



ECONOMIC DIRECTIONS

A Publication of Saint Vincent College's Alex G. McKenna Economic Education Series

CENTER FOR ECONOMIC AND POLICY EDUCATION, SAINT VINCENT COLLEGE, LATROBE, PENNSYLVANIA

VOLUME 3 NUMBER 1 DECEMBER 1992



"President-elect Clinton seems to have endorsed a plan that sounds like play or pay . . . I have already noted what I see as the serious disadvantages of this approach from the standpoint of both efficiency and equity."

(The following is a transcript of a lecture delivered by Dr. Patricia M. Danzon, Celia Moh Professor of Health Care Systems, Insurance and Risk Management at the Wharton School, University of Pennsylvania, at Saint Vincent College, Latrobe, Pennsylvania, on September 30, 1992. The lecture was the first presentation in the 1992-1993 Alex G. McKenna Economic Education Series of lectures on election year topics.)

© 1992

For the first time in over a decade, health care is a major issue on the policy agenda. This presents a unique opportunity to improve substantially the efficiency and the equity of our health care system. But as the proposals multiply and become increasingly long on rhetoric and short on substance, there is a real risk that this opportunity will be missed and matters made perhaps worse. The focus tends to be on fixing the symptoms rather than addressing the underlying problems. The dilemma is that as the electorate becomes sufficiently concerned about health care, it becomes too hot politically for politicians to face up to the really tough choices.

Tonight, I plan to provide an overview of the three main approaches to achieving universal health coverage: a universal public program, an employer mandate or "play or pay", and an individual choice approach with tax credits. Before turning to these reform options, I shall first review what is wrong with the status quo, to identify the real problems that the proposed alternatives are intended to address.

The Status Quo

The symptoms that have given rise to current concern for health care reform can be summarized briefly: cost and access. Health care costs have risen more rapidly

than GNP over the last two decades. Health care was about 6% of the GNP in the 1960s; it is now 13% and projected to rise persistently under current trends. Other countries appear to be more successful at controlling health care costs. The next highest to the U.S. are Canada and Sweden. They now spend about 10% of GNP on health care and are holding steady. It is important to note, however, that spending 13% of GNP on health is not necessarily bad, if we are getting value for our money. If we get more value from spending on health care than we would from other goods and services, so be it; let it be 13%, 15% or whatever. The more

valid concern — and one that is troubling people increasingly — is that we may be spending millions of dollars on services that are of very low benefit, if any. That is the cost issue that we should be addressing, not the percentage of GNP. High spending is not a concern if the value of the benefits received is at least equal to the cost.

The U.S. is also unique among industrialized countries in having a significant fraction of the population without formal health insurance. Exact numbers vary depending on the survey, but roughly 15% of the population (or anywhere from 31 to 37 million people) lack formal insurance and a significant additional percentage fear losing their health insurance if they lose their job. The concern is that, if one has to buy coverage in the individual (non-group) insurance market, coverage may be either unavailable, limited by exclusions on pre-existing conditions or available only at very high cost. Coverage for small firms and individuals is significantly more costly than coverage through large group plans, because of diseconomies of small scale and other factors I shall discuss later.

Thus the problems of rising costs and gaps in coverage appear to be more severe in the U.S. than in other countries. The U.S. also relies more on competitive private markets to deliver health insurance. Other countries rely on public or quasi-public health insurance. Some people therefore conclude that high costs and incomplete coverage are an inevitable consequence of



ECONOMIC DIRECTIONS

A Publication of Saint Vincent College's
Alex G. McKenna Economic Education Series.

CO-EDITORS

Dr. Gary M. Quinlivan
Associate Professor of Economics

Mr. Lee J. Weissert
Instructor in Economics

ASSISTANTS TO THE EDITORS

Mr. Robert C. Baldini, C '93
Mr. Christopher M. Berdnik, C '93

STAFF

Mr. Raymond M. Hrin, C '93
Mr. John R. Gierl, C '93
Ms. Jennifer A. Klimko, C '94
Mr. Joseph D. Ward, C '95
Ms. Kristen L. Sagath, C '95
Mr. Maxwell S. Bulk, C '95
Mr. Gregory E. Loya, C '95
Mr. Philip J. McGivney, C '93
Mr. Grant R. Gulibon, C '94



WELCOME — Greeting Dr. Danzon (second from right) to Saint Vincent College were Robert Mazero, M.D., (left) Medical Director at Latrobe Area Hospital; Andrew Stofan, (second from left) president of the Latrobe Area Chamber of Commerce, who introduced the speaker; and Dr. Gary M. Quinlivan, (right) director of the Alex G. McKenna Economic Education Series, director of the Center for Economic and Policy Education, and Associate Professor of Economics at Saint Vincent College.

competitive private insurance markets. But correlation does not imply causation. With appropriate public backup to assure that coverage is universal and affordable, competitive private insurance markets can work well and exert the beneficial forces of competition to improve efficiency in the delivery of health insurance and medical care. But our present policies are not designed to assure that coverage is universal and affordable. On the contrary, public policies are often perverse and contribute to the problems with the status quo.

Perverse Public Policies

Let us examine some of the major public policies that contribute to the cost and access problems. First is the tax treatment of employer contributions to health insurance. Employer contributions to health insurance are not taxable income to the employees. That is equivalent to subsidizing employer contributions at a rate equal to the employee's marginal tax rate. The average subsidy rate is at least 30% because it includes state and federal income and payroll taxes. Like any subsidy, this distorts the purchase of insurance and leads us all to buy more extensive coverage than we would if we were paying a full dollar for a dollar's worth of coverage. The result is that, because we are extensively insured, we do not act as cost conscious consumers in medical care markets. Because we pay very little out of pocket, we tend to buy more and higher quality services; we want

the latest technology even if it is only slightly superior to the older technology that costs a lot less. This tax treatment of insurance is a major factor leading to overinsurance that in turn drives the inflation of health care prices, volumes, and technology.

At the same time, this subsidy is inequitable because the magnitude of the subsidy increases with the employee's tax bracket and the amount of coverage. The rate of subsidy is as high as 50% for people in high income and tax brackets, while lower income people receive little if any subsidy because their tax rates are low. The subsidy is available only to those who get employment based coverage; it excludes people who do not work or whose employers do not offer coverage. Finally, by current estimates this tax loophole costs the federal government about \$67 billion in foregone tax revenues, which is more than enough to cover the uninsured.

A second feature of public policy that contributes to our problems is the proliferation of state mandated benefits. These mandates require insurers to provide certain costly coverages in any insurance plan that they sell. The intent of these mandated benefits may be benevolent, to assure comprehensive coverage. But studies have shown that the effect is often counterproductive because employers that might have offered a basic no-frills plan now cannot afford to offer any plan. In addition, states are increasingly adopting

anti-competitive regulations which limit the ability of insurers to adopt strategies to control costs through managed care, selectively contracting with "preferred providers" that are willing to contract at lower costs. These regulations further limit the ability of insurers to offer lower cost plans. Ironically, state mandated benefits and anti-competitive regulations increase costs most for small groups and individuals who would face relatively high costs even without the mandates. Firms that are large enough to self-insure are exempt under the federal Employee Retirement and Income Security Act (ERISA), which preempts state regulation of self-insured plans.

Third, and perhaps most fundamentally, there are no policies designed to assure that coverage is universal and affordable. Private markets alone cannot assure universal coverage or affordable coverage. We have two public programs, Medicare for the elderly and Medicaid, that cover a subset of the lower income population. But Medicaid is targeted at low income persons who are in single parent families, the aged and the disabled. It generally does not apply to two parent families and the working poor.

Major Options for Universal Coverage

There are three main approaches for achieving universal coverage: first, an employer mandate or *play or pay*, whereby employers are required to either provide coverage or contribute a payroll tax to a new public program that would cover everybody not covered through employment; second, a *monopoly public program*, based on the Canadian model or expanded Medicare, where a single government-run program would cover all citizens; and third, the *individual choice* approach, whereby individuals would be required to obtain coverage but would have a choice of whether they obtained it through employment or through other private insurance plans, with a system of tax credits to assure that coverage is affordable.

Play or Pay

Under the *play or pay* approach, employers would be required to provide coverage to all workers and their non-employed dependents or to pay a payroll tax on uncovered workers to help finance a new public program in each state for those not covered through employment. The new public program would replace Medicaid. Payroll taxes in the proposed range of 7-9% payroll would not suffice to finance the new program; additional federal taxes and premium contributions by individuals would also be required. The public program might either be publicly run like

Medicaid or the state might contract with private insurers, with the state acting as a broker or sponsor. Individuals could enroll through the public sponsor; that would offer them a choice among approved private plans. Plans would be required to enroll any applicant at controlled premium rates. Since these rates would not necessarily cover costs, the public sponsor would transfer funds or cross-subsidies among plans, based on their risk pool.

The *play or pay* proposals are usually unclear on whether individuals who did not obtain employment-based coverage would be required to purchase insurance from these new public programs, or whether that would be optional. If there is not an individual mandate then subsidies alone, if set at reasonable levels, will not assure universal coverage. We would probably have to pay everyone sub-

(DRGs). The proposals differ on whether other insurers might offer managed care plans, **capitation** arrangements, HMOs, et cetera.

Several *play or pay* plans would place a global cap on total expenditures. A cap on total expenditures nationwide would be set at the federal level and divided up among the states. Each state would then determine how to control spending to remain within its target. For example, it might allocate some fraction to be spent on physicians, hospitals, and other services; alternatively, it might make allocations among different insurance plans. Details have not been specified - which is not surprising, since there are no easy solutions.

What are the effects of *play or pay*? It attempts to build on the present system, extending employment-based coverage, which accounts for about 80% of private



CO-EDITORS — Christopher M. Berndnik, C '93, center, and Robert C. Baldini, C '93, right, who serve as assistants to the editors of *Economic Directions*, show Dr. Danzon a copy of the series publication.

sidies of almost 100% of the cost of coverage to induce the last unwilling person to buy coverage voluntarily. Paying such large subsidies to everyone is a highly inefficient means of assuring universal coverage. Thus, if we want universal coverage through something other than a universal public program, an individual mandate in addition to the employer mandate is essential under the *play or pay* approach.

Several *play or pay* proposals require the public programs to pay providers according to current Medicare reimbursement systems - paying physicians according to a regulated fee schedule and paying hospitals a fixed rate per admission

insurance at present, and it appears to have lower requirements in terms of new taxation than some of the other alternatives. But this is deceptive. Essentially, *play or pay* is financed largely by a hidden tax on labor. Employers either have to provide coverage or pay a payroll tax per worker. Who would bear this tax? Given the current situation of globally competitive markets for most goods and services, the additional tax can not be passed forward in higher prices to consumers. It can not be shifted back as a lower rate of return on capital because equity markets are also globally competitive: equity capital will not remain in the U.S. if a higher rate of return can be earned overseas. So the only

"Health care was about
6% of the GNP in the 1960s,
it is now 13% and projected
to rise consistently
under current trends."

place the tax can fall is on the newly insured workers. In the long run, workers will bear the cost of the insurance through lower wages; if wages do not fall, there will be fewer jobs. Many of the workers who are currently uninsured and who would be affected by the new mandate already earn low wages and have relatively low incomes. Surely this source of financing a new insurance program is inequitable and would attract little support if the magnitude of the costs and who pays were made explicit.

A second concern is that although an employer mandate may appear to be a minor extension of our current system, in fact it may rapidly evolve into a public monopoly system, either by default or by design. The reason is that many employers and their employees would be better off paying rather than playing, i.e. paying the payroll tax rather than providing the insurance. Recent estimates by the Urban Institute and the Rand Corporation indicate that, at a 7% payroll tax, 66 million privately insured employees would be shifted to these new public plans. The logic is simple. If you are an employer with a relatively low wage workforce or a high risk workforce, it would cost more than 7% of payroll to provide insurance. You and your workers would be better off paying a 7% payroll tax. Conversely, for an employer with a high wage workforce or a relatively young healthy workforce, providing coverage for that workforce may cost less than 7% of payroll, in which case you would play rather than pay. The likelihood is that firms that have a relatively large share of low-wage workers, older workers, or high risk workers and small firms would tend not to play - they would put their workers in the new public plan.

This shifting of millions of employees from their current private coverage to new public programs could be avoided by raising the payroll tax rate. At a higher payroll tax rate, it is more advantageous for more employers to provide insurance rather than to assign their workers and pay the tax. But the higher the tax rate, the greater

the costs that must be borne by workers, either through lower wages or loss of jobs.

Most *play or pay* plans make no change in the tax treatment of employer contributions. They leave in place the current regressive tax subsidy to employer contributions which, as I argued earlier, stimulates demand for insurance that in return stimulates inflation of medical costs. *Play or pay* plans would control expenditures through arbitrary caps on total expenditures. These are arbitrary limits on supply that do not address the demand for medical care that is the underlying force driving cost inflation. Arbitrary expenditure limits are not designed to achieve an efficient level of expenditure on health care - the level of spending at which marginal value is equal to marginal cost.

In addition, *play or pay* is horizontally inequitable - the amount of subsidy that any family would receive would differ, depending on whether they got their insurance through their employer or through the new public program. Once this inequity became apparent, it is an additional reason why *play or pay* is likely to evolve into a universal public program.

With all these disadvantages of *play or pay*, what are its advantages? The overwhelming political appeal is that the costs are largely off-budget. By that I mean that a large share of the financing comes about through the extra contributions that are mandated, that employers contribute but that must ultimately come out of workers' wages. The cost of this mandate and who ultimately pays for it is not explicit or clearly visible to voters. So it is politically much easier to mandate that employers *play or pay* than to explicitly legislate new federal taxes as would be required under other options that are more open about their financing mechanisms.

The Canadian Model

We turn next to the single payer plans. There are two main variants, a pure *Canadian model* and a variant that extends the current *Medicare system to all citizens*. The *Canadian model* is a single public program that would replace all other private and public insurance, including Medicare and Medicaid. Although insurance would be a public monopoly, the provision of services would remain private or quasi-private. Physicians would remain independent contractors. But they would be paid by a single public buyer according to a government-set fee schedule. In Canada, control of the fees schedule, with increases less than the rate of inflation, is the main mechanism for controlling costs. There would be no co-payment; physicians would not be allowed to bill above the fee schedule; and there would be global caps on total spending on physician services.

Hospitals would be paid according to global budgets - each hospital would be assigned an annual budget to cover their operating expenses. Capital expenditures would be totally controlled by the states. No private insurance would be permitted, except for services that are not covered by the public program.

The advantages claimed by proponents of this approach are its simplicity and that it would have much lower administrative costs. Simple accounting numbers suggest that overhead costs in the *Canadian model* are about 1% of total spending; whereas, overhead costs are about 12% of spending for private insurance in the U.S. Proponents of this approach claim that we could save over \$70 billion in administrative expense, which would more than suffice to cover the uninsured. I am skeptical. My research leads me to the conclusion that these accounting numbers are very misleading and are totally uninformative about the real efficiency of a health care system. There are very big hidden costs in a *Canadian* approach. Let me comment on those that are most important.

Physicians have responded to the tight control of their fees per visit by cutting back on the services that they provide on the average visit and by increasing the number of visits. Patients have to make more visits to get the same amount of services. The result is additional patient time spent in travel and waiting in the physician's office. These additional patient time costs are a real resource cost of the health system that does not show up in Canadian accounting statements of administrative cost or health care spending. By contrast in the U.S., private insurers control cost and utilization through co-payments, managed care, and capitation arrangements with physicians - all of which entail administrative expense that shows up in accounting statements. But these mechanisms prevent the distortions and waste of patients' time that results

About the Series

The Alex G. McKenna Economic Education Series is presented by the Center for Economic and Policy Education at Saint Vincent College. These periodic lectures are open to the general public and their purpose is to explore the role of free markets in solving many of the social problems confronting the United States and the world today. Dr. Gary M. Quinlivan, associate professor of economics at Saint Vincent, directs the series.

The Alex G. McKenna Economic Education Series is made possible by a grant from the Philip M. McKenna Foundation Inc. of Latrobe, Pennsylvania.

under a Canadian-style system that forgoes patient co-payments, managed care, utilization review, and physician-targeted incentive systems to control costs. The waste of patients' time in Canada is not as extreme as in Japan, which also uses a very tight fee schedule but does not use managed care or other information-based strategies for controlling cost. The average length of a physician visit in Japan is five minutes and the average Japanese makes 12 visits to the physician per year. In the U.S., on average, we make four visits and the average visit length is 15 to 20 minutes. The amount of physician contact is the same, but the cost of patients' time is severalfold higher if multiple trips are required. This is a waste of patients' time. Quality of care probably also suffers but this is much harder to measure.

On the hospital side, the Canadian approach to controlling cost is global annual budgets for hospitals and tight controls on new capital acquisition. Global budgets do achieve the superficial goal of controlling total spending. But they do not control total real resource cost or assure that the maximum value is obtained from the resources spent. Global budgets provide no incentive for hospitals to produce the maximum output for the given budget. On the contrary, a hospital that makes more effort to increase the number of patients treated or to provide higher quality care simply attracts more patients, incurs more hassle, more work, and receives no additional revenue. Partly because there is little incentive to use beds efficiently, in Canada the average length of hospital stay is much longer than in the U.S. but there are long waits for most elective procedures. The safety valve in Canada is that people come down to the U.S. The queues are not yet as bad in Canada as in other countries such as the U.K. that place arbitrary limits on total hospital spending. My point is that this method of controlling costs incurs lower visible administrative cost. But it generates hidden costs in the form of lost productivity, pain and suffering, discomfort, etc., that people incur because they are not able to get prompt access to medical care.

Another hidden cost in the *Canadian model* results from the lack of choice. Eliminating choice saves administrative cost. Under a public monopoly system, there is no marketing and people do not spend time evaluating alternatives because there are none. But if the public monopoly does not offer citizens the form of health insurance or health care that they would prefer and be willing to pay for, that is a real loss of potential well-being.

A final hidden cost of the Canadian approach is the productivity cost of tax-based financing. The overhead figures reported reflect only the costs of collecting

the tax revenue. This does not measure the full resource costs of raising taxes, which includes the losses in productivity that result when people change their behavior to avoid the taxed activities. Studies done in the U.S. to estimate the real costs of raising tax revenue show that, for every dollar that is raised in tax revenue, there is a loss of between 17 cents and 50 cents in foregone productivity because people adjust their behavior in ways that are inefficient, in order to avoid taxed activities. These hidden costs of taxation are a real cost of a tax-financed system of health insurance.

Making adjustments for these hidden costs of patient time, foregone productivity and real costs of taxation, my estimates indicate that the true overhead costs of the Canadian system are in fact higher than the overhead costs of private insurance in the U.S.

Medicare For All

The second approach to a single payer model, *Medicare for all*, is much more complex. Like our current Medicare system, it would include co-payments; it would permit people to opt out into HMOs, or to purchase supplementary Medigap insurance to cover the co-payments. This approach would offer consumers somewhat more choice than the Canadian approach. But it still relies primarily on a public monopoly insurance mechanism financed by taxes. There is no evidence that government is efficient at running insurance programs. Indeed, it is ironic that these proposals to extend Medicare to the entire population should emerge at the same time that the more limited current Medicare program is trying to persuade its beneficiaries to opt out into privately run HMOs and other plans that are more effective at controlling costs. If in fact most people would opt out into private plans or purchase supplementary private insurance under a *Medicare for all* plan, it would be far more efficient to permit them to enroll directly in private plans of their choice.

Individual Choice with Tax Credits

This brings us to the third option. Here I should reveal my biases, since I am a co-author on one of these plans, together with Mark Pauly, John Hoff and Paul Feldstein. Our plan, which we call *Responsible National Health Insurance*, has been adopted by the American Enterprise Institute. A similar plan has been developed by the Heritage Foundation. The basic idea is simple. Everyone would be required to obtain coverage. They could get coverage through employment, through other groups, or purchase it individually. Thus there would be no employer mandate: the

mandate would be placed on individuals, not on employers. This avoids the tax on labor and distortion of labor markets.

In order to make coverage affordable, there would be a system of refundable tax credits. If the amount of tax that you owe is less than the credit that is due to you, you would either get a cash refund or a voucher to be used to obtain health insurance. These tax credits would be based on income, with larger credits going to lower income people; the credits would be phased out for upper income people. This system of tax credits would replace the current tax exclusion for employer contributions. It would also differ from the current system in that the amount of tax credit would be fixed, not open ended. The tax subsidy you receive would not increase, the more generous the insurance plan you buy. It would be neutral by source of insurance, not confined to those who get insurance through employment.

This approach would require no major new public programs. People would obtain insurance through private insurance plans. We propose that each state would contract, by competitive bid, with at least one private insurer to act as a fallback insurer with which people would be enrolled if they do not arrange other coverage.

The implementation of this approach would require no new bureaucracies. For the majority of the population who file tax returns, enforcement would be through the IRS. When you filed your tax return, you would simply have to provide evidence that you had coverage and your credit would be based on your income. Of the people who do not file tax returns, most would be enrolled through existing welfare agencies. The small number of individuals who neither pay taxes or receive welfare would be enrolled in the fallback insurer by medical providers when they sought care, just as many providers now seek to enroll those without insurance in Medicaid.

The required coverage would be basic medical benefits with catastrophic financial protection. The maximum out of pocket cost that a family could face would depend on their income. People could buy additional supplementary coverage beyond the required basic benefits, if they so wished, but without additional tax subsidies.

This approach has advantages in both efficiency and equity, relative to either *play or pay* or a single payer approach. Our proposal would achieve universal coverage with no new taxes. Indeed, a reasonable set of credits could be financed simply by closing the existing tax loophole for employer contributions since, as previously mentioned, this entails foregone tax

revenues of over \$60 billion. Our tax credit approach has a more equitable distribution of the costs than either the status quo or *play or pay*. Under our plan, higher income people would pay more and lower income people would receive larger insurance subsidies, whereas *play or pay* leaves intact the current regressive tax treatment of employer contributions, which offers larger subsidies, the higher your tax bracket and the more insurance you get. Placing the mandate on individuals rather than employers avoids distortions in labor markets and loss of jobs. Individuals would remain free to obtain their coverage through employment and we anticipate that the great majority would continue to do so since employment-based coverage through large firms has real cost savings. But we expect that other insurance groups would develop and that the individual insurance market would function more efficiently and at lower cost. These improvements would occur because the requirement that everyone obtains coverage eliminates the adverse selection risk currently faced by insurers in the individual market. Further cost savings would occur because our plan would eliminate the state mandated benefits, the restrictions on selective contracting and the like. The individual choice approach would not place arbitrary limits on health care expenditures. Spending would be determined by consumer preferences. But we anticipate that cost inflation would moderate because the open-ended subsidy to buying more generous coverage would be eliminated. Once people face the full cost of coverage at the margin, they will be more cost conscious in their choice of health plan and more likely to choose plans that control spending and offer lower premiums. If people are paying a dollar on a dollar for more generous coverage, if they want to spend more, so

be it. Thus this approach would rely on competition among insurance plans, in a market of cost-conscious consumers, to control costs. There is accumulating evidence that competition stimulates insurers to be increasingly innovative in designing systems to control costs through various managed care strategies.

This approach leaves the maximum possible choice for consumers, within the constraint of universal coverage. A final advantage - at least in our opinion - is political transparency: this approach makes explicit what is being subsidized by whom and by how much. Our hope is that this would lead to more rational decision-making and more efficient and equitable decisions.

Clinton's Plan

President-elect Clinton seems to have endorsed a plan that sounds like *play or pay*, although he has not explicitly committed to an employer mandate or *play or pay*. But the description, at least as it appeared in a recent *New England Journal* article, seems to be *play or pay* with new public programs in every state and global expenditure caps. I have already noted what I see as the serious disadvantages of this approach from the standpoint of both efficiency and equity.

Center Announcements

Upcoming Alex G. McKenna lecturers include Dr. Richard B. McKenzie of the University of California, Irvine (February 17, 1993, "Reality is Tricky: Exorbitant Claims that Misguided Public Policy During the Last Decade") and Dr. Rachel McCulloch of Brandeis University (April 28, 1993, "Foreign Investment in the United States: Source of Strength or Sign of Weakness?").

Congratulations to Dr. Gary Becker, the 1992 Nobel Laureate in Economics. Dr. Becker was our first Alex G. McKenna Economic Education Series lecturer (September 16, 1986, "Pressure Groups and Political Power").

On April 14, 1993, the Center will host an all day conference entitled: "Economics in a Cultural Context: Selected Topics on Social Institutions and Economic Development." Participants include Dr. Dwight R. Lee, University of Georgia; Dr. S. Robert Lichter, Co-Director of the Center for Media and Public Affairs in Washington D.C.; George Weigel, the President of the Ethics and Public Policy Center in Washington D.C.; Dr. Don Lavoie, George Mason University; Dr. Peter L. Berger, Director of the Institute for the Study of Economic Culture at Boston University; and Dr. Brigitte M. L. Berger, Boston University. The keynote speaker will be Dr. Thomas Sowell, Senior Fellow of Hoover Institution, Stanford University.

Congratulations to 1991-92 Economic Directions staff members Mr. Michael J. Kozy, now a Ph.D. Economics student at Boston College, Ms. Linda Wirfel, Ph.D. Economics student at Notre Dame, Mr. Dennis J. Yanan, Ph.D. History student at Temple University, and Mr. James E. McBride who was accepted at the Duquesne School of Law.

Saint Vincent College subscribes to a policy of equal opportunity. Saint Vincent complies with the 1964 Civil Rights Act, Title IX of the Educational Amendment of 1972, the IRS Anti-Bias regulation, and Section 504 of the Rehabilitation Act of 1973. In so doing, Saint Vincent does not discriminate against any individual on the basis of race, color, sex, religion, ethnic origin, or handicap in any of its programs, activities, or employment decisions. The Director of Personnel, Saint Vincent College, Latrobe, Pennsylvania 15650-2690 is the college officer with responsibility for overseeing the implementation of this equal opportunity policy and the affirmative action plan.



**ECONOMIC
DIRECTIONS**

Saint Vincent College
Latrobe, Pennsylvania 15650-2690

Non Profit Organization
U.S. POSTAGE PAID
Latrobe, PA 15650-2690
Permit No. 110

On Our Mailing List?

If you would like your name to be added to the mailing list for the Alex G. McKenna Economic Education Series Lecture and the Economic Directions newsletter, please send your name and address to:

Dr. Gary M. Quinlivan,
Center for Economic and Policy
Education, Saint Vincent College,
Latrobe, Pennsylvania 15650-2690.