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GREATER CLEVELAND GROWTH ASSOCIATION
CLEVELAND, OHIO
12:00pm NOON

• ACKNOWLEDGEMENTS FOR PRESIDENT BUSH

Acknowledge Richard W. Pogue, chairman of the Greater Cleveland Growth Association, thanking him for the opportunity to address the membership of the Growth Association -- America's largest chamber of commerce, with 11,000 members.

Acknowledge Robert B. Horton, chairman of British Petroleum, thanking him for being so gracious and allowing the President to follow his remarks.

Per Bob Coffin:

Lan Patterson - CEO, COSE [greets POTUS]

GOV. GEORGE VOINOVICH [NO WIVES]
LT. GOV. MIKE DeWine [NO WIVES]

NO FLOTUS PARTICIPATION

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THE WHITE HOUSE

Office of the Press Secretary
(Cleveland, Ohio)

For Immediate Release February 6, 1992

REMARKS BY THE PRESIDENT
TO THE GREATER CLEVELAND GROWTH ASSOCIATION

Stouffer Tower City Plaza Hotel
Cleveland, Ohio

12:36 P.M. EST

THE PRESIDENT: Thank you very much for that welcome back to Cleveland. And first let me thank Dick Pogue, the Chairman of the Greater Cleveland Growth Association, and all who made this wonderful forum possible. I'm pleased to be back here in Cleveland, the capitol city of the North Coast.

Hello to Bob Horton, who I understand not only warmed up the crowd but made it very difficult for me to come on as the next speaker. I salute what he and so many other business leaders in this community have done and are doing. You always get this feeling of cooperation between the business community and the government of Cleveland, the city government. I had that when I first came here and Mayor Ralph Perk was in office -- and particularly, did I get that feeling when George Voinovich came in as your mayor and energized this place to a fare-thee-well, and business pitched right in. And you have this wonderful community spirit that this organization really epitomizes, Dick. And I am grateful to be here.

And so let me get on with just saying I'm very pleased to have been introduced by George Voinovich, the great Governor of this state now. And may I salute Mike DeWine, who is over here, the Lieutenant Governor. We've got some other friends with us, too. I know that Bob Taft is out here, the Secretary of State. Three distinguished members of the United States Congress came with us -- Ralph Regula, Mike Oxley and Dave Hobson. And I'm sure I'll forget somebody, but nevertheless I see our State Senate President Stan Aronoff sitting over here. So that takes care of it. We've got good representation from Ohio's government; we've got representation from the wonderful congressional delegation; and we have outstanding representation here from the medical community and, of course, from the business community at large.

Good things are happening here for the Cleveland Cavs. (Laughter.) In fact, I told the Governor I was going to be speaking today about the number one health issue on every Clevelander's mind. He said, "Mr. President, Mark Price's left knee is just fine." (Laughter.)

People who know northern Ohio know that this region's o: the move. In addition to the world-renowned Cleveland Clinic -- now the city's number one employer -- Northern Ohio is also home to some of the most innovative approaches to health care. COSE and Clevelan Health Quality Choice are pioneers. Communities across the country can follow your lead to create workable solutions to health care challenges. And I had a briefing in Washington from the leaders of these organizations and that really is why I've chosen to come to Cleveland this morning to address the health care crisis in our country and lay out my four-point program for comprehensive health care reform.

Reform is urgent for more reasons than one. Right now, far too many Americans are uninsured and those who are insured pay

MORE

too much for health care. And we're going to do something about that.

The one thing this crisis isn't about -- and I was reminded of this in my visit to the hospital just now -- the one thing it is not about is the quality of care. American health care is first-rate. It is the best in the entire world. And right now, the vast majority of Americans have access to that health care system. But the cost has skyrocketed: from $74 billion in 1970 to $800 billion today. And if we keep going at the same rate, that $800 billion will double to $1.6 trillion by the year 2000.

These numbers alone would make the case for reform. They tell us there's a connection we simply can't ignore between what we pay for health care and the long-term health of our economy. But cold statistics don't show us the worry that people feel; the all-too-familiar fear about what happens to their health care if they change jobs, or worse still, if they lose their jobs. And in these hard times, we simply cannot accept the fact that one in every seven Americans is uninsured.

There's a better way. And my plan puts the emphasis on expanding access while preserving the choice people now have over the type of health care coverage and health care they receive. My plan will give Americans a greater sense of security -- help ease the fears that so many Americans have that changing jobs will cost them their health coverage. And the key here is portability -- changing the system to ensure people that they will always have access to health insurance no matter where they work. And finally, my plan will cut costs. It helps us make health insurance more affordable, and more affordable means more accessible.

And my plan will preserve what works and reform what doesn't. And above all, it will ensure every American universal access to affordable health insurance.

We stand at a crossroads. We can move forward dramatically to reform our market-based system or we can force ourselves to swallow a cure worse than the disease.

Some people have scribbled out a prescription for disaster. They want to nationalize our health system: put government in control of the system, let government control the prices, let government ration the kind of health care people get, let government tell people looking for care how much they'll get, what kind, and when.

Nationalized systems cover everyone. But keep in mind the drawbacks that come with a nationalized system: long waiting lists for surgery; shortages of high-tech equipment responsible for so many of the miracles of modern medicine. Let me cite just one example for you. The Cleveland Clinic performs 10 coronary bypass surgeries a day, I'm told; high tech, high quality surgery without any wait. But if you live in British Columbia, the wait for coronary bypass surgery is six months. It's no wonder so many people from abroad come to American hospitals for surgery.

When you nationalize health care, you push costs higher, far higher. Some studies estimate that nationalized health care would cost the average American family a huge new tax burden. For the nation, a staggering $250 billion to $500 billion a year in new taxes. Such a massive tax increase is simply unacceptable and the American people should not be asked to accept it. And for that price, you get the worst of both worlds -- no one has an incentive to control costs and everyone pays.

But there are other proposals out there that sound simple, but are every bit as harmful. One's called play or pay. Each employer must play, meaning, provide insurance for employees, or pay a payroll tax to finance government health coverage. Businessmen and women tell me horror stories about health care costs spiralling out of control. Well, play or pay will leave a lot of small businesses -- businesses struggling on the edge of survival right now -- with a tough choice. They can cut workers' wages to pay for mandated health care, they can fire some workers to cover the workers they keep or they can raise prices and pass along the cost to the consumer. Some studies put the cost in jobs lost under play or pay as high as half-a-million or more. Lower wages, lost jobs, higher costs: anyway you look at it, that's the wrong choice for America.

Step away from the rhetoric -- strip it out of there and play or pay just creates a back-door route to nationalized health care. And it encourages employers to stop offering benefits, throw the problem in the government's lap, and dump millions of fully-insured workers into a public plan like Medicaid. And because the new employer taxes in play or pay don't pay for the program, the American taxpayer will obviously foot the bill. And I am not about to let that happen.

You won't hear this from the people pushing play or pay. Ask them about the side effects of their proposal, and they'll say, take two aspirin and call me after the election.

I don't believe people want to be shoveled into some new health care bureaucracy. They want good health. A large part of the answer is prevention. And every one of us can make changes in our behavior to reduce the risk of disease and illness. And pardon me for being just a little bit old-fashioned but what we're talking about is behavior -- drugs, alcohol abuse, risky sexual behavior, you know what I'm talking about. And there's nothing wrong discussing that, trying to do better in this field. Tomorrow, in San Diego, I'll focus in more detail on the ways prevention can help people live healthier lives and help keep our economy healthy, too.

But today, I want to focus on the health care system -- on this comprehensive, market-based reform plan I have. The fact is, we do not have to create a new government bureaucracy to give Americans access to affordable, quality health care. We need a system that delivers, a system that works for America, a system that puts quality care within reach of every American family.

Our system should be built on choice, not central control. It should keep costs down and open up access. But above all, it should allow all Americans to rest secure when it comes to health care, to ease their worry that if they change jobs, if they or their kids develop serious health problems, they'll still be able to count on the coverage they need.

Now, my comprehensive four-point plan meets every one of these common-sense tests. And here's how it works. Point one, we will make health care more accessible by making health insurance more affordable. For low-income individuals and families, I propose a health insurance credit -- up to $3,750 dollars a year to guarantee people, even people too poor to file taxes, the ability to purchase private health insurance. That will give these families a certificate or voucher to be used strictly for health care worth more than $300 dollars a month. They can use it to buy into the plan their employers offer but they could never afford or they can shop for whatever private plan suits them best. That's the American commitment to choice at its best.

For middle-income individuals and families, I propose a health insurance tax deduction of $3,750. American families with incomes under $80,000 will receive new help from either the credit or the tax deduction. Let me tell you what that means -- new help to purchase health insurance for 95 million Americans. And once again, this insurance will be portable -- people who change jobs would have insurance regardless of their health -- and this is important -- or regardless of their family's health.

But best of all, my plan will bring health care coverage to almost 30 million uninsured Americans -- security to people who for far too long have had to do without.

That's the first point in this four-point plan, access. Point two, we will cut the runaway costs of health care by making the system more efficient. Today, I'm asking you to learn a new acronym -- HIN -- Health Insurance Networks. Insurance costs obey the law of large numbers. The larger the group being insured, the lower the cost per individual. Pooling, pooling lowers insurance costs and significantly cuts administrative costs. HIN s will provide incentives for small companies to do what Cleveland's COSE group has done, when it brought 10,000 small businesses together to make a joint purchase of health care. The nation should listen and follow.

Another way to drive costs down, make everyone a better health care consumer. Right now, most people pay more attention to the price of toothpaste than the comparative costs of health care. People don't waste much time thinking about the costs of their care but in the end, we all pay the price.

We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people shopping for health care a kind of blue book for medical costs. Innovations like these will help all of us keep the costs of quality health care as low as possible.

Point Three, we will wring out waste and excess in the present system. We've targeted medical malpractice for reform. It is time to put an end to these astronomical, sky's-the-limit lawsuits. You shouldn't have to pay a lawyer when you go to the doctor. (Applause.)

And our doctors, the most able and dedicated in the world, shouldn't be living in fear of these outrageous lawsuits. And high malpractice premiums mean higher doctors' bills, higher hospital costs, costs passed along not only to the patient, but to every American taxpayer.

Now, I have challenged the health insurance industry to cut red tape, to share common forms, to simplify and speed up claims processing. And here's a challenge for the next four years -- there is no reason almost all health insurance claims can't be processed electronically. That single step would eliminate a mountain of health care paperwork and pare back costs. We've got to attack the excesses of mandated benefits. When states now order health insurers to cover 1,000 different types of treatment, something's gone wrong. -- covering manicures for Millie. It's gone too far. And I think everybody knows it and we should challenge the states to do something about the excessive mandates that shoot these costs right up through the roof.

Fourth and finally, we will get the growth in government health programs under control. Right now, government health care programs can claim a dubious distinction, they are the fastest growing parts in the federal budget. For those of you interested in history, go back and listen to what was said about these programs at their inception. Go back and hear the rhetoric on the floor of the United States Congress. And now compare that to what actually happened to the costs. This year alone -- this year alone, let me

repeat that -- Medicaid costs will increase by 38 percent. We will not, repeat, not cut benefits. We can make real savings simply by reducing this huge rate of increase. We must bring runaway costs under control. Smart, sensible efficiencies will help our reform plan pay for itself.

The federal government should also give states the flexibility to design these new universal access programs for the poor -- programs that will provide quality services to all their citizens. I've just met with Governor Voinovich and the rest of the governors. Regardless of party, Democrat or Republican it doesn't matter, they want flexibility. And we must give it to them. Right here in Ohio, your Governor has proposed health care reforms that will do for this state what we want to do on the federal level. States should be able to use new federal resources to design programs that work -- not some one-size-fits-all solution imposed by Washington.

Providing affordable care, efficient care, wringing out excess and waste and controlling federal growth. These four points will create the kind of market-based reform plan that will give Americans the kind of health care they want and deserve and put an end to the worry that keeps them awake at night.

Remember what people want. People want quality care, care they can afford and care they can count on, care they can rely on. I keep coming back to what works for this country. Think about the challenges we face as a nation. Anyone who is concerned about competitiveness has to see controlling health care costs as key to a healthy economy. We've got to make certain our reform corrects our weaknesses without destroying our strengths. When we talk about health care, we're talking about matters of the most personal nature -- in some cases, literally, life and death and decisions that go with it. We don't need to put government between patients and their doctors. We don't need to create another wasteful federal bureaucracy. As President I simply will not let that happen.

We need common sense, comprehensive health care reform and we need it now. And my plan I really believe is the right plan -- a plan that meets our obligation to all Americans by putting hope and health within their reach.

Cleveland has led the way. Your hospitals, COSE, citizens in this community way out front for these principles. And it's most appropriate that I give this speech to the nation on health care reform right here in this city that is leading the way.

Once again, my thanks for this warm Cleveland welcome. May God bless you all, and the United States of America. Thank you very, very much. (Applause.)

END 1:00 P.M. EST

BUSH HEALTH PLAN WOULD BE FINANCED BY MEDICARE CURB

LESS MONEY FOR HOSPITALS

Tax Credits and Tax Deductions Would Help 90 Million Buy Family Health Coverage

2/3/90

By ROBERT PEAR
Special to The New York Times

WASHINGTON, Feb. 2 — President Bush's proposal to help 90 million Americans buy health insurance with new tax credits and tax deductions would be financed mainly by curbing the growth of Government health programs like Medicare and Medicaid, Administration officials and members of Congress say.

In a speech on Thursday in Cleveland, Mr. Bush intends to unveil the proposal, which is designed to help people who have no insurance and those who have difficulty paying for it.

Mr. Bush also plans to travel to San Diego on Friday to visit an immunization clinic and speak to a Rotary Club about his proposals. The trip is meant to help Mr. Bush answer Democratic charges that he has ignored health and other domestic issues.

A confidential set of questions and answers, prepared in advance of Mr. Bush's announcement by officials at the White House Office of Management and Budget, says, "The President's plan will not hurt beneficiaries in any way." The document notes that Medicaid and Medicare would continue growing, but at a slower rate.

Less for Hospitals

Administration officials said in interviews that the President's plan would cut back payments to many hospitals and doctors that treat elderly people under Medicare and poor people under Medicaid. It would, for example, reduce special allowances now paid to teaching hospitals and hospitals that serve large numbers of low-income patients.

A Federal budget official working on the President's plan said it would reduce "selected sources of excessive reimbursement to both doctors and hospitals."

Democrats have their own proposals for overhauling the nation's health care system. With Democratic majorities in the House and the Senate, Congress is unlikely to approve Mr. Bush's proposal. But, the White House officials said, the President would be able to say that he had seriously addressed the nation's health care problems as he campaigned for re-election.

Medicare Premiums May Drop

A White House document describing Mr. Bush's proposal suggested that it might eventually lead to a reduction in premiums under Medicare, the Federal health insurance program for 34 million elderly and disabled people.

In the document, the White House asks, "Is the President's plan going to accomplish its cost savings by severely reducing Medicare payments to physicians and hospitals — to the point that providers won't want to treat Medicare patients?"

After saying that would not happen, the document adds, "Bringing the costs of Medicare under control may reduce the premium contributions for seniors." The monthly Medicare premium has not been reduced since the pro-

Bush Health Insurance Plan to Be Fin

Continued From Page A1

gram was created. It started at $3 in 1980 and is now $31.80.

Administration officials contended that hospitals could absorb cutbacks in their Medicare payments because, under Mr. Bush's plan, more people would have private health insurance and would be able to pay their bills, thus reducing the hospitals' burdens of bad debt and charity care.

"Over 90 million Americans would receive new assistance for health care" under the plan, the White House document says.

Alarm at Hospitals

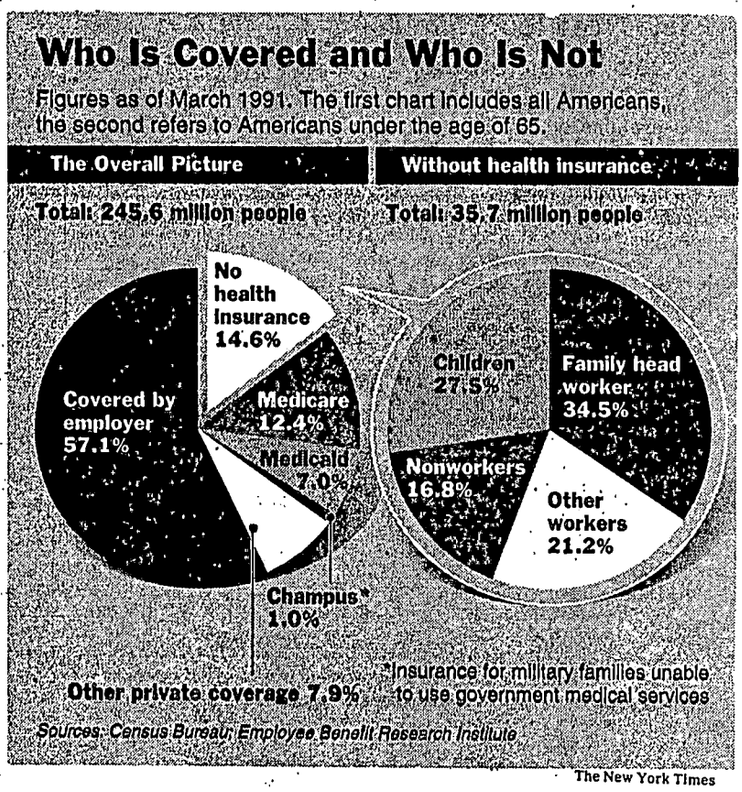
But hospital executives, especially those at urban teaching hospitals, expressed alarm at the prospect of slower growth in Medicare payments, at a time when their revenues are often inadequate to cover the costs of treating patients.

Dr. Spencer Foreman, president of Montefiore Medical Center in the Bronx, said: "There is no assurance there would be a match between the institutions that are cut and the institutions that benefit under the proposals being discussed by officials in Washington. For teaching hospitals in New York City, which operate at nearly full capacity but barely break even, I fear there would be a reduction in Medicare payments without an equivalent offsetting gain."

Medicare and Medicaid account for two-thirds of the revenue that Montefiore gets for treating patients admitted to the hospital: $300 million of $450 million expected for this year.

Richard J. Pollack, executive vice president of the American Hospital Association, said that under current law, "more than two-thirds of the nation's hospitals are expected to lose money in their treatment of Medicare patients, and the situation is even worse under Medicaid."

More than 35 million people have no health insurance. Another 34 million people are covered by Medicare, and nearly 30 million are covered by Medicaid. About 177 million people, including many enrolled in Medicare, have some type of private health insurance.



The New York Times

Health is emerging as a pivotal issue in this year's election. Mr. Bush is already denouncing Democratic proposals that would require employers to provide health insurance or would establish a system of national health insurance run by the Government.

Michael D. Bromberg, executive director of the Federation of American Health Systems, which represents 1,400 investor-owned hospitals, said he did not expect swift action on Mr. Bush's proposal. "It hasn't got a chance in a million," he said. "Nobody expects Bush's plan to pass, not even Bush."

Some Democrats in Congress want to pass a comprehensive health care bill this year, believing they would reap political benefits if Mr. Bush vetoes it. Mr. Bromberg said, "We will have a stalemate until after the elections because the two parties are moving in totally different philosophical directions on this issue."

The White House document says Mr. Bush's plan would reduce "an unsustainable high rate of growth" in payments to doctors and hospitals, but would not cut the total amount spent on Medicare, $118 billion last year.

The Administration's efforts to slow the growth in Medicare and Medicaid follow logically from Mr. Bush's pre-

anced by Curbing Growth of Medicare

A plan to help 90 million American buy health insurance.

mises and promises. Administration officials have publicly said that his plan will expand access to health care, will be comprehensive and willll pay for itself, but will not raise taxes.

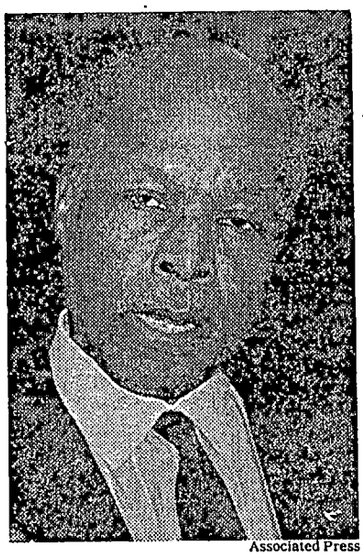
At a news conference last week, Kevin E. Moley, an Assistant Secretary of Health and Human Services, said the President's plan was intended to provide "universal access to health care," and he said "there will be no tax increase."

Appearing today on the ABC News program "This Week," Dr. Louis W. Sullivan, the Secretary of Health and Human Services, said annual spending on health care averages "$2,700 per capita for every man, woman and child" in the United States. "We have enough dollars in the health-care system," he said. "We're not spending them in the wisest way. The President's plan will redirect those dollars to spend them more effectively."

Budget Changes to Come

In his 1993 budget request last week, President Bush proposed few legislative changes in Medicare and Medicaid. But a Federal health official said people should "stay tuned" because Mr. Bush's comprehensive health care plan envisions huge savings in the two programs. The proposed savings were omitted from the budget because the Administration was still working on details of its health plan last week.

Administration officials said they had not determined the cost of Mr. Bush's plan; their estimates range from $55 billion to $100 billion over five years. Members of Congress who have been briefed on the plan by Administration officials estimate that 40 percent of the money would come from Medicare and 60 percent from Medicaid.



Associated Press

Dr. Louis W. Sullivan, the Secretary of Health and Human Services, said annual spending on health care averages $2,700 per capita for every man, woman and child in the United States.

Asked about the financing of Mr. Bush's proposal, a Republican member of Congress said, "I can't make the numbers add up, and I know how the Administration plans to pay for it."

Sara Rosenbaum, a senior fellow at the George Washington University Center for Health Policy Research, said, "The Administration would finance health care for poor people who have no health insurance by cutting health care for poor people who have insurance through Medicaid."

Tax Credits for the Poor

Mr. Bush would offer tax credits to poor people so they could buy health insurance. The credit would be $3,750 a year for a family and $1,250 for an individual. The Administration says this would be enough for people to buy "high-quality basic health insurance." Unlike most credits, this one would be available to people so poor they pay no income taxes.

To higher-income people who do not qualify for the tax credit, Mr. Bush would offer tax deductions. The White House document says the President's plan "will provide individuals and families with up to $3,750 in deductions for the cost of purchasing health coverage." The deductions are meant to help people buy insurance, not to pay the full cost.

The tax credit and deduction amounts would be "set at a uniform level across the nation." There would be no adjustment for cities with high medical costs like New York and Los Angeles.

The White House document describing the President's proposal says Mr. Bush "would require employers to provide information about health insurance plans and arrange enrollment in group coverage" for their workers. But Mr. Bush's plan does not require employers to contribute to the cost of such health insurance, as many Democrats propose.

Coverage for Almost Everyone

While "there is no mandatory coverage" under Mr. Bush's plan, "it is expected that over 98 percent of Americans would be covered," the document says.

"Some Americans — we expect under two million low-risk middle-income people — may choose not to buy health insurance, regardless of improved affordability, and spend their money elsewhere while gambling on their current good health," it says.

In hopes of slowing the growth of Medicaid, Mr. Bush is expected to propose flat per capita grants to the states for each Medicaid recipient. White House officials say such grants would provide a new incentive for states to rein in Medicaid costs by enrolling poor people in health maintenance organizations and other prepaid health plans, which provide a wide range of medical services in return for a fixed monthly fee.

Mr. Bush's plan would also limit damages in medical malpractice cases and encourage states to set up alternative methods of resolving such disputes to reduce the number of cases in court. He would change Federal law to make it easier for small companies to band together and buy health insurance for workers. He also wants to prohibit insurance companies from discriminating against people who have medical problems when they apply for coverage.

Kemp Likes Bush Plan but Sees 'Gimmicks'

WASHINGTON, Feb. 1 (AP) — Jack F. Kemp, Secretary of Housing and Urban Development, Saturday praised parts of the economic recovery plan presented by President Bush in the State of the Union Message but said others amounted to "gimmicks."

"Its no secret that I've never liked tax credits," Mr. Kemp said on the "Evans and Novak" interview program on the Cable News Network. "Basically those are gimmicks."

Mr. Kemp, who is frequently mentioned as a possible favorite of conservatives for the 1996 Republican Presidential nomination, also said Mr. Bush's order adjusting the Federal tax-withholding tables so that less is withheld from the paychecks of many Americans was "clearly" a gimmick.

At the White House, Roman Popadiuk, a spokesman for the President, said, "I can only say that I have no comment, but the President's programs are very real and very substantive."

Mr. Kemp said the only way to give a lift to the sluggish economy would be to cut the tax on capital gains to 15 percent "or eliminate it altogether."

A cut in the capital gains tax has long been a goal of the Bush Administration, and in the State of the Union Message the President proposed an even deeper reduction than he urged last year. Under the Administration's new plan, the rate, currently capped at 28 percent, would drop to as little as 15.4 percent, depending on the length of time the asset was held.

Among the elements of the President's plan that won Mr. Kemp's praise was the proposal that first-time home buyers be permitted to withdraw money from their individual retirement accounts without penalty.

But the human cost of bad quality care is staggering. In a 1991 study, Harvard Medical School researchers calculated that 7,000 people died in New York hospitals from medical negligence in a single year. That suggests that as many as 80,000 people nationwide may be dying annually from negligence. And bad care also costs a lot of money. Misdiagnosis, substandard surgery, improper drug therapies and hospital-acquired infections result in more and longer hospitalizations.

Forbes Regional Health Center near Pittsburgh discovered in a roundabout way how improved quality produces dividends beyond healed bodies. In 1989, Richard N. McGarvey, Forbes's medical director, took a disturbing call from a statistician who had been analyzing patient outcome data. The data, Dr. McGarvey was told, indicated that Forbes was less successful than certain nearby hospitals in treating standard pneumonia.

Concerned, Dr. McGarvey began pulling patient charts to learn if the problem could be traced to any specific doctors. His initial conclusion: No specific individual was responsible. Moreover, most of the deaths could be explained, either because patients were already critically ill from other diseases or because they had requested not to be resuscitated.

"At this point, Dr. McGarvey could have walked away," says Dr. John Harper, associate medical director at Forbes. "But instead of being defensive, and saying, 'I can explain my results to anybody,' he said, 'Let's look at how we can improve.' "

As the internal investigation progressed, one doctor's patients appeared to be faring better than others. The doctor turned out to be a young staff member who hadn't yet been fully indoctrinated in the ways of Forbes. Unlike his colleagues, he took part in certain diagnostic workups. As a result, his tests were more timely and accurate, permitting quicker, more appropriate treatment.

Dr. McGarvey turned up other clues, which he used to guide him in changing how Forbes treated its pneumonia patients. Soon, Forbes's patients were faring better. And, as an unexpected benefit, patients remained hospitalized fewer days, while Forbes consumed 15% fewer resources—personnel, medication, tests and so on—in treating them.

To encourage more institutions to be-

Please Turn to Page B2, Column 5

HEALTH

Clevelanders Bet Top Health Care Will Be Cheaper

By Walt Bogdanich
Staff Reporter of The Wall Street Journal

President Bush will travel to Cleveland today to unveil his vision of health care reform. But to the disappointment of many Clevelanders, he is expected to largely ignore the city's own pioneering experiment in controlling health care costs.

At a time when the profits of U.S. corporations are being bled by rising medical costs, Cleveland executives believe they have found an antidote: attack bad quality medical care as a way to lower costs.

Their strategy evolved from a 1990 study that showed they could load their sick employees on planes and fly them 750 miles to Minnesota's Mayo Clinic for treatment and still pay less than if the patients went to nearby Cleveland hospitals.

This discovery provided a wake-up call for Cleveland's corporations as well as a lesson that some health experts say has been lost in the intensifying national debate on health care—namely, that good quality care needn't cost more than bad care, and often costs less.

Energized by the study, Cleveland companies are using their economic leverage to persuade doctors and hospitals to help in attacking substandard medical care. "Quality is the way to cost containment, because quality costs less in the long run," says Dale Shaller, a Minneapolis-based health policy consultant who has helped guide the Cleveland project.

To be sure, the reasons for rising health care costs go beyond inattention to quality, and touch on everything from an aging population to expensive new drugs and diagnostic equipment.

Clevelanders Bet Top Medical Care Will End Up Being Less Expensive

Continued From Page B1

have like Forbes, high quality care needs to be rewarded. But rewards are slow in coming because government, corporations and insurers—the biggest purchasers of medical care—often fail to recognize that quality differs greatly from hospital to hospital and even from department to department in a single institution.

"In most large metropolitan areas, you are 50% more likely to die in the worst hospital than the best," says Walt McClure, chairman of the Center for Policy Studies, a Minneapolis think tank. He contends that because society rewards bad medical care right along with good care, bad providers have little incentive to improve.

Medicare, for example, "doesn't care how poor the quality is—it just says, 'here's a fixed price that fits all, take it or leave it,' " says Dr. Alan Brewster, a Westborough, Mass., pioneer in using patient outcome data to measure how successfully hospitals treat certain ailments.

Because of the work of Dr. Brewster and others like him, Cleveland corporations were able to convince Cleveland hospitals and doctors that it was possible to identify, with a reasonable degree of certainty, the high-quality providers. The trick then became how to convince those with specific problems to improve.

While patients acting as individuals can rarely reform a hospital, patients acting in concert can. And that is the heart of the Cleveland plan. With some 350,000 individuals covered through various employee benefit plans, Cleveland corporations plan to direct their workers to the highest quality, low-cost providers by making anyone who chooses to go elsewhere pay extra.

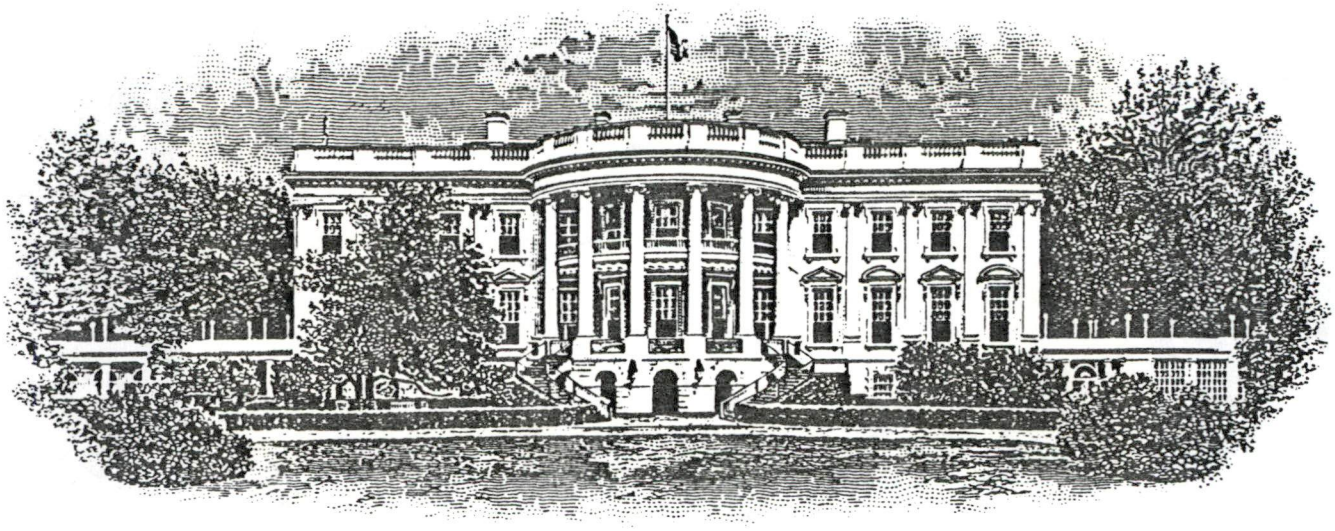
Employees aren't scheduled to receive procedure-specific data until midsummer, but Cleveland-area hospitals, fearful of looking bad, are already scrambling to improve. C. Wayne Rice, president of the Greater Cleveland Hospital Association, says, "I had one hospital administrator tell me, 'This project is doing more to upgrade the quality in my institution than anything I have seen in 30 years.' "

And like Forbes, not all hospitals need to be threatened with a loss of business. The quality management gurus who have been trying to sell America's corporations on such concepts as continuous quality improvement are beginning to find a receptive ear among hospital executives.

Dr. Howard Hiatt, who has studied medical negligence in America's hospitals, suggests that administrators begin looking at the thousands of medication errors that are harming patients. The savings could be considerable, he says.

Several important roadblocks to improvement remain. Many doctors and hospitals are reluctant to admit that their counterparts across town may be doing a better job. What's more, many patients still find it comforting to believe that their doctor or hospital is the best.

The solution, say some health-care activists, is to educate consumers about the differences and increase the research in patient outcome measurements. For too long, says John B. Hexter, president of Cleveland's Health Action Council, information about quality "has been kept out of the hands of the purchaser, be it the corporation or the consumer."



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TO BOB TEETER

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COMMENTS CLEVELAND HEALTH REMARKS

FROM DAN MC GROARTY

* DEPARTMENT OF COMMUNICATIONS *

OFFICE NUMBER 456-2930

Scully out all day

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Jack Hansen bruno

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McGroarty/Bunton

February 5, 1992
5:30 pm
[health]

PRESIDENTIAL REMARKS: GREATER CLEVELAND GROWTH ASSOCIATION
CLEVELAND, OHIO
FEBRUARY 6, 1992
12:20 P.M.

[Introductory acknowledgements.] I'm pleased to be back in Cleveland, capital city of the North Coast. Hello to Bob Horton, head of BP {British Petroleum}, a man committed to this great city. My good friend, Governor George Voinovich -- and Lt. Gov. Mike DeWine: a team that's providing top-notch leadership for this state. Joe Gorman of TRW, who travelled with me early this year to East Asia. // Good things are happening here -- for the Cleveland Cavs: a great season. [[In fact, I told the Governor I was going to be speaking today about the number one health issue on every Clevelander's mind, and he said: Mr. President -- Mark Price's left knee is just fine. //]]

People who know Northern Ohio know this region's on the move. In addition to the world-renowned Cleveland Clinic -- now the city's number one employer -- Northern Ohio is also home to some of the most innovative approaches to health care. COSE [COZY] and Cleveland Health Quality Choice are pioneers: communities across the country can follow your lead to create workable solutions to health care challenges. / That's why I've chosen to come to Cleveland this morning to address the health care crisis -- and lay out my four-point program for comprehensive health care reform. //

Reform is urgent -- for more reasons than one. / Right now, far too many Americans are uninsured -- and those who are insured pay too much for health care. And we're going to do something about that. //

The one thing this crisis isn't about is quality of care. American health care is first-rate, the best in the world. And right now, the vast majority of Americans have access to that health care system. But the cost has skyrocketed: from $74 billion dollars in 1970 to $800 billion dollars today. And if we keep going at the same rate, that $800 billion will double to $1.6 trillion by the year 2000.

These numbers alone would make the case for reform. They tell us there's a connection we simply can't ignore between what we pay for health care and the long-term health of our economy. But cold statistics don't show us the worry people feel -- the all-too-familiar fear about what happens to their health care if they change jobs -- or worse still, if they lose their jobs. // And in these hard times, we simply cannot accept the fact that one in every seven Americans is uninsured. //

There's a better way. / My plan puts the emphasis on expanding access -- while preserving the choice people now have over the type of health coverage and health care they receive. My plan will give Americans a greater sense of security -- help ease the fears so many Americans have that changing jobs will cost them their health coverage: the key here is portability -- changing the system to ensure people they'll always have access

to health insurance -- no matter where they work. // Finally, my plan will cut costs. It helps us make health insurance more affordable -- and more affordable means more accessible.

My plan will preserve what works -- and reform what doesn't. And above all, it will ensure every American universal access to affordable health insurance. //

We stand at a crossroads. We can move forward to dramatically reform our market-based system -- or we can force ourselves to swallow a cure worse than the disease.

Some people have scribbled out a prescription for disaster: they want to nationalize the health system. Put government in control of the system: let government control the prices, let government ration the kind of health care people get -- let government tell people looking for care how much they'll get, what kind, and when.

Nationalized systems cover everyone. But keep in mind the drawbacks that come with a nationalized system: long waiting lists for surgery -- shortages of the high-tech equipment responsible for so many of the miracles of modern medicine. // Let me cite just one example: The Cleveland Clinic performs 10 coronary bypass surgeries a day. High tech, high quality surgery -- without any wait. But if you live in British Columbia, the wait for coronary bypass surgery is six months. It's no wonder so many people from abroad come to American hospitals for surgery.

When you nationalize health care, you push costs higher -- far higher. Some studies estimate that nationalized health care would cost the average American family a huge new tax burden -- for the nation, a staggering $250 to $500 billion dollars a year in new taxes. //

Such a massive tax increase is simply unacceptable. //

And for that price, you get the worst of both worlds: No one has an incentive to control costs -- and everyone pays. //

But there are other proposals out there that sound simple, but are every bit as harmful. One's called "Play or pay." Each employer must "play" -- meaning: provide insurance for employees, or "pay" -- a payroll tax to finance government health coverage.

Businessmen and women tell me horror stories about health care costs spiralling out of control. Well, Play or Pay will leave a lot of small businesses -- businesses struggling on the edge of survival right now -- with a tough choice: They can cut workers' wages to pay for mandated health care, they can fire some workers to cover the workers they keep -- or they can raise prices, and pass along the cost to the consumer. Some studies put the cost in jobs lost under "Play or Pay" as high as half-a-million or more. // Lower wages, lost jobs, higher costs: any way you look at it -- that's the wrong choice for America. //

[[Massachusetts passed a "Play or Pay" scheme back in 1988. It was supposed to become law this year, 1992 -- but as time drew near, the state legislature pushed it out to 1995. Why did they

back off? Because the signals were clear. They knew that businesses -- small businesses mainly -- would pack up and leave Massachusetts, or go out of business because they couldn't bear the additional expense.]]

Strip away the rhetoric, and "Play or pay" just creates a back-door route to a nationalized health care. It encourages employers to stop offering benefits, throw the problem in the government's lap, and dump millions of fully-insured workers into a public plan like Medicaid. And because the new employer taxes in Play or Pay don't pay for the program -- the American taxpayer will foot the bill. / I'm not about to let that happen. //

You won't hear this from the people pushing Play or Pay. Ask them about the side-affects of their proposal, and they'll say: Take two aspirin -- and call me after the election. //

I don't believe people want to be shoveled into some new health care bureaucracy. They want good health. // A large part of the answer is prevention: every one of us can make changes in our behavior to reduce the risk of disease and illness. {Pardon me for being old-fashioned, but what we're talking about is behavior, life-style -- you know what I'm talking about -- and there's nothing wrong with that.} / Tomorrow, in San Diego, I'll focus in more detail on the ways prevention can help people live healthier lives -- and help keep our economy healthy, too.

But today, I want to focus on the health care system -- on my comprehensive, market-based reform plan. / The fact is, we

don't have to create a new government bureaucracy to give Americans access to affordable, quality health care. We need a system that delivers -- a system that works for America -- a system that puts quality care within reach of every American family.

Our system should be built on choice -- not central control. It should keep costs down -- and open up access. But above all, it should allow all Americans to rest secure when it comes to health care -- to ease their worry that if they change jobs, if they or their kids develop serious health problems, they'll still be able to count on the coverage they need. //

My comprehensive four-point plan meets every one of these common-sense tests. Here's how:

Point one: we will make health **care** more **accessible** by making health **insurance** more **affordable.** For low-income individuals and families, I propose a health insurance **credit** -- up to $3,750 dollars a year to guarantee people, even people too poor to file taxes, the ability to purchase private health insurance. That will give these families a certificate or voucher to be used strictly for health care worth more than $300 dollars a month. They can use it to buy into the plan their employers offer but they could never afford -- or they can shop for whatever private plan suits them best.

That's the American commitment to choice at its best.

For middle-income individuals and families, I propose a health insurance **tax deduction** of $3,750. / American families

their care -- but in the end, we all pay the price. We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people "shopping" for health care a kind of "blue book" for medical costs. // Innovations like these will help all of us keep the costs of quality health care as low as possible.

Point Three: we will wring out waste and excess in the present system. We've targeted medical malpractice for reform. It's time to put an end to these astronomical, sky's-the-limit lawsuits. // You shouldn't have to pay a lawyer when you go to the doctor. // And our doctors -- the most able and dedicated in the world -- shouldn't be living in fear of these outrageous lawsuits. //

High malpractice premiums mean higher doctors' bills, higher hospital costs -- costs passed along not only to the patient, but to every American taxpayer. / 15% increase per year

I have challenged the health insurance industry to cut red tape -- to share common forms, and to simplify and speed up claims processing. Here's a challenge for the next four years: There is no reason almost all health insurance claims can't be processed electronically. That single step would eliminate a mountain of health care paperwork and pare back costs.

[[We've got to attack the excesses of mandated benefits. States now order health insurers to cover a thousand different types of treatment. Something's gone wrong. Next, they'll be covering manicures for my dog Millie.]]

Fourth and finally, we will get the **growth** in federal health programs **under control**. Right now, government health care programs can claim a dubious distinction: they are the fastest growing parts in the federal budget. This year alone, Medicaid costs will increase by 38 percent. / We won't cut benefits -- we can make real savings simply by reducing this huge rate of **increase**. / We must bring runaway costs under control.

Efficiencies like this will help our reform plan pay for itself. //

The federal government should also give states the flexibility to design new universal access programs for the poor -- programs that will provide quality services to all their citizens. I've just met with the Governors -- they want flexibility, and we'll give it to them. Right here in Ohio, Governor Voinovich has proposed health care reforms that will do for this state what we want to do on the federal level. / States should be able to use new federal resources to design programs that work -- not one-size-fits-all solutions imposed by Washington.

Providing affordable care, efficient care, / wringing out excess and waste and controlling federal growth: these four points will create the kind of market-based reform plan that will give Americans the kind of health care they want and deserve -- and put an end to the worry that keeps them awake at night.

Remember what people want. People want quality care / care they can afford / care they can count on.

I keep coming back to what works for this country. // Think about the challenges we face as a nation: anyone who concerned about competitiveness has to see controlling health care costs as key to a healthy economy. / We've got to make certain our reform corrects our weaknesses without destroying our strengths. / When we talk about health care, we're talking about matters of the most personal nature -- in some cases, literally, life and death decisions. We don't need to put government between patients and their doctors. We don't need to create another wasteful federal bureaucracy. This President won't let that happen. //

We need common sense, comprehensive health care reform -- and we need it now. My plan is the right plan -- a plan that meets our obligation to all Americans by putting hope and health within their reach. //

Once again, my thanks for this warm Cleveland welcome. May God bless the United States of America.

# # #

20TH STORY of Level 1 printed in FULL format.

Business Insurance

May 6, 1991

SECTION: Pg. 1

LENGTH: 1784 words

HEADLINE: States rethinking health cover laws;
Massachusetts plan appears doomed

BYLINE: By JERRY GEISEL

DATELINE: BOSTON

BODY:

The so-called "play or pay" centerpiece of Massachusetts' landmark universal health care law -- often hailed as a model of bold state action to achieve universal health care coverage -- is on the road to repeal.

And, the expected demise of Massachusetts' approach could influence other state as well as federal lawmakers as they grapple with how to improve Americans' access to health care coverage, health care experts say.

But, the search for a solution will continue, they add.

Under the 1988 Massachusetts statute, most employers, starting next January, face a new "medical security contribution" tax that could total as much as $ 1,680 per employee.

However, an employer with a health care plan can offset the security contribution tax by each dollar spent on its health care plan. Employers whose annual health care expenses exceed $ 1,680 will be exempt (see story, page 80).

In addition, the law, among other things, imposes a small tax on employers to fund state coverage for poor unemployed residents. But, state legislators and others are not seeking repeal of these provisions.

At the time of enactment, then-Gov. Michael Dukakis hailed Massachusetts' so-called "play or pay" approach as a model other states could use to achieve universal health care coverage.

The exception would have been Hawaii, where -- as a result of a special exemption from the Employee Retirement Income Security Act of 1974 -- employers have been required for years to provide health care coverage to employees working 20 hours per week or more (see story, page 1).

Even business groups, long opposed to government involvement in the employee benefit arena, said the Massachusetts approach was preferable to proposals by Sen. Edward Kennedy, D.-Mass., the congressional champion of expanded health care coverage, that specified the design of employer-provided plans.

1991 Business Insurance, May 6, 1991

But the Massachusetts model, conceived during a robust economic era, now may never get off the ground.

Repeal of the law now is likely, because of a slumping state economy, a changed political climate and stiff opposition from small business.

"Realistically, repeal probably is in the offing. Support for the law has largely evaporated because of the economic situation," said State Rep. John McDonough, D-Boston, a key supporter of the law.

"The employer mandate likely will go. Many legislators already have written off the law," said Stephen Caulfield, a managing director with William M. Mercer Inc. in Boston.

"At this point I would bet on repeal," said Rhonda Davis, a consultant in the Boston office of Hewitt Associates.

Other state health care observers say that if the law is not repealed, then it definitely will be delayed from its scheduled Jan. 1 effective date.

"I don't think there is a prayer this law will be implemented next year," said Alan Sager, an associate professor at Boston University's School of Public Health.

The repeal drive could begin as soon as this month when Massachusetts legislators take up new budget legislation. Political observers there expect repeal amendments to be inserted in the budget proposals.

Earlier this year, the Legislature, as a compromise between those who favor keeping the law and those backing repeal, agreed in another budget proposal to delay the employer health care tax to 1994 from 1992.

But, the state's new governor conservative Republican William Weld, vetoed that proposal, saying that the best court of action is repeal, not delay.

"The issue has become will or will not the law be repealed," said Steven Triangle, vp-public affairs at Blue Cross/Blue Shield of Massachusetts in Boston.

Benefit observers say the problems with the Massachusetts health care statute have implications beyond the Bay State.

Supporters of the law say a repeal of the law would discourageother states or Congress from acting on similar proposals.

If the Massachusetts law if repealed, opponents of similar health care access proposals will say: 'Look what happened in Massachusetts.' That is unfortunate," Rep. McDonough said.

Indeed, U.S. Department of Health and Human Services Secretary Dr. Louis Sullivan last month told the House Ways and Means Committee that the problems the Massachusetts law has encountered is an example of why Congress should not adopt a "play or pay approach."

"If the idea is not working in one small Northeastern state, it seems foolhardy to impose this on our vast and varied nation of 250 million people," Dr. Sullivan told the House panel, which is now grappling with the access issue.

The growing opposition to the Massachusetts statute "makes very explicit the political problems of 'play or pay,'" said Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington think tank.

"States' legislatures will be reluctant to take on the seemingly intractable problem of a lack of health access through a mandate-type approach because of what has happened here," predicted Mercer's Mr. Caulfield.

Others point out that the political firestorm that has erupted over the Massachusetts health care law is a dramatic example that only federal action -- rather than state action -- can solve the access problem.

"One state alone cannot do it. A state-by-state approach is never going to work without federal help," asserted Alain Enthoven, a professor at Stanford University's Graduate School of Business in Stanford, Calif.

The controversy over the Massachusetts health care law also provides more evidence that there are no simple answers to improving access for the 34 million Americans not covered by employer health care plans, health care experts say.

"We are nowhere near a solution. There is no silver bullet for solving the access problem," said Stuart J. Brahs, vp-federal government relations in the Washington, D.C., office of the Principal Financial Group, a diversified financial services company.

"There is a consensus that something must be done to improve access. But there is no consensus on what that something shoudl be," agreed Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans, an employer-supported benefits lobbying group in Washington, D.C.

While supporters of the Massachusetts health care law concede that repeal appears likely, they say the drive to improve health care access for the nation's uninsured -- now about 16% of the population -- will not end.

"If the law is repealed, the crisis for the uninsured has not ended. It is one just one battle. No matter what, you will see more proposals," predicted Robert Restuccia, executive director of Health Care for All, a consumer advocacy group in Boston.

In fact, some benefit observers believe the problems in Massachusetts and the lack of a congressional consensus only are a temporary delay in the search for answers to improve health care access.

"The mistake would be to confuse what is the short-term impasse with permanent inaction," observed Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

The current drive to repeal the employer health care mandate would have been difficult to imagine three years ago when the proposal cleared the Massachusetts Legislature and was signed by Gov. Dukakis.

But as EBRI's Mr. Salisbury notes, much can happen between the time a law is passed and the time it is ready to go into effect.

In the case of Massachusetts, what changed the most was a rapid and steep turnover in the economic climate.

In early 1988, Massachusetts's unemployment rate was in the 3% range, among the lowest in the nation, leading some to describe the state economy as "The Massachusets Miracle."

In those heady economic times, there was little concern that a health care tax could hurt employers, benefit experts recalled.

"Everyone was feeling the glow from the boom years. There was a feeling some quarters of, 'So what if employers have to kick in more?'" Hewitt's Ms. Davis said.

But Massachusetts' bright economy began to dim last year as onetime state strengths -- real estate and the financial service industries -- developed major problems.

The state's unemployment rate in March, the most recent month for which statistics rate will rise even higher.

In this deteriorating economic climate, support for a statute that would impose a tax on employers of as much as $ 1,680 per employee began to evaporate, explained Mr. McDonough, the Boston Democratic representative.

"A feeling developed that it would be tough enough for small employers to survive, let alone pay a new tax or provide health care coverage," said Barbara Kalfin, a consultant with The Wyatt Co. in Boston.

The change in governors also has contributed to the loss of support for the statute's requirement that employers be taxed unless they offer health care coverage, observers say.

While Mr. Dukakis was an enthusiastic supporter of the employer mandate citing it during his 1988 presidential campaign as a model for the nation, his successor, Gov. Weld, has opposed the mandate from the time he took office earlier this year.

"We had a new Republican administration with a very different set of priorities," said Mercer's Mr. Caulfield.

"Gov. Weld feels the mandate would hurt small business. It is a burden that employers in these times can ill afford," a spokeswoman for the governor explained.

Without gubernatorial support, it becomes very difficult to implement a law of this type, Rep. McDonough said.

Rising opposition from small busiess also have weakened support for the employer mandate, many Massachusetts observers say.

Groups like the National Federation of Independent Business and The Massachusetts Restaurant Assn. have intensified their efforts to repeal the employer mandate.

The mandate "is a quick fix that places the burden exclusively on employers. This is something many of our members -- with low profit margins -- cannot afford," said Cindy Eid, director of government affairs for the Massachusetts Restaurant Assn. in Westboro, Mass.

"For many employers, the problem is just staying in business and paying other mandated costs, like workers compensation," said Carolyn Bovierd, state director of the NFIB in Boston.

"I think legislators now realize that access to health care is a bigger problem than just trying to make employers pay for it. It was a naive approach," Ms. Bovierd said.

But, Mr. Restuccia of the consumer advocacy group Health Care for All, says that just as there is a minimum wage requirement there also should be a minimum health care benefit requirement.

"The law is not a panacea, but it is a good step forward," he said.

19TH STORY of Level 1 printed in FULL format.

Business Insurance

May 6, 1991

SECTION: OPINIONS; Pg. 8

LENGTH: 707 words

HEADLINE: Plan fails to address costs

BODY:

AS THE POLITICAL firestorm over Massachusetts' universal health care statute demonstrates, expanding access to the health care system through employer mandates is no simple task.

Three years ago, Massachusetts captured national attention with its bold approach to improving access to health care. Legislation enacted that year, but not due to go into effect until January 1991, requires employers with more than five employees to pay a "medical security tax" equal to 12% of the first $ 14,000 of each employee's wages, up to $ 1,680 per employee. This tax would go to the state, which would use the funds to provide coverage for employees working for companies not offering group plans (see story, page 1).

However, this tax is offset by the per-employee amount an employer spends on its health care plan. If a plan costs at least $ 1,680 per employee, as most health care plans offered by large and mediumsized employers do, the employer is exempt from the tax.

Back in 1988, the Massachusetts approach, known simply as "play or pay," was recognized as a refreshing break from other proposals to expand access to health care, most notably the proposal championed in Congress by Sen. Edward Kennedy, D-Mass.

Under the Kennedy proposal -- a model of government interference in the design of benefit plans -- employers would be forced to offer health care plans that met specific coverage requirements. And, the way the Kennedy legislation was drafted, there would be nothing to prevent legislators from boosting those requirements each time they were pressured by special interest groups.

By contrast, the Massachusetts approach leaves the design of health care plans up to employers and their workers. There is no government micro-management of health plans; the employer either pays a tax or offers a health care plan.

But as the effective date of the Massachusetts employer mandate nears, it is becoming clear that the program, while preferable to the Kennedy proposal, still won't work.

For example, many small companies in Massachusetts probably will not be able to afford either to provide coverage or pay the tax. Small business lobbyists say the last thing Massachusetts needs at a time when unemployment is nearing double digits is another tax on employers.

At the same time, we wonder how long the $ 1,680 per-employee tax, at a time of soaring health care inflation, could be kept at that level. With corporate health care costs now averaging about $ 3,000 per employee, spending $ 1,680 per worker won't go very far.

Even if employees were forced to pay 20% of the premium under the Massachusetts system, there still likely would not be enough money to ensure that all Massachusetts residents would have an adequate level of health care coverage.

In short, if the $ 1,680 benchmark remained on the books, it would mean that Massachusetts would have to subsidize coverage, a politically unrealistic proposition at a time when the state is fighting a huge budget deficit.

In short, where the Massachusetts approach has failed is that it does nothing to control the one thing that is restricting access to health care: the cost of services. Employers don't provide coverage, not because they don't want their employees to have access to health care services, but because they can't afford to. And as health care costs continue to escalate, more and more employers will be unable to afford to offer a health care plan.

However, some simple things can be done on a national level to lower health care costs, which will increase access to the health care system. Congress, for example, should pre-empt state rules that mandate specific benefits for insured group health care plans -- one factor that continues to drive up the cost of health care. More rational medical malpractice laws are needed to protect health care providers from outlandish awards. And, insurers and employers need to exert more pressure on providers to eliminate waste in the health care delivery system.

Simply requiring employers to offer health care coverage -- whether through a Massachusetts-type system or through a system like the one Sen. Kennedy proposes -- will create more problems than it will solve.

7TH STORY of Level 1 printed in FULL format.

September 30, 1991

SECTION: Pg. 24

LENGTH: 648 words

HEADLINE: Study: Many Employers Will Pay Rather Than Play

BYLINE: BY MARY JANE FISHER

DATELINE: WASHINGTON

BODY:

Between one and two million small employers would find it cheaper to pay than "play" for health insurance coverage under proposals currently before Congress, according to a study by the NFIB Foundation of Washington, D.C.

"The incentive in the 'play or pay' approach to health insurance coverage for a significant number of employers is to pay," the study concluded.

It found that the incentives are particularly strong for employers hiring unskilled and part-time workers.

For example, the Foundation said a small business owner with eight employees at 89 an hour and two part-time employees at $ 6.50 an hour could cut costs of an average premium in half by paying into a federal fund.

The Foundation is an affiliate of the National Federation of Independent Business of Washington, D.C. Entitled "It's Cheaper to Pay Than It Is To Play," the study was conducted by William Dennis, the Foundation's chief economist.

The findings were based on provisions of the Senate Democratic leadership bill, HealthAmerica, S.1227, introduced by Senate Majority Leader George Mitchell of Maine and three senior Senate Democrats (NU, June 10).

However, the report is "equally applicable to Massachusetts' failed universal health care program and the fall-back position in Oregon's current experiment with tax incentives to small employers for providing employee health insurance," the Foundation said.

The "pay or play" approach requires employers to either provide a basic employee health insurance package or to pay a tax into a public fund that would finance health care coverage.

As employers respond to the incentives provided, the cost of health insurance coverage under the public plan will be significantly greater than the revenues generated, according to the report. "Thus," it reported, "play or pay substitutes public insurance for private -- at an unknown but substantial cost to the taxpayer."

The Mitchell bill would provide tax incentives that effectively lower the premium cost, the Foundation said.

It noted that the most important tax incentive in the bill would be a 25 percent credit on the first $ 3,000 of per employee premium for each full-time employee earning less than $ 20,000 a year. The incentive would apply only to firms with fewer than 60 employees.

Under the bill, the Foundation said the employer's share of the average premium would reach 8 percent of payroll at the $ 15-plus per hour level for a full-time employee.

It predicted that the $ 15 figure would translate into a business with average full-time employee costs, including fringe benefits and payroll taxes, of almost $ 30,000 a year.

"Since small employers pay as much as 20 percent more for the same coverage as large employers, small business employees could enjoy relatively greater benefits in the federally subsidized program . . .," according to the Foundation.

In addition, the study said, another incentive encouraging small employers to take the pay option would be "elimination of the 'hassle' of shopping for and purchasing insurance, and acting as the mediator between the insurer and employees."

The Foundation concluded that the bill would encourage many employers to drop existing private employee health insurance packages by offering a more financially attractive federal alternative.

"Thus, it is likely that a huge number of small business owners, perhaps a majority, will elect the pay option," the Foundation said.

"And if huge numbers select the pay option," the Foundation predicted that "S. 1227 effectively begins a federal takeover of private health insurance, offering the unhappy prospect of a nationalized Medicare-type public insurance system replete with uncontrolled costs."

The NFIB has a membership of more than 500,000 small businesses. Members' gross receipts average less than $ 300,000 a year, and they have an average of five employees.

3RD STORY of Level 1 printed in FULL format.

Daily Report For Executives

December 3, 1991, Tuesday

SECTION: ANALYSIS AND REPORTS; DER No. 232; PG. C-9

LENGTH: 1673 words

HEADLINE: Massachusetts, ONLY PIECES REMAIN OF LAW ESTABLISHING UNIVERSAL HEALTH CARE

BODY:

Rarely has a piece of health care legislation been tied so tightly with one state politician like the Massachusetts Universal Health Care law is to former governor and Democratic presidential candidate Michael S. Dukakis. Like Dukakis' 1988 presidential bid, the universal health care law has been derailed.

As initially adopted, the program (Chap. 88-23) was intended to provide coverage for the state's 600,000 uninsured residents by mandating employer-based coverage and creating a series of purchasing pools for those not covered by workplace insurance.

But now, more than four years later, only bits of the landmark universal health care bill remain.

Two Measures

The Massachusetts law was actually two separate and distinct measures contained in one legislative act-a health care cost-containment and hospital financing mechanism, and the universal coverage provision.

Estimates currently show that total spending for medical treatment annually in Massachusetts ranges between $10 billion and $12 billion. The cost to the private sector for hospital charges and medical costs totals approximately $6 billion annually in Massachusetts. An equal amount is spent by the state and federal government on funding various health care programs.

Because the typical uninsured person in Massachusetts is either a low- or middle-income worker, or the dependent of such an employee, the Universal Health Care plan looked first to the employer for coverage. Persons who are unemployed, have disabilities, or are enrolled in other social programs were expected to be provided with insurance through new or expanded state programs. Taxes on employers and state subsidies were designed to allow other uninsured residents of the state to buy coverage from the Department of Medical Security on a sliding scale basis.

It was the mandate on employers to provide coverage for their workforce that was the heart of the program which drew both criticism and praise.

Implementation of the major mandate, a requirement that employers either provide their workforce with health care coverage or pay $1,680 per employee into a

state fund to provide such coverage, was originally set for Jan. 1, 1992. After repeated attempts to repeal this provision, Gov. William Weld (R) agreed to a three-year delay of the mandate in August. It is widely expected to be repealed before the new 1995 effective date, said Marijo McCarthy, a spokeswoman for the Smaller Business Association of New England.

SBANE opposed the employer mandate at the time it was adopted. McCarthy's view in 1988 is still the same today, she told BNA: ''It is next to impossible to force small employers to provide an employee benefit that many cannot get and even more cannot still, four years later, afford.''

A smaller mandate which took effect in 1990 requires employers to contribute 0.12 percent of an employee's first $14,000 in wages, up to $16.80 a year, into a fund to purchase health care benefits for workers receiving unemployment.

But that program has recently come under attack. Despite the fact that it has been in place since early 1990, critics charge it has benefited only a fraction of the population it is designed to serve. To date, it has spent only $14.1 million, nearly half of that on administrative costs, while amassing a trust fund balance of $42 million, according to Jeffrey Ritter, commissioner of the Department of Medical Security. Throughout the period, the jobless rate in Massachusetts has been among the highest in the country; it currently stands at 8.9 percent.

State officials estimated that 30,000 workers a month would be eligible for the health care benefits-payable to low- and middle-income workers receiving unemployment insurance benefits-and that, on average, about half that number would participate in the program, Ritter told BNA. Instead, the number peaked at 10,050 in June 1991 and then dropped sharply after the state stopped paying extended unemployment benefits; there now are 6,300 workers receiving health insurance benefits, he said.

Legislators and worker advocates charged that the state has made little effort to inform workers of the program and that strict eligibility requirements based on family income in the year prior to a job loss are rigid and unrealistic. Massachusetts AFL-CIO President Joseph C. Faherty said ''basing benefits on income 52 weeks prior to unemployment penalizes those who struggle to maintain jobs.''

Under the program, workers who meet the income eligibility requirements can receive either direct medical care coverage or partial reimbursements of premium payments to keep their existing coverage. The maximum total family income to qualify is $19,860 for an individual, $26,640 for a family of two, $33,420 for a family of three, and $40,200 for a family of four (with $6,780 added for each additional family member).

Those who choose to keep the health insurance they had when they were employed receive up to $80 per month for individual coverage and up to $200 a month for family coverage. In addition, a larger reimbursement is payable to low income workers. Unemployed workers who meet the lower income eligibility standard ($6,620 for an individual, $8,880 for two, $11,140 for three, $13,400 for four, etc.) receive up to $140 a month for individual coverage and $350 per month for family coverage.

A legislative proposal now pending before the state legislature to expand the

program (H 6166) would base income eligibility on a combination of the previous six months of income and a projection of six months of UI benefits; eliminate deductibles and copayments for those with the lowest incomes and establish a sliding scale of payments, based on income, for other participants; and ensure that information about the plan is available for non-English-speaking persons.

The Universal Health Care law also incorporated a number of community-based programs intended to expand health care coverage.

The Commonhealth program was implemented in July 1988 as the first phase of universal health care. Administered by the Department of Public Welfare, Commonhealth provides medical coverage to persons who are in transition from welfare programs to work, disabled children, and disabled adults. In May of 1989, the Department of Medical Security implemented a program called CenterCare to provide primary health coverage to uninsured people by using participating community health centers. These centers receive a monthly payment based on their enrollment.

According to DMS spokesman Laurence Collins, these programs are still in effect, but have been cut back considerably due to lack of funding. A pilot program intended to test different approaches to providing health insurance to the uninsured will be terminated. A program requiring students to purchase health insurance through their institution or demonstrate that they are covered by a comparable plan is in place and working extremely well, Collins said.

Hospital Financing

A second provision of the 1988 Universal Health Care Law dealt with the issue of hospital financing. That hospital financing mechanism expired on Sept. 30 and state lawmakers are back at working attempting to craft a new agreement. A bill (H 6100) pending before the House Ways and Means Committee would revise the manner in which hospitals would be reimbursed for the $5 billion in bills they issue each year and simplify hospital finance regulations.

That measure also has extensive provisions relating to small group health insurance reform. It is these reforms, says SBANE's McCarthy, that will help the employer to provide workplace-based coverage.

As now written, the bill would mandate whole group coverage and renewability of coverage. It would also limit the waiting period for pre-existing conditions to six months and credit time in a previous plan. It would apply to employers with two to 25 workers and cover all currently mandated benefits.

The bill would also authorize the Department of Medical Security to establish a small business health insurance pool and would limit rate hikes.

But, while McCarthy said the bill addresses the issue of accessibility, it does not solve the problem of affordability. SBANE is afraid that the proposed legislation simply replicates the pilot program designed to provide an affordable product under the Universal Health Care Law which has been phased out. McCarthy has called on the legislature to amend the bill to ''allow all health insurance providers to offer a basic plan of medical benefits, with only the necessary basic mandates.'' She also urged that the product be made

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available to sole practioners.

Concern over certain provisions of the bill have also been expressed by the Life Insurance Association of Massachusetts. Elizabeth Rothberg, LIAM health policy associate, told BNA that a reinsurance pool must be part of any bill. ''Because commercial insurers would be changing their practices significantly there must be some allowance for the sharing of substantial losses.''

Richard Mastrangelo, spokesman for the Associated Industries of Massachusetts, which represents the state's larger firms, said the most important feature of any really workable health care bill is the signature of the president of the United States. ''Health care is a national issue that can only be addressed at the federal level,'' he argued. To attempt to resolve the issue at the state level automatically leads to the concern that you put that particular state's employers at a competitive disadvantage, he said.

Mastrangelo said that even at the time the Universal Health Care Law was adopted in 1988, it was clear that it was going to be a burden on business at a time when business could ill afford it.

By BNA staff correspondent Martha Kessler, Boston.

[See text in original or call BNA Plus at 800-452-7773 or 202-452-4323.]

2ND STORY of Level 1 printed in FULL format.

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HEADLINE: Weld may retain, revise universal health care

BYLINE: By Richard A. Knox, Globe Staff

KEYWORD: MASSACHUSETTS; HEALTH; LAW; WILLIAM WELD; STATISTIC; INSURANCE; COST

BODY:

Although Massachusetts' universal health care law has been widely written off as a doomed remnant of the Dukakis era, there are growing signs the landmark experiment will be retooled, but not dismantled, by the incoming Weld administration.

With just a fraction of the state's estimated 400,000 medically uninsured residents now enrolled, the promise of health care coverage for all, made in April 1988, hangs in the balance. The factors at play include:

- Governor-elect William Weld is backing off his campaign pledge to "repeal universal health care." Paul Cellucci, the lieutenant governor-elect, now says the Weld team would retain many of the complex law's new programs and pursue the same goal - health care for all.

- Key business leaders are now urging Weld to delay rather than kill the most bitterly opposed feature of the law, the "business mandate." This provision would require most firms to offer employees health insurance by 1992 or pay $ 1,680 per worker annually into a new Health Security Trust Fund created to provide the coverage.

- Even though implementation of the law has been slower than planned, few want to take away health insurance from the more than 76,000 Massachusetts citizens who have gained coverage since its inception. "We wouldn't have insurance otherwise," said one of those enrollees, Mary Robbins, who had repeatedly tried without success to buy coverage for the small Saugus heating and air conditioning firm she owns and operates with her husband.

- New estimates from the Department of Medical Security, the agency struggling to implement the program, challenge the prevailing assumption that full implementation of universal health insurance will require additional state funding.

- A decision to fall back on the old mechanism of paying for care of the uninsured, the state's Uncompensated Care Pool, would incur major costs and political liabilities. The costs, covered by a surcharge on all insured citizens' hospital bills, have hit $ 405 million this year and will balloon even more rapidly if ways are not found to chip away at the number of uninsured. The question is where the money will come from: the beleaguered state budget, or businesses and their employees already burdened by high health insurance

premiums.

For these reasons and more, those who understand the intricacies of health-care financing say there is no way for the state simply to walk away from the problem of finding a way to pay the health costs of the uninsured.

Although the 1988 universal health care law, now known as Chapter 23, was closely linked with Gov. Dukakis and his shattered presidential ambitions, the concept has a history that transcends parties and ideologies. It was a Republican governor, Samuel Walker McCall, who first proposed universal health insurance in Massachusetts almost 74 years ago.

While Weld has yet to detail his health policy plans, he has designated the lieutenant governor-elect as his spokesman on those issues, and Cellucci, in an interview, said the incoming administration will not neglect the health-care needs of the uninsured.

"Clearly one of our priorities will be to ensure that every citizen has access to health care," he said. "But we don't have a magic wand. We're not saying, 'We'll take Chapter 23 away and here's what we're going to put in its place.' We're saying we think it needs some work and some changes."

However, Cellucci said the administration still opposes the guts of the law, the $ 1,680-per-worker tax to be levied by January 1992 on businesses that employ more than five workers and do not offer health insurance plans. Smaller businesses, which often do not offer insurance, have fought this so-called business "mandate," saying it would cost jobs and even bankrupt them.

But one of the state's largest business lobbies, Associated Industries of Massachusetts, is urging Weld to delay the mandate for two years rather than repeal it.

"We'd like to maintain the universal health care law rather than throw out the baby with the bathwater," said Jack Cogswell of Associated Industries, whose 3,000 members tend to be larger firms.

It is not that Associated Industries likes the mandate. Rather, the organization is persuaded that repealing it will remove pressure for fundamental changes needed to make health insurance more affordable for all businesses.

"We want the mandate in order to further negotiations," Cogswell said. "It's a club that hopefully will never be used."

That argument has support even in some segments of the small-business community, although most remain rabidly opposed. "Our best interest isn't necessarily to dig in our heels and say, 'Get rid of the mandate,' " said Marijo McCarthy of the 2,000-member Smaller Business Association of New England. "My reply to Weld is that repeal is great as long as we don't lose the momentum to reform the small-business insurance market. Mandate or not, that problem exists."

At the state agency charged with implementing universal health care, one key official says the biggest obstacle is the "atmosphere of defeatism" that enveloped it in the wake of Dukakis' presidential defeat and the state budget crisis.

1990, The Boston Globe, December 11, 1990

That atmosphere has obscured the achievements of the new agency, the Department of Medical Security, says deputy commissioner Hal Belodoff, but it has not quenched its conviction that universal coverage is affordable, and not the extravagance its critics have claimed.

The agency has just completed calculations that show, it says, that it is possible to cover all Massachusetts residents who lack health insurance without new state funding.

Overall, the agency estimates it would cost about $ 1 billion to provide a standard health policy to the more than 400,000 residents who currently lack any coverage, as well as to the 230,000 people who currently have expensive and limited nongroup policies and would probably switch to the state-subsidized program envisioned under the law.

That $ 1 billion would come from three sources, the agency said. Up to $ 250 million would be shifted from the existing Uncompensated Care Pool; $ 328 million would be raised by the reviled $ 1,680-per-worker tax on businesses; and almost $ 500 million would be collected in premiums paid by those in the program according to their income.

The agency staff figures that 43 percent of the $ 1 billion cost would be met by money already in the system - the Uncompensated Care Pool money and premiums now being paid by people who buy nongroup insurance policies. The rest would come from the new employer tax or beneficiaries' contributions.

"This is not the budget buster that everyone thought it was," said the agency head, James A. Hooley.
The push to repeal Chapter 23 will have to confront tough questions of what to do about the 76,000 Massachusetts residents who are currently being covered under the law, including the growing number of unemployed.

For instance, since she lost her job and with it her health insurance earlier this year, Mary Sharkus of South Boston has broken her wrist, her 4-year-old son John Jr. had a second-degree burn and husband John was hospitalized for a recurring bone infection.

Most of her bills have been covered by the Health Security Plan, a little-known feature of the universal health insurance law that now covers more than 7,500 unemployed people. Most persons pay no premiums but must pick up a chunk of the cost of their care through deductibles and copayments to their doctors, hospitals, druggists and other providers.

"You cannot survive in this world without health insurance," Sharkus said. "Hospitals can't refuse you care, but credit companies will harass you. And I'm telling you they are very rude."

"This costs me a lot out of pocket, but it's better than nothing," added Daniel Majka of Wheelwright, who got laid off from his job as a South Barre lumberyard foreman in August. One of his three sons was subsequently hospitalized for a hernia operation that cost $ 2,000.

The plan is financed by a new $ 16.80 a year tax that all Massachusetts companies must pay for each employee, a levy that raises $ 34 million a year and could support 30,000 claimants.

1990, The Boston Globe, December 11, 1990

This "little mandate" has not been controversial, and each week the state receives more calls from companies planning layoffs who want to brief their employees on the new safety-net program.

With unemployment rising, the Weld administration will probably leave the Health Security Plan in place, Cellucci said, but its coverage also extends to other groups, including:

- Students no longer covered under their parents' insurance.

- "Uninsurable" disabled adults who otherwise would have to quit work to qualify for Medicaid.

- Former welfare recipients who need coverage so they can afford to take a job.

- Families with disabled children.

- Low-income community health center patients.

- Owners of small businesses and their employees, who most often complain they are frozen out of the health insurance marketplace.

- Self-employed individuals and others who work at firms that do not provide insurance.

Take Chris Anslono, owner of Lynn Carburetor and Auto Service. Anslono said he kept losing employees to larger shops that offered health benefits until last spring, when the firm joined a pilot program offered under the law, one of five launched so far by the Department of Medical Security.

"Dollarwise we were competitive, but we couldn't offer insurance," Anslono says. "We've had at least a dozen insurance companies out over the past couple of years. Their rates were ridiculous and the coverage was terrible."

Now Anslono is happy to pay John Hancock Mutual Life Insurance Co. $ 1,000 a month - 15 to 20 percent below prevailing small business premiums - to cover himself, his three employees and their dependents.

Enrollment in the voluntary pilot programs has been disappointing, however. By now, the state had hoped to sign up almost 10,000 individuals and small businesses in the five programs, but barely 1,000 have enrolled.

Opinions differ on why. One Senate aide who helped draft Chapter 23 said it shows that the mandate is necessary, that many businesses not offering health insurance will not step up to the plate even if subsidized coverage is available.

At the Department of Medical Security, Belodoff disagreed: "It's premature to conclude that people won't buy in voluntarily. The issue in the small-business market is price, price, price. Even though" the pilot programs "are cheaper, sometimes 20 to 25 percent cheaper, when you've been getting by paying zero, 20 percent off doesn't seem like a great deal."

1990, The Boston Globe, December 11, 1990

One factor in the disappointing enrollment, Belodoff said, is the lack of aggressive marketing by all but one of the participating insurance companies. The exception, John Hancock, had much more success. Belodoff speculated that the cloud of uncertainty around the law has made businesses shy of offering a new benefit they might later have to renege on.

One insight from the experiment is the popularity of the state-subsidized coverage among individuals rather than small firms. Self-employed people and those in firms that do not offer insurance quickly filled the 500 available slots. New York state had a similar experience.

To some this suggests the state should push subsidized individual coverage as one way to make a dent in the "uninsurance" problem.

"Why don't we subsidize Blue Cross-Blue Shield nongroup coverage on a means-tested basis?" asked former state insurance commissioner Peter Hiam of Boston University School of Publied Care Pool, which pays for hospitals' free care and bad debts.

That translates into higher premiums for the insured workers and employers who support the pool - a trend that works against efforts to make Massachusetts' business climate more attractive.

Under Chapter 23, businesses that provide insurance have enjoyed a 24 percent cut in the surcharge, and some view with alarm the return to an open-ended obligation to fund the pool.

"The Uncompensated Care Pool is a tax most people don't even see, and it's probably one of the biggest single tax items, even though it's not on the budget," observed Kenneth E. Thorpe at the Harvard School of Public Health. "It's going to grow and grow, and you can't just walk away from it and pretend it doesn't exist."

New Jersey serves as an example. There, businesses with health insurance and their employees currently pay a 19 percent surcharge on hospital bills, and it is expected to hit 24 percent next year. In Massachusetts, the surcharge is currently below 11 percent.

But hospitals are expected to charge the pool up to $ 405 million this year, and the figure is growing at 9 percent annually. Under Chapter 23, the state is supposed to pick up any amount over $ 312 million, but the state fiscal crisis has prevented it from paying any of its share.

"I don't think the Weld administration has an idea how complex this issue is," said Rep. John McDonough (D-Jamaica Plain), expected to become House chairman of the Legislature's Joint Health Care Committee. "All I've heard them say is that the pool can be used to pay for everything."
Since Massachusetts took the first step, at least a dozen other states have begun to explore approaches toward universal coverage. But even outside the state, there is a widespread perception that the Bay State experiment is a failure.

Said a New Jersey consumer lobbyist: "The first thing you hear is, 'We don't want to do what Massachusetts did.' "

1990, The Boston Globe, December 11, 1990

Given the difficulty of tackling the problem of America's uninsured at the state level, some of those most involved think this reaction is far too harsh.

"If it all went away tomorrow," said Steve Tringale, a Massachusetts Blue Cross-Blue Shield executive who helped draft Chapter 23, "we'd still be in a better position to figure out what you can and can't do, and address all the policy issues, than anyone else in the country."

GRAPHIC: CHART

suggestions,
from Hanns Kuttner, 2/5/92:

page 5:

Massachusetts passed a "Play or Pay" plan in 1988. It was supposed to become law in 1992 -- but now the state legislature has pushed it back to 1995. Why did they back off? Because they knew if that plan took effect, businesses -- small businesses mainly -- would pack up and leave Massachusetts, or go out of business because they couldn't bear the additional expense.

page 8:

Mandated benefits are out of control. States now order health insurers to cover a thousand different types of treatment -- from hair transplants to beauty treatments. [Next they'll cover maincures for Millie...]

State mandates of treatments covered: handful to 1000.

Hair transplants....

EXCESSIVE mandates....

Mandated benefits out of control - ~~1000's~~ from a handful to 1000....

next thing they'll be mandating beauty treatments....

Millie

THE WHITE HOUSE
WASHINGTON

Date _____

TO:

FROM: **OFFICE OF COMMUNICATIONS**
Room 122 OEOB, Ext. 2930

THE WHITE HOUSE
WASHINGTON

Date ______________

TO:

FROM: OFFICE OF COMMUNICATIONS
Room 122 OEOB, Ext. 2930

I'm talking about an old-fashioned idea....

~~PARDON PARDON ME FOR BEING OLD FASHIONED~~....

ACCESS

MAJOR PROVISION OF PLAN (PASSED IN 1988) TO TAKE EFFECT 1/92.

Delayed to 1/95.

If we do this nationally—they move overseas

Repealed....

They knew that if it took effect

Why did the Mess keep [illegible]....

1991
344

2/day

Linda Carter
Administrator
of Cardiology
Mt. Sinai Hospt.
Cleveland

University Hospitals

(216) 844-5000

Coronary Bypass?

Cardiology -

2-4/day

Mt. Sinai (Cleveland)

(216) 421-3959

Linda Carter - Cardiology

City/State: Cleveland, OH

Event: GCGA

Date: 1/31/92

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McGroarty/Bunton
February 4, 1992
5:30 pm
[health]

PRESIDENTIAL REMARKS: GREATER CLEVELAND GROWTH ASSOCIATION
CLEVELAND, OHIO
FEBRUARY 6, 1992
12:00 NOON

Bob Horton

[Introductory acknowledgements.] I'm pleased to be back in Cleveland, capital city of the North Coast. [[opening humor...]]

People who know Northern Ohio know this region's outgrowing the old rustbelt image. In addition to the world-renowned Cleveland Clinic -- now the city's number one employer -- Northern Ohio is also home to some of the most innovative approaches to health care. COSE [COZY] and Cleveland Health Quality Choice are pioneers: communities across the country can follow your lead to create workable solutions to health care challenges. / That's why I've chosen to come to Cleveland this morning to address the health care crisis -- and lay out my <u>four-point program for comprehensive health care reform</u>. //

Reform is urgent -- for more reasons than one. / Right now, far too many Americans are uninsured -- and those who are insured pay too much for health care. And <u>we're going to do something about that</u>. //

The one thing this crisis <u>isn't</u> about is <u>quality</u> of care. American health care is first-rate, the best in the world. And right now, the vast majority of Americans have access to that health care system. But the <u>cost</u> has skyrocketed: from $74 billion dollars in 1970 to <u>$800 billion dollars today</u>. And if we

keep going at the same rate, that $800 billion will double to $1.6 trillion by the year 2000.

These numbers alone would make the case for reform. But cold statistics don't show us the worry people feel -- the all-too-familiar fear about what happens to their health care if they change jobs -- or worse still, if they lose their jobs. // And in these hard times, we simply cannot accept the fact that one in every seven Americans is uninsured. //

There's a better way. / My plan puts the emphasis on expanding access -- while preserving the choice people now have over the type of health coverage and health care they receive. My plan will give Americans a greater sense of security -- help ease the fears so many Americans have that changing jobs will cost them their health coverage: the key here is portability -- changing the system to ensure people they'll always have access to health insurance -- no matter where they go, no matter what. // Finally, my plan will cut costs. It helps us make health insurance more affordable -- and more affordable means more accessible.

My plan will preserve what works -- and reform what doesn't. And above all, it will ensure every American universal access to affordable health insurance. //

We stand at a crossroads. We can settle on sensible reforms -- or we can force ourselves to swallow a cure worse than the disease.

Some people have scribbled out a prescription for disaster: they want to nationalize the health system. Put government in control of the system: let government control the prices, let government ration the kind of health care people get -- let government tell people looking for care how much they'll get, what kind, and when.

Right now, across Lake Erie, Canada's system covers everyone. But keep in mind the drawbacks that come with a nationalized system: long waiting lists for surgery -- shortages of the high-tech equipment responsible for so many of the miracles of modern medicine. // Let me cite just one example: The Cleveland Clinic performs 10 coronary bypass surgeries a day. [UNIVERSITY HOSPITALS OF CLEVELAND] Mt. Sinai hospital, which I just visited, does ___ a day. High tech, high quality surgery -- without any wait. But if you live in British Columbia, the wait for coronary bypass surgery is six months. It's no wonder so many Canadians come to Seattle's hospitals for surgery.

PR OFFICE - 216-444-5680 Phyllis Mains

3,200 open heart surgeries per year

When you nationalize health care, you push costs higher -- far higher. Some studies estimate that a Canadian-style plan would cost the average American family a huge new tax burden -- for the nation, a staggering $250 to $500 billion dollars a year in new taxes. //

Such a massive tax increase is simply unacceptable. //

And for that price, you get the worst of both worlds: No one has an incentive to control costs -- and everyone pays. //

But there are other proposals out there that sound simple, but are every bit as harmful. One's called "Play or pay." Each employer must "play" -- meaning: provide insurance for employees, or "pay" -- a payroll tax to finance government health coverage.

Businessmen and women tell me horror stories about health care costs spiralling out of control. Well, Play or Pay will leave a lot of small businesses -- businesses struggling on the edge of survival right now -- with a tough choice: They can cut workers' wages to pay for mandated health care, they can fire some workers to cover the rest -- or they can raise prices, and pass along the cost to the consumer. Some studies put the cost in jobs lost under "Play or Pay" as high as half-a-million or more.

Strip away the rhetoric, and "Play or pay" just creates a back-door route to a nationalized health care. It encourages employers to stop offering benefits, throw the problem in the government's lap, and dump millions of fully-insured workers into a public plan like Medicaid. And because the new employer taxes in Play or Pay don't pay for the program -- the American taxpayer will foot the bill. / I'm not about to let that happen. //

You won't hear this from the people pushing Play or Pay. Ask them about the side-affects of their proposal, and they'll say: Take two aspirin -- and call me after the election. //

I don't believe people want to be shoveled into some new health care bureaucracy. They want good health. // A large

part of the answer is prevention: every one of us can make changes in our behavior to reduce the risk of disease and illness. {Pardon me for being old-fashioned, but what we're talking about is just plain clean-living -- and there's nothing wrong with that.} / Tomorrow, in San Diego, I'll focus in more detail on the ways prevention can help people live healthier lives -- and help keep our economy healthy, too.

But today, I want to focus on the health care system -- on my comprehensive, market-based reform plan. / The fact is, we don't have to create a new government bureaucracy to give Americans access to affordable, quality health care. We need a system that delivers -- a system that works for America -- a system that puts quality care within reach of every American family.

Our system should be built on choice -- not central control. It should keep costs down -- and open up access. But above all, it should allow all Americans to rest secure when it comes to health care -- to ease their worry that if they change jobs, if they or their kids develop serious health problems, they'll still be able to count on the coverage they need. //

My comprehensive four-point plan meets every one of these common-sense tests. Here's how:

Point one: we will make health care more accessible by making health insurance more affordable. For low-income individuals and families, I propose a health insurance credit -- up to $3,750 dollars a year to guarantee people, even people too

poor to file taxes, the ability to purchase private health insurance. That will put in their hands a certificate or voucher worth more than $300 dollars a month. They can use it to buy into the plan their employers offer but they could never afford -- or they can shop for whatever private plan suits them best.

That's the American commitment to choice at its best.

For middle-income individuals and families, I propose a health insurance **tax deduction** of $3,750. / American families with incomes under $80,000 will receive new help from either the credit or the tax deduction. Let me tell you what that means: new help to purchase health insurance for 95 million Americans.

Once again, this insurance will be portable: people who change jobs would have insurance regardless of their health -- and this is important -- or their family's health.

But best of all, my plan will bring health care **coverage** to 30 million uninsured Americans -- **security** / to people who for far too long have had to do without. //

That's the first point in my four-point plan: access.

Point two: we will **cut the runaway costs** of health care by making the system more **efficient**. Today, I'm asking you to learn a new acronym: HIN -- Health Insurance Networks. / Insurance costs obey the "law of large numbers:" The larger the group being insured, the lower the cost per individual. "Pooling" lowers insurance costs -- and significantly cuts administrative costs. HIN's will provide incentives for small companies to do what Cleveland's C.O.S.E. [COZY] group has done -- when it

brought 10,000 small businesses together to make a joint purchase of health care.

Another way to drive costs down: make everyone a better health care consumer. Right now, most people pay more attention to the price of toothpaste than the comparative costs of health care. People don't waste much time thinking about the costs of their care -- but in the end, we all pay the price. We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people "shopping" for health care a kind of "blue book" for medical costs. // Innovations like these will help all of us keep the costs of quality health care as low as possible.

Point Three: we will wring out waste and excess in the present system. We've targeted medical malpractice for reform. It's time to put an end to these astronomical, sky's-the-limit lawsuits. // You shouldn't have to pay a lawyer when you go to the doctor. //

Right now, people do just that: high malpractice premiums mean higher doctors' bills, higher hospital costs -- costs passed along to the patient. / I have challenged the health insurance industry to cut red tape -- to share common forms, and to simplify and speed up claims processing. Here's a challenge for the next four years: There is no reason almost all health insurance claims can't be processed electronically. That single step would eliminate a mountain of health care paperwork and pare back costs.

Fourth and finally, we will get the growth in federal health programs under control. Right now, government health care programs can claim a dubious distinction: they are the fastest growing parts in the federal budget. / We must bring runaway costs under control. We won't cut benefits -- we can make real savings simply by reducing the rate of increase.

Efficiencies like this will help our reform plan pay for itself. //

The federal government should also give states the flexibility to design new universal access programs for the poor -- programs that will provide quality services to all their citizens. I've just met with the Governors -- they want flexibility, and we'll give it to them. States will be able to use new federal resources to design programs that work -- not one-size-fits-all solutions imposed by Washington.

Providing affordable care, efficient care, / wringing out excess and waste and controlling federal growth: these four points will create the kind of market-based reform plan that will give Americans the kind of health care they want and deserve -- and put an end to the worry that keeps them awake at night.

Remember what people want. People want quality care / care they can afford / care they can count on.

I keep coming back to what works for this country. // We've got to make certain our reform corrects our weaknesses without destroying our strengths. / When we talk about health care, we're talking about matters of the most personal nature --

in some cases, literally, life and death decisions. We don't need to put government between patients and their doctors. We don't need to create another wasteful federal bureaucracy. This President won't let that happen. //

We need common sense, comprehensive health care reform -- and we need it now. My plan is the right plan -- a plan that meets our obligation to all Americans by putting hope and health within their reach. //

Once again, my thanks for this warm Cleveland welcome. May God bless the United States of America.

# # #

McGroarty/Bunton
February 4, 1992
10:00 am
[health]

PRESIDENTIAL REMARKS: GREATER CLEVELAND GROWTH ASSOCIATION
CLEVELAND, OHIO
FEBRUARY 6, 1992
12:00 NOON

"The Comeback City" — Bob from BP

[Introductory acknowledgements.] I'm pleased to be back in Cleveland, capital city of the North Coast. [[opening humor...]]

People who know Northern Ohio know this region's outgrowing the old rustbelt image. Cleveland Clinic is world-renowned -- and it is now the city's number one employer -- and Northern Ohio is also home to some of the most innovative approaches to health care. COSE [COZY] and Cleveland Health Quality Choice are pioneers: communities across the country are going to be following your lead to create workable solutions to health care challenges. / That's why I've chosen to come to Cleveland this morning to address the health care crisis -- and lay out my <u>four-point program for comprehensive health care reform</u>. //

Reform is urgent -- for more reasons than one. / The crisis I mentioned isn't in <u>quality</u> of care. American health care is first-rate, the best in the world. And right now, the vast majority of Americans have access to that health care system. But the <u>cost</u> has skyrocketed: from xxx in 19-- to $800 billion dollars today. And if we keep going at the same rate, that $800 billion will double to <u>$1.6 trillion</u> by the year 2000.

These numbers alone would make the case for reform. But cold statistics don't show us the <u>worry people feel</u> -- the all-too-familiar fear about what happens to their health care if they

(13.7% of population is uninsured)
1/7

change their job -- or worse still, if they lose their job. //
And in these hard times, it is simply unacceptable that one in ✓ Harris
every seven Americans is uninsured. // (down play the #)

There's a better way. / My plan puts the emphasis on expanding access -- while preserving the choice people now have over the type of health coverage and health care they receive. My plan will give Americans a greater sense of security -- help ease the fears so many Americans have that changing jobs will cost them their health coverage: by encouraging coverage that is portable -- coverage that an employee can carry with them. Finally by cutting costs, we're going to make health insurance more affordable -- and more affordable means more accessable.

My plan will preserve what works -- and reform what doesn't. And above all, it will ensure every American universal access to basic health care. //

We're at a crossroads. The question now is whether we'll settle on sensible reforms -- or whether we'll force ourselves to swallow a cure worse than the disease. ✓

Some people are pushing a prescription for disaster: we can nationalize the health system. Put government in control of the system: let government control the prices, let government ration the kind of health care people get -- let government tell people looking for care how much they'll get, what kind, and when.

Right now, across Lake Erie, Canada's system covers everyone. That's the goal we're striving for -- but keep in mind the drawbacks that come with a nationalized system: the long

waiting lists for surgery -- the shortages of the high-tech equipment responsible for so many of the miracles of modern medicine. // Let me cite just one example: the Magnetic Resonance Imaging techology -- the M.R.I. -- used to diagnose everything from tumors to torn cartilage. In all of Canada, you'll find only 12 M.R.I. machines. There are 15 right here in Greater Cleveland alone.

In the end, nationalizing health care pushes costs far higher. Some studies of Canadian-style plans now circulating in the Congress estimate the costs of that plan for the average American family at more than $4000 dollars a year -- for the nation, a staggering $250 billion dollars a year. // You get the worst of both worlds: No one has an incentive to control costs -- and everyone pays. //

But there are other proposals out there, equally harmful. One's called "Play or pay." Each employer must "play" -- meaning: provide insurance for his employees, or they "pay" -- a payroll tax to finance government health coverage.

Businessmen and women tell me horror stories about health care costs spiralling out of control. Well, Play or Pay will leave a lot of small businesses -- businesses that are on the edge right now -- with a tough choice: They can cut workers' wages across the board to pay for mandated health care, they can fire some workers to cover the rest -- or they can raise prices, and pass along the cost to the consumer. Some estimates put the jobs lost under "Play or Pay" as high as half-a-million or more.

Strip away the rhetoric, and "Play or pay" is guaranteed to be a back-door route to a nationalized health scheme. It creates incentives for employers to stop offering benefits, and dumps millions of fully-insured workers into Medicaid. And because Play or Pay doesn't pay for itself, the American taxpayer will foot the bill.

You won't hear this from the people pushing Play or Pay. Ask them about the side-affects of their proposal, and they'll say: Take two aspirin -- and call me after the election. //

Keep in mind what people want: the point of all our programs isn't simply health care -- but health. // A large part of the answer is prevention: the changes each one of us can make to avoid behavior that raises risk of disease and illness. Tomorrow, in San Diego, I'll focus in more detail on the ways prevention can help people live healthier lives -- and help keep our economy healthy, too.

But today, I want to focus on the health care system -- on my comprehensive, market-based reform plan. / The fact is, we don't have to create a new government bureacracy to give Americans access to affordable, quality health care. We need a system that delivers -- a system that works for America -- a system that puts quality care within reach of every American family.

Our system should be built on choice -- not central control. It should keep costs down -- and open up access. But above all, it should allow all Americans to rest secure when it comes to

health care -- to ease their worry that if they change jobs, or if they or their kids develop serious health problems, they won't be able to count on the coverage they need. //

My comprehensive four-point plan meets every one of these common-sense tests. Here's how:

Point one: we will make health **care** more **accessable** by making health **insurance** more **affordable.** For low-income individuals and families, I'm proposing a health insurance **credit** -- up to $3,750 dollars a year to help people, even people too poor to file taxes, purchase private health insurance. ~~Each~~ will receive a certificate or voucher for more than $300 dollars a month. They can use it to buy into the plan their employers offer but they could never afford -- or they can shop for whatever private plan suits them best.

For middle-income individuals and families, I'm calling for a health insurance **tax deduction** of $3,750. / Every American family with incomes under $80,000 -- that's 95 million Americans -- will receive new help from either the credit or the tax deduction.

Once again, this coverage will be portable: people who change jobs can take their coverage with them.

But best of all, will bring **security** to 30 million uninsured Americans -- people who will at long last receive health care coverage they'd had to do without. //

That's the first point in my four-point plan: access.

Point two: we will **cut the runaway costs** of health care by

making the system more **efficient**. Today, I'm asking you to learn a new acronym: HIN -- Health Insurance Networks. / Insurance costs are governed by the "law of large numbers:" The larger the group being insured, the lower the cost per individual. The idea beind HIN is to provide incentives for small companies to do what Cleveland's C.O.S.E. [COZY] group has done -- when it brought ~~11,000~~ 10,000 small businesses together to make a joint purchase of health care. 150,000 employees, dependents, retirees enrolled in plan

back to 10,000 the Chamber has 11,000 mbrs.

Another way to drive costs down is to make everyone a better health care consumer. Right now, most people pay more attention to the price of toothpaste than the comparative costs of health care. People don't waste much time thinking about the costs of their care -- but in the end, we all pay the price. We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people "shopping" for health care a kind of "blue book" for medical costs. // Innovations like these will help all of us keep the costs of quality health care as low as possible.

(?)

Point Three: we will wring out **waste and excess** in the present system. We've targeted medical malpractice for reform. You shouldn't have to pay a lawyer when you go to the doctor. Right now, people are doing just that: high malpractice premiums are built into rising doctors' bills -- and passed along to the American people. / And I am challenging the health insurance industry to cut red tape -- to share common forms, and to simplify and speed up claims processing. {There is no reason

1989 $5.6 billion $ malpractice insurance

half of all health insurance claims can't be processed electronically within the next four years. That single step would eliminate a mountain of health care paperwork and pare back costs.

Fourth and finally, we will get the **growth** in federal health programs **under control**. Right now, government health care programs can claim a dubious distinction: they are the fastest growing parts in the federal budget. We won't cut benefits. We won't raise premiums. We can make real savings simply by reducing the rate of **increase**.

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decisions. We don't need to put government between patients and their doctors. We don't need to create another wasteful federal bureaucracy. We need common sense, comprehensive health care reform -- and we need it now. My four-point plan is the right plan -- a plan that meets our obligation to all Americans by putting hope and health within their reach. //

Once again, my thanks for this warm Cleveland welcome. May God bless the United States of America.

# # #

tax increase -- massive tax increase.

Between 2-4 Coronary Bypasses per day

Nancy Nigosian, Administrator
Cardio thoracic
Surgury

(216) 844-5827

University Hospitals, Cleveland

The Cleveland Clinic Foundation
Division of Health Affairs
One Clinic Center • 9500 Euclid Avenue
Cleveland, OH 44195-5123
216/444-5680 • Fax Number: 216/444-7021

Date: 2/5/92

To: Jeannie Bunton

Company/Department: White House Communications

Location (City/State): Washington, D.C.

Fax Number: (202) 456-6218

From: Phyllis Marino

Location (Dept/Mail Code): KK-2

Page 1 of 21 pages (cover sheet included in page count)

If received incomplete, please call at 216/444-8923

Jeannie-

I checked again and we do about 10 bypass surgeries each day.

This book is a consumer guide. If you'd like the real thing, I can FedEx it to you.

Thanks.
Phyllis

Hospitals and doctors are not all alike . . .

. . . they vary in quality due to differences in their training, experience and services. These differences in quality become greater and matter more when you need sophisticated medical care for a complex condition.

A surgeon, for example, who performs a complex procedure often, has better success with it than a surgeon who does the same procedure only occasionally. The complication rate and the death rate for the same procedure may be many times higher at one hospital than another.

Clearly, the doctor and hospital that you choose have a direct impact on how well you do — especially when you need treatment for a condition such as heart disease, a problem affecting one out of four Americans.

Some 68 million of us have some form of heart or blood vessel disease. It is this country's number one cause of death. Although this is a frightening statistic, you can be comforted by the fact that there are many treatment options available to help you get well.

But this means making some difficult and important decisions such as choosing a doctor and a hospital for your treatment. No one has more at stake than you; it's one of the most important decisions of your life.

This brochure deals with a particular form of heart disease — coronary artery disease. You may be reading this because you have been told you have a high risk of developing coronary artery disease, because your doctor suspects you have already developed this condition, or because you're considering surgery. Comparisons like those we talk about making are not possible in an emergency. If you make these comparisons early, you will be prepared should the need for treatment arise.

How Do You Judge Quality?

A Step-by-Step Guide

This guide helps you choose a doctor and hospital by:

- explaining the most common kind of heart disease — coronary artery disease;
- describing the testing involved in its diagnosis — cardiac catheterization;
- describing two forms of treatment — balloon angioplasty and coronary artery bypass surgery;
- explaining six points that indicate quality; and
- providing questions and answers from The Cleveland Clinic Foundation that you can use to compare doctors and hospitals.

Most of us do more research when we buy a car or a television set than when we choose a doctor and a hospital. That may be because we don't know what questions to ask or what to base our evaluation on. There is no consumer magazine that rates doctors and hospitals the way *Consumer Reports* rates air conditioners.

There are many different ways to measure quality care, and there is no universal agreement on which should be used. However, at The Cleveland Clinic Foundation, we believe that you can use the following six points, or quality indicators, to compare health care providers:

- **Credentials**
- **Experience**
- **Range of services**
- **Participation in research and education**
- **Patient satisfaction**
- **Outcome**

Choosing a doctor or hospital is often influenced by values. You may want to go to a hospital that is close to home. You may want a hospital with a specific religious affiliation. But when you need specialized medical care for heart disease, it is essential that you also include in your decision a doctor's qualifications and a hospital's track record. These quality indicators will help you with that kind of evaluation should you require treatment for coronary artery disease.

Coronary Artery Disease

This condition occurs when fatty deposits such as cholesterol build up inside the coronary arteries that carry blood to the heart. Over time, these deposits narrow the arteries, blocking the flow of blood and oxygen to the heart. This causes many people to experience chest pain (angina), which can be severe. Left untreated, coronary artery disease can trigger a heart attack.

How is it treated?

If you or a family member is diagnosed as having coronary artery disease, both medical and surgical treatment options are available. All have the goal of increasing the flow of blood and oxygen to the heart. Medical treatment may include the use of drugs, a change in diet to limit cholesterol, and development of a supervised exercise program.

When medical treatment does not work, or when the disease worsens, further testing and procedures to treat the problem may be recommended. In this case, your doctor may discuss with you some of the following procedures.

Cardiac catheterization. This diagnostic X-ray test is performed to identify blockages in the heart vessels. A long, thin tube called a catheter is inserted into a blood vessel in the arm or groin and threaded into the coronary arteries. Dye is injected through the catheter and X-ray movies of the vessels are taken.

Balloon angioplasty. The formal name for this non-surgical procedure is percutaneous transluminal coronary angioplasty, or PTCA. During this procedure, a catheter with a balloon on its tip is inserted into an artery in the leg. It is then guided into the narrowed coronary artery. Once there, the balloon is inflated, widening the narrowed area and increasing blood flow to the heart.

Coronary artery bypass surgery. In this procedure, a detour is made around the narrowed or blocked part of the coronary artery by sewing in another blood vessel. Until recently, the leg's saphenous vein was used to bypass the blockage. However, use of the internal thoracic (internal mammary) artery appears to be more effective because it remains open longer. This has become the vessel of choice for use in most — but not all — patients. And when a patient needs more than one bypass graft, the surgeon will have to use both the thoracic artery and the leg vein.

Where Do You Begin?

Measuring quality in ways that are useful to consumers is a new idea in health care. Because of that, it may not be possible to get complete information for each of these quality indicators. But when providers are willing to give you as much information as possible, it's a good sign. It shows that they are dedicated to maintaining and improving their quality, responsive to patients, and confident of their capability.

If you are told that you have coronary artery disease or that you need surgery, talk to your family doctor or cardiologist. Get the names of several doctors and hospitals that have the most experience with diagnosing and treating this condition. Ask the questions that we suggest. Make comparisons. Then make your decision. Be an informed consumer for yourself and your family.

How to Use Quality Indicators

How can you use these indicators to judge if one doctor or hospital is better for you than another? By combining information from more than one quality indicator, according to a report "The Quality of Medical Care: Information for Consumers" produced by the U.S. Congress, Office of Technology Assessment.

According to the report, patients about to have heart surgery can be confident if the hospital performs a high number of heart surgeries, if it has a low mortality (death) rate, and if the surgeon has extensive training and experience in the procedure.

On the other hand, the report states: "*...if a hospital had a high mortality rate and a low volume of procedures, the patient might wish to question the surgeon about that hospital and about alternatives, even if other hospitals required longer travel.*"

1 Credentials

Do the doctor and hospital measure up?

Credentials have been set by nationally recognized medical professional organizations to verify that doctors and hospitals meet certain standards in the delivery of health care.

Doctors:

Board certification, or an international equivalent, is a sign that doctors are highly trained in their field. Doctors who specialize, such as cardiologists and heart surgeons, should also be board certified in the specialty in which they are practicing. Each specialty has a national board which is responsible for setting standards doctors must meet in order to be certified. Doctors who are board certified in their specialty have completed the amount of training that the specialty board requires, have practiced for a specified number of years in that specialty, and have passed a difficult examination in their specialty area. Some excellent doctors are not board certified. Board certification, however, is generally a good indication of competence and experience.

Hospitals:

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the nationwide authority that surveys hospitals. The JCAHO decides whether a hospital gets, keeps or loses accreditation based on its meeting certain criteria for staffing, equipment and facility safety requirements. Although accreditation is voluntary, most hospitals go through the process. If the hospital that you are considering is not accredited, it is important to know why.

For information about a hospital's status, call the Joint Commission on Accreditation of Healthcare Organizations at 708/916-5800.

Hospitals that do measure up are often in the public spotlight for their medical advances and the quality of their care. Information about a hospital's reputation is available through the mass media, books such as *The Best Hospitals in America*, the government, and consumer groups.

Is the heart surgeon board certified in thoracic surgery?

At the Cleveland Clinic, all 9 surgeons who perform bypass surgery are board certified in their specialty.

Is the cardiologist who performs the cardiac catheterization or balloon angioplasty board certified in cardiology?

All Cleveland Clinic cardiologists are either board certified in their specialty or have significant years of experience practicing in their specialty. Of our 35 cardiologists, 31 are board certified in internal medicine or its equivalent. Of those, 27 are also board certified in their subspecialty of cardiology. Those who do not have certification are senior staff members who have the equivalent in many years of experience, recognition by their peers, or accomplishments in their field.

Board certification became a requirement at the Cleveland Clinic in 1989 for doctors who are being appointed to the medical staff.

Is the anesthesiologist board certified in anesthesiology?

12 of 15 cardiothoracic anesthesiologists are board certified. Those who are not certified are senior staff with significant years of experience in their specialty.

Is the hospital accredited by the JCAHO?

Yes.

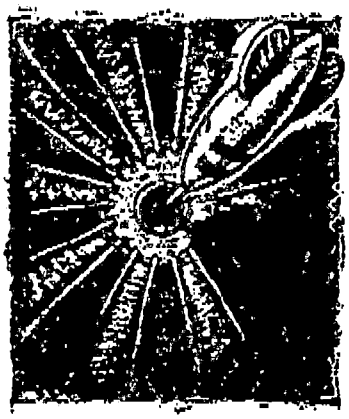
Has the hospital been positively and consistently recognized for medical excellence and leadership?

Yes. Most recently the Cleveland Clinic was recognized as a leader in cardiology based on a survey of 400 medical specialists in the August 5, 1991 issue of *U.S. News & World Report*. A previous survey in the April 30, 1990 issue of the magazine also recognized the Cleveland Clinic for excellence in cardiology.

For two years in a row, those same *U.S. News* issues have named the Cleveland Clinic one of "America's Best Hospitals." The Cleveland Clinic has also been singled out for excellence in "The Best Hospitals in America" (Henry Holt and Co., 1987); and "The Best in Medicine: Where to Get the Finest Health Care For You and Your Family" (Crown, 1990).

2 Experience

Does practice make perfect?



In the case of complex, specialized medical care for heart disease, the more experience the doctor and hospital have with the necessary procedures, the better the results usually will be.

There is evidence to show that outcomes are better for angioplasty procedures when more are done. The same is true of bypass surgery. The survival rate for heart bypass patients is greater when patients are operated on in hospitals that perform many bypass procedures, according to a study by the U.S. Department of Health and Human Services' National Center for Health Services Research.

Other studies confirm that the most successful bypass teams perform more procedures per year and have worked together longer than those with less successful records.

It may be important to ask whether the doctor performs all procedures at one hospital or at several. If the doctor performs procedures at more than one hospital, this increases the volume but means the doctor is working with different teams. The teams, therefore, don't have as much experience working together as they would if the doctor were working with the same team at the same hospital all the time.

The survival rate for heart bypass patients is greater when patients are operated on in hospitals that perform many bypass procedures.

We mentioned earlier the importance of using the internal thoracic (internal mammary) artery in coronary bypass surgery due to its long-term benefit to the patient. Despite its advantages, only about half of the nation's heart surgeons use this artery. The technique is newer, takes longer and is more difficult to perform than a vein bypass. It may be important to find out how experienced the doctor is with this technique.

Volume Guidelines

Some organizations have suggested volume requirements for the number of times a procedure should be performed in order to be performed competently.

Cardiac catheterizations:

A catheterization lab should perform a minimum of 300 cases per year, according to the Report of the Inter-Society Commission for Heart Disease Resources.

Balloon angioplasty (PTCA):

A hospital should perform at least 200 balloon angioplasties (PTCAs) each year, according to a task force of the American College of Cardiology, the American Heart Association, and the American College of Physicians.

A physician should perform a minimum of 75 procedures each year as the primary operator.

Coronary artery bypass surgery:

A hospital should perform at least 150 open-heart operations per year, according to guidelines from the American College of Surgeons. Other organizations give guidelines of 200 or 300.

How many cardiac catheterizations are performed each year at the hospital?

At the Cleveland Clinic, 4,568 diagnostic cardiac catheterizations were performed in our catheterization lab in 1990.

How many angioplasties are performed each year at the hospital?

The Cleveland Clinic performed a total of 1,270 angioplasties in 1990, 1,208 of which were elective.

How many bypass surgeries are performed each year at the hospital?

In 1990, we performed a total of 1,860 bypass surgeries. Most of these (1,351) were performed on patients who were having first-time bypass surgeries only (without an additional procedure such as valve repair). The remainder of the procedures (509) were reoperations on patients who had already had one or more bypass surgeries.

How experienced is the anesthesia staff who will be providing anesthesia during bypass surgery?

The Department of Cardiothoracic Anesthesiology at the Cleveland Clinic provides anesthesia to more than 3,000 patients undergoing all types of open heart surgery each year.

Were all procedures performed by the doctor at one hospital or several?

All our physicians perform all procedures exclusively at the Cleveland Clinic.

How long has the hospital been performing bypass surgery?

The Cleveland Clinic, a pioneer in bypass surgery, has been performing this procedure since 1967.

Does the surgeon who may perform your bypass surgery have experience with using both the internal thoracic artery and the leg vein?

Yes. All surgeons who perform this procedure are experienced in both techniques. The Cleveland Clinic Foundation pioneered use of the internal thoracic artery.

3 Range of Services

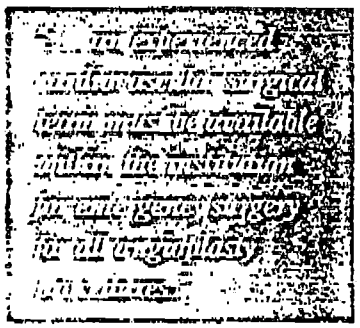
What services are available?

Hospitals with a broad range of services can treat more complex medical conditions and better handle complications that may occur. If complications arise, you want the best care available, and you want it immediately.

Range of specialty departments:

Problems that involve the heart and circulatory system don't exist in isolation. Related conditions such as diabetes or high blood pressure could endanger the kidneys, brain and other organs. Therefore, immediate access to a full range of specialty departments within a facility is critical.

Availability of a full range of specialty departments is also important if complications arise that are related to diagnosing and treating your heart disease.



During angioplasty, for example, a small percentage of patients will need urgent surgery for complications that may occur. "For this reason, there is general agreement that an experienced cardiovascular surgical team must be available within the institution for emergency surgery for all angioplasty procedures," according to a task force of the American College of Physicians, American College of Cardiology, and the American Heart Association.

Range of diagnostic and treatment options:

Surgery for heart disease is not the only treatment option available. And even when surgery is required, it is usually preceded by a long period of medical treatment. It's important, therefore, to go to a facility that can treat heart disease in a variety of ways. That way you will get the most effective, appropriate and cost-effective treatment available.

Is help available from a full range of specialty departments should complications arise due to related conditions?

The Cleveland Clinic's 500 physicians — all on staff full-time — provide care in 78 specialties and subspecialties. Because all these specialties are represented at one facility, prompt consultation, diagnosis and treatment are available.

Is an experienced heart surgery team available within the facility for emergency surgery?

If complications arise during cardiac catheterization or balloon angioplasty, experienced heart surgery teams are available 24 hours a day at the Cleveland Clinic.

Does the hospital offer a variety of options for diagnosing and treating heart disease?

The Cleveland Clinic offers the following range of options:

State-of-the-art drug regimens

Electrocardiography

Echocardiography

A full range of cardiac nuclear medicine procedures including positron emission tomography (PET scans)

Magnetic resonance imaging and spectroscopy

Doppler studies

Stress testing

Holter monitoring

Outpatient cardiac catheterization

Balloon angioplasty

Valvuloplasty

Coronary artery bypass surgery

Left ventricular mapping

Valve repair and replacement

Combined bypass surgery and valve operation

Heart transplantation

Other heart operations (includes congenital heart surgery and aortic aneurysm repair)

Laser angiosurgery

Coronary atherectomy (Rotablator)

AICD (Implantable defibrillator)

Pacemakers

Stents

Cardiomyoplasty

Maze surgery

Radiofrequency ablation

4 Participation in Research and Education

What type of hospital is it?

There are many advantages to selecting a hospital that combines patient care with research and education.

Ideally, the individuals engaged in patient care, research and teaching are organized around a given disease or class of patients, facilitating the sharing of knowledge, research and clinical findings. This approach results in the most rapid transfer of basic scientific knowledge from the laboratory to care delivered at the patient's bedside.

Private, not-for-profit, teaching hospitals had lower mortality rates than other types of hospitals . . .

Those individuals on the staff of such a hospital are exposed to an important interchange of ideas. They are also exposed to the newest treatments and forms of technology. At teaching hospitals, physicians are available 24 hours a day.

There may be other advantages to choosing a teaching hospital. Private, not-for-profit, teaching hospitals had lower mortality rates than other types of hospitals, a study in the December 1989 issue of the *New England Journal of Medicine* suggested.

Is the hospital associated with a teaching program?

Yes. Incorporated in 1935, The Cleveland Clinic Educational Foundation sponsors one of the nation's largest physician postgraduate training programs.

Does the hospital conduct research or clinical trials related to heart disease?

- Approximately 70 cardiovascular research projects are funded annually. Aiding in the capability to conduct research projects is our Cardiovascular Information Registry, which contains the largest cardiovascular data base of a single institution in the world, with over 125,000 patient entries. Information from this registry provides the basis for our quality assessment efforts. In addition, scientific papers that have been based on information from the registry have contributed to changes in the practice of medicine and surgery. Registry results, for example, enabled the Cleveland Clinic to determine the long-term advantage to patients of the internal thoracic artery over the leg vein in coronary artery bypass surgery.
- The Cleveland Clinic is participating in two of the largest clinical trials on coronary artery bypass surgery and angioplasty and in studies to reduce atherosclerosis in coronary artery bypass grafts, both funded by the National Heart, Lung, and Blood Institute. The Clinic is one of the few centers in the country doing research on both the artificial heart and other cardiac-assist devices.
- Basic research in heart and circulatory disease includes programs in atherosclerosis and vascular cell biology, mechanisms of hypertension, fundamental processes involved in myocardial cell growth, studies in cardiac biochemistry and physiology, and heart-brain interactions in cardiovascular disease. Cardiovascular research programs alone attract approximately $7.3 million per year from the National Institutes of Health—making the Cleveland Clinic one of the largest and most comprehensive centers of cardiovascular science in the region.

Does the hospital have fully accredited residency training programs in heart disease?

The Accreditation Council on Graduate Medical Education has accredited our residency training programs in cardiology, cardiothoracic anesthesiology, and thoracic and cardiovascular surgery. Presently, 72 physicians are being trained in these programs.

5 Patient Satisfaction

Is everybody happy?

If you ask one person about his or her experience with a doctor or a hospital, you get one person's point of view. Patient satisfaction surveys allow you to judge quality based on the experience of many previous patients. This provides you with a more objective measure to use.

Most hospitals routinely use surveys to learn if patients are satisfied with their medical experience. They can use these results to improve their services.

Patient satisfaction often reflects the personal side of care. Surveys ask questions such as, How willing are the doctors and nurses to listen? Do they answer questions and explain treatments? How much time does the doctor spend with the patient? Is the hospital clean? Is the food good?

Patient satisfaction information can predict what your experience in a particular hospital is likely to be.

How satisfied are hospitalized patients with their experience at this facility?

95% of patients who are hospitalized at the Cleveland Clinic for treatment of coronary artery disease are satisfied with their hospital care.

92% say they would return.

How satisfied are outpatients with their experience at this facility?

99% of coronary artery disease patients who come to the Cleveland Clinic for outpatient services are satisfied with their experience.

94% say they would return.

Is there a program to help patients and their families with difficulties that may arise during a hospital stay?

Cleveland Clinic Foundation patients may call an ombudsman — another name for a patient-relations representative — if they have concerns about their care.

Patients in the Cleveland Clinic hospital may also dial a 24-hour Helpline if they have any problems, questions, suggestions or concerns regarding service.

6 Outcome Indicators

What are the risks?

All risks of death and complications associated with a procedure can't be eliminated, especially for seriously ill patients. However, your risk can be reduced by choosing a hospital with a low mortality rate.

The mortality rate, or the death rate associated with a procedure, is the most important measure of your risk and a sensitive measure of quality.

Although the greatest period of risk is during the hospital stay, your risks are also affected by the type of patient you are. Mortality rates generally will be higher for patients who are over age 65, who have other medical conditions like diabetes, who are having a repeat coronary procedure, or who are undergoing multiple procedures such as bypass surgery with a valve repair.

Ask the doctor and the hospital for their mortality rates. Try to compare rates for patients most like yourself. It's important to try to compare apples with apples so that you know what your risks really are. This may be difficult, however, because mortality rates may be reported differently. If a doctor or hospital can't give you mortality rates or is reluctant to give information, look at alternatives.

We are providing our rates. To give you an idea of what expected mortality rates might be, we've included references to nationally recognized studies. We've tried to cite studies that are as comparable as possible considering that there is no one national data source that reports standardized rates.

How volume affects mortality

A mortality rate of zero may look good at first glance. But it may be meaningless if only two procedures have been done. If the sample is too small, statistics lose their significance.

That's why mortality information must be looked at in light of provider experience — the volume of procedures done at the hospital and by the doctor. A zero mortality rate may be more an indication of good luck than skill if only two procedures were performed. And just the opposite. If the hospital does one procedure and the patient dies, a 100 percent mortality rate doesn't tell you anything.

What is the hospital's mortality rate for cardiac catheterization?

The Cleveland Clinic's mortality rate for cardiac catheterization in 1990 was 0.02%. This is more than six times lower than a 0.13% expected mortality rate cited in an October 1, 1985 issue of the *American Journal of Cardiology*.

We performed 4,568 diagnostic cardiac catheterizations in 1990.

What is the hospital's mortality rate for elective coronary angioplasty?

The Cleveland Clinic's 1990 mortality rate was 0.3% for elective simple and complex angioplasty. This is three times lower than a 1% expected mortality rate cited by a joint task force of the American College of Cardiology and American Heart Association in August 1988.

We performed 1,208 elective simple and complex angioplasties in 1990.

What is the hospital's mortality rate for elective coronary artery bypass surgery for patients under age 65?

The Cleveland Clinic's 1990 mortality rate was 1.0%.*

A mortality rate of 3.1% occurred in the national, multicenter Coronary Artery Surgery Study that was reported in the *Journal of Thoracic and Cardiovascular Surgery*, December 1984.

For patients over age 65?

The Cleveland Clinic's 1990 mortality rate was 1.8%.* Of these patients 52% were over the age of 70, with the oldest being 87 years old.

A mortality rate of between 4.9% to 7.8% for patients over age 65 is described in Medicare's Prospective Payment and the American Health Care System Report to Congress in June 1989.

What percentage of patients require emergency surgery following elective angioplasty?

At the Cleveland Clinic in 1990, 1.8% of patients required emergency surgery following unsuccessful angioplasty. An expected range is 3% to 6%, according to a task force of the American College of Physicians, American College of Cardiology and American Heart Association in June 1990.

*Rates are based on a total of 1,351 procedures. They are figured at discharge for patients who were having their first bypass surgery without related procedures such as valve repair or replacement.

Pioneering Work in Heart Disease

The Cleveland Clinic Foundation is recognized worldwide for its comprehensive commitment to understanding, controlling and preventing diseases of the heart and circulatory system. Doctors and scientists here have pioneered many advances in cardiovascular care:

- Performance of the world's first saphenous vein bypass procedure in 1967 to detour blood around blocked arteries in the heart
- Invention and development of cardiac catheterization in the late 1950s to detect life-threatening obstructions in the coronary arteries
- Refinement of the heart-lung machine that enables surgeons to operate on a stopped heart
- Pioneering use of internal thoracic artery grafts in bypass surgery, which have increased ten-year survival rates for Cleveland Clinic patients from 88 percent to 93 percent
- Major discoveries linking high blood pressure to atherosclerosis
- Understanding the role of cholesterol in cardiovascular disease
- Pioneering use of techniques to repair leaking mitral and aortic valves.

Cardiology Update

National leadership. Four past presidents of the American Heart Association have been physicians on the Cleveland Clinic staff.

Heart transplants. Between August 1984, when the Cardiac Transplantation Program began, and October 1991, Cleveland Clinic surgeons have performed 166 heart transplants. Current survival rates are 84 percent for one year. The Clinic was one of the first 20 U.S. centers approved by Medicare for heart transplantation.

Pediatric cardiovascular care. Pediatric heart specialists at the Clinic see 1,600 children annually, 200 of whom — some as young as newborns — require heart surgery.

Opening heart valves without surgery. The Clinic is a leader in the use of a new technique, called balloon valvuloplasty, which uses a balloon to widen the opening of narrowed

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For Information

If you need more information to make a fully informed choice, please call us at one of the numbers below:

216/444-8919
(in Cleveland)

800/545-7718
(toll-free outside Cleveland)

heart valves without major surgery. We performed 45 balloon valvuloplasties in 1990.

Largest experience in valve surgery. When heart valves become narrow or leaky, Clinic cardiovascular surgeons replace or repair them. Valve repair has become an increasingly attractive alternative to valve replacement since it is associated with fewer complications and with improved function. This has been aided by our capabilities in transesophageal and intraoperative echocardiography. The Cleveland Clinic performed 834 valve surgeries in 1990.

Extensive experience with coronary artery disease recurrence. The Cleveland Clinic is recognized worldwide for its expertise in coronary artery reoperations — surgery being conducted because coronary artery disease has recurred over time. Because reoperations are often more technically difficult and patients are often older, provider experience is very important. In addition, the Cleveland Clinic is exploring the use of balloon angioplasty on patients with recurrent disease in saphenous (leg) vein grafts.

State-of-the-art electrophysiology capabilities. The Clinic has three newly equipped electrophysiology laboratories for the evaluation and treatment of heart rhythm problems that lead to sudden death. In 1990, more than 700 patients were evaluated here for rhythm problems.

Expertise in anesthesia delivery. The Cleveland Clinic has the first and largest department in the world specializing in cardiothoracic anesthesiology. The Department of Cardiothoracic Anesthesiology at the Clinic provides anesthesia for more than 3,000 patients undergoing heart surgeries each year. It has pioneered the testing of new anesthetic agents to be used in cardiac anesthesia.

Excellence in hypertension. In 1990, the Cleveland Clinic was designated a Specialized Center of Research in Hypertension by the National Heart, Lung, and Blood Institute.

Through such activities, The Cleveland Clinic Foundation continues to maintain its international reputation for excellence and innovation in the diagnosis and treatment of heart disease. Its affiliated Cleveland Clinic Florida is drawing upon this experience and expertise to establish corresponding state-of-the-art programs in cardiology and cardiac surgery.

THE CLEVELAND CLINIC FOUNDATION

9500 Euclid Avenue Cleveland, OH 44195

The Cleveland Clinic Foundation is a multispecialty academic medical center, recognized as a National Referral Center and an international health resource. It is dedicated to providing quality specialized care supported by education, research and responsibly applied technology. It comprises an outpatient Clinic, a Hospital with 899 staffed beds, a Division of Education and a Research Institute.

Produced by the Division of Health Affairs

McGroarty/Bunton
February 4, 1992
1:45 pm
[health]

PRESIDENTIAL REMARKS: GREATER CLEVELAND GROWTH ASSOCIATION
CLEVELAND, OHIO
FEBRUARY 6, 1992
12:00 NOON

Ackn: Bob Flom Bp

"the Come back" city

[Introductory acknowledgements.] I'm pleased to be back in Cleveland, capital city of the North Coast. [[opening humor...]]

People who know Northern Ohio know this region's outgrowing the old rustbelt image. In addition to the world-renowned Cleveland Clinic -- now the city's number one employer -- Northern Ohio is also home to some of the most innovative approaches to health care. COSE [COZY] and Cleveland Health Quality Choice are pioneers: communities across the country can follow your lead to create workable solutions to health care challenges. / That's why I've chosen to come to Cleveland this morning to address the health care crisis -- and lay out my <u>four-point program for comprehensive health care reform</u>. //

Reform is urgent -- for more reasons than one. / Right now, far too many Americans are uninsured -- and those who are insured pay too much for health care.

The one thing this crisis <u>isn't</u> about is <u>quality</u> of care. American health care is first-rate, the best in the world. And right now, the vast majority of Americans have access to that health care system. But the <u>cost</u> has skyrocketed: from 74 billion xxx in 19~~--~~ 70 to $800 billion dollars today. And if we keep going at the same rate, that $800 billion will double to <u>$1.6 trillion</u> by the year 2000.

PORTABLE ACCESS

These numbers alone would make the case for reform. B
cold statistics don't show us the worry people feel -- the
too-familiar fear about what happens to their health care if they
change jobs -- or worse still, if they lose their jobs. // And
in these hard times, we simply cannot accept the fact that one in
every seven Americans is uninsured. //

There's a better way. / My plan puts the emphasis on
expanding access -- while preserving the choice people now have
over the type of health coverage and health care they receive.
My plan will give Americans a greater sense of security -- help
ease the fears so many Americans have that changing jobs will
cost them their health coverage: by encouraging coverage that is
portable (access) -- coverage that employees can carry with them.
Finally, my plan will cut costs. It helps us make health
insurance more affordable -- and more affordable means more
accessible.

My plan will preserve what works -- and reform what doesn't.
And above all, it will ensure every American universal access to
basic health care. //

We stand at a crossroads. We can settle on sensible reforms
-- or we can force ourselves to swallow a cure worse than the
disease.

Some people have scribbled out a prescription for disaster:
they want to nationalize the health system. Put government in
control of the system: let government control the prices, let
government ration the kind of health care people get -- let

government tell people looking for care how much they'll get, what kind, and when.

Right now, across Lake Erie, Canada's system covers everyone. But keep in mind the drawbacks that come with a nationalized system: long waiting lists for surgery -- shortages of the high-tech equipment responsible for so many of the miracles of modern medicine. // {Let me cite just one example: the Magnetic Resonance Imaging technology -- the M.R.I. -- used to diagnose everything from tumors to torn cartilage. In all of Canada, you'll find only 12 M.R.I. machines. There are 15 right here in Greater Cleveland alone.}

1990 FIGURE - NO REGISTRY FOR MRI's IN CANADA

When you nationalize health care, you push costs higher -- far higher. Some studies estimate that a Canadian-style plan would cost the average American family more than $4000 dollars a year -- for the nation, a staggering $250 billion dollars a year. // For that price, you get the worst of both worlds: No one has an incentive to control costs -- and everyone pays. //

But there are other proposals out there, equally harmful. One's called "Play or pay." Each employer must "play" -- meaning: provide insurance for employees, or "pay" -- a payroll tax to finance government health coverage.

Businessmen and women tell me horror stories about health care costs spiralling out of control. Well, Play or Pay will leave a lot of small businesses -- businesses struggling on the edge of survival right now -- with a tough choice: They can cut workers' wages to pay for mandated health care, they can fire

some workers to cover the rest -- or they can raise prices, and pass along the cost to the consumer. Some studies put the cost in jobs lost under "Play or Pay" as high as half-a-million or more.

Administration White Paper

Strip away the rhetoric, and "Play or pay" just creates a back-door route to a nationalized health care. It encourages employers to stop offering benefits, throw the problem in the government's lap, and dump millions of fully-insured workers into Medicaid. And because Play or Pay doesn't pay for itself, the American taxpayer will foot the bill.

You won't hear this from the people pushing Play or Pa

Ask them about the side-affects of their proposal, and they say: Take two aspirin -- and call me after the election.

We can't keep ignoring problems people care about -- a

keep ignoring it...

won't. People don't want to be shoveled into some new heal

Sure doesn't THAT

care bureaucracy. They want good health. // A large part

the answer is prevention: the changes each one of us can make to

(s)

avoid behavior that raises risk of disease and illness.

Tomorrow, in San Diego, I'll focus in more detail on the ways prevention can help people live healthier lives -- and help keep our economy healthy, too.

But today, I want to focus on the health care system -- on my comprehensive, market-based reform plan. / The fact is, we don't have to create a new government bureaucracy to give Americans access to affordable, quality health care. We need a system that delivers -- a system that works for America -- a

system that puts quality care within reach of every American family.

Our system should be built on choice -- not central control. It should keep costs down -- and open up access. But above all, it should allow all Americans to rest secure when it comes to health care -- to ease their worry that if they change jobs, if they or their kids develop serious health problems, they'll still be able to count on the coverage they need. //

My comprehensive four-point plan meets every one of these common-sense tests. Here's how:

Point one: we will make health **care** more **accessible** by making health **insurance** more **affordable.** For low-income individuals and families, I propose a health insurance **credit** -- up to $3,750 dollars a year to help people, even people too poor to file taxes, purchase private health insurance. Each will receive a certificate or voucher for more than $300 dollars a month. They can use it to buy into the plan their employers offer but they could never afford -- or they can shop for whatever private plan suits them best.

For middle-income individuals and families, I propose a health insurance **tax deduction** of $3,750. / Every American family with incomes under $80,000 -- that's 95 million Americans -- will receive new help from either the credit or the tax deduction.

Once again, this coverage will be portable: people wh change jobs can take their coverage with them.

(?)

But best of all, will bring **security** to 30 million uninsured Americans -- people who will at long last receive health care coverage they'd had to do without. //

That's the first point in my four-point plan: access.

Point two: we will **cut the runaway costs** of health care by making the system more **efficient**. Today, I'm asking you to learn a new acronym: HIN -- Health Insurance Networks. / Insurance costs obey the "law of large numbers:" The larger the group being insured, the lower the cost per individual. HIN's provide incentives for small companies to do what Cleveland's C.O.S.E. [COZY] group has done -- when it brought ~~11,000~~ 10,000 small businesses together to make a joint purchase of health care.

Another way to drive costs down: make everyone a better health care consumer. Right now, most people pay more attention to the price of toothpaste than the comparative costs of health care. People don't waste much time thinking about the costs of their care -- but in the end, we all pay the price. We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people "shopping" for health care a kind of "blue book" for medical costs. // Innovations like these will help all of us keep the costs of quality health care as low as possible.

Point Three: we will wring out **waste and excess** in the present system. We've targeted medical malpractice for reform. malpractice figure You shouldn't have to pay a lawyer when you go to the doctor. Right now, people do just that: high malpractice premiums mean

higher doctors' bills -- as they pass their legal bills along to you. / I have challenged the health insurance industry to cut red tape -- to share common forms, and to simplify and speed up claims processing. {There is no reason half of all health insurance claims can't be processed electronically within the next four years. That single step would eliminate a mountain health care paperwork and pare back costs.

Fourth and finally, we will get the growth in federal health programs under control. Right now, government health care programs can claim a dubious distinction: they are the fastest growing parts in the federal budget. / We must bring runaway costs under control. We won't cut benefits. We won't raise premiums. We can make real savings simply by reducing the rate of increase.

Efficiencies like this will help our reform plan pay for itself. //

The federal government should also give states the flexibility to design new universal access programs for the poor -- programs that will provide quality services to all their citizens. States will be able to use new federal resources to design programs that work -- not one-size-fits-all solutions imposed by Washington.

Providing affordable care, efficient care, / wringing out excess and waste and controlling federal growth: these four points will create the kind of market-based reform plan that will

give Americans the kind of health care they want and deserve -- and put an end to the worry that keeps them awake at night.

Remember what people want. People want care they can afford / care they can carry with them / and care they can count on.

I keep coming back to what works for this country. When we talk about health care, we're talking about matters of the most personal nature -- in some cases, literally, life and death decisions. We don't need to put government between patients and their doctors. We don't need to create another wasteful federal bureaucracy. We need common sense, comprehensive health care reform -- and we need it now. My four-point plan is the right plan -- a plan that meets our obligation to all Americans by putting hope and health within their reach. // IS THIS TRUE?

Once again, my thanks for this warm Cleveland welcome. May God bless the United States of America.

# # #

LIVE LONG AND PROSPER. NANSO, NANSO. !!

- Ann Combs
523 8233
- Dept. of Labor -
(202) 523-666666

Ann Combs
523-8233.

Dept. of Labor
523-666666

THE WHITE HOUSE
WASHINGTON

Date _____

TO:

FROM: **OFFICE OF COMMUNICATIONS**
Room 122 OEOB, Ext. 2930

City/State: Cleveland, OH

Event: GCGA

Date: 1/31/92

OFFICE OF PRESIDENTIAL ADVANCE

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TELECOPIER COVER SHEET

Date: 1.29.92 **Time:** 2:47

Fax No.: 456-6218 **Client No.:** 0011

To: Dan McGroarty or Jeannie Benton

From: Deborah Steelman

Number of Pages (excluding cover sheet): 7

Person Sending:

Other Instructions: More to follow!

Connie Hilliard

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THE GROWTH ASSOCIATION
CLEVELAND

FAX COVER SHEET

DATE: 2/4/92

TO:

NAME: Jeannie Bunton

FIRM: The White House

CITY: Where Else?

FAX NUMBER: 202-456-6218

****

FROM:

NAME: John Pock

GREATER CLEVELAND GROWTH ASSOCIATION
200 TOWER CITY CENTER
50 PUBLIC SQUARE
CLEVELAND, OH 44113-2291
FAX: 621-6013
PHONE: 621-3300 Ext. 247

****

TOTAL NUMBER OF PAGES INCLUDING THIS COVER SHEET: 3

SPECIAL NOTES OR INSTRUCTIONS:

I've highlighted what I think are the key points. Please call if you need any more —

John

The Council of Smaller Enterprises

COSE is

- the small business division of the Greater Cleveland Growth Association (Cleveland's Chamber of Commerce). COSE was founded in 1972.

- 10,000 small companies (150 employees or under) employing almost 190,000 people in the greater Cleveland area, making COSE the largest local small business organization in the country.

- Largest private purchaser of health care in the state of Ohio.

COSE's Health Care Coverage Program for Smaller Companies

Demographics

8,500 COSE members participate in one of a dozen health care programs, providing coverage to more than 61,000 workers and just over 150,000 lives -- meaning that about one out of every ten Clevelanders carries an insurance card that says "COSE" on it.

COSE members invest a combined $163 million in group health care premiums with carriers whose programs we sponsor, making us the largest purchaser of health care coverage in Ohio. COSE is NOT an insurance company, a Multiple Employer Trust (MET) or a Multiple Employer Welfare Arrangement (MEWA); we are simply a purchasing group.

Unusual Aspects of COSE plans

1. The average COSE member has just over seven employees. Given that the working uninsured are, for the most part, employed in companies with fewer than 10 employees, the COSE plan impacts that part of the market where the access/ affordability dilemma is most severe.

2. 20 % of the Companies joining our plans did not have health care coverage before joining COSE. While plans are not designed for employers who are not insured, they have increased access to coverage for a number of small companies.

3. Joining COSE reduces employers costs by an average of 35% over similar plans in the Greater Cleveland marketplace. Those savings enable many small companies to improve the benefits they offer to their workers and still pay less for their coverage.

4. COSE costs are very stable. The trend factor increases charged by commercial insurers to small companies in the Greater Cleveland area have increased cost of coverage by 152% since 1986. COSE members prices have increased 57% over the same period .

Why is COSE successful?

Aggressive management of health care programs, with a focus on driving down administrative costs.
An exceptional **information system** to support our decisions.
An excellent **partnership** with carriers, especially Blue Cross & Blue Shield of Ohio

What can be learned from COSE?

1. The market can work. COSE is entirely a creature of market forces, and COSE's experience shows that the private sector can be affective in the voluntary marketplace. The private sector can find ways to attack these issues, if it is willing to be creative, take risks and make tough decisions.

2. The delivery and financing of health care is primarily a local issue. National reform attempts will fail unless they are created with sufficient flexibility to enable local communities , especially local purchasers, to design and manage delivery systems that meet those communities' unique needs.

COSE 's Other Activities

Management Education and Assistance -- COSE conducts almost 100 programs per year designed to assist small business people, from start up to high growth companies, to operate more efficiently and effectively in an increasingly difficult environment. Through our federally funded Small Business Development Center, two full time counselors and 300 volunteers provide over 3,000 hours of one on one small business counseling for start up and existing businesses.

Government Action Program -- COSE's government program involves giving our members the opportunity to speak out as their own advocates in the legislative process, dealing with issues that impact their companies' bottom lines.

Member Benefits -- COSE offers awide range of benefits for members, from purchasing discounts to a group workers' compensation program and health care benefits.

McGroarty/Bunton
January 30, 1992
2:30 pm
[health]

PRESIDENTIAL REMARKS: GREATER CLEVELAND GROWTH ASSOCIATION
CLEVELAND, OHIO
FEBRUARY 6, 1992
XX:00 A.M.

[Introductory acknowledgements.] // Pleased to be back in Cleveland.... [[opening humor...]]

Reference Cleveland Clinic? I want to take this opportunity to address the urgent question of health care -- and lay out my five-point program for health care reform. //

I said the question is urgent. It is -- for more reasons than one. {First, spiraling costs.} Two years ago, I asked Secretary Sullivan to study this issue {cost, quality and accessibility...}. The quality of American health care is first-rate, the best in the world. But the cost has skyrocketted: from xxx in 19-- to $800 billion dollars today. And according to projections, that $800 billion will double to $1.6 trillion by the year 2000.

These numbers alone would make the case for reform. But sheer questions of cost don't get at the worry people feel -- the all-too-familiar fear about what happens to their health care if they lose their job -- or even if they leave their job for a better one. // {Right now, one in every seven Americans is uninsured. ....You lose more than your paycheck -- you lose your health insurance as well.}

Challenge -- tough choices. Our aim: a system that ensures all Americans access to health care.

There are two ways we can go:

We can nationalize the health industry. Put government in control of the system: let government control the prices, let government ration the kind of health care people get -- let government tell people looking for care how much they'll get, what kind, and when.

That's the way it's done right now across Lake Erie. Canada's system covers everyone. But keep in mind the drawbacks: No choice. Long lines. And in the end, nationalizing health care pushes costs even higher. [[Canada stat?]] You get the worst of both worlds: No one has an incentive to control costs -- and everyone pays.

We've got to think twice before we move toward nationalized health care. Anyone who's spent months checking the mail for that income tax refund -- or tried to track down a missing social security check -- or whiled away a day in line at the DMV is going to think long and hard before they ~~ask~~ put the government in charge of..... //

let the government issue tongue depressors

You may have heard about one radical plan now circulating on Capitol Hill. It's called "Play or pay." Each employer "plays" -- provides insurance for his employees, or they "pay" -- a payroll tax to finance government health coverage. This scheme, say its advocates, gives employers a choice. Well, so does the

guy with the gun in your back when he says: "Your money or your life." //

Play or Pay is going to leave a lot of small and medium-size businesses with a tough choice: They can cut workers' wages across the board to pay for mandated health care, they can fire some workers to cover the rest -- or raise prices, and pass along the cost to the consumer. Some estimates put the jobs lost under Play or Pay as high as half-a-million or more -- and the cost to employers at $30 billion and counting. //

Ask the advocates of this plan: Can't we do better? Isn't there a way to get health care without creating inflation and unemployment?

But in the end, strip away the rhetoric, and "Pay or play" is really the back-door route to a nationalized health scheme. It create incentives for employers to stop offering benefits, and dump workers into the federal system. And because Play or Pay doesn't pay for itself, the American taxpayer will foot the bill. //

Don't look for this analysis from the people pushing Pay or Play. Ask them about the side-affects of their proposal, and they'll say: Take two aspirin and call me after the election. /

We need a system that delivers -- a system that works for America.... Fortunately, we don't have to create a new government bureacracy to give Americans access to affordable, quality health care.

That system should be built on choice -- not central control. It should keep costs down -- and open up access. Finally, it should allow all Americans to rest a little easier when it comes to health care -- to ease the worry if they change jobs or develop serious health problems. //

....Today, let me lay out my comprehensive five-point plan:

First, we're going to make health insurance more **affordable** for low-to-middle income families. For low-income individuals and families, I'm proposing a health insurance credit -- up to $3,750 dollars a year to help people purchase private health insurance. {For middle-income individuals and families,} I'm urging Congress to pass a health insurance tax deduction of $3,750. / Every American family with incomes under {$80,000} will be eligible for either the credit or the tax deduction. They'll find health insurance more affordable -- and they'll be free to choose the plan and the doctors that serve them best.

Second, we're going to make health care more **efficient**. Twenty years ago, President Nixon pioneered a new idea in health care -- the HMO. Today, I'm asking you to learn a new acronym: HIN -- Health Insurance Networks. / Insurance costs are governed by the "law of large numbers:" The larger the group being insured, the lower the cost per individual. The idea beind HIN is to provide incentives for small companies to do what Cleveland's C.O.S.E. [COZY] group has done -- when it brought 10,000 small businesses together to make a joint purchase of health care.! By cutting costs, we're going to make health

"Consolidated purchasing power"
made a commitment to support one-another

insurance more affordable -- and more affordable means more accessable.

Third, we're going to wring out **waste and excess** in the present system. We've targetted malpractice for reform. You shouldn't have to pay a lawyer when you go to the doctor. Right now, people are doing just that: high malpractice premiums are built into rising insurance costs -- and passed along to the American people. / We're also going to create incentives to challenge the health insurance industry to cut red tape -- to simplify and speed up claims processing. {Increase electronic filing. [Go to a "credit-card style" system....]}

Fourth, we're going to get the **growth** in federal health programs **under control**. Right now, {Medicare} can claim a dubious distinction: fastest growing program in the federal budget. We won't cut benefits. We won't raise premiums. We can make real savings simply by cutting the rate of increase. We've set a target we can reach -- one that will cut the rate of growth from {10.6% to 9.4%}. Efficiencies like this will help our reform plan pay for itself. //

Fifth and finally, we're going to **expand information** -- help people be better health care **consumers**. Right now, most people pay more attention to the price of toothpaste than the comparative costs of health care. People don't waste much time thinking about the costs of their care -- but in the end, we all pay the price. / We need to follow the lead of initiatives like Cleveland Health Quality Choice -- programs that give people

"shopping" for health care a kind of "blue book" for medical costs. Innovations like this one will help all of us keep overall costs as low as possible.

These five points: affordable care, efficient care, / wringing out excess and waste, attacking federal growth, and getting more health care cost information into the hands of American consumers ....

Key: preserve quality, control costs -- improve access.

....

....Keep coming back to what works for this country. This plan should rest on choice. When we talk about health care, we're talking about matters of the most personal nature -- in some cases, literally, life and death decisions. // We don't need to put government between patients and their doctors. We don't need to create another wasteful federal bureaucracy. <u>We need a health care system that works</u>. //

....

Once again, my thanks for this warm Cleveland welcome. May God bless the United States of America.

# # #

pull the plug
Complete physical
tongue depressor
temperature
weighing in
stable condition
Comma
head injury
Subdural hematoma
Miocardial infarction
stop the bleeding
- diagnosis
national x-ray
intensive care

patient

go ahead and take it; it's good for you
hard pill to swallow
Vital statistics
cure the disease / miss the patient

(214) 892-5538 @ home

Bill Bryant –

Della → will fax @ NOON today
acks –

6410
213

COSE – small biz. division 10,000+
GROWTH ASSOC. 11,000+ members largest chamber in U.S.

John Polk @ COSE

↓

of 10,000 mbrs
8,500 COs involved in plan
65,000 employees enrolled in plan
150,000 workers, family and retirees
employees, retirees & dependents

"The Comeback City"

I would like to:

use bigger no.
3 16
12 | 3750
36
15

① Break down health insurance credit to "per month" figure...

Yes!

How would voucher be used...?

certificate

② Find % of families eligible for either credit or deduction

~95 million people ≈ benefit financially. 14.9 million ≈ receive a full credit.

or %?

③ Figures on what malpractice costs add to doctors bills / hospital costs?

$5.6 billion 1989 malpractice cost - amt. $ ins.

also - What has POTUS said re Play or Pay thus far...?

DMcG

reduce # peopl. c/p ins. to under 2% of pop. (4.9 million people)

CLEVELAND

CLOSE 11,000 mbrs. around to mkt

POTUS INTRO DICK POGUE
CHAIR, CLEVE GROWTH ASS.

1,500 audience 400 closed event
1,100 ball
GRAND BALL - STOUFFER TOWER
CITY PLAZA HOTEL

annual mtg. (#?)

Bob Horton Chair BP (sic) was [comes from London to do keynote address]

preempted

— POTUS [12:20] p. prompted(?)

Hotel 1924 historical Marker
Cleveland 3rd largest corporate headquarters

talk re sm. bis. in international trade

(Mod lunch)

head table 2 tiered 30 people
don't know who's they

ack's: Bill Bryant, Pres. Grow. Assoc.
Bob Horton
Hogue
Polk

Greater Cleveland Growth Association

Open Press

Remarks TBD / Teleprompter TBD

Est. 1929; Hotel is a national historical marker; was Hotel Cleveland

1,500 Attendees – 11,000 ballroom 400 – in room

– Grand Ballroom - Stouffer Tower City Plaza Hotel

Audience make up

Time POTUS Speaks

Introducing POTUS (Dick Pogue(SP))

Dais Participants

Background on Association

Dec Sullivan, & Governor

Largest Chamber of Commerce in Country

Hotel is site of half a billion dollars worth of construction.

Sherwin Williams, TRW, British Petroleum, LTV

Ranked 3rd ~~among~~ of cities w/most corporate headquarters – NY & Chicago are 1st & 2nd

Thank Association for allowing ~~me to~~ POTUS

Annual Meeting

Flats – industrialized area (smokestack)

Robert Horton - BP in T'L trade

"Turn Back to the Bible – and read it."

Exec VP of Assoc Mike Benz

Carol – Re speech needs

Mary Jacobson – Social Security / Cleveland

* Della – Public Relations for Growth Assoc.

Bob Horton – British Petroleum America
BP sets barometer in Cleveland – maj corp.
Praise Bob Horton
Bob Horton will discuss
Roll out address for new strategy to involve
small bus ~~to~~ in international trade

POTUS remarks 15-20 minutes / prompter
Remarks – time: 12:15 – 12:20

Head table – about 30 people; 2-tiered

Chairman – CGA
B. Horton – 11:55
speaks for 18-20 mins
Intro. 12:15 (by Chairman)
POTUS 12:20 (speaks for 15-20)

GC Growth Association
- Bill Bryant-Pres
- Dick Pogue – Chairman
> of 2nd largest law firm in country

Other acks
- Bob Horton

Plans

- Parking garage
- Seafood restaurant across street

Grand Ballroom
w/flower carpet

"The Comeback City" - Cleveland
- Turning point = '78-79 defaulted on debts to banks
- Since then - the whole public-private partnership initiative has brought city back to life.

Looks to America — "The Comeback Country"

Curtain - maroon ~~co~~ curtaining
Blue backdrop w/ banner saying:
"Greater Cleveland Growth Association"
w/acknowledgements
Bob Horton, Bill Bennett, Dick Pogue
Chandeliers

Feb 6 - 40th anniversary of Queen's accession to the throne - but also marks anniversary of her father's death.