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Divider Title: 13

Theme 1:

As in rural America, access to primary care providers is a major concern in many low-income urban neighborhoods.

17% of Michigan residents (1.6 million people) are HMO participants (16.7%).

4% of infants were born to women who received either late or no prenatal care in 1989.

40% of two-year-olds in Michigan were not appropriately immunized last year.

15% of the Michigan population was medically underserved in 1990.

Low-wage earners have a 40% chance of being uninsured; people looking for work have a 40% chance of being uninsured.

Theme 2:

Health care problems related to substance abuse is a concern throughout America -- but is of particular importance to urban areas. The relationships between substance abuse and HIV infection, substance abuse and homelessness, and substance abuse and low infant birthweights, pose major challenges to urban health care systems.

Theme 3:

The illegal drug trade also hampers efforts to revitalize inner-cities and attract new businesses. Employees, workers, and shoppers won't go to areas they deem hazardous; yet these areas need increased economic activity to provide viable alternatives to drugs.

Theme 4:

A key to getting the American economy energized is to reduce the burden of health care costs on American businesses. Thus, health care reform and economic reform are closely related.

Business health spending nearly doubled from 1980 to 1985 ($65 billion in 1980 to $115 billion in 1985), then rose 62% from 1985 to 1990 (to $186 billion in 1990).

The average company health plan cost per employee more than doubled from $1,645 in 1984 to $3,968 in 1992.

Contrary to popular belief, private business is paying a larger share of the private health care bill and individuals a smaller share. From 1980 to 1990, the business share of private health care spending rose from 40% to 43%.

If health care costs had grown at the rate of the overall economy from 1980 to 1990, employers would have saved $1,015 per insured worker in 1992.

Retiree health benefit obligations represent 7% of the book value of the 200 largest corporations in the United States. The impact of retiree costs varies greatly by company. Some examples of retiree health obligations as a percentage of the value of the firm (stockholders' equity): General Motors, 70%; Chrysler, 54%; AT&T, 38%; Ford, 29%; Boeing, 14%; General Electric, 8%; Philip Morris, 7%; IBM, 6%.

Standard & Poors says GM will remain at a "significant competitive disadvantage for the foreseeable future" because of its huge pension and health care obligations to retirees.

Theme 5:

Small businesses need a mechanism for obtaining competitively priced insurance. Health Insurance Purchasing Cooperatives (HIPCs) or other strategies are needed to pool health care risks across small businesses.

In 1991, 49% of all uninsured workers were employed by firms with fewer than 25 employees.

In 1990, 27% of firms with fewer than 10 employees offered health benefits, compared with 98% of firms with 100 or more employees.

Firms of fewer than 25 employees benefited from a health care subsidy of $14 billion from larger firms that provided insurance to their employees through dependent care coverage (1991).

Theme 6:

The high cost of health care and insurance is a brake on business expansion or investment in new plants or R&D, while keeping prices for U.S. goods high. Worldwide competitiveness of some U.S. products suffers thereby.

The cost of health care per car for U.S. manufacturers in 1990 was $1,086 and for Japanese auto makers was $552.

Despite the growing burden of health care costs, U.S. hourly compensation costs for production workers in manufacturing remain below the European average. In 1991, U.S. costs were $15.45 per hour compared with $18.16 in Europe, and $14.41 in Japan.

Moreover, from 1975 to 1991, European compensation costs rose 8.2% and Japanese costs 10.2% per year compared to 5.7% per year in the U.S. Thus, rising health care costs have had a limited impact on the competitiveness of U.S. firms, although some particular firms, e.g., in the auto industry, may have been more severely impacted.

In 1991, at least $17.2 billion of medical care costs of public programs or the costs of caring for the un/under-insured were shifted onto private business.

Theme 7:

The employment-related health insurance approach leaves millions of individuals living in rust-belt cities vulnerable to loss of coverage in periods of economic recession and business down-sizing and closure.

Higher costs will force more than half of U.S. employers to make significant changes in their benefit plans. 56% of those employers plan to change workers' health benefits.

Two-thirds of employers have made changes to their retiree medical plan in the last two years or intend to make changes by 1993. The most common changes are raising retiree contributions (47% of employers making or intending to make this change), increasing cost sharing (40%), and tightening eligibility requirements (21%).

Theme 8:

Social problems (e.g., lack of education, poverty, cultural intolerance) are such major determining factors in the health status of individuals that changes in the health care system only may have a minimal impact on the health of city-dwellers.

HEALTH CARE ISSUES AFFECTING BUSINESS

Spending on health by businesses nearly doubled between 1980 and 1985, then rose 62 percent from 1985 to 1990 (to $186 billion in 1990).

The average company health plan cost per employee more than doubled from $1,645 in 1984 to $3,968 in 1992.

Health was the major issue in 83 percent of labor negotiations in 1990.

Contrary to popular belief, private business now is paying a larger share of the private health care bill and individuals a smaller share.

The cost of health care per car for U.S. manufacturers in 1990 was $1,086 and for Japanese auto makers was $552.

Higher costs will force more than half of U.S. employers to make significant changes in their benefit plans. Fifty-six percent of those employers plan to change workers' health benefits. Two-thirds of employers have made changes to their retiree medical plan within the last two years or intend to make changes by 1993.

Standard & Poors says that General Motors will remain at a "significant competitive disadvantage for the foreseeable future" because of its huge pension and health care obligations to retirees.

HEALTH CARE FACTS ABOUT MICHIGAN

Michigan's uninsured rate has increased primarily because of a decline in employment-based coverage, not offset by a rise in Medicaid coverage.

Two-thirds of Michigan residents see cost and affordability as central problems in health care (1991).

Forty percent of two-year-olds in Michigan were not appropriately immunized last year.

Manufacturing accounted for 23 percent of employment in 1989, down from 32 percent in 1979.

More than half of men arrested in Detroit tested positive for a drug and more than two-thirds of women arrested tested positive.

###

What stake do all of us have in the health care of our urban areas? (e.g., high public services costs; treatment of AIDS, TB; high rates of low birthweight, substance abuse).

Growth in the health care sector means jobs across a broad range of skill levels:

> Do we lose or gain more jobs because of a growing health care sector?

Will changes in the health care system have any appreciable impact on the health status of inner-city residents if other social issues are not addressed in some manner?

Can private non-profit hospitals and health care providers be used more effectively to address the health care needs of inner-city residents, thus relieving the burden on public health care institutions?

What is the appropriate role of business and labor in health care reform? What is each willing to give up to get a more affordable and efficient system?

$w/tpg/rural.themes
3/10/93

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Divider Title: 14

HEALTH: WHAT SHOULD HILLARY KNOW?
Detroit Free Press (FP) - WEDNESDAY March 17, 1993
By: AMY WILSON
Edition: METRO FINAL Section: WWL Page: 1C

TEXT:
Pretend you've got Hillary Rodham Clinton's ear for just one minute.

Without using fancy phrases like "managed care," "regional cooperatives" and "global budgeting," what one thing would you tell her to help formulte an evenhanded health care policy for this country?

Clinton and Tipper Gore will be in Dearborn on Monday asking for our opinion.

So what is our opinion? Is the answer for providers to be more efficient? To cap "last-ditch" efforts to save lives? To put an end to outrageous medical malpractice payouts?

Should we continue to get most of our benefits from our employers? Should we regulate drug costs? Should the government pay for long-term care for elderly eople? Should we always get to pick our doctors? Should doctors test for everything?

Do you want a reformed system in which everything is prepaid by a universal insurance, all bills are paid, no paperwork gets shuffled?

And what, exactly, are you willing to sacrifice to make sure there is health care for the uninsured? Are you willing to have less so that some folks can have some? Is there such a thing as too much health care?

In short, what do you believe is the greatest unmet need for Americans in search of quality health care?

Tell us.

CALL US TODAY

Talk to our reporters from 8 to noon TODAY ONLY. (The call is free.) We'll include your comments in a Free Press story to run on the day the first lady is in town. CALL 222-5978.

HEALTH CARE FINDING THE RIGHT CURE WILL NEED INPUT FROM ALL SIDES
Detroit Free Press (FP) - SATURDAY March 6, 1993
Edition: METRO FINAL Section: EDP Page: 8A
Word Count: 504

MEMO:
IN OUR OPINION

TEXT:
Anyone with a piece of the U.S. health care pie wants badly to protect it. Hospitals don't want price controls. Doctors don't want to be second-guessed. Insurers want to continue brokering the system. Consumers want everything but the bill.

It may be that Hillary Rodham Clinton was trying to protect her health care task force from just such a welter of competing interests when she shut the door on the American Medical Association this week. It's a justifiable worry that special interests may pick the proposed reforms to death before they're even down on paper.

But sooner or later, the doctors have to be invited into the room. If providers and consumers aren't asked to help shape, or at least comment on, plans to overhaul the system, they will be that much more inclined to oppose them. And it will be much easier to block those changes if they can charge that no one who ever bought a bedpan or took a pulse had a role in shaping them.

Ms. Clinton's task force reportedly is picking the best brains in the country as it goes about its work. But there is a kind of hubris in expecting those brains, or even the formidable Ms. Clinton, to develop in 100 days a wonder plan that solves all the ills of the system everywhere and at once. If the task force produces such a marvel, more power to it.

But there would be no shame if the task force started modestly, setting guidelines and allowing states freedom to experiment in how to achieve them. President Bill Clinton should not feel so driven by his campaign promises to produce a magic plan swiftly that he produces one with serious error in it.

Already in Washington, there are signs of people jumping the gun. The administration is said to be seeking millions of dollars from business and unions to sell a plan no one knows anything about yt. Members of Congress are talking about raising cigarette taxes, or massive and unspecified new health care taxes, even though we don't know what they will pay for.

Any plan the task force comes up with will represent one of the most fundamental and expensive changes in social policy since the introduction of Medicare and Medicaid. It will shake up an industry that employs 8.5 million people, accounts for one out of every seven dollars spent in this country, and -- for better or worse -- affects the well-being of 250 million Americans from the delivery room to the death certificate.

It's an industry that cries out for cost efficiency, for universal coverage, for more compassion and human values and less cold technology and paperwork. But achieving such an overhaul will not be easy, and politics and negotiation are inevitable parts of the process.

Ms. Clinton and the brains she is picking are certainly smart enough to know that. Or, at least, that's what their well-wishers are hoping.

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Divider Title: 15

STATE SUMMARY

Population, 1991 (est.)	9,368,000
Personal income per capita, 1990	
(in current dollars)	$18,378
number of families in poverty, 1989	251,687
Age distribution, 1990	
under 5 years	7.6%
5 to 17 years	18.8%
65 and over	11.9%
Race, 1990	
White	83%
Black	14%
American Indian	1%
Asian	1%
All Other	1%
Persons of Hispanic origin	2%
Births, 1989	
with low birth weights	7.6%
Physicians	
rate (per 1,000 persons)	1.85
Dentists, 1990	
rate (per 1,000 persons)	0.63
Hospitals, 1990	
number	205
occupancy rate	67.2%
personnel (x 1,000)	148,800
Social Security beneficiaries, 1990	

total	1,490,000
Medicare, 1990	
enrollment	1,233,000
payments ($ mil)	4,618
Medicaid, 1990	
recipients	1,048,000
payments ($ mil)	2,195
State & local government expenditures, 1989-90 ($ per capita)	
total	$3,949.79
health & hospitals	353.55
Federal aid grants to state & local government, 1991 ($ mil, except per capita)	
per capita total	$579.24
Medicaid	207.52
Unemployment rate, 1991	
total	9.2%
Civilian labor force, 1991	
manufacturing	1,106,000
Union membership in manufacturing, 1989	486,900

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Divider Title: 16

CONVERSATIONS ON HEALTH

Dearborn, Michigan
March 22, 1993

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Betty Sauvie
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*Susan Schooley, M.D.
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I need opportunity to enroll all members, delivers in communities

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Divider Title: 1/15/7

March 21, 1993

ST. JOHN HOSPITAL & MEDICAL CENTER

DATE: March 22, 1993
LOCATION: Detroit, MI
TIME: 8:30 a.m.
FROM: Kim Tilley

I. PURPOSE

There are two purposes for this visit, (1) to tour the hospital's neo-natal intensive care unit and (2) to meet with patients from different areas of the hospital who are generally concerned about health care costs.

(NOTE: Senator Riegle* is proud of the neo-natal unit and specifically requested that this tour be done.)

II. BACKGROUND

The Sisters of St. Joseph opened St. John Hospital in 1952 to serve the Detroit area east-side community. The Hospital has since expanded and evolved into a comprehensive health center, with numerous sites and services throughout the eastern metropolitan area of Detroit and beyond. It is now called St John Hospital and Medical Center.

St. John Hospital and Medical Center, like all Michigan hospitals, is a not-for-profit institution, meaning any excess revenue goes back into hospital operations. (There are some revenues from for-profit sources that are used to help assist with hospital operations.)

St. John Hospital and Medical Center is one of the largest employers in the area with over 5,000 employees. The tertiary institution has a 650-member medical staff. Nearly 200 of the medical staff members hold faculty position at Wayne State University of Medicine. Residency programs include family practice, general surgery, internal medicine, o/gyn, pathology and pediatrics.

During 1991-92, admissions totaled over 23,000. The areas of specialty care include: a cardiology program which serves over 15,000 patients each year; laser technology, lithotripsy and three dimensional imaging; a transplant center that is doing innovative kidney transplantations and pancreatic research.

In addition, St. Johns Hospital and Medical Center is noted for it high-risk obstetrics, neonatal and pediatric intensive care, emergency trauma services and rehabilitation.

INFORMATION ON THE NEO-NATAL UNIT FOLLOWS

III. PARTICIPANTS

Curbside greeters:

Glenn Wesselmann - President and CEO of St. John's
Frank Wilson - Vice President, Medical Affairs
Diane Janusch - Vice President, Nursing Affairs
Thomas Russell - Chairman, Board of Director

PATIENT LIST AND BRIEF HISTORIES FOLLOW

IV. PRESS PLAN

Arrival/departure	-	Open
Neo-natal tour	-	Closed
Meeting w/ patients	-	Open

V. SEQUENCE OF EVENTS

o Curbside greeting;
o Proceed to neo-natal unit and smock up;
o Neo-natal unit tour;
o Proceed to Lower Level Conference Room for meeting with patients;
o Senator Riegle acts as moderator, welcomes MEG, DS and Rep. Collins, then makes brief remarks;
o Open discussion;
o Depart.

VI. REMARKS

None.

* NOTE: Annette Rickel, a member of Senator Riegle's staff, is serving on the children's sub-committee of the Mental Health Working Group which is part of the President's Health Care Task Force.

St. John Hospital and Medical Center®

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Detroit, Michigan 48236-2172
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CONTACT: Mike Kairis
(313) 343-3970

Neonatal Intensive Care Unit
FACT SHEET

The St. John Hospital and Medical Center Neonatal Intensive Care Unit (NICU) is a 30-bed, level-three regional referral patient care unit -- caring for all types of infants. Patients include premature and full-term babies (born at the hospital or transported in from any of 14 community hospitals) requiring skilled nursing and medical care.

- The unit saw 556 babies last year:
  - 51 percent were black
  - 49 percent were white

Payor Group:	Number of Cases	Patient Days	Total Costs
Medicaid and Uninsured	228	5627	$ 5,277,893
Other	278	4930	4,743,061
Total	506	10557	$10,020,954

Payor Group:	Average Length of Stay	Ave. Cost per Case	Ave. Cost per Day
Medicaid and Uninsured	24.68 days	$23,149	$937.96
Other	17.73	17,061	962.08
Total	20.86	$19,804	$949.22

- Medicaid and uninsured babies represent 53 percent of our Neonatal patient days and costs. They have an average cost per day of more than $900 and an average cost per case of more than $23,000. We believe that there exists a very real opportunity to save large amounts of health care dollars by investing in prenatal care. In addition, the quality of life for those babies that are brought to full-term would undoubtedly be greatly improved.

- All babies on the unit are treated alike, regardless of the family's ability to pay.

- St. John Hospital's patient length of stay is below the national average.

- One baby left the unit after staying for three-and-a-half years. There was no place for the baby to be cared for with the skill level needed. Charges for that baby were $1.7 million.

(continued on back)

- The NICU's facilities and equipment have been specifically designed, and personnel organized, to provide care for the sick newborn through the use of the most advanced techniques of Neonatology.

- The St. John Hospital NICU is a family-centered primary nursing care unit.

- There are 81 employees on the unit, including a neonatal nurse practitioner (clinical nurse specialist in Neonatology) and specially trained nursing staff of 57 RNs, one family-centered care coordinator, two LPNs, four nurse assistants, five student nurse techs, six unit secretaries and a foster grandparent. Additionally, working on the unit at different times are six neonatologists (physician specialists), medical residents, a social worker and discharge planner, and a foster grandparent. Home care nurses are available, if needed.

- There are parent-to-parent discussion groups as a support system.

- The NICU is one of the hospital's most labor intensive units. Recent medical technology advances allows staff to sustain infants who, a few years ago, would have had virtually no chance of surviving to their first birthday. Patients are largely pre-term babies, some as premature as 23 weeks.

- Staff to patient ratios are one-to-one and one-to-two for the most acutely ill babies, to three-to-one for the others.

- Low birth-weight babies are seen from less than one pound. The smallest baby to go home in the last year came to the unit at one pound-one-ounce.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	To Kim Tilley From Todd A. Weiler re: Patient Interviews (2 pages)	n.d.	P6/b(6)

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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Carol Rasco (Meetings, Trips, Events)
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FOLDER TITLE:
Conversations on Health - Robert Wood Johnson Foundation 3-22-93 Detroit [2]

rw140

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PAGE 2

First lady takes forum to Henry Ford campus

■ **Selected:** Hillary Rodham Clinton brings hearing to the Dearborn college because of its reputation for educating industrial workers.

By Rosalva Hernandez
THE DETROIT NEWS

Henry Ford Community College's reputation for educating industrial workers landed it one of only four national hearings on health care reform led by First Lady Hillary Rodham Clinton.

For the first time, Tipper Gore, wife of Vice-President Albert Gore, will join Rodham Clinton at one of the hearings.

The Robert Wood Foundation, a national philanthropic organization that focuses on health care issues, is sponsoring the hearings to let health care professionals and average citizens voice their opinions.

Rodham Clinton is chairing a presidential committee that will propose health care reform legislation.

Sue Brown, Henry Ford spokeswoman, said she was not surprised the community college was selected. President Clinton made the campus his first Michigan campaign stop.

"He came specifically because of our national reputation in retraining displaced workers," Brown said Thursday. "We specialize in retraining engineering and manufacturing employees."

Marc Kaplan, spokesman for the New Jersey-based Robert Wood Foundation, said organizers wanted "to go someplace where health care impacts on industry, and Dearborn is the heartland of the auto industry."

About 350 health care experts, professionals and residents affected by health care problems have been invited to the closed hearings.

Foundation and college officials agreed to allow a few health care students and faculty to watch from a gym balcony. Closed circuit television will be set up in the campus' Fine Arts building, Brown said.

Joanne Ebert, a part-time receptionist at the college, was given a last-minute invitation to speak.

Ebert, whose 28-year-old daughter suffers from Crohn's disease, which destroys the lining of the colon, was invited to ask about medical insurance coverage.

Ebert said she and her husband had to take a second mortgage on their home to loan their daughter $16,000 for an operation and medical costs when her insurance carrier refused to pay. The illness was deemed a pre-existing condition.

"I'm looking at my daughter and what she had to go through," said Ebert. "There's a whole lot of people out there who don't have the money to pay for their medical costs."

Hillary's health forum

■ **What:** "Conversations On Health" Michigan Forum, one in a series of panel discussions on health care reform.

■ **When:** 10 a.m. to 4 p.m., Monday.

■ **Where:** Henry Ford Community College, Athletic Memorial Building, 5101 Evergreen, Dearborn.

■ **Featured guests:** First Lady Hillary Rodham Clinton, Health and Human Services Secretary Donna Shalala, Tipper Gore and 13 Michigan citizens with a variety of health care concerns. Divided into three topic sessions.

■ **Sponsor:** Robert Wood Johnson Foundation.

■ **Who can attend:** About 350 people, plus some Henry Ford health care students and faculty, are invited to the forum. It's closed to the public. However, the forum will be shown live on wide-screen TV in the Fine Arts Building on campus.

Page 1B
The Detroit News

Publication The Det. News

In The News

St. John Hospital and Medical Center and Its Affiliates

Marketing and Public Relations
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Detroit's top problem is lack of jobs, residents say

By Heidi Mae Bratt
THE DETROIT NEWS

Metro Detroit residents say a shortage of jobs is their No. 1 problem.

Alcohol and drug abuse, crime and the lack of affordable medical care are the next most critical problems, say more than 2,500 residents surveyed by the Community Needs Assessment Partnership, a new coalition of 19 high-profile organizations.

The state's unemployment rate is 7.9 percent, slightly higher than the national rate of 7.2 percent.

"Clearly unemployment and the lack of resources to provide food, shelter and clothing is key and important," said Geneva Williams, president and CEO of coalition member United Community Services. "We in this area are faced with that as a very critical problem."

A final report will be released in March, said Mary Solomon Smyka, spokeswoman for The United Way For Southeastern Michigan, which helped launch the study.

Oakland County residents ranked crime sixth; Detroiters put it second.

The report will be distributed to coalition members and agencies throughout Metro Detroit.

"Our purpose in providing this survey," said partnership chairman Ed Scribner, president of the Metropolitan Detroit AFL-CIO, "is to prompt human services providers to rethink and re-evaluate what they are doing."

Coalition members include the Detroit mayor's office, Detroit Renaissance Inc., Greater Detroit Chamber of Commerce, Michigan Department of Social Services, Wayne State University Center for Urban Studies, Southeast Michigan Council of Governments and Jewish Federation of Metropolitan Detroit.

Detroiters' priorities

The Community Needs Assessment Partnership, a new coalition of 19 high-profile organizations, conducted a first-time survey of residents' perceptions of problems facing Metro Detroit. Among those considered:

Critical (ranked)

1. Shortage of jobs
2. Alcohol and drug abuse
3. Crime
4. Lack of affordable health care

Severe (not ranked)

- Teen-age pregnancy
- Racial and ethnic discrimination
- AIDS
- Family violence
- Hunger or homelessness
- Educational disadvantages
- Family or individual stress or mental or emotional illness

Serious (not ranked)

- Children or teens with behavioral or emotional problems
- Not taking care of one's own health or safety
- Lack of adequate housing
- Lack of affordable after-school care
- Illiteracy
- Shortage of day-care
- Shortage of recreational facilities
- Unable to get help for elderly
- Cannot affect the community
- Children and teens with no place to live
- Housing in need of major repairs
- Unable to get help for seriously ill or disabled people
- Not knowing where to get help in general
- Not being able to afford legal services

Publication DETROIT NEWS
Date JAN 11 1993 ; Page/section

In The News
St. John Hospital and Medical Center and Its Affiliates

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Medicaid aims for tighter belt, better care with 'managed care'

A return to "old-fashioned medicine" is hoped for as Michigan moves more than 800,000 of its 1.1 million Medicaid recipients to a less costly health care program.

The "managed care" program will save the state money, but also should provide better access to better care for welfare recipients, Sally Hetrick, the state's Medicaid director, said Tuesday.

"It's almost a return to old-fashioned medicine, where patients know their doctor and doctors know their patients," she said. "That's ideal, but on an anecdotal basis we know it's happening."

Under managed care, Medicaid recipients must choose a primary care physician or health-maintenance organization from a list of providers who have signed contracts with the state.

If they go to providers without state contracts, the state will not pay the bills. Visits to specialists will be covered by Medicaid only if they were recommended by the primary provider.

Managed care is designed to emphasize preventative care, promote early treatment and eliminate unnecessary services.

"People are more apt to get the types of medical service that they need if they are in a managed care program," Hetrick said. "Not only that, they will get the care they need in the appropriate setting."

The biggest segment of those affected by the move will be the state's 672,000 recipients of Aid to Families with Dependent Children, Hetrick said. That includes about 281,000 in Wayne County, nearly all of whom already have been enrolled.

About 320,000 Michiganians currently are enrolled.

The program has been almost fully implemented in Wayne County. Recipients in Oakland, Macomb and Genesee counties were notified of the plan in October and told to choose their primary care provider within a year.

The state also has started implementing the plan in Marquette, Muskegon, Oceana, Saginaw, Bay and Monroe counties, Hetrick said.

In Genesee County, for example, about 59,000 residents are being asked to choose from one of two HMOs or from 118 physicians who have contracts with the state.

"We've had no problem with it," said Connie Smith, assistant to the vice president of clinical affairs at Mott Children's Health Center in Flint. "Most people are happy to sign up with a (steady) doctor."

The program eventually will be mandatory for most affected recipients statewide, although some rural counties may be allowed to participate on a voluntary basis, she said.

"If we cannot assure access through managed care, then we just leave it alone," Hetrick said.

Officials hope the program will trim about 10 percent from Michigan's annual $3.2 billion Medicaid bill by the time it is implemented in all 83 counties, hopefully by the end of 1994.

Seven of the 17 HMOs licensed in Michigan have signed on with the program, and about 1,520 doctors — 847 in Wayne County —have signed contracts, Hetrick said. Both numbers are expected to increase.

From the Associated Press

Publication Macomb Daily
Date Dec 2, 1992 ; Page/section

In The News
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Hospitals pair up to save lives

Open-heart surgery patient 397 recovering from historic operation

By TRACY WILSON
Times Herald

Agnes Van Dusen is weak. But at least she is alive.

Ms. Van Dusen, 69, of Port Huron, is recuperating from the first open-heart surgery performed in St. Clair County. Her single-bypass operation was possible under a new $4 million collaboration between Mercy and Port Huron hospitals.

The arrangement, called Partners at Heart, is a joint operating agreement in which the two hospitals will share open-heart surgery and angioplasty facilities.

Besides surgery, the hospitals also will share other aspects of cardiac health care including prevention, education, diagnosis, treatment and rehabilitation.

As many as 800 open-heart and angioplasty patients eventually may be treated each year under the agreement.

The two hospitals will share revenues and costs.

The surgeries are being performed at Port Huron Hospital. About $750,000 of the pact's $4 million cost will be used for renovations at the hospital, corporate consultant Gary LeRoy said.

Mercy Hospital, meanwhile, will start interim cardiovascular care while a new 30,000-square-foot cardiac lab and educational facility is built near the hospital.

Angioplasty — an operation which improves circulation in cardiac vessels — is not yet being performed. But operations should be scheduled within a month or so, Mr. LeRoy said.

"We can't continue to compete with each other on something like this — the community can't support two different open-heart programs," Mr. LeRoy said of the agreement.

Staff members at both hospitals will spend 350 hours learning operating techniques and getting hands-on training at St. John Medical Center in Detroit.

"I'm very excited about this collaboration," said Sister Catherine McGroarty, president and chief operating officer at Mercy Hospital.

The pact was formed after the hospitals obtained a state certificate of need for the project in 1990.

"This is an historic moment for the community — that the hospitals could come together on such a major service is significant," Sister McGroarty said.

Ms. Van Dusen's surgery, by Dr. Douglas Lees, took three hours.

Doctors opted for a bypass after discovering Ms. Van Duesen had a clogged coronary artery. She had complained in early January of chest pain.

Ms. Van Dusen, a *Times Herald* mail room employee, is optimistic about her recovery.

In the meantime, two favorite activities — dancing and three-mile walks — are out of the question for a while.

"It'll be a couple of months before I'm back out doing what I was doing," she said. "But I'll be out there soon — I'm a stubborn hillbilly."

Publication PORT HURON TIMES HERALD
Date FEB. 1 1993 ; Page/section

In The News
St. John Hospital and Medical Center and its Affiliates

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Study finds families take $1,800-hit for health care

BY MICHELE CHANDLER
Free Press Business Writer

Rising health-care costs translated to the average Michigan family taking a $1,804 pay cut this year, according to a study released Thursday by the Service Employees International Union.

"Working families have paid for our country's failure to control runaway health costs with squeezed family budgets and falling living standards," said the union's president, John Sweeney. "It is clear that economic rebuilding in the U.S. is not possible without stringent measures to contain health-care costs."

The union commissioned the national study, based on data analysis by health economics consulting firm Lewin-ICF, based in Fairfax, Va. The union has 1 million members, including 40,000 in Michigan.

The $1,804 figure is based on estimates that Michigan families would have spent less on health care and been paid more if health-care spending growth, starting in 1981, had not exceeded the growth rate for the gross national product.

Health-care costs have been increasing at about 12 percent annually. The study suggests that health-care cost increases since 1980 should not have exceeded the growth of the gross national product — an average of about 8 percent annually.

The study was endorsed by John Shepherd, vice president of government relations of Safeway Inc. grocery chain and a member of the National Leadership Coalition for Health Care Reform. The group includes businesses, unions, consumer groups and health-care providers; it endorses national health-care reform to ensure coverage for all who work.

"If we had controlled costs the way the rest of the world does, American business would be spending, on average, $2,000 rather than $3,000 per employee per year," Shepherd said.

Nationwide, the study found that a family earning the national average of almost $36,000 took the equivalent of a 5-percent pay cut this year because of the increasing cost of health care.

Average out-of-pocket health-care spending nationwide more than doubled, from $939 in 1980 to $2,303 in 1992, the study found.

Publication DETROIT FREE PRESS
Date OCT 23 1993 : Page/section

In The News
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UAW president calls for reform of health care

BY JOHN LIPPERT
Free Press Labor Writer

Insisting that America's health-care system needs radical surgery, UAW President Owen Bieber called Monday for a Canadian-style plan that's far more extensive than reforms endorsed last week by Big Three automakers.

Bieber endorsed a "single-payer" system, in which every doctor and hospital in the country would be paid by just one government or quasi-government agency.

Bieber said he likes the approach primarily because of its tight cost controls. He said cost controls in the current federal Medicare system work well, but are subverted when doctors boost private-sector prices to offset their losses on Medicare.

Bieber said he was delighted recently when President-elect Bill Clinton said he may opt for a "single-payer" approach to resolving a mushrooming crisis in providing health care for retirees.

Critics, however, insist that a single agency spending $900 billion annually, or one-seventh of the entire U.S. economy, would be unmanageable.

On Friday, leaders of the Big Three automakers endorsed a more limited approached, already supported by Clinton, that included:

- Universal access for 35 million Americans currently uninsured.
- A national health-care budget to hold down costs, either through specific price controls or broad spending limits.
- Managed competition, in which purchasing cooperatives of companies and individuals would be formed to force doctors and hospitals to compete, on the basis of quality and price, in delivering a federally mandated and federally monitored package of minimum benefits. Unlike the current U.S. plan, in which health benefits are fully deductible, workers opting for more than the minimum benefits would pay taxes on the value of the difference.

On Monday, Bieber acknowledged he may have to settle for more modest reforms than he wants. But, he added, "No longer are we arguing about whether we need health-care reform. We are now seriously engaged in a discussion about what kind of health-care reform provides the greater benefit."

Bieber said he wasn't asked for concessions on health care or other areas during meetings last week with Clinton and Big Three automakers. He said he'll expect the automakers to make up the difference between current benefits and any minimum package enacted in Washington.

Specifically, he said General Motors shouldn't try to copy the $1.6 billion in pension concessions the UAW recently gave to Navistar. Unlike GM, he said, Navistar "is half a step away from bankruptcy."

Bieber declined to rule out the kind of nine-year agreement that the United Steelworkers indicated it might accept at major U.S. steel companies, if job security guarantees are sufficient.

Publication DETROIT FREE PRESS
Date JAN. 12, 1993 ; Page/section

In the News
Detroit, MI 48236
(313) 343-3970
St. John Hospital and Medical Center and its Affiliates

Costs threaten health of uninsured families

By Diane Katz
THE DETROIT NEWS

The listing of debts in Donald and Lisa Brown's bankruptcy file explains why the Warren couple considered abortion when her second pregnancy was confirmed.

Medical bill: $10,500
Medical bill: $4,128.13
Medical bill: $977
Medical bill: $544
Medical bill: $480
Medical bill: $348
Medical bill: $160
Medical bill: $130
Medical bill: $119
Medical bill: $90
Medical bill: $85
Medical bill: $30
Medical bill: $21
Medical bill: $14.98

Living without insurance and struggling under the $18,000 owed for her first child's complicated birth three years ago, Lisa took to her knees and begged the Lord to intervene. Anything to release her from the decision no woman ever likes to make.

"I cried all the time. This was devastating to us," said Lisa, 25. "Our marriage wasn't going to survive any more medical bills."

The Browns already had fled Virginia for Michigan to escape the hounding telephone calls, unannounced visits and threatening letters of bill collectors. Hope for the future was in short supply.

"The end of the tunnel was all dark," Lisa said.

Tens of millions of people also know insurance hell, fearing the slightest cough or ache will worsen or an unexpected medical condition will require care that they can ill afford.

The uninsured are increasing. About 35 million Americans, 14 percent of the population, have no health coverage. Among Hispanics and blacks the figures are grimmer: 26 percent and 20 percent, respectively.

In Michigan, one in nine residents — more than a million people — are unprotected.

Most of these are not loafers who'd get coverage if they'd only get a job. More than two-thirds of the uninsured are in working families, blue-collar and middle-class folks whose employers don't provide coverage and who can't afford it themselves. Increasingly, their choices in life are dictated by their insurance status.

The Browns chose against abortion. Instead, Donald quit his job with a moving company so the family would be eligible for Medicaid.

"We had no other choice," Lisa said.

Baby Sarah is now a year old. Donald is working at a new job. And the couple has filed for bankruptcy to rid them of their crushing debt.

Those with coverage cannot rest assured that the problem belongs to the have-nots alone. Benefits are eroding for almost everyone. And the cost of charitable care or public care — services provided to those who can't pay — eventually is passed on to others when added to doctor bills, insurance premiums and taxes, inflating the expense that even the more affluent find harder to handle.

America spent $675 billion on medical care last year — 12 percent of the Gross National Product. That's more than defense. More than Social Security. Forty percent more per capita than Canada, the world's runner-up in medical spending.

If the United States used health care like industrial competitors Germany and Japan, the nation could free $300 billion a year.

"Very clearly, one of the reasons the average American is worse off today than 10 years ago is the rising cost of health care," said Walter Maher, director of federal relations for Chrysler Corp.

The uninsured did little to cause the forces responsible for swelling their ranks, and can hardly control those factors: medical costs rising at twice the rate of general inflation, insurance premiums jumping 10 percent to 25 percent a year, a malpractice mess and fewer businesses offering basic benefits.

Another reason, some say, is greed among a few in the medical establishment.

"Private health insurance can no longer provide us with security and peace of mind," says Robert M. Brandon, vice-president of Citizen Action, a consumer advocacy group.

Plastic talks

Mike Goines was covered by Blue Cross before the box company he worked for moved south. Now, Goines, 37, works for a Detroit auto parts store that does not offer benefits.

Publication DETROIT NEWS / FREE PRESS
Date July 21, 1991; Page/section

His breathing is labored. His chest is tight. It hurts a lot of the time, he says.

Goines has waited three months for an appointment at Detroit's Bruce Douglas public health clinic. The lists are long for free services.

The emerging reality in America is that even basic care is rationed by ability to pay. Sign in at almost any physician's office and you're invariably asked for an insurance card. If you can't pull one from your pocket or purse, you'll find it difficult to see a doctor.

Most doctors are humane. Most are ethical. But doctors are also in business. And there is only a fixed amount of free or reduced-fee care they will provide.

"It's become very difficult for a patient without an already established source of care to find a doctor," said Vernon Smith, director of Michigan's Medicaid program.

The cost of care prevented 18 percent of Americans from visiting a doctor, clinic or hospital last year, according to a survey by the Associated Press.

The evidence is piling up in the nation's emergency rooms, which handle 90 million visits annually.

Many of the patients present true emergencies. Some are a lot more serious than they should be. But lacking an on-going doctor-patient relationship, without consistent and comprehensive care, people delay care. They just get sicker.

A pregnant woman without health coverage is about one-third more likely to delay prenatal care until her last trimester. An uninsured person with a chronic illness is about 40 percent less likely to see a physician. One-quarter of America's children do not see a doctor once a year; 30 percent do not get childhood vaccines.

"It's no surprise that patients come here," said Dr. Brooks Bock, chief of emergency medicine at Detroit Receiving Hospital. "Nobody else wants to take care of them."

State of emergency

Laura Skeens, 31, of Detroit, didn't know she was pregnant when she was fired from her job last February. When she did find out a few weeks later, she applied to a Medicaid program offering maternity care. Eight weeks passed before she was processed and examined at a public health clinic.

Laura miscarried April 13. It was the untreated diabetes, she said.

Her Medicaid was canceled after she lost the baby. Social Services said her husband earns too much at his job paying $4.75 an hour, Laura said. Now she walks around dizzy and weak, afraid to conceive again.

The problem is not that the uninsured go without any care. Public clinics will, depending on eligibility, provide some services. Emergency rooms by law must stabilize any patient in a life-threatening condition.

The problem is that such a system rewards illness.

"By the time you are critically ill, you do get taken care of," said Margaret Campbell, a nursing specialist at Detroit Receiving Hospital. "That's why some of these patients wait until they are real sick, when they know they will get admitted.

"If they just go for preventive care, either they are not going to be seen or they will be billed."

Hospitals provided $11.1 billion in uncompensated care in 1989, an increase of $7.2 billion over 1980. The cost to Michigan hospitals that year was about $352.9 million.

Such a system breeds monumental waste.

Forgoing prenatal care may end up costing $2,000 a day in a neonatal nursery — $30,000 for an average stay. Immunizations ignored, cancers undetected, untreated diabetes and uncontrolled blood pressure — the price is more than monetary.

The Journal of the American Medical Association reported a study earlier this year in which hospital records from nearly 600,000 patients were analyzed. The result: In-hospital death rates were 1.2 to 3.2 times higher among uninsured patients than those with private coverage.

"Are there unnecessary deaths because people don't have good continuous coverage and access to health care? Absolutely," said James Kenney, president and CEO of the Greater Detroit Area Health Council.

Shifting costs

Frank Piciurro and his wife, Barb, are part-time workers whose jobs don't provide insurance. The couple paid $480 a month to cover themselves and three kids.

Making the monthly premium meant scrimping on everything else. The premium nearly equaled the rent on their Roseville home. They canceled last year.

Now they pay cash to visit the doctor. And they hope that they won't need a hospital.

Most Americans — nearly 60 percent of those insured — receive coverage through their jobs. The tradition dates back five decades, after draft boards began moving men from the factories to the battle front.

World War II created a labor shortage that would have fueled inflation if employers boosted wages to attract scarce workers. The War Labor Board capped wages that companies could offer. Unions responded by suggesting health benefits instead of money.

The idea spread fast. About 12 million Americans had private insurance in 1940; the number nearly tripled by 1945 and doubled again by 1950. Ten years later, 122 million were insured — more than 10 times the number a generation earlier.

The system seemed to work as long as health care costs remained stable.

Those without jobs and benefits paid what they could. Hospitals and doctors covered the difference by "cost shifting."

Under such shifting, a doctor or hospital will charge an insurance company or a patient who pays cash a higher price for service to offset the cost of treating those patients who don't pay or pay less under Medicaid and Medicare.

The open-ended system fueled inflation; costs began outpacing insurers' and employers' ability to finance the increase. And such third-party payers began insisting on fixed fees, leaving less fat to cover uncompensated care.

"This country has always financed charity care by shifting the cost to the people who can pay," said Darlene Burgess, a vice-president of Metro Detroit's Henry Ford Health System. "What's new is hospitals and physicians have really lost that ability to cost shift because of the negotiated rates."

The national average cost of health care per employee was $1,724 in 1985 and $3,217 in 1990.

Excess capacity

Karen Sanborn earns $6.35 an hour at a florist shop in Flint. Insurance for herself and two sons ran out four years ago, when her ex-husband was laid off from General Motors Corp.

She tried paying $287 a month for a policy with a $1,500 hospital co-pay. After six payments she had to cancel.

Last summer, she visited the welfare office to inquire about help. A caseworker said the agency could help only if she quit her job or became pregnant.

Otherwise, the worker said, she was wasting their time.

Out of the carnage of World War II emerged a legion of physicians and nurses with greatly improved skills, all ready to apply new technologies.

Rapid medical advances brought cures that spurred even more demand for medical treatment. Insurance to pay for it all became essential.

Unlike other markets, the increased supply of medical services did not drive down costs. On the contrary.

The number of physicians per capita 35 years ago was about 141 per 100,000 Americans. That rose to 200 by 1980, and is estimated to reach 260 soon.

Every new doctor, each new machine and medication, is offered to a public that doesn't do much comparative shopping. Consumers rely almost exclusively on health providers to tell them what to buy.

"We have MRI and scanners and lithotripters and lasers and God only knows what other piece of technology running off the assembly line," said Sister Dinah White, a vice-president of Southfield's Providence Hospital. "We say, 'Here is the smorgasbord, start with the chocolate.' "

Excess hospital capacity doesn't help, either. The Greater Detroit Area Health Council estimates a 30-percent gap between capacity and utilization.

The federal government created Medicare and Medicaid for the old and needy who couldn't themselves join the newly insured by the mid-1960s. The move made the feds the leading purchaser of medical services.

Initially, physicians balked at what they considered "socialized" medicine. Then they realized the bonanza wrought by all the new patients calling for appointments that the government would pay for.

"We try to reconstruct a person's health without any thought to cost," said Dr. Murray Levin, a Bloomfield Hills internist. "Patients don't ask, and I don't think about it."

In 1965, state and federal governments spent about 5 percent of revenue on health care. By 1989, that spending had tripled.

Reduced benefits

Marie Palazolla lost her medical coverage when she took child-care leave from her Mt. Clemens teaching job. Nothing prepared her for the quotes on premiums she received for a comparable policy — $300, $400, $500 a month.

Palazolla settled for a downgraded plan costing $140 a month. Dental, optical, prescriptions, office visits — all she once took for granted — are now paid from her savings.

It's a real shock, she says.

More and more, even the insured are feeling squeezed as third-party payers try desperately to control exponentially increasing costs.

The big players, large corporations that for decades subsidized the entire medical system through cost-shifting, no longer are as willing or as able to do so.

The National Association of Manufacturers surveyed its 8,500 members in February. A third said they will reduce medical benefits within two years. According to the Federal Mediation & Conciliation Service, 60 percent of the 85 strikes it is mediating involve health benefits.

"Workers don't want to pay higher premiums or get reduced benefits," said Douglas Fraser, former president of the United Auto Workers and now chairman of the Committee for National Health Insurance, a Washington-based interest group. "So you have this conflict at bargaining tables throughout the land."

More and more, employers are scrutinizing how health care is used and are requiring authorization for treatments and services. Workers are paying a larger share of their coverage in the form of higher deductibles and co-payments. More fees are capped or fixed.

The problem is compounded by the nature of the private sector. Jobs that are least likely to include health coverage are with smaller businesses and service companies. And that is where the largest number of jobs are being created.

"What that suggests," said Vernon Smith, director of Michigan's Medicaid program, "is that if we have a problem now, the problem is going to be much greater as we go down the road."

Cheap option

Sheryl Setter, 38, is a cosmetologist in Marquette. The salon where she works offers an employee-paid insurance plan.

The plan isn't open to Sheryl. She has diabetes and arthritis, two "pre-existing" conditions that insurers routinely reject. So she sticks with the Blue Cross she's had for years.

She shopped for a cheaper policy without luck. Increasing her deductible made the Blue Cross premium cheaper.

She earns $600 a month. She pays $200 a month for medication, $115 for her premium and $64 for each office visit.

Insurance is a state-regulated enterprise. In the past 18 months, 17 states have relaxed laws that had required insurance companies to offer minimum levels of health benefits.

A new stripped-down policy in Kansas offers a $5,000 deductible; in Kentucky, one package covers a maximum of 14 hospital days, no outpatient coverage, $300 deductible and 20 percent co-pay for hospitalization.

Insurers say small businesses need a cheap option. "We feel it's worthwhile to have some coverage for people who need health care coverage as opposed to no coverage," said Richard Coorsh, spokesman for the Health Insurance Association of America.

Limits on treatment now affect an estimated 81 million of the 222 million Americans under age 65. These include an expanding list of conditions insurers will not cover if they existed before the policy went into effect.

Defensive medicine

Janice Thomas, 22, lost her medical insurance when her husband was discharged from the U.S. Army.

When she experienced some unusual vaginal bleeding, Janice went for help to the emergency room of a hospital near her Westland home. They put her a room where she waited for several hours, she said.

A doctor came, conducted a brief examination, and told her to go home. As she was leaving, the doctor told her to wait. He wanted to do a more thorough exam. Then he said he wanted to transfer her to another hospital.

Janice wonders if it had something to do with insurance or malpractice or something.

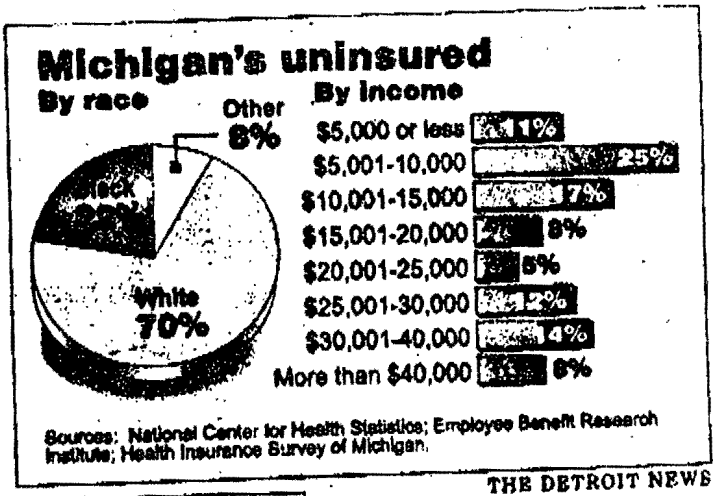
The American Medical Association estimates that $12 billion to $14 billion each year is spent on defensive medicine — procedures carried out solely to protect doctors from malpractice claims.

"You have to do it all the time," said Dr. Andrew Barnosky, a medical director at Wyandotte Hospital. "You do it all the time to protect the medical record and to protect and justify your diagnostic impression.

"A big, big component of what effects health care costs is extremely defensive medical practice and medical practice that has a large degree of risk-shifting behavior. As a result of that, the cost of practice escalated."

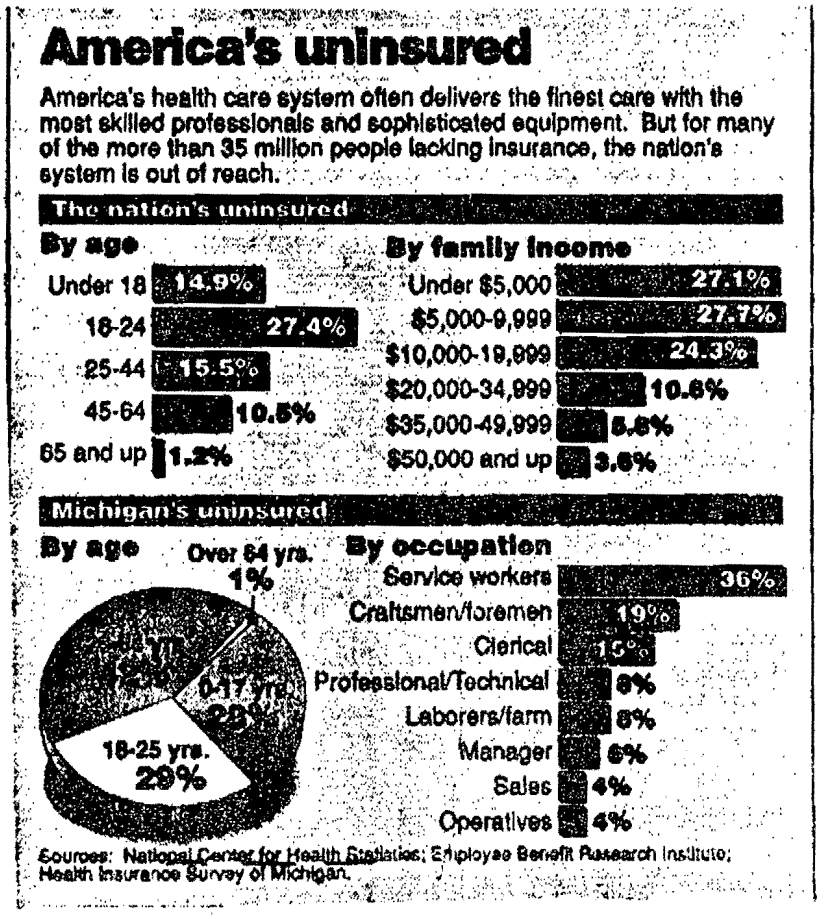
There is a direct correlation between early intervention and outcome. So doctors are more reluctant to treat those most likely to delay care — the uninsured.

"Physicians are deathly afraid," said Donald Snell, former CEO of Detroit's Hutzel Hospital. "We're frightened to death to take care of them."



WHAT WE FOUND

- **The numbers:** Thirty-five million Americans, including 1 million in Michigan, lack basic medical coverage.
- **The toll:** The uninsured lack access to care and are vulnerable to more serious illness.
- **Draining system:** The cost of coverage cripples small firms and weakens U.S. companies' ability to compete.



In The News

St. John Hospital and Medical Center and its Affiliates

Marketing and Public Relations
22101 Moross Road
Detroit, MI 48236
(313) 343-3970

Prioritizing health care is a must

Metro Detroit's hospitals operate 13 open-heart surgery centers. Critics say that may be too many, both because of unnecessary duplication and because the number of patients served at some of the hospitals falls well below the number of surgeries experts believe are needed annually to hone skills and reduce mortality rates. (St. John Hospital, for example, has the highest number of heart surgeries in the area and its mortality rate is 2 percent below the national average.)

Two Detroit-based groups — the Greater Detroit Area Health Council and the Economic Alliance for Michigan, a business-labor coalition — have pushed for tougher criteria to create new open-heart centers.

Last week, the state's Certificate of Need Commission agreed and decided to hold a hearing Oct. 19 on the proposed tighter standards. A final decision will be made in December.

Last week's decision by the CON Commission to make the heart programs a priority is good news.

Existing centers may be pleased if the competition is limited, but hospitals with no open-heart centers may be distressed if the standards are tightened. These centers can be profitable.

But the way needs are now established to obtain state permission to create new centers is absurd. Consider this: Under current rules, a hospital that can't justify an expensive open-heart surgery program on its patient load alone can "borrow" data from other hospitals on *their* discharged patients who may someday exhibit symptoms that will require surgery some day at the second hospital.

So last week's decision by the CON Commission to make the heart programs a priority is good news for Michigan business, which ends up footing a lot of the health-care tab. A couple of footnotes:

■ The five-member CON Commission, including four new Engler appointees, is flexing its muscles in an appropriate manner. Michigan's employers and insurers don't have enough money to let hospitals pick and choose the programs they want, regardless of duplication within their marketplace. By making open-heart surgery programs a priority, the commission also overrode the recommendations of the state Health Department staff, which doesn't consider the heart programs a priority.

Publication CRAIN'S DETROIT BUSINESS
Date [illegible] 1993 Page/section

■ The lobbying on this issue showed encouraging signs of life within the Greater Detroit Health Council, which has been too passive on cost-containment issues in the past.

Health care is at the top of many business agendas. Policymakers need to balance cost with quality and access, and that's not easy.

It will take a strong vision of how to juggle those priorities. A strong business-labor coalition must back up the state's attempts to curb rising health-care costs by reigning in free-market arguments that result in costly new programs for which business picks up the tab. CCB

MEET AND GREET WITH MICHIGAN DIGNITARIES

Andrew Mazzara, President, Henry Ford Community College

Gerald Stockwell, Chairman and Member of the Board of Trustees, Henry Ford Community College

Senator Carl Levin (D-MI)
Senator Carl Levin is a strong single payer advocate. He considers the Congress and the Administration to be excessively concerned over the amount of front end taxes that would be required for a single payer system. He believes the public supports that approach because it is the most efficient and responsive system which would address the public's needs. He is a highly respected liberal Senator, who does not react with knee-jerk radical gestures. Because of his influence and strong support of the single payer system, we will need to provide him with a solid and convincing alternative to the single payer system. He is a team player, and open to discussion.

Senator Levin sits on the Senate Committee on Armed Services; the Senate Committee on Governmental Affairs, of which he is the Chairman of the Committee Oversight of Government Management Subcommittee. He also sits on the Senate Committee on Small Business, of which he serves as Chairman of the Innovation, Manufacturing and Technology Subcommittee.

Senator Don Riegle (D-MI)
Senator Don Riegle supported the Mitchell, Rockefeller, Kennedy health care legislation which was patterned after the play or pay type model of health care coverage. He views himself as a leading health care advocate in the U.S. Senate, and is a proponent of universal coverage and comprehensive reform. He is a strong defender of coverage for mental health, and for coverage of children and pregnant women. Recently, he has focused his efforts toward retiree health issues, and will push health liability included in the package. His wife, Lori Hansen Riegle, who will be travelling with him, is particularly concerned about domestic violence.

Senator Riegle is Chairman of the Senate Committee on Banking, Housing, and Urban Affairs; the Senate Committee on the Budget; and the Senate Committee on Finance, of which he is Chairman of its Health for Families and the Uninsured Subcommittee.

Rep. John Dingell (D-MI)
We understand that Congressman Dingell is beginning to become concerned with the lack of visible political strategy around health care and the fact that it appears we may be unable to include health reform in a reconciliation package. He is concerned that we will have a difficult time getting the proposals through the Senate if this occurs. In order to address these concerns, we are holding a meeting on jurisdictional issues with the House parliamentarian on Monday and with Howard Paster and the House Chairs from the related Committees on Wednesday, the 24th.

As you know, Congressman Dingell is committed to helping the Administration. He is concerned about early retirees and their health benefits, particularly as this issue impacts the auto industry. He has long proposed financing health care with a value added tax.

Chairman of the Committee on Energy and Commerce, Dingell also serves as the Chairman of the Subcommittee on Oversight and Investigations. As you know, Dingell has introduced the National Health Insurance Act (H.R. 16), which has been referred to the Energy and Commerce and the Ways and Means Committees. Congressmen Buyer (R-IN), Gingrich (R-GA) and Smith (R-TX) currently co-sponsor the bill with Chairman Dingell. There is no companion bill to H.R. 16 in the Senate at this time. Dingell has also introduced legislation (H.R. 33) to amend the Public Health Service Act to require certification of labs engaged in drug testing. Another piece of legislation Dingell has introduced that is worthy of note is a joint resolution (H.J. Res. 20) calling for a Constitutional Amendment to limit election expenditures for those seeking federal office. Dingell has represented Detroit's industrial corridor in the 16th district of Michigan since 1955.

Henry Ford Community College is located in Congressman Dingell's district.

Rep. Barbara-Rose Collins (D-MI)
Congresswoman Collins is representing Detroit in her second term. St. John's Hospital is located in her district. Collins serves on the Government Operations Committee as well as the Public Works and Transportation Committee and as Vice-Chair of its Investigations and Oversight Subcommittee. She also sits on the Post Office and Civil Service Committee and is Chair of its Postal Operations and Service Subcommittee. Collins has not introduced any health care legislation or had any significant involvement in the health reform process. She will, however, be concerned with the impact of health reform on the medically underserved in urban areas as well as with women and minority health care issues.

Rep. John Conyers (D-MI)
Congressman Conyers serves as Chairman of the Committee on Government Operations and its Subcommittee on Legislation and National Security. He also sits on the Judiciary and the Small Business Committees. Conyers is an advocate of minority health access and the impact of health reform on inner cities. He is also concerned with training more primary care physicians. Conyers was an important player in establishing the Congressional Black Caucus and has long advocated a Cabinet level post to handle the environment. He has represented Detroit since 1965.

Rep. William Ford (D-MI)
Congressman Ford is Chairman of the House Committee on Education and Labor and its Postsecondary Education and Training Subcommittee. As you know, his Committee will have jurisdiction over a large portion of the health care legislation. He sponsored the Family and Medical Leave Bill (H.R. 1) that, as you know, was signed into law in the Rose Garden on February 2. He has also sponsored the Comprehensive Occupational Safety and Health Reform Act (H.R. 1280) and has long advocated worker safety standards. Ford is an active supporter of organized labor and will have trouble if a tax cap is included in the Administration's proposal. He will also closely monitor any changes to ERISA. Ford has represented the 13th district of Michigan since 1965.

Rep. Dale Kildee (D-MI)
Congressman Kildee sits on the Education and Labor Committee and serves as Chair of its Subcommittee on Elementary, Secondary and Vocational Education and as Vice-Chair of the Human Resources Subcommittee. He sits on the Budget and the House Administration Committees as well. In the last Congress, Kildee fought for full funding of Head Start and has recently introduced the Child Nutrition Act (H.R. 8) to amend the School Lunch Act. He continues to promote his education initiatives in this Congress. Kildee has represented Flint since 1977.

Rep. Sander Levin (D-MI)
As you know from your meeting last week, Congressman Levin serves on the Ways and Means Committee as well as its Health Subcommittee. Levin would like to be more involved with health reform and should be consulted more regularly. He views himself as an influential player on health care and is next in line to Stark on the Health Subcommittee. He will be a team player. Levin has worked extensively in the past to increase mental health coverage under medicare. Levin is a union advocate and is especially concerned with retired health issues. He also wants strong cost-containment measures and is a defender of Teachers' hospitals. As you may know, Congressman Levin is the brother of Senator Levin.

Rep. Bart Stupak (D-MI)
Congressman Stupak is a new member of Congress representing the redrawn, formerly Republican, first district of Michigan. He has quickly gained a reputation for being very bright and a team player. He is interested in making his mark and would like a seat on Dingell's Energy and Commerce Committee. He has taken seats on the Armed Services and the Merchant Marine and Fisheries Committees. Stupak campaigned primarily on improved educational programs and providing universal health care coverage.

MEET AND GREET AT DETROIT AIRPORT

Richard Austin	Secretary of State
Mandell Berman	MLB Investment Corporation
Owen Bieber	President, United Auto Workers
Dr. Margaret Betts	Chair, Detroit Health and Social Services Committee
Dr. Victoria Binion	Herman Kiefer Hospital
Jim Blanchard	former governor
Elizabeth Brater	Mayor of Ann Arbor, coordinated municipal officials for Clinton/Gore, in a tight race for reelection on April 5th
Ruth Broder	Staff member, Senator Levin's office
Gary Corbin	Chairman, Michigan Democratic Party
Jackie Curry	County Commissioner and Clinton/Gore Co-Chair
Debbie Dingell	General Motors Foundation executive
John Dingell	Congressman
Mike Duggan	Deputy Wayne County Executive
Peter Eckstein	Director of Research, Michigan AFL-CIO
Gilbert Frimet	Attorney and Democratic activist
Frank Garrison	President, Michigan AFL-CIO
Freeman Hendrix	Assistant Wayne County Executive
David Hermelin	Democratic activist
Shanda Hurkett	Democratic activist
Spencer Johnson	President, Michigan Hospital Association
Frank Kelly	Attorney General

Carol King	Exec. Director, MI Abortion Rights Action League
Dr. David Lieberman	Director, Monroe County Public Health Department
Julius Maddox	President, Michigan Education Association
Joseph Mangone	Political Director, United Auto Workers
Elizabeth Misuraca	Exec. Assistant to the Wayne County Executive
Charles Neumann	President, Michigan Education Social Services
Larry Owen	Attorney, chief fundraiser for Clinton/Gore
Faylene Owen	President, Mica Consulting Corp.
Paul Seldenright	Director, Cmte. on Political Education, MI AFL-CIO
Shelby Solomon	Director of Gov't Services, Medstat Systems Health Care Management
Ron Thayer	Wayne County Dept. of Jobs and Economic Development
Joanne Watson	Executive Director, Detroit NAACP
Bev Wolkow	Michigan Education Association
Dr. Claude Young	Virginia Park Medical Center

Clinton Presidential Records
Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: 418

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Linda Moore, Political Affairs

SUBJECT: Michigan Politics

DATE: March 20, 1993

Jobs and the economy are the major issues of concern to the people of Michigan. The state is experiencing a slight economic upturn right now. For the first time since 1978, Michigan's unemployment rate is below the national average, but there is still great uncertainty about the future of the auto industry and the state's economy.

PRESIDENTIAL ELECTION RESULTS

	Detroit	Michigan
Clinton	60%	44%
Bush	28%	37%
Perot	12%	19%

GOVERNOR ENGLER

Governor Engler just proposed a plan to provide medicaid health coverage to an estimated 80,000 children, age 16 and under, who do not currently have health insurance. (News clips on this proposal and other political and policy matters are attached.) He will not be in attendance at the hearing, but his proposal will almost certainly be mentioned.

Governor Engler was appointed by the National Governors Association to serve on a welfare reform task force. He has inferred that this appointment was made by the President and therefore his position on welfare reform has been vindicated. He has made severe cuts in Michigan's welfare programs and has no proven plan for putting people back to work.

Governor Engler is up for re-election in '94. The Democratic field is expected to be large. Those who have announced thus far: former Congressman Howard Wolpe, who was neutral in the primary but a strong Clinton supporter in the general, and State Senator Debbie Stabenow who supported Tsongas in the primary but was a strong Clinton supporter in the general. Governor Blanchard is rumored to be considering a rematch with Engler but there is little evidence that he will actually run.

Two others who are mentioned by the press as potential contenders are: Larry Owen, member of the Board of Trustees of Michigan State University and chief fundraiser for the Clinton campaign in Michigan; and Doug Ross, founder and president of Michigan Future, a bipartisan think tank concerned with the state's economic future. Doug also played a leadership role in the Clinton primary and general election campaigns.

Other statewide officials are: Lt. Governor Connie Binsfield (R), Attorney General Frank Kelly (D) and Secretary of State Dick Austin (D). You will see Kelly and Austin at the meet and greet at the airport.

DETROIT MAYORAL RACE

Mayor Coleman Young is not faring well in the polls and is ailing physically. He has not announced whether he will seek reelection this fall. Since the votes from Detroit were crucial to our vote total in Michigan, it is important that you appear supportive of the Mayor but not involved in the race. The primary will be held this August. Potential Democratic candidates include Dennis Archer, former Michigan Supreme Court Justice and an early Clinton supporter; Sharon McPhail head of the Detroit NAACP chapter and a member of the Detroit school board; and Paul Hubbard, head of New Detroit, a political/social/business group founded to improve race relations in Detroit.

CONGRESSIONAL DELEGATION

Sen. Riegle is up for re-election in '94 and he is vulnerable due to his involvement in the Keating Five scandal. Macomb County Prosecuting Attorney Carl Marlinga will challenge him in the primary. This has Democrats worried about heavy targeting by the Republicans for that seat as well as others. There are 10 Democrats and 6 Republicans serving in the House. Six of these races were won with under 55% of the vote. Members of the delegation feel insecure about their own re-election and are worried about making tough votes (such as gays in the military).

The members of the delegation are as follows:

Sen. Carl Levin (D)
Senator Don Riegle (D)
Congressman Billy Ford (D)
Congressman Jim Barcia (D)
Congressman Bob Carr (D)
Chairman John Dingell (D)
Congressman Peter Hoekstra (R)
Congressman Dave Camp (R)
Congressman Nick Smith (R)
Majority Whip David Bonior (D)
Congressman Dale Kildee (D)
Congressman Sandy Levin (D)
Congressman Bart Stupeck (D)
Congressman John Conyers (D)
Congresswoman Barbara Rose Collins (D)
Congressman Joseph Knollenberg (R)
Congressman Fred Upton (R)
Congressman Paul Henry (R)

THE STATE PARTY

Gary Corbin was recently re-elected as chair. You will see him and other party stalwarts and Clinton supporters at the hearing and the meet and greet at the airport Monday afternoon. There is a great deal of factionalism within the state party right now. The Democrats lost the governor's seat in '90 and lost control of the state house in '92.

Everyone believes that labor has too much control. There is a fear that if the party continues down its current path, Senator Riegle will not get the support he needs for his reelection bid.

Organized labor worked steadfastly **against** the President in the primary. The Michigan Education Association endorsed the President very early and served as our campaign's infrastructure throughout the primary and the general elections.

STATE LEGISLATURE

The Michigan legislature is evenly split among Republicans and Democrats. The speakership and the committee chairmanships are held by the Democrats one month, Republicans the next. the Senate is controlled by Republicans. Because of a recent state senate special election, a state house seat has opened up. There is a hotly contested race underway that will decide which party gets control of the State House. It is still too soon to tell who the candidates will be or to gauge our chances of winning the seat.

RECENT NEWS ITEMS

On Wednesday, March 17, the **Bloomfield Hills students** who were stranded in the Great Smoky Mountains returned home to an emotional welcome. 122 students participated in the hike. Many became lost when a huge blizzard hit the area. The y were rescued by National Guard helicopters.

Prominent Detroit restaurateur **Chuck Muer**, his wife and another couple went sailing off the Florida coast and have been missing for more than a week.

Dr. Jack Kevorkian said in an interview with Barbara Walters on 20/20 last week that his next suicide assist will probably come in the next few weeks. Kevorkian has helped 15 people die since June 1990. He has not been present at a death since Governor Engler signed a bill last month banning the practice.

Legislation has been reintroduced in the state legislature that would make it a civil infraction to block **abortion clinics** or health facilities. Sponsors of the bill hope the recent shooting death of a Florida doctor who performed abortions will bring the legislation additional support.

Bills that would make it a crime for **underage drinkers** to attempt to purchase alcohol recently cleared a House committee. Companion bills are being considered in the senate. Current law prohibits minors from purchasing or possessing alcohol, but the law says nothing about attempting to buy it. Teenagers caught violating the statute would be fined, ordered to undertake community service and would have their driver's licenses suspended.

INSIDE TODAY

Volume 162, Number 304

Engler offers medical plan for kids

BY JACQUELYNN BOYLE
Free Press Lansing Staff

LANSING — About 80,000 children whose parents earn too much to qualify for Medicaid but too little to afford private health insurance would get state-paid coverage under a $51-million plan unveiled Monday by Gov. John Engler.

Called "Healthy Kids," Engler's proposal targets the working poor — people with low-paying jobs that don't provide insurance. The program won't cover adults, but it will provide comprehensive benefits for children under 16.

State would cover 80,000 children of the working poor

Engler's announcement comes one week before first lady Hillary Rodham Clinton arrives in Michigan for a public discussion of health care issues. She is heading a task force charged with reforming the nation's health care system.

"We're choosing not to wait for Washington," Engler said at a news conference. "We're saying to every mother and father in Michigan: You can rest easier at night if your child becomes sick."

Engler, elected in 1990, has been blasted by advocates for poor and mentally ill people for eliminating welfare for more than 80,000 adults, closing several state mental health hospitals and cutting many human service programs.

Department of Social Services Director Gerald Miller said fear about

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what might happen if children become ill is the most common concern of recipients who say they want to get off government assistance. They fear losing Medicaid if they work, leaving their families unprotected.

Beverley McDonald, executive director of the Michigan League for Human Services and a frequent Engler critic, said this proposal will help those struggling families.

"I'm delighted with this. I had been discouraged about the state's lack of support for the working poor. We encourage people to work and be independent, but we don't put programs in place to help them when they do that," she said.

Details are still being worked out, but here are the program's main points:

- Full Medicaid coverage would be provided to children under 16 in families with incomes less than 150 percent of the federal poverty level. The ceiling would be about $18,000 for a family of three and about $30,000 for a family of six. Engler aides said about 950,000 Michiganders have no health insurance, including 185,000 children.
- The $51-million program will be funded with $24.4 million in state dollars and the rest in federal grants. The proposal is part of Engler's $7.8-billion budget for 1994 to be presented to the Legislature on Friday. If the plan is approved, it will begin Oct. 1.
- The state will develop an outreach program to find eligible families. Though still being developed, efforts would include seeking out minimum-wage employers and checking Michigan Employment Security Commission computer lists.
- The state also will provide an unspecified amount of money for Caring for Children, a private program administered by Blue Cross & Blue Shield of Michigan that provides limited coverage to 1,600 low-income children. Caring for Children is funded by private donations; state money will make it eligible for some matching federal funds.

The program still awaits approval from the Legislature. In 1990, lawmakers rejected a similar proposal by former Gov. James Blanchard, saying the cash-strapped state couldn't afford it. Blanchard's $13-million "Healthy Start" plan was smaller than Engler's program, covering only children under 10.

Neither Engler nor Budget Director Patti Woodworth would say specifically where the state money would come from.

Engler, who promised that his 1994 budget won't include welfare cuts, mentioned "better money manage-

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Det. F.P./Pg. 8A Date 3/19

Neither Engler nor Budget Director Patti Woodworth would say specifically where the state money would come from.

Engler, who promised that his 1994 budget won't include welfare cuts, mentioned "better money management." Woodworth said cryptically, "All of that will be revealed in time," referring to the scheduled release Friday of the budget blueprint.

But two key legislators already are behind the program. Sen. Dan DeGrow, R-Port Huron, and Rep. Bob Emerson, D-Flint, who chair key subcommittees on each chamber's Appropriations Committee, attended Engler's news conference to voice support.

"Families often put off visiting a doctor when a child is sick because they just don't have the money. The Healthy Kids program will give parents greater peace of mind," DeGrow said.

AT A GLANCE

PROBLEM: An estimated 185,000 Michigan children 15 and under have no health insurance. Those children frequently go without routine medical care. That often leads to more serious illnesses and visits to emergency rooms. Also, some nonworking parents remain on welfare because they don't want to take jobs with no health insurance and lose coverage through Medicaid, which covers about 500,000 children in Michigan.

PROPOSAL: Create a "Healthy Kids" program to extend Medicaid coverage, including hospitalization, routine office visits and prescription drug coverage, to approximately 80,000 kids of working poor parents, beginning in October. The program would cost about $51 million, with $24.4 million from the state and the rest in federal grants.

ELIGIBILITY: Families with incomes below 150 percent of poverty level could participate. The ceilings would be about $18,000 for a family of three and about $30,000 for a family of six.

TO BE HEARD: Contact your state representative or state senator. You can get phone numbers and addresses from your city, township or county clerk's office.

First lady's health forums offer no specifics

By Laura Parker
NEWS WASHINGTON BUREAU

DES MOINES — Hillary Rodham Clinton's traveling health care road show may be good TV, but it reveals very little about the direction her husband's health-care reform is taking.

About 300 invited guests, mostly health-care professionals, gathered here Monday to talk about the trouble with applying a national solution to rural areas where doctors and hospitals are often 50 miles or more from their patients.

But even after five hours of far-ranging and technical discussions, Rodham Clinton didn't provide any specifics about what her health-care task force back in Washington may produce.

■ Health: Firms, unions fight surgery requests. Page 9A

"I haven't heard anything new today," said Steve Bragg, vice-president of the Pella Corp. a window manufacturer in Pella, Iowa.

Dr. Clinton MacKinney, a rural physician in Cresco, Iowa, said "all of us want more of a hint from her about the direction she's going."

Sheldon Gilgore, chairman and chief executive officer of drug-maker Searle & Co., one of the panelists, said: "There was really no opportunity for dialogue. Everybody got a couple of minutes so it was a chance for a sound-bite or two," but not a meaningful discussion of health-care reform.

The forum was the second of four meetings, all sponsored by the Robert Wood Johnson Foundation, a private philanthropic organization based in Princeton, N.J.

Rodham Clinton visits Dearborn Monday to examine industrial and urban health-care issues. She traveled to Tampa, Fla., last week to hear horror stories from the elderly, and closes out the series of meetings back in Washington in late March with a two-day session with national health-care organizations.

The forums are closed to the general public. Both the participants and the audience are hand-picked and issued invitations by the foundation.

Lisa Kaputo, Rodham Clinton's press secretary, denied published reports that the White House retained veto power over the guest list.

"This is solely a foundation event," she said.

Bragg, who served as a panelist at one of three panel discussions, said he was asked by the White House to testify.

Please see Health, 4A

Salameh's funds may not have come from terrorists

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By Richard W
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Health: First lady's forums offer no specifics

From page 3A

Rodham Clinton may physically be center stage, but she lets Dr. Steven A. Schroeder, the foundation president, serve as moderator. She sits, brow furrowed, and listens to the panelists. She asks questions and takes notes, which she keeps in a thick three-ring notebook.

When Rodham Clinton speaks, she is conversant on the issues — a fact that few failed to note and praise.

"She's a real policy wonk" said Beverly Davies, a Des Moines businesswoman who is working a statewide health care reform project. "I'm glad to see a first lady my age doing things other than kissing babies."

The forum touched the hot buttons of the Clinton health reform agenda: the high cost of drugs and vaccines and the shortage of general practitioners.

At one point, when the subject of general practitioners was raised, Rodham Clinton pointed out that the federal government encourages medical students to specialize by providing Medicare funding to subsidize teaching hospitals.

"We can't change that until the message from the federal government changes," she said.

As the meeting closed, Rodham Clinton said she heard a lot about community solutions from Iowans.

"It is not going to be easy to make the changes required," she said. "We may have to figure out a national system that unleashes that kind of creativity and that sense of responsibility and see the possible changes that can flow from that."

When she arrived Monday morning, Rodham Clinton did a more traditional first lady gig — she stopped by the farm of Phil and Evelyn Lehman in nearby Slater to visit in the living room with the Lehmans and their neighbors. The neighbors, Brad and Bobette Rogers, told her how their son's arm had been partially severed in a lawn mowing accident and how their insurance now doesn't cover his ongoing surgical needs.

Another neighbor, Jim Kaplan, described how he'd had to sell a calf to pay for his insurance premium.

Rodham Clinton smiled sympathetically as they spoke.

"What I really want to do is to listen," she said.

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From page 3A

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JOBLESS COMP

Business should share the pain of fixing the fund

Michigan's unemployment compensation system faces a number of problems: The trust fund has been depleted, tax penalties have been triggered, and the percentage of the work force protected by the system has been steadily shrinking.

Looking at those problems, the Michigan Senate, pushed by the State Chamber of Commerce and the governor, has found the obvious answers: Cut benefits, restrict eligibility, and rebuild the balance in the trust fund account. The Senate whisked through a program that would improve the solvency of the system. The Senate bill did not ask any significant contribution by business; all of it was to be done on the backs of either the unemployed or workers who would no longer be eligible for unemployment benefits.

The House made a stab at trying to change the package so that there is some degree of shared pain by business and by workers to see that the system is restored to health. But the negotiations stalled, and the Republican leader of the House is prepared to use his leverage, if no agreement is reached, to get the bill reported out of the House committee as it came over from the Senate. If the Republicans can find a few Democratic defectors, they will try to pass the changes that restrict eligibility and cut benefits in the guise of a freeze.

There certainly is reason for trying to find ways to hold down the cost of the system and restore its solvency without an unreasonable burden on business. But what about the unreasonable burden on the unemployed?

The cost of strengthening the solvency of the system could be met by a combination of some restraints on benefits and an approach that increases the wage base on which unemployment insurance taxes are paid and puts more of the burden on those industries with greater cyclical unemployment. If there is some effort to achieve balance between the burden on business and the burden on the unemployed, it ought to be possible for the House to improve on the Senate version and come a little closer to fairness.

None of this begins to tackle the question of how many people are not even covered by unemployment insurance today, but that will probably have to wait for another day. Repairing the fund is the more pressing issue.

It is indeed time to get the unemployment insurance system on a sound footing. To do so will require some new restraint in benefits. To be fair, it ought also to require that some of the damage to individuals be mitigated by expanding the wage base and rearranging the responsibility for paying to keep the system strong and solvent.

PRESCRIPTION DRUGS

Legislation helps keep the lid on illegal sales

In 1989, when the Legislature adopted the Triplicate Prescription Program, this state had one of the nation's more serious problems of illegal resale of otherwise legal drugs. That program, known as Trip Script for short, has cut sharply into such diversions.

Indeed, the triplicate prescription policy, with the state getting a copy, has resulted in a 30-percent reduction in so-called Schedule II drug sales in Michigan. That suggests just how much of the market for such medications was, in fact, illegal. But the state already knew that. A 1982 Wayne State University survey had shown more than 60 percent of the drugs sold on the street originated from pharmacies.

A program that helps prevent the illegal resale of legal drugs should be renewed.

HEALTH CARE

Task force sends positive signal on mental care

After years of neglect and underfunding, there is an almost bottomless need for mental health services in this country.

One-third of homeless Americans are said to suffer some form of mental illness. Prisons are crowded with persons who would have benefited from treatment before they became offenders, and have just as pressing a need afterward.

Substance abuse, which we have in abundance, is linked to or exacerbated by mental illness. Untreated depression is a major brake on productivity in the work force. Schizophrenia carries with it pain and tragedy unimaginable to those who have not had to deal with it.

Meanwhile, state mental health programs are decimated by budget cutting, and cities everywhere are host to the bizarre or pathetic figures turned loose by an overwhelmed system.

There is not a bottomless well of money to pay for mental health services. So while it is welcome news that the President's Task Force on Health Care Reform, chaired by Hillary Rodham Clinton, is seriously considering a federal plan to cover the cost of treating mental illness, that news has to be tempered by caution about how to pay for it.

Mental health services account for about $67 billion of the nation's $900-billion-plus annual health care bill. The administration predicts that adding treatment for an array of conditions including severe mental illness, alcohol and drug abuse, and emotional illness in children will add another $6.5 billion a year. That is probably a wildly optimistic figure, just as early predictions about the cost of Medicare and Medicaid were.

The reform panel is weighing such options as higher cigarette and liquor taxes. The bottom line is that there can be no good and permanent solution to the mental health problem except in the context of a totally revamped health care system, with universal and affordable coverage and financing and rational cost control.

But it is a breakthrough that the panel takes mental illness seriously enough to include treatment for it in a mainstream health care system. Eventually, the benefits and savings from treating mental illness early and adequately will be visible enough to justify the expense. And then the wonder will be not how to pay for it, but why it took us so long to do so.

Engler's 'Healthy Kids' deserve fuller coverage

Gov. John Engler's plan to provide health insurance to 80,000 children of "working poor" Michigan families beginning this year sounds exciting and commendable. But the governor still needs to address several important questions about the scope and funding of the initiative.

Mr. Engler's "Healthy Kids" proposal would subsidize the costs of basic medical care, hospitalization and prescription drugs for children under the age of 16 whose parents have neither their own nor employer-paid health coverage, but still make too much money to qualify for Medicaid. The state also would contribute to a less extensive, private child-insurance program run by Blue Cross & Blue Shield of Michigan.

money would fund the balance) within a state budget that includes a substantial structural deficit. The absence of a clear funding source derailed a less ambitious plan for child health insurance offered three years ago by former Gov. James Blanchard.

There is a sensible way not only to finance the governor's proposal but also to make its coverage truly universal, a course urged by key members of his own administration: Increase state taxes on cigarettes and other tobacco products.

Mr. Engler says he considers such a proposal merely "hypothetical." With proper political leadership — the kind of leadership the governor showed earlier this year in building the case for a state tax increase on hard liquor — it need not be.

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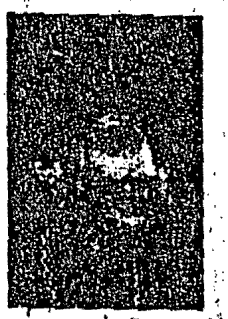
EPA chief will visit automakers, but they think she'll be a tough sell

Day 48 of the presidential term

By Bryan Gruley
NEWS WASHINGTON BUREAU

WASHINGTON — Carol Browner, chief of the Environmental Protection Agency, will be busy when she visits automakers in Detroit this month.



Browner: Sympathetic ear?

On the March 22 trip, which was announced Monday, Browner is scheduled to lunch with executives, tour a factory and check out emissions-control facilities.

Along the way, she just might hear about a few favors the Big Three would like from her and the Clinton administration.

No one in the industry is betting she'll grant them. Auto officials have been wary of Browner, a former aide to environmentally minded Vice-President Al Gore, since her nomination.

And many feel the EPA still is home to career staff members who, in the words of one auto lobbyist, "want to stick it to us."

CLINTON'S FIRST 100 DAYS

Browner will visit Detroit at the automakers' invitation. "She was eager to do it," said EPA spokesman Dave Cohen.

Browner, 37, unabashedly labels herself an environmentalist. She was Gore's legislative director when, as a senator, he was supporting bills to raise fuel-economy standards. More recently, Browner headed Florida's Department of Environmental Regulation.

Her "green" background has automakers wondering if she will advocate tougher regulations than her predecessors in the Bush and Reagan administrations.

Her trip to Detroit is consistent with the vow she made at her confirmation hearing to begin "a new era in communication between the EPA and America's business community" and end the "adversarial relationship that now exists."

She has yet to take firm positions on issues concerning the industry. But automakers got an unsettling signal last week when the EPA said it would not appeal a recent federal court ruling on vapor recovery canisters.

The court ordered automakers to install the devices, which capture the polluting gasoline fumes that escape during refueling. Under President Bush, the EPA decided not to require the canisters, partly because the car companies argued that they pose a fire hazard.

The carmakers hope EPA will stand aside while they appeal the court ruling.

They also hope to persuade the agency to:

- Avoid pushing for states to adopt California's tough anti-pollution program affecting vehicles.

More than a dozen states have adopted or are considering California's low-emissions vehicle plan. The automakers are fighting several of the efforts in the courts.

- Advocate state emissions inspection programs that don't make it too difficult or costly for car owners to have their cars tested and, if necessary, repaired. Carmakers fear consumers will blame them if the programs are too tough, and that won't help sales.

■ This article continues a daily chronicle of the first 100 days of the Clinton presidency.

Obituaries

James J. Curto, collected coins, tokens

By Louis Mioczko
THE DETROIT NEWS

James J. Curto resente[d] called a "coin collecto[r]"

"Coins [a]re money [i]n

Saturday, March 6, 1993 in the Bon S[e]cours Nursing Care Center in Pointe.

2 years, Mr. Curto was a civil with the Michigan Consoli- Co., and he retired as chief in 1968.

Grosse Pointe real- [c]ollecting coins [a]nd

News and other publications.

Born in Calumet, Mich., he earned his engineering degree at the University of Michigan in 1924 and joined the gas company in 1928.

He is survived by his wife, Lilian; a son, Fred; three grandsons and five great grandsons.

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Clinton's plan could work: U-M economists

DETROIT NEWS STAFF

The U.S. economy will grow significantly this year and the federal deficit will shrink if President Bill Clinton's plan for the economy is adopted, economists at the University of Michigan predicted Monday.

The economists also backed Clinton's call for a moderate fiscal stimulus package, cautioning that a sustained recovery will require more job creation and increased household income.

"Energized by consumer demand in the last half of 1992, the economy has shifted into higher gear," said a statement prepared by Saul Hymans, Joan Crary and Janet Wolfe, professors in the school's department of economics, to update their annual economic forecast, which was released in November.

The economy will expand by 3.2 percent this year, compared with 2.1 percent in 1992, and the deficit will shrink to $275 billion, compared with $289 billion last year, the economists said.

The forecast was based on President Clinton's program including tax relief for lower-income households, higher taxes on the wealthy and foreign corporations, a broad-based energy tax and investment tax credits, among other considerations.

With such a package, the economists said:

- The unemployment rate will decline to about 6.6 percent by the end of 1993 and under 6.5 percent by the end of 1994.
- Inflation will rise by 3.7 percent during 1993, and by 4.2 percent during 1994.
- The federal deficit will decline to $204 billion in 1994, and to under $175 billion in 1995.

Meanwhile, B. Joseph White, dean of the school's business school, said U.S. business must develop "an army" of new leaders to compete in the emerging global economy.

Speaking to the Detroit Economic Club Monday, White said that the workplace of the future will demand fewer managers, highly trained workers, and extremely high performance expectations.

White said the development of the workplace "is fueled by performance and cost requirements, growing confidence in self-managing work groups, and fast evolving information and communications technology."

UAW's Bieber vows 'vigorous fight' against NAFTA

By Richard A. Ryan
NEWS WASHINGTON BUREAU

WASHINGTON — United Auto Workers President Owen Bieber vowed Monday night to use the union's political muscle to defeat the North American Free Trade Agreement.

"I say to you tonight that this UAW will not let George Bush's NAFTA deal stand," Bieber told 1,000 delegates to the opening session of the union's annual Community Action Program Conference. "We will wage the most vigorous fight that we are capable of waging."

Bieber's vow came during an hour-long speech that was filled with praise for President Bill Clinton and Clinton's support of union goals. He failed to mention, however, that Clinton supports NAFTA and has said he will submit the agreement to Congress after completion of additional negotiations on worker safety and protection of the environment with Mexico and Canada. Those three-country negotiations begin tomorrow.

NAFTA, which creates the largest free-trade zone in the world, was signed by President Bush last December. It was ratified by the legislatures of all three countries, and is scheduled to take effect Jan. 1, 1994.

Bieber claims that the trade agreement will result in a massive migration of U.S. jobs, particularly in the automobile industry, to Mexico.

Enactment of a national health care plan to cover all Americans is another top UAW priority, Bieber said. He also suggested a value-added tax as one way of paying for it.

Raising taxes, Bieber said, "is not something you would have heard from someone in the labor movement" a few years ago.

Bieber also warned the Big Three automakers that efforts to cut medical benefits for UAW members in contract negotiations later this year "could lead to a strike" in the fall. The three-year contract expires Sept. 14.

"This union will not surrender the employer-paid health care benefits we have fought so hard to win and to protect," he said as the UAW members leaped to their feet in a rousing cheer.

Clinton Presidential Records
Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Divider Title: 19

STATE OF MICHIGAN
OFFICE OF THE GOVERNOR
LANSING

JOHN ENGLER
GOVERNOR

March 19, 1993

Mrs. Hillary Rodham Clinton
First Lady
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

By way of this letter, I welcome you to the great State of Michigan and offer my best wishes for success as you seek insight into the problems and possibilities for reform of our nation's health-care system. I believe you will find that Michigan is a microcosm of the health-care challenges we confront across the country. I regret that I am unable to attend your hearing, and I thank you for this opportunity to convey my personal observations and recommendations for reform.

The problems confronting health care are obvious: Costs are too high, access is too limited, and performance is poor. The cost of health care is now the number one budget concern of families, businesses, and government at all levels. Michigan's largest employer, the automobile industry, spends over $1,000 per car on employee health care -- more than it does for steel. One quarter of our state general revenues is spent on health care, and double-digit inflation has been the norm for nearly 30 years.

Coverage for Michigan's citizens compares favorably with the nation as a whole. Only 9% of our citizens are uninsured, while up to 18% of all Americans are without coverage. Michigan's Medicaid program is also the most generous among the United States, offering coverage for virtually every optional service permitted by the federal government. Just recently, I proposed to further expand coverage for over 80,000 poor and near-poor children through my "Healthy Kids" initiative. Unfortunately, Michigan still has hundreds of thousands of citizens who lack even the most basic coverage.

Perhaps the greatest challenge we face is to improve performance. Michigan's infant mortality rate, while improving, is still unacceptably high, with rates in the inner city of Detroit exceeding those of many third world countries. Even though we have provided free, Michigan-made DTP vaccines to all of our children for nearly 40 years, immunization rates for young children, ages 0-2 years, in some areas are still only 30%. Worst of all, Michigan ranks "dead last" among states in excess deaths due to chronic disease.

For these reasons and more, I believe it is time for reform. I further believe that providing universal access for all citizens is not only a moral imperative, but a necessary pre-condition to controlling costs.

The Michigan Leaders' Health Care Group, which I co-chair with Harold Poling, CEO of Ford Motor Corporation, and which consists of a partnership of business, labor, government, and health-care providers, has adopted a series of principles for national reform that I recommend to you as the policy compass for your deliberations. These principles have been provided to the Task Force under separate cover. In addition, I have endorsed the December 15, 1992, statement produced by the National Governors' Association, as well as several other business and governmental organizations, that defines the respective roles of states and the federal government.

I recommend support for the reform framework known as "managed competition" as it has been articulated by Alain Enthoven and the so-called Jackson Hole Group. This plan calls for universal coverage with a federally established standard benefit package that is community rated and provided primarily through employers. Health care would be provided by vertically integrated provider organizations, similar to the most advanced HMOs, that are accountable for delivering all of the benefits defined by the standard package under one roof. Payments for services would be "bundled" or capitated, and providers would share risk. The purchasing power of multiple employers would be consolidated into "purchasing cooperatives," thereby leveling the playing field between provider and payer, and eliminating the third-party middle man. A unique and cost-saving feature of the plan is its potential to merge health coverage currently provided through multiple insurance sources, including auto, health, and workers' compensation, into one plan.

I understand that the Task Force is advocating "managed competition"; however, reports indicate that a greater emphasis is being placed on "management" than on "competition." Managed competition must <u>not</u> be reduced to a buzzword. True managed competition does <u>not</u> entail global budgets, limits on capital investments in technology, or price controls because it restructures the fundamental relationship between payers and providers of health care to eliminate the need for such heavy-handed governmental regulation.

Paying a single price for a defined set of benefits on a per-person basis and putting providers at risk for excess costs removes incentives to overuse services by transforming profit centers into cost centers. Amassing the purchasing power of multiple small employers and individuals will equalize the relationship between historically powerful providers and weak purchasers. One result of this new relationship will likely be a consolidation of the health-care insurance industry and a reduction in administrative overhead costs that currently approach 25%. Community rating will prevent the "cream skimming" and risk avoidance that currently plagues the health-insurance industry.

I am especially concerned that the Task Force may be considering price controls in its desire for short-term cost containment. As you know, total health-care costs are the product of price and volume. Price controls will not contain costs unless concurrent controls over service volume, i.e., rationing, is instituted. I would strongly recommend against any efforts to ration care because it will result in pitting one part of society against another. Neither price fixing nor service rationing are necessary if the Task Force sticks to the basic tenets of managed competition.

There are two key federal law changes that are necessary to make managed competition work: First, it is necessary to permit waivers of the federal ERISA pre-emption law for state plans so that all employers may be brought into a purchasing cooperative, and, second, it will be necessary to amend federal anti-trust laws to permit the vertical integration of physician- and hospital-based services into accountable health plans. I strongly recommend these essential changes in federal law.

Finally, as a governor, I am concerned that all states be granted the tools and flexibility to serve as true "laboratories of democracy" in the reform effort. Specifically, I encourage you to remain modest in setting a standard benefit package so that states may supplement according to their needs; I discourage any recommendation to cap entitlement programs like Medicaid because such action would result in unacceptable cost shifts to the private sector; and I support providing states with the flexibility to incorporate Medicare into comprehensive health plans.

I wish to draw your particular attention to the impact that Medicaid reform may have on state mental health systems like Michigan's, which utilize community-based waivers to provide personal care services to thousands of mentally ill and developmentally disabled persons. Over $400 million worth of care is provided to mentally ill and developmentally disabled persons under the current Medicaid program in Michigan, and I urge that this care <u>not</u> be disrupted by changes in Medicaid.

Thank you for this opportunity to express my views to you and the Task Force on this most important matter. I look forward to your May 4 recommendations and the ensuing debate over national health care reform.

Sincerely,

John Engler
Governor

JE/DLS/jlf