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1999-0118-F

FOIA Number:
1999-0118-F

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Health Care Reform Endorsements

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HERITAGE TALKING POINTS

A Checklist on Vital National Issues

A POLICY MAKER'S GUIDE TO THE HEALTH CARE CRISIS

PART II: THE HERITAGE CONSUMER CHOICE HEALTH PLAN

By Stuart M. Butler, Ph.D.

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The Heritage Foundation
214 Massachusetts Avenue, N.E.
Washington, D.C. 20002-4999
U.S.A.
202/546-4400

March 5, 1992

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By Stuart M. Butler, Ph.D.

INTRODUCTION

Part I of this *Talking Points* series on health care explained that proposals to reform America's health care system generally are based on one of three approaches. Each approach uses a different mechanism to allocate health care resources and to determine what services a family receives. These three methods are:

1) The Single-Payer (or "Canadian") Approach. The government becomes the monopoly provider of health care financing. It fixes a budget for health care and allocates money to hospitals, and it sets physician fees.

2) The "Play or Pay" Approach. The government gives employers a choice: either provide at least a specified health insurance plan to employees and their families, or pay a payroll tax to finance a public program for their health benefits, as well as for those Americans not currently insured. The government runs the public program and employers are responsible for financing and managing private insurance.

3) The Consumer Choice Approach. Americans are allowed to choose the health care plan they want. Unlike today, where government help to obtain a plan effectively is restricted to employer-sponsored plans, families would receive the same amount of government help wherever they obtained coverage. Further, there would be more help for the sick and the low-paid, less for the healthy and the high-paid. No national budget for health care would be set by the government, and efficient allocation and cost control would be determined by consumer choice and competition among providers.

Many of the key features of a consumer-based system already exist in the Federal Employee Health Benefits Program (FEHBP). This covers congressmen and their staff, agency heads and employees, and judicial branch employees—in all over nine million workers, their dependents, and retirees. Several proposals are versions of a consumer-based system. The Bush Administration's recent health proposal would establish such a system for today's uninsured.

A comprehensive proposal has been introduced in the Senate (S. 2095) by Steve Symms and Larry Craig, both Idaho Republicans, and elements of a consumer-choice model are included in a bill (S. 1936) introduced by Senator John Chafee, the Rhode Island Republican.

In addition, The Heritage Consumer Choice Health Plan has been developed by The Heritage Foundation.[1]

This *Talking Points* examines the Heritage plan in detail. It reviews the plan's features and implications. It also contains the findings of an analysis of the Heritage plan by Lewin/ICF, a leading Washington-based econometric firm specializing in health economics. The Lewin/ICF study was commissioned by Heritage. Lewin/ICF conducts similar analyses for the Administration, Congress, and the private sector.

HOW THE HERITAGE CONSUMER CHOICE HEALTH PLAN WORKS

The Heritage plan would create a health care system in America in which all families would have access to an affordable health plan and would choose the plan they wanted. Today a family normally must change its plan, or even lose coverage, when the head of household changes jobs or faces unemployment. Under the Heritage proposal, the family would keep the same insurance without interruption when changing jobs—much as families keep the same life insurance, car insurance, homeowner's insurance or mortgage. In addition, the tax code would be changed to give more help to lower-paid or sick families to afford health care. This change would not increase the federal deficit.

Reduced to its central elements, the Heritage plan involves two principal steps:

Step #1: Convert the tax exclusion for company-sponsored plans into a tax credit for plans from any source.

When a family is covered by an employer-sponsored health plan as part of the breadwinner's total compensation, the value of the benefits is not included in the family's taxable income. This is like a tax deduction for the family.[2] This is known as a "tax exclusion." For the vast majority of Americans, this is the only

1 See Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989); Stuart M. Butler, "Using Tax Credits to Create an Affordable Health System," Heritage Foundation *Backgrounder* No. 777, July 20, 1990; Stuart M. Butler, "A Tax Reform Strategy to Deal With the Uninsured," *The Journal of the American Medical Association*, Volume 265, May 15, 1991.

2 It is actually more generous than a tax deduction for lower-paid families and many middle-income families, because Social Security taxes are not applied. Tax deductions by contrast are free of income tax, but not of Social Security taxes.

way they can obtain a tax break for health care costs (for the implications of this, see *Talking Points, Part I: The Debate Over Reform*, February 12, 1992).[3]

Under the Heritage plan, the current exclusion for company-provided plans, as well as other minor health tax deductions, would be replaced with a new tax credit available to all non-elderly and non-Medicaid families for the purchase of health insurance and out-of-pocket medical costs. The cost to the Treasury for the credit would exactly equal the cost of current tax breaks. In Washington jargon, this makes the plan "budget neutral."

Q: What does that mean for employees who have a company plan? Would they pay higher taxes?

A: Generally no. It just means families would gain tax relief in a different way. If they had a company-sponsored plan, the cash value of that plan now would appear as a taxable item on their end-of-year W-2 tax form from the employer. But the family then would be able to claim a credit for the cost of employer-sponsored plan and for out-of-pocket costs, such as deductibles. Further, if the family chose a plan from a source other than their employer, the employer would be required to "cash out" their current benefits by adding the value of those benefits to the worker's paycheck. As described below, the Lewin/ICF analysis of the proposal indicates that most families would pay slightly lower total taxes after this switch. And while some families would pay higher taxes, it would be because they had found ways to cut their medical insurance costs and thus gained more (taxable) income for other purposes.

Q: What about families without a company plan?

A: They would receive a credit for buying insurance and out-of-pocket medical care. Today these families normally receive no tax help or any other assistance, unless they go on welfare.

Q: What about the working poor, who pay little or no tax?

A: The new credit would be refundable. This means that if the family's credit exceeded its tax liability, it would receive the difference from the government, in the form of a voucher that could be used only for health care.

3 Three smaller tax breaks are available for some Americans. The self-employed can deduct 25 percent of the cost of insurance. Americans with high out-of-pocket medical costs can deduct the amount in excess of 7.5 percent of their adjusted gross income if they itemize their tax return. And low-income working Americans can obtain a credit for certain insurance to cover their children, through the earned income tax credit (EITC).

Step #2: Require all households to purchase at least a basic package of insurance, unless they are covered by Medicaid, Medicare, or other government health programs.

All heads of households would be required by law to obtain at least a basic health plan specified by Congress. The refundable credit system partially would offset the cost of such a plan for most Americans, as the exclusion does today for those with company-sponsored plans.

In addition to these core steps, the Heritage plan would institute reforms to smooth the transition to the consumer-based national system and to enable the market for health insurance and medical care to operate more effectively. Among these, the plan would:

✘ **Reform the insurance market:** The private insurance market would be reformed to make a standard basic package available to all at an acceptable price (see below).

✘ **End state insurance mandates:** Most states mandate that insurance sold within their borders must cover certain services. These mandates would in effect be preempted, to allow the basic plan to be marketed throughout the United States and to permit new types of group sponsors to sell plans. In addition, plans could not be made subject to state restrictions on managed care. These state mandates could be preempted by federal law, as they are for the Federal Employee Health Benefits Program. Or the federal government could widen current exemptions from state mandates for self-insured company plans to include any plan that complies with the insurance requirements of the Heritage proposal.[4]

✘ **Place requirements on employers:** In a system based on the Heritage proposal, employers would be required by law to do two things:

1) **"Cash out" benefits during a one-year transition period.** Employers would have to add the cash value of their existing plan to the paychecks of any employee wishing to switch to an alternative plan or if the employer decided to terminate the plan. This means employees would be what economists call "held harmless" by the change. After

4 Heritage analysts believe that today's concerns about state mandates actually would decline or even disappear in a full-scale consumer based system. The reason is that voters would have a strong incentive to resist new insurance mandates since these would translate directly into higher insurance premiums they would pay. Today the higher costs due to mandates are buried in "free" company plans. Significantly Congress, which could mandate services in the federal employee system, chooses not to do so in large part because employees would face higher premiums if there were congressional mandates. See Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.

the transition, employers and employees would bargain for compensation packages as they do today.

2) **Introduce a payroll deduction for health insurance and adjust withholdings.** Employers would be required to make a payroll deduction each pay period, at the direction of each employee, and send the amount to the plan of the employee's choice. This would be like the payroll deduction that many employees instruct their employers to make for contributions to a 401(k) or similar savings plan. In the federal employee health system, a worker's agency or congressional office makes a similar payroll deduction to pay for premium costs.

Employers also would be required to adjust the employee's withholdings to reflect their estimated health credit, just as they do now when, say, an employee buys a house and becomes eligible for the mortgage deduction. This means that employees would not have to wait until the end of the year to claim the credit.

Q: What about a low-paid worker who does not have taxes withheld?

A: Actually even the low-paid normally have Social Security taxes withheld. In any case the employer would estimate the refundable credit available to the employee and send this, plus any contribution by the employee, to the employee's chosen plan. The employer would adjust the total withholdings sent to the IRS to reflect refundable credits for any employees.

Q: What about the unemployed?

A: If an individual became unemployed, normally he or she would become eligible for a larger credit, since family income would fall. For the unemployed, the government would send the value of the credit to the individual's plan. In addition, the unemployment check could be adjusted to reflect the contribution, if any, due to the plan by the individual. Further, since the paperwork for this change in the payment method would take time, health plans would not be permitted to drop coverage if a working family became unemployed. When the paperwork is complete, the plan would receive premium payments due during the interval.

ADVANTAGES OF THE HERITAGE PLAN

A consumer-based plan would have profound and beneficial effects on America's health care system. Among the most important:

✓ **Every American family would have access to affordable and adequate health care.**

Under the Heritage plan, all Americans—most important, all Americans now uninsured—would be enrolled in a health plan or covered by a public program (chiefly Medicaid or Medicare programs).

✓ Americans no longer would lose coverage when then they changed jobs.

American families would be able to obtain health coverage from any source, not just their employers, with exactly the same tax benefits. This means health insurance would be "portable." So when a worker changed jobs, he or she would take the family's health plan to the next job, just as they normally keep the same life insurance protection or mortgage company. For this reason, worries about "pre-existing condition" clauses in a new employer's plan would disappear, and families would keep the same doctor and benefits of their chosen plan.

✓ Americans could choose new kinds of group plans.

The fact that individuals will buy health plans does not mean that individuals must buy the kind of individual coverage typically sold today. Individual plans today tend to be more expensive for a number of reasons. Their administrative and marketing costs, for instance, are high because the insurer has to collect premiums from each individual. Group plans, such as those run by employers, cost less because the insurer is dealing in "bulk" and can negotiate with medical institutions.

Under the Heritage proposal, families could still gain the financial advantages of group purchasing. They could still join groups structured around their employer. More important, families could join plans organized by other groups and still receive tax benefits. Today, of course, if families are not part of an employer group plan, typically the families enjoy no tax benefits. Several new types of group probably would emerge. Among them:

Unions

Under the federal employee system, 35.5 percent of enrollees are covered in plans organized by a union or other employee organization. In many instances, these union plans are open to non-union members.[5] Sometimes the union health plan is much larger than the union itself. There are about 500,000 members of the Mail Handlers Plan, for instance, but only about 30,000 regular members of the union.

Union-sponsored plans likely would become a growth industry under the Heritage proposal. They would possess a marketing advantage because many workers would trust a union-sponsored plan rather than one from most other sources, particularly one promoted by management. Unions might also see a health plan as a good recruiting tool for attracting individuals as regular members. Further, many unions already have expert health benefits negotiators who could easily become the administrators of the union's own plan.

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5 Technically, enrollees pay a small fee to become associate members of the union for the purposes of coverage, but are in no sense regular union members.

Churches

In many communities the church easily could sponsor a group health plan. This is especially true in the black community, where typically the church already functions as a social and economic development agency. Similarly, the Church of Jesus Christ of Latter Day Saints (that is, the Mormon church) carries out a sophisticated social welfare function for its members. Sponsoring a health plan for members would be a natural development.

Farm bureaus

Some state farm bureaus, such as Virginia's, already have a health plan for farm-based families. But often families receive limited or no tax breaks for joining such plans. With the Heritage proposal as law, farm bureaus and similar organizations would have a natural market niche in rural areas, especially for seasonal or casual workers.

Sickness groups

In some cases, a family might choose a plan offered by an organization of individuals suffering from a particular ailment. Many such organizations exist and give advice on obtaining treatment. Making a plan available to members would be a simple step. These plans, moreover, would structure medical services around the particular needs of the member, say a diabetic. Today, a diabetic typically has to take a standard company-sponsored plan containing items he or she does not use and then pay out-of-pocket for additional specialized services.

✓ Costs would be controlled effectively and efficiently.

The Heritage plan uses the best device ever found to hold down costs without sacrificing quality and efficiency: consumer choice within a competitive market. This works well and simply in the huge Federal Employee Health Benefit System, where cost increases are running at about one-third to one-half less than increases in company-sponsored plans.[6] It also works well in non-company insured markets, such as cosmetic surgery. It also works in every other private sector of the economy.

The Heritage plan would permit it to work in health care. Families would "shop around," comparing the premium prices and benefits of rival plans and making their choice accordingly, just as they do for life insurance, a car or a house, or college education for their children—and as federal workers do for health plans. Premium costs would be reduced by virtue of the tax credit, but families would still save money by choosing the least expensive plan that met their needs. In turn, plan organizers would have to compete aggressively for the family's dollars by developing plans that combined attractive benefits with a

6 See Moffit, *op. cit.*

good price—precisely the same imperative that keeps costs under control elsewhere in the economy.

✓ **The Heritage plan is budget neutral.**

The Heritage plan would not increase the federal deficit. This means that it is budget neutral. This is because the new credit system would cost the same as existing tax breaks for health care. As explained below, the plan also is budget neutral for states.

Q: Does a system based on the Heritage proposal have to be budget neutral?

A: No. But the basic plan could be made more generous to, say, the lower-paid by additional help from a state or the federal government. This, of course, would mean an extra cost to the budget.

DETAILS OF HOW THE HERITAGE CONSUMER CHOICE HEALTH PLAN WOULD WORK

The Heritage Foundation contracted with Lewin/ICF to construct a model of the plan within the framework of Lewin's econometric model of the health care economy. Lewin/ICF conducts econometric analysis for government and the private sector and is among the most highly respected companies in the field of health analysis. For purposes of this model, Lewin made small modifications, some to enhance the basic plan and others to simplify the modelling process. This required various assumptions and produced specific results.

✓ **How the tax credits would be structured**

Lewin/ICF modelled three versions of the basic Heritage plan. Other versions are of course possible. In each version, Lewin calculated the credit percentages that would result in budget neutrality for the federal government and the states. These are presented in Table 1. Minor adjustments could be made in the rates to produce more rounded numbers without departing significantly from budget neutrality.

Version #1 is a voucher plus a flat credit for remaining insurance and out-of-pocket costs. Each individual in a family would qualify for a refundable credit to help buy insurance. This "health insurance voucher" would be equal to a maximum of $220 per individual per year (80 percent of $275) or $880 for a family of four. In addition, the family could claim a flat 18 percent refundable credit for all insurance costs and out-of-pocket costs above $275 per year per individual (that is, above the amount subject to the voucher).

Version #2 is a sliding scale credit for all insurance costs and out-of-pocket costs. In this version, families would receive a sliding scale credit to help offset the cost of insurance and out-of-pocket costs. As these costs rise as a proportion

Table 1

Federal Tax Credit Alternatives

Tax Credit Version #1

- 80 of the cost of premiums up to $275 per family members, plus
- 18 percent of premiums over $275 per member, plus
- 18 percent of umreimbursed medical expenses.

Tax Credit Version #2

Premiums and Unreimbursed Expenses as a Percent of Gross Household Income	Percent Reimbursed Under the Credit
Below 10%	21%
10% - 20%	45%
20% or more	65%

Tax Credit Version #3

- 75 percent of premiums up to $275 per family member, plus
- 14 percent of premiums over $275, plus

Unreimbursed Expenses as a Percent of Gross Household Income	Percent Reimbursed Under the Credit
Below 10%	21%
10% - 20%	45%
20% or more	65%

Note: The credits are refundable.
This structure of credits is budget neutral at the state and federal levels.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

of family income, the percentage credit also would rise. The structure of this sliding scale credit is much like the child care credit in today's tax code.

Version #3 is a combination of the first two. A voucher and flat rate credit would apply to insurance costs only, and a sliding scale credit to out-of-pocket costs. This version would encourage families to buy a basic plan, but give them a bigger incentive to accept higher deductibles and copayments.[7]

✓ The minimum benefits package required by law

Table 2 indicates the minimum benefits package that would be required by law under the Heritage proposal, as chosen by Heritage analysts and priced by Lewin/ICF. For a family of four this plan is estimated to cost $277.33 per month or $3,327.84 per year, so it is by no means a "bare bones" plan. It should be noted that the plan has been priced on a per capita basis. In practice family plans cost less than the total would be if each member bought a separate plan. So the cost for a family in the model is probably an overestimate in some cases. Equivalent coverage options would be permitted. For instance, instead of 75 percent coverage for physician services, a plan may have a higher percentage, but a

Table 2

Basic Plan Required by Law

Minimum standard coverage required for all Americans.

- $1,000 deductible ($2,000 per family).
- $5,000 cost-sharing maximum.

Benefit	Coinsurance
Inpatient Hospital Services (365-day per stay maximum)	80%
Outpatient Hospital Services	80%
Hospital Alternatives (extended or home health care)	Yes
Physician Services	75%
Prenatal/Well-Baby/ Well-Child Care	75%
Diagnostic Tests	75%
Prescription Drugs (inpatient)	75%
Emergency Services	100%
Mental Health Care	Not Covered
Dental Care	Not Covered
Vision Care	Not Covered

Average monthly cost of the plan is $69.33 per person.

Actuarial equivalent alternatives are permitted.

Note: Individuals covered by a government health program such as Medicare and Medicaid are exempt from those coverage requirements.

Actuarially equivalent plans are ones with different coverage or benefit levels than those specified here, but whose total cost is the same for individuals with the same actuarial characteristics such as age, sex, and geographic location.

7 A copayment, or coinsurance, is the percentage of an otherwise insured medical bill that must be paid by the patient.

lower percentage for inpatient prescription drugs. A prepaid managed health plan (such as a Health Maintenance Organization, or HMO) with at least the same basic coverage would be permitted.

The legally-required basic plan would limit deductibles for a family to no more than $2,000 and total unreimbursed costs (including the deductible) to no more than $5,000, often known as the "stop loss" amount or amount above which there is "catastrophic" protection. A family could choose a plan with a lower deductible or catastrophic protection, but normally that would mean a higher premium. These unreimbursed medical costs would be offset by a credit in each version of the Heritage plan (they are not normally given tax relief today) and so would be less costly to a family than the same amounts included in a company-sponsored plan today.

✓ The employer's responsibility

Table 3 summarizes the responsibility of employers. In essence employers act as bookkeepers for their employees, handling premium payments and tax adjustments on the employee's behalf. One important assumption is made about Social Security (FICA) tax. If employer-provided plans become subject to tax (offset, of course, by the new credit), the value of those benefits also would become subject to the "employer's share" of Social Security tax. Heritage analysts instructed Lewin/ICF to assume in modeling the plan that in con-

Table 3

The Employer's Responsibiliy

Employers have the option of:

- ❐ Continuing to provide health benefits; or
- ❐ Discontinuing the health plan.

For employers who continue to provide benefits:

- ❐ The average amount of the employer's contribution is counted as taxable income to the employee.*
- ❐ Employees may not take cash in lieu of coverage.

For employers who discontinue coverage:

- ❐ Employers must maintain their current level of effort by converting benefits to income.
- ❐ Employers must deduct premiums for workers.

Employers will hold workers harmless for the employer share of increased FICA tax payments due to taxation of benefits.

* Separate employer contribution amounts would be used for persons with single and family coverage.

verting current benefits to cash during the transition year, employers pay this extra tax (see below). Other than this small tax, there would be no change in taxes or total employee compensation costs for an employer.

✓ Changes in the insurance market.

Table 4 indicates the proposed reforms of the insurance market under the Heritage Consumer Choice Plan. The most important of these is that all health plans henceforth would be required to guarantee annual renewal for any enrollee who wished to do so, with a premium increase no greater than the average for all enrollees covered by the carrier. This means that insured individuals could not be dropped, or charged unduly high premiums, if they became sick. In addition, under the Heritage plan, three underwriting requirements would be placed on insurance companies—at least during a transitional period while the insurance market adjusted to the new financing system.

First Requirement: Uninsurable Americans (those for whom insurance is impossible in a free market except at prohibitive prices) who are currently uninsured would be randomly assigned to insurers and plans doing business in a state. This would spread the cost of insuring high-risk families among existing plans.

Second Requirement: If an insurer now covers a family, say through a employer-based plan, that insurer would be required to continue coverage if the employee wished it. This means a sick person now in a company-sponsored plan would not be dropped if the employer ended the plan or the employee moved. The insurer would be required to convert the group coverage to individual coverage, so the worker would not lose coverage if he or she changed jobs.

Table 4

Insurance Market Reforms

Reform of renewal practices.

- Guaranteed renewal.
- Renewal Premium updated by carrier-wide average increase.
- Changes in premium due to changes in health status are prohibited.

Current marketing/underwriting practices modified during at least the transition period.

- Uninsurable individuals who are currently uninsured are randomly assigned to carriers.
- Insurers must extend portable, individual coverage to all persons they now cover through employment-based group plans.
- In converting from group to individual coverage, premiums are permitted to vary by no more than 25 percent on the basis of age, sex, and geography-adjusted premiums.

State mandates are preempted by standard benefit package.

State Laws restricting selective contracting and managed care plans are preempted.

Third Requirement: Plans could not charge more than 25 percent above or below the average charged for new enrollees with similar characteristics. This means that sick families, who today often find the cost of coverage prohibitive, could not be charged premiums more than 25 percent above those for similar families of average health. If a family switched plans, moreover, the new carrier could not charge them more than 25 percent above the average premium charged for similar families.

✓ Modelling assumptions made by Lewin/ICF

Lewin/ICF had to make certain assumptions about consumer behavior and other features of the basic Heritage plan to "run the numbers." Some of these are crucial; others simply were to ease the process of modelling and could be changed in any final program. These are contained in Tables 5 and 6. Among the most important:

First Assumption: All employers are presumed to discontinue their existing plans and convert their value into additional cash income for employees. This makes the calculations easier and more reliable, but is not crucial to the plan. Some large companies might well continue to provide coverage.

Second Assumption: Healthy families buy a basic plan and pocket the savings, while currently insured Americans in poor or fair health either maintain their existing coverage or upgrade to better coverage. The model assumes all the uninsured buy the basic package, which includes catastrophic protection (although some doubtless would buy more elaborate plans).

Table 5
Key Assumptions

Employers who now offer insurance:

- All will discontinue coverage and convert benefits to wages.
- Firms with over 1,000 workers establish employee premium financed cafeteria plans, which will reduce administrative costs.

Workers now covered by employer insurance:

- Those in poor/fair health will select plans that at least maintain their existing level of coverage.
- Those in good/excellent health will downgrade to the standard package.
- Health services utilization for persons who downgrade coverage will decline based upon price elasticities reported in the literature (a price elasticity of -0.2 was selected).

Persons now covered by non-group insurance:

- Persons who now have coverage in excess of the minuimum standard will maintain that coverage.
- Others will upgrade to the minimum standard.

Currently uninsured persons:

- All will take the minimum standard package.
- Utilization will adjust to levels reported by insured persons with similar charactoeristics.

No change is assumed in the number of persons enrolled in Medicaid.

Third Assumption: Administrative costs are assumed to be lower than for today's individual health insurance plans. However, Lewin/ICF does not assume that all employers would make a payroll deduction for employees and send premiums to the chosen insurer. In fact, Heritage analysts make that a legal requirement. This might mean somewhat lower administrative costs than Lewin/ICF projects.

Table 6
Administrative Cost Assumptions

Administrative costs would be the same as under current policy for workers in firms where the employer arranges employee deductions.

Administrative costs for others purchasing individual insurance would be 21.9 percent of claims. This retention rate was estimated as follows:

Administrative Costs for Individual Coverage as a Percentage of Claims

	Current Policy[a]	Assumed level Under Tax Credit[b]
Claims Administration	9.3%	8.0%
General Administration	12.5	10.0
Interest Credit	-1.5	-1.5
Risk and Profit	8.5	2.7
Commissions	8.4	0.0
Premium Taxes	2.8	2.7
Total	**40.0%**	**21.9%**

a: Hay/Huggin estimates of administrative costs for groups with 1 to 4 members under current policy.

b: Hay/Huggin estimates of administrative costs for groups with 1 to 4 members under a voluntary risk pooling arrangement adjusted to assume that insurer profits as a percent of claims correspond to the national average observed in the current system.

Source: Congressional Research Service, "Cost and Effects of Extending Health Insurance Coverage," Washington, D.C. October 1988.

HOW TOTAL SPENDING WOULD BE AFFECTED

Effect #1: Total U.S. spending on health care would fall immediately by $10.8 billion. Families initially would save $18.8 billion.

Households would pay directly for their own coverage under the Heritage plan, rather than have their employer paying for it as happens today. As a result, total household health payments would, in the first instance, go up substantially. But the cost would be more than offset by two items, as indicated in Table 7: the tax credit (worth a total of $84.9 billion), and the increase in wages due to firms cashing out existing benefits (for a total increase in cash wages of $148.7 billion). This would leave families as a whole ahead by $18.8 billion. Private employers, as well as federal, state and local governments, would save on health costs, but pay their employees more in cash income. The net effect on total health spending, concludes Lewin/ICF, would be a reduction of $10.8 billion.

Q: Would this one-time saving be all the cost reduction under the Heritage plan?

A: No. Lewin/ICF does believe that the pattern of spending after these changes would continue in line with today's trend. However, Heritage analysts believe the new incentives for families to shop around for the best bargain would hold the annual growth of spending significantly below current trends. If the general increase were to be held to the rate in recent years of the consumer-based Federal Employee Health Benefits Program, for instance, American families would save tens of billions of dollars each year in health costs, with bigger savings each year compared with current projections.

Table 7

Change in National Health Spending by Source of Payment

(billions of dollars)

	Subtotals	Change in Spending
Impact on Payors		
Household Payments		$129.9[a]
Premium Payments	$88.2	
Out-of-Pocket Spending	62.7	
Tax Credits	(84.9)	
Eliminate Tax Exclusion	63.9	
Private Employers[b]		(112.4)
Federal Government[b]		(5.1)
State Governments[c]		(23.2)
Net Change in Health Spending		
Changed in Health Spending		(10.8)
Utilization for Newly Insured	8.9	
Utilization for Currently Insured	(21.8)	
Insurer Administrative Costs	2.1	

Note: Figures indicate increase in spending. Reductions in spending are in parenthesis.

a The increases in household health spending will be offset by increased wages of $148.7 billion.

b Reflects elimination of employee coverage. Employer savings in health spending will be offset by increases in wages not shown here.

c Reflects elimination of employee coverage and savings to county hospitals.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Effect #2: The plan would be budget neutral at the federal and state levels

The Heritage proposal is budget neutral. Tables 8 and 9 indicate the impact in federal and state revenues. Significantly, the states would enjoy a windfall of $13.2 billion by cutting costs at public hospitals that treat the uninsured. These uninsured would now be covered by insurance partly financed with a tax credit. States with income taxes also would receive extra taxes since taxable wages would rise because of the elimination of the tax exclusion for company plans. To preserve budget neutrality at federal and state levels, the Heritage plan assumes that the states make a contribution to the federal tax credit equal to their net savings.

Q: How would the states contribute to the federal credit?

A: One way could be through a reduction in the federal share of funding for the federal-state Medicaid program, or reductions in other federal health grants to states. This makes sense because the federal credit would help lower-paid state residents to afford care, thus relieving the health care costs of a state. The Bush Administration's proposed low-income health credit would be financed in part in this way. Another method would be to require states to make a contribution to the credit (such as being responsible for a fixed dollar amount of the insurance voucher in versions #1 or #3 of the Heritage plan).

Table 8

Sources and Uses of Federal Funds Under the Tax Credit Program in 1991

(in billions of dollars)

Sources of Funds			Uses of Funds		
Elimination of Tax Exclusion			**Tax Credits**		**$84.9**
Federal Income Tax	39.7		**Civil Service Plan (FEHB)**		
OASDI Payroll Tax	21.2		Health Benefits	(4.6)	
HI Payroll Tax	5.7		Wages	4.6	
		$66.6	OASDO and HI Taxes	0.5	
					0.5
Eliminate Deduction for Health Expenditures in Excess of 7.5 percent of AGI		**2.5**	**Corporate Income Tax Loss***		**2.5**
Contribution from State and Local Governments		**18.8**			
Total Sources of Funds		**$87.9**	**Total Uses of Funds**		**$87.9**

Note: Number in parenthesis represent negative amounts.

* We assume that the full amount of the employer share of the increase in OASDI and HI payroll taxes is absorbed by employers as reduced profits resulting in a change in corporate income tax payments.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Q: Could states introduce their own health credit?

A: Yes. In fact a credit in a state's tax code would be a logical addition to the basic federal plan. Several states, including Maryland and Minnesota, already are considering a state health tax credit.

Q: Could states add funds to the plan to give more help to the low-paid?

A: Yes. In one version of the Heritage proposal, Lewin/ICF was asked to assume that each state would supplement the federal program with a program to cover the expenses of any family that, despite the federal credit, faced out-of-pocket costs of more than 20 percent of its income. In modeling this version, states were given discretion in how they would structure such additional assistance. Taking together the various savings to states and local governments, thanks to the federal credit and tax changes, Lewin/ICF calculated that the new program would cost state and local governments $6.7 billion more than they now spend on health care. In this variant of the plan, the states would not contribute to the cost of the federal credit. Thus for federal budget neutrality, the federal credits would have to be less generous.

Table 9

Sources and Uses of State Funds Under the Tax Credit Program in 1991

(billions of dollars)

Changes in Revenues			Changes in Expenditures		
Elimination of State Income Tax Exclusion[a]		**$8.3**	**Public Hospitals**		**($13.2)**
Premium Taxes[b]			**State and Local Worker Benefits**		
Current Revenues	(1.6)		Health Benefits	(23.8)	
Revenues Under Policy	1.5		Wages	23.8	
			OASDI and HI Taxes	2.0	
		(0.1)			**2.0**
State Corporate Income Tax Loss		**(0.6)**	**Contribution to Federal Tax Credit**		**18.8**
Net Change in Revenues		**$7.6**	**Net Change in Expenditures**		**$7.6**

Note: Number in parenthesis represent negative amounts.

a The increase in wages under the program will result in an increase in state income tax payments.

b Premium tax revenues decline due to the reduction in the value of health insurance coverage under the tax credit program.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Effect #3: With all the changes employers would pay less than $10 a month extra per average employee.

Table 10 shows the bottom line for employers. Employers would be required to pay the "employer's share" of the Social Security tax payable on "cashed out" health benefits returned to the employee as extra wages. On the other hand, this extra tax would reduce profits and thus corporate income taxes. The net effect would be an annual increase in costs to employers averaging $104.80 per employee (or just $8.73 per month).

Table 10

Change in Employer Health Spending Under the Tax Credit Program in 1991

(billions of dollars)

		Change in Spending
Current Employer Expenditures for Health Care[a]		$124.3
Convert Employee and Dependent Benefits to Wages[b]		0.0
Benefit Payments	(120.2)	
Wages	120.2	
OASDI and HI Tax on Benefits (employer share)		10.9
Change in Employer Costs		10.9
Change in Corporate Taxes[c]		(3.1)
Net Change in Employer costs (Change in costs per worker of $104.8 per year)		$7.8

Note: Number in parenthesis represent negative amounts.

a Includes the employer share of expenditures for workers, dependents, and retirees.

b Employer contributions for worker and dependent benefits are converted to wages. Retiree coverage is assumed to be retained.

c The entire amount of the increase in OASDI and HI payroll taxes is assumed to be absorbed by employers as reduced profits resulting in a change in corporate income taxes.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

WHAT THE HERITAGE PLAN MEANS FOR TYPICAL FAMILIES

Impact 1: As a whole, American families would save $18.8 billion in the first year of the plan, and would not lose coverage if they changed or lost their job.

Table 11 indicates the aggregate impact of the plan on American households not on Medicaid or Medicare. Families would be affected in several different ways. Since families would select and pay for their own health plan, typical workers would pay more in premiums as well as out-of-pocket costs. They also

would lose the tax exclusion for any company-provided benefits. Yet, they would also receive extra income, because employers would be required to give them cash instead of benefits and they would receive a new tax credit to replace the tax exclusion. The net effect is that working age households would have a total of $18.8 billion more in their pockets after all these changes. They would also be able to choose their own health plan and keep it if they changed jobs.

Table 11

Change in Household Health Spending Under the Tax Credit Program in 1991

(billions of dollars)

Health Spending		
Premium Payment		$88.2
Employee Contribution in Employer Plans	(45.2)	
Individual Premium Payments	133.4	
Out-of Pocket Expenses		62.7
Tax Credit		(84.9)
Eliminate Tax Expenditures (individual share)		61.4
Federal	53.1	
State	8.3	
Eliminate Health Expense Deduction (over 7.5% AGI)		2.5
Net Change in Health Spending		129.9
Wage Effect		
Increased Wages (offset to change in health spending)		(148.7)
Net Impact on Households		($18.8)

Note: Number in parenthesis represent negative amounts.
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Impact 2: A family with an annual income below $50,000 typically would receive higher tax breaks for its health care plan.

Table 12 shows how the value of tax breaks for health coverage would be affected for typical households.[8] Today the typical family earning less than $10,000 gets just $50 a year in tax relief under the tax exclusion system. Under version #1 of the Heritage plan, this family would receive $372 more in (refundable) tax benefits and $684 more under version #2. A family earning over $50,000, but less than $75,000, would lose just $13 in tax breaks under version 1, or just over $1 a month. Families as a whole would receive more federal tax relief under the plan than they do because health cost savings to the states would be added to the funds to finance the new credit.

8 All figures cited here from Tables 12 and 13 are averages for all families within income class.

Table 12
Average Change in Federal Tax Benefits for Families by Income Under the Tax Credit Plan in 1991

	Current Tax Exclusion	Net Change in Tax Benefits		
		Tax Credit Version #1	Tax Credit Version #2	Tax Credit Version #3
Family Income				
less than $10,000	$ 50	$ 372	$ 684	$ 476
$10,000 - $14,999	207	462	664	517
$15,000 - $19,999	366	444	612	487
$20,000 - $29,999	594	365	451	372
$30,000 - $39,999	857	365	401	388
$40,000 - $49,999	986	256	182	248
$50,000 - $74,999	1,373	(13)	(232)	(84)
$75,000 - $99,999	1,427	(32)	(345)	(129)
$100,000 or more	1,463	47	(285)	(55)
All Families	$ 802	$250	$250	$250

a Includes federal income taxes and the employer and the employee share of the OASDI and HI payroll taxes.
b The tax credits are structured to be budget neutral
Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Q: Does the Heritage plan mean, as some have charged, that families would lose tax relief for their health benefits?

A: No. Only the method of tax relief would change—from tax-free company plans to a refundable tax credit. Indeed, as Table 12 shows, most families would receive larger tax breaks for health care.

Impact 3: In version #1 of the proposal (voucher with flat 20 percent credit), typical families with annual incomes between $15,000 and $100,000 would pay less, after taxes, on health care than they do today. All families could choose their health plan and it would be portable.

Chart 13 shows the net change in federal taxes broken down by income level. The top row indicates the value of the current tax break for employer-paid insurance. The next three rows show the change in health costs when the current tax exclusion is eliminated and the next row computes the increases in wages when current benefits are converted to cash.

The next three rows show the typical refundable tax credit for each version of the Heritage proposal. The final three rows show the "bottom line" for each family broken down by income. These rows indicate the net change in a family's health care spending compared with the current system. Figures in parentheses indicate a reduction in spending compared with today. For this bottom line, the family now would have at least a basic plan of their choice that they could take from job to job, with a limit on total out-of-pocket costs.

Table 13

Average Net Impact of Alternative Tax Credit Options on Families by Income (1991)

	All Households	Family Income								
		less than $10,000	$10,000 - $14,999	$15,000 - $19,999	$20,000 - $29,999	$30,000 - $39,999	$40,000 - $49,999	$50,000 - $74,999	$75,000 - $99,999	$100,000 or more
Household Health Spending Under Current Law	$1,841	$887	$1,223	$1,428	$1,638	$2,106	$1,954	$2,295	$2,400	$3,238
Changes in Health Spending										
Change in Premium Payments[a]	1,214	671	930	991	1,100	1,279	1,312	1,459	1,679	1,854
Change in Out-of-Pocket Payments for Care	692	108	286	367	519	769	990	1,059	1,053	1,176
Elimination of State and Federal Tax Expenditures[b]	745	35	154	283	500	736	875	1,330	1,397	1,492
Wage Effects										
Increased Wages (counted as an offset to health spending)	(1,767)	(162)	(657)	(1,119)	(1,531)	(2,060)	(2,313)	(2,681)	(2,754)	(2,770)
Tax Credits (Federal and State)										
Version #1	(1,052)	(422)	(669)	(810)	(959)	(1,222)	(1,242)	(1,360)	(1,395)	(1,510)
Version #2	(1,052)	(734)	(871)	(978)	(1,045)	(1,258)	(1,168)	(1,141)	(1,082)	(1,178)
Version #3	(1,052)	(526)	(724)	(853)	(966)	(1,245)	(1,234)	(1,289)	(1,298)	(1,408)
Change in After-Tax Health Spending Net of After-Tax Change in Income										
Version #1	(168)	210	44	(288)	(371)	(498)	(378)	(193)	(20)	242
Version #2	(168)	(82)	(158)	(456)	(457)	(534)	(304)	(26)	293	574
Version #3	(168)	126	(11)	(331)	(378)	(521)	(370)	(122)	77	344

Note: Figures in parenthesis represent negative numbers.

a Includes individual premium payments less employee contributions to employer plans eliminated under the tax proposal.

b Includes the additional taxes paid on employer benefits converted to income including: federal income taxes; the employee share of OASDI and HI payroll taxes; and state income taxes.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Impact 4: In version #2 of the proposal (a sliding scale credit), typical families with annual incomes below $75,000 would pay less, after taxes, on health care than they do today. All families could choose their health plan and it would be portable.

See Table 13.

Impact 5: In version #3 of the proposal (voucher with sliding scale credit), typical families with annual incomes between $10,000 and $75,000 would pay less, after taxes, on health care than they do today. All families could choose their health plan and it would be portable.

See Table 13.

Impact 6: Case studies of typical families under the Heritage plan are given below.

SELECTED CASE STUDIES

Case #1: A young two-parent farm family with one child and has a family income of $25,000 per year. The family has no insurance and average health. In a typical year pays out $1,500 in essential hospital and doctor bills, but has no major medical protection.

Under the Heritage plan, this family selects a basic plan offered through their state farm bureau. The plan costs $2,500 and the family pays $500 in out-of-pocket expenses.

	Today	Under Heritage Proposal
Tax relief for health	0	$1,051
Extra cash income		0
Net extra taxes paid under Heritage proposal		-1,051
Change in disposable income after tax changes and health spending under Heritage proposal	N/A	-449*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #2: A young single blue-collar worker in excellent health currently works for a major industrial company and earns $21,000. The worker currently has an employer-paid health plan with no deductible worth $3,000 per year.

Under the Heritage plan, the worker switches to a basic plan sponsored by his union. For this plan he pays $850 and he pays out $450 in out-of-pocket costs. The employer adds $3,000 to his paychecks over the year and makes a payroll deduction equal to the premium for his union plan and sends the money to the union.

	Today	Under Heritage Proposal
Tax relief for health	$450	$ 404
Extra cash income		3,000
Taxes on extra income	N/A	450
Net extra taxes paid under Heritage proposal	N/A	46
Change in disposable income after tax changes and health spending under Heritage proposal		+1,654*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #3: An engineer, aged 50, with a manufacturing company has a non-working spouse, two children, and a typical history of health problems. Currently he earns $45,000 and has a company-paid plan. The company pays the premium of $6,000 and the family pays out the full $600 each year in deductibles and copayments. This year, however, the company has decided to lay off the worker. Although he fortunately has the offer of another job paying the same total compensation of $51,000 ($45,000 + $6,000) with a small engineering firm, that firm says it will not give part of the compensation in the form of health benefits, because it cannot arrange affordable group coverage. So he faces the prospect of being uninsured.

Under the Heritage proposal, he elects to continue his current plan, converted to individual coverage for his family and paid for by himself. The plan will cost the same premium with the same deductibles and copayments.

	Today (old job)	Under Heritage Proposal (new job)
Tax relief for health	$1,254	$1,870
Extra cash income		6,000
Taxes on extra income	N/A	1,254
Net extra taxes paid under Heritage proposal		-616
Change in disposable income after tax changes and health spending under Heritage proposal		+616*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

Case #4: A two-earner professional family, with one child, earns $130,000 per annum. The family is covered under the father's policy, which is paid by his employer and is worth $7,000. The family pays a deductible of $600. In addition, the family has mortgage interest payments and other deductions of $30,000 per year.

> **Under the Heritage plan,** the family decides to take the $7,000 value of its current plan in cash and instead buy a less comprehensive policy with a $3,000 premium and out-of-pocket costs of $1,500.

	Today	Under Heritage Proposal
Tax relief for health	$2,235	$1,321
Extra cash income		7,000
Taxes on extra income		2,235
Net extra taxes paid under Heritage proposal		914
Change in disposable income after tax changes and health spending under Heritage proposal	N/A	+2,186*

The change in disposable income is the additional income received by the family less the extra direct payments for health care and the less the net extra taxes paid.

COMMONLY ASKED QUESTIONS ABOUT THE HERITAGE CONSUMER CHOICE HEALTH PLAN

Q: Are American families capable of choosing health plans?

A: **Yes.** About 9 million federal workers and federal retirees do so every year under the Federal Employee Health Benefits Program (FEHBP).[9] These workers include mail room clerks, janitors, and messengers, as well as professional economists, congressmen and cabinet secretaries. In the Washington, D.C., area they choose from among over thirty plans. They can make choices because consumer organizations, the local press, their family doctors, employee organizations, and other groups supply them with "user friendly" information on which to base their choices. The same kinds of information would quickly mushroom for 100 million American households choosing health plans as exists today to help these households buy a car, a house, or a mutual fund.

Q: How would costs be controlled?

A: **In the same way as they are controlled in the automobile or computer market—by cost-conscious consumers buying a product from among competing suppliers.** Critics of consumer-based cost control claim that families cannot question the cost of specialized medical procedures. But this ignores the way consumer choice would work. Most Americans know little about carburetors or steering systems in an automobile. If they bought a car by purchasing all the components individually from different firms the car no doubt would be very expensive, and would not run well. Instead they buy completed cars from among rival assembly firms. In turn these firms bargain for quality and price from component makers.

Essentially the same process would operate in a consumer-based health system —and does so today in the FEHBP. Families would choose among competing plans. The plan organizers, not the families, would bargain with doctors and hospitals to keep costs down. That system of consumer choice and competition has enabled the FEHBP to keep its premium increases well below those of private employer-sponsored plans.

Q: How would the obligation to buy insurance be enforced?

A: **In two ways.** Taxpayers would have to attach proof of insurance or enrollment in a public program to their tax return or face a fine. In addition, employees would have to furnish their employers with proof of insurance, which would be forwarded to the government. Those unable to show they had

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9 See Moffit, *op. cit.*

coverage might be assigned to Medicaid by the state but billed for all or part of the cost of coverage. To be sure, some individuals still would evade the law, but the number is likely to be small.

Q: Would the Heritage plan foster lower-cost managed care plans?

A: It probably would, but only because families freely chose managed care in a competitive market. In the consumer-choice Federal Employee Health Benefits Program, federal workers choose HMOs (a form of managed care) at about double the national rate. But managed care would not be artificially encouraged, as some reform plans would do. If a more efficient form of health care delivery were to emerge and satisfy consumers, it would win customers under the Heritage proposal.

Q: What would happen to the very sick under the Heritage plan?

A: They would be able to purchase a plan of their choice at no more than 25 percent higher premiums than similar families with normal health, and they would have the right to renew the plan each year without premium increases any larger than those for healthy individuals in the plan. They would receive a higher tax credit to offset part of this higher premium. Today they are often unable to obtain insurance.

Q: What about the very healthy?

A: Typically they would opt for a "lean" basic plan and enjoy higher after-tax incomes. Today they are typically overinsured and tend to adopt a "use it or lose it" attitude to health services. Further, the healthy and wealthy would pay higher taxes, which would pay for the cost of generous credits for the poor and sick. But this does not mean the healthy and wealthy would object. They simply would take less of their income in insurance coverage and more in (taxable) cash income for other uses—much like getting a taxable raise.

Q: Wouldn't some of the working poor pay more for health care under the Heritage plan?

A: As Table 13 shows, under versions #1 and #3 of the Heritage plan, lower-paid families typically could pay slightly more than they do today—although under the least-attractive version that would be an average of no more than $18 per month. But for this money the family now would have insurance, and insurance it could renew automatically each year and keep from job to job.

Further, as indicated earlier, states and the federal government could choose to increase the help given to the lower-paid. The federal government could change the tax credit formula, in a budget neutral way, to give extra help to the

poor by reducing the tax relief for middle and upper income families. Or if the federal government decided to increase net spending (or tax help) for health, it could make the credit more generous for the lower-paid. States could introduce their own budget neutral credit, or they could add funds to assist the lower-paid.

Q: What about those families on Medicaid?

A: Medicaid would not be affected directly by the proposal. Today a head of household on welfare typically has to give up thousands of dollars in Medicaid health benefits if he or she leaves welfare and takes a job without health benefits. But under the Heritage Plan, many families now on welfare (and Medicaid) would choose to take a job because a refundable credit for health care insurance would be available. This would reduce Medicaid and AFDC costs.

Q: What about those now on Medicare?

A: The basic Heritage plan does not change Medicare. However, it would be quite logical to allow working Americans to keep their health plans when they retire, with the federal government making a financial contribution to these plans in place of today's Medicare cumbersome reimbursement system. This "voucherizing" of Medicare would encourage retirees to shop for the best plan for their needs. The FEHBP operates in much this way for federal retirees.

Q: How does the Heritage plan differ from the Bush Administration's recent health reform proposal?

A: For those now uninsured, both plans are quite similar, except that the Bush plan gives a refundable credit only for the poor, and a deduction for non-poor uninsured families. But it would, like the Heritage plan, cover today's uninsured and enable them to obtain a "portable" plan. The Bush plan, however, would have little or no effect on the costs of company-provided plans, because it makes no changes at all in the tax treatment and so would not encourage employees with company-sponsored plans to seek better value for money.[10] There is also no explicit mechanism in the Bush plan to pay for its new credit and deduction.

Q: Does the Heritage plan have to be introduced all at once?

A: No. It could be phased in gradually. One first step might be to limit the tax exclusion for company-sponsored plans to, say, $4,000 per year for a family, and use the tax revenue to fund a credit for out-of-pocket health expenses ex-

10 See Stuart M. Butler, "What's Right and Wrong with Bush's Health Plan," Heritage Foundation *Executive Memorandum* No. 321, February 7, 1992.

ceeding 5 percent of family income. In later years the exclusion limit could be lowered, and more generous credits made available.

CONCLUSION

The Heritage Consumer Choice Health Plan is a comprehensive reform of the American health care system designed to assure affordable access to health care for all Americans without an increase in taxes and with an improvement in the efficiency of the health care system.

Unlike the Canadian system preferred by some lawmakers, the Heritage plan would not institute government-controlled rationing and waiting lists. And unlike the "play or pay" system, it would not compound the problems of today's system with new payroll taxes and a huge new public program. Instead it would change the way government helps Americans to obtain care, making that help more equitable, and it would trigger in health care the same dynamic forces that secure quality and efficiency in the rest of the economy—consumer choice and competition.

6 P.M., 2/14/92

ASSOCIATION AND GROUP ENDORSEMENTS FOR THE PRESIDENT'S HEALTH CARE PROPOSAL

American Farm Bureau Federation
Business Roundtable
Healthcare Equity Action League
Healthcare Leadership Council (see attached)
National Association of Wholesalers-Distributers
National Coalition of Hispanic Health and Human Services Organizations
National Committee for Quality Health Care
National Federation of Independent Business
National Restaurant Association

6:00 P.M., 2/14/92

REMARKS FROM CONSTITUENT LEADERS
REGARDING THE PRESIDENT'S COMPREHENSIVE HEALTH CARE REFORM PLAN

"The empowerment of individual consumers was given a resounding vote of confidence today in the health care proposals announced by the President...Too often government has made all the decisions for the poor and especially the working poor. The President's plan provides families in poverty with the resources to make decisions about their health care."

-- Jane L. Delgado, Ph.D., President and CEO
National Coalition of Hispanic Health and
Human Services Organizations

"We commend the President for his market-based proposals which build on the strengths of our current system. We believe the President's plan is a vehicle to provide health care to all Americans...It is especially important for the Administration and the Congress to work together to provide broader access to healthcare, while instituting measures to control its spiraling costs."

-- Robert C. Winters, Chairman, Task Force on
Health, Welfare and Retirement Income
The Business Roundtable

"Health care reform needs to be market-oriented. It needs to control escalating costs which are currently crushing employers of all sizes. And it needs to solve the cost-induced access problem. The President has put on the table a major reform package that points America in the right direction on this vital issue."

-- Dirk Van Dongen, President
National Association of Wholesaler-Distributors

"[The President's plan] controls costs, gives everyone access to health care, reforms the insurance market and offers businesses incentives. This is far more favorable to small business than nationalized, government-run plans based on higher taxes and a bigger bureaucracy."

-- John Motley, Vice President
National Federation of Independent Business, and
Member, Healthcare Equity Action League

"We oppose taxing employers and employees out of jobs and businesses in order to create an unproven system of national health insurance that working Americans do not want."

-- Mark Gorman, Director, Government Affairs
National Restaurant Association, and
Member, Healthcare Equity Action League

"The President's proposals are consistent with HLC's primary objective: building on the strengths of our current private sector based system while ensuring access to affordable, quality care for all Americans...These proposals already have bipartisan support in Congress and can bring us relief now, if politics don't get in the way...[These proposals are also] the only health care alternative that compatible with economic recovery. It will get people covered and keep them covered but it won't raise taxes, cost jobs or put the burden on any one group of employers."

-- Pam Bailey, President
Healthcare Leadership Council

President Bush's health care plan contains some sound and positive concepts, most notably a proposal to allow the self-employed to deduct 100 percent of the cost of their health care insurance premiums...the tax deduction for the self-employed represents an important reform for a group that has been hard hit by spiraling health care costs.

-- Dean Kleckner, President
American Farm Bureau Federation

EMPLOYERS UNITED FOR REFORM

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)
STEERING COMMITTEE

Aetna Life & Casualty
American Apparel Manufacturers Association
American Association of Preferred Provider Organizations
American Bakers Association
American Cyanamid Company
American Farm Bureau
American Furniture Manufacturers Association
American Hardware Manufacturers Association
American Hotel & Motel Association
American Institute of Architects
American International Hospital
American Managed Care & Review Association
American Trucking Association, Inc.
AMGEN Inc.
Amway Corporation
Associated Builders and Contractors
Associated Equipment Distributors
Association of Health Insurance Agents
The Beer Institute
Beneficial Management Corporation
Burroughs Wellcome Company
Cancer Treatment Centers of America
Carl Karcher Enterprises
Caterair International Corporation
Central Reserve Life Insurance Company
The CIGNA Corporation
Citizens for a Sound Economy
Council of Smaller Enterprises
Eli Lilly & Company
Employee Benefits South, Inc.
Evanston Hospital Corporation
Federation of American Health Systems
Florists' Transworld Delivery Association
Food Marketing Institute
The Grand Union Company
Group Health Association of America
Hampshire House
Harman Management Corporation
Harris Methodist Health System
Health Industry Distributors Association
Health Industry Manufacturers Association
Health Insurance Association of America
Health Midwest
Health One
Healthcare Leadership Council
Hershey Foods Corporation
Hillcrest Baptist Medical Center
Humana Inc.
Industrial Distribution Association
International Mass Retail Association
John Hancock Mutual Life Insurance Company
Kimberly Quality Care
The Law Offices of Deborah Steelman
Marriott Corporation
Massachusetts Mutual Life Insurance Company
McDonald's Corporation
Melrose Diner, Inc.
Metropolitan Life Insurance Company
Mobile Technology Inc.
Morrison Incorporated
Motorola Inc.
National-American Wholesale Grocers' Association
National Association of Aluminum Distributors
National Association of Chain Drug Stores
National Association of Convenience Stores
National Association of Health Underwriters
National Association of Temporary Services
National Association of Wholesaler-Distributors
National Committee for Quality Health Care
National Council of Chain Restaurants
National Council of Community Hospitals
National Federation of Independent Business
National Medical Enterprises, Inc.
National Restaurant Association
National Retail Federation
National Wholesale Druggists' Association
New York Life Insurance Company
NMTBA-The Association for Manufacturing Technology
Pagonis & Donnelly Group, Inc.
Pennsylvania Hospital
PepsiCo
The Principal Financial Group
Printing Industries of America
The Prudential
Schering-Plough Corporation
Sears, Roebuck and Co.
ServiceMaster Management Services
Society of American Florists
St. Joseph Healthcare Group, Inc.
Super Valu Stores, Inc.
The Travelers Companies
U.S. Chamber of Commerce
U.S. Federation of Small Businesses, Inc.
Wendy's International, Inc.
Western Growers Assurance Trust
Wills Eye Hospital

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HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)
GENERAL MEMBERSHIP

Advertising Specialty Institute
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Air-conditioning & Refrigeration Wholesalers Association
Alabama Wholesale Beer & Wine Association
Albertson's, Inc.
Allen Park (MI) Chamber of Commerce
Alliance of American Insurers
The Aluminum Association
American Council on Education
American Electronics Association
American Federation of Small Businesses
American Machine Tool Distributors Association
American Meat Institute
American Paper Institute
American Society of Computer Dealers
American Supply Association
American Traffic Safety Services Association
American Veterinary Distributors Association
American Wholesale Hardware Association
Appliance Parts Distributors Association
Ardmore (OK) Chamber of Commerce
Arnett & Company Health Communications
Associated Beer Distributors of Illinois
Associated General Contractors
Association for Suppliers of Printing and Publishing Technologies
Association of Commerce and Industry (MI)
Association of Ingersoll-Rand Distributors
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Bob Chinn's Crabhouse Restaurant
Boon-Chapman
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California Association of Wholesalers-Distributors
California Beer & Wine Wholesalers Association
California Trucking Association
Central Wholesalers Association
Ceramic Tile Distributors Association
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Greater North Dakota Association/WAM Council
Greater O'Hare (IL) Association
Greater Raleigh (NC) Chamber of Commerce
Greater Washington Food Wholesalers
Hardee's Food Systems, Inc.
HealthTrust, Inc.
Henderson (NV) Chamber of Commerce
Hobby Industry Association of America
Hoffmann-La Roche Inc.
Home Health Care
Hospital Corporation of America
Hospitality Association of South Carolina
Illinois Restaurant Association
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Independent X-ray Dealers Association
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Mid-America Supply Association

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Montgomery County Pharmaceutical Association of Pennsylvania
Motorcycle Industry Council
Mount Vernon (NY) Chamber of Commerce
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National Appliance Parts Suppliers Association
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National Association of Container Distributors
National Association of Electrical Distributors
National Association of Fire Equipment Distributors
National Association of Floor Covering Distributors
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National Association of Meat Purveyors
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National Association of Wholesale Independent Distributors
National Beer Wholesalers Association
National Building Material Distributors Association
National Business Forms Association
National Business Owners Association
National Candy Wholesalers Association
National Club Association
National Commercial Refrigeration Sales Association
National Electronic Distributors Association
National Fastener Distributors Association
National Food Distributors Association
National Frozen Food Association
National Grocers Association
National Independent Poultry & Food Distributors Association
National Industrial Glove Distributors Association
National Insulation and Abatement Contractors Association
National Lawn & Garden Distributors Association
National Locksmith Suppliers Association
National Marine Distributors Association
National Office Products Association
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National Paper Trade Association
National Sash & Door Jobbers Association
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Petroleum Marketers Association of America
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Pocono Mountains Chamber of Commerce
Post Card Distributors Association of North America
Potlach Corporation
Power Transmission Distributors Association
Product Marketing Association
Pueblo (CO) Chamber of Commerce
Reno Sparks Convention and Visitors Authority
Rhode Island Hospitality Association
Riverdale Texaco
Safety Equipment Distributors Association
Santa Ana (CA) Chamber of Commerce
Schiffli Lace & Embroidery Manufacturers Association
Schererville (IN) Chamber of Commerce
Scripps Memorial Hospitals
Shoe Service Institute of America
Small Business of America
Snack Food Association
Society of Professional Benefits Administrators
South Carolina Beer Association
Southern Wholesalers Association
Southworth Milton Inc.
Specialty Tools & Fasteners Distributors Association
Spraying Systems Company
St. Lucie County (FL) Chamber of Commerce
Steel Service Center Institute
Storm Lake (IA) Chamber of Commerce
Suspension Specialists Association
Swartz Restaurants Corporation
Tennessee Malt Beverage Association
Tennessee Restaurant Association
Texas Restaurant Association
Textile Care Allied Trades Association
Thomas Jefferson University Hospital
Thornton Gardens, Inc.
Twinsburg (OH) Chamber of Commerce
United Products Formulators & Distributors Association
United Restaurant & Lodging Association
Virginia Restaurant Association
Walker Health Insurance Services, Inc.
Wallcovering Distributors Association
Warren County (PA) Chamber of Commerce
Washington (IL) Chamber of Commerce
Waste Management Inc.
Water & Sewer Distributors of America
Wausau Hospital Center
Western Association of Fastener Distributors
Western Suppliers Association
Wholesale Beer Distributors of Arkansas
Wholesale Beer Distributors of Texas
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Wholesale Stationers' Association
Wine & Spirits Wholesalers of America
Wisconsin Wholesale Beer Distributors Association
Woodworking Machinery Distributors Association
Woodworking Machinery Importers Association

THE WHITE HOUSE
WASHINGTON

DATE: 2/18

TO: Nick Calio

FROM: GREG FITCH
Office of Public Liaison
Room 196, OEOB, x7142

FYI —

See your attachment. Check names & spellings of organizations. They tend to take it personally if we're wrong.

6 P.M., 2/14/92

ASSOCIATION AND GROUP ENDORSEMENTS FOR THE PRESIDENT'S HEALTH CARE PROPOSAL

American Farm Bureau Federation
Business Roundtable
Healthcare Equity Action League
Healthcare Leadership Council (see attached)
National Association of Wholesalers-Distributers
National Coalition of Hispanic Health and Human Services Organizations
National Committee for Quality Health Care
National Federation of Independent Business
National Restaurant Association

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National Restaurant Association

6:00 P.M., 2/14/92

REMARKS FROM CONSTITUENT LEADERS
REGARDING THE PRESIDENT'S COMPREHENSIVE HEALTH CARE REFORM PLAN

"The empowerment of individual consumers was given a resounding vote of confidence today in the health care proposals announced by the President...Too often government has made all the decisions for the poor and especially the working poor. The President's plan provides families in poverty with the resources to make decisions about their health care."

-- Jane L. Delgado, Ph.D., President and CEO
National Coalition of Hispanic Health and
Human Services Organizations

"We commend the President for his market-based proposals which build on the strengths of our current system. We believe the President's plan is a vehicle to provide health care to all Americans...It is especially important for the Administration and the Congress to work together to provide broader access to healthcare, while instituting measures to control its spiraling costs."

-- Robert C. Winters, Chairman, Task Force on
Health, Welfare and Retirement Income
The Business Roundtable

"Health care reform needs to be market-oriented. It needs to control escalating costs which are currently crushing employers of all sizes. And it needs to solve the cost-induced access problem. The President has put on the table a major reform package that points America in the right direction on this vital issue."

-- Dirk Van Dongen, President
National Association of Wholesaler-Distributors

"[The President's plan] controls costs, gives everyone access to health care, reforms the insurance market and offers businesses incentives. This is far more favorable to small business than nationalized, government-run plans based on higher taxes and a bigger bureaucracy."

-- John Motley, Vice President
National Federation of Independent Business, and
Member, Healthcare Equity Action League

"We oppose taxing employers and employees out of jobs and businesses in order to create an unproven system of national health insurance that working Americans do not want."

-- Mark Gorman, Director, Government Affairs
National Restaurant Association, and
Member, Healthcare Equity Action League

"The President's proposals are consistent with HLC's primary objective: building on the strengths of our current private sector based system while ensuring access to affordable, quality care for all Americans...These proposals already have bipartisan support in Congress and can bring us relief now, if politics don't get in the way...[These proposals are also] the only health care alternative that compatible with economic recovery. It will get people covered and keep them covered but it won't raise taxes, cost jobs or put the burden on any one group of employers."

-- Pam Bailey, President
Healthcare Leadership Council

President Bush's health care plan contains some sound and positive concepts, most notably a proposal to allow the self-employed to deduct 100 percent of the cost of their health care insurance premiums...the tax deduction for the self-employed represents an important reform for a group that has been hard hit by spiraling health care costs.

-- Dean Kleckner, President
American Farm Bureau Federation

HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)
STEERING COMMITTEE

Aetna Life & Casualty
American Apparel Manufacturers Association
American Association of Preferred Provider Organizations
American Bakers Association
American Cyanamid Company
American Farm Bureau
American Furniture Manufacturers Association
American Hardware Manufacturers Association
American Hotel & Motel Association
American Institute of Architects
American International Hospital
American Managed Care & Review Association
American Trucking Association, Inc.
AMGEN Inc.
Amway Corporation
Associated Builders and Contractors
Associated Equipment Distributors
Association of Health Insurance Agents
The Beer Institute
Beneficial Management Corporation
Burroughs Wellcome Company
Cancer Treatment Centers of America
Carl Karcher Enterprises
Caterair International Corporation
Central Reserve Life Insurance Company
The CIGNA Corporation
Citizens for a Sound Economy
Council of Smaller Enterprises
Eli Lilly & Company
Employee Benefits South, Inc.
Evanston Hospital Corporation
Federation of American Health Systems
Florists' Transworld Delivery Association
Food Marketing Institute
The Grand Union Company
Group Health Association of America
Hampshire House
Harman Management Corporation
Harris Methodist Health System
Health Industry Distributors Association
Health Industry Manufacturers Association
Health Insurance Association of America
Health Midwest
Health One
Healthcare Leadership Council
Hershey Foods Corporation
Hillcrest Baptist Medical Center
Humana Inc.
Industrial Distribution Association
International Mass Retail Association
John Hancock Mutual Life Insurance Company
Kimberly Quality Care
The Law Offices of Deborah Steelman
Marriott Corporation
Massachusetts Mutual Life Insurance Company
McDonald's Corporation
Melrose Diner, Inc.
Metropolitan Life Insurance Company
Mobile Technology Inc.
Morrison Incorporated
Motorola Inc.
National-American Wholesale Grocers' Association
National Association of Aluminum Distributors
National Association of Chain Drug Stores
National Association of Convenience Stores
National Association of Health Underwriters
National Association of Temporary Services
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United Restaurant & Lodging Association
Virginia Restaurant Association
Walker Health Insurance Services, Inc.
Wallcovering Distributors Association
Warren County (PA) Chamber of Commerce
Washington (IL) Chamber of Commerce
Waste Management Inc.
Water & Sewer Distributors of America
Wausau Hospital Center
Western Association of Fastener Distributors
Western Suppliers Association
Wholesale Beer Distributors of Arkansas
Wholesale Beer Distributors of Texas
Wholesale Distributors Association
Wholesale Florists & Florist Suppliers of America
Wholesale Stationers' Association
Wine & Spirits Wholesalers of America
Wisconsin Wholesale Beer Distributors Association
Woodworking Machinery Distributors Association
Woodworking Machinery Importers Association

Middle Atlantic Wholesalers Association
Mississippi Malt Beverage Association
Missouri Beer Wholesalers Association
Missouri Restaurant Association
Montgomery County Pharmaceutical Association of Pennsylvania
Motorcycle Industry Council
Mount Vernon (NY) Chamber of Commerce
Music Distributors Association
National Appliance Parts Suppliers Association
National Appliance Service Association
National Association of Chemical Distributors
National Association of Container Distributors
National Association of Electrical Distributors
National Association of Fire Equipment Distributors
National Association of Floor Covering Distributors
National Association of Flour Distributors
National Association of Hose and Accessories Distributors
National Association of Meat Purveyors
National Association of Realtors
National Association of Recording Merchandisers
National Association of Service Merchandising
National Association of Sign Supply Distributors
National Association of Sporting Goods Wholesalers
National Association of Wholesale Independent Distributors
National Beer Wholesalers Association
National Building Material Distributors Association
National Business Forms Association
National Business Owners Association
National Candy Wholesalers Association
National Club Association
National Commercial Refrigeration Sales Association
National Electronic Distributors Association
National Fastener Distributors Association
National Food Distributors Association
National Frozen Food Association
National Grocers Association
National Independent Poultry & Food Distributors Association
National Industrial Glove Distributors Association
National Insulation and Abatement Contractors Association
National Lawn & Garden Distributors Association
National Locksmith Suppliers Association
National Marine Distributors Association
National Office Products Association
National Paint Distributors
National Paper Trade Association
National Sash & Door Jobbers Association
National School Supply & Equipment Association
National Solid Wastes Management Association
National Spa & Pool Institute
National Truck Equipment Association
National Welding Supply Association
National Wheel & Rim Association
National Wholesale Furniture Association
National Wholesale Hardware Association
New England Paper Merchandising Association
New England Wholesalers Association
New York State Beer Wholesalers Association
New York State Plumbing & Heating Wholesalers
New York State Restaurant Association
North American Horticultural Supply Association
North American Wholesale Lumber Association
Northamerican Heating & Airconditioning Wholesalers Association
North Carolina Beer Wholesalers Association
North Carolina Wholesalers Association
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Northern Rhode Island Chamber of Commerce
Northwestern Public Service Company
Oklahoma State Chamber of Commerce & Industry
Optical Laboratories Association
Orange County (NY) Chamber of Commerce
Oregon Restaurant and Hospitality Association
Outdoor Power Equipment Distributors Association
Pacific Southwest Distributors Association
Pasadena (CA) Chamber of Commerce
Pennsylvania Chamber of Business and Industry
Pennsylvania Restaurant Association
Pet Industry Distributors Association
Petroleum Equipment Institute
Petroleum Marketers Association of America
Piscataway-Middlesex Area (NJ) Chamber of Commerce
Pocono Mountains Chamber of Commerce
Post Card Distributors Association of North America
Potlach Corporation
Power Transmission Distributors Association
Product Marketing Association
Pueblo (CO) Chamber of Commerce
Reno Sparks Convention and Visitors Authority
Rhode Island Hospitality Association
Riverdale Texaco
Safety Equipment Distributors Association
Santa Ana (CA) Chamber of Commerce
Schiffli Lace & Embroidery Manufacturers Association
Schererville (IN) Chamber of Commerce
Scripps Memorial Hospitals
Shoe Service Institute of America
Small Business of America
Snack Food Association
Society of Professional Benefits Administrators
South Carolina Beer Association
Southern Wholesalers Association
Southworth Milton Inc.
Specialty Tools & Fasteners Distributors Association
Spraying Systems Company
St. Lucie County (FL) Chamber of Commerce
Steel Service Center Institute
Storm Lake (IA) Chamber of Commerce
Suspension Specialists Association
Swartz Restaurants Corporation
Tennessee Malt Beverage Association
Tennessee Restaurant Association
Texas Restaurant Association
Textile Care Allied Trades Association
Thomas Jefferson University Hospital
Thornton Gardens, Inc.
Twinsburg (OH) Chamber of Commerce
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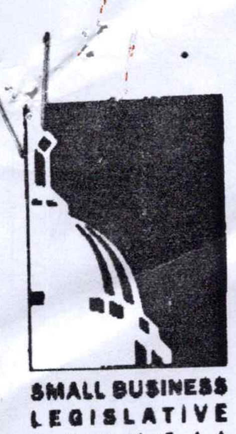

NEWS RELEASE

For more information contact:

(202) 639-8500

February 7, 1992

"We welcome President Bush's health care reform initiative," said Robert D Bannister, Chairman of the SBLC. "His proposal has provided a framework for addressing the issue of individual access to health care. It is a credible alternative to such concepts as 'play or pay' and national health insurance programs."

Bannister continued, "We are pleased to note the President has also embraced several initiatives to improve small business access to health care. We have long supported such recommendations.

"Our number one priority is to rein in out-of-control health care costs," continued Bannister. "SBLC has articulated a game plan to accomplish this goal. We are hopeful we can build upon the President's foundation to accomplish this. We look forward to working with Congress and the administration to construct a reform measure that will provide the cost discipline the health care provider community is either unwilling or unable to provide."

The Small Business Legislative Council (SBLC) is a permanent, independent coalition of nearly one hundred trade and professional associations that share a common commitment to the future of small business. Our members represent the interests of small businesses in such diverse economic sectors as manufacturing, retailing, distribution, professional and technical services, construction, transportation, and agriculture. Our policies are developed through a consensus among our membership. Individual associations may express their own views. For your information, a list of our members is enclosed.

/S2083
Enclosure

1156 15th Street, N.W. - Suite 510 Washington, DC 20005 (202) 639-8500 / FAX (202) 296-5333

Members of the Small Business Legislative Council

Air Conditioning Contractors of America
Alliance for Affordable Health Care
Alliance of Independent Store Owners and Professionals
American Animal Hospital Association
American Association of Nurserymen
American Bus Association
American Consulting Engineers Council
American Council of Independent Laboratories
American Floorcovering Association
American Machine Tool Distributors Association
American Road & Transportation Builders Association
American Society of Travel Agents, Inc.
American Sod Producers Association
American Subcontractors Association
American Textile Machinery Association
American Trucking Associations, Inc.
American Warehouse Association
Architectural Precast Association
Associated Builders & Contractors
Associated Equipment Distributors
Associated Landscape Contractors of America
Association of Small Business Development Centers
Association of the Wall and Ceiling Industries-International
Automotive Service Association
Automotive Warehouse Distributors Association
Bowling Proprietors Association of America
Building Service Contractors Association International
Business Advertising Council
C-PORT
Christian Booksellers Association
Council of Fleet Specialists
Electronics Representatives Association
Florists' Transworld Delivery Association
Helicopter Association International
ndependent Bakers Association
ndependent Medical Distributors Association
Independent Sewing Machine Dealers Association
International Association of Refrigerated Warehouses
nternational Bottled Water Association
International Communications Industries Association
nternational Formalwear Association
nternational Franchise Association
Jewelers of America, Inc.
Machinery Dealers National Association
Manufacturers Agents National Association
Manufacturers Representatives of America, Inc.
Mechanical Contractors Association of America, Inc.
Menswear Retailers of America
NMTBA-The Association for Manufacturing Technology
National Association for the Self-Employed
National Association of Brick Distributors
National Association of Catalog Showroom Merchandisers
National Association of Chemical Distributors
National Association of Home Builders
National Association of Investment Companies
National Association of Passenger Vessel Owners
National Association of Personnel Consultants
National Association of Plumbing-Heating-Cooling Contractors
National Association of Realtors®
National Association of Retail Druggists
National Association of Small Business Investment Companies
National Association of the Remodeling Industry
National Association of Truck Stop Operators
National Campground Owners Association
National Candy Wholesalers Association
National Chimney Sweep Guild
National Coffee Service Association
National Electrical Contractors Association
National Electrical Manufacturers Representatives Association
National Fastener Distributors Association
National Food Brokers Association
National Grocers Association
National Knitwear & Sportswear Association
National Limousine Association
National Lumber & Building Material Dealers Association
National Moving and Storage Association
National Ornamental & Miscellaneous Metals Association
National Paperbox Association
National Parking Association
National Precast Concrete Association
National Shoe Retailers Association
National Society of Public Accountants
National Tire Dealers & Retreaders Association
National Tooling and Machining Association
National Tour Association
National Venture Capital Association
Opticians Association of America
Organization for the Protection and Advancement of Small Telephone Companies
Petroleum Marketers Association of America
Printing Industries of America, Inc.
Professional Plant Growers Association
Retail Bakers of America
SMC/Pennsylvania Small Business
Small Business Council of America, Inc.
Society of American Florists
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National Coalition of Hispanic Health and Human Services Organizations

1501 Sixteenth Street, NW • Washington, DC 20036 • (202) 387-5000

PRESS RELEASE

FOR RELEASE: February 6, 1992
CONTACT: Adolph P. Falcón
(202) 797-4327
(202) 797-4322

COSSMHO Applauds Consumer Choice in President's Health Proposals

WASHINGTON, D.C. -- "The empowerment of individual consumers was given a resounding vote of confidence today in the health reform proposals announced by the President," said Jane L. Delgado, Ph.D., President and CEO of the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO). Dr. Delgado continued, "We as Americans are different than others in the decisions we want government to make for us. Too often government has made all the decisions for the poor and especially the working poor. The President's plan provides families in poverty with the resources to make decisions about their health care."

Under the President's plan, families living at or below the poverty level would receive a health insurance voucher of $3,750. These new resources ensure that families in poverty will be able to make the decision about what type of health coverage best meets their needs rather than the government dictating a welfare plan of coverage.

According to Dr. Delgado, "These proposals, if enacted, would dramatically alter the health insurance picture in Hispanic communities. Today, according to data from the National Medical Expenditure Survey, more than one half (51.3%) of Hispanics in poverty are uninsured compared to 35.1% of blacks and 36.1% of whites in poverty. Under the President's plan, all of these people would have the resources to purchase health insurance most appropriate to their family's needs."

Members: Daniel C. Maldonado, Chair, Washington, DC • Ambassador Phillip Sanchez, Vice Chair, Fresno, CA • Aida L. Giachello, Ph.D., Chicago, IL • Rosa [illegible] .S.W., New York, NY • Jorge J. Lambrinos, Washington, DC • Sara Salvide, M.P.A., Brownsville, TX • Rita Solar-Ossolinski, Washington, DC • Cynthia Ann Telles, [illegible]ngeles, CA • Fernando Treviño, Ph.D., Galveston, TX • Pedro A. Valez, Ph.D., Ponce, Puerto Rico • Corporate Advisory Council: Karen Katen, Vice President, [illegible]nager, Roerig/Pfizer Inc., Council Chair • David W. Anstice, President, Merck Sharp & Dohme • James L. Craig, M.D., Vice President, Director, Health and Human [illegible] eneral Mills • Thomas Draper, Vice President, Community Affairs, Time Warner Inc. • George Kaufmann, Vice President, Worldwide Pharmaceutical Marketing, [illegible] Company • Jan Siemsen, Vice President International, Johnson & Johnson, Intl. • Robert Subin, Vice President, Group General Manager, Grocery for Campbell [illegible]oup Company • Special Corporate Counsel: George S. Triadafilou, Esq., Bower & Gardner • President and Chief Executive Officer: Jane L. Delgado, Ph.D.
• PRINTED ON RECYCLED PAPER •

COSSMHO is the nation's only national Hispanic organization with a primary mission to improve the health and well being of Hispanic communities throughout the United States. Consistent with this mission, COSSMHO does not accept funding from tobacco or alcohol companies or their subsidiaries; the only national Hispanic organization to have adopted this policy. Founded in 1973, COSSMHO pursues its mission through its members - local Hispanic community-based agencies - and by conducting research, and pursuing policy initiatives. COSSMHO is a not-for-profit organization with a membership of over 1,000 individuals and institutions, entirely Hispanic-focused, working in the fields of medicine, public health, social services, mental health, substance abuse, and public administration. COSSMHO's membership is the largest representation of Hispanic community-based organizations in any national organization.

The Business Roundtable

To: Bobbie Kilberg
From: Tom O'Hara

Drew Lewis
Chairman
Robert E. Allen
Cochairman
James T. Lynn
Cochairman
James D. Robinson III
Cochairman
Robert C. Winters
Cochairman

New York
200 Park Avenue
New York, New York 10166-0097
(212) 682-6370 FAX (212) 682-0194
William L. Lurie
President
Richard W. Anthony
Executive Director-Public Information
Richard F. Kibben
Executive Director-Construction
Washington
1615 L Street, N.W.
Washington, D.C. 20036-5610
(202) 872-1260 FAX (202) 466-3509
Samuel L. Maury
Executive Director

FOR IMMEDIATE RELEASE

Contact: Richard Anthony
(202) 872-1260

Karen Howell
(201) 802-8533

February 6, 1992

BUSINESS ROUNDTABLE COMMENDS BUSH HEALTH REFORM PROPOSALS

WASHINGTON - Robert C. Winters, chairman of the Business Roundtable Task Force on Health, Welfare and Retirement Income, expressed enthusiastic support for the Administration healthcare proposals announced today.

"We commend the President for his market-based proposals which build on the strengths of our current system," said Winters. "We believe the President's plan is a vehicle to provide health care to all Americans.

"We are encouraged that bills in both houses of the Congress already include a number of these positive approaches. We look forward to working with the Administration in the days ahead to help enact these important measures.

"It is especially important for the Administration and the Congress to work together to provide broader access to

healthcare, while instituting measures to control its spiraling costs." The Business Roundtable is an association of some 200 major corporations represented by their chief executive officers who focus and act on public issues. Winters is chairman and CEO of The Prudential.

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ARG

The Heritage Foundation

MEMO

To: HEALTH CARE POLICY MAKERS

From: DAVID M. MASON, *Director of Executive Branch Liaison* DM

Date: FEBRUARY 9, 1992

Subject: THE BUSH HEALTH PLAN, CONGRESS' GREAT DEAL and TALKING POINTS ON THE HEALTH CARE DEBATE

President Bush's Health Care Plan takes some steps toward market-oriented reform, but doesn't go far enough, writes Stuart Butler, Heritage's Director of Domestic Policy Studies, in **What's Right and Wrong with Bush's Health Plan**, which is enclosed along with two other Heritage papers on health care.

If Congress is looking for a proven model of a competitive health system, it need look no further than its own health plan-- the same one that covers all federal employees. The "FEHB" gives consumers a broad choice of plans, controls costs, and keeps administrative overhead down. **Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program**, by Heritage Deputy Director of Domestic Policy Studies, Bob Moffit, asks: if its good enough for Congress, why isn't a consumer-based health plan good enough for the rest of America?

Finally, if you're looking for a guidebook to the range of debate on health care, look no further than **A Policy Maker's Guide to the Health Care Crisis, Part 1: The Debate Over Reform.** These Heritage Talking Points, also written by Stuart Butler, provide a simple but comprehensive overview of the current debate over health reform, including descriptions of the major alternative plans.

I am sure that you will find these Heritage publications on health care useful. We will continue a heavy publication schedule on the health care debate over the next several months. If you are interested in Heritage's health care activities or our own reform plan, please contact me. If you have colleagues who would also be interested in our health research, please have them return the enclosed form.

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 6, 1992

THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM

FACT SHEET

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

The President's four-point plan will:

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

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

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

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

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

Elements of the President's Plan

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

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

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

I. Expanding Access to Health Care

Transferable Health Insurance Tax Credits and Deductions

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

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

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

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

1. Transferable Health Insurance Tax Credits (Certificates)

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

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

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

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

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

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

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

2. Deductions

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

3. Increased Help for the Self-employed

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

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

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

II. Insurance Market Reform

A. <u>Basic Benefits</u>.

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

B. <u>Insurance Security</u>.

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

C. <u>Health Insurance Networks (HINs) - Pooled Purchasing Power</u>.

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

D. <u>Mandated Benefits</u>.

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

E. <u>Insurance Affordability</u>.

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

III. Containing Health Care Costs

A. Malpractice and antitrust reform.

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

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

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

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

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

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

B. Reducing administrative costs.

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

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

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

F. <u>Expansion of cost-effective services in underserved areas</u>.

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

G. <u>Prevention</u>.

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

H. <u>Improving Consumer Information</u>.

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

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

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

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

C. Expanded use of coordinated care.

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

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

D. Efficiencies in public programs.

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

E. Increased flexibility in state programs.

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

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

Embargoed Until
12:00 Noon
February 6, 1992

The President's Comprehensive Health Reform Program

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.[1]

Case #1

A family of two parents and a child with one working parent without employer coverage, and a total family income of $10,000 (just below the poverty level):

[Full Credit of $3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a $3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning $8,500 per year. No employer health insurance is provided:

[Full Credit of $3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for six months; after the six-month period, the family may be charged three percent of the family income as a Medicaid premium in this case, $255 for six months of coverage. After one year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a $3,750 transferable credit to buy basic health insurance through the State group health plan (or another private plan) when they no longer qualify for Medicaid.
- The President's plan removes the current incentive for AFDC families to remain on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of four with a modified adjusted gross income of $60,000 (in which the filer is married and filing jointly), and no employer sponsored health insurance:

[Full Health Care Deduction of $3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a $3,750 tax deduction (a benefit of approximately $1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family could buy more affordable coverage through a large group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual with intermitent income at the minimum wage and not eligible for Medicaid (e.g. most males or a woman who is not a mother):

[Individual Credit of $1,250]

- Under the current system, this individual has no access to health insurance, and

[1] The examples presented assume the fully-phased in program, and use 1993 income thresholds.

usually receives "unreimbursed care" through hospital emergency rooms.

- Under the President's plan, this person would receive a $1,250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.

Case #5

A family of four with a modified adjusted gross income of $50,000, and a $1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of $2,750 ($3,750 minus employer contribution of $1,000), making their health insurance much more affordable.

Case #6

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. A pre-existing condition exclusion may also apply, interrupting coverage.
- Under the President's plan, regardless of the employee's health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could not be denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged.)

Case #7

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers could charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill.

Case #8

A small employer with an employee just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Coverage Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance—at any price.
- Under the President's plan, insurers would be required to offer coverage to any group, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #9

A family of four with a modified adjusted gross income of $17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a $3,750 deduction—whichever provides the greater benefit) because their in-

come faces between 100 percent and 150 percent of the tax threshold.

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #10

An individual is planning on choosing a health plan and wants to get the best quality plan for the best price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited knowledge of the relative prices of insurance an health care services. Nor are they aware of the hospitals and doctors included in the plan—or of the relative quality of local hospitals and doctors.

- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. State insurance commissioners will collect information on area providers, and also on individual providers such as physician, hospitals, labs and other facilities—both on price and quality. This information will be made available by employers. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider best suited to their needs and the best value for their health care dollar.

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NAW FAX-SVC
FEB 06 '92 04:59PM TRAVELERS

News Release

TheTravelers

The Travelers Corporation
and its affiliated companies
One Tower Square
Hartford, CT 06183-1060

STATEMENT OF F. PETER LIBASSI,
SENIOR VICE PRESIDENT,
THE TRAVELERS
ON BUSH HEALTH PLAN PROPOSAL

President Bush's program correctly rejects budget-busting national health insurance and play or pay schemes. The president stated emphatically that he favors the market-based solution to the problems of health care cost and access.

The Bush plan also comes out strongly in favor of managed care, both in the private sector and Medicaid and Medicare. This is an effective way to assure continued quality of health care while controlling costs.

We welcome the proposed tax credit for low-income families, tax deductions for middle-income families, and malpractice reforms.

And we are encouraged that the president's insurance reform proposals appear similar to plans already adopted in Connecticut, North Carolina, and Massachusetts. These plans guarantee insurance coverage and renewability to all small employers and ensure continuation of coverage when changing jobs.

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Contact:

John Gustavsen (203) 277-7967
Rosanne Hennessey (203) 277-9101

2/6/92

N · A · W NATIONAL ASSOCIATION OF WHOLESALER-DISTRIBUTORS
1725 K Street, N.W. • Suite 710 • Washington, D.C. 20006 • 202/872-0885 • FAX: 202/785-0586

NEWS

Contacts: • Ron Schreibman, CAE
Vice President — Communications
• Philip B. Jaffa
Director — Communications

FOR IMMEDIATE RELEASE

NAW APPLAUDS BUSH HEALTH CARE INITIATIVE

Washington D.C. (Thursday, February 6, 1992) ... The National Association of Wholesaler-Distributors (NAW) enthusiastically applauds President Bush's health care reform initiative. "Health care reform needs to be market-oriented," says NAW President Dirk Van Dongen. "It needs to control the escalating costs which are currently crushing employers of all sizes. And it needs to solve the cost-induced access problem. The President has put on the table a major reform package that points America in the right direction on this vital issue."

Van Dongen notes that key elements of the President's plan are consistent with a number of reforms already endorsed by NAW and by the Healthcare Equity Action League (HEAL), a key coalition of 400 small and large businesses, corporations, associations, health care providers and insurers of which NAW serves as Executive Secretariat.

Specifically, NAW and HEAL have called for encouraging managed care, eliminating pre-existing conditions clauses, allowing full health insurance deductibility for the self-employed, insurance market reform to ensure that employers of all sizes can secure affordable coverage for their employees, reform of the malpractice laws and limiting costly state-mandated insurance coverages. "The President said it best about state mandates," remarked Van Dongen, "Pretty soon some state will probably insist on health insurance coverage for Millie's manicures!"

-more-

Van Dongen described the basic challenge facing policymakers as "getting people covered and keeping them covered regardless of pre-existing conditions or change of job and making that coverage affordable." That, in Van Dongen's view, is a manageable task. "We know how to do that. There's bipartisan support for it in Congress. We can get relief today, if politics do not get in the way."

Van Dongen reiterated his industry's opposition to mandated "play or pay" schemes or national health insurance: "We do not need costly mandates on business that will necessarily be passed on to all consumers in higher product costs. We do not need government rationing of health care. We do not need higher taxes. The federal government has done a great deal to cause the current crisis. A larger role for the federal government is a guaranteed formula for disaster."

"The President's plan will bring about the type of health care reform Americans want," says Van Dongen. "Americans want a private system with choice, not a government-mandated, one-size-fits-all, program that breeds more bureaucracy."

"We need to build on best of what we have," says Van Dongen, "and NAW intends to work with the President and like-minded Members of Congress to get the job done now and to get the job done right. If we fail, quality, accessible health care in America will go the way of the house call."

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The National Association of Wholesaler-Distributors is a federation of national wholesale distribution trade associations and corporations which, collectively, total approximately 40,000 firms.

HOLD FOR RELEASE UNTIL 1:00 PM THURSDAY, FEBRUARY 6, 1992

NFIB NEWS

Contact: Terry Hill or Angela Jones (202) 554-9000

BUSH HEALTH PLAN GETS HIGH MARKS FROM SMALL BUSINESS

WASHINGTON, Feb. 6---Small-business owners welcome a new plan announced today by President Bush to reform America's health care system through a step-by-step, market-oriented approach, the nation's largest small-business advocacy organization said today.

"It controls costs, gives everyone access to health care, reforms the insurance market and offers businesses incentives," National Federation of Independent Business chief lobbyist John Motley said, calling the plan an important step in the debate over health care. "This is far more favorable to small business than nationalized, government-run plans based on higher taxes and a bigger bureaucracy."

NFIB represents more than 500,000 small and independent businesses in all 50 states. According to a series of surveys conducted by the organization through the 1980's, two-thirds of all small companies offer health insurance, but unprecedented cost increases prevent broader coverage. Among those who do not provide the benefit, two out of three want to but cannot afford it.

Motley said the president's proposal would stabilize the health care marketplace by controlling costs through managed care programs, medical malpractice reform and the elimination of costly state mandates. Other key items for entrepreneurs include allowing full deductibility for health insurance premium costs and cooperative purchasing plans.

Self-employed business owners, some two million of whom are uninsured, are presently allowed to deduct only 25 percent of their health insurance costs. Full deductibility, Motley said, would be a major incentive for them to purchase coverage for themselves and millions of their workers. The measure could bring health care to up to 15 million of the nation's 30 million to 35 million uninsured citizens.

"The free market approach can work if given a chance," Motley said. "Now is not the time to throw out our entire health system and subject millions of people to an experimental program run by the government."

NFIB is a founding member of the Healthcare Equity Action League, a broad alliance of small and large businesses, organizations, health care providers and insurers. The group advocates a seven-step, incremental reform plan which shares many ideas with the administration's proposal.

# # #

SMALL BUSINESS VIEWS ON THE PRESIDENTS' HEALTH PROPOSAL

The cost of health insurance has been the most important issue to American small business owners since 1983. As the cost of health care and health insurance has skyrocketed, small business owners have faced ever-increasing problems in obtaining and maintaining affordable health insurance for themselves, their families and their employees. By late 1980, 91 percent were telling NFIB that its cost had become "prohibitive."

President Bush' recently announced health proposal is welcome news to small business owners because it is comprehensive and market oriented. It contains important insurance market reforms and cost containment measures, building upon the current health care system to provide access to affordable health care.

Most importantly, the President's proposal builds upon the political consensus that has begun to develop to enact a number of needed reforms in 1992. Several of the President's proposals are also included in legislation that has been introduced by Sen. Lloyd Bentsen and Rep. Dan Rostenkowski. These consensus recommendations are backed by HEAL, a broad-based coalition of more than 400 businesses, health care providers and insurers, co-founded by NFIB.

More specifically, the President's proposal contains the following important provisions for small business owners:

* 100% deductibility for self-employed business owners. Unlike corporations, self-employed business owners cannot deduct from their taxes the full cost of health insurance. The proposal permits the self-employed to fully deduct their health insurance premiums, enabling them to pay for insurance for themselves and their employees.

* Insurance market reform. This includes:
    * Preemption of state mandates
    * Essential care policies
    * Guaranteed availability, guaranteed renewability and guaranteed portability

* Medical cost controls. The proposal makes significant reforms in medical malpractice procedures, encourages the publishing of rates and fees so patients can become better consumers, and provide for practice protocols for doctors and health care providers, all of which will reduce the cost of health care and insurance.

* Small business insurance purchasing groups. Small businesses will be able to pool together to reduce individual risk, thus spreading costs over a large group. This should increase stability in health insurance prices.

* Managed care. Many states have inhibited co-operative arrangements in which, for example, a group of doctors agree to provide services at a given cost and in which patients agree to get pre-approval for non-emergency treatment and meet other requirements. Such arrangements can significantly aid in controlling costs. The current proposal would strongly encourage managed care as a cost containment measure.

The President's health proposal will help stabilize the insurance marketplace, make health insurance more affordable, and guarantee that small business owners and individuals can get insurance when they need it. Most importantly, it does so without destroying jobs.

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5 K Street, N.W. • Suite 710 • Washington, D.C. 20006 • 202/872-0885 • FAX: 202/785-0586

NEWS

Contacts: • Ron Schreibman, CAE
Vice President — Communications
• Philip B. Jaffa
Director — Communications

Greg
Pls start
Health
supporters
List.
Cherrie
(see attached)

FOR IMMEDIATE RELEASE

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HIGHLIGHTS:
The President's Plan For Comprehensive Health Care Reform

The President's Plan is a comprehensive, market-based reform that builds on the strengths of our current system to provide access to *affordable insurance* for all Americans.

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

- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.

- **The President's plan will *reduce the cost* of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups -- so they can receive the same favorable health coverage enjoyed by large employers. Millions of people who now can not find affordable insurance will be helped.

- **The President's plan provides new help to the middle class to pay for health care.** Up to $3,750 in health insurance costs can be deducted by families with incomes less than $80,000. Over 90 million Americans will receive new assistance for health costs.

- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as would costly State mandated benefit laws. The comprehensive plan encourages individuals, employers and health providers to use coordinated care systems.

- **The President's plan will use the power of an informed marketplace** to help control costs by providing consumers with better information and by giving individuals the resources to choose the coverage that best meets their needs.

- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.

- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the U.S. health system.

- **The President's plan would expand services in underserved areas.** Many inner city and rural areas have acute shortages of doctors and clinics. The President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to increase preventive care in these areas.

The President's Plan Does Not:

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

HEALTHCARE EQUITY ACTION LEAGUE
EMPLOYERS UNITED FOR REFORM

FOR RELEASE AFTER 1:00 PM, FEBRUARY 6, 1992

HEAL SAYS PRESIDENT'S HEALTH CARE REFORM PLAN BEST FOR AMERICANS

WASHINGTON, D.C., Feb. 6, 1992 -- Members of the Healthcare Equity Action League (HEAL) praised the health care reforms announced today by President Bush in Cleveland as a strong and positive market-oriented proposal in the health care debate.

"The President's plan builds on the strengths of our current health care system and tackles the serious problems with common sense reforms that the majority of Americans support," said John Motley, vice president of federal governmental relations for the National Federation of Independent Business and a HEAL member.

"A recent USA TODAY, CNN, Gallup poll found that 64 percent of Americans surveyed believe that reform of our private health care system is the best way to solve the health care crisis, not government-sponsored national health insurance."

Another survey conducted recently by the American Association of Retired Persons found that while Americans strongly favor change in the current system, their support does not extend to proposals that mean the loss of choice of health care providers, loss of services and added costs of major overhaul that would result from enactment of "play or pay" or national health insurance, Motley noted.

HEAL's coalition of nearly 400 small and large businesses, corporations, associations, health care providers and insurers advocates many of the basic reforms in the President's plan.

"HEAL members want to get people covered, keep people covered and reduce health care costs," said HEAL member Dirk Van Dongen, President of the National Association of Wholesaler-Distributors. "The President's reforms can be enacted now and accomplish these goals."

HEAL members also are concerned about the impact of "play or pay" and national health insurance on American jobs and business. "We oppose taxing employers and employees out of jobs and businesses in order to create an unproven system of national health insurance that working Americans do not want," said Mark Gorman, director of government affairs of the National Restaurant Association and a HEAL member.

HEAL's proposed reforms would control health care costs and make coverage available to more people by allowing the self-employed to deduct 100 percent of their health insurance premiums, reforming medical malpractice laws and pre-empting state laws that restrict cost-saving managed care plans and require coverage of costly, unnecessary procedures such as hair transplants.

- more -

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The HEAL reforms also would prohibit the denial of claims or insurance for pre-existing conditions once an individual has been covered or when an employee changes jobs or files claims.

"The vast majority of Americans -- 85 percent -- has health insurance," said Pam Bailey, president of the Healthcare Leadership Council and HEAL member. "They are concerned about keeping their coverage and not losing it when they change jobs or file large claims. These concerns would be answered by HEAL's proposed reforms."

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CONTACT: For more information or to arrange interviews, please call Sharon Brown, (202) 833-4284.

HEALTHCARE EQUITY ACTION LEAGUE
EMPLOYERS UNITED FOR REFORM

HEALTH CARE REFORM PROPOSALS AND THE QUESTIONS THEY RAISE

U.S. Sen. Bob Kerrey — National Health Insurance

The presidential campaign trail is where Sen. Kerrey (D-NE) is pressing his version of a national health insurance plan similar to that of Rep. Marty Russo. "The Health USA Act of 1991" would replace existing private and public health insurance — including Medicaid, Medicare and the military system CHAMPUS — with state-administered plans financed by federal and state funds.

All health care plans would operate under state-negotiated financing and payment contracts. Health USA would continue reliance on private hospitals, physicians and other health professionals to deliver services. All persons would be required to enroll.

Financing would come from federal and state funds currently spent on Medicare, Medicaid and other health programs, some copayments, a 5 percent payroll tax on employers and employees, excise taxes, increased corporate and individual income taxes, an increase in the amount of Social Security benefits that is taxed and a surtax on unearned income.

The plan would be administered at the federal level by a new independent commission aided by a national advisory board.

A recent study by the Republican staff of Congress' Joint Economic Committee found that a Canadian-style, government-financed health care plan like Sen. Kerrey's would cost the U.S. government $81.5 billion per year.

National health insurance raises serious questions:

Will American quality of care suffer? With limited funds, will hospitals deteriorate through lack of capital investment?

Will patients have to wait for expensive kinds of care when they really need it?

Can the federal government — with its IRS and S&L track record — administer such a huge program with efficiency and compassion?

Will the increased taxes to pay for the system hamper business and stifle job creation? Will added health care costs drive small businesses out of business?

Do the plans have an accurate concept of costs a decade from now, with more elderly in nursing homes, greater populations and uncertain business climates?

Under a national plan, will we maintain over the long term the access, quality and freedom of choice we now enjoy?

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TEL: 202-872-0885 • FAX: 202-785-0586

U.S. Rep. Marty Russo — National Health Insurance

"The Universal Health Care Act," sponsored by Rep. Russo (D-IL), would provide health insurance coverage to all U.S. residents.

The compulsory national health insurance program would be funded through premiums for the elderly, employer payroll taxes, increases in corporate and individual income taxes and removal of the cap on wages subject to the Medicare Hospital Insurance payroll tax. A National Health Trust Fund would contain and disperse these monies.

The Department of Health and Human Services (HHS) would establish a national health care budget and decide how much each state could spend.

Annual budgets would be allotted for hospital and nursing home costs. Physicians and other health care professionals would be paid according to established fee schedules.

Several commissions would be established to advise Congress and HHS on changes in budgets and fees. All current federal, state and military health benefit programs would be eliminated.

This dramatic reform proposal prompts many questions:

First and foremost, do Americans really want national health insurance? Do they want services to be rationed when the budget allocations run out? Do they want to wait for services? Do they want treatment decisions to be based on health concerns or budgetary considerations? Do they want to remove incentives for quality care by paying everybody the same amount, regardless of performance?

Given the track record on management of the nation's savings and loan institutions, can the government really handle this huge, new bureaucracy? Will the consolidation save money or cost even more to administer?

Will political influence on a government-run health program cause costs to spiral in election cycles? Will health care access and quality be equal in all parts of the country?

With no free-market incentive, will research and innovation be compromised or threatened? With limited resources, will the technology we develop be available to all who need it?

How will increased taxes on the elderly's long-term care and Social Security benefits affect their well-being?

What is the impact of increased health care taxes on wage earners? On the businesses that employ them? What will the costs be for business and government 10 years from now?

Have we given up on fixing the current system — one whose quality is the envy of the world?

U.S. Sens. George Mitchell and Edward Kennedy — "Play-or-Pay"

Sens. George Mitchell (D-ME) and Edward Kennedy (D-MA) are actively pushing in the Senate a plan known as "play or pay," or the "HealthAmerica: Affordable Health Care for All Americans Act." It would require employers to play by providing coverage meeting basic standards or pay an increased percentage of their payroll to enroll their workers in AmeriCare, a new public insurance program.

Governor Bill Clinton, a Democratic presidential hopeful, endorses this type of plan.

AmeriCare would be administered by the states subject to national standards, replacing the current Medicaid program for the poor. It would provide coverage to the poor, the unemployed and employees whose employers opt to contribute to the public plan rather than provide private benefit plans. An individual also could purchase a private, qualified health plan.

Financing of benefits would come from employer premiums, employee premiums, premiums of AmeriCare enrollees, some copayments and deductibles, state revenues, federal payment to states, full deduction of health plan costs for self-employed individuals and a tax credit for small employers. Premiums would be based on the ability to pay.

An independent Federal Health Expenditure Board, coordinating with state purchasing consortia, would be established to negotiate cost containment programs between purchasers and providers of health care.

The Mitchell-Kennedy plan's cost to the federal government is estimated at approximately $6 billion in the first year.

The questions concerning "play or pay":

Who will foot the bill for this $6 billion plan? How much will individual taxes be increased to cover new costs? What will those costs be in a few years?

How will businesses survive the additional $30 billion annually in increased health care premiums (cited by an Urban Institute and Rand Corporation analysis)?

How will struggling small businesses afford the estimated 71 percent increase in the cost of doing business under "play or pay" (cited in the same study)? Will workers lose real jobs in the name of universal health insurance?

Will the federal government become the national health insurer when large and small businesses determine it is cheaper to transfer employees to the public plan? Doesn't this threaten to preclude employees' choice of private plans?

Who will pay the $35 billion in additional yearly health care costs this plan would impose on the federal government? Can we say what those costs will be in a decade?

Bentsen, Chafee, Johnson-Chandler—Market-Based Health Care Reform

A number of congressional leaders from both sides of the aisle are supporting measures that would reform the existing U.S. health care system now.

These measures include increased tax deductions for health insurance for the self-employed, pre-emption of state laws that discourage managed care programs, pre-emption of state health insurance mandates that inflate the cost of premiums, options to guarantee availability of insurance to small employers and individuals, reform of medical malpractice laws and increased access to preventive care.

Notable among the market-based reform approaches are the following.

U.S. Sen. Lloyd Bentsen — Basic Reform

Sen. Bentsen (D-TX), chairman of the Senate Finance Committee, was one of the earliest to introduce reform measures through the "Health Insurance Reform and Cost Control Act." U.S. Rep. Dan Rostenkowski (D-IL), chairman of the House Ways and Means Committee, supports similar legislation. Their bills emphasize access and affordability for small businesses and the self-employed.

Among the key provisions in the Bentsen-Rostenkowski legislation are increased tax deductions for the self-employed, federal requirements of insurers to sell coverage with basic benefits to any qualifying employer, limitation on rate increases, guarantees of eligibility when employees change jobs and restrictions on variations in premiums for small employers.

The plan would cost an estimated $8 billion to $10 billion over a five-year period. The bills do not include financing.

U.S. Sen. John Chafee — Basic Reform

Sen. Chafee (R-RI) introduced the "Health Equity Access and Improvement Act," which has been adopted as the Republican Task Force proposal.

Sen. Chafee's plan would provide tax credits for businesses and individuals to help purchase health insurance, establish new rules that would allow states to offer assistance to low-income individuals not eligible for Medicaid, reform medical malpractice laws, increase access to preventive care, and limit rate increases for and offer policies tailored to small businesses.

The measure would encourage the use of managed care plans, particularly for employees of small businesses, through tax credits and pre-emption of state anti-managed care laws.

U.S. Reps. Nancy Johnson and Rod Chandler — Basic Reform

Reps. Nancy Johnson (R-CT) and Rod Chandler (R-WA) introduced "Health Equity and Access Reform Today (HEART)" to ensure availability of a low-cost, basic health policy — MedAccess — through all employers.

The measure would establish standards for health insurance carriers offering health benefits plans to small employers. The carriers would be required to offer MedAccess plans to any small employer that applied. The bill would prohibit the imposition of pre-existing condition limitations, limit premium increases and prohibit canceling of coverage or denial of coverage renewal.

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HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

MEDIA ADVISORY
February 6, 1992

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TEL: 202-872-0885 • FAX: 202-785-0586

HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

The Healthcare Equity Action League: Its Recommendations and Membership

The Healthcare Equity Action League (HEAL) seeks to reform the nation's health care system so Americans can obtain health insurance, afford to pay for it and not lose it when they need it most. HEAL looks to accomplish its goals by building on the best of the current health care system and making those aspects accessible and affordable to people currently left out. It does not favor scrapping the current system for unworkable, costly government-imposed controls.

HEAL is a large and diverse group. More than 360 companies and organizations representing 1 million employers and 35 million employees are members of HEAL. They are small and large businesses, corporations, associations, health care providers and insurers. They are united around a set of proposals for which there is already a broad consensus — proposals that can and should be enacted now.

The positive steps HEAL is proposing would reform the health care system while maintaining its basic structure. These practical steps would help make the best of the private insurance system available and affordable to more Americans and keep it available to those who are in danger of becoming uninsured.

In addition, HEAL's proposals have broad, bipartisan political support and could be enacted now to bring quick relief to the problem of health care accessibility and cost. They include the following:

- Significantly lower the cost of health insurance by eliminating more than 1,000 state rules mandating many specific and costly provisions. These provisions, which in some cases require businesses to pay for hair transplants, acupuncture and in vitro fertilization, inflate the cost of insurance.
- Pre-empt state laws that restrict managed care health plans. This would allow the insurer to monitor costs, treatments and practices to assure better care and further reduce insurance costs.
- Allow small businesses to deduct 100 percent of their health insurance premiums. Currently, incorporated businesses may deduct 100 percent, but many small business owners and the self-employed are only allowed a 25 percent deduction. By changing the tax code to allow full deductability for all businesses, smaller companies would have an incentive to obtain or expand health insurance.

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- Empower consumers and encourage personal responsibility. Patients need timely, reliable information on fees, physician practices and protocols as well as treatments and their outcomes in order to be effective participants in their own health care — and to stimulate a market-driven health care system. Wellness education also is needed to help contain future health care costs.

- Bring health care costs under control by pursuing innovative purchasing and managed care techniques. Health care providers must be part of the solution to escalating health care costs.

HEAL was formed to combat the idea that the nation's health care problems can only be solved by totally restructuring the system. HEAL rejects national health insurance and so-called "play or pay" mandated coverage programs as proposed solutions.

For example, under the "play or pay" option, all employers would be forced to provide health insurance to employees or pay a tax. HEAL contends that the tax increase needed to finance <u>either</u> of these plans would place unreasonable financial burdens on taxpayers and small business, possibly costing employees their jobs or driving small firms out of business.

In addition, HEAL believes the resulting system would <u>not</u> improve the quality of health care. Instead, it's quite likely a national health insurance program administered by a federal bureaucracy would diminish the quality of care by having the government decide how much health care patients can receive and when they can receive it.

Instead, HEAL proposes a better way — one that is attainable, preserves jobs, delivers quality care and provides life-long security of coverage at a reasonable cost.

For further information: **Jane Robbins** (202) 833-4822
Larry Shainman (202) 833-4293

1/92

HEALTHCARE EQUITY ACTION LEAGUE
EMPLOYERS UNITED FOR REFORM

FOR RELEASE AFTER 1:00 PM, FEBRUARY 6, 1992

HEAL SAYS PRESIDENT'S HEALTH CARE REFORM PLAN BEST FOR AMERICANS

WASHINGTON, D.C., Feb. 6, 1992 -- Members of the Healthcare Equity Action League (HEAL) praised the health care reforms announced today by President Bush in Cleveland as a strong and positive market-oriented proposal in the health care debate.

"The President's plan builds on the strengths of our current health care system and tackles the serious problems with common sense reforms that the majority of Americans support," said John Motley, vice president of federal governmental relations for the National Federation of Independent Business and a HEAL member.

"A recent USA TODAY, CNN, Gallup poll found that 64 percent of Americans surveyed believe that reform of our private health care system is the best way to solve the health care crisis, not government-sponsored national health insurance."

Another survey conducted recently by the American Association of Retired Persons found that while Americans strongly favor change in the current system, their support does not extend to proposals that mean the loss of choice of health care providers, loss of services and added costs of major overhaul that would result from enactment of "play or pay" or national health insurance, Motley noted.

HEAL's coalition of nearly 400 small and large businesses, corporations, associations, health care providers and insurers advocates many of the basic reforms in the President's plan.

"HEAL members want to get people covered, keep people covered and reduce health care costs," said HEAL member Dirk Van Dongen, President of the National Association of Wholesaler-Distributors. "The President's reforms can be enacted now and accomplish these goals."

HEAL members also are concerned about the impact of "play or pay" and national health insurance on American jobs and business. "We oppose taxing employers and employees out of jobs and businesses in order to create an unproven system of national health insurance that working Americans do not want," said Mark Gorman, director of government affairs of the National Restaurant Association and a HEAL member.

HEAL's proposed reforms would control health care costs and make coverage available to more people by allowing the self-employed to deduct 100 percent of their health insurance premiums, reforming medical malpractice laws and pre-empting state laws that restrict cost-saving managed care plans and require coverage of costly, unnecessary procedures such as hair transplants.

- more -

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The HEAL reforms also would prohibit the denial of claims or insurance for pre-existing conditions once an individual has been covered or when an employee changes jobs or files claims.

"The vast majority of Americans -- 85 percent -- has health insurance," said Pam Bailey, president of the Healthcare Leadership Council and HEAL member. "They are concerned about keeping their coverage and not losing it when they change jobs or file large claims. These concerns would be answered by HEAL's proposed reforms."

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In addition, HEAL's proposals have broad, bipartisan political support and could be enacted now to bring quick relief to the problem of health care accessibility and cost. They include the following:

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HEALTHCARE EQUITY ACTION LEAGUE
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HEALTH CARE REFORM PROPOSALS AND THE QUESTIONS THEY RAISE

U.S. Sen. Bob Kerrey — National Health Insurance

The presidential campaign trail is where Sen. Kerrey (D-NE) is pressing his version of a national health insurance plan similar to that of Rep. Marty Russo. "The Health USA Act of 1991" would replace existing private and public health insurance — including Medicaid, Medicare and the military system CHAMPUS — with state-administered plans financed by federal and state funds.

All health care plans would operate under state-negotiated financing and payment contracts. Health USA would continue reliance on private hospitals, physicians and other health professionals to deliver services. All persons would be required to enroll.

Financing would come from federal and state funds currently spent on Medicare, Medicaid and other health programs, some copayments, a 5 percent payroll tax on employers and employees, excise taxes, increased corporate and individual income taxes, an increase in the amount of Social Security benefits that is taxed and a surtax on unearned income.

The plan would be administered at the federal level by a new independent commission aided by a national advisory board.

A recent study by the Republican staff of Congress' Joint Economic Committee found that a Canadian-style, government-financed health care plan like Sen. Kerrey's would cost the U.S. government $81.5 billion per year.

National health insurance raises serious questions:

Will American quality of care suffer? With limited funds, will hospitals deteriorate through lack of capital investment?

Will patients have to wait for expensive kinds of care when they really need it?

Can the federal government — with its IRS and S&L track record — administer such a huge program with efficiency and compassion?

Will the increased taxes to pay for the system hamper business and stifle job creation? Will added health care costs drive small businesses out of business?

Do the plans have an accurate concept of costs a decade from now, with more elderly in nursing homes, greater populations and uncertain business climates?

Under a national plan, will we maintain over the long term the access, quality and freedom of choice we now enjoy?

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U.S. Rep. Marty Russo — National Health Insurance

"The Universal Health Care Act," sponsored by Rep. Russo (D-IL), would provide health insurance coverage to all U.S. residents.

The compulsory national health insurance program would be funded through premiums for the elderly, employer payroll taxes, increases in corporate and individual income taxes and removal of the cap on wages subject to the Medicare Hospital Insurance payroll tax. A National Health Trust Fund would contain and disperse these monies.

The Department of Health and Human Services (HHS) would establish a national health care budget and decide how much each state could spend.

Annual budgets would be allotted for hospital and nursing home costs. Physicians and other health care professionals would be paid according to established fee schedules.

Several commissions would be established to advise Congress and HHS on changes in budgets and fees. All current federal, state and military health benefit programs would be eliminated.

This dramatic reform proposal prompts many questions:

First and foremost, do Americans really want national health insurance? Do they want services to be rationed when the budget allocations run out? Do they want to wait for services? Do they want treatment decisions to be based on health concerns or budgetary considerations? Do they want to remove incentives for quality care by paying everybody the same amount, regardless of performance?

Given the track record on management of the nation's savings and loan institutions, can the government really handle this huge, new bureaucracy? Will the consolidation save money or cost even more to administer?

Will political influence on a government-run health program cause costs to spiral in election cycles? Will health care access and quality be equal in all parts of the country?

With no free-market incentive, will research and innovation be compromised or threatened? With limited resources, will the technology we develop be available to all who need it?

How will increased taxes on the elderly's long-term care and Social Security benefits affect their well-being?

What is the impact of increased health care taxes on wage earners? On the businesses that employ them? What will the costs be for business and government 10 years from now?

Have we given up on fixing the current system — one whose quality is the envy of the world?

U.S. Sens. George Mitchell and Edward Kennedy — "Play-or-Pay"

Sens. George Mitchell (D-ME) and Edward Kennedy (D-MA) are actively pushing in the Senate a plan known as "play or pay," or the "HealthAmerica: Affordable Health Care for All Americans Act." It would require employers to play by providing coverage meeting basic standards or pay an increased percentage of their payroll to enroll their workers in AmeriCare, a new public insurance program.

Governor Bill Clinton, a Democratic presidential hopeful, endorses this type of plan.

AmeriCare would be administered by the states subject to national standards, replacing the current Medicaid program for the poor. It would provide coverage to the poor, the unemployed and employees whose employers opt to contribute to the public plan rather than provide private benefit plans. An individual also could purchase a private, qualified health plan.

Financing of benefits would come from employer premiums, employee premiums, premiums of AmeriCare enrollees, some copayments and deductibles, state revenues, federal payment to states, full deduction of health plan costs for self-employed individuals and a tax credit for small employers. Premiums would be based on the ability to pay.

An independent Federal Health Expenditure Board, coordinating with state purchasing consortia, would be established to negotiate cost containment programs between purchasers and providers of health care.

The Mitchell-Kennedy plan's cost to the federal government is estimated at approximately $6 billion in the first year.

The questions concerning "play or pay":

Who will foot the bill for this $6 billion plan? How much will individual taxes be increased to cover new costs? What will those costs be in a few years?

How will businesses survive the additional $30 billion annually in increased health care premiums (cited by an Urban Institute and Rand Corporation analysis)?

How will struggling small businesses afford the estimated 71 percent increase in the cost of doing business under "play or pay" (cited in the same study)? Will workers lose real jobs in the name of universal health insurance?

Will the federal government become the national health insurer when large and small businesses determine it is cheaper to transfer employees to the public plan? Doesn't this threaten to preclude employees' choice of private plans?

Who will pay the $35 billion in additional yearly health care costs this plan would impose on the federal government? Can we say what those costs will be in a decade?

Bentsen, Chafee, Johnson-Chandler—Market-Based Health Care Reform

A number of congressional leaders from both sides of the aisle are supporting measures that would reform the existing U.S. health care system now.

These measures include increased tax deductions for health insurance for the self-employed, pre-emption of state laws that discourage managed care programs, pre-emption of state health insurance mandates that inflate the cost of premiums, options to guarantee availability of insurance to small employers and individuals, reform of medical malpractice laws and increased access to preventive care.

Notable among the market-based reform approaches are the following.

U.S. Sen. Lloyd Bentsen — Basic Reform

Sen. Bentsen (D-TX), chairman of the Senate Finance Committee, was one of the earliest to introduce reform measures through the "Health Insurance Reform and Cost Control Act." U.S. Rep. Dan Rostenkowski (D-IL), chairman of the House Ways and Means Committee, supports similar legislation. Their bills emphasize access and affordability for small businesses and the self-employed.

Among the key provisions in the Bentsen-Rostenkowski legislation are increased tax deductions for the self-employed, federal requirements of insurers to sell coverage with basic benefits to any qualifying employer, limitation on rate increases, guarantees of eligibility when employees change jobs and restrictions on variations in premiums for small employers.

The plan would cost an estimated $8 billion to $10 billion over a five-year period. The bills do not include financing.

U.S. Sen. John Chafee — Basic Reform

Sen. Chafee (R-RI) introduced the "Health Equity Access and Improvement Act," which has been adopted as the Republican Task Force proposal.

Sen. Chafee's plan would provide tax credits for businesses and individuals to help purchase health insurance, establish new rules that would allow states to offer assistance to low-income individuals not eligible for Medicaid, reform medical malpractice laws, increase access to preventive care, and limit rate increases for and offer policies tailored to small businesses.

The measure would encourage the use of managed care plans, particularly for employees of small businesses, through tax credits and pre-emption of state anti-managed care laws.

U.S. Reps. Nancy Johnson and Rod Chandler — Basic Reform

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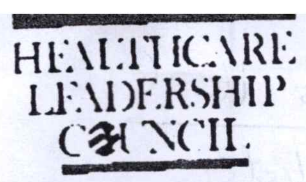

HLC Talking Points

o The President's plan will bring about the type of health care reform Americans want -- a system built on the best of what we now have, not the creation of a new national health program.

o According to recent polls, nearly two out of three Americans don't want national health insurance and the rationed care and loss of choice that come with it. Instead, they believe that reforming our private health care system is the best solution.

o The President's proposals are consistent with the HLC's primary objective: building on the strengths of our current private sector based system while ensuring access to affordable, quality care for all Americans, either through a private plan or through a government safety net. These proposals already have bi-partisan support in Congress and can bring us relief now -- if politics don't get in the way.

o The market oriented reform supported by the President is the only health care alternative that's compatible with economic recovery. It will get people covered and keep them covered but it won't raise taxes, cost jobs or put the burden on any one group of employers.

o The Congress has a clear choice: enact a plan which is based on the free market as proposed by the President and the HLC or watch quality, accessible health care go the way of the house call.

o Key points in the President's plan include:

- Guaranteeing access to health insurance for the poor through vouchers worth up to $3,750 in coverage per family.

- Reducing the cost of insurance for small business through major market reforms.

- Ensuring value by encouraging the growth of coordinated care (managed care) in private plans, Medicaid and Medicare.

- Expanding services in underserved areas by increasing funds for preventive services through Community Health Centers, Migrant Health Centers and the National Health Service Corps.

- Providing relief to over 90 million people by making up to $3,750 in health insurance costs deductible by families with incomes less than $80,000.

The President's plan does not include government price regulation, massive tax increases, costly mandates on small business or benefit reductions for poor older Americans.

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1500 K Street, NW, Suite 360
[illegible], DC 20005

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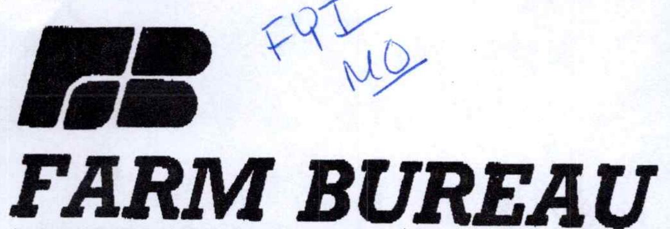

NEWS

AMERICAN FARM BUREAU FEDERATION
600 Maryland Ave., SW • Suite 800 • Washington, DC 20024 • (202) 484-3600
225 Touhy Ave. • Park Ridge, IL 60068 • (312) 399-5850

Contact: Don Lipton 202/484-3624 Dave Lane 202/484-3610

Bush Health Plan Includes Vital Provision for Farmers

FOR IMMEDIATE RELEASE

WASHINGTON, Feb. 7, 1992--President Bush's health care plan contains some sound and positive concepts, most notably a proposal to allow the self-employed to deduct 100 percent of the cost of their health insurance premiums, according to the American Farm Bureau Federation.

AFBF President Dean Kleckner said the tax deduction for the self-employed represents an important reform for a group that has been hard hit by spiraling health insurance costs. "This is an issue that is extremely important to farmers and ranchers, and we will continue to work hard to see that full deductibility is made permanent," Kleckner said.

The self-employed are currently allowed only a 25 percent deduction, a provision which is set to expire June 30. (The president's budget, unveiled Jan. 29, proposed extending the 25 percent deduction to Dec. 31, 1993.)

Kleckner noted that Farm Bureau will study Bush's overall proposal more closely to determine its impact on rural Americans, but "in general, we feel the administration's overall effort is worthy of our support. We agree with the market-oriented approach he has proposed."

Farm Bureau is concerned, Kleckner said, about the methods to be used to finance the plans that have been proposed by Bush and several members of Congress.

(more)

Kleckner hailed the Bush plan's opposition to a national health care system such as Canada's and to a "play or pay" system in which employers would be offered the choice of providing insurance coverage for their employees or paying a tax to fund a government insurance plan.

Both plans, said Kleckner, would mean "more government involvement in medicine at astronomical costs to taxpayers."

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