PLAY OR PAY

Under a "play-or-pay" approach to expanding health insurance access, employers would be required to play by providing private insurance for workers or pay a payroll tax to fund public insurance for their employees. This plan would produce disastrous economic results.

- Employers who discover it's cheaper to "pay" into a government program than to "play" by offering private health insurance will opt to pay.

  -- Assuming a 7 per cent payroll tax, 52 million people who now have employer-based plans will be forced to into the public plan because it would be less expensive for their employer to pay the payroll tax than to continue to purchase private insurance.

  -- 8l percent of those employed by small businesses will be enrolled in the public plan.

- The cost of the play-or-pay mandate will be borne eventually by workers -- in the form of reduced wages and fewer jobs. Most workers who are uninsured are on the low end of the wage scale, and are struggling now to make ends meet.

- Initially, however, businesses will bear the burden -- and small businesses would suffer disproportionately. Again, assuming a 7 percent tax, insurance costs will increase by $30 billion. For small firms of 25 workers costs would rise by 71 percent.

- As these costs are shifted to employees, jobs will be lost -- between 350,000 and 750,000 in the short term and potentally two million in the long run.

- It would be costly for the tax payer as well.

  -- The Urban Institute estimates that a 7 percent payroll tax -- which is what is being proposed in the major pieces of legislation -- will not adequately fund the public plan: there will be a $37 billion gap, which would come from general revenues.

U.S. Senate
Republican Policy
Committee
Don Nickles, Chairman
Rick Lawson, Staff Director

Issue Alert

January 16, 1992

Taxpayers Would Pay and Pay for "Play or Pay," Labor Department Finds

Congressional enactment of "play or pay" legislation could drive as many as 52 percent of non-elderly Americans into a government-run health insurance program at a net cost to taxpayers of $36.4 billion in the first year, according to a study funded by the Labor Department and released on January 9.

The study, produced by the Urban Institute, examined the effects of requiring employers either to sponsor health insurance coverage for their employees or pay a new tax on wages. Senate Majority Leader George Mitchell has advanced legislation (S. 1227) that would impose a "play or pay" mandate on employers. The Senate Labor Committee is scheduled to mark up S. 1227 on January 22. [A detailed description and analysis of the measure can be found in "HealthAmerica: The Democrats' Proposal for Health Care Reform," an RPC *Policy Analysis*, issued June 19, 1991.]

Using data from the March 1990 Current Population Survey and an economic model known as TRIM2, the study predicted how employers would respond to payroll tax rates of 7 percent and 9 percent. Although S. 1227 does not stipulate a tax rate, leaving that task instead to the Secretary of HHS, it is generally assumed that the rate would fall in the 7-to-9 percent range.

The report was based on a model which utilized certain assumptions about employer requirements, benefit packages, coverage requirements and workers' premiums that are similar to those contained in S. 1227 [see Table 1 for a list of assumptions].

"Dumping" Workers onto the Public Plan

The study found that many employers would find it cheaper to pay a tax on payroll than to purchase private coverage for their employees even if they currently provide such coverage. If the wage tax rate were 7 percent, an estimated 111.9 million non-elderly Americans — more than three times as many people as are now covered under Medicare — would be enrolled in the public plan, according to the study. Roughly 51.7 million of these public-plan participants would be workers and dependents who are now covered under employer-sponsored private plans.

If the payroll tax were higher, fewer employers would choose to pay it. At a 9-percent tax rate, an estimated 84.8 million people, including nearly 32.3 million workers and dependents who now have employer-provided insurance, would end up in the public program.

Higher Costs for Government

Neither the 7-percent nor the 9-percent rate would cover the cost of the new public program. The study estimates that if the payroll tax rate were 7 percent, the federal government would have to raise $36.4 billion in additional revenues to finance the program in its first year. If the rate were 9 percent, the additional costs to government would be $25.2 billion. [See Table 2 for a complete list of cost figures.]

This lower cost to the public sector under a 9-percent tax rate does not reflect overall health care savings. The study found that the combined additional cost to the government and private employers is roughly the same under both tax rates. The difference is in the relative amounts paid by businesses and taxpayers. Under a lower tax rate, the government assumes a greater proportion of the cost; under a slightly higher rate, businesses would pay the greater share. Regardless of rate, both the government and employers would pay more for health insurance.

Higher Costs for Employers

If the tax were 7 percent, employers would spend $29.7 billion more for health insurance than they currently do. This figure would reach $44.3 billion under a 9-percent tax.

These additional costs, although they would be borne by firms of all sizes, would not fall evenly on all employers. Some businesses, notably those that could drop costly health insurance plans and enroll their workers in the public program, would spend less for health insurance than they do now. Others, especially smaller firms, would face large increases. The study estimates that health care costs — whether in the form of private insurance premiums or payroll taxes — would more than double for firms with fewer than 25 workers if the payroll tax were 9 percent. Their costs would increase by 71 percent under a 7-percent tax. The report did not explore the impact of these higher costs on jobs, wages or consumer prices.

Potential Refinements to "Play or Pay"

Proponents of "play or pay" note that estimated costs to the government could be reduced by raising the payroll tax rate. They also say that "play or pay" would save money by eliminating uncompensated care — care provided without charge to uninsured people. The cost of such care is often shifted to people with private and public insurance coverage through higher costs of health care services.

The report does suggest that higher payroll tax rates would produce a smaller government program. That is because the higher the rate, the more likely that an employer will prefer purchasing private coverage to paying the tax. By requiring everyone to have public or private health insurance, "play or pay" resolves the problem of uncompensated care.

The report also found, however, that "play or pay" would increase health insurance spending by at least $52 billion, even assuming savings of $15 billion from the elimination of uncompensated care provided by hospitals. Raising the payroll tax rate simply shifts costs from the government to employers, with predictably adverse results for marginal businesses. The report also suggests that such a rate hike would disproportionately affect small businesses since they are more likely than larger firms to opt for paying the tax.

"Play or Pay" or "Pay and Pay"

Proponents of "play or pay" say that the proposal would increase access to health care while containing runaway costs. The study, commissioned by the Labor Department, suggests that "play or pay" would have many unintended consequences, burdening small employers and creating a massive government-run insurance program that would dwarf Medicare and Medicaid. Tens of millions of workers and their families who now have employer-sponsored coverage would be shifted to this public program at considerable cost to taxpayers. The findings of the study should figure prominently in Senate debate over S. 1227 later this year.

Staff Contact: Doug Badger, 224-2946

Table 1
Play or Pay Employer Mandates: Simulation Assumptions

Employer Requirements	Must either pay 80% of the cost of a uniform benefit package for workers and their dependents or pay a payroll tax.
Benefit Package	1) All employers can purchase insurance at average rates currently available for firms in their region in the same size/industry group. 2) The uniform benefit package includes deductibles of $200 for singles and $500 for families; a 20% coinsurance requirement; covers well care; preadmission certification required.
Coverage Requirements	1) Hours of work: persons working 18 hours a week or more included in play or pay mandate; employers pay a payroll tax on the wages of persons working less than 18 hours. 2) Primary payer: workers accept coverage through own employer; dependents covered through primary worker's plan; coordination of benefits for persons with dual coverage.
Workers' Premiums	Pay 20% of the cost of the employer's premium or the cost of the public plan if full time, less subsidies for low-income persons.
Public Plan	1) Government pays premiums equal to those currently available to large (1000+) firms. 2) Persons not covered through employer enroll in public plan. 3) Families pay full public plan premium when not enrolled by employer, subject to premium subsidies.
Government Subsidies	1) Premiums for persons in private and public plan: reduced by 2 percentage points for each 10% that income is below 200% of poverty. 2) Premiums for families enrolled in public plan with incomes between 200-400% of poverty not to exceed 3.5%, 4%, and 5% for those with income less than 250%, 325%, and 400% of poverty, respectively. 3) Government pays cost-sharing for persons with incomes below poverty; and shares costs for persons with incomes between 100-200 percent of poverty.

Table 2

Insurance Costs by Payor: Current System Compared to Play or Pay

Billions of 1989 Dollars

9 Percent Play or Pay Plan

	Current	Mandate	Difference
Employers	$128.9	$173.2	+$44.3
Individuals[1]			
Group Premiums	$31.1	$23.2	-$7.9
Other Premiums[2]	14.5	22.6	+$8.1
Total	$45.6	$45.8	+$0.2
Government			
Public Coverage[3]	$27.6	$53.2	+$25.2
Total	$217.1	$272.2	+$69.7
Uncompensated Hospital Care	(4)	$0.0	-$15.0
Total Insurance Costs	**$217.1[5]**	$272.2	+$55.1[5]

7 Percent Play or Pay Plan

	Current	Mandate	Difference
Employers	$128.9	$158.6	+$29.7
Individuals[1]			
Group Premiums	$31.1	$18.2	-$12.9
Other Premiums[2]	14.5	28.2	+13.7
Total	$45.6	$46.4	+$0.8
Government			
Public Coverage[3]	$27.6	$64.4	+$36.4
Total	$217.1	$269.4	+$67.3
Uncompensated Hospital Care	(4)	$0.0	-$15.0
Total Insurance Costs	**$217.1[5]**	$269.4	+$52.3[5]

Source: The Urban Institute's Transfer Income Model (TRIM2), based on the March 1990 Current Population Survey.

Notes:
1. Individual premiums are net of premium subsidies paid by government.
2. Includes private, nongroup premiums under current system (Holahan and Zedlewski, 1991) and premiums in public plan under mandate.
3. Medicaid costs for nonelderly, noninstitutionalized (Holahan and Zedlewski, 1991).
4. Uncompensated care under the current system is included in insurance costs of direct payors (employers, individuals, and government).
5. The current insurance system is far less comprehensive than the pay or play systems. Fewer persons have coverage, and out-of-pocket cost sharing is not covered for low-income persons with health insurance. Thus, many of the additional costs shown under the play or pay options would simply offset out-of-pocket health care spending under the current system.

Wall St. Jrnl.; 1-3-92

'Play or Pay' Health-Care Plan Is Bound to Be a Loser

By Stuart M. Butler

U.S. businesses are worried about the spiraling costs of health care—and should be, since they're picking up much of the tab. But before they buy into any of the reform proposals offered by official Washington, they and their employees need to understand that Washington is second to none in good intentions gone awry.

This is especially important now, because several major corporations, including Chrysler, Bethlehem Steel, Dayton-Hudson, Westinghouse Electric, and Xerox have lined up behind a "mandated benefits" plan requiring employers to provide

Pricing Health Care

medical insurance to their employees or pay a new tax to fund a public program. The "play or pay" approach is bound to lead to surging costs, hiring discrimination against workers with large families or medical problems, endless lawsuits brought by job-seekers who think they're victims of such discrimination, and eventually to the kind of nationalized health system none of us really wants.

For some companies the costs of providing medical insurance for employees has doubled, tripled, even quadrupled in recent years. Hay, Huggins & Co., a benefits consulting firm, estimates that the typical company now pays nearly $4,500 a year for health insurance for each employee and employee family, a 400% increase since 1980. The typical employee also is paying more for this coverage, says Hay/Huggins: about $1,300 a year, compared to just $150 a year, on average, in 1980. Is it any wonder why business managers want to get this monkey off their corporate backs?

The trick, of course, is to reform the present system in a way that eliminates the gaps in coverage for workers in small firms or those changing jobs; promotes cost-consciousness; encourages competition; cuts down on the administrative paper work that has turned most doctors' offices into accounting jungles, and delivers the kind of top-quality medical care that Americans expect.

Most business leaders correctly reject the wholesale nationalization of American health care, knowing full well that it hasn't worked in any other industry and won't work in medicine either.

Thus, after initially flirting with proposals to have the U.S. establish a Canadian- or British-style national health system—which would shift the burden of funding U.S. medicine to the same lawmakers who can't balance their own checkbooks—most corporations are now looking elsewhere. And the alternative of choice at the moment appears to be play or pay.

Under this plan, companies would be given a choice: either provide at least a minimum specified package of health insurance benefits to all of their employees and their families, or pay into a government fund that would provide coverage to the uninsured. Either way, many executives figure, they will be better off financially than they are today. The reasoning is simple: For more than 45 years—ever since the IRS ruled that company-paid medical benefits are tax free to employees—employees receiving such benefits have been pushing for companies to provide more "free" coverage. In unionized workplaces, tax-free medical benefits frequently are considered a much higher priority than taxable wages.

In theory, because it would allow companies to pay a fixed tax (a figure of 7% of payroll currently is being touted) as an alternative to ever-more-costly health insurance, play or pay would get many employers off the hook—or so they think.

In reality, nothing starts off small and simple in Washington and stays that way—especially if Congress can mandate increases in benefits without raising taxes. Thus, over time, the "basic" benefits package inevitably will grow. When constituents start complaining that the basic benefits supplied by their employers don't cover this and don't include that, Congress will start including more services under the mandated minimum and reducing the co-payments required of beneficiaries.

Additional pressure to expand the minimum benefits package would come from those "providers" initially excluded from the system. Having the government require people to buy insurance that pays for the service you provide is a nice way to increase demand for that service, whether it's orthopedic surgery or acupuncture treatments. State lawmakers already have done so, enacting more than 800 laws during the past 15 years requiring insurers to cover specific providers or services—even when there was little consumer demand.

When insurance costs get high enough, equaling or exceeding the costs of paying into the government insurance fund, business executives will either find ways to cut costs, or drop the company insurance and pay the government's non-insurance tax.

With the government at least partially determining the nature of the insurance coverage a company offers, cutting costs becomes tricky—and invites trouble. The surest way to cut insurance costs is to reduce the full time work force, or make sure you hire people unlikely to incur high medical costs.

Imagine how a personnel manager would react to an overweight candidate for a minimum wage job who smoked heavily during the interview and insisted on showing the manager pictures of his five kids. Required by law to provide medical coverage to such a worker and his family, the company would have a powerful incentive to avoid hiring him, or to dump such workers into the government pool.

If this sounds illegal, you're probably right. Even if it's not illegal today, it will become illegal. Under the main bill in Congress to create a play or pay system, sponsored by Senate Majority Leader George Mitchell, companies electing to provide insurance could face heavy fines and crippling damage suits if there is reason to believe they discriminated in their hiring practices against workers considered high medical risks. That would open the way for unsuccessful job-seekers to claim they were denied employment because they have diabetes, or hypertension, or because they smoke, or are 30 pounds overweight, or have five kids. Faced with the prospect of such lawsuits, on top of all the problems of keeping health insurance costs under control, doubtless most employers would choose to pay, not play.

Thus play or pay is a weigh station on the road to a giant Medicaid program for all Americans—a phony alternative that will become so unattractive over time that eventually we'll get those long lines and waiting lists, so common in Canada and Britain, despite ourselves.

Mr. Butler is director of domestic policy studies at the Heritage Foundation, Washington, and co-author (with Edmund Haislmaier) of "A National Health System for America" (Heritage, 1989).

Los Angeles Times

CIRCULATION: 1,242,884 DAILY / 1,539,425 SUNDAY

MONDAY, JANUARY 13, 1992

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PERSPECTIVE ON HEALTH CARE REFORM

L.A. Times; 1/13/92

'Pay or Play' Is a Losing Gamble

The Democrats would give us the ultimate bureaucracy. There are better ways to improve medical care.

By LOUIS W. SULLIVAN

"Pay or play," a phrase that sounds like a new game in Las Vegas, is the catchy nickname for a health-care reform proposal that has been introduced by Democrats in Congress. Advertised as a simple way to get more people insured, it's really a back door to national health care, which would be a cumbersome bureaucratic system.

The idea is simple—deceptively so. Under the "pay or play" proposal, all employers would be required to either provide health insurance to their full-time employees or pay into a public health insurance system to be run by the federal government.

Of course, all Americans want a health-care system that works better and provides access to care for everyone. And "pay or play" has garnered a lot of attention because it sounds easy and fair.

But the truth is that "pay or play" would result in the worst of all worlds: closed businesses, lost jobs, huge new expenses for both the private sector and the taxpayer, and an enormous new bureaucracy. It would start us down the road to a nationalized health insurance system and lead eventually to rationing of health care and long waits for medical care—something the American people won't, and shouldn't, tolerate.

True enough, this proposal is one way we could expand access to care. But it should really be called "pay . . . and pay . . . and pay some more."

It would hurt many of those it's meant to help, including small businesses. It would even result in tens of millions of Americans who are now covered by private health insurance being transferred unnecessarily to a new government-run program; many businesses would opt to drop private insurance and let employees be covered by the government instead, because the government plan, subsidized by taxpayers, would be the cheaper alternative.

Is that the kind of health-care reform we want?

This week, many Democratic members of Congress will be holding orchestrated "town meetings" around our nation. The idea is to highlight the health-care issue. That's fine—except that they'll be promoting the "pay or play" scheme. And it is unlikely that both sides of the story will be told.

Fortunately, the Department of Labor released an independent study of "pay or play," last Thursday, done on contract by the Urban Institute and RAND Corp. It estimates the real effects that "pay or play" would bring about, and it is an eye-opener.

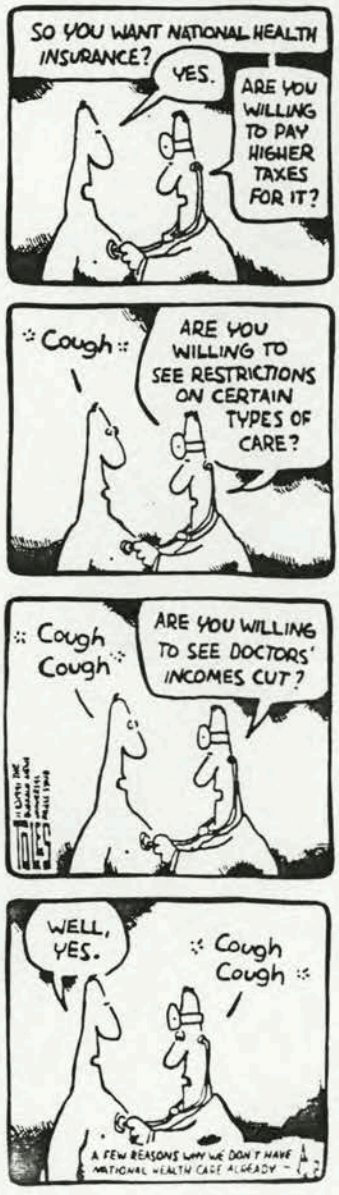
Based on the 7% payroll tax proposed in leading Democratic bills, the study finds that:

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

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

— Employers would incur new costs of almost $30 billion. The burden would fall especially on small businesses. For many, this would simply mean closing shop—and eliminating jobs. Small businesses employ more than half of Americans in the private work force.

— Even with the new tax on payroll for employers who chose it, the vast new public plan would cost more than that tax would bring in. Therefore, an additional $36.4-billion subsidy would be borne by the general taxpayer. The new plan would represent a 131% increase over spending on the current public programs it would replace, notably Medicaid.



If "pay or play" sounds like a gamble, it is. It's an unnecessary, high-cost gamble with our economy, our small businesses and our health care.

America has set the world standard in medical care. No reform proposal should put that accomplishment in jeopardy. The fact is, we already spend more on health care than any other nation—about $2,600 per person per year. What's needed is to spend those dollars more effectively—to get better care and better health for the money we're already committing.

The Bush Administration is developing a comprehensive reform proposal. Our plan will not be simplistic, because the problems are not simple. They vary from inability to buy private insurance at a reasonable cost, to inflexibility in public programs, to outright unavailability of services in some areas. We need a balanced package of reforms that treat a variety of problems while addressing the root causes of waste and inefficiency in our system.

We need to make private health insurance more affordable and more available, especially for small businesses. We also need to ease the barriers to coordinated care plans which can deliver high-quality care at lower cost. We need to support research into what really works, in order to avoid wasteful treatments.

We need to look at incentives, including our tax code. How can we reward cost-effective choices by both professionals and patients? Are the subsidies we provide for health care today as fair as they should be?

We need to upgrade and expand our primary health-care system. Timely and less expensive primary care can often mean emergencies and costs avoided later on. And, of course, we need to encourage healthy behavior and choices by individuals. No single action can improve our nation's health status more than this one.

America needs reforms that preserve quality of care, improve access and control costs. Our health-care system doesn't need to gamble on "pay or play." It needs to "perform."

Dr. Louis W. Sullivan is secretary of Health and Human Services.

QUOTES ON

Play-or-Pay Plans

"Introducing a bill [like HealthAmerica] is like wrapping up an empty box and putting it under the Christmas tree -- It is designed to disappoint."

-- Sen. Durenberger
June 19, 1991

"We often act in haste and repent at leisure. That's why I think we need much more serious discussion before we attempt legislative action."

-- Rep. Rostenkowski
September 6, 1991
BNA (No. 173)

"There is no radical utopian solution that will preserve the necessary diversity needed to meet the needs of our people... Those who argue that there is a silver bullet or easy, single solution to health reform are either knowingly misleading the public or frighteningly irresponsible. There is no single panacea."

-- Secretary L. Sullivan, M.D.
September 24, 1991
Health News Daily

"Mandates exacerbate the symptom of the problem rather than attacking the root of the problem."

-- Sen. McCain
March 21, 1991

"Lee Iacocca will like [HealthAmerica]. For years, he's wanted to dump Chrysler's health care costs on government and the Senate Democrats are offering him a chance."

-- John Goodman
June 11, 1991
The Wall Street Journal

"Employers will not be tricked into accepting a play-or-pay mandate only to discover years later than S. 1227's promises to curtail health care inflation were illusory."

-- Society of Professional Benefit Administrators
June 5, 1991

"There is a quantum leap between undertaking a voluntary responsibility and absorbing a mandatory requirement."

-- Phillip Chisholm
April 24, 1991
Small Business Legislative Council

"While a play-or-pay system sounds good at first blush, the increased payroll burden for marginal businesses and the chilling effect on business start-ups would likely mean lost jobs. Without job creation or, worse, with job destruction, we could end up with more, rather than fewer, lacking health insurance."

-- Secretary L. Sullivan, M.D.
June 20, 1991
Health News Daily

"We certainly need national health coverage. I am not sure that we need national health insurance. The [Kennedy bill] cannot work. Like every other plan, it simply attempts to capture more revenues to cover traditional forms of care. We will go broke trying to do that."

-- John D. Golenski, ethics consultant
Kaiser Permanente
July 17, 1989
Health Week, p. 28

"Some 34 million Americans are presently not covered...But the uncovered population is not as serious a problem as the aggregate numbers might suggest. According to the National Center for Health Statistics (NCHS), most are employed people between the ages of 15 and 40 with a low incidence of serious medical problems. They could be [covered] with a modest increase in public and private spending on health insurance."

-- Gary S. Becker, Professor
University of Chicago
September 9, 1991

Business Week

"I have operated my business since 1982. It took me five years before I was fiscally able to purchase a health plan for my employees. In 1988 that cost was $190.00 per month per family...In 1990 it jumped to $496.00. During this time period we also felt the burden of rising Social Security taxes, unemployment insurance premiums, workers compensation and a host of other taxes...I hope that the time does not come that the cost of those premiums forces me to drop coverage all together."

-- Teresa Matregrano, owner
Blue Star Glass (NH)
11 employees
Testimony before ACSS

"Attempting to legislate now would be a terrible mistake. It would delay by years the reforms we agree are needed."

-- Rep. Rostenkowski
October 10, 1991
Health News Daily

"While many policymakers thought there was consensus when catastrophic legislation was passed in 1988, "in reality, it was the political equivalent of New Coke, and the President and I have no intention of letting a debacle of that kind happen with health care reform."

-- Secretary Louis Sullivan
Bureau of National Affairs
Report for Daily Executives
October 22, 1991

NATIONAL HEALTH INSURANCE

National Health Insurance would abolish the private insurance system the majority of Americans now enjoy and replace it with a government-funded, government-administered program. The Canadian system is the model frequently proposed as a solution to the health care problems of this country - but it is costly, quality suffers and it stifles innovation. As has been said, a national health insurance plan combines the compassion of the IRS and the efficiency of the Post Office at Pentagon prices.

Taxes will increase

- Implementation of a national insurance scheme would require new government spending of between $189 billion and $339 billion. Options would include: raise the combined employer-employee payroll tax from 15% to 29%; raise income income tax rates across-the-board by 14%; or impose a new national sales tax of approximately 10%.

- The Canadian system has failed to control cost growth - Canadian health care costs continue to grow faster than U.S. costs. Between 1970 and 1990, Canada's expenditures grew annually 10.8%, compared with 10.5% in the U.S.

- Steep new taxes would be needed to finance the plan. As a percentage of Gross Domestic Product (GDP) taxes in Canada are 5% greater than in the U.S. States would also be required to levy new taxes to fund the plan.

- Crude price controls would be required to control rising costs. These constraints would force hospitals to cut back on staff - jeopardizing the quality of care. Shortages and waiting lines for care would result. As a result of staff cuts, post-operative death rates in Canada are 40 percent higher than in U.S. hospitals for certain high-tech, life-saving surgical operations.

Quality Suffers

- Rationing through delaying, and in some cases, denying care, exists everywhere in national health insurance plans to keep demand for "free services" under control. In Canada, for instance, a patient waits for an average of 23.7 weeks (almost 6 months) for a coronary artery bypass.

- Patients not receiving timely access to diagnostic procedures - such as MRIs, CT scans and mammogram under national health schemes - can suffer setbacks due to delayed treatment. The entire population of Newfoundland, with a population of 579,000, has only one CAT scanner. And those in Canada needing acute care and forced to wait - risk death.

Innovation is Stifled

- Government and political control of hospital capital and operating budgets limits the adoption of medical technology in Canada. Heart valve surgery and bypass surgery for patients ages 65-74 and 75+ were consistently performed less often in Canada. The government would be in the position of denying care to older patients in favor of those who are younger.

- Limited availability of medical technology in Canada has prompted "medical refugees" coming to the U.S. to seek advanced medical care. For example, the British Columbia Health Association has contracted with Seattle hospitals for coronary bypass surgeries and Ontario and Alberta have similarly contracted with U.S. hospitals for high technology care.

CHICAGO TRIBUNE ORANGE COUNTY REGISTER CAMDEN COURIER-POST
READING (Pa) EAGLE ROANOKE TIMES & WORLD NEWS October 9, 1991

Canada's health system has its ills

By Edmund F. Haislmaier

Charles Coleman was 63 years old when his doctors told him he might die unless he underwent coronary bypass surgery. In the four months that followed his diagnosis, Coleman's surgery was postponed 11 times; doctors at Toronto's St. Michael's Hospital cited a bed shortage in the intensive care unit as the cause of the delays. At one point, Coleman waited in the hospital 13 days before being discharged without surgery.

Although the surgery was finally performed, members of Coleman's family said the long ordeal had so weakened him that he became "a broken man" and lost his will to live. He died eight days after his surgery.

This sad case, although dramatic, is not remarkable in Canada, where the health-care system has been fully nationalized for the past two decades.

In spite of its flaws, the Canadian system is the very model frequently proposed as a solution to the health-care problems in the United States. What its U.S. proponents find most attractive about the Canadian system is that it appears to provide universal health insurance coverage at a lower cost than our present system, which has left an estimated 31 million Americans uninsured.

In the early 1960s, Canada was spending a slightly higher percentage of its gross national product on health care than was the United States, roughly 6 percent versus 5.5 percent. After 1971, however, when the main elements of Canada's current system were introduced in all provinces, costs began to diverge, with Canada spending considerably less of its GNP on health than the United States. In 1989, for example, U.S. health-care spending was 12 percent of GNP; Canada's was only 9 percent of GNP.

The simple conclusion, drawn countless times from these data, is that Canada significantly limited the growth of medical spending once the government took control of health-care financing.

This simplistic comparison is misleading. Between 1967 and 1987, real per capita health-care spending increased at an average annual rate of 4.58 percent in Canada, versus 4.38 percent in the United States. But GNP growth was, on the average, higher in Canada than in the United States during the same period. Between 1967 and 1987, Canada's real per-capita GNP grew 74 percent, while the real growth in U.S. per-capita GNP was only 38 percent. (These figures are in each country's own currency.)

In other words, Canada has done no better than the United States in controlling the growth in health-care costs. Canada's health-care/GNP ratio has remained lower simply because its GNP has increased more rapidly than our own.

While Canadian federal and provincial governments have failed to control the growth of heath-care spending by any meaningful measure, they have certainly tried—with less than happy results.

Canadian hospital administrators have been put in an awkward position because their budgets are fixed by the government. This means treating more patients doesn't bring them any more revenue; it simply eats up their budgets. And treating patients with costly illnesses consumes their budgets even faster. This creates a dilemma. They won't look like competent managers if they spend their entire budgets before the end of the year. On the other hand, if they treat fewer patients, their budgets will be safe, but they won't look competent either. How do administrators respond to this set of conflicting pressures?

To start with, they know that most of the cost of treating patients usually comes from the expensive medical services that are provided during the first day or so of hospitalization. After that, most patients use fewer medical services and more of the hospital's less expensive "hotel" services. So the answer presents itself: Avoid admitting patients who are costly to treat unless, of course, it's a life-threatening emergency. To keep hospital beds full, they admit patients requiring less-costly care, treat them, and keep them in the hospital. As one doctor put it, "The best way to stretch a fixed hospital budget is by keeping sick people out and healthy people in."

While Canadian federal and provincial governments have failed to control the growth of heath-care spending by any meaningful measure, they have certainly tried—with less than happy results.

Such practices inevitably produce both full hospitals and long waiting lists for major medical care. In April 1989, one Ontario newspaper reported that 1,600 people were "waiting for heart surgery and the list is steadily increasing." Similarly, the Winnipeg Free Press reported in July 1989 that "Doctors and nurses at Brandon General Hospital lashed out yesterday at bed closings that have left 91 patients, including cancer victims, waiting up to six weeks for urgent surgery. Most of the patients have cancer of the breast, large bowel, or lungs." And the Edmonton Journal reported last year that the only hospital doing cardiovascular surgery in northern Alberta had 210 adults and children on its waiting list. "The average wait is six months, although some people have been waiting as long as a year," said a hospital spokesman.

The lucky majority of Canadians who are reasonably healthy continue to find ready access to routine, low-cost medical services. The unfortunate minority with serious conditions, however, increasingly are expected to take a number and wait.

Edmund F. Haislmaier is a health-care analyst at the Heritage Foundation. This article is excerpted from Policy Review, the foundation's quarterly journal.

Wall St. Jrnl.; 12-11-91

Don't Look for Better Health From National Health Insurance

By Victor Fuchs

Pricing Health Care

With some exceptions, such as Medicare, health insurance in the U.S. is a private, voluntary matter. Most Americans are insured. The one in seven who are not can be grouped into six categories:

1. *The poor.* The largest group of the uninsured consists of individuals and families whose low income makes it unfeasible for them to acquire insurance, either on their own or as a condition of employment. About 20% of the uninsured have no connection with the workforce, but the rest are either employed or are dependents of employed persons. The Health Insurance Association of America, the principal association of private health insurers, estimates that 31% of uninsured workers earned less than $10,000 in 1989; another estimate puts the figure at 63%. In any case, it is clear that the great majority of uninsured workers cannot afford to give up a substantial fraction of their wages in order to obtain health insurance.

The frequently heard explanation, "small employers cannot provide health insurance" is misleading. Employers do not bear the costs of insurance; workers do, in the form of lower wages. Lawyers, accountants and other highly paid professionals organized in small firms usually have health insurance. A more accurate description of the problem would be, "many workers in small firms cannot afford health insurance."

2. *The sick and disabled.* Many men and women who are not poor are still unable to afford health insurance because they have special health problems and therefore face very high premiums or are excluded from some coverage entirely.

3. *The "difficult."* Some people are neither poor nor sick, but have difficulty in obtaining insurance at average premiums. They may be self-employed or out of the labor force entirely. In order to reach and service such individuals, insurance companies incur abnormally high sales and administrative costs.

4. *Low users.* Some people do not expect to use much medical care. They may be in particularly good health; they may be Christian Scientists. For them, health insurance is a bad buy unless they can acquire it at below-average premiums.

5. *Gamblers.* Most people buy health insurance in part because they are risk averse. They would rather pay a fixed, known premium than run the risk of a huge expense in event of a serious illness. But not everyone is risk averse: The gambler says, "I'd rather save the premium and take my chances."

6. *Free-riders.* The final category consists of individuals who remain uninsured because they believe that if they do get sick, they will get care anyway, with somebody else picking up the bill.

Review of the six categories suggests that national health insurance is, from an analytic point of view, rather simple: All it requires is subsidization of those who are unable to afford insurance and compulsion of those who are unwilling to acquire it. The best short explanation of why the U.S. does not have national health insurance is that the majority of Americans have resisted subsidizing those who are unable to afford it and have been reluctant to force coverage on those who do not obtain it voluntarily.

Opponents of national health insurance frequently assert that it would result in a substantial increase in the total cost of care. In fact, on a per-capita basis, and adjusting for differences in real income, the U.S. spends much more on medical care than any other country. The average American spends about 40% more than the average Canadian. And Canada spends more per capita than any European country.

How can this be? Countries with national health insurance find other methods to contain health care spending. The most obvious saving is in administration: In the U.S., approximately 6% of national health expenditure is accounted for by administration. To this must be added several percentage points incurred by providers for billing and other administrative activities directly attributable to the American system of financing care. By contrast, the Canadian system of provincial health insurance imposes minimal administrative and billing costs on providers and payors.

But savings on administration are only part of the answer. Nearly all countries with national health insurance rely heavily on what I call "upstream resource allocation." The key to this type of resource allocation is governmental control of capital investment in facilities and equipment, speciality mix of physicians and the development and diffusion of high-cost medical technology. There are, for instance, more physicians per capita in Canada than in the U.S., but there are many fewer who specialize in complex surgical and diagnostic procedures.

The price that Canadians and Europeans pay for such controls is delay or inconvenience in obtaining access to high-tech services, and in some cases not receiving such services at all. Whether such delays or denials have a significant effect on the health of the popuation is not known with certainty.

There is no conclusive answer to the question: Does national health insurance improve the health of the population by increasing access to care—or does it worsen health by constraining the introduction of new technology and destroying incentives? In my judgment, national health insurance has little effect on health one way or the other.

In particular, national health insurance does not eliminate or even substantially reduce differentials in health outcomes across socioeconomic groups. In England, for instance, infant mortality in the lowest socioeconomic class is double the rate of the highest class, just as it was before the introduction of national health insurance in the late 1940s.

Even in the relatively homogenous populations of egalitarian Scandinavia, life expectancy varies considerably: The age-standardized mortality rate for male hotel, restaurant and food service workers is double that for teachers and technical workers. In Sweden, a study of age-standardized death rates among men 45-64 found substantial differentials across occupations in 1966-70 and slightly greater differentials in 1976-80.

National health insurance does seem to control health costs, but it doesn't much improve health outcomes. Will lower costs alone suffice to overcome America's reluctance to subsidize and compel people in a national health insurance system? In my view, the prospects in the short run are poor. Some public opinion polls indicate a readiness for national health insurance, but they are not credible indicators of political behavior.

In the long run, though, national health insurance is not dead. The need to curb costs will push the country toward a national system, although the timing will depend largely on political factors producing a major change in the political climate. Short of that, we should expect modest attempts from Washington to increase coverage and contain costs, accompanied by immodest amounts of sound and fury.

Mr. Fuchs is a professor of economics at Stanford University. This is adapted from an article in the winter issue of Health Affairs.

QUOTES ON

National Health Insurance

"A national health insurance-type system combines the compassion of the IRS and the efficiency of the Post Office at Pentagon prices."

-- Connie Horner
April 19, 1991
Health News Daily

"All Americans must have access to quality health care, but it cannot be done simply by the federal government writing a check."

-- Secretary L. Sullivan, M.D.
February 20, 1991
The Washington Post

"The most preposterous aspect of the discussion about a national health insurance system for the U.S. is that we cannot even afford the health care systems we have now. The United States is running an economy-crippling budget deficit, yet it is presumed that the Government could afford to run a costly health care system."

-- Henry Lerner, M.D.
February 3, 1991
The New York Times

"...national health insurance typically works by vastly reducing the level and quality of medical care or by expropriating the labor and resources of the health care industry and its workers."

-- Henry Lerner, M.D.
February 3, 1991
The New York Times

"A universal health insurance system also has major disadvantages. It centralizes decision-making to a troubling degree...With a single payment source, there is always the danger that system-wide spending decisions will be driven by the government's budget needs, rather than by the nation's health needs or the needs of the economy as a whole."

-- Sen. Kennedy
July 18, 1991

"We often act in haste and repent at leisure. That's why I think we need much more serious discussion before we attempt legislative action."

-- Rep. Rostenkowski
September 6, 1991
BNA (No. 173)

"I don't believe that letting the federal government be the manager of all health care in this country is going to provide the care that is going to be cheaper and still get the same quality medical care and accessibility."

-- Rep. Archer
September 6, 1991
BNA (No. 173)

"There is no radical utopian solution that will preserve the necessary diversity needed to meet the needs of our people... Those who argue that there is a silver bullet or easy, single solution to health reform are either knowingly misleading the public or frighteningly irresponsible. There is no single panacea."

-- Secretary L. Sullivan, M.D.
September 24, 1991
Health News Daily

"One problem is that government is inherently incapable of administering an insurance program that prices risk accurately... witness the deposit insurance debacle at the federal level and the auto liability crisis in California."

-- John Goodman
June 11, 1991
The Wall Street Journal

"The day to day rationing by physicians and hospitals that takes place constantly in the Canadian system might be legally impossible here -- Delays would be considered imprudent, if not malpractice."

-- Stuart Butler
July 29, 1991
Testimony before House Energy & Commerce

"In Canada, the impact of centralized decision making puts younger patients ahead of those of advance age. Effectively forced by limited resources to choose, physicians allocate care to the young."

-- The Seniors Coalition
August/September 1991

"...before we dash, as a nation, headlong into the financial black hole that nationalization of health insurance would certainly create -- or repeat the now repealed Massachusetts miracle -- we ought to learn the lessons of the now repealed Medicare Catastrophic Coverage Act and enter into a dialogue with the American people about what's good about our current system..."

-- Sen. McCain
August 2, 1991
Congressional Record (No. 121)

"A health care system in which the government controls prices and sets budgets will lead, inevitably, to serious shortfalls in quality and access. If the Medicaid program is an example of government-run health care, we shouldn't be giving them the whole health care system."

-- Michael Bromberg, Executive Director,
Federation of American Health Systems
July 31, 1991

"We certainly need national health coverage. I am not sure that we need national health insurance. The [Kennedy bill] cannot work. Like every other plan, it simply attempts to capture more revenues to cover traditional forms of care. We will go broke trying to do that."

-- John D. Golenski, ethics consultant
Kaiser Permanente
July 17, 1989
Health Week, p. 28

"While many policymakers thought there was consensus when catastrophic legislation was passed in 1988, "in reality, it was the political equivalent of New Coke, and the President and I have no intention of letting a debacle of that kind happen with health care reform."

-- Secretary Louis Sullivan
Bureau of National Affairs
Report for Daily Executives
October 22, 1991

"...global expenditure limits alone would create a pressure cooker effect...We would be screwing down the cap and turning up the heat...in about two years, we would blow the lid off."

-- Gail Wilensky
Bureau of National Affairs
Report for Daily Executives No. 198
October 11, 1991

Foundation for Reform: Quotes from Dr. Louis Sullivan
Secretary of the U.S. Department of Health and Human Services

"Americans clearly sense that they would lose more than they would gain by abandoning our current, basically sound system, to embrace radical, untested alternatives in either direction."

"The real problem, contrary to the myth that the uninsured do not receive care, is that the search for care is difficult, time consuming, and too often demeaning..."The belief that, by itself, putting an insurance card in every pocket will cure our health care ills is false prophecy from those preaching easy solutions."

"Pay-or-play proposals [like those introduced by Democrats in Congress] would result in lost jobs, higher employer costs, higher taxes and a hug new government-run health program. The fact is that pay-or-play is the wrong medicine, and we shouldn't take it."

"It is unacceptable and unnecessary to put real jobs in jeopardy in order to address health care needs. We need to protect jobs, and improve access to insurance and to health care. We can do both."

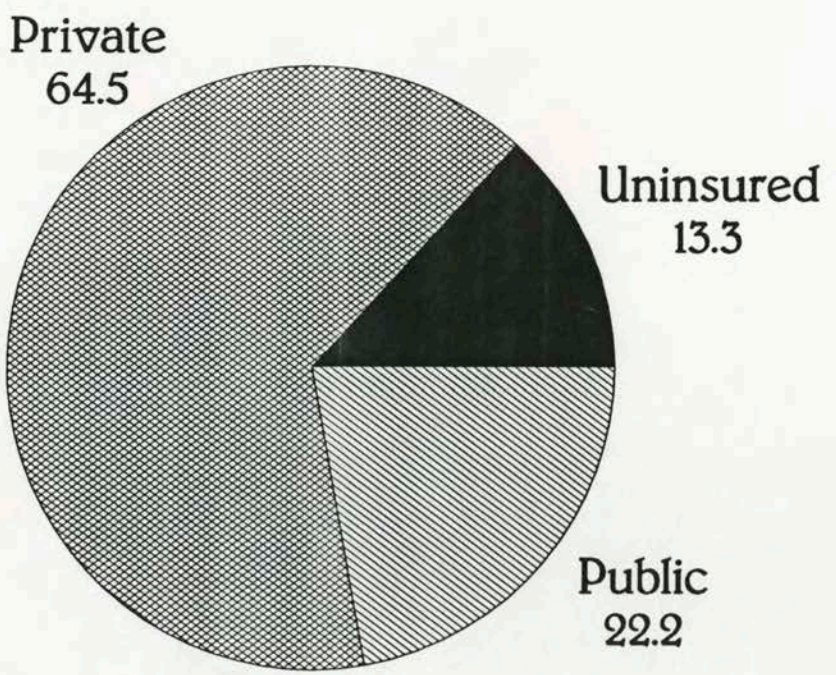
Effect of Overall Reform Proposal on the Number of Uninsured Americans

(People in millions; assumes 1991 uninsured population)

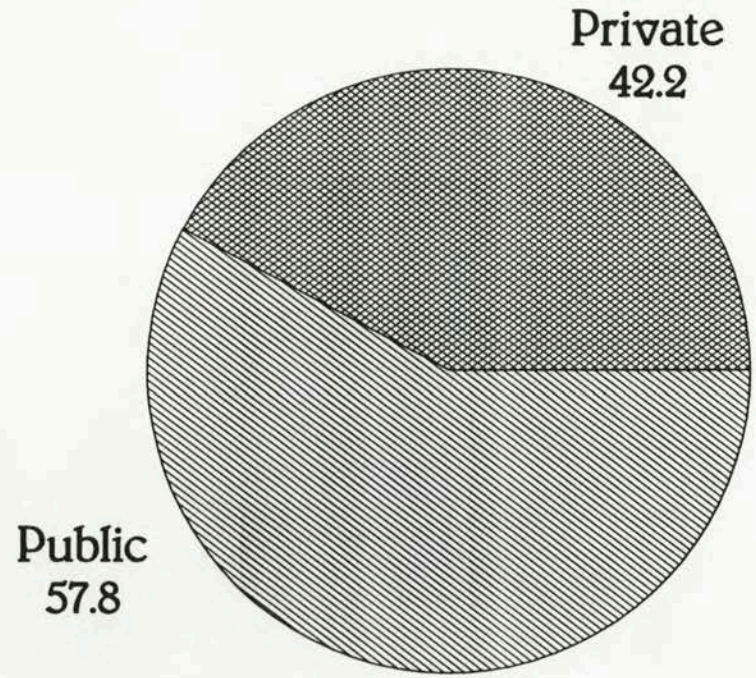
Income Level	Below 100 Percent of Poverty	Between 100 & 150 Percent of Poverty	Totals	As Percent of Total Population
Current Law Uninsured	15.4	5.7	34.1	12.8 %
Covered Through Tax Credits and Deductions	14.9	5.0	24.1	9.1 %
Covered Through Market and Other Reforms	0.4	0.6	5.0	1.9 %
Total Newly Covered	15.4	5.6	29.2	11.0 %
Remaining Uninsured	0.1	0.2	4.9*	1.8 %

* *Many of the 4.9 million remaining uninsured are eligible for a credit or deduction, but choose not to take advantage of the program.*

Source of Health Insurance Coverage for U.S. Population



Current System

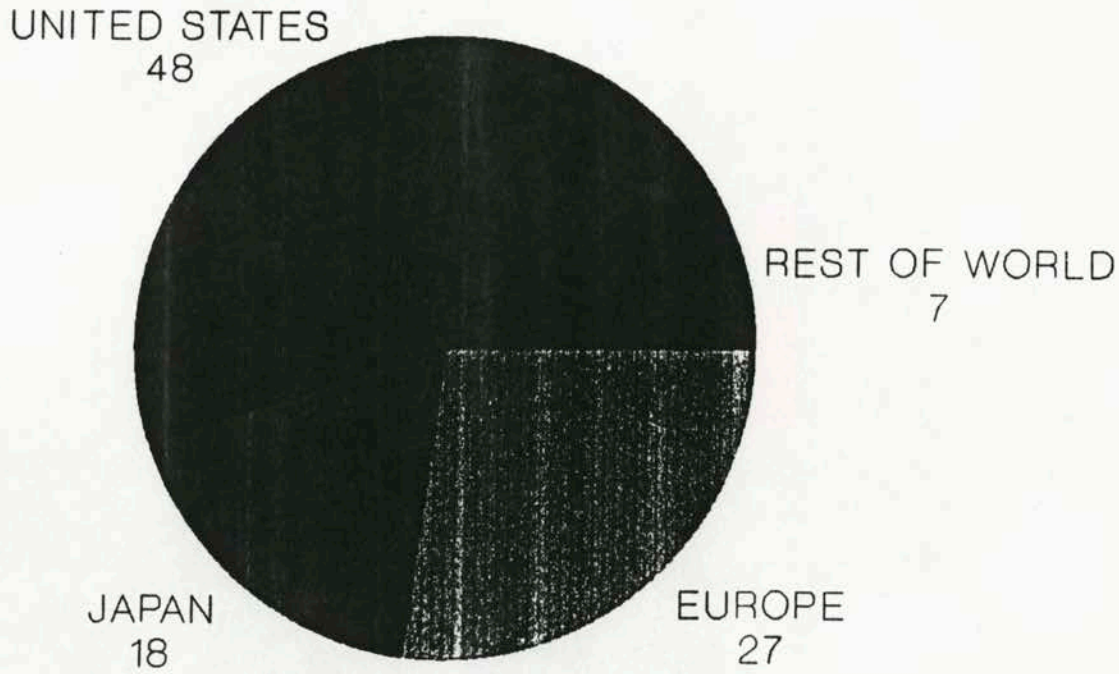


Play-or-Pay
with a 7% Tax

SOURCE: The Urban Institute, "Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs," January 8, 1992

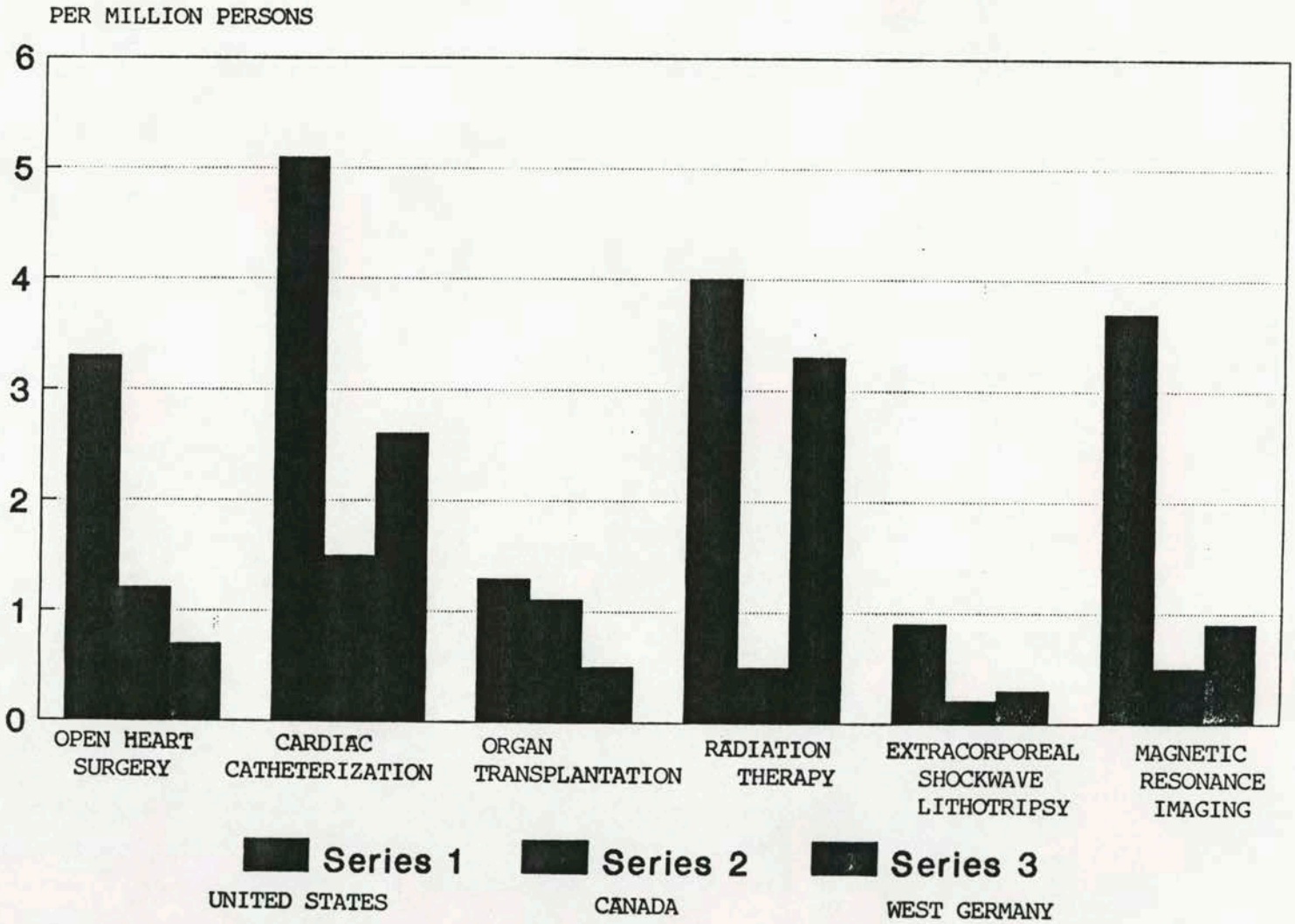
PRODUCTION OF MEDICAL EQUIPMENT

United States and the World, 1991



SOURCE: Medicine & Health, January 27,1991

COMPARATIVE AVAILABILITY OF SELECTED MEDICAL TECHNOLOGIES



SOURCE: Dale A. Rublee, "Medical Technology in Canada, Germany and the U.S." Health Affairs, 1989

++++++++++++++++ REUTER ++++++++ Key Station 1 ++++++++ V. U1291 ++++++++++++++

YELTSIN PUSHES FOR RECKONING WITH VICE-PRESIDENT PYKN

MOSCOW, FEB 13, REUTER - RUSSIAN PRESIDENT BORIS YELTSIN THREW DOWN THE GAUNTLET TO HIS CONSERVATIVE VICE-PRESIDENT, ORDERING HIM TO PUSH THROUGH RADICAL AGRICULTURAL REFORM OR ANSWER TO PARLIAMENT.

BUT MAJOR-GENERAL ALEXANDER RUTSKOI, SIGNALLED DETERMINATION TO RESIST YELTSIN WITH A SHARP ATTACK ON GOVERNMENT REFORMS.

HE ALSO RISKED ANGERING OTHER FORMER SOVIET REPUBLICS BY SUGGESTING RESTORATION OF A UNIFIED STATE ON TERRITORY OF THE FORMER SOVIET UNION.

RUTSKOI'S ASSIGNMENT TO AGRICULTURAL REFORM IS SEEN AS POSSIBLY THE MOST DIFFICULT AREA IN THE ADMINISTRATION.

13-FEB-1153. FEP170 L13214155 HZCG

CONTINUED ON - PYKO

++++++++++++++++ REUTER ++++++++ Key Station 1 ++++++++ V. U1291 ++++++++++++++

YELTSIN PUSHES FOR RECKONING WITH VICE-PRESIDENT -PART 2 PYKO

RUTSKOI IS FIRMLY OPPOSED TO RADICAL CHANGE.

A LACK OF REFORMING ZEAL FROM THE FORMER FIGHTER PILOT -- YELTSIN IS DEMANDING RAPID BREAK-UP OF THE OLD FARM BUREAUCRACY AND PRIVATISATION OF LAND -- COULD QUICKLY FORCE A SHOWDOWN BETWEEN THE TWO IN PARLIAMENT.

RUTSKOI ENJOYS BROAD SUPPORT AMONG CONSERVATIVES, COMMUNISTS AND ARMY OFFICERS.

YELTSIN, ANSWERING QUESTIONS AFTER A SPEECH ON HIS RECENT FOREIGN TRIP, SAID HE HAD REACHED A GENERAL UNDERSTANDING WITH RUTSKOI IN TWO HOURS OF TALKS ON WEDNESDAY NIGHT.

13-FEB-1153. FEP172 L13214155 HZCG

CONTINUED FROM - PYKN

CONTINUED ON - PYKP

pg 1

YELTSIN TOLD PARLIAMENT HE WAS PLANNING SOME CHANGES TO HIS ECONOMIC POLICIES TO ENSURE BETTER SOCIAL PROTECTION OF THE POOR AND STIMULATE GROWTH.

"LIFE CHANGES CONSTANTLY. (CHANGES) ARE NATURAL AND INEVITABLE," YELTSIN TOLD PARLIAMENT, ACKNOWLEDGING PUBLIC OUTCRY FOR MORE SOCIAL PROTECTION IN THE FACE OF HIGHER PRICES.

"IT HAS BECOME CLEAR WE NEED A SERIES OF MEASURES, WHICH CANNOT BE PUT OFF, TO STIMULATE OUR ECONOMIC COURSE. MEASURES WILL BE DISCUSSED TO INTRODUCE THE NECESSARY CHANGES," HE SAID. HE GAVE NO DETAILS.

13-FEB-1153. FEP173 L13214155 HZCG

CONTINUED FROM - PYKQ

CONTINUED ON - PYKQ

++++++++++++++++ REUTER ++++++++ Key Station 1 ++++++++ V. U1291 ++++++++++++++++

YELTSIN PUSHES FOR RECKONING WITH VICE-PRESIDENT -PART 4 PYKQ

"TO OCCUPY HIS TIME TO THE LIMIT, HE (RUTSKOI) HAS BEEN ENTRUSTED WITH THE TASK OF OVERSEEING AGRICULTURAL REFORM IN RUSSIA," YELTSIN TOLD PARLIAMENT TO A WAVE OF LAUGHTER.

"HE CAN REPORT TO THE PRESIDENT TWICE A MONTH AND TO PARLIAMENT EVERY MONTH," HE ADDED.

AS AN ELECTED OFFICIAL, RUTSKOI CANNOT BE SACKED FROM THE VICE-PRESIDENCY BY YELTSIN. ONLY PARLIAMENT CAN DECIDE HIS FATE IN A CRISIS.

IN RUSSIA'S COMMUNIST PAST THE POST OF PARTY AGRICULTURE SECRETARY WAS FREQUENTLY SEEN AS A POLITICAL LIABILITY, THE IRONY QUICKLY RECOGNISED BY DEPUTIES ON THURSDAY.

13-FEB-1154. FEP174 L13214155 HZCG

CONTINUED FROM - PYKP

MORE

pg 2

++++++++++++++++ REUTER ++++++++ Key Station 1 ++++++++ V. U1291 ++++++++++++++

RUSSIAN OFFICIAL SAYS OUTPUT FELL AS PRICES ROSE PYIL

BY JANET GUTTSMAN

MOSCOW, FEB 13, REUTER - RUSSIA'S FIRST MONTH ON THE ROAD TO A MARKET ECONOMY WAS MARKED BY TUMBLING OUTPUT AND SHARPLY RISING PRICES, THE HEAD OF THE STATE STATISTICS COMMITTEE SAID.

AT A NEWS CONFERENCE WHICH LIFTED A VEIL OF SECRECY OVER STATE STATISTICS, GOSKOMSTAT CHAIRMAN PAVEL GUZVI SAID PROGRESS TOWARDS A MARKET ECONOMY HAD BEEN SLOW, DESPITE THE RUSSIAN GOVERNMENT'S JANUARY 2 MOVE TO FREE PRICES FROM STATE CONTROL.

"UNFORTUNATELY THE MOVE TOWARDS A MARKET ECONOMY IS NOT IMPROVING PEOPLE'S LIVES," GUSVI SAID, ADDING, "THERE ARE VERY FEW PRODUCTS FOR WHICH PRODUCTION HAS RISEN."

13-FEB-1054. FEP673 L13204240 MZCE

RUSSIAN OFFICIAL SAYS OUTPUT FELL AS PRICES ROSE -PART 2 PYIM

GOSKOMSTAT WILL DISAPPEAR THIS YEAR, TO BE REPLACED BY A NEW BODY LOOKING AT FIGURES IN THE COMMONWEALTH OF INDEPENDENT STATES WHICH SUCCEEDED THE SOVIET UNION.

GUSVI SAID RUSSIAN RETAIL PRICES HAD RISEN 350 PCT IN JANUARY FROM DECEMBER. PRICE RISES WERE LIKELY TO CONTINUE IN FEBRUARY AS PEOPLE BEGIN RUNNING OUT OF GOODS HOARDED SINCE LATE LAST YEAR.

IN THE THREE MONTHS TO JANUARY PRICES HAD RISEN 28 PCT, HE SAID.

GUZVI SAID OVERALL OUTPUT HAD FALLEN BY 15 PCT IN JANUARY AS HIGHER PRICES BEGAN TO BITE.

13-FEB-1054. FEP674 L13204240 MZCE

CONTINUED FROM - PYIL CONTINUED ON - PYIN

pg 1

RUSSIAN OFFICIAL SAYS OUTPUT FELL AS PRICES ROSE -PART 3 PYIN

MANY FACTORIES HAVE COMPLAINED THAT THE HIGHER PRICES COULD TRIGGER A WAVE OF BANKRUPTCIES, MAKING MILLIONS OF WORKERS UNEMPLOYED. SOME FIRMS HAVE CUT PRODUCTION BECAUSE CUSTOMERS CANNOT AFFORD TO BUY MORE EXPENSIVE GOODS.

GUZVI SAID VIRTUALLY THE ONLY EXCEPTION TO THE BLEAK PRODUCTION PICTURE WAS IN OIL PRODUCTS, WHERE GOVERNMENT STIMULI MEANT OUTPUT OF DIESEL FUEL AND HEATING OIL WAS SLIGHTLY ABOVE LAST YEAR'S LEVELS.

OVERALL OIL EXTRACTION HAD FALLEN BY 14 PCT IN THE YEAR TO JANUARY, DOWN FROM A FALL OF 11 PCT IN THE YEAR TO DECEMBER, HE SAID.

13-FEB-1035. FEP676 L13204240 HZCE

CONTINUED FROM - PYIM CONTINUED ON - PYIO

RUSSIAN OFFICIAL SAYS OUTPUT FELL AS PRICES ROSE -PART 4 PYIO

GUZVI SAID THE OUTLOOK WAS ALSO GLOOMY IN THE AGRICULTURAL SECTOR. THE AREA OF LAND UNDER GRAIN CULTIVATION WAS LIKELY TO FALL THIS YEAR.

JANUARY TRACTOR OUTPUT WAS 50 PCT BELOW YEAR-AGO LEVELS AS PRODUCERS STRUGGLED TO ADJUST TO CHANGING CIRCUMSTANCES AS VAST STATE-OWNED FARMS ARE BROKEN UP INTO SMALLER UNITS, HE SAID.

13-FEB-1055. FEP678 L13204240 HZCE

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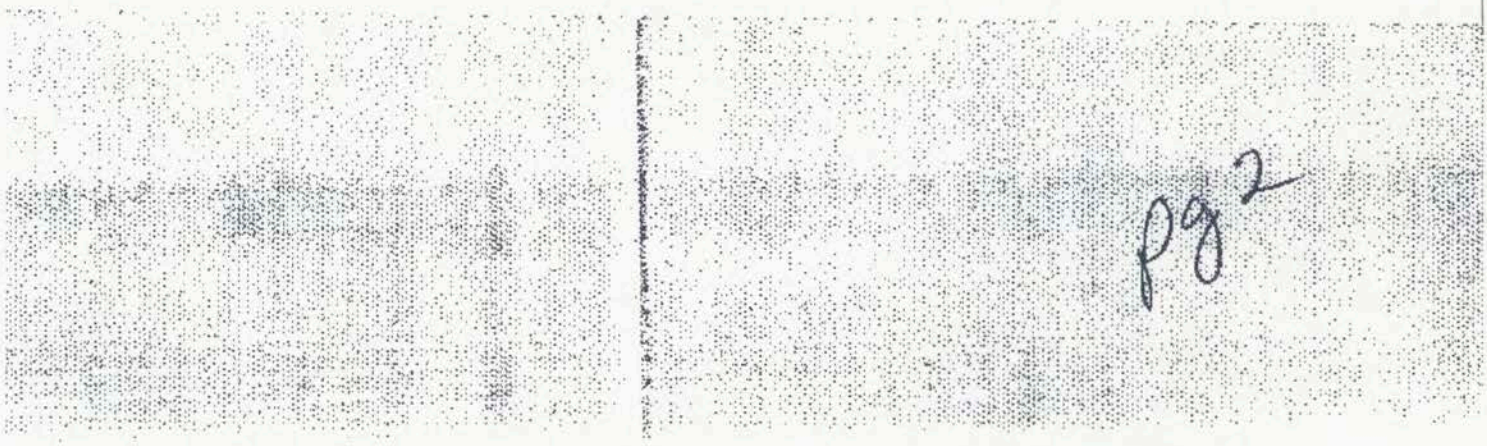

09:09 PM
05-Feb-92

MARCH 20 GROWTH PACKAGE ONLY -- TREASURY SCORING

(Dollars in Millions)

	Fiscal Years						
	1992	1993	1994	1995	1996	1997	1992-97
Growth Incentives							
Enhance Long-Term Investment: Capital Gains	$600	$3,800	$2,100	$300	$300	($200)	$6,900
Passive Loss Relief for Real Estate	(130)	(418)	(396)	(449)	(516)	(592)	(2,501)
Investment Tax Allowance (ITA)	(6,055)	(1,580)	3,529	941	810	623	(1,732)
Simplify and Enhance AMT Depreciation	(204)	(376)	(354)	(261)	(179)	(123)	(1,497)
Facilitate RE Invest. by Pension Funds/Others	-*	-*	-*	-*	-*	-*	-*
First-Time Homebuyers Tax Credit of $5,000	(201)	(2,067)	(2,535)	(637)	167	110	(5,163)
Waive Penalty for Withdrawals From IRA's for 1st-Time Homebuyers	(5)	(79)	(97)	(117)	(125)	(92)	(515)
Total Cost of Growth Package	**($5,995)**	**($720)**	**$2,247**	**($223)**	**$457**	**($274)**	**($4,508)**
Pay-As-You-Go Offset:							
PBGC Reforms	$8,700	$2,500	$2,396	$1,276	$2,725	$2,112	$19,709
Extend Statute of Limitations on Collecting Defaulted Student Loans	266	0	0	0	0	0	266
CSRS: Extend Elimin. of Lump-Sum Option	0	0	0	0	2,144	2,926	5,070
Increase CSRS Employee Contributions	0	448	1,053	1,216	1,219	1,209	5,145
Commodity Credit Corp: Reduce Farm Subsidies (off-farm income over $100,000)	5	65	150	150	150	150	670
Limit Medicare Subsidy to 25% for High Income Persons ($100,000 Single, $125,000 Couple)	59	313	427	580	757	963	3,099
Subtotal	**$9,030**	**$3,326**	**$4,026**	**$3,222**	**$6,995**	**$7,360**	**$33,959**
Total	**$3,035**	**$2,606**	**$6,273**	**$2,999**	**$7,452**	**$7,086**	**$29,451**

TO: Senator Dole
FROM: Vicki Vicki

TALKING POINTS
PROSTATE CANCER
FEBRUARY 6, 1992

- Of men over the age of 50, one in three has, or will develop prostate cancer.
- There are over 130,000 new cases of prostate cancer diagnosed every year, and almost 40,000 men die each year from the disease.
- We hear a lot about diseases like breast cancer and AIDS, but what we don't hear is that just about as many men die of prostate cancer each year as women die of breast cancer. And the number of deaths each year from AIDS is the same as the number of deaths from prostate cancer in this country.
- Prostate cancer is the most common type of cancer among men and is the second leading cause of death from cancer in the U.S.
- Approximately two-thirds of prostate cancers spread to other organs of the body, most often the bones.
- Early detection is very important if the rate of deaths is going to be reduced, yet only 20% of American men have yearly physical health exams.
- The current methods of prostate cancer screening are digital rectal exam, ultrasound, biopsy, and a blood test called PSA (prostate specific antigen).
- The PSA test, while not 100% reliable, is gaining more and more acceptance among doctors as the best, least invasive screening tool for prostate cancer.
- In my home state of Kansas, hospitals around the state conduct periodic prostate cancer screenings throughout the year, <u>free of charge</u> to any man who asks for it. This very likely occurs in other states as well. I encourage you to ask about it. Call your State Hospital Association or State Health Department to see what type of screening programs your state offers.
- I'm not saying that every man should run out and get a PSA test today. But I am concerned that not enough men are aware of the high rate of prostate cancer until they are faced with their own diagnosis. I know I wasn't.
- Prostate cancer is <u>treatable</u>. The key to saving lives is early detection. Ask to be tested so that we don't have to talk about those 40,000 deaths every year from the disease.

AMERICAN UROLOGICAL ASSOCIATION, INC.
AMERICAN FOUNDATION FOR UROLOGIC DISEASE, INC.

MEDICARE PROSTATE CANCER SCREENING BENEFIT

Prostate cancer is the most common cancer among men and is the second leading cause of death from cancer in the United States. Since approximately two-thirds of prostate cancers have spread beyond the prostate when first identified, earlier detection of clinically significant localized cancer is very important if mortality is to be reduced. The current methods of prostate cancer screening are digital rectal examination (DRE), prostate specific antigen (PSA), and transrectal ultrasound (TRUS). While none of those choices provides sufficient specificity to be identified as the ideal screening method, PSA is rapidly gaining acceptance among urologists as the best available screening tool and is being widely applied. TRUS is rarely used for screening due to its high cost and inadequate yield. PSA compared to DRE has the following advantages: the result is objective and quantitative, the result is independent of the examiner's skill, and the procedure is more acceptable to patients and many physicians. The cost of PSA ranges between $30-50.

Catalona and associates reported on the measurement of PSA as a screening test for prostate cancer in 1,653 ambulatory men 50 years of age or older. It was concluded that PSA is useful in the detection of prostate cancer. Although PSA is the most accurate test, it is not sufficiently sensitive to be used alone. Rather, an elevated PSA should cause the urologist to be suspicious about the possibility of prostate cancer and investigate further.

Population wide screening of all men over 50 is still somewhat controversial; however, testing of men in higher risk categories may be a more cost effective approach. For example, a screening benefit could cover men over 65, men with a family history of prostate cancer or Afro-American men.

Recommendation: Medicare should cover prostate cancer screening, including PSA. The Secretary of Health and Human Services should work with urologists to develop criteria for the use of PSA and other screening tools, to expand the list of covered screening procedures as appropriate, and to establish appropriate payment rates.

1120 North Charles Street • Baltimore, Maryland 21201 • 301-727-1100

AMERICAN UROLOGICAL ASSOCIATION, INC.
AMERICAN FOUNDATION FOR UROLOGIC DISEASE, INC.

THE CASE FOR A SEPARATE INSTITUTE AT THE NATIONAL INSTITUTES OF HEALTH TO SUPPORT RESEARCH AND TRAINING IN DISEASES OF THE URINARY SYSTEM, THE REPRODUCTIVE SYSTEM AND THE KIDNEYS

Diseases of the urinary system, the reproductive system and the kidneys afflict some 13 million Americans annually. They are responsible for 6 million hospitalizations and over 80,000 deaths a year. One of these diseases, prostate cancer, is the second leading cause of cancer deaths and the leading cancer among men. Collectively these diseases disproportionatly affect women, blacks and the elderly.

Despite the broad impact of these diseases (8% of all health care costs), support for research into their causes, cures and prevention is lacking. Less than 1% of the budget of the National Institutes of Health is devoted to supporting research and training in these fields. Even these funds are often inefficiently utilized because they are spread over at least seven institutes. Grant applications for these funds may be reviewed by any of 25 different study sections, which often lack the expertise to review complex grant proposals in these fields because so few specialists in these areas participate. In fact, only two urologists sit on NIH study sections. The excessive division of this research dangerously fragments the outlay of federal funds. Because all receive a little, none are able to produce a lot. The fragmentation of funds results in the duplication of administrative and professional costs and prevents the development of a coordinated program at NIH for research in diseases of the reproductive system, the urinary system and the kidneys. A new structure must be created at NIH that will solve these problems.

In 1990 the National Kidney and Urologic Diseases Advisory Board (NKUDAB) examined this problem and concluded in its long range plan "Window in the 21st Century" that "a separate institute is needed that can recognize and respond to the devastating and costly nature of kidney and urologic diseases." The leadership and expertise now exist at the NIH to make major strides to combat these diseases and disorders. All that is needed is for the proper structure to be put in place. Research and training in the following areas, among others, should be combined in this new institute -- prostate cancer; benign prostatic hyperplasia; end stage renal disease; poly cystic kidney disease; infertility and sexual dysfunction; renal stone disease; bladder cancer; bladder dysfunction, including incontinence and interstitial cystitis; sexually transmitted diseases; urinary tract infections; kidney and urologic diseases of diabetes mellitus; and hypertensive renal disease in minorities.

Creation of a new institute is the right step to take now in order to focus the country's efforts to combat these diseases.

1120 North Charles Street • Baltimore, Maryland 21201 • 301-727-1100

Mon, Feb 3

January 28, 1992

TO: Senator Dole

FROM: Vicki Vicki

RE: Meeting with American Urological Association

I was called by Randy Fenninger of the American Urological Association. He explained that Dr. McCloud of Walter Reed Hospital referred you to Dr. Jay Gillenwater, President of AUA, and that you called him last week in Florida.

I am scheduled to meet with Randy Fenninger and another representative of AUA on Monday, February 3 at 11:00 to discuss some proposals they have related to prostate cancer screening.

If your schedule permits, would you like to drop by the meeting?

YES _____ NO _____

February 7, 1992

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: ADMINISTRATION'S HEALTH PROPOSAL

The long awaited proposal was unveiled yesterday by the President in a speech before the Greater Cleveland Growth Association. The response was predictable -- the Republicans welcomed the Administration's involvement in the debate while not embracing all the details. The Democrats condemned the Presidents for not doing enough.

The Plan.

A. Tax Credits and Deductions.

The most critical component of the White House Plan is a transferable tax credit or tax deduction to be used solely for the purchase of health insurance. These credits and the deductions will be available for low and moderate income individuals and families.

The states will actually administer the program and will be given the option of identifying insurers in the state who will participate in this program and deal with this new population in a new program or, "integrating" this new population with its medicaid program. However, regardless of what the state decides the individual can actually choose the insurance they want and take "their" credit to this insurer.

B. In addition to the tax credits the proposal includes:

1. Malpractice reform

2. Insurance Market Reform

- Requiring insurance companies to eliminate underwriting practices that favor healthier and younger populations, leaving the more vulnerable individuals uninsured.

- Small market reform proposals that are virtually identical to those in the Republican Task Force Bill and the Bentsen/Durenberger Bill.

3. Increase the insurance deduction for the self-employed to 100 percent.

4. Changes in Medicare and Medicaid to encourage the use of managed care (i.e., HMO's) versus fee for service.

5. Some increase in funding for community health centers.

There are no specific financing mechanisms although the Administration will provide a long list of Medicare and Medicaid cuts and other proposals that could be used. There will be no revenue items on the list including the so-called tax cap.

Comment.

Conceptually, the Administration plan is similar to the Republican Task Force bill in that it uses the existing private insurance system to provide coverage to a broad range of individuals. In the case of the Administration plan, the individual never really gets the credit -- but, rather a voucher that they use to gain access to an insurance company or a state run medicaid-like plan.

The small business provisions that provide for some insurance reforms are very similar to our proposals and those of Senator Bentsen and seek to make insurance more affordable. There are also insurance reforms that help people keep their coverage if they move from job to job.

An area where the Administration does far less than we do is with respect to the public health care programs; for example, the community health centers. We viewed these programs as part of a safety net to help ensure access to care for the poor.

The criticisms that will be lodged are likely to fall into two categories; those related to the suggested financing provisions and those related to the program design.

Financing.

Not unlike Mitchell and the Republican Health Task Force, the Administration avoids specifying a method of paying for this new $100 B (over 5 years) program. They do, however, strongly suggest the use of Medicare and Medicaid cuts -- which will no doubt subject them to some real criticism. While reasonable reductions can be made -- you'll have a hard time defending cutting health care programs for the poor (Medicaid) to provide more health care for other low income individuals.

Program Design.

The use of credits will be criticized as administratively complex and costly. The Democrats will also claim that the Administration's bill is simply a bail out of the insurance companies and provides little real reform. In fact, the Democrats pay or play bill continues to use the private insurance companies for the employed unless, of course, their company chooses to pay the new payroll tax, resulting in their employees being covered under the public program. Others will argue that the credits (vouchers) are unlikely to result in real increased access to care for the homeless and indigent as they are unlikely to know how to access the program.

Opponents will also argue that the value of the credits (vouchers) is far below the average cost of health insurance and will be of little real use in expanding coverage. Further, because the credit amount is the same nationwide, some will argue that those who live in expensive areas like New York, Los Angeles, Chicago, etc., will be able to afford very little while those in Mississippi will be greatly advantaged. There is, in fact, legitimacy to both of these criticisms.

The proposed cost containment measures are difficult to quantify as they depend on administrative savings, malpractice reforms and initiatives to get Medicare and Medicaid patients into managed care arrangements. Unlike the Democrats, there is no explicit attempt to control payments on overall expenditures. The President will be criticized for doing too little to really control costs.

The Administration has done well in laying out a proposal that addresses a wide range of concerns. While people can argue with the details, they certainly can't legitimately say the proposal isn't a serious one. We can argue that we are trying to strengthen the existing system and mainstream those who have had no access in the past. Further we are avoiding creating a new Federal bureaucracy and putting small business at great risk.

At the moment the Administration does not intend to put their proposal into legislative language for introduction.

Health Care Reform
Side-by-Side Comparison
(Republican Bill)

Provision	S. 1936 Health Care Task Force Bill	Administration
Tax Credits		
Individuals Tax Credit Eligibility by Income Level:	Full Credit Individuals below $10,000 Families below $20,000	Full Credit 100% of poverty or below Individual below $6,620 Family (4) below $13,400 (Not available to Medicaid-eligible individuals.)
	Partial credit Individuals between $10,000 and $16,000 Families between $ 16,000 and $32,000	Partial Credit 100% to 150% of poverty Individuals between $6,620 and $9,930 Family (4) between $13,400 and $20,100
Amount of Credit:	Individual $600 Family $1200	Individual $1250 Couple $2500 Family $3750
Use of Credit:	Funds go to individual for purchase of health insurance or to pay provider.	Funds go to State or insurance company for purchase of insurance only.
Prevention Tax Credit	$250 credit for preventive tests not covered by insurance.	No provision
Business Tax Credits	25% credit for small businesses first offering insurance or insurance for dependents. Phased out over 5 years.	No provision
	25% credit for all businesses that begin to offer a managed care plan. Phased out over 5 yrs.	No provision
	20% credit for small businesses buying insurance through purchasing group. Permanent credit.	No provision

Tax Deductions For Health Insurance Premiums

Individual eligibility:	All individuals regardless of income.	All Individuals Below: $50,000 individual $65,000 couple $80,000 family (Individuals cannot claim both the tax credit and the tax deduction.)
Amount of deduction:	Deduct 100% of insurance premium costs, less amount of individual tax credits.	Insurance premiums: Individual. $1250 less employer contribution Couple $2500 less employer contribution Family $3750 less employer contribution
Self-employed	Deduct 100% of premium costs.	Same

Medicaid and Other Low Income Individuals	Maintain current Medicaid program.	States have two options:
	Develop new state-run program with federal match for individuals not eligible for Medicaid w/family incomes below 200% of poverty. Federal outlays capped at an aggregate of $10,000 per person per year. States set services and eligibility levels. Enhanced match for those enrolled in managed care program.	1. Revise financing of current Medicaid program through capitation. Per capita amount adjusted annually for acute care population: CPI + 6% in 1993 CPI + 5% in 1994 CPI + 4% in 1995 CPI + 3% in 1996 CPI + 2% in 1997 For individuals not eligible for Medicaid. States would define a benefit package with the value of the tax credit for those under poverty and at least two insurance companies would be required to develop a policy. Individuals would choose one of policies and full amount of tax credit would be given to insurance companies by Federal government. 2. States would pool per capita Medicaid amount and tax credit for eligible individuals and develop a program to serve total population. Other features: For employed individuals, tax credit would go to employer which is required to offer/facilitate health insurance for all employees. Non Medicaid eligible individuals can opt out of State-run program and go to an insurance company. Funds from credit would go to insurance company.

Other Public Programs	Increase in funding for community health centers and other community-based providers, National Health Service Corps, Area Health Education Centers, childhood immunizations, and rural health transition grants.	Increase funding for community health centers, National Health Service Corps, childhood immunizations, infant mortality, Head Start and Early Childhood Development, breast and cervical cancer mortality prevention and childhood lead poisoning prevention.
Insurance Market Reform for Small Group Market	Eliminate medical underwriting, limit pre-existing conditions, limit rate increases. State enforcement with Federal tax penalty.	Eliminate medical underwriting, limit pre-existing conditions and temporarily limits rate increases. State enforcement with Federal fall-back.
Anti-Managed Care Laws	Federal preemption for approved managed care plans.	Federal preemption.
State Mandated Benefits	Preempted for approved managed care plans and for insurance policies purchased through small business purchasing groups.	Preempted for managed care plans and for policies purchased through small business purchasing groups.
Medical Liability	Requires states to develop alternative dispute resolution, caps on non-economic damages, periodic payments on awards, elimination of joint and several liability encourages settlement, and limits attorneys' fees.	Provides incentives to states to cap non-economic damages, eliminate joint and several liability, cap non-economic damages, and promote pre-trial alternatives.
State Experimentation	States may develop proposal to cover all state residents and get broad waivers from Medicare, Medicaid, Public Health Service, Department of Veterans Affairs, and ERISA.	States may develop proposal to cover all individuals below 100% of poverty and get Medicaid waivers.
Employer Mandates	No provision	All business are required to "facilitate" or provide access to health insurance to their employees. No employer administration or contribution required.
Financing	No provision	Reductions in Medicare and Medicaid.
Administrative Costs	Shared cost to small employers through group purchasing	Same, plus requires uniform claims processing standards and promotes electronic billing.

Minimum Package	**Benefit**	Developed by Secretary of HHS.	Set by States.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 6, 1992

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM

FACT SHEET

The President today announced his four point plan for comprehensive reform of the Nation's health care system. Following the outline the President offered in his State of the Union Address, the plan seeks to use market forces and incentives to forge a more efficient health care system.

The President's four-point plan will:

1. Make health care more accessible by making health insurance more affordable;

2. Reduce the runaway costs of health care by making the health care system more efficient;

3. Cut waste and excess in the present system; and

4. Get the growth in government health programs under control.

The President's plan is spelled out in detail in a 94 page white paper released today.

Elements of the President's Plan

The President's plan addresses the two major problems facing the U.S. health care system -- inadequate access to affordable health care for some Americans and excessive growth in the cost of health care for all Americans.

In addressing these problems it enhances the quality of our health care system, widely acknowledged as the best in the world. Moreover, it recognizes and builds upon the strengths of America's health care system: the freedom of individuals to choose physicians, hospitals, and health plans; diversity and

flexibility in the financing, organization and delivery of care; the best educated and most skilled physicians and health professionals in the world; millions of volunteers who assist in providing quality health care; world leadership in biomedical research; dramatic technological innovation and in new methods of assuring quality health care.

I. Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

A transferable health insurance tax credit (certificate) and deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Ninety five million Americans will benefit from these provisions.

Both the credit and deduction would be available for health insurance costs of up to $1,250 for individuals, $2,500 for married couples, and $3,750 for families of three or more. For those with employer-provided health benefits, the credit or deduction would be adjusted for any employer contributions. Individuals could take either the credit or deduction, guided by which is more financially advantageous. The credit and deduction would benefit those with modified adjusted gross income ranging up to:

- $50,000 for single persons;
- $65,000 for persons filing as heads of households, and
- $80,000 for married persons filing jointly.

Both the credit and the deduction would phase out in the last $10,000 of the income range.

1. Transferable Health Insurance Tax Credits (Certificates)

Transferability. The credit could be transferred only to an insurer for the purchase of health insurance; it could not be used for other purposes or received as cash.

Eligibility. All who do not receive assistance from other federal programs (e.g., covered by Medicare, Medicaid, and other federal health programs) would be eligible.

Income Range. When phased in, the maximum credit would be available to all with incomes of up to 100 percent of the tax filing threshold -- the sum of the standard deduction

and taxpayer and dependent exemptions, a tax code concept that approximates the poverty threshold. Above that level, the credit would phase down to a minimum credit at 150 percent of the tax filing threshold. The minimum credit would be 10 percent of the maximum: $125 for individuals, $250 for two person households, and $375 for households of three and larger.

-- For example, if the credit were in effect today, a family of two parents and two children with adjusted gross income of $14,000 would obtain the maximum credit, enabling them to buy up to $3,750 of health insurance.

Risk Adjustment. States would implement broad health risk pools for credit recipients. As a result of transfers carried out by the pool, insurers would be able to provide insurance to the sick and healthy at nearly uniform rates.

Administration. Individuals eligible for the credit would not need to wait until filing a tax return to obtain a credit; a certificate could be obtained at any time during the year by applying to a governmental office designated by a state government. A state might select a state agency, such as the Employment Service, or it might contract with the Social Security Administration to certify eligibility.

2. Deductions

Individuals with incomes up to the top of the income range could choose, instead of the credit, to deduct the cost of health insurance, up to the maximum that applies to their tax filing status (either $1250, $2500, or $3750.) As noted above, the maximum would be adjusted for the amount of employer contributions towards the cost of health insurance.

3. Increased Help for the Self-employed

All of the self-employed would be entitled to deduct 100 percent of the cost of their health insurance premiums or receive the applicable credit, whichever is of greater value. Current law allows the self-employed to deduct only 25 percent of the cost of health insurance.

The cost of the health insurance tax credit and deductions in the President's plan would be offset by savings achieved through use of the measures to contain health care costs outlined below. These include the system efficiencies in the health care delivery system arising from a greater role for market forces, reduced administrative and malpractice costs,

more healthy personal behavior and the effects of preventive services to lessen the need for health services, and greater cost-effectiveness in publicly funded programs. No additional taxes are needed or required.

II. Insurance Market Reform

A. Basic Benefits.

States, working with private insurers, would develop basic health insurance benefit packages equal to the value of the health insurance tax credit. This would enable low-income families to purchase health care coverage.

B. Insurance Security.

Health insurers would be required to insure all groups that want to buy health insurance. Coverage would be guaranteed and renewable. Pre-existing conditions clauses that limit coverage during the first months with a new employer would no longer be allowed.

C. Health Insurance Networks (HINs) - Pooled Purchasing Power.

A new way of purchasing insurance -- HINs -- would enable small firms to purchase low cost, high quality health insurance by reducing administrative costs and by exempting insurance sold through HINs from excessive state premium taxes. HINs would also allow national associations to sell health insurance plans on a nationwide basis.

D. Mandated Benefits.

States have passed numerous laws mandating that health insurance include specified benefits or coverage provisions, now numbering close to 1,000. Excessive mandated benefits that increase costs and limit consumer choice over the scope of insured benefits would no longer be allowed.

E. Insurance Affordability.

In the near term, the premiums insurers charge for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition to deliver the highest quality at the lowest costs.

III. Containing Health Care Costs

A. Malpractice and antitrust reform.

The threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The practice of defensive medicine has contributed substantially to rising health care costs.

The President's plan would provide incentives to states to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care.

New procedural reforms would promote alternative dispute resolution (ADR). A party that refused ADR and then lost the suit at trial would pay the other party its attorney fees.

Also, the potential of guidelines and standards of care to reduce the uncertainty that leads to defensive medicine will be explored.

Fear of antitrust liability has also helped produce an often inefficient and duplicative distribution of sophisticated services and equipment. Quality of care is diminished by the reluctance of professional review boards and hospitals to discipline physicians. Finally, the emergence of new, more competitive systems for delivering health care has raised new questions about the application of the antitrust laws to the health care system.

The President's proposal will provide additional guidance on the application of the antitrust laws in these areas and provide a "safe harbor" for certain joint activities relating to the sharing of equipment by providers.

B. Reducing administrative costs.

Insurance law changes and market reforms will end the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs.

For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased,

compared to 10 percent for large employers. Marketing and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of administering insurance and therefore help substantially reduce premiums. Small businesses would benefit from these efficiencies. HINs would follow uniform claims processing standards, yielding additional administrative savings.

C. Expanded use of coordinated care.

In 1990, about 40 million Americans were enrolled in one of a variety of coordinated care arrangements -- up from 10 million in 1980. The President's plan encourages broader use of coordinated care in the public and private sectors, including preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point of service plans that allow individuals to choose between the PPO and HMO option, case management, and other forms of coordinated care.

New coordinated care arrangements would be allowed in the Medicare program. States would have incentives to use coordinated care in Medicaid programs. Restrictions on the operation of coordinated care in the private sector would be ended.

D. Efficiencies in public programs.

Health expenditures at all levels of government account for 44 percent of national spending on health services. Cost containment will be achieved in these programs through greater reliance on coordinated care, participation in the overall trend towards lower administrative costs, recapturing some subsidies made duplicative by the new tax credit and deduction, and reforms to stem program abuses.

E. Increased flexibility in state programs.

States would be free to redesign their entire health care systems. The acute care portion of the Medicaid program, covering hospital and doctor services, would be restructured, moving from an open ended entitlement to a per capita payment arrangement. With this change, current federal restrictions on the use of coordinated care and review processes for waiver requests would be dropped.

With respect to the relationship of Medicaid to the new transferable health insurance tax credit, states could choose to combine current Medicaid funding with the new

credit to develop a single unified health plan for low-income persons.

F. Expansion of cost-effective services in underserved areas.

The President's FY 1993 budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand primary and preventive care in these areas.

G. Prevention.

The President's budget includes $26.4 billion, a nearly $4 billion (18 percent) increase for preventive health activities. Prevention funding has increased over $11 billion (74 percent) since 1989. Among other activities, the President's FY 1993 budget proposes increases of 18 percent for childhood immunizations and infant mortality reduction, a 27 percent increase for Head Start and Early Childhood Development, a 24 percent increase for breast and cervical cancer mortality prevention, and a 90 percent increase for childhood lead poisoning prevention.

H. Improving Consumer Information.

While health care services can be costly, information about the cost and quality of providers is not readily available. To assist individuals and employers shopping for insurance and health care, "blue books" like guides for other goods and services would provide price and quality data to make comparison shopping possible. The information will cover the average cost of services and the quality of care provided by physicians, hospitals, and clinical laboratories.

The white paper on the President's Comprehensive Health Reform Program also presents an analysis of two of the options for health care reform that were rejected in the President's decision making process: a national health insurance program and a "play or pay" benefit mandate/payroll tax.

The paper concludes with examples showing the President's plan at work in the context of these examples.