowledge gaps, to formulate a research agenda for the future, and to support innovative prevention and other service-oriented projects.

Service Integration -- In recognition of the complex and multiple problems of many families, HHS is working with a number of states and local communities to better integrate services. The goal is to focus on an integrated approach to providing assistance which increases the self-sufficiency of families.

WOMEN'S HEALTH

A vast knowledge gap exists between men's and women's health -- how, for example, different disease conditions uniquely affect women, and the different prevention and treatment measures women require. The Bush Administration has established women's health needs as a national public health priority and is moving forward with bold, new initiatives.

Women's Health Initiative -- The Bush Administration has proposed the largest-ever study of women's health issues. The Women's Health Initiative will, at a cost of an estimated $500 million over 10 years, track at least 140,000 women to evaluate preventive approaches to cancer, heart disease, and osteoporosis.

Action Plan for Women's Health -- Released in September 1991 by the Public Health Service, the Action Plan for Women's Health lists the results of a nationwide assessment of the priority health concerns confronting women and identifies specific goals to be pursued and activities to be undertaken by HHS.

Breast and Cervical Cancer -- The Bush Administration has proposed a 24 percent increase in funding for breast and cervical cancer prevention in FY 1993 -- to $515 million. These funds will be used to pay for mammograms and pap smears for needy women and Medicare beneficiaries, and expand public education efforts on the detection and control of these cancers.

HIV/AIDS and Women -- The Social Security Administration published regulations listing symptoms for determining disability that, for the first time, take into account the fact that HIV and AIDS may manifest themselves differently in women.

Disability Benefits for Widows -- The Social Security Administration published regulations allowing widows to receive, for the first time, consideration of the same factors to determine disability as those used for workers.

The Surgeon General Speaks Out -- Surgeon General Antonia C. Novello, M.D., appointed by President Bush, has emerged as one of the nation's most powerful voices on behalf of women's health. Her no-nonsense approach -- "If you're going to smoke like men, you're going to die like men" -- has sparked a new awareness among women of the need to focus more keenly on health promotion and disease prevention issues.

OLDER AMERICANS

Our nation's older citizens represent not only a link to our past -- but a bridge to the future in the depth of their experience and their adherence to the values representing the best of America. The Bush Administration is committed to safeguarding the interests of our older Americans and to enhancing the quality of their life.

Social Security -- President Bush said, in his 1990 State of the Union address, "The last thing we need to do is mess around with Social Security." Because he has held firmly to this commitment, the Old Age and Survivors Insurance fund, from which Social Security benefits are paid, remains financially sound and will remain so well into the next century.

Nursing Homes -- Major new federal requirements to improve the quality of care in nursing homes and protect residents' rights became effective in October 1990. Also in 1990, a rule was issued which protects nursing home residents from being charged for costs payable by Medicare and Medicaid. And regulations requiring, for the first time, nurse aides in nursing homes to meet training and competency standards were issued in September 1991.

Breast and Cervical Cancer/Medicare -- Because half of all new cases of breast cancer occur in women aged 65 and older, the Medicare program began helping to pay for mammograms, to screen for early detection of the disease, in January 1991. Some 5.3 million women are expected to receive these benefits during the current fiscal year. And Medicare began helping to pay for cervical cancer detection in July 1990.

Prescription Drug Safety -- So far in the Bush Administration, the Food and Drug Administration has issued guidelines intended to encourage drug manufacturers to carry out thorough evaluations on the effects of drugs on people over age 65; and has issued a rule requiring that information about the effects of prescription drugs on the elderly be included in the drugs' physician labeling.

Misleading Solicitations/Advertising -- The Bush Administration has cracked down on the deplorable practices of using terms, symbols, or emblems to mislead the elderly into thinking that solicitations or advertising represents official correspondence or endorsement from the Social Security Administration or the Health Care Financing Administration (Medicare). Under new regulations, violators now face stiff monetary penalties for such practices.

National Eldercare Campaign -- Launched by HHS's Administration on Aging in December 1991, the National Eldercare Campaign is a nationwide, multi-year effort to mobilize the resources of a wide spectrum of individuals, agencies, and organizations on behalf of older persons at risk of losing their self-sufficiency.

Medicare/Medigap -- The Bush Administration is implementing sweeping reforms in the supplemental health insurance for Medicare beneficiaries known as Medigap. Beneficiaries may no longer be denied coverage because of pre-existing conditions if they buy a Medigap policy within six months of becoming eligible. One standard benefit package must be offered by every carrier that fills in gaps such as drug reimbursement. Additional changes will simplify the language of policies.

FOOD AND DRUG INITIATIVES

President Bush's goal for the Food and Drug Administration was to revitalize -- and restore public confidence in -- the ability of the agency to regulate the safety and effectiveness of food products, medicines, and medical devices. Many of the boldest and most ambitious actions in the agency's history have already been undertaken.

Food Labeling -- The most sweeping overhaul of food labeling regulations in over fifty years was announced in November 1991. The new regulations will end the confusion consumers now face, eliminate unfounded claims, and -- for the first time in our nation's history -- provide Americans with the clear, true, and understandable information they need to make healthy dietary choices.

Drug Approval -- Major reforms in the FDA's drug approval process were announced in November 1991. Under these reforms, patients with serious and life-threatening diseases will benefit from earlier access to important new drugs; unnecessary regulatory burdens will be eased; and American competitiveness will be strengthened.

Drug Effectiveness -- In a broad clean-up of ineffective ingredients in non-prescription drug products, the FDA banned 223 ingredients in 19 classes of products in November 1990. The ineffective substances banned range from pine tar in dandruff products to ox bile in laxatives.

HIV/AIDS Drugs -- In May 1990, the Bush Administration announced the "parallel track" plan for speeding the availability of investigational new drugs for people with HIV and AIDS-related diseases. And in October 1990, the FDA approved dideoxyinosine (DDI), the second drug (AZT is the other) that has been found to be effective against AIDS.

ALCOHOL AND ILLICIT DRUG ABUSE

The toll exacted on health, society, and the economy by alcohol and illicit drug abuse is staggering. In the most recent study, the cost of alcohol problems in America were estimated to exceed $70 billion a year, with an additional $44 billion a year attributed to drug problems. Charged with addressing the health aspects of alcohol and drug abuse, HHS in the Bush Administration has moved forward vigorously with bold new initiatives.

ADAMHA Reorganization -- The Bush Administration has proposed a major reorganization of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) which will allow for enhanced basic research and more effective targeting of alcohol, drug abuse, and mental health preventive and treatment services to the people who need them.

National Training Center -- The Bush Administration announced establishment of a National Volunteer Training Center for Substance Abuse Prevention in October 1991. Headquartered in Washington, D.C. with five training sites to be designated in each of the 10 HHS regions, the center will train thousands of volunteers from around the country in effective anti-drug abuse strategies.

Perinatal Addiction Center -- Establishment of a National Perinatal Addiction Prevention Resource Center was announced in August 1991. Based in Washington, D.C., the center will provide information, training, and technical assistance for public policy development related to maternal alcohol and drug use, both before and after giving birth.

Grants for Addicted Women and Children -- The availability of grants was announced in February 1991 for demonstration projects to seek effective methods of coordinating medical care with drug treatment and other services for Medicaid-eligible, drug-addicted pregnant women and children.

Waiting List Reduction Grants -- A $75 million grant program to help drug treatment facilities to reduce or eliminate waiting lists was begun in 1989. Priority is given to applicants that have the largest waiting lists and the longest average wait for services.

Community Partnership Program -- Launched in April 1990, this initiative supports some 150 demonstration grants to fight alcohol and drug problems through community-based coalitions of public agencies and private organizations.

"Campus" Demonstration Program -- A $68 million program launched in August 1991, this program provides funding for communities to introduce a "campus" approach in residential treatment programs, under which as many as five to eight providers using different methods occupy a common facility.

BIOMEDICAL AND BEHAVIORAL RESEARCH

Biomedical and behavioral research is crucial in our efforts to address many of America's most pressing health problems -- diseases such as cancer, AIDS, heart disease, and many others. The Bush Administration has placed a high priority on strengthening our biomedical research efforts and capabilities. Funding has increased 35 percent since 1989 and the President's FY 1993 budget proposal will support over 24,000 research project grants -- a record number.

Human Genome Project -- The Bush Administration is pushing ahead vigorously in support of the massive effort to map the human genome -- literally to understand the information encoded on the human chromosome. Gene mapping will help us understand inherited disorders and could lead to new strategies for the prevention of more than 3,500 diseases of known genetic origin, and to a better understanding of other diseases such as cancer, depression, and hypertension.

Medical Treatment Effectiveness -- In 1989, HHS created an agency to conduct a program of research on medical treatment effectiveness. This research provides scientific information about the most effective medical strategies for practitioners, consumers, employers, educators, and insurers.

Public/Private Partnerships -- The Bush Administration is working to form a greater partnership between public and private research. Laboratories in several Public Health Service agencies are, for example, collaborating with industry scientists in joint research projects under Cooperative Research and Development Agreements.

MINORITY HEALTH

There remains in our nation a shockingly wide disparity in health status between our white and minority populations. In almost every category of mortality, for example, minority deaths are greater than those of whites. Since our minorities are disproportionately represented among our disadvantaged, many of the programs and initiatives mentioned above have their greatest impact among these groups. However, the Bush Administration has recognized the need to take steps aimed specifically at our minority populations.

Minority Male Initiative -- This new special initiative reaches out to young minority males who, as a group, are faced with serious health and social problems at rates far exceeding the population at large. It provides funding to local organizations for efforts to find local solutions to specific local problems, and for demonstration projects to support innovative programs of outreach and service coordination.

The initiative includes program activities of several agencies such as the Minority Male Grant Program, the High-Risk Youth Grant Program, the Critical Populations Grant Program, the Target Cities Grant Program, and the Criminal Justice Program.

Health Training and Research -- The Bush Administration has greatly increased activities for the recruitment and training of minority health and biomedical research professionals. Initiatives include recapitalizing the Health Professional Student Loan Program, Minority Biomedical Research Support grants, the and the establishment of a new federal construction program to enable Historically Black Colleges and Universities to improve their research infrastructure.

The National Institutes of Health is developing a 4-year plan to increase support for minority health and training, establishing Minority Program Advisory Board, and supporting pilot projects aimed at developing new approaches recruiting and retaining minority students in the health professions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

March 26, 1992

Dear Colleague:

In our continuing effort to keep you informed on the President's Comprehensive Health Reform Program, I am happy to send you copies of two of the speeches given by Secretary of Health and Human Services, Louis W. Sullivan, as well as recent news clippings related to the plan. The speeches, delivered to the Independent Insurance Agents of America and the South Carolina Chamber of Commerce, could prove helpful in providing a clear articulation of the President's goals.

If you have any questions or wish any further information or materials, please feel free to contact my office at (202) 245-1850.

Sincerely,

Alixe R. Glen
Assistant Secretary
for Public Affairs

Enclosures

U.S. Department of Health & Human Services
Office of the Assistant Secretary for Public Affairs
Speechwriting Division
Washington, D.C. 20201

"Reforming America's Health Care System"

Remarks by U.S. Health and Human Services Secretary Dr. Louis Sullivan to the South Carolina Chamber of Commerce on February 21, 1992, in Columbia, S.C.

I am delighted to be here today to speak about a topic much in the news recently and one that is vitally important to you as business people — that is, reforming the American health care system. Specifically, I'd like to talk about the plan that President Bush announced two weeks ago.

Theme

I need not remind you that the issues involved in health care financing and delivery are very complex. Accordingly, the President's plan is comprehensive. It includes 12 different categories of proposals, each of which targets particular problem areas.

But at the same time, these many separate proposals work together in a coordinated way. For while details are complex, the mission is clear: it is to provide affordable health insurance, slow the growth in costs, improve access and continuity of care, and make health insurance more secure.

We want to take what is fundamentally a good system, a system that has set the world standard in health care, and make it better. We want to preserve the benefits that the great majority of Americans enjoy today ... make those benefits more affordable and safe for the future ... and extend them to every citizen of our country.

You have undoubtedly heard other proposals which may appear simpler. But their apparent simplicity is misleading. If we are to be responsible and realistic in confronting the problems of our health care system today, then we must acknowledge at the outset: there is no one simple answer, no panacea, no magic wand, no substitute for sound analysis and hard work.

However, before we can select the particular paths, there is a single, greater decision which must be made. It concerns the fundamental direction we wish to take, and it is a decision which must be made by our citizens as a whole.

We want to take what is fundamentally a good system, a system that has set the world standard in health care, and make it better.

The President put this decision succinctly in his recent State of the Union Address. He said:

Really, there are only two options: We can move toward a nationalized system — which will restrict patient choice in picking a doctor and force the government to ration services arbitrarily. Or we can reform our own private health care system — which still gives us, for all its flaws, the best quality health care in the world.

Let's consider each of the alternatives.

The Democratic alternative

The proposals which have been put forward by Democratic members of Congress — whether called national health insurance, or expanded Medicare, or Americare, or "Play-or-Pay" — have this in common: they would all lead us to a government-controlled health care system. Some would do so forthrightly; others attempt to conceal that end. But the truth is that each of these proposals would ultimately put a government bureaucracy in charge of health care financing and health care choices.

In contrast to those proposals, the President would maintain the integrity of the private sector in the health care area. His plan would strengthen the government's role in some important respects:

- it would expand the safety net for the uninsured and those in need;
- it would correct problems in the private insurance market, making insurance more available and secure;

■ and it would strongly encourage the use of coordinated care, which provides workable incentives for high quality, with cost control.

The President's plan

Fundamentally, however, the President's plan differs from the Democratic plans because it would protect consumer choice and private market mechanisms. And it is these private structures, not government promises or wishful thinking, that are truly the best hope for the future of our health care system. If we want to achieve the right balance of cost, quality and access for our citizens, then it makes sense to leave as much choice as possible in our citizens' own hands, to make the decisions that are best for their own circumstances.

Let me briefly re-cap some highlights of the President's plan:

I'll start with the most important element for businesses — particularly small businesses. The President's plan would revolutionize the way health insurance is offered, establishing "risk pools," so that smaller businesses and individuals can enjoy the more favorable health insurance terms that larger businesses enjoy.

We would do this through a mechanism called health insurance networks. And we would eliminate those burdensome state mandates imposed on health insurance policies, which drive up the costs of premiums and restrict competition.

Health insurers would be required to provide coverage to all employers requesting it. Coverage would be guaranteed, renewable, and no limits would be allowed on pre-existing medical conditions. Insurance coverage would be secure. And workers would no longer face "job lock" — the inability to change jobs for fear of losing access to insurance.

Insurance affordability would also be enhanced by limits on premium costs. Altogether, the savings from small market reforms will mean lower premiums for small companies.

There would be new health insurance credits and a new tax deduction would benefit more than 90 million Americans. Together, these provisions would make health insurance available to those with low incomes, and make insurance more affordable for those with middle incomes. For example:

If the tax credit were fully in effect today, a family of four, with adjusted gross income up to $14,300, would obtain the maximum credit, enabling them to buy $3,750 of health insurance.

Likewise, a family of four, making $60,000 but without employer-sponsored health insurance, could take the full tax deduction of $3,750, providing about $1,050 that would help with the purchase of insurance.

States would be required to develop a basic health insurance package which could be purchased with the tax credit. At the same time, consumers would be free to purchase alternative insurance, if they preferred.

Self-employed persons are helped in the President's plan by being able to deduct 100% of the cost of health insurance on their tax returns. Current law allows for only 25%.

The President's proposal encourages the use of "coordinated" health care. Under this type of arrangement, insured individuals will enroll in a program in which they may choose their own personal doctor, who, in turn, will coordinate the care they may need by other medical specialists, or particular health care facilities.

Not only has this method of service delivery proven more affordable, it also enhances the concept of the "family doctor" in medical practice.

The President's plan includes malpractice reform. It also includes initiatives to reduce administrative costs and insurance paperwork, and increase flexibility for state Medicaid programs. In the 1993 budget released two weeks ago, major expansions were also proposed for clinics and providers in underserved areas as well as new resources for disease prevention activities.

Finally, we propose to improve consumer information. The President's plan envisions "blue books" of information comparing costs and quality of care provided by physicians, hospitals, clinical laboratories, and other health care providers.

Conclusion

These are the elements of the President's proposal. They include fundamental reform of the insurance market to ensure availability and affordability. They provide access for all poor families, and support for middle-income families in the purchase of health insurance. And they en-

courage the growth of coordinated care, with its incentives for quality plus cost control.

Most importantly, they rely on the free market system to continue to provide the finest health care in the world.

In the weeks and months to come, the United States will be answering a fundamental question: Will we turn to government, subjecting our health care sector to the whims and vacillations of budgets and bureaucrats? Or will we maintain our mixed private/public system, drawing on the best strengths of the private market?

Stated another way, the question becomes: How many Americans would turn in the private sector coverage they have today for a government-run system? I believe the answer to that question is self-evident

And on that note, I would be happy to entertain some questions from you.

For reprints of this or any other speech by Dr. Sullivan, contact Cliff Lorick, Director of Speechwriting, at 202-245-7470.

U.S. Department of Health & Human Services
Office of the Assistant Secretary for Public Affairs
Speechwriting Division
Washington, D.C. 20201

"What's at Stake in Health Care Reform"

Remarks by U.S. Health and Human Services Secretary Dr. Louis Sullivan to the Independent Insurance Agents of America on March 23, 1992, in Washington, D.C.

I am delighted to be with you today. It gives me an opportunity to reinforce the Bush Administration's commitment to maintaining a strong private health insurance system in the United States. It also gives me an opportunity to challenge you — to ask you to redouble your efforts in educating the American people at the grass roots about the stakes involved in health care reform.

The challenge in health care reform

One of the greatest challenges we face in implementing the President's plan is that most Americans do not fully understand the jargon — and some underlying concepts — behind the health care debate.

For example, we've seen a number of polls purporting to show that Americans might favor "national health insurance." But further investigation reveals that respondents to those surveys do not know what national health insurance really is — it just sounds like a positive concept to them. Because when some of those same pollsters conduct focus groups, then explain that national health insurance means government-run medicine, support declines dramatically.

(I suppose it would be like a pollster asking, "Would you favor elimination of the exclusionary rule if it would reduce crime?" I'm sure a large percentage would say, "Well...sure...I guess so." Individual respondents may or may not favor eliminating the exclusionary rule, but most would be left wondering what it is.)

And so it is with health care reform. We must not leave the public wondering what the debate is all about — what it is they would be getting under the various proposals.

As businessmen represented in every community, every congressional district across America, independent insurance agents are in a position to educate other businessmen, government officials, and the public at large about what the various proposals would lead to.

Let it be understood: the proposals which have been put forward by Democratic members of Congress . . . would lead us to a government-controlled health care system.

What the alternative proposals would mean

Let it be understood: the proposals which have been put forward by Democratic members of Congress — whether called national health insurance, or expanded Medicare, or Americare, or "Play-or-Pay" — all have this in common: they would lead us to a government-controlled health care system.

(I am reminded of the story of the antique collector who was travelling through Illinois, and came across a man chopping wood. He said to the man, "That looks like a pretty old ax you've got there." The man said, "Yes, it used to belong to Abe Lincoln." The antique collector said, "It doesn't look that old." And the man said, "Well, it's had four new handles and two new heads since Lincoln owned it.")

While some of the Democratic proposals might purport to work within the current system, the truth is that we would end up with something completely different from what Americans have come to enjoy and expect in health care. For ultimately, we would put a government bureaucracy in charge of health care financing and health care choices.

The President's alternative

Fortunately, President Bush's health care reform plan offers an alternative: better access to health insurance for all Americans, health care security, affordability, and choice. Americans must understand what it will mean for them:

The middle class — families with incomes up to $80,000 —will get help through a new income tax deduction.

For poor families, the plan guarantees access to health care through a health insurance credit.

Self-employed persons would be able to deduct 100% of the cost of health insurance on their tax returns. Current law allows for only 25%.

Security is provided by assuring that no one will lose insurance coverage when they change jobs or get sick. The insurance market would be reformed so that persons would not

be excluded because of preexisting illness once they have coverage.

Smaller businesses, and individuals, will be able to pool into larger groups, so they can enjoy the more favorable insurance terms available to large businesses.

Systems of "coordinated" health care will be encouraged so an individual's personal doctor will coordinate their care with other medical professionals or facilities, improving quality, reducing costs, and reinforcing the concept of the "family doctor."

The President's plan includes malpractice reform. It also includes initiatives to reduce administrative costs and insurance paperwork, and increase flexibility for state Medicaid programs.

Some charge that the President's plan is too complex. Yes, the issues involved are complex, so the President's plan is comprehensive.

But while details are complex, the mission is clear: We want to take what is fundamentally a good system, a system that has set the world standard in health care, and make it better. We want to preserve the benefits that the great majority of Americans enjoy today ... make those benefits more affordable and safe for the future ... and extend them to every citizen of our country.

The Pay-or-Play alternative

Let me return briefly to one of the Democratic proposals — the one known as pay-or-play, that would mandate employer-provided health insurance benefits. Your staff suggested that I discuss this, because as small businessmen yourselves, you have personal concerns about the adverse consequences of this proposal on smaller businesses. We share those concerns — both for the short term, and the long term.

In January, the Department of Labor released an independent study — conducted under contract by the Urban Institute and the RAND Corporation — on the real effects of pay-or-play. Based on the 7 percent payroll tax being proposed in the leading Democratic bills, here's what the study found:

■ Employers would incur new costs of almost $30 billion. The burden would fall especially on small businesses. For many, this would simply mean closing shop — and eliminating jobs.

■ Even with the new tax on payroll for employers who chose it, the vast new public plan would cost more than the tax would bring in. An additional $36 billion subsidy would be born by the general taxpayer. The new plan would represent a 130 percent increase over spending on the current public programs it would replace, notably Medicaid.

■ The public plan would grow to cover 112 million people, or more than half of our non-elderly population. It would be more than three times the size of Medicare.

■ Fifty-two million people now covered under employer-sponsored plans would lose their private coverage as employers chose to pay the new tax rather than maintain private insurance. More than one-third of those who now have employer-supplied private insurance would be shifted to the government-run plan.

In sum, pay-or-play would not be good for the insurance industry; it would not be good for businesses and the economy in general; it would create a new out-of-control government bureaucracy; and — most importantly — it would be detrimental to the health care of our citizens. How many Americans would want to turn in the private sector coverage they have today for a government-run system?

Conclusion

The stakes involved in the health care debate have been overly characterized in the media in political terms. In reality, the stakes are much higher, for they embody what we hope to become as a society.

The stakes include ideology and philosophy — whether we want to remain true to our commitment to choice and the private sector in health care delivery, or run counter to our long success with it by starting down the muddy road of centralized planning.

The stakes also involve our economic well-being — whether we can reduce the growing drain on our national finances and still continue to provide quality care.

And the stakes are societal — whether we can efficiently provide a basic human need for all our citizens, or whether we are going to have a growing chasm between the haves and the have-nots in health care.

For all these reasons — as well as for your own self-interest as an industry — I implore you to help us in educating the public about the issues involved in the health care debate, and what the various proposals will mean for every American.

President Bush and I ask you to do this individually in your respective communities, and collectively as the Independent Insurance Agents of America.

Thank you, and now I'll be happy to entertain some questions.

For reprints of this or any other speech by Dr. Sullivan, contact Cliff Lorick, Director of Speechwriting, at 202-245-7470.

Providence Sunday Journal 1-5-92

Sullivan promotes Bush health plan in R.I.

HHS secretary offers praise for Women & Infants

By DAVE CROMBIE
Journal-Bulletin Staff Writer

PROVIDENCE — Secretary of Health and Human Services Louis W. Sullivan came to town yesterday touting President Bush's comprehensive health-care package, and blaming the Democratic-controlled Congress for not spending enough to reduce infant mortality.

Dr. Sullivan toured the special-care nursery of Women & Infants Hospital where about 65 babies — most born prematurely — are patients.

During the 20-minute tour, Sullivan told the hospital's chief of pediatrics, Dr. William Casbore, that he was "very impressed with this facility."


SULLIVAN

The United States has one of the highest infant mortality rates in the industrialized world. After his hospital tour, Sullivan was asked why the government was not doing more to combat infant mortality.

Sullivan blamed Congress, saying it had cut Bush administration requests for money. The President wanted $170 million, but Democrats cut it to $25 million, he said. The figure is higher now, he said, but not as high as Mr. Bush wants.

In response to another question, Sullivan said the decision on making condoms available in schools to combat AIDS and other sexually transmitted diseases is a local issue, not one the federal government should get involved in.

"In the Department of Health and Human Services, we have educational material available to local districts on preventive measures," he said.

This information, he said, includes abstinence, as well as the use of condoms. The New York City public school system distributes condoms in its schools.

But the focus of yesterday's visit to Rhode Island was to promote the Bush administration's comprehensive health-care plan. Health care "oms as a major issue in this year's esidential campaign because an stimated 37 million Americans do not have health insurance and because the cost of health care is so high.

The Bush plan would use vouchers and tax credits to encourage Americans without insurance to ticipants would be able to choose from a variety of plans.

One reporter asked Sullivan why the United States could not simply adopt a Canadian-style health-care system that provides free medical care on a cradle-to-grave basis.

Sullivan responded that such a system adapted for the United States would cost $250 billion to $500 billion over what is currently being spent on health care. "Canadians demand less of their system," he said.

Americans prefer having choices and would like to a health-care system that gives them choices, not a monolithic system run by the government, Sullivan said.

He said Canadians often have to wait for surgery, and many choose to come to Buffalo, N.Y., or Detroit for surgery because of delays.

Sullivan is part of a string of major administration officials who have come to the region for Mr. Bush. On Thursday, it was Secretary of Labor Lynn Martin; Friday, Robert Mosbacher, general chairman of the 1992 Bush-Quayle campaign was here, and tomorrow 11:30 a.m. Vice President Dan Quayle will attend a rally at Green State Airport. For an invitation the rally, call 942-1992.

But Bush's Republican primary opponent, Patrick Buchanan, is visit Rhode Island in person toda At 5 p.m., he will give a speech Providence College and then go the Sheraton Airport Hotel in Warwick, to greet supporters at 6 p.m.

Cabinet member touts Bush health plan here

BY CHRIS LAWSON
Staff Writer

America needs an overhaul of its health care system, but massive changes and additional government bureaucracy are not the answer, according to said Dr. Louis P. Sullivan, the secretary of Health and Human Services.

Sullivan spoke to more than 150 Greene County business leaders, health professionals and politicians at a breakfast yesterday at Greene Memorial Hospital in Xenia.

"There is enough money in our current health care system," Sullivan told the crowd. "We just need to spend it more wisely. We don't need the heavy hand of government bureaucracy smothering the creativity that made our nation number one in the world."

The nation's leading health care administrator was in the area yesterday to receive an honorary doctorate degree from Central State University. Sullivan oversees the federal department responsible for health, welfare, food and drug safety, medical research and income security programs.

We don't need the heavy hand of government bureaucracy smothering the creativity that made our nation number one in the world.

Louis Sullivan

Sullivan went to the Greene Memorial breakfast to pitch President George Bush's health care reform package before traveling to Central State.

Flanked by U.S. Rep. Dave Hobson (R-Springfield) and hospital president Herman Menapace, Sullivan spent more than an hour defending the president's plan to revamp the current system and denouncing other plans currently before Congress.

"It was a terrific opportunity to hear what the president's package is all about," said Menapace afterwards. "Dr. Sullivan was able to give us some insight into a very complex problem."

Sullivan said the president's plan for health care reform capitalizes on the strengths of the current system and streamlines the way providers do business. Cost containment is a key in the president's plan and Sullivan said that can be achieved through such initiatives as reduced administrative costs and standardized billing.

He warned that massive structural changes — such as implementing a national health care policy or other tax increase-based proposals — could spell disaster for the health care industry.

"We don't need a government bureaucracy managing our health care system," he said. "We have the most ad-

Turn to page 3

Sullivan. . .

Continued from page 1

vanced health care system in the world. What we need to do is to preserve the strength of that system, but contain costs in order to make health care affordable and accessible to all 250 million people in America."

Sullivan said the president has a four-pronged approach to solving the nation's health care woes: broaden access of available coverage; increase the security of existing coverage; make care more affordable; and preserve the element of choice within the system.

Currently, health care costs are 12 percent of America's Gross National Product (GNP), Sullivan said, or around $800 billion. In 1960, health care accounted for 5.6 percent of the GNP, indicating costs are continuing to spiral out of control.

"If we don't change the system, that figure will reach 20 percent of GNP by the year 2000," he said. "We can't afford that."

Sullivan said America is tops in terms of per capita health care coverage for its' citizens. More than $2,700 is spent, on average, for every American. However, more than 13 percent of Americans have no health insurance.

The president's plan would include health insurance credit vouchers for people living at or below the poverty level.

"The vouchers would be sufficient to purchase basic health insurance coverage," Sullivan said. "More than 90 million Americans would benefit."

Other elements of the president's plan include malpractice reform and caps on damages people can receive from malpractice suits.

"There is too much money being spent on defensive medicine, close to $20 billion to $30 billion a year," he said. "We've also got to promote ways to unclog the courts."

Other initiatives that Sullivan and the president hope to pursue are standardized billing to reduce paperwork and expansion of primary care clinics in local communities. Sullivan said he also supports major lifestyle changes in all Americans. Smoking, alcohol abuse and lack of physical exercise are killing too many people, he said.

"Much of the injuries and illness are caused from our lifestyles," he continued. "Medicine has been coming in after the house has caught fire. We want to prevent the fire in the first place."

The key to solving the current health care problem, he said, is to support incremental changes in the system, not massive reform. He said the president's plan would virtually pay for itself through cost savings and reform.

Greene Memorial's president agreed.

"There's no question that there is going to be a major overhaul" Menapace said. "However, I prefer the idea of trying to take the ills out of the present system. Let's clean those up before we do a massive restructuring."

Beavercreek Daily News (Ohio): 1-4-92

Sullivan pitches plan at Greene Memorial

HHS secretary shuns more government bureaucracy

By CHRIS LAWSON
Staff Writer

America needs an overhaul of its health care system, but massive changes and additional government bureaucracies are not the answer, said Dr. Louis P. Sullivan, the secretary of Health and Human Services.

Sullivan spoke to more than 150 Greene County business leaders, health professionals and politicians at an early morning speech yesterday at Greene Memorial Hospital in Xenia.

"There is enough money in our current health care system," Sullivan told the crowd. "We just need to spend it more wisely. We don't need the heavy hand of government bureaucracy smothering the creativity that made our nation number one (in terms of health care) in the world."

Photo By D. Anthony Bolkin

Louis Sullivan

The nation's leading health care administrator was in the Miami Valley Tuesday to receive an honorary doctorate degree from Central State University.

As head of HHS, Sullivan oversees the federal agency responsible for the major health, welfare, food and drug safety, medical research and income security programs serving more than 250 million Americans.

Sullivan came to GMH to pitch President George Bush's health care reform package to Greene County leaders before traveling to Central State.

Flanked by U.S. Rep. David L. Hobson, R-Springfield, and GMH President Herman Menapace, Sullivan spent more than an hour defending the president's plan to revamp the current system and denouncing opposition plans currently before Congress.

"It was a terrific opportunity to hear what the president's package is all about," said Menapace, a Beavercreek resident. "Dr. Sullivan was able to give us some insight into a very complex problem."

Sullivan said the president's plan for health care reform centers on capitalizing on the strengths of the current system and streamlining the way

health care providers do busi
ness. Cost containment is a key
in the president's plan and
Sullivan said that can be
achieved through such initia
tives as reduced administra
tive costs and standardized
billings.

He warned that massive
structural changes such as
implementing a national
health care policy and/or other
tax increase based proposals
could spell disaster for the be-
leaguered industry.

"We don't need a govern-
ment bureaucracy managing
our health care system," he
said. "We have the most ad-
vanced health care system in
the world. What we need to do
is to preserve the strength of
that system, but contain costs
in order to make health care
affordable and accessible to
all 250 million people in
America."

Sullivan said the president
has a four-pronged approach
to solving the nation's health
care woes: broaden access of
available coverage; increase
the security of existing cover-
age, make such care more af-
fordable; and preserve the el-
ement of choice within the sys-
tem.

Currently, health care costs
are 12 percent of America's
Gross National Product,
Sullivan said, or around $800
billion. In 1960, health care
accounted for 5.6 percent of
GNP, indicating costs are con
tinuing to spiral out of control.

"If we don't change the sys
tem, that figure will reach 20
percent of GNP by the year
2000," he said. "We can't afford
that."

Sullivan said America is
number one in terms of per
capita health care coverage
for its' citizens. More than
$2,700 is spent, on average, for
every American. Those figures
exceed the number two coun
try by more than 40 percent, he
added.

However, despite those
numbers, more than 13 per-
cent of Americans are without
any health insurance at all, he
said.

The president's plan would
include insurance credit
vouchers for people living at
or below the poverty line.

"The vouchers would be suf-
ficient to purchase basic
health insurance coverage,"
Sullivan said. "More than 90
million Americans would ben-
efit."

Other elements of the
dent's proposed plan in
malpractice reform and
on damages people coul
ceive from malpractice su

"There is too much
being spent on defe
medicine, close to $20
billion a year," he said. "
also got to promote ways
clog the courts (with u
sonable malpractice) suit

Other initiatives
Sullivan and the presi
hope to pursue are stan
lized billing in order to re
paperwork and expansi
primary care clinics in
communities. Sullivan sa
also supports major lifes
changes in all Ameri
Smoking, alcohol abuse
lack of physical exercis
killing too many, he said.

"Much of the injuries
illness are caused from
lifestyles," he said. "Med
has (too often) been comi
after the house has caught
We want to prevent the fi
the first place."

The bottom line to sol
the current health care
lem, he said, is to suppo
cremental changes to the
tem, not massive reform
said the president's
would virtually pay for i
through cost savings an
form.

Greene Memorial's p
dent agreed.

"There's no question
there is going to be a
overhaul" Menapace
"However, I prefer the id
trying to take the ills o
present system. Let's c
those up before we do a
sive restructuring."

Sullivan: Bush proposal cures health care system

By Geraldine A. Collier
Staff Reporter

With an eye on the primary Tuesday in New Hampshire, President George Bush's chief spokesman on health issues hopscotched across Massachusetts yesterday.

Touting his boss's health care plan before heading north for similar appearances in the Granite State this weekend, Dr. Louis W. Sullivan, U.S. secretary of Health and Human Services, compared Bush's plan with several different plans offered by Democratic candidates.

'CORRECT THE DEFICIENCIES'

Bush's plan "would correct the deficiencies in our health system," Sullivan told about 100 people gathered for a speech sponsored by the Worcester Area Chamber of Commerce. He said the various Democratic plans "would get rid of the system."

Sullivan, who spoke earlier in the day in Boston, said the plans offered by the Democratic candidates would all lead to a government-controlled health care system. "Each of those proposals would ultimately put a government bureaucracy in charge of health care financing and health care choices," he said.

HOT TOPIC

Health insurance has become a hot political topic since November when a Democratic candidate for the U.S. Senate in Pennsylvania

Louis W. Sullivan

rode to an unexpected victory on that issue. Many unemployed have lost their health care coverage along with their jobs. Others fear they will be left unprotected, if they become unemployed or are employed by companies that do not offer health benefits.

A variety of suggestions have been put forth by the Democratic candidates, ranging from Sen. Paul Tsongas' plan involving care under a mixture of government and private insurers to former California Gov. Jerry Brown's wish to adapt wholesale the Canadian system of national health care.

Plans offered by Iowa Sen. Thomas Harkin, Nebraska Sen. Robert Kerrey and Arkansas Gov. William Clinton vary in detail, but focus on government provision of health care coverage for all.

Bush's plan would:

- Require health insurers to provide coverage to all employers requesting coverage for their employees, with no limits allowed on pre-existing medical conditions, but limits on premium costs.

- Offer new health insurance credits and a new tax deduction that would allow low- and moderate-income people without employer-sponsored insurance to buy health insurance.

For example, a family of four, with adjusted gross income up to $14,300, would obtain the maximum credit, enabling them to buy $3,750 of health insurance.

FULL DEDUCTION

A family of four, making $60,000, could take the full tax deduction of $3,750, providing about $1,050 that would help with the purchase of insurance.

- Require states to develop a basic health insurance package that could be purchased with the tax credit.

Financing this and other changes in health care provision would be underwritten by reducing the rate of increased costs for government-sponsored Medicare and Medicaid plans over several years, said Sullivan.

Health-care reform moves a step closer

Sullivan: Administration will cooperate with Democrats

By NORM BREWER
Gannett News Service

WASHINGTON — The Bush administration stands ready to work with Democrats in reforming the current health care system, Health and Human Services Secretary Louis Sullivan pledged Tuesday.

Some members of the Senate Finance Committee charged that President Bush's plan, which would basically preserve the current system, will fail to control costs or ensure access. But Sullivan warned the senators against discarding the health insurance system the nation now has, even though it has some flaws.

The upshot seemed to be improved chances in Congress for legislation designed to make incremental improvements this year, but not for major reforms that some lawmakers believe are crucially needed.

Sen. John Chafee, R-R.I., asked Sullivan if the administration would work on proposals to reform small group insurance, care for pregnant women and young children, give deductions to self-employed taxpayers, tighten management of care to hold down costs, and provide money for community health facilities.

"I would be very anxious to do just that," Sullivan answered.

Sen. Lloyd Bentsen, D-Texas, the panel's chairman, also set a relatively cooperative tone, saying the Bush budget has "unexpectedly generous increases" in spending for maternal care and "remarkably small cuts" in Medicare, Medicaid and Child Welfare Services.

"The administration seems to have seen the light, or perhaps it anticipated the heat, and took steps to avoid an unpleasant confrontation in an election year," Bentsen said.

Bentsen and Sen. Dave Durenberger, R-Minn., have proposed improved care for pregnant women and children and insurance reforms. The latter would set standards for what a basic health policy must cover, limit costs paid by policy holders, and restrict when a policy could be canceled.

While Bentsen and Sullivan may find themselves negotiating, the administration remains a long way from the kinds of major reforms being pushed by more liberal senators.


SULLIVAN

Central to Bush's plan is giving lower-income workers a tax credit to help them buy health insurance. Sullivan portrayed that as up to $1,250 for an individual and $3,750 for a family.

But Sen. John Rockefeller, D-W.Va., said fruitful negotiations cannot be expected until the administration becomes more candid.

Only someone with about $6,750 annual income would qualify for the full tax credit, Rockefeller said.

Of the perhaps 37 million Americans who do not have insurance, only 14 million of them would qualify for the full credit, he said.

Wash. Post; 2-28-

FDA Urged to Treat Tobacco as Drug

Associated Press A8

Three prominent health organizations said yesterday that they want tobacco to be considered an addictive drug and regulated by the Food and Drug Administration.

"The health of the American people can no longer be sacrificed for the profits of the tobacco industry," the presidents of the American Heart Association, the American Lung Association and the American Cancer Society said in a letter to President Bush.

"If tobacco is to remain on the market, it should be treated for what it is, an addictive drug," said the letter, adding that cigarette smoking is responsible for more than 400,000 U.S. deaths annually.

The FDA is an agency of the Health and Human Services Department, where Secretary Louis W. Sullivan has been an outspoken critic of smoking. Department officials had no comment about the call for FDA regulation.

President Bush's Comprehensive Health Reform Program

To deal with the shortcomings of the current U.S. health care system, President Bush has proposed a comprehensive reform package that would offer tax credits and deductions to low- and middle-income Americans to purchase private insurance, reform small market insurance to ensure availability and portability of insurance, allow creation of Health Insurance Networks to allow small businesses and nonprofit organizations to pool their purchasing power, reduce administrative costs, and control the growth of government health programs. Combined, the proposals would build on the strengths of the present private/public system and preserve consumer choice and free market discipline.

By Louis W. Sullivan

The oft-repeated statistics documenting the concerns about the U.S. health care system have by now seeped into the national consciousness. About 13 percent of the gross domestic product (GDP) is spent on health care, and this figure is projected to reach 16 percent by the year 2000. Neither individual Americans nor the national economy can support the current growth rate of the health care system. Although the U.S. spends far more on health care than any other nation, 13 percent of Americans — 34.7 million people — do not have access to health insurance. While there is broad agreement on the issues facing the health care system, there is no consensus on the type of approach needed to address them.

The current focus on the problems in the health care system has led many people to overlook the system's tremendous strengths: the vast majority of Americans receive high quality, state-of-the-art medical care; Americans generally can choose their physicians and hospitals; and market incentives promote innovation in biomedical research and health care delivery. Rather than radically alter the system through greater government regulation, President Bush proposes a comprehensive market-oriented approach that builds on the strengths of the health care system while attacking the problems of access to care and cost control. This market-based approach will:

1. Make health care more accessible by making health insurance more affordable;
2. Reduce the runaway costs of health care by making the health care system more efficient;
3. Cut waste and excess in the present system; and
4. Get the growth in government health programs under control.

Availability and Affordability

The President's plan gives assistance to moderate- and low-income individuals and families to purchase health insurance. A central feature of this approach is the provision of tax credits and deductions, enabling people to shop around for affordable health plans. By providing tax credits and deductions rather than simply enrolling uncovered individuals in public programs, people become more aware of the costs of medical care, gain an incentive to seek the best buys in health insurance, and are free to exercise choice over the type of health care coverage they will receive.

When the plan is fully implemented, families with incomes below the tax filing threshold, approximately the poverty line, would receive a credit of up to $3,750, sufficient to purchase basic health benefits. Similarly, individuals would receive $1,250 and two-person families $2,500. Eligible individuals, married couples, or families with incomes above the tax threshold would receive a partial credit, decreasing to 10 percent of the maximum credit amount at 150 percent of the tax threshold. Those with annual incomes between 150 percent of the

Louis W. Sullivan, MD, is Secretary for the U.S. Department of Health and Human Services.

tax interest and $50,000 for joint, and $30,000 for individuals, two-person families or larger families respectively. A family receive the greater of the minimum credit or the deduction. Up to $3,750.

Insurance Reforms

Significant reforms in the health insurance market would accompany the tax credits and deductions in the President's proposal. First, states would have to ensure the availability of basic health insurance packages, the value of which could not exceed the maximum tax credit. The "basic" insurance package, as defined by each state, could be provided by any certified health insurer. If no insurers offer the "basic" insurance package, the state insurance commissioner could mandate that two or more health insurers with large shares of the state health insurance market offer "basic" plans.

The President's plan would encourage the creation of insurance networks that would allow small firms to pool their purchasing power

Second, the plan would correct some distortions in the health insurance market caused by health insurers' practice of risk selection in which health insurers use medical information such as preexisting medical conditions to avoid high-risk individuals and groups. Risk selection enables health insurers to gain a premium cost advantage over health plans insuring individuals who are, on average, less healthy. The proposed reform program would decrease risk selection through the creation of two broad risk pools in each state — one for small groups and the other for people receiving health insurance tax credits. With the establishment of risk pools, insurers covering a less healthy population on average could receive a net transfer from a risk pool, while insurers with healthier than average populations would have to pay into the risk pool.

Until risk pools were established, the plan would create "premium bands," which would place limits on the difference that an insurer can charge to groups with different health risks. The premium bands would not affect premium variations between insurers and would eventually be eliminated.

Third, small businesses, which employ a large proportion of the uninsured, often have difficulty providing insurance because of high marketing and overhead costs associated with their policies and the unstable risk pool of a small business which encourages risk selection. The President's plan would encourage the creation of Health Insurance Networks (HINs), nonprofit voluntary organizations in which small businesses pool their purchasing power to gain the same cost advantages as larger businesses. The plan would extend the Employee Retirement Income Security Act (ERISA), which covers self-insuring employers, to HINs. This would exempt HINs from some state laws that increase insurance costs by mandating premium taxes or mandating coverage of costly services in insurance packages.

Fourth, the market would be reformed to assure the availability, portability, and security of noncancelable health insurance coverage. By state mandates, insurers would have to accept all employees of every employer who applies for coverage, providing coverage to all individuals in the applying employer groups. Importantly, health insurers no longer could deny an individual in an applicant group health coverage based on health status. If an insurer provides policies to individuals receiving tax credits, no one receiving tax credits can be denied coverage. Except in cases of fraud, misrepresentation, or nonpayment of premiums, health insurers would have to renew coverage for a group.

Moreover, under the proposal, workers would no longer have to fear "job lock," the possibility of losing coverage due to their own or a family member's preexisting condition when they changed jobs. Neither an individual nor family members of an individual changing jobs could be denied coverage on the basis of a preexisting coverage exclusion. Finally, colleges and universities would have to extend health insurance plans of new graduates and other students for six months after they have left the institution.

These reforms would bring about significant improvement in the structure, breadth, and affordability of health care insurance. These small group reforms could decrease pre-

miums up to an estimated 2 percent for almost 70 million workers and their dependents. Overall, through small group reforms and the tax credits and deductions, nearly 95 million individuals would benefit directly from the Administration's plan. Five years after the program is adopted, approximately 24 million Americans are estimated to become newly covered because of tax credits and deductions. While five million would become newly covered due to reduction of premium costs from health insurance market reforms.

Controlling Costs

If the President's plan is enacted, total health expenditures could be cut by an estimated 5 to 14 percent by 1997. Improved market efficiency would be responsible for a significant part of this cost control. One way that the health market's efficiency would be increased is through the plan's emphasis on promoting coordinated care. Coordinated care systems include case management, preferred provider organizations (PPOs), point of service systems (POSs), and health maintenance organizations (HMOs).

In a POS, beneficiaries choose a primary care physician who makes referrals, as medically necessary, to specialists who are part of the POS network. Many studies have shown that effective coordinated care arrangements are less costly than traditional fee-for-service systems. Throughout the 1980s, there has been a trend in the private sector toward such efficient and medically necessary coordinated care. In 1980 only 2 percent of workers in medium or large firms were in coordinated care health plans; by 1989 participation was nearly 27 percent. Competing coordinated care plans have incentives to maintain quality and competitive prices. Growth in coordinated health care plans, encouraged by the President's plan, will increase competition among health plans, thereby enhancing their incentives to improve quality and control prices.

Within five years, states would develop comparative provider-specific outcomes and quality data for consumers and purchasers on cost and quality.

The President's plan would also promote consumer knowledge and, as users act on that knowledge, lead to enhanced market efficiency. All employers would provide their employees with information, prepared by the relevant state's insurance commissioner, comparing the basic insurance plans offered in the states and their costs. The plan also would promote greater investment in medical outcomes research and related areas so that states could develop appropriate information and information dissemination mechanisms. Within five years, states would develop comparative provider-specific outcomes and quality data for purchasers and consumers on both cost and quality.

Cutting Waste and Excess

One target for cost control is excess administrative costs, which would be reduced in a number of ways under the plan. The creation of HINs would contribute to reductions in administrative costs faced by small businesses purchasing health insurance plans. Currently, the administrative burdens borne by small companies significantly exceed those of larger employers. [illegible] Aggregating multiple small companies together in HINs would significantly reduce the current differential between large and small employer groups.

Another initiative is the development of electronic claims processing, designed to assure availability of patient insurance information to providers at the point of service. Paperwork for providers, consumers, and insurers would be reduced through streamlining the billing process.

A second target for cost cutting is wasted resources now devoted to "defensive medicine" and medical liability insurance. Malpractice premiums have increased from $2.7 billion in 1984 to $5.6 billion in 1989. Defensive medicine accounts for $15 billion to $20 billion of health care spending annually. The President's plan would encourage the states to implement a number of effective and tested malpractice reforms: placing caps on the allowable noneconomic damages; eliminating joint and several liability for noneconomic damages; eliminating the collateral source rule that allows for double-recovery; requiring structured payments for malpractice awards as opposed to lump sum payments; promoting pretrial alternative dispute resolution to encourage reasonable settlements; and implementing procedures to enhance the quality of care.

The President's proposal would expand access to primary care and prevention promoting thereby both more effective and cost-efficient medical care. For example, the President's fiscal 1993 budget proposes to increase funding for the National Health Service Corps, a program providing physicians to underserved areas, by 19 percent to $120 million. Additionally, funding for Community and Migrant Health Care cen-

ters will increase substantially in combination with the President's other reforms. Preventive care also is promoted by the President's budget, which proposes increased funding for child immunization services, infant mortality prevention, and a lead poisoning prevention initiative.

Controlling Growth

From 1980 to 1993, federal Medicaid spending will have grown from $14 billion to $84 billion, while Medicare spending will have soared from $34 billion to about $131 billion. At present rates of growth, Medicare could be more than one-quarter of the entire federal budget.

States would have to ask the federal government for waivers to have fee-for-service Medicaid plans.

The President's plan proposes several elements designed to control the growth in Medicare and Medicaid while maintaining quality. In an effort to promote more prudent public spending, the proposal calls for increased use of coordinated care. Only 3 percent of Medicare beneficiaries and 10 percent of Medicaid recipients were in coordinated care systems in 1991. To promote coordinated care, the plan would increase the level of payments to HMOs with risk contracts and change federal Medicaid participation from open-ended cost-based reimbursement to prospectively determined per capita payment. This would promote efficiency in the Medicaid program.

The per capita payment would be based on total per capita costs for the acute care portion of Medicaid in a state in 1992, and the per capita costs would be indexed annually for general inflation plus an additional amount for medical cost inflation. The plan would eliminate anti-coordinated care laws such as restrictions on reimbursement rates and some restrictions on financial arrangements for coordinated care. States would have to ask the federal government for waivers to have fee-for-service Medicaid plans, instead of the current reverse practice of applying for waivers to develop coordinated care Medicaid plans.

The plan would preserve the flexibility of state approaches. A state could maintain existing Medicaid eligibility and benefit levels while shifting enrollment into coordinated care programs. Under this approach, the new transferrable tax credit system would operate separately from the existing Medicaid program, though states would play an important role in qualifying individuals for the tax credit. Alternatively, a state could combine its existing Medicaid programs with the new health insurance credit system to develop a new universal access program covering all state residents with incomes below poverty. Under this approach, a state could operate a single public insurance program or could provide credits for purchase of private coverage.

Alternative Approaches

A number of health care reform plans have been proposed as solutions to the cost and access problems of the health care system. In addition to the President's plan, two major proposals dominate the debate over health care reform. The first, national health insurance, is based on the Canadian model and calls for the government to serve as the sole insurer for all Americans. The second, termed "play-or-pay," mandates that employers provide health insurance for its workers or pay a payroll tax to fund a government health plan to insure uncovered employees.

While these plans are often presented as simple cure-alls for the nation's health care ailments, both would cause significant problems for the health care system. The President rejects the Canadian model because it would result in new taxes, waiting lines for surgery, restricted access to advanced technology, and government rationing of care. Likewise, the President rejects "play-or-pay" because, if adequately funded, it would increase unemployment and lower wages as employers tried to meet the cost of the mandates and, if underfunded, would soon degenerate into national health insurance.

Summary

The recent unveiling of the President's plan has contributed greatly to the debate over solutions to the access and cost control problems of the present health care system. At the center of the debate is the question of which direction our health care system should go. Rather than unwisely relying on greater government regulation and control of the health care system, the President's plan builds on the strengths of the present private/public system and offers the opportunity for Americans to have the security of health care coverage and to receive care in a more efficient health care market.

While government action is needed to solve some specific problems, consumer choice and free market discipline should remain the bases of our health care system.

Arguments/Themes

[Defensive]

Theirs	Ours
Access	Cost
Comprehensive plan	No proof any comprehensive plan would work
	Cost containment elements are a figment
Universal access	Universal insurance isn't universal access
	Lists of problmes universal insurance won't solve[1]
Importance of expanding access	Effects on quality if they try to do it in a "budget neutral" way
Budgeting to control costs	Budgeting means not getting the health care you expect.

---

[1]Underserved areas; personal responsibility to seek care -- the example of immunization; class/race differences that affect provider willingness to serve -- TN Medicaid study

[Offensive]

Ours	Theirs
Costs are rising rapidly	Universal budgeting
Lack of solutions on cost	
Results	How much we spend
Value: our system is the most expensive in the world. Do we get what we pay for?	We need to make consumption of health care more equitable between the insured and uninsured
Unaffordability of insurance	Require employers to provide insurance
Adverse effects on small employers (including non-profit) - # of jobs we'll send to Mexico	Social equity; those who work for small employers shouldn't be worse off
Horizontal inequities: - For low income people: Paternalism in forcing people to consume health care -- irony of health insurance card for the homeless - Public budget: rising health costs crowds out other public purposes (e.g., governors, Medicaid, and education)	Health care is society's highest priority
Exploding costs of current public programs	Spend our way out of our problems. We're Democrats -- we spend -- its up to Republicans to come up with solutions
Need for market forces to play a greater role if costs are to be contained	Global budgeting
Lack of competition among providers	
Points of light	Providers should be paid for serving everyone; health care is a business, not a charity

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Facts

Theirs	Ours
31 million uninsured	• Only 4.1% chronically (28+ mos) uninsured • 50% of the times someone loses insurance they regain it within four months
"uninsured"	• Uninsured doesn't mean without health care; uninsured consume 70% of the level of the insured • This amount -- $1400 [ck] per year. This is not some "wholly unacceptable" amount, its the amount the average Brit, covered by national health insurance, consumes. • The burden should be on the system to tell us how we can get more for the amount already being spent

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THE WHITE HOUSE
Washington

DATE: 3/26/92

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PERSPECTIVE

Editorials

Be ready to stress the positive

With the 1992 political spotlight on healthcare, those who manage hospitals have an extraordinary opportunity to help the public understand and accept reform of the system.

But there's another side of the coin. For not only will the public be bombarded with information about skyrocketing medical costs and the plight of the uninsured, it also will hear strong voices addressing the fraud and waste that permeates healthcare.

As costs escalate and as reform efforts develop, more scathing exposes, such as Walt Bogdanich's *The Great White Lie: How America's Hospitals Betray Our Trust and Endanger Our Lives* and the Feb. 24 issue of *U.S. News and World Report* on healthcare fraud, are bound to surface.

Consider that *U.S. News* estimates healthcare fraud and abuse cost somewhere between $50 billion and $80 billion each year, "a figure that dwarfs the estimated $5 billion lost through criminal fraud in the entire savings and loan debacle."

Hospital managers, even those who believe their institutions are not engaging in any shady, price-gouging activity, shouldn't ignore such attacks on the industry. Instead, administrators should use the lingering stain of bad publicity to explain how their hospitals control costs and police fraud. Hospitals that measure clinical quality should identify areas in which they excel. The information can then be shared with local news organizations and such constituent groups as employees, the medical staff and governing board.

Ignoring and avoiding bad news or unpleasant questions can produce more damage than taking an unpopular stand. However, that doesn't mean individual healthcare managers have the sole responsibility of defending the entire system.

To its credit, the American Hospital Assn. decided to issue a public relations advisory on Mr. Bogdanich's book and warned hospitals to take the charges seriously (See related story, p. 40). But it also suggests that administrators welcome scrutiny of hospital performance. Developing a communications and education strategy also will help the staff and the board understand the necessity of providing safe and effective care.

Clark W. Bell
Editor

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FAX TRANSMISSION

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Seen p. 4

Comments on President Bush's Comprehensive Health Reform Proposal

Kenneth E. Thorpe
Department of Health Policy and Administration
University of North Carolina at Chapel Hill

The President's plan is designed to guarantee access to health care among the poor, and help finance the cost of coverage for the middle class. Various proposals, such as shifting toward coordinate care, are designed to reduce the cost of insurance and health care. The analysis presented below examines the likely effect of the President's proposal on reducing the number of uninsured, and reducing health care spending.

1. At most, the President's plan would reduce the number of uninsured by at most 17 million. A more likely estimate is closer to 9 million.

Under the President's proposal, the poor would receive transferable credits ranging from $1250 to $3750 depending on family structure. Those living in poverty could use these dollars either to purchase benefit packages developed by each state, or purchase a more traditional, comprehensive package. Both surveys, and revealed preferences, indicate the currently uninsured are unlikely to purchase less comprehensive benefit packages, even when heavily subsidized. A recent survey in Massachusetts found that 7 percent of the uninsured would purchase a basic (i.e. 20 percent copayment, $500 deductible) even with a heavily subsidized price.[1] Many states have already introduced innovative, and less comprehensive, insurance products to entice uninsured individuals to purchase coverage. These products have enrolled few subscribers, and have done little to reduce the number of uninsured.[2] In light of the survey data, and actual behavior, few of the uninsured are likely to actually enroll in less comprehensive plans.

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[1]Robert Blendon, Karen Donelan, Carol Lukas, Kenneth E. Thorpe, Martin Frankel, Ronald Bass, Humphrey Taylor, "The Uninsured and the Debate Over the Repeal of the Massachusetts Universal Health Care Law", Journal of the American Medical Association, 267 (8) February 26, 1992:1113-17.

[2] Families USA Foundation, Barebones Coverage, Health Insurance That Doesn't Insure, Washington DC, June 1991.

The uninsured are, however, more likely to purchase comprehensive plans. The same Massachusetts survey found that 56 percent of the uninsured would purchase a conventional package with a steep subsidy (i.e. The subsidy totaled 70 percent of the cost of a comprehensive package). Numerous empirical studies estimating the price sensitivity of individuals to reductions in the price of insurance have also been completed.[3] These studies estimate as a best guess that the price elasticity of demand for insurance is around -0.6; thus a 10 percent reduction in price would increase the number of individuals purchasing insurance by 6 percent. Applying both the survey and empirical data to the President's tax subsidies yields the following estimates concerning the number of individuals likely to purchase insurance (see Table 1). Nationally, the price of a comprehensive package costs $2100 per year (unpublished data, House Ways and Means, Health Subcommittee). The individual voucher would cover 59 percent the cost of comprehensive care. As our survey results, and market behavior, reveal that few would actually enroll in less comprehensive programs, the estimates below project the number enrolling in a comprehensive plan.

Table 1. Currently Uninsured and Potential Number of Newly Covered (millions)

% "Adjusted" Poverty	Uninsured	Voucher Value individual	Newly Covered
100	15.4	$1250	5.5
150	5.7	$ 125	1.7
150+	13.6	varies*	2.0
TOTAL	34.7		9.2 million

* The estimates are based on an individual making $35,000 per year (family of four) who can deduct $3750; resulting in a cash benefit of $1050 (a 25 percent subsidy for a family plan). The 150 percent category assumes a $625 (individual) and $1875 (family) tax credit.

Assuming individuals are interested in comprehensive plans, only 7.3 million individuals are likely to purchase such coverage. Even if one assumes that all low income individuals would purchase less comprehesive plans--clearly an upper estimate--only 17.2 million

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[3]See Frank Sloan and Killard Adamache, "Taxation and the Growth of Nonwage Compensation" Public Finance Quarterly 14 (2) April 1986:115-137 or Howard Chernick, Martin Holmer and Daniel Weinberg, "Tax Policy toward health insurance and the demand for medical services" Journal of Health Economics 6 (1) 1987:1-26 for examples.

individuals would receive coverage; some comprehensive with the poor receiving less comprehensive plans.

2. The benefits of the program are not directed toward the poor.

As the tax benefits flow to all individuals up to $80,000 income, the dollar benefits flow to families at 5 and 6 times the poverty line (see Table 2). The President's plan is contrasted with the National Leadership Coalition Plan, which fully subsidizes health care for the poor, and limits contributions to 3 percent of annual income among those earning 100 to 200 percent of poverty. For ease of comparison, I examine a married, joint filer, family of four that can purchase insurance for $3750.

Table 2. Federal Tax Subsidies Under President's Plan and National Leadership Coalition Plan

	President's Plan		National Leadership Coalition	
Income	Federal Subsidy	What Family Pays for Ins.	Federal Subsidy	What Family Pays
10,000	$3750	0	3750	0
17,000	$ 570	$3180	3240c	510
20,000	$ 562	$3188	3150	600
30,000	$562	$3188	0	750**
35,000	$1050	$2700	0	750
35,000*a	$210	$540	0	750
50,000*	$210	$540	0	750
60,000*	$210	$540	0	750
80,000*	$210	$540	0	750

* Currently insured through group plan.
** Employed
a. Assumes employer contributes $3000; employer $750. Since employee can deduct $750, a $210 benefit, the employee receives health care for $540 ($750-210). Subsidy figures do not include current tax expenditure related to employer-provided health insurance contributions.

b. National Leadership Coalition plan assumes all workers receive coverage through the workplace, with 80 percent of the premium financed by the employer.

c. Actual subsidy depends on extent of employer contribution. If the cost of insurance is $3750, the employer's contribution is limited to 3% of $17,000 ($510). If the employer makes a 7 percent of payroll contribution (assuming the firm wide average wage was $17,000, the employer would contribute $1190, and the federal subsidy in this case would total $2,050.

As displayed in Table 2, the President's plan distributes federal tax benefits across a broader spectrum of wage earners than the National Leadership Coalition plan. Unlike the coalition plan, which concentrates benefits entirely among those under 200 percent of poverty, the President's plan is relatively regressive. For instance, the value of the deduction is worth $562 for a family of 4 earning $30,000 (in the 15 percent marginal tax bracket) yet is worth $1,050 for the family earning $35,000 (in the 28 percent bracket, in 1991). The proposal also subsidized premiums paid by higher income workers, reducing their effective contribution from 20 percent to 14.4 percent.

3. The Tax Deduction Provides Incentives for Employers To Reduce Their Health Benefit Contributions. This Shifts Costs To The Federal Government, Increasing The Cost of the Program.

Under the proposal, all families with incomes below $80,000 per year may deduct the difference between an employer's contribution for health insurance and $3,750. On average, an employer typically finances 80 percent of an employee's health insurance premium; approximately $3,000 per year. Employees may deduct $750, a cash value of $113 for families earning under $35,000 and $210 for families with incomes between $35,000 and $80,000. The tax deduction provides clear incentives for employers to reduce their contribution for health insurance. As is illustrated below, reductions in employer contributions will make both the employer and employee better off, shifting increasing portions of health insurance premiums to the federal government and taxpayers.

Knowing the value of the deduction to the employee, suppose the employer reduces his contribution by a modest amount, say $210 (the cash value of the tax deduction under the proposal) (See Table 3). The employer now pays $2,790, rather than $3,000.

Table 3 Gaming the System: The Erosion of Employer-Sponsored Health Insurance

	Current Policy	President's Plan
Employer Pays	$3000	$2838*
Employee Pays	$ 750	$ 691**
Federal Government Pays	$ 0	$221

* Net of employer contribution and new corporate tax liability.
** Net of employee contribution and tax subsidy.

Federal figure does not include tax expenditure related to employer-sponsored fringe benefits.

This allows the employee to deduct $960, a cash value of $269 for a family earning $80,000 per year. With the deduction, the employee's cost of health insurance falls from $750 per year to $691 per year ($960-$269). However, the reduction in the employer's contribution would, in the short run, also reduce his costs, likely increasing net income and his corporate income tax liability. Assuming an average marginal corporate tax rate of 23 percent, this would increase his costs by (.23 times $210) $48. It also increases federal tax revenue by $48, but the employee deduction increases federal spending by $269; for a net new taxpayer expense of $221. This simple example reveals the clear and perverse incentives for employees to reduce their contributions, reducing spending on health care and shifting an increasing amount of costs to federal taxpayers.

4. The President's Plan Will Do Little To Contain Costs, and Will Promote Additional Cost Shifting/Price Discrimination/Payment Differentials in the Health Care Market.

The proposal relies largely on coordinated care to achieve reductions in health spending over time. Currently, 27 percent of the workforce, 3 percent of Medicare beneficiaries and 10 percent of Medicaid enrollees are in managed care arrangements (either an HMO, Preferred Provider Arrangement or a Point of Service Managed Care Plan). Empirical analyses have documented cost reductions associated with these plans. In the Medicaid population, recent evaluations indicate that coordinate care within the Medicaid program reduces spending per enrollee by 5 to 10 percent.[4]

[4]D. Freund et al. "Evaluation of the Medicaid Competition Demonstrations" Health Care Financing Review 11 (2) Winter 1989: 81-97 Winter 1989.

Evaluations of point of service plans in the private sector have found similar reductions in spending.[5]

The literature is quite clear on managed care; relative to "unmanaged" care it reduces spending. However, the literature also notes that these savings are one-time effects, with premiums in managed care plans increasing at the same rates found in conventional plans.[6] Recent data from the Health Insurance Association of America provide additional evidence that premium growth in conventional plans and managed care plans are rising at similar rates.[7]Thus, reliance on managed care seems unlikely to alter significantly the growth in federal spending.

Even if managed care within the Medicare program did reduce spending, such reductions would appear simply to increase cost shifting. Even with reductions in uncompensated care, pressure on private payers to finance the difference between Medicare payments are costs will escalate. Data from PROPAC highlight the growing difference between per case Medicare payments and costs; with the difference largely and increasingly financed by private payers.

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[5]R. Goetzel, K. Thorpe, et al. "Measuring the Effectiveness of a Point of Service Managed Care Program: The Southwestern Bell Corporation Study" Journal of Health Care Benefits, forthcoming 1992.

[6]Joseph P. Newhouse, W. B. Schwartz, A. P. Williams and C. Witsberger, "Are Fee-for-Service Costs Increasing Faster than HMO Costs? Medical Care 23 (8) 1985:960-966.

[7] Elizabeth Hoy, Richard Curtis, Thomas Rice "Change and Growth in Managed Care" Health Affairs, Winter 1991:18-36.

FILE

Letter: From President Bush

N.Y. Times; 8-2-92

Market-Based Health Reform Is Best

To the Editor:

As the people of this country seek reform in health care, it is reassuring to see The New York Times's editorials confirm what many already know: that market-based reforms are the best way to make radical changes in the health care system. Old-fashioned models for health care reform, including Canadian-style systems or greater taxes — direct or indirect — on today's job-producing small businesses, provide no real answers for the future.

The proposals my Administration released earlier this year include many of the elements referred to in your series of editorials. I believe we must preserve the best in today's health care system — high quality and choice — while reducing the costs and providing access to health care for all Americans. The only way to reform our system capable of accommodating the changes of the coming decades is through radical changes in the delivery of private health coverage. The proposals advanced in my program will generate this restructuring — the "managed competition" you have so heartily endorsed.

Added to the voices of millions who believe market-based reforms are indeed the best hope for real change, your voice has already enhanced the prospects for enacting these proposals. If the nation stays focused on this urgent goal — access for all in a restructured competitive health care system — we can quickly make health care reform a reality. I look forward to working with the American people to urge Congress to solve our very real health care financing problems by enacting market-based reform legislation.

GEORGE BUSH
President

Washington, July 31, 1992

N.Y. Times; 8-2-92

The Guts to Reform Health Care

Liberal Congressman Ron Wyden of Oregon is for it. The Conservative Democratic Forum is for it. So too is President Bush and, according to some advisers, Bill Clinton. *It* is "managed competition," the best plan to reform health insurance and the only one with a chance to become law.

Yet it's way too early to rejoice. Politicians say they're for managed competition, but most — including the candidates — have yet to face up to harsh realities. Patients will find their choice of physicians restricted; taxpayers will have to make do with smaller health care deductions.

President Bush — despite his hosannas to the plan in the letter below — hasn't given voters that message. Neither has Bill Clinton, who so far has offered little more than vague pieties. Until they do, talk of reform will remain empty rhetoric.

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The fight over health care reform requires two key decisions. Will the plan provide universal, therefore expensive, coverage? And will health costs be controlled by government fiat or by tightly structured markets, the essence of managed competition?

Until recently, many Democratic leaders leaned toward price controls. What was needed, they said, was a preset cap on total health expenditures that would be enforced by setting prices for every doctor, every hospital.

What many have come to understand is that managed competition offers a better answer. Under this system, consumers would be combined into large groups and represented by sophisticated sponsors. The sponsors would negotiate with doctors and hospitals, forcing them to provide high-quality treatment at reasonable cost.

Sponsors would pay providers a fixed fee for each patient, independent of how much care the patient turned out to need, thus encouraging doctors to keep patients healthy and provide the most efficient care when they are sick. This is the method health maintenance organizations already use to control costs.

But Congress can't encourage the use of managed competition unless it tightens the tax code. Consumers won't choose sponsored plans as long as they are allowed, as under current law, to deduct the full cost of wasteful plans. Congress must limit tax deductions to the cost of well-managed sponsored plans; it must disallow higher deductions for wasteful plans.

Mr. Bush understood all this when he announced the outlines of his plan in February. His plan was smart, in places ingenious, and consistent with managed competition. But when it came to the two key decisions, Mr. Bush punted. He failed to propose universal coverage. And he didn't limit tax deductions. Mr. Clinton has also evaded tough choices. He's for universal coverage, but doesn't say how to pay for it or how to contain health care costs.

An optimist can be glad that consensus is at hand. But realists worry that there's no one with the guts to make reform happen.

REVIEW & OUTLOOK

GATT Riddance?

We were sorry to see it happen, but the collapse of the trade talks does finally clear the air on free trade. Perhaps we can even start to understand that the best policy for a nation is to pursue free trade not multilaterally or bilaterally, but unilaterally.

Why, after all, shouldn't American consumers have access to the cheapest goods anywhere in the world? Why wouldn't buying the cheapest products be a benefit in international competition? The Europeans broke up the Uruguay round by refusing to cut their agricultural subsidies. If they want to tax themselves in order to sell food below its replacement cost, why should we bar such gifts at our borders? Instead of threatening to ban subsidized products, we ought to threaten to buy more of them.

These are heretical suggestions, we recognize. And they are not likely to be popular with American farmers or others who have to compete with subsidized imports. Those threatened by imports might have to find other outlets for their labor and capital, but society in general would grow richer at the expense of European taxpayers. In the end, tariffs and other trade barriers are not a tax on foreigners, but a tax on American consumers.

These heretical truths have often been obscured, ironically, by the General Agreement on Tariffs and Trade. This estimable organization did do much to open markets, providing an international cover for politicians of various nations to do the right thing. But its most savvy critics recognize that GATT has always had its own protectionist tilt: The more barriers I have to trade away, the more I can brag about besting the furriners in negotiation. We won't give up the barriers that make us poorer unless you give up the barriers that make you poorer.

Because the Europeans refused to stop subsidizing their farmers, for example, we now can't stop subsidizing our farmers. The much-ballyhooed federal budget agreement counted on billions of dollars in savings in U.S. farm subsidies, but linked these cuts to GATT cutting world-wide subsidies. So domestic spending cuts in the budget are already vanishing; Dick Darman, call your office.

The apparent death of multilateral negotiations ought to increase odds that some country, preferably the United States, will see the advantages of lowering its trade barriers regardless of reciprocity. While it now sounds heretical, unilateral free trade has at times been practiced to great advantage. There is even a current example, in the plethora of attractively priced goods available in the free port of Hong Kong.

The best test of unilateral free trade, however, occurred in 19th-century Britain. Repeal of the Corn Laws replaced potato famines with decades of economic growth. Removing trade barriers caused dislocations in certain industries, but Britain thrived. Interestingly, imports soared but so did exports from Britain when other countries had to lower *their* trade barriers to compete in world markets with low-cost British producers.

"During the last 60 years we have indulged in no tariff wars; we have fallen back on no elaborate devices, or shrewdly, too shrewdly, calculated plans for negotiation or retaliation," Winston Churchill said at the time, "but yet we find that our goods enter all the other countries of the world on as good terms as have ever been secured by any nation through the most elaborate of fiscal weapons."

An early owner of this newspaper, C.W. Barron, made similar observations. Just after World War I, he wrote that England "will buy of anybody, anywhere, that will sell her better goods, or give her lower prices," Barron wrote. "If Germany wished to dump her bounty-fed beet sugar in the English market, closing the English sugar refineries, she was welcome. England would take the German sugar and make marmalade and it is because of this German bounty-fed beet sugar that Tommy in the trenches had to be fed up with marmalade."

The decades since developed countries abandoned unilateral free trade have taught some important lessons, including most importantly that trade wars do not free trade. Everyone also understands that interdependent economies require open trading, a truth more compelling in the threat of world-wide recession. The question now is which country will be the first to embrace unilateral free trade and reap its considerable rewards.

Canadians Cross Border to Save Their Lives

By JOHN A. BARNES

WINDSOR, Ontario—Four days before Christmas 1989, William Byng, a 50-year-old retired teacher in this city of nearly 200,000 just across the river from Detroit, suffered a major heart attack. After two weeks in the hospital, during which he says few internal tests were performed, he was prescribed some medication and simply sent home.

"I asked if they shouldn't look more closely. My doctor just said, 'Look, don't even talk to me about bypasses or anything like that,' " Mr. Byng says.

By chance, Mr. Byng's daughter happened to mention her father's plight to another doctor. He told her to call a man named Michael Billett at something called Heartbeat Windsor, a private, voluntary organization founded in 1989 that has helped nearly 400 wait-listed Canadian heart patients obtain critically needed surgery in the U.S. Some Canadians, recalling the days when runaway American slaves were smuggled to Canada, call it their "reverse underground railroad" to health care.

Within days of his daughter's call, Mr. Byng was being examined by cardiologists at Harper Hospital in Detroit. They recommended a triple bypass without delay. Mr. Byng had his operation on Feb. 19 of this year.

"Had I not met the right people at the right place at the right time, I would not be here," he says now. "I have nothing but praise for the American health-care system. The Canadian doctors mean well, but we simply don't have the resources."

William Byng's experience with the "free" Canadian health system is far from atypical.

"American doctors and politicians come up here expecting to find a health-care paradise," says Mr. Billett, a bearded 37-year-old, seated at his desk in an austere office on a Windsor backstreet. "But you can't hold yourself up as the best health-care system in the world when people are simply being sent home to die."

Established nationwide in 1971 (although some provinces had their own health-care systems earlier), the Canadian system is supposed to guarantee equal access to health care, at no direct cost to the citizen, with any practitioner the patient chooses. The system is "single-tiered"—private insurance does not exist. Except for a handful of physicians who eschew government payments and deal with their patients in cash, one cannot pay a Canadian doctor to ensure faster treatment.

As a result of this system, Canadians are not shy about consulting their physicians. Most statistics show Canadians to be among the healthiest people in the world. (The absence of a large urban underclass might skew the figures.) Canadians sensitive to comparisons with their southern neighbor routinely cite their health-care system as an aspect of life superior to that of the U.S. Most polls show overwhelming popular support for it.

Will

By DANIEL HEN

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Last Hurrah

"Stay strong," Governor Mario Cuomo beseeched a crowd supporting the violence-tinged strike against the New York Daily News. "You're fighting for all of us."

The governor, we keep reading, is the current front-runner for the next Democratic presidential nomination, so his views on labor policy must be of some moment. He says the federal law permitting employers to replace striking workers "must be changed." He said, "we need to establish a balance in this country between the people who work and the people who invest and manage."

Mr. Cuomo was not alone. Legislation to outlaw hiring anyone else to take jobs vacated by strikers has already been introduced by Senator Howard ("Finder's Fee") Metzenbaum, who visited New York yesterday to take testimony on his brainstorm. New York's top Catholic, John Cardinal O'Connor, appeared at both the rally and the hearing to testify that hiring workers violates one or another of the Ten Commandments. Jesse Jackson singsonged, "They talk about violence—but busting workers is violence; using the homeless to take jobs is violence; refusing to be fair is violence."

None of these worthies seemed much to notice the elephant in the room—that the decisive element in the strike is that the Daily News can't distribute; newsstand dealers have seen enough violence and threats that they're afraid to sell it. The New York Times reported the other day that one of its clerks was roughed up buying copies of the News for its newsroom to check.

The Tribune Co. board met yesterday in Chicago, and decided to keep the paper open, but we'll see. The outcome of this strike may give us a good indication of where a President Cuomo would lead the nation.

Congress Confesses

Ever since the HUD scandal hit the front pages last year, we have pointed out there were *two* scandals. The one seized on by the media concerned "influence peddling" under former Secretary Sam Pierce. The other, a more silent scandal, involved Congress' routine misuse of HUD money for local pork-barrel projects, something the Members insist on calling "constituent service." Now, even Congress has fessed up to the double standard and called for an end to all political influence in housing policy.

As soon as the HUD scandal discredited the agency last year, Congress seized the opportunity to add 40 projects to HUD's "discretionary fund," projects for which HUD had no paperwork and that had not been the subject of any congressional hearings. The projects were inserted in closed-door committee meetings where no minutes were taken. Four of the projects were in the home district of Rep. Bob Traxler of Michigan, the chairman of the House subcommittee that writes HUD spending bills.

HUD Secretary Jack Kemp branded the earmarking "disgraceful," and even threatened not to spend the money. But this year Congress' HUD Pork Barrel got even deeper. Sixty-one projects—a 52% increase—were added to the housing bill to reward individual Members of Congress.

This was finally too blatant for the House Government Operations Committee, which has been investigating HUD for 16 months. The committee, chaired by Rep. Tom Lantos (D-Calif.), issued a report last month that understandably criticizes Secretary Pierce for mismanagement and favoritism, although the worst abuses were in programs Congress had insisted on keeping alive over his objections. However, in a rare move the committee placed some of the blame for the mess at HUD on Congress. "There is a need to take politics and discretion out of housing programs," it said. "This applies equally to the executive and legislative branches."

Noting that Congress frequently authorizes housing projects outside of normal HUD or congressional channels, the committee concluded: "Just as it was wrong for HUD under Secretary Pierce to dole out housing units and grants to former HUD officials and the politically well-connected . . . so too Congress should not earmark funding for housing projects."

Of course, one critical report doesn't even begin to end the double standard that exists between executive branch favoritism and Congress' constituent service. Aside from seeing whether the remark has any effect on HUD bills, we now need similiar comments about congresspersons not intervening on behalf of individual research grants, military bases, federal procurement contracts, post offices and regulated thrift institutions. Then Congress might have time to spare for such tasks as meeting its schedule for passing a federal budget.

care system is great as long as you don't get sick," says Mr. Billet, who ran an ambulance service for many years. "If you just want a basic doctor visit, it's no problem. It's when you really need health care—a major operation—that the system breaks down."

Indeed, the grim fact is that access to major procedures is strictly rationed. Canada has 12 magnetic resonance imagers, used for diagnoses, or one for every 2.1 million people. This compares with 1,375 in the U.S., or one for every 182,000 people. In all of Canada there are only 11 facilities doing open heart surgery, compared with 793 in the U.S. Only 14 sites do organ transplants, compared with 319 in the U.S. When ratio of population is considered, the U.S. has an excess of capacity in these specialized areas, while Canada suffers a shortage. Result: waiting.

The waiting can be especially protracted if the patient is very young or verging on old age. Two-year-old Joel Bondy was slated for cardiac surgery last January in London, two hours up the highway from Windsor, because the border city has no specialized cardiac-care facility. Joel's operation was repeatedly postponed, as more critical cases were moved up. Alarmed at their son's deteriorating condition, Joel's parents got in touch with Heartbeat Windsor, which scheduled him for surgery in Detroit.

Embarrassed by media coverage of the Bondys' plight, Ontario officials informed the family that Joel could have his operation immediately—in Toronto. After Joel endured a four-hour ambulance ride, a hospital bed was not immediately available. The family had to spend the night in a hotel room. The delay was fatal. Joel Bondy died the next day, four hours before he was to enter the operating room.

And those who do cross the border can still have problems with the Canadian system. Canadian doctors refused to dispatch Monique Nadon's medical records to Cleveland, where Heartbeat Windsor had scheduled her heart surgery. "There were about 2½ weeks of angry phone calls, threats of legal action and a lot of lies about 'shipping problems,'" says her father, Patrick Nadon. Monique, now age three, was luckier than Joel Bondy: She finally had her surgery and is recovering at home.

The surgeries are paid for through a loophole in Ontario law, which states that the provincial government will compensate any doctor or hospital up to 75% of cost for operating on an Ontarian overseas. American hospitals are happy to accept the partial payment as payment in full rather than see their beds remain empty.

Mr. Billett's organization has now contracted with several Detroit hospitals to transport emergency cardiac cases directly through the tunnel, rather than force patients to endure the long trek by road or helicopter to the cardiac-care facility in London. "I just got sick of seeing people die needlessly," Mr. Billett says. "It's as simple as that."

Mr. Barnes is deputy editorial page editor of the Detroit News, where another version of this article appeared.

THE WHITE HOUSE

WASHINGTON

JULY 2, 1992

MEMORANDUM FOR GAIL WILENSKY

FROM TONY SNOW TS

SUBJECT OP-ED

Gail:

I like the op-ed very much. It hits the points we need to make and puts the onus on Democrats to get moving. Nevertheless, I'd suggest several sorts of changes. Rather than doing them and resubmitting a piece to you, I thought it might make sense to put the suggestions on paper. If they make sense to you, we'll proceed.

1) Opening:
I think it might make sense to slap readers with the choice right away. Everybody in America wants affordable, reliable, first-rate health care -- now. The good news is that we could start making their lives better tomorrow. The bad news is that we must rely on Democrats, who seem more eager to regard the issue as a political plumb, and not as a priority.

I'm sure there's a snappier way to set it up, but you get the idea: Note a) the universal desire to fix the system and b) the possibility of immediate Congressional action. After that, we can describing the ways in which we improve our present system, and prevent a Canada-style, go-to-America-if-you're-really-sick system.

We must create the proper political drama and give people a sense of the real struggle behind the scenes: Will we saddle innocent Americans with a system that has proved a failure elsewhere, or will we improve the world's best system and offer its riches to everyone in the United States?

2) Pay or play: You may need to be a little more explicit on price-setting, and explain that some Democrats want to do for health care what Richard Nixon did for inflation. I'd also suggest a personal anecdote from your HCFA days. It helps to mention your previous association, but go further.

3) Examples: Use examples to explain just what Action Now would achieve.

For instance, Job lock provisions would ensure that someone with a heart condition could switch jobs. We might even want to offer up some homily: If you're good enough to hire, you're good enough to cover. Or: Your job should not be a life or death

situation. (I know, pretty lousy: But you get the idea.)

4) Explain some technical terms: "'swipable' cards," "MediSave accounts," the importance of "Action Now."

5) Look for fun facts: As I read the piece, I wondered about a few fun facts. For instance,

Cost controls and medical costs: Is there any literature on what cost controls have done to medical costs? Can we argue that some of our noble efforts have inflated costs instead of controlling them? What, if anything, would this plan cost taxpayers and consumers? What, if anything, would it save?

Paperwork costs and savings: How much money do American companies now spend on health-care paperwork? (a good factoid for use in the swipable cards passage). How many tons of paper does this consume? Just how much would this reduce paperwork? Would it cut down on the number of bewildering forms people now must fill out if they wish to purchase a simple vial of prescription medicine? Would it eliminate those intolerable insurance lounges in hospitals, where the weary and sick await their turns to fill out forms?

Liability costs: How much of the average medical bill goes to pay liability insurance and wicked, greedy, awful, offal trial lawyers? It might be nice to note that it costs $xxxx on average to bring a baby into the world, $yyyy of which goes directly to the local lawyer.

Total costs: If we wanted to get insanely adventurous, we might even devise a pie chart that shows just where the average medical dollar goes -- the insurance company, the lawyer, the accountant, the federal government. Of each penny, how much actually goes for treatment and medication? Such a visual also could help us make the case that coverage would get cheaper right away if we cut out the overhead and got right to the patient.

Health information: How would we make health insurance information available? How would we make it comprehensible? Right now, HMOs and PPOs and even some insurance firms advertise -- about deductibles, co-pays, choice in selecting physicians, etc. What's new about our idea?

Costs of inaction: Finally, what will Americans forfeit this year if we don't act. Debaters often employ the crass and effective device of arguing that a foe's policy (or lack thereof) will cause innocent babes to die and blood to flow through the streets. Without being unduly hysterical or inaccurate, what price can we attach to Democrats' inaction?

6) Include the unkindest fact of all: We're only trying to

give the American public access to the sort of health care system that Congress has designed for itself.

I know this long roster of comments looks daunting. It's not meant to be. Indeed, with the proper factoids, we can get this thing ready to go in a couple of hours. I'd suggest trying the Washington Post this weekend (i.e., Sunday). It should be a good one for them.

Sorry I've run on so long. I hope this makes sense.

Cheers.

THE WHITE HOUSE

WASHINGTON

August 27, 1992

NOTE TO: Gail Wilensky

FROM: French Hill

SUBJECT: Our Healthcare Talking Points

Reflecting on the coverage of the President's healthcare proposal, I would volunteer the following observations:

1) Our criticisms of the opponent's plan are doing well. Please the attached article from Reader's Digest providing more fodder on Canada's failed plan.

2) Our explanation of the President's plan is less crisp and understandable.

3) Some easy, family-oriented examples on each of our points would make it much more real. We need to use less jargon, e.g. "pre-existing condition" and instead talk (as Secretary Martin did) about "the child born with the rheumatic heart."

   Some ideas:

   -- explain "health networks" as ways that real companies can bind together and lower health insurance costs. Use an example.

   -- explain how malpractice litigation raises healthcare costs, e.g. everyone can relate to the costs of having a child. So, ten years ago it cost $ X to have a baby, today it costs $ 5X. Malpractice premiums ten years ago were $ Y and today they $ 5Y. Thus, these costs are driving up your cost. Today, 80% of all obstetricians are defendants in lawsuits.

   -- In this manner plow through each of the President's key principles. They will sell more effectively.

cc: Hanns Kuttner

71ST YEAR Reader's Digest SEPTEMBER 1992

An article a day of enduring significance, in condensed permanent booklet form

Some in Congress think we can fix our problems by adopting Canada's plan. Before they vote, let's see how that system actually works

HOW NOT TO IMPROVE HEALTH CARE

BY IAN R. MUNRO, M.D.

LITTLE JOEL BONDY of Leamington, Ontario, was born with heart deformities that restricted the blood flow to his lungs. He needed open-heart surgery—soon—to live. The nearest equipped pediatric facility was the Hospital for Sick Children, four hours away in Toronto. But under Canada's national health-care system, commonly called Medicare, that hospital had closed hundreds of beds. For the remaining stripped-down services, there was a long waiting list.

After many delays, Joel's desperate parents notified administrators they were taking him to a hospital in the United States. Amid embarrassing news reports about the boy's plight, the Hospital for Sick Children gave him an early surgery date.

But it was too late. Joel Bondy died four hours before surgery was to begin. He had waited nearly two months for his operation.

Kent Maerz has keratoconus, a disease of the cornea. Last August the 22-year-old Calgary student needed a corneal transplant within a few months to correct his rapidly deteriorating vision. Under Canada's Medicare, the operation would cost his family nothing. But the wait would be two to three years.

Maerz paid his own way to get a transplant at McIntyre Eye Clinic and Surgical Center outside Seattle, Wash., in February. The travel and the operation cost Maerz's family

DR. IAN R. MUNRO is director of the Humana Craniofacial Institute at Medical City Dallas Hospital.

almost $5000. So far, the Alberta Health Care Insurance Plan has reimbursed them only $644. "If I had a choice, I wouldn't pay taxes for Medicare," says Maerz. "When I needed it, it didn't do me any good."

Today, many Americans believe the U.S. health-care system is dangerously flawed. Angered by the cost of private health insurance, which millions cannot afford, a strong majority—69 percent, according to a poll in *The Wall Street Journal*—think the United States should adopt national health insurance.

Legislation to create a system closely modeled on Canada's has 71 co-sponsors in the House of Representatives and broad union support. Sen. Paul Wellstone (D., Minn.) has introduced a similar measure in the Senate. But before Americans leap to national health care, they should look at how the Canadian plan, perhaps the purest system of national health insurance in the world, really works.

When a Canadian visits his doctor, the doctor bills the government. If the patient visits a hospital, the hospital pays for his care out of a lump sum of money the government gives it each year, and bills him nothing. That means the government pays in full for all health care—except for voluntary procedures such as face lifts—for every citizen. There is no private health care to speak of, even for the very rich.

Medicare is popular in Canada, especially among those who have not been seriously ill. After all, it appears to be totally free. In fact, it is very, very expensive.

The average Canadian already pays *46 percent* of his income in taxes. But Canada's health-care spending is growing faster than inflation, faster than its population and faster than the country's gross national product. Today, the United States has the costliest health-care system in the world. But Canada's is second, and both countries' per-person costs have been rising at the same rate for years.

With Canadian taxpayers stretched to the limit, how has Medicare responded to its runaway costs? It has not delivered the unlimited care it promises. It simply spends less, even when patients need more.

A Magnetic Resonance Imager (MRI) takes pictures to determine the shapes and positions of tumors. Tennessee, with 4.9 million people, has more MRI scanners than all of Canada, with 26.6 million people. "There's a six-month wait for an MRI," says Dr. Walter Kucharczyk of The Toronto Hospital. "Some patients suffer because of the wait."

A lithotriptor uses sound waves to smash kidney stones and gallstones. The United States has more than three times as many lithotriptors per patient as Canada. It also has about three times as many open-heart-surgery and cardiac-catheterization units.

Under Canada's national health-care system, operating rooms and surgical beds are dwindling. To

save money, Canadian hospitals routinely close additional beds and reduce surgical capacity in the summer and around Christmas.

So patients wait. In Newfoundland the average wait for a coronary-artery bypass is *one year*.

To avoid making the critically ill wait too long, patients are ranked. "Emergent" cases—like heart attacks and car accidents—require care within 24 hours. "Urgent" cases are next in importance. Patients not actually in danger are classified "elective."

But many elective patients, while not dying, are in pain. Kenneth Hill, an orthopedic surgeon in Burnaby, B.C., does hip replacements for arthritis patients. The average wait for this "elective" procedure is 27 weeks. But without surgery, some of Hill's patients cannot even get off his examining table unassisted. "They can survive on painkillers," he says. "But the quality of their lives is impaired, and some don't have many years left."

Moreover, getting classified "urgent" doesn't necessarily speed treatment. On Saturday, August 25, 1990, a CAT scan revealed a mass in Stanley Roberts's brain. If the mass was an abscess, it could kill within days.

On Monday Roberts's doctors decided he needed an "urgent" stereotactic biopsy to diagnose the mass. But the nearest equipped hospital, Vancouver General, had shut down 13 neurosurgery beds for the summer and could not take Roberts until the following Tuesday—eight days later. With Roberts visibly deteriorating, his desperate son pleaded to speed things up. But the hospital would not open an operating room after hours and incur overtime costs for staff. By Friday, Roberts was dead of an abscess.

In the United States, admits Dr. Alan Hudson, president and CEO of The Toronto Hospital, "you'll get your X ray tomorrow and your operation the next day, and they'll apologize that they can't do them both right now."

Small wonder that many sick Canadians head for the border. In 1990, half the lithotripsies performed at Buffalo General Hospital in New York—602—were on Canadians. Even government officials seek care in the United States. When Quebec Premier Robert Bourassa developed a cancerous mole, it was removed at the National Cancer Institute in Bethesda, Md.

Border-crossing can help rich or desperate Canadians. But it cannot ultimately solve these other problems of Canadian Medicare:

1. Overuse. Because it's free, Canadians visit doctors' offices almost twice as often as Americans. The cost is driving taxes up and Medicare under.

Dr. William Weaver of Vancouver sees patients who roam from doctor to doctor seeking prescriptions for narcotics, at no cost to themselves. William Rudd, a colorectal surgeon in Toronto, was recently the 24th doctor a patient

consulted for the same complaint. The malady? "An emotional disease, projected onto the body," says Rudd. "But the exam cost $110. Multiply that by 24 times and tens of thousands of people!"

Abuse of emergency rooms—expensive to run but free to use—is rampant. Doctors complain about parents who appear at night with children who have colds, because it is inconvenient to see a doctor during the day. Some non-urgent patients arrive at emergency rooms in ambulances. The ambulance is free; taxis charge a fare.

"The problem," says Weaver, "is the foolish generosity of the system." Dr. Joan Charboneau, of Mississauga, Ontario, agrees: "If something appears to be free, people don't feel responsible for how they use it."

2. Special access. One of Medicare's proudest boasts is "equitability." The system is supposed to guarantee that no Canadian gets better health care than any other. But some irate Canadians say equitability is a sham. "Bureaucrats, politicians and senior businessmen jump the queues by phoning hospital administrators," says David Somerville of the National Citizens' Coalition. "It's not even illegal; the hospital just says they're 'urgent.'"

Then there's the National Defence Medical Center (NDMC), a 244-bed hospital in Ottawa run by the Canadian military. Theoretically, it serves the armed forces. But according to a report by Auditor-General Ken Dye, 61 percent of its patients were nonmilitary—including members of Parliament, diplomats and senior bureaucrats.

NDMC has its own CAT scanner and a nationally renowned cardiopulmonary unit. It is the only hospital in Ottawa equipped with a helicopter pad. "I don't think we'll get fundamental reform until those with the power to make changes feel the pain of the system themselves," Somerville says.

3. Patients mattering less and less. Dr. Charles Wright, a manager at Vancouver General Hospital, says administrators maintain waiting lists on purpose, the way airlines overbook. As for urgent patients on the lists who are in pain, Wright argues that "the public system" will decide when their pain requires care. These are "societal decisions," he declares. "The individual is not able to decide rationally."

A patient at a Canadian hospital doesn't pay for his stay, nor is it paid for by his own insurance. Each patient is a drain on the fixed budget the hospital gets from the government. For this reason, Canadian hospitals have no financial incentive to offer good service. In fact, to save money, many rush, delay or shortchange care—deliberately.

In 1989 Ontario began opening mammography screening clinics for all women over 50. It was suggested that radiologists evaluate *100 mammograms per hour*. Twenty per hour is normal. When radiologists protested, the suggestion was dropped.

However, the fee per mammogram was reduced by almost half, so the pressure to "read" faster remained. "Would they want their mothers' mammograms rushed?" asks one radiologist in disgust.

4. Demoralized doctors packing up and leaving. I'm originally from England, which nationalized health care in 1948. By the time I was in medical school in 1960, an English child could wait two to three years to have his tonsils removed—and I knew I couldn't stay.

The first legal foundations of Medicare in Canada were not laid until 1965, the year after I emigrated. Another ten years would pass before Medicare began undermining medicine. In 1971 I joined Toronto's Hospital for Sick Children, one of the finest pediatric hospitals in North America. "Sick Kids" had 800 beds and no waiting lists. The equipment was superb. But in the mid-1970s the government's influence over health care intensified. By the mid-1980s, Sick Kids had only 630 beds. (Today it has 511.) My outpatients were waiting three months for CAT scans. I wanted to do research, but it was impossible to get the money. I could no longer do the job for which I was trained. In 1986 I left Canada for the Medical City Dallas Hospital in Texas, where I am today pursuing my research and performing surgery.

Across Canada, frustrated doctors are leaving. In 1990, despite tight visa rules, 8263 Canadian doctors were practicing in the United States. Since visa rules were loosened in April, that number is expected to rise sharply.

Some come to the United States seeking more money. Others want access to facilities and technology. Virtually all are convinced, as I was, that they can no longer deliver appropriate care in Canada.

It will be a sad irony if America adopts the Canadian system. In fact, Canadian officials are talking about moving away from national health care—charging patients fees for using emergency rooms and doctors' offices, for example, and limiting coverage for the wealthy. "The system is getting worse day by day," says Dr. William Goodman of Toronto. "America is now where we were 35 years ago—and you're making all the same mistakes."

When an individual's medical expenses become crushing, most people believe their government should step in. But to nationalize all health care as Canada has done would be to toss our system out of the frying pan and into the fire. Patients must be free to make their own arrangements with their own insurers and doctors, or there is no hope for American health care.

In the words of Toronto *Globe and Mail* columnist Terence Corcoran: "You can believe that socialized medicare is the most moral system in the world if you want. But the fact is that socialized medicare will not work."

Reprints of this article are available. See page 212.

want (or need) to sell a $150,000 farm or business to purchase an annual income of perhaps $25,000 makes the farmer or small proprietor "rich," therefore deserving punishment—but a decision to hold onto a farm or business that generates the same $25,000 a year in personal income makes such a farmer not rich.

This is the human reality utterly concealed by the static income-distribution tables so familiar in the capital-gains debate. The people classed as "rich" by virtue of capital gains will in most cases not be the same every year. But current law classes—and taxes—them as if they were rich.

The best, perhaps the only, argument for the additional tax is the possibility that investors can find ways of reporting ordinary income as capital gains; thus, having at least some taxation of capital gains can provide a fail-safe source of revenue if the government's attempt to enforce the tax law fails. But the answer is to draft the law to prevent such schemes—not to remedy one unfairness with another.

Jeffrey Bell and John Mueller are principals of Lehrman Bell Mueller Cannon, Inc., an economic and political forecasting firm in Arlington.

the over-$200,000 class; instead they rose 20 and 86 percent respectively. The fact that revenue increased after the top capital-gains rate was cut to 20 percent implies that the current rate of up to 28 percent is too high and that more revenue could be "unlocked" by lowering it.

President Bush is correct in his strong instinct to veto any capital-gains cut accompanied by a "trade" for a higher top income tax rate—even one in the form of a "millionaire surtax." Any agreement to raise tax rates, coming so soon after the increase in the top rate enacted in 1990, would signal effective repeal of the Tax Reform Act of 1986 and the philosophy behind it—that lower rates on all should be paid for by treating everyone fairly. The evil caused by the defeat of a broad-based, low-rate tax system in which everyone must pay would far outweigh the economic pluses of a lower tax on capital gains.

Commitment to a low-rate system is the best means of ensuring that the rich pay more. And history tells us that the best way of increasing the government's capital-gains receipts is to cut these rates well below the punitive and unfair levels that apply today.

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Robert McIntyre is direc

By Mo Sussman

I Was a Chef for the

A Bill of Unfair: The Feds Have Made Hash o

UNDER THE cover of running a restaurant, I am actually a tax collector for the government: I collect Social Security, Medicare and federal income withholding taxes; sales, workers' compensation, unemployment and withholding taxes for the District of Columbia; and income withholding taxes for Maryland and Virginia.

The reason I don't think of myself as a restaurateur is that almost all of the money we take in goes to cover expenses. As the recession has driven business down, the government continues to pile one payroll expense on top of another. Congress and President Bush do a lot of talking about wanting to help business create more jobs, but the fact is that even now Congress is considering another massive cost-hike in the form of mandated health benefits. At a time when jobs are particularly precious commodities, policy-makers seem determined to make it harder to employ people.

In the past decade, workers' compensation costs have tripled in most states. Over the last two years the federal minimum wage rose from $3.35 to $4.25. Since 1979, the Social Security tax rate (employer and employees combined) increased from 12.3 percent to 15.3 percent and the amount of wages subject to it have more than doubled, from $22,900 to $55,000.

Because Congress in 1987 changed the way restaurants must count their employees' tip income, we now pay substantially more Social Security taxes on each employee. This policy is more than costly; it's unfair. The Treasury Department counts *all* of an employee's tips as wages when calculating Social Security taxes—an approximate additional cost to me of about $1,000 a month. But, when it comes to determining whether workers receive at least the minimum wage, the Labor Department largely disregards tip income. This means a restaurant must pay at least half of the minimum wage, even to employees who receive $30,000, $40,000 or more a year in tips. Restaurants have no control over tip income.

Nor do they determine wage levels. In 1987, economists throughout the country, as well as the Congressional Budget Office, predicted that a minimum wage increase would result in serious job loss among teenagers, the disadvantaged and the unskilled. Congress nevertheless voted to raise the minimum wage by 27 percent in 1989. Two years later, and they're talking about mandated health benefits. As the mandates mount, the administrative burden and costs are proving too much for many businesses to bear.

There are only three ways a restaurant can absorb these costs. One is to lower the quality of the food we serve, and I don't consider that an option. Second, we could raise prices. When we opened in 1979, we charged $9.50 for a sirloin steak. Today we charge $26. To cover the cost
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Mo Sussman is the owner of Joe and Mo's Restaurant in downtown Washington.

Washington Post 3/8

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1981 tax act also stemmed from the Fed's tight-money policies in reaction to huge projected budget deficits. Only after the 1982 tax act stopped the phase-in of some of the most egregious 1981 business tax cuts did the Fed loosen up enough to let the economy recover.

The checkered history of the investment tax credit is also instructive. Originally adopted in 1962, it was beefed up in 1964, temporarily suspended in late 1966, brought back in early 1967, repealed in 1969, reenacted in 1971, increased in 1975 and again in 1981, reduced in 1982 and repealed (again) in 1986.

A 1978 analysis of the 1962-76 experience by economists Lawrence Summers and Alan Auerbach was almost totally negative. They found that the credit didn't increase total business investment but instead changed its composition and timing—away from what the marketplace otherwise would have demanded. (Summers, now chief economist for the World Bank, has since

Robert McIntyre is director of Citizens for Tax Justice.

very least business sense. Another idea would provide an "incremental" tax credit for business equipment investments that exceed a company's average for the previous three years. This might sound good at first—after all, why reward investments that would have been undertaken anyway?—but the "incremental" credit has perverse effects. For example, the credits would be "pro-cyclical," swelling when the economy and business investment are expanding but shrinking when investment contracts. And they would encourage all kinds of leasing deals, corporate reorganizations and other tax-avoidance schemes as companies tried to maximize their advantages by lowering the base against which "new" investment is measured.

What Bush and Tsongas—and the rest of the politicians who are carrying water for the loophole lobby—can't seem to grasp is that paying people and corporations to make investments that otherwise make no business sense doesn't help economic growth—it impedes it.

ı Chef for the IRS

:e Feds Have Made Hash of My Restaurant

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$26. To cover the cost of some of the health care plans Congress is considering, we'd have to charge $32—pretty steep even for the most generous expense account.

That leaves the third option, raising prices less dramatically and laying off workers as well. Such a step would hit customers with a double whammy: They pay more, and the smaller staff makes it tougher to provide them with quality service. Dissatisfied customers would mean still less business, further cutbacks and, pretty soon, another closed restaurant. Many other types of service businesses, such as dry cleaners and retailers, will face the same kind of choices.

Somehow Congress got the idea that if they "phase in" each new payroll expense it won't hurt as much. Sure. And a heaping portion of chocolate mousse is less fattening if you eat it slowly. A restaurant—or any business—can't finesse the bottom line and survive with new expenses being piled on every year or so, any more than you can fool your waistline with slow mousse. Either way, it's belly up and belly out.

Consider the so-called "play or pay" health care proposal that would force all employers to buy health insurance for their workers (at whatever cost) or to pay a percentage of their payroll to the government. Advocates claim it won't cost the public anything because employers will absorb the expense. Guess again. Higher employment costs and payroll taxes mean higher prices, lower salaries and lost jobs.

"Play or pay" also shows the way public policy tends to be made for corporate giants at the expense of small and medium-size businesses. Virtually all large corporations already provide health care plans for their workers. In fatter times, costs were passed on to consumers through higher prices. But that's harder to do in the face of tough foreign competition and a recession. Big corporations, therefore, have nothing to lose by paying the government for health coverage. It will save them money and the trouble of administering their own health plans.

The big losers are the little guys like me, whose margin-hugging businesses can't withstand new health care costs, either in the form of health insurance or payroll taxes. Estimates of the tax burden range up to $1,800 per employee per year.

You need only look at the "closed" signs on so many restaurants to see how the economic downturn, combined with heavy-handed tax and wage policies, have brutalized my industry. Hardest hit are independent establishments and white-tablecloth restaurants, that—even in the best of times—have an 80-percent chance of failure in their first two years of operation. Thousands have been driven out of business in the past few years.

Public policy-makers are among my best and most valued customers. Because they are in a service business too, I'm inclined to give them a real tip: Everybody pays when you hand small business the check. Oh, and if anyone wants to invest in the restaurant business, call Mo immediately.

HEALTH CARE REFORM PROPOSALS

Address a HEAL organizing rally. HEAL is an organization of business and health groups that support market-oriented health care reform. Much of their focus is on small business. They are in the process of organizing local chapters in key Congressional districts. The President could address a meeting of one of these chapters where he could foster support for his health care reform proposal. **Time frame**: May or June.

Roosevelt Room Meeting with Health Care Supporters. This same group met with Secretary Sullivan and Sam Skinner on the day the President released his health care plan. They are the core supporters of our initiative. **Time frame:** a Presidential drop-by is scheduled for April 1.

Address Baltimore Business/Health Care Seminar. HHS recommends that the President address the annual Baltimore health seminar organized by CEO Alex Brown. The conference attracts over 1,000 CEOs and CFOs interested in health care policy. **Time frame:** May 4-6.

Commencement Address at Moorehouse Medical School. Secretary Sullivan was the founder and former dean of the Moorehouse Medical School in Atlanta. A well-known HBCU, Moorehouse would be an excellent site for a commencement address focused on health care reform. **Time frame:** checking.

Great American Workout. Last year, Arnold Schwarzenegger joined the President on the South Lawn to promote this fitness initiative, which stresses the personal responsibility and health care aspects of our reform proposal.

OTHER HEALTH EVENTS

Release Healthy Start Public Service Campaign. The Ad Council has prepared a series of public service announcements aimed at promoting the infant and maternal health initiatives of the Administration. A White House Presidential speech in conjunction with this release could stress the key elements of our infant mortality package. **Time frame**: early May (Mother's Day).

Roundtable Meeting on Immunization. Over the last year, Secretary Sullivan visited six cities to conduct immunization "summits" with state and local health officials. The President could travel to any of these cities to receive a briefing on the Administration's efforts to increase childhood immunization. **Time frame**: open.

Information

THE WHITE HOUSE

WASHINGTON

March 20, 1992

MEMORANDUM FOR ROGER PORTER

FROM: HANNS KUTTNER

SUBJECT: REGIONAL COMPARISONS OF HEALTH INSURANCE PLANS FALLING WITHIN THE PRESIDENT'S PROPOSED LIMITS

Attached please find regional comparisons of health insurance plans meeting the President's proposed tax credit/deduction limits stratified by age or sex.

ATTACHMENTS

General notes:

- The definition of family is assumed to be policyholder, spouse and child. Child cut-off is 19 years of age unless person is a student, in which case they are covered until 24 yrs./age.
- Rates are for urban areas.
- Rates shown are for individual plans.
- Unless specified, amounts are per month costs.
- Average HMO premiums nationwide are calculated at $133.40/single person and $354.28/family of three.
- An (*) indicates a State subsidy is available up to 200 percent of federal poverty level.
- Unless specified, plans do not include co-payments or deductibles.

SOUTH

PLAN: Florida Health Access, HIGH OPTION

BENEFITS: Basic unlimited inpatient, outpatient, maternity and emergency care services; limited home health and convalescent care; limited mental health and substance abuse treatment. Co-payment: $5 physician visits, no hospital.

PRODUCT PRICING:	single	family
<29	$98.30	$241.60
30-44	$104.59	$286.92
45 +	$124.58	$322.87

PLAN: Florida Health Access, STANDARD OPTION

BENEFITS: Basic unlimited inpatient, outpatient, maternity and emergency care services; limited home health and convalescent care; limited mental health and substance abuse treatment. Co-payment: $10 physician visits, $100 first 5 hospital days.

PRODUCT PRICING:	single	family
<29	$90.68	$222.88
30-44	$96.48	$264.69
45 +	$114.92	$297.86

PLAN: Alabama Coalition for the Medically Uninsured

BENEFITS: Basic unlimited inpatient and outpatient hospital care; 6 physician visits, emergency and maternity care. Choice of delivery from public (op. 1) or private (op. 2) hospitals and providers. Co-payment: (op. 1) and (op. 2) $8 outpatient physician visits, $20 inpatient visits, $50 ER visits.

PRODUCT PRICING:	single	family
Op. 1	$45.07	$110.86
Op. 2	$73.96	$186.32

PLAN: Tennessee Primary Care Association

BENEFITS: Basic physician and hospital inpatient and outpatient services; maternal and emergency care services; home health care, mental health and substance abuse services as riders. Co-payment: $200 hospital and physician inpatient services, $5 outpatient physician services, $5 maternity care. PREMIUM DOES NOT VARY BY AGE.

PRODUCT PRICING:	single	family
	$65.84	$177.75

PLAN: City of Birmingham, Alabama

BENEFITS: Basic inpatient and outpatient physician and hospital services; maternal and emergency care services; home health care and prescription drugs. Co-payments: Option A and Option B, both $10 physician visit, $5 prescription drugs, and $40 ER visit. PREMIUM DOES NOT VARY BY AGE.

PRODUCT PRICING:	single	family
Option A	$72.39	$185
Option B	$47.05	$110

EAST

PLAN: MAINECARE*

BENEFITS: Basic unlimited inpatient and outpatient care; maternity and emergency medical services; hospice and home care; limited mental health and substance abuse services. Plan subsidized by State to 200 percent of federal poverty level. Co-payment: both plans, $5 physician visit. PREMIUM DOES NOT VARY BY AGE.

PRODUCT PRICING:	single	family
	$79.75	$238.46

PLAN: Delaware BC/BS, CHOICE 2000 INDIVIDUAL ACCT.

BENEFITS: Basic and emergency physician and hospital inpatient care; substance abuse and mental health services; maternity services

PRODUCT PRICING:

	single	family
<30	$188.05	$314.87
30-39	$207.40	$347.28
40-44	$235.06	$393.58
45-49	$247.18	$430.62
50-54	$273.78	$458.41
55-59	$309.72	$518.60
60-64	$351.20	$588.06

WEST

PLAN: Arizona Health Care Group, PLAN A

BENEFITS: Basic unlimited inpatient and outpatient hospital and physician care; emergency and maternal care and home health services. Co-payment: $10 physician visits, $5 prescription drugs, $50 ER services.

PRODUCT PRICING:

	single	family
0-39	$85.54	$274.51
40-55	$124.70	$400.20
56 +	$283.42	$909.54

PLAN: Arizona Health Care Group, PLAN C

BENEFITS: Inpatient hospital and physician services with $250 co-payment and $15 co-payment for physicians services. Emergency and maternal care services with $75 co-payment and prescription drug benefits with $10 co-payment.

PRODUCT PRICING:

	single	family
0-39	$72.87	$234.27
40-55	$106.23	$341.52
56 +	$241.42	$776.19

PLAN: Utah Community Health Plan

BENEFITS: Basic unlimited inpatient and outpatient physician and hospital care; preventive care services; mental health and maternity services available as riders. Limited ambulatory, home health and dental care services except in cases of accidental injury. Co-payment: $5 prescription drugs, $10 primary care visits, $20 specialist visits, $50 ER visits, $75 outpatient surgery, $100 maternity care, $150 first four days inpatient hospital services, $350 first three days of hospital maternity care.

PRODUCT PRICING:

	male	female	child
<30	$56.26	$73.35	$20.41
30-39	$59.52	$69.69	
40-44	$59.30	$64.06	
45-49	$62.39	$65.35	
50-54	$74.71	$77.67	
55-59	$95.96	$97.60	
60-64	$109.74	$111.02	

PLAN: Denver Shared Cost Option for Private Employers

BENEFITS: Preventive and primary care benefits with $15 co-payment for physicians' services; hospital inpatient care and nonprimary outpatient services with $250 deductible; limited alcohol and substance abuse treatment; catastrophic medical expenses with 50 percent coinsurance after the first $500 dollars.

PRODUCT PRICING:

	male	female	family
<30	$35.45	$66.50	$118.10
30-34	$40.99	$63.85	$129.39
35-39	$48.58	$66.92	$138.88
40-44	$58.27	$77.40	$145.37
45-49	$70.06	$91.88	$155.86
50-54	$84.79	$111.18	$171.08
55-59	$103.25	$136.64	$200.38
60-64	$127.37	$168.70	$241.78

PLAN: San Fransisco Bay Area Business Group on Health

BENEFITS: Basic inpatient and outpatient physician and hospital benefits except routine checkups; home health care and maternal care services; emergency care services; and limited mental health care services. $250 annual deductible, 20 percent coinsurance rate. No co-payments.

PRODUCT PRICING:		male	female	family
BC/BS	25-34	$101	$101	$230
	35-44	$121	$121	$263
	45-54	$155	$155	$323
	55-64	$215	$215	$431
Kaiser	25-64	$126	$126	$332

NORTHWEST

PLAN: Blue Cross/Blue Shield

BENEFITS: Basic inpatient and outpatient physician and hospital services; maternity and emergency care services; limited prescription drug and mental health benefits. MUST BE A NON-SMOKER. PREMIUM DOES NOT VARY BY AGE.

PRODUCT PRICING:	single	family
HMO	$103	$236
PPO	$91	$207

PLAN: Washington Basic Health Plan*

BENEFITS: Basic unlimited physician and hospital inpatient and outpatient care; emergency and maternity care services; preventive care services and prescription drugs. Co-payment: $5 outpatient physician visit, $50 inpatient admit, $25 ER visit.

PRODUCT PRICING:	male	female	one or more children
0-18			$111.10
19-39	$103.10	$103.10	
40-54	$133.50	$133.50	
55-64	$167.80	$167.80	

MIDWEST

PLAN: Blue Cross/ Blue Shield III (COSE)

BENEFITS: Basic unlimited hospital and physician inpatient and outpatient services; mental health/substance abuse coverage; maternity and emergency care; prescription drugs and organ transplants. Plan requires 20 percent co-payment for physician and hospital services after $100 deductible for singles or $200 for families.

PRODUCT PRICING:	single	family
<30	$58.07	$211.23
30-39	$70.30	$226.89
40-49	$103.91	$250.35
50-59	$140.58	$302.51
60 +	$190.50	$399.00

PLAN: Blue Cross/ Blue Shield IV (COSE)

BENEFITS: Basic unlimited hospital and physician inpatient and outpatient services; mental health/substance abuse coverage; maternity and emergency care; prescription drugs and organ transplants. Plan requires 20 percent co-payment for physician and hospital services after $250 deductible for singles or $500 for families.

PRODUCT PRICING:

	single	family
<30	$53.05	$192.98
30-39	$64.22	$207.28
40-49	$94.94	$228.72
50-59	$128.44	$276.38
60 +	$174.03	$364.53

PLAN: Preferred Care of Ohio

BENEFITS: Basic unlimited inpatient and outpatient hospital and physician care, maternal and emergency care services, prescription drugs. Co-payment: $10 physician visit, $50 ER visit, $5 prescription drugs, $2 maternity care visit.

PRODUCT PRICING:

	single	family
<30	$78.75	$297.64
30-39	$95.33	$319.69
40-49	$140.92	$352.75
50-59	$190.64	$426.24
60 +	$258.35	$562.20

PLAN: Michigan Blue Care Network Option

BENEFITS: Basic unlimited inpatient and outpatient physicians and hospital services; maternal and emergency medical services; home health services; limited mental health and substance abuse services. Co-payment: $3 prescription drugs, $5 physician services, $5 maternal health services, $ 25 ER services. PREMIUMS DO NOT VARY BY AGE.

PRODUCT PRICING:

single	family
$91.18	$227.95

MID-ATLANTIC

PLAN: NY State Program for the Uninsured, for CHILDREN

BENEFITS: Outpatient benefits only for 0-12 year olds. Co-payment: $3 prescription drugs.

PRODUCT PRICING: $650 for NYC, $500 for outlying areas

PLAN: NY State Program for the Uninsured, ER PLANS

Benefits: Basic unlimited inpatient and outpatient physician and hospital services, emergency medical and maternity services, well-baby care, and prescription drug benefits. Limited mental health. PREMIUMS DO NOT VARY BY AGE.

PRODUCT PRICING:

single	family
$	

PLAN: NY State Program for the Uninsured, INDIVIDUALS

Benefits: Basic unlimited inpatient and outpatient physician and hospital services, emergency medical and maternity services, well-baby care, and prescription drug benefits. Limited mental health. PREMIUMS DO NOT VARY BY AGE.

PRODUCT PRICING:

single	family
$	

PLAN: New Jersey Blue Cross/Blue Shield

BENEFITS: Basic inpatient and outpatient hospital and physician benefits; prescription drug coverage; maternity and emergency medical services; mental health and substance abuse services. $1000 deductible. Co-payment: 20 percent on prescription drug services.

PRODUCT PRICING:

single	family
$506.16/quarter	$1223/quarter

PLAN: NY State Program for the Uninsured*

Benefits: Basic unlimited inpatient and outpatient physician and hospital services, emergency medical and maternity services, well-baby care, and prescription drug benefits. Limited mental health. PREMIUMS DO NOT VARY BY AGE.

PRODUCT PRICING:

	single	family
Saratoga	$60.44	$133.17
Manhattan	$113.02	$249.01
Bronx	$170.81	$512.43

PLAN: New Jersey Blue Cross/Blue Shield

BENEFITS: Basic inpatient and outpatient hospital and physician benefits; prescription drug coverage; maternity and emergency medical services; mental health and substance abuse services. $1000 deductible. Co-payment: 20 percent on prescription drug services.

PRODUCT PRICING:

single	family
$506.16/quarter	$1223/quarter