93-126365

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

MEMORANDUM

TO: SECRETARY BENTSEN
FROM: LESLIE SAMUELS LBS
DATE: OCTOBER 8, 1993
RE: ATTACHED MEMORANDA

Attached are additional memoranda on subjects related to health care reform. As with the memos we sent earlier, these memos ask for your approval and/or guidance regarding certain aspects of the health care reform proposal.

Specifically, the memos address the following issues:

- Design of the Tax Cap
- Independent Contractors and Outsourcing of Workers
- Tax Treatment of Nonprofit Health Care Organizations
- Tax Treatment of Managed Care Entities
- Tax Incentives for Health Care Providers in Rural Areas

In addition, we wanted you to be aware that the health care plan currently contemplates two other tax changes that you may find of interest:

- Application of the HI tax to all State and local government workers. As you know, this proposal was made on a number of occasions by the Reagan and Bush Administrations and was rejected by Congress.
- A means-related Medicare Part B premium beginning at $100,000 for single individuals and $120,000 for couples. We believe that the intent is that these premiums will be collected by the IRS.

Treasury will be involved in the drafting of these proposals.

cc: R. Altman
A. Munnell
M. Weiss

DEPARTMENT OF THE TREASURY
WASHINGTON

October 8, 1993

MEMORANDUM FOR SECRETARY BENTSEN

THROUGH: LESLIE B. SAMUELS
ASSISTANT SECRETARY (TAX POLICY)

FROM: JANET HOLTZBLATT (622-1327) AND
RANDY HARDOCK (622-0170)

SUBJECT: Tax Treatment of Employer Provided Health Insurance Under Health Reform

SUMMARY: This memorandum discusses a number of issues relating to the tax treatment of employer-provided health insurance under health reform, including the 100 percent deduction for the self-employed.

DISCUSSION:

1. Overview.

Based on the September 7 draft and discussions with Mr. Magaziner, we believe that there is general agreement on several key issues regarding the tax treatment of employer-provided health insurance:

- Employer contributions for the comprehensive (i.e., standard) benefit package (up to 100 percent of the costs of the package) would be excluded from income for purposes of calculating individual income and employment taxes.

- Employees would include in taxable income and wages the following items: employer-paid premiums on supplemental plans; employee premiums, co-pays and deductibles paid by the employer through cafeteria plans, including flexible spending accounts (FSA); and other employee co-pays and deductibles that the employer voluntarily agrees to pay.

- The health insurance deduction for self-employed persons would be increased to 100 percent of the costs of the comprehensive benefit package (thus, a cap would also apply to the 100 percent deduction for the self-employed).

- The tax cap would become effective January 1, 2003.

- Employee contributions for health benefits through cafeteria plans would be disallowed, effective January 1, 1997. OK

A number of other issues must still be resolved. With respect to these issues, we recommend that:

- The 100 percent health insurance deduction for self-employed taxpayers will apply to contributions made to regional alliances. (As a consequence, a self-employed taxpayer would be able to claim the deduction once his residence state establishes a regional alliance, whether that is in 1997 or earlier.)

- The 25 percent health insurance deduction for self-employed workers would be extended from January 1, 1994 to December 31, 1996. OK

- Employers may pay all or part of the employee's share of the premium. Employers that do so must make the same dollar contribution for all employees within a geographic area (generally a regional alliance) the same family status, unless a bona fide collective bargaining agreement requires otherwise.

- Employer contributions for the comprehensive health insurance package for retirees under age 65 would be excludable from income and payroll taxes (under the generally applicable rules). OK

- Federal subsidy payments for retiree health insurance benefits would be excludable from income. However, the subsidy benefit would be taxed at the same income thresholds as Medicare Part B premiums.

- All employer contributions for health insurance benefits for retired workers, age 65 and over, would be excluded from income as under current law. Active workers, age 65 or over, would be treated in the same fashion as younger workers; i.e., employer contributions toward the comprehensive benefit package would not be taxable, while contributions in excess of the comprehensive benefit package would be taxable.

- All other Federal subsidies for health insurance (e.g., subsidies to low-income individuals) would be excluded from the income of the recipient.

- Prepayments for qualifying medical expenditures under section 213 must be deducted over the period of the benefit.

Based on our initial discussions with Mr. Magaziner, we do not believe that he will object to our recommendations. These and related issues are discussed in greater detail below.

2. Detailed Discussion.

Effective Date and Transition Rules for Tax Cap: Under the September 7 draft, the tax cap would become effective when a state establishes qualified health alliances. Employees within the state would be exempted from the tax cap until 2003 if their firm offered a more generous benefit package than the standard plan (as in effect in the year 2000) prior to January 1, 1993, and their employer registered their plan with the Department of Labor during 1994.

Issue 1: Should there be a 10-year grandfather rule based on the specifics of existing arrangements?

There are significant (and perhaps insurmountable) administrative, policy and political problems with this proposal. Tracking employer health insurance plans over a ten-year period would be a difficult task for either the IRS or DOL. We would strongly recommend that if a decision is made to delay the impact of the tax cap proposal, that it be done on a uniform basis with a delayed effective date, rather than with a grandfather provision that is based on the specifics of existing arrangements that vary across industries and employers.

On Labor Day, Mr. Magaziner stated that he was not anticipating much revenue pick-up from the tax cap over the budget period. In subsequent conversations, he has stated that he was willing to step away from the registry concept in response to Treasury's concern about this aspect of the proposal. Because of commitments made to labor unions, Mr. Magaziner is adamant about the 2003 effective date.

Mr. Magaziner has made other statements to staff which suggest that he wants to phase-in some aspects of the tax cap proposal sooner than 2003 in order to increase consumers' awareness of the costs of health insurance. As a consequence, he would prefer that the provision to eliminate employee contributions in cafeteria plans become effective in 1997 (when all states are required to have health alliances operating).

Self-employed Health Insurance Deduction: In his speech before the National Governor's Association in August, the President announced that the health reform plan would include a proposal to increase the health insurance deduction for self-employed persons to 100 percent. As further specified in the most current drafts, this proposal would be limited to 100 percent of the costs of the comprehensive benefit package and presumably could not exceed a taxpayer's total self-employed earnings. As under current law, the deduction would apply only to individual income taxes. The proposal would also eliminate the current law restriction that the deduction would not be available to self-employed individuals whose spouses are employed by a firm which offers a health insurance plan.

Issue 1: Should the self-employed health insurance deduction be limited to 80 percent of the costs of the comprehensive benefit plan?

Allowing self-employed workers to exclude 100 percent of the costs of health insurance may

appear unfair because employees will typically be able to exclude only 80 percent of the costs of the comprehensive plan (i.e., the portion required to be paid by employers) from individual income taxes. However, employees will be able to negotiate with their employers to increase their contributions up to the full costs of the plan. Employees can make similar arrangements under current law, but employers may want their workers to directly bear some of the costs of health insurance in order to constrain their demand for expensive policies. As a consequence of health reform, employers' costs would not generally rise as a consequence of their workers' decisions to purchase more expensive policies, and thus more workers may be able to negotiate tax-preferred arrangements with their employers. We thus recommend that self-employed workers be able to exclude 100 percent of their contributions. We also recommend that the deduction be limited to 80 percent under certain circumstances (e.g., a self-employed person who fails to provide similar benefits to his employees should not receive the full benefits of the deduction). agree

Issue 2: Should self-employed workers be able to deduct contributions for the comprehensive benefit package from the SECA base?

As under current law, employees will be able to exclude the employer contributions for the comprehensive benefit plan from both income and social security tax bases. In contrast, self-employed persons will only be able to deduct the costs of the comprehensive benefit plan for purposes of calculating their individual income tax liability. While there is much merit to a proposal excluding health insurance premiums from the SECA base, we do not believe that this is the appropriate time to make this recommendation. Mr. Magaziner has referred to this proposal as providing "rough justice" because it provides self-employed persons with somewhat offsetting gains and losses relative to employees. agree

Issue 3: When will the 100 percent deduction for self-employed workers become effective?

OMB and Treasury staff have discussed making the effective date for this proposal January 1, 1997 (when all states are required to have established regional alliances). Alternatively, the provision could become effective as states establish regional alliances (between 1995 and 1997). Thus, self-employed workers who bought health insurance through regional alliances could receive the 100 percent deduction. This would be somewhat more difficult to administer during the transition period, but it would extend the benefits of the 100 percent deduction earlier to many self-employed individuals and make the health reform proposal more attractive to the self-employed. We recommend that the 100 percent deduction for self-employed workers become effective as states establish regional alliances. agree

Issue 4: Prior to the imposition of the tax cap for employees, should the self-employed be able to deduct the costs of any health insurance plan?

We recommend that self-employed workers would only be able to deduct up to 100 percent of the costs of the comprehensive benefit plan, beginning in 1997, rather than the full costs of any plan prior to 2003. Small business may oppose this provision, because it effectively imposes OK

the tax cap on the self-employed six years before the rest of the workforce. But on the other hand, the proposal will still provide most self-employed persons with far more generous tax treatment than they currently receive. Providing them with an even more generous benefit -- which will then be cut-back in six years -- may create greater political backlash in the future.

We further recommend that the current 25 percent self-employed deduction be extended between January 1, 1994 and December 31, 1996. OK

Equal Contribution Rule: The September 7 draft contains nondiscrimination rules with respect to contributions made by employers towards the employee portion of the premium for the comprehensive benefit package. The employee portion is equal to the full costs of the benefit plan for the relevant family status minus 80 percent of the weighted average premium of plans for the relevant family status within the regional alliance.

Under the proposal, employers may pay all or part of the employee share of the premium. Employers that do so must make the same dollar contribution for all employees with the same family status, unless a bona fide collective bargaining agreement requires otherwise. Any additional employer contribution may not vary according to the health plan selected by the employee, and the employer must provide a rebate to the employee if the contribution exceeds the employee's share of the premium. Such a rebate is taxable income to the employee. OK

Issue 1: Should the "equal contribution rules" reflect differences in the costs of health insurance across regions?

The rule that employers must make the same dollar contribution for every employee ignores differences in health costs among regional alliances. For example, an employer with plants in New York and Alabama could be required to contribute the same dollar amount towards the health insurance costs of workers located in the two states. Alternatively, the employer could be required to provide the same percentage of the comprehensive plan to workers. An employer who paid the full costs of one worker's plan would pay the full costs of all workers' plans. This option would resolve the regional disparity issue, but it would not encourage employees to purchase cheaper plans.

Instead, we would recommend that employers be required to provide the same dollar contribution for all employees within a geographic area (generally defined as a regional alliance). Employees would still be entitled to receive a rebate if they chose a less expensive plan, but the size of the rebate would reflect the costs of plans within their region of the country.

Issue 2: How should the "equal contribution rules" be administered?

The September 7 draft does not explain how the "equal contribution" rules would be enforced. For example, employers could be denied tax deductions for health insurance contributions for failure to meet these standards. Under this option, the IRS would have responsibility for enforcing the provision, but at considerable cost. The IRS would have to

monitor the costs of all comprehensive benefit plans within a region, contributions within a firm by worker, and the family status of employees (since the size of the contribution will vary with family status). Instead, we recommend that these standards be enforceable by the Department of Labor subject to civil penalties and fines. CK

Retirees: The drafts of the health policy book have not included a discussion of the tax treatment of employer contributions for retirees or older workers.

Issue 1: What should be the tax treatment of employer contributions for retirees under the age of 65?

We would favor treating employer contributions for retirees under the age of 65 (i.e., the payment by employers of the employees' share) in the same fashion as contributions made on behalf of active workers. Subsidies provided by the Federal government would also be excludable from income. On occasion, Mr. Magaziner has expressed interest in means-testing the Federal subsidy for retired workers. This could be accomplished by taxing the Federal subsidy in the same fashion as Medicare Part B premiums under the health reform proposal (over $100,000 if single and $125,000 if filing a joint return). We believe this would be appropriate. OK

Issue 2: What should be the tax treatment of health insurance benefits for retirees age 65 and over?

On the whole, Medicare benefits will not be as generous as those received under the comprehensive benefit package, and thus taxing employer contributions for the entire Medigap policies would be unduly harsh. But, it would be administratively and politically difficult to try to equate, and thus tax, some portion of Medigap contributions in a manner similar to that contemplated for supplemental plans for younger workers. On balance, we recommend not taxing employer contributions for Medigap policies for retired workers, as under current law. CK

The issue of the post-65 retirees is further complicated by another aspect of the plan. The September 7 draft contains a proposal which would allow individuals to choose to remain in the regional alliances when they reach age 65. If they remain in the alliance, they continue to receive the nationally guaranteed comprehensive benefit package with the full range of options available to individuals younger than age 65. Their premiums, however, would be determined separately and likely would be higher than the community-adjusted premium for younger workers. Medicare would pay a fixed amount to the regional alliance, and beneficiaries would pay the difference between Medicare's payment and the plan's premium. We would recommend that employer contributions toward the comprehensive benefit plan within a regional alliance should also be exempt for older retired individuals. CK

Issue 3: What should be the tax treatment of health insurance benefits for active workers age 65 and over?

If older workers continue to be covered by their employer through the regional alliance, they will be subject to the same rules as younger workers. agree

Itemized Medical Deduction: There has been no discussion to date regarding the treatment of the itemized medical deduction with respect to acute care.

Issue 1: Should the deduction be limited to only include expenses related to the comprehensive benefit plan?

Since the basic benefit package contains limits on annual out-of-pocket expenditures, this would effectively limit the deduction to the sum of the individual's contributions on premium plus out-of-pocket expenditures (limited at $1,500 for individuals and $3,000 for families). These limitations could be justified on the grounds that only benefits within the nationally-determined basic benefit plan should receive any tax-preferred treatment. The cost of care beyond the basic benefit package would become more expensive as a result.

On the other hand, it may be difficult to argue that the taxpayer with $30,000 of medically necessary nursing home care expenses or $5,000 for an experimental drug which is not yet part of the comprehensive benefit package has the same ability to pay as the healthy taxpayer.

Issue 2: Should prepayments for acute care be subject to the same limitations as those contemplated for long-term care? (Mary Heath, 622-0868)

Under current law (section 213), individual taxpayers are allowed an itemized deduction for expenses not reimbursed by insurance or otherwise, for medical care of the taxpayer, the taxpayer's spouse and dependents. The deduction is only available to the extent that those expenses exceed 7.5% of AGI. Medical care expenses are statutorily defined to include payments for diagnosis, cure, mitigation, treatment or prevention of disease, transportation essential to medical care, and insurance covering medical care. Treasury regulations contain specific examples of qualifying medical expenses. The regulations also state that, while capital expenditures are not generally deductible, capital expenditures that otherwise qualify as expenses of medical care will not be disqualified medical expenses simply because they are capital. Examples of these types of expenditures are cited in the regulations and include wheelchairs, a seeing eye dog, artificial limbs, etc.

There has been an issue as to whether prepaid medical insurance or prepaid medical care expenses are currently deductible under the guidance of this regulation. Clearly, the allowance of a deduction of this sort could serve to undermine the 7.5% limitation. The IRS has concluded in several revenue rulings, however, that in cases where a liability to pay in advance was incurred by a taxpayer (in one instance, the prepayment of medical care was included in a lump-sum entrance fee for a retirement home; in the second instance, the taxpayer made payments in advance for the care of his disabled dependent, with care to be provided only in the event of his death or inability to care for the dependent), the full prepayment was qualifying medical expense in the year paid.

Recently, the IRS was requested to rule that an individual's lump-sum contribution to a VEBA which was to provide medical care to the individual for approximately the next 4 years was a currently deductible medical expense. The lump-sum was received by the taxpayer as a result of its employer terminating its retiree health care plan, distributing the proceeds, and advising recipients of the VEBA contribution option. The IRS believes that it may have to issue a favorable ruling on this request, even though it sets a dangerous precedent and is bad tax policy.

In order to avoid this treatment going forward, we recommend that section 213 be modified to prevent current deductions for lump-sum or prepayment arrangements for medical care in advance. Long-term care provisions currently under consideration (and the subject of a separate memorandum) would prevent this by their terms (i.e., long term care could only be funded over a period of time with level annual payments). OK

DEPARTMENT OF THE TREASURY
WASHINGTON

October 8, 1993

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Catherine L. Creech (622-1341)
Michael D. Thomson (622-1334)
Attorney/Advisors

THROUGH: Leslie B. Samuels
Assistant Secretary (Tax Policy)

SUBJECT: Health Care: Independent Contractors/Outsourcing

Summary

The Administration's mandate to employers to pay a significant share of their employees' health insurance premiums will increase the importance of proper classification of workers as either employees or independent contractors. This employer mandate will exacerbate the perceived noncompliance incentives that already exist for workers to claim independent contractor status. Under current law, the status of workers is determined by applying a twenty-factor test derived from the non-tax common law rules defining the employer-employee relationship. Because these rules are subjective and extremely sensitive to the particular facts, the current law is criticized as being imprecise and unpredictable. In addition, proper classification of workers is complicated by the provisions of Section 530 of the Tax Reform Act of 1978 (not a Code provision). Section 530 prohibits the IRS from correcting erroneous classifications of workers covered by Section 530 as independent contractors for employment tax purposes, including prospective corrections, as long as the employer has a reasonable basis for that classification. Section 530 does not, however, have universal application, thus creating whipsaw situations and inequitable competitive distortions. Section 530 also prohibits the IRS from issuing any guidance regarding classification of workers. To address these problems, we recommend that Treasury propose the changes in law discussed below in connection with the Administration's health care reform proposal.

Recommendations

* Revise Section 530. To correct the distortions and difficulties caused by Section 530, revise and codify Section 530, including: allowing the IRS to issue guidance on classification and to reclassify workers prospectively; applying the revised Section 530 to all firms and workers for all Federal tax purposes; clarifying certain terms; and making other technical modifications.

* **Grant Authority to Develop New Classification Rules**. To address the fundamental uncertainty in the current rules for classifying workers, authorize the Secretary to develop a new test (or tests) for determining workers' status, which could deviate substantially or entirely from the existing test based on the common law employer-employee relationship.

* **Enhance Compliance Rules**. To lessen the incentive for improperly classifying workers as independent contractors, increase the penalty for failure to file required information returns (i.e., Form 1099-Misc.).

* **Adopt Limited Health-Care Anti-"Outsourcing" Rules**. To prevent firms from obtaining subsidies for their employees' insurance premiums by reorganizing into a group of commonly controlled "small" employers, adopt a relatively stringent "controlled group" test for purposes of testing a firm's eligibility for premium subsidies.

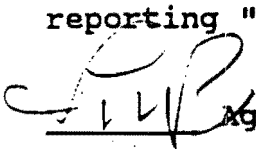
Discussion

Revise Section 530. As long as the underlying classification test is difficult to apply with any degree of certainty, Section 530 serves a useful function because it protects taxpayers from large retroactive assessments. However, because Section 530 originally was intended only as a "stopgap" measure, as a permanent provision it requires substantial revision and clarification. For example, its prohibition on IRS guidance has seriously impeded the IRS's ability to convey its position to taxpayers other than in the context of an audit or by private letter ruling. This also increases the risk of inconsistent application of the IRS's rules by its own agents.

In addition, Section 530 presently applies only to firms and only for employment tax purposes, and excludes certain workers and arrangements. Thus "whipsaw" situations may arise where the firm claims one treatment under the protection of Section 530 while the worker claims the opposite treatment under the common law test. Similarly, the worker may be treated as a contractor for one purpose but as an employee for other purposes. Furthermore, some taxpayers complain that Section 530 provides unfair competitive advantages to firms that are, in effect, grandfathered under its safe harbors. These taxpayers believe that Section 530 allows those firms that are within its provisions to reduce their labor costs relative to other firms that are compelled to treat their workers as employees under the common law. Finally, as a result of a 1986 amendment, certain technical service workers in three-party, or "brokered," arrangements are excluded from the protections afforded by Section 530. There is no compelling policy justification for continuing such patchwork application of the rules.

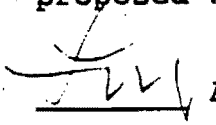
We also recommend that certain terms in Section 530 that apparently have created interpretive questions be clarified. For example, a "substantially similar position" should be clarified to mean similar both in function and in the relationship between the firm and the worker. Similarly, the safe harbor based on a "long-standing recognized practice of a significant segment of the [firm's] industry" should be clarified that (i) "long-standing" does not exclude emerging industries; (ii) "significant segment" may include less than a majority of the applicable industry; and (iii) the "industry" is determined by reference to the taxpayer's competition.

Along the same lines, the current consistency requirements of Section 530 are very stringent. We recommend that these rules be relaxed slightly to allow (i) employers to change worker status from contractor to employee without losing Section 530 protection for prior treatment (to eliminate the current disincentive to "come clean"); and (ii) minor reporting deficiencies (to prevent loss of Section 530 protection due to reporting "foot faults").



_____ Agree _____ Disagree _____ Need to discuss

Authority to Devise a New Classification Standard. The subjective nature of the underlying common law test puts tremendous strain on the administration of the myriad of employment-based tax rules. It would be desirable to develop clearer rules for determining employment status. However, taxpayers and policymakers have been struggling with this issue for over twenty years, and it is not feasible to craft such a rule within the context and timeframe of the initial health-care reform package. For that reason, we propose that the Administration's package simply direct the Secretary to write new rules. While the flexibility that the proposal would provide would be optimal, we recognize that some may be skeptical of such "blank check" authority, particularly given the perception that the IRS is overzealous in its application of the common law. Therefore, we will continue to work to develop a more detailed proposal; such a proposal could conceivably end up as a new statutory definition or as guidance in legislative history to the proposed statute (directing the Secretary to develop a new rule).



_____ Agree _____ Disagree _____ Need to discuss

Compliance Measures. To emphasize the increased importance of proper classification of workers, it is necessary to alter some aspects of current law that perhaps encourage taxpayers to claim independent contractor status. For example, there is

concern that some workers use the less-restrictive rules governing contractors to avoid full reporting of income. One of the most effective tools to ensure full income reporting by independent contractors is the Form 1099 information reporting requirements for payments made to individual contractors. The penalty for failure to file a Form 1099, however, is only $50. To encourage better compliance with these reporting requirements, we recommend that the penalty be increased (with appropriate relief for minor inadvertence). Many proposals have been made recently in this regard, and we are reviewing these with the IRS to develop a specific proposal. We are also reviewing with the IRS whether any other compliance initiatives would be appropriate in this package.

_____ Agree _____ Disagree _____ Need to discuss

Limited Anti-"Outsourcing" Rules. Firms should be prevented from obtaining greater government subsidies for their share of their employees' premiums by reorganizing themselves into one or more "small" employers (particularly of low-wage employees) that remain under common control. In this situation, little has changed economically, and a mere change in the form of the business should not result in different premium costs. We propose adopting the 50% control test in Section 52 of the Code (pertaining to targeted jobs credits, and also used in other contexts such as the "unrelated purchaser" requirement for the nonconventional fuels tax credit in Section 29 of the Code).

We do not recommend that we make any attempt to restrain "outsourcing" to unrelated firms (e.g., contracting with an unrelated firm to perform low-wage tasks, such as janitorial services, rather than hiring employees to perform these tasks). We believe that such a rule would be difficult to administer. We also understand that the White House is aware that the proposed premium subsidy structure is likely to result in some amount of this behavior.

_____ Agree _____ Disagree _____ Need to discuss

DEPARTMENT OF THE TREASURY
WASHINGTON

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Michael Schultz (622-1343) MS
Attorney-Advisor

THROUGH: Leslie B. Samuels
Assistant Secretary (Tax Policy)

SUBJECT: Treatment of Nonprofit Health Care Organizations After Health Care Reform

1. Background: Current Law

Hospitals. Nonprofit hospitals can qualify as charitable organizations exempt from tax under section 501(c)(3). The standards that a nonprofit hospital must meet to qualify for exemption, however, are unclear.

The regulations provide that section 501(c)(3) uses the term "charitable" in its generally accepted legal sense, referring to the common law applicable to charitable trusts. Under common law, the promotion of health is a charitable purpose. Therefore, a nonprofit hospital is charitable, in the common law sense, even if it provides services only to those able to pay the cost of the services.

A 1969 revenue ruling held that a hospital is a tax-exempt charitable organization under section 501(c)(3) if it promotes the health of a class of persons broad enough to benefit the community and operates to serve a public, rather than a private, interest. This "community benefit" test is to be applied based on all the facts and circumstances. The following factors would support a finding that a hospital is charitable: (i) the hospital operates an emergency room open to all without regard to ability to pay, (ii) the hospital provides inpatient care to all who are able to pay for the care, either directly or by third party reimbursement, (iii) the hospital is governed by a board representative of the community, and (iv) the hospital has an open medical staff, with staff privileges available to any qualified physician. The Internal Revenue Service has come to view the various factors cited in the 1969 revenue ruling as preconditions to exemption. This position has not been adopted, however, in regulations, revenue rulings or other precedential guidance.

"Staff Model" HMOs. A "staff model" HMO provides health care services to its members at its own clinics, using its own medical staff. A nonprofit staff model HMO can qualify for exemption under section 501(c)(3) as a charitable organization

under the same standards that apply to nonprofit hospitals.

Non-staff model HMOs. A non-staff model HMO does not operate its own clinics, but instead contracts with independent providers to provide medical treatment to its members. HMOs of this type may pay providers on either a fee-for-service or a "capitated" basis--that is, payment of a fixed amount per patient per period.

A nonprofit, non-staff model HMO qualifies for exemption, if at all, as a social welfare organization described in section 501(c)(4). An organization of this type may be disqualified for exemption under section 501(m). Section 501(m) provides that an organization cannot qualify for exemption under section 501(c)(3) or (4) if the provision of "commercial-type insurance" is a substantial part of its activities. "Incidental" insurance of a kind customarily provided by an HMO, however, is not commercial-type insurance.

The Service has adopted the position that whether the insurance provided by a non-staff model HMO is incidental depends on the method by which it pays providers. If the HMO pays at least its primary care providers on a capitated basis, the Service views the insurance provided by the HMO as incidental. The Service reasons that if an HMO pays providers on a capitated basis, it does not bear risk itself, but instead transfers the risk to the provider. Under a capitated payment arrangement, the HMO will pay the provider the same amount regardless of the amount of treatment required by the patient. By contrast, if an HMO pays providers on a fee-for-service basis, the HMO does bear risk. Therefore, in the Service's view, the insurance provided by the HMO is not incidental.

2. Implications of Health Care Reform

Health care reform may not require any change in the rules governing the tax exemption of nonprofit health care organizations. Nonetheless, health care reform may be an appropriate opportunity to clarify the standards that a nonprofit health care organization must meet to be exempt.

It may be appropriate, in light of health care reform, to deny tax exemption to HMOs. This measure could be justified as a means of leveling the playing field for all organizations that bid to provide coverage through an alliance. HMOs and traditional indemnity insurers, however, do not compete on a level playing field today. Indemnity insurers are subject to tax, while some HMOs--approximately one-third of the total--are exempt from tax. It is not obvious that health care reform makes the establishment of a level playing field more important than it is today.

3. Issues to be Addressed

A. Treatment of Nonprofit Hospitals

We assume that nonprofit hospitals will remain eligible for tax exemption after health care reform. Although there is no clear policy rationale for exempting from tax nonprofit hospitals, retention of the exemption may be justified on the basis of long-standing tradition.

Tax exemption for nonprofit hospitals may be defended because health care services benefit society as a whole. Maintaining a healthy work force, for example, may improve productivity and the general standard of living. This rationale is similar to the rationale for the exemption of educational institutions. The demand for health care services, however, is less elastic than the demand for educational services. Therefore, the presence of external social benefits is less likely to result in an inadequate quantity of health care services. As a result, this "external benefit" rationale may have less force in the case of health care than in the case of education.

Assuming that nonprofit hospitals remain eligible for exemption, health care reform may provide an appropriate opportunity to clarify the standards that govern their exemption. As noted above, the existing standards are unclear. The regulations and the common law definition of charity suggest that a nonprofit hospital qualifies as a charitable organization simply by providing health care services, even if it limits those services to patients able to pay the cost of the care. By contrast, those at the Service who administer this area of the law have informally adopted a more stringent set of standards. In connection with health care reform, we could adopt standards based on the common law, a more stringent set of standards such as those advocated by the Service, or a third approach that would involve procedural rather than substantive standards.

Alternative 1: Common Law Standards. Under the common law definition of charity, a hospital qualifies as a charitable organization simply by providing health care services to those able to pay the cost of the care. Explicit adoption of the common law standards would offer several advantages. Because the regulations define charity with reference to these common law standards, a good case can be made that, notwithstanding the informal position of the Service, the common law standards already govern the exemption of hospitals. Their explicit adoption could be viewed as merely clarifying instead of changing the law.

Explicit adoption of the common law standards would be consistent with a trend that began with the 1969 ruling. Prior to 1969, the Service took the position that a

nonprofit hospital qualified for exemption only if it provided care to the indigent to the extent of its financial ability. The 1969 ruling eliminated this requirement, largely in response to the enactment of Medicare and Medicaid and the rapid growth of medical and hospital insurance. The United States Court of Appeals for the D.C. Circuit upheld the validity of the 1969 ruling against a challenge by a welfare rights organization. The court emphasized that the concept of charity is fluid, and that the 1969 ruling that eliminated the charity care requirement was an appropriate response to changes in the health care environment. Similarly, clarification that the qualification of hospitals as charitable organizations should be governed by the relatively broad common law standards would arguably be an appropriate response to the movement toward universal coverage effected by health care reform.

Alternative 2: Specific Objective Requirements. Those in the Service who work in the area of health care have argued for a set of requirements that would be more stringent than the common law standards. They suggest that a hospital be required to meet a number of specific, objective standards to qualify for exemption, including, for example, maintenance of an open emergency room, nondiscriminatory treatment of Medicare and Medicaid patients and a board representative of the community and not controlled by staff physicians. The principal advantage of this approach is that, through the promulgation of numerous specific and detailed requirements, tax exemption could be limited to those hospitals that provide the greatest benefit to their communities. This approach, however, could be less flexible than adoption of the common law standards. The more specific the requirements, the less likely they are to take into account the differing circumstances of various communities or to remain appropriate in the face of changes in the health care environment. This second alternative would also be more difficult for the Service to apply: it would require many factual inquiries and difficult health policy judgments regarding the value of a hospital's services. Finally, adoption of the standards recommended by the Service could be politically difficult to the extent that those standards are viewed as more stringent than current law.

The Service views an independent board requirement as important to prevent physicians from controlling provider organizations. They are concerned that physicians could use this control to divert to themselves the resources of the provider organization by, for example, payment of excessive compensation. Current law prohibits this type of activity by denying exemption under section 501(c)(3) to any organization whose earnings inure to the benefit of an individual. Current law does not provide any prophylactic measures to prevent inurement. It may be difficult to justify the enactment of prophylactic measures, such as an independent board requirement, that would apply solely to health care providers. Some providers could find it difficult to recruit board members who are independent but nonetheless

knowledgeable about the health care field. On the other hand, the size of the health care industry may make concern about inurement in that industry greater than in other sectors of the nonprofit community.

The benefits of any prophylactic measures to prevent inurement would be reduced if new sanctions are enacted that would apply to inurement when it occurs. Under current law, the sole sanction for inurement is the revocation of the organization's exemption. Revocation of exemption, however, may be disproportionately severe in relation to the inurement involved, and may adversely affect those who benefit from an organization's services. The lack of a sanction for inurement other than revocation has caused the Service difficulty in enforcing the inurement prohibition. The possibility of enacting "intermediate" sanctions, such as excise taxes, on inurement is being considered in connection with hearings conducted by the Ways and Means Oversight Subcommittee.

Alternative 3: Procedural Standards. It may be possible to adopt an approach that would be less stringent than that advocated by the Service, but would provide greater assurance of community benefit than would be provided by adoption of the common law standards. This approach would focus on the process by which a hospital determines the services it provides, instead of attempting to measure the community benefits that result from those services. Under this approach, hospitals would be required periodically to analyze the health needs of their communities and develop plans to meet those needs. To further insure that hospitals are responsive to the interests of their communities, they could be required to involve community representatives in their self-assessment and goal-setting programs.

Decision:

_____ Alternative 1: Common Law Standards

_____ Alternative 2: Specific Objective Requirements

_____ Alternative 3: Procedural Standards

_____ Let's Discuss

B. Treatment of HMOs

Health care organizations may be arrayed on a continuum, with pure providers, such as hospitals, at one end and traditional indemnity insurers at the other. Recent changes in the health care environment, such as the growth of HMOs, have blurred

the distinctions between these two poles. HMOs and other hybrid organizations may be viewed as occupying positions along the continuum. Assuming that hospitals will remain eligible for tax exemption and indemnity insurers will remain subject to tax, a line will have to be drawn somewhere along the continuum of health care organizations to separate those that can qualify for exemption from those that cannot. As noted above, it is not entirely clear where current law draws the line between potentially exempt and non-exempt organizations.

Staff model HMOs clearly can qualify for exemption under current law. The eligibility of non-staff model HMOs for exemption is less clear. Under the Service's informal position, those non-staff HMOs that pay at least their primary care providers on a capitated basis are eligible for exemption. Other non-staff HMOs are denied exemption by section 501(m).

Alternative 1: Codification of Informal Service Position. Codification of the Service's informal position may be appropriate in connection with health care reform. Under this alternative staff model HMOs would be exempt, as would non-staff model HMOs that pay at least their primary care providers on a capitated basis. Other non-staff model HMOs would be subject to tax.

The General Counsel Memorandum in which the Service announced this position represents the only authority on point, and is therefore the best evidence of the current state of the law. Any position adopted as part of health care reform could be easier to defend politically to the extent that it could be characterized as simply clarifying existing law, instead of denying exemption to organizations that are arguably exempt today.

Alternative 2: Deny Exemption to All HMOs. Denying exemption to all HMOs could be justified on the grounds that any organization whose operations consist, in part, of providing insurance should be subject to tax. Obviously, HMOs would oppose such a position. In particular, the staff model HMOs, including such powerful organizations as Kaiser Permanente, could argue that they would be treated unfairly in comparison with nonprofit hospitals. A staff model HMO, like a hospital, provides health care services; it simply charges for its services on a prepaid, rather than a fee-for-service, basis. The staff model HMOs could argue that they provide greater social benefit than hospitals, because the manner in which they charge for their services does not encourage overutilization and excessive costs. If we denied exemption to all HMOs, staff model HMOs could be expected to reorganize by dividing into separate entities their provider and insurance functions. In this manner, the income attributable to their provision of services could remain exempt.

Alternative 3: Deny Exemption to Non-Staff Model HMOs. A third alternative would be to deny exemption to non-staff model HMOs, but allow staff model HMOs to remain eligible for exemption. This approach could be justified on the grounds that any organization that directly provides health care treatment should be exempt. Non-staff model HMOs would, of course, oppose this approach. They would argue that they would be treated unfairly in comparison with staff model HMOs--that tax exemption should not turn on the relatively formalistic distinction of whether an organization provides services through its own staff or through contractual arrangements with independent providers.

In short, wherever the line is drawn between those health care organizations that are eligible for exemption and those that are not, those that are just on the taxable side of the line will complain, arguing that they cannot be meaningfully distinguished from those just on the exempt side of the line. Ultimately, the location of this line may be best drawn on the basis of practical and political considerations, rather than on the basis of any clear policy rationales.

Decision:

c. 7/13 ____ Alternative 1: Codification of Informal Service Position

____ Alternative 2: Deny Exemption to all HMOs

____ Alternative 3: Deny Exemption to Non-Staff Model HMOs

____ Let's Discuss

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

MEMORANDUM TO SECRETARY BENTSEN

THROUGH: Leslie B. Samuels
Assistant Secretary (Tax Policy)

FROM: Beth A. Brooke
Taxation Specialist
622-1332

SUBJECT: Taxation of Managed Care Entities Under the Health Care Reform Proposal

The purpose of this memorandum is to highlight tax issues and make recommendations for your consideration with respect to the taxation of managed care entities that currently exist and that will emerge as a result of health care reform.

BACKGROUND

Managed care entities, which I will refer to generally as health maintenance organizations, typically deliver comprehensive health care to members on a prepaid basis. An HMO member is the equivalent of an insurance company's insured.

Over the years, many different types of HMO have emerged. Staff model HMOs operate their own facilities and employ physicians who work exclusively for the HMO. An individual practice association, or IPA, typically contracts with independent physicians or physician groups to accept members on a prepaid basis or on a fee-for-service basis. Typically, the member pays monthly premiums to the IPA HMO. When the member needs medical care, he or she goes to the health care provider that he or she selected as the primary care physician in the HMO network. The primary care physician has contracted with the IPA HMO to provide medical services to members and is paid a fixed amount per month (capitation) based on the member's age and sex or on a fee-for-service basis.

Under current law, the tax treatment of HMOs is uncertain. It is unclear whether an HMO should be taxed as an insurance company or as a regular corporation. If taxed as an insurance company, the HMO is entitled to deduct an estimate of the liability for services rendered to members prior to the end of the tax year but for which a claim has not been received by the HMO. These are referred to as incurred-but-not-reported claims (IBNR). Because IBNR claims are often significant, deductibility is important. It is uncertain whether regular corporations can sustain a tax deduction for IBNR claims due to the Supreme Court's decision in *General Dynamics*.

In practice, most HMOs claim a deduction for their IBNR liability regardless of whether they file as insurance companies or as regular corporations. If they file as insurance companies, their IBNR liability is subject to discounting. Under the discounting rules, approximately 96 percent of the IBNR liability is deductible. As regular corporations, 100 percent of the liability is typically claimed as a deduction.

The only published authority with respect to the taxation of HMOs as insurance companies is provided in Revenue Ruling 68-27, 1968-1 C.B. 315 and Private Letter Ruling 8424058. Revenue Ruling 68-27 has limited practical application. It held that a staff-model HMO was not an insurance company. However, in practice, the Internal Revenue Service is unaware of any for-profit HMOs that operate as staff models.

The Internal Revenue Service is currently contemplating revoking Revenue Ruling 68-27 because the rationale for its holding is suspect. A technical advice memorandum will soon be issued by the Internal Revenue Service that will conclude that a for-profit IPA HMO is taxable as an insurance company. We are currently discussing with the Internal Revenue Service whether to also publish a revenue ruling to that same effect. The Service would like to publish authoritative guidance so that IRS field agents will stop inappropriately attempting to broadly apply Rev. Rul. 68-27 and argue that IPA HMOs are not insurance companies.

RECOMMENDATION

Our recommendation is that all for-profit HMOs and similar managed care entities be taxed as property/casualty insurance entities under the provisions of subchapter L of the Internal Revenue Code. There is little distinction between the operation of HMOs and insurance entities. Taxing HMOs as insurance companies creates a better matching of income and expense. Premiums would be recognized over the period that coverage for medical services is provided. Corresponding liabilities would be accrued and deductible to the extent that the HMO is liable to provide services. Accordingly, a deduction would be provided for accrued IBNR claims at year end. OK

We should allow the IRS to publish their technical advice memorandum to treat an IPA HMO as an insurance company but not to issue a similar revenue ruling. This should provide sufficient direction to the IRS field agents without constraining our options to resolve this issue legislatively in conjunction with health reform. ✓

ADVANTAGES

- Under health reform, managed care is seen as the vehicle to control health care cost in the future. Tax

policy needs to support the continued viability of these organizations. Restricting the deductibility of IBNR claims could harm the financial viability of HMOs.

- The taxation of HMOs must be clarified. Uncertainty with respect to the taxation has existed far too long.

- During the past year, IRS audits of HMO entities has proliferated. Issues that are being raised by IRS agents are generally not being supported by the IRS National Office. Accordingly, there is a significant resource waste in the IRS audit process.

- HMOs would be taxed on a level playing field with Blue Cross and Blue Shield organizations and other indemnity insurers with which they compete.

- If we assume as a baseline that HMOs can deduct their IBNR liability under current law, our recommendation to tax them as insurance companies should raise revenue, but not a significant amount. When taxed under the insurance provisions, the IBNR liability would be subject to discounting, unearned premium reserves would not be fully deductible, and 15% of certain tax-exempt interest would be taxable.

DISADVANTAGES

- To the extent that HMOs are projected to grow in number, had we recommended that HMOs not be taxed as insurance companies and statutorily clarified that IBNR liabilities are not deductible, the provision would probably have raised revenue.

- Treatment of HMOs as insurance companies could have implications with respect to tax-exempt HMOs. We have discussed this matter with Internal Revenue Service and they believe they can continue to draw an appropriate distinction between for-profit and tax-exempt HMOs. OK

DEPARTMENT OF THE TREASURY
WASHINGTON

October 8, 1993

MEMORANDUM TO SECRETARY BENTSEN

FROM: **P. VAL STREHLOW**

THROUGH: **LESLIE B. SAMUELS**
ASSISTANT SECRETARY (TAX POLICY)

SUBJECT: **PROPOSED HEALTH CARE REFORM PROPOSALS FOR HEALTH CARE PROFESSIONALS IN CERTAIN AREAS**

A. Overview

The draft description of the health care reform proposal contains four incentives aimed at certain health care professionals practicing in rural areas. Three out of these four were included in legislation introduced by Senator Pryor earlier this year and last year. We understand that the decision has been made to extend these incentives to health care professionals practicing in certain urban areas.

Since the early 1970s, the problems of shortages of health care professionals in certain geographic areas have been the target of the National Health Service Corps (NHSC) program. Pursuant to NHSC, participating health care professionals who agree to practice in "health professional shortage areas" may receive scholarships, monthly subsidy payments, or amounts that are used for the repayment of educational loans. According to the September 7 description of the health care reform plan, the NHSC (and related programs) would be expanded.

Given this proposed expansion of the existing spending programs, we have serious concerns about potential problems that may be associated with the addition of tax benefits to the incentive package. For example, it will be virtually impossible for the Internal Revenue Service (IRS) to monitor the validity of deductions and credits on tax returns where eligibility for such benefits depends on obligations under the NHSC program. In fact, having two federal agencies (i.e., HHS and IRS) overseeing different incentives creates the potential for inconsistent levels of compliance and enforcement.

We also are concerned that adequate consideration has not been given to limiting the new tax incentives to those that (i) represent more efficient mechanisms (compared to existing or proposed spending programs) for achieving the desired goals, and (ii) do not duplicate existing incentives. **In addition, one could make a strong argument that all of these incentives should be reduced (or eliminated) for high-income taxpayers.**

Notwithstanding our serious concerns, it may not be possible for us to get these incentives removed from the reform proposal for political reasons. At this point, therefore, a critical issue may be whether we devote energy to that end.

B. The Proposed Tax Incentives

1. Nonrefundable Credit for Certain Health Care Providers.

Description. This proposal would provide a $1,000/month tax credit for physicians (and a $500/month credit for physician assistants and nurse practitioners) who work in rural health professional shortage areas. To be eligible for the credit, the individual must first apply for certification, and be certified, by HHS (in a manner similar to that currently in effect under the NHSC program). The maximum number of months for which an individual is eligible for the credit would be the 60-months of a "mandatory service period." Previously claimed credits would be subject to complete or partial recapture if the full mandatory service period is not completed.

The NHSC program appears to target primarily health care professionals who are just completing their education. The proposed tax credit would provide an incentive to other health care professionals (e.g., those who are more experienced) to establish a practice in health professional shortage areas. As currently contemplated, the credit would not be available to health care professionals that already have established practices in health professional shortage areas. In an effort to coordinate this tax incentive with NHSC programs, individuals who are participating in NHSC programs, or who had defaulted on NHSC obligations, would not be eligible for the credit. We heartily agree with these limitations. agree

We have specific concerns about the inability of the IRS to monitor a taxpayer's eligibility for this credit -- e.g., whether the taxpayer claiming the credit has a full-time practice in the health professional shortage area. Other significant administrative concerns stem from (i) taxpayers forgetting that the credit is only available for 60 months, and (ii) the likelihood that noncompliance with the recapture rules may be fairly high.

The certification requirement has been strengthened in an attempt to limit the number of taxpayers who improperly claim the credit. At the same time, however, the close relationship to the NHSC program and the necessary involvement of HHS raises the concern about other federal agencies being able to bestow, at least in part, federal tax benefits.

As far as we are aware, no thought has been given to dropping this incentive in favor of developing alternative incentives, or expanding existing incentives, in the NHSC program.

Recommendation. We should strongly recommend that this incentive be dropped, in favor of attempting to develop appropriate expansions of the NHSC program.

Decision.

Agree _____ Disagree _____ Let's discuss FM 3

2. Exclusion from Gross Income of National Health Service Corps Loan Repayments

Description. This proposal would exclude from income any payment made on behalf of any taxpayer by the NHSC Loan Repayment Program. Under the current NHSC program (i.e., without regard to any proposed expansion), annual loan repayments may be as much as $35,000.

More generally, however, the need for the proposed exclusion is **highly questionable** in light of the current law requirement under the National Health Service Act that HHS make "gross up" payments to reimburse the individual for increases in federal, State, or local income tax liability resulting from the loan repayments. These gross up payments equal 39 percent of the loan repayments made under the program (so, for example, a participant benefitting from $35,000 in loan repayments would receive a $13,650 gross up payment). Certainly participating health care providers should not be able to exclude the repayments from income **and** receive the gross up.

While there is agreement on this point, we are concerned about the implications of replacing the gross up payment mechanism with an exclusion from income. While the exclusion may be less costly (i.e., many NHSC participants will be subject to an effective federal tax under 39 percent), this change would shift of a significant portion of the Loan Repayment program's cost from HHS to Treasury. We question the advisability of such a shift, especially in light of the IRS's limited ability to monitor a practitioner's compliance with his or her NHSC obligations.

Recommendation. We should suggest that this incentive should be dropped as unnecessary, given HHS's current gross-up obligation.

Decision.

Agree ___/___ Disagree _____ Let's discuss _____

3. Increased Expensing for Medical Equipment

Under this proposal, an additional $10,000 of expensing under section 179 would be available for property used by a physician in the active conduct of such physician's full-time trade or business of providing health services in a rural health professional shortage area. As OBRA '93 increased the general section 179 annual limit from $10,000 to $17,500, that limit would be increased to $27,500 under this proposal. (Senator Pryor's bill would have provided a $15,000 increase, from the prior-law maximum of $10,000 to $25,000.)

Assuming that there are shortages of medical equipment in health professional shortage areas (that market forces are not likely to resolve), we would recommend that this

proposal be limited to physicians (including partnerships consisting solely of physicians) who use the equipment themselves. There are at least two important reasons why this incentive should not be available to investors who purchase such equipment and then lease it to physicians. First, it is unlikely that very much of this subsidy (in the form of immediate cost recovery) would be passed along by the owner to the physician in the form of reduced rent.[1] Second, it will be extremely difficult for the IRS to monitor whether the owners in such cases are eligible for the expensing (i.e., an examination of the investor's records will not in every case establish that the equipment is actually being used in a physician's full-time practice in a health professional shortage area).

In addition, we have concerns about developing an appropriately narrow statutory definition of medical equipment.

Recommendation. We should recommend that this proposal be dropped as unadministrable or, if not dropped, limited to equipment owned directly by the physician(s) using the equipment.

Decision.

Drop _____ Limit LWB ~~Let~~'s discuss _____

4. Deductibility of Student Loan Interest

This proposal would allow certain health care providers to deduct up to $5,000 per year in interest paid on student loans. The individuals eligible for this deduction are those who (i) satisfy the definition of a qualified health services provider (for purposes of the monthly credit described above, including the HHS certification requirement), and (ii) perform services under agreements with communities which are designated as health professional shortage areas.

This provision was not part of Senator Pryor's bill. Thus, we may have a better chance at having it dropped. In addition to having doubts as to whether it, in and of itself, will provide much of an incentive, we are concerned about it being a precedent that leads to a further expansion of student loan interest deductibility. Also, given the numerous technical definitions involved (e.g., "qualified education loan interest," "qualified health services provider," "qualified higher education expenses," and "qualified tuition and related expenses"), the provision will raise undoubtedly raise numerous administrative problems for both affected taxpayers and the IRS.

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[1] On the other hand, it is conceivable that physicians in shortage areas may only be able to afford to rent, rather than purchase, certain items of medical equipment. If this is a common problem, restricting this incentive to physician-owners may defeat the purpose of the incentive.

Recommendation. We should strongly recommend that this incentive be dropped, perhaps in favor of encouraging States and communities to provide appropriate incentives.

Decision.

Agree ✓ Disagree _____ Let's discuss _____

93-126189

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

ACTION

October 8, 1993

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Alicia Munnell

SUBJECT: State and Local Governments are not Subject to Health Care Payroll Cap

SUMMARY

As you know, under the Health Security Act, no private sector company will be forced to pay more than 7.9 percent of its payroll on health care premiums. Premiums which exceed this cap will be subsidized by the federal government. Last Saturday, the White House announced that state and local governments will not be eligible for this federal subsidy. On Monday, representatives of state and local governments objected strenuously to this policy at a House Government Operations Committee hearing.

This memo summarizes HHS's rationale for not extending the premium caps to state and local governments and our concerns about this decision. Our understanding is that the decision was made without any estimates of the costs of providing the subsidy. We would like to ask HHS to estimate the costs of extending the subsidy.

DISCUSSION

George Greenberg from HHS gave the following rationale for this policy:

1) State/Federal Relationship: It is not appropriate for the federal government to subsidize the costs of state and local governments. These governments have their own tax base, unlike the private sector, and have the ability to raise revenues.

2) Cost: Given the large size of the total government workforce, the cost of such a subsidy would be substantial. While no estimates of this cost have been done, the number would "not be trivial." The financing aspect of the President's initiatives already face tough scrutiny, and it would be difficult to justify such additional costs. Note: if the costs are indeed substantial, the concerns of the state and local officials are not misplaced -- if the cost were small, there would be no issue.

Edward S. Knight

3) Jobs: The subsidies were originally put in place to refute any argument that the plan would cause a loss of jobs. The subsidies will enable small businesses which do not currently cover their workers to do so at a discounted cost, minimizing job loss. States and localities that already insure their workers will not be faced with such increased costs.

4) Political Necessity: The subsidies were also meant to attract the support of small business and business in general. No similar judgement has been made as to the political necessity of providing subsidies to state and local governments.

5) Mitigating Circumstances: States and localities will benefit from other aspects of the Health Security Act. For example, the rate of growth of Medicaid will be reduced, saving state resources. In addition, states will benefit from community rating and elimination of "cost shifting."

On the other hand, not extending the subsidy raises two fundamental issues of fairness:

1) Fairness -- Payroll Costs: The payroll costs of local governments per employee vary directly with taxable capacity: governments in wealthy communities pay higher wages than governments serving poor communities. Thus, the relatively fixed cost of the standard benefit package will be a larger proportion of the payroll costs of a government serving a poor central city than of a government serving a comfortable suburb. It follows that the 7.9 percent cap would direct the federal subsidy to poorer local governments. Likewise, without the subsidy, the employer mandate would be more burdensome for poor communities than for rich ones, contrary to the President's principle of fairness.

2) Fairness -- Tax Base: Essentially, the price of a public service is the tax rate facing a local taxpayer. Even if payroll costs were the same in high and low income communities, tax prices would be different. A government's tax price partly depends on the value of its tax base. The richer the tax base, the lower the tax rate necessary to finance a given level of public services. The cost per employee of the standard health-care package is likely to be the same throughout a metropolitan area. Given the disparities in tax bases, the tax price of the public employer's health care obligation will vary substantially: the tax price will be higher for poor governments than for rich ones. Thus, the failure to apply the cap to state and local governments means that the plan will be further skewed against governments with weak tax bases.

The next step in evaluating this policy would be to determine the cost of treating state and local governments like the private sector. In addition, it would be helpful to assess the impact on state and local governments of not providing the subsidy.

Do you approve of asking HHS to estimate the costs of extending the subsidy?

Approve ✓ Disapprove ____ Let's Discuss ____

But, I don't
we should take on
the extra cost.

LB

TREASURY CLEARANCE SHEET

NO. 93-126189
Date 10-8-93

MEMORANDUM FOR: ☒ SECRETARY ☒ DEPUTY SECRETARY ☐ EXECUTIVE SECRETARY
☐ ACTION ☐ BRIEFING ☐ INFORMATION ☐ LEGISLATION
☐ PRESS RELEASE ☐ PUBLICATION ☐ REGULATION ☐ SPEECH
☐ TESTIMONY ☐ OTHER _____

FROM: Alicia H. Munnell

THROUGH: _____

SUBJECT: State and Local Governments are not Subject to Health Care Payroll Cap

REVIEW OFFICES (Check when office clears)

- ☐ Under Secretary for Finance
  - ☐ Domestic Finance
  - ☐ Economic Policy
  - ☐ Fiscal
    - ☐ FMS
    - ☐ Public Debt
- ☐ Under Secretary for International Affairs
  - ☐ International Affairs
- ☐ Enforcement
  - ☐ ATF
  - ☐ Customs
  - ☐ FLETC
  - ☐ Secret Service
- ☐ General Counsel
- ☐ Inspector General
- ☐ IRS
- ☐ Legislative Affairs
- ☐ Management
- ☐ OCC
- ☐ Policy Management
  - ☐ Scheduling
- ☐ Public Affairs/Liaison
- ☐ Tax Policy
- ☐ Treasurer
  - ☐ E & P
  - ☐ Mint
  - ☐ Savings Bonds
- ☐ Other _____

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
A. Rittenberg	AR	10/8/93	Economic Policy	
REVIEWERS				

SPECIAL INSTRUCTIONS

☐ Review Officer — Date — Roger D. Martin

☐ Executive Secretary — Date — Edward S. Knight

DO F 80-02.1 (04/89)

93-126499

DEPARTMENT OF THE TREASURY
WASHINGTON

October 13, 1993

MEMORANDUM FOR SECRETARY BENTSEN AND DEPUTY SECRETARY ALTMAN

FROM: LESLIE SAMUELS, ALICIA MUNNELL, JERRY MURPHY, ALAN COHEN AND MARINA WEISS

SUBJECT: Issues Relating To Federal Health Care Subsidies

The Administration's Health Care Reform plan calls for Federal subsidies to low-income individuals and to employers to help pay for the health care of all Americans. The specific mechanism by which the Federal government provides such support is, however, not clearly spelled out in the September 7 draft (and, to the extent it is clarified in HHS legislative drafting, may be done so in a manner Treasury may find objectionable). This memorandum notes several key policy issues relating to the mechanism by which Federal subsidies are provided. We would like to discuss these issues with you, as well as the question of how, and in what forum, these issues should be raised within the Administration.

I. Should Federal subsidies to low-income individuals, early-retirees, and employers be treated as an entitlement program, a capped entitlement program, or a discretionary program requiring annual appropriations?

A. The September 7 draft of the proposal refers to the subsidies as open-ended entitlements. However, we understand that the draft legislation calls for the employer subsidy to be treated as a discretionary program and the individual subsidy (about 2/3 the total) as an open-ended entitlement program. We recommend against treating all (or some) of the Federal subsidies as a discretionary program. This would create undue uncertainty as to the availability of the subsidies, without which health care coverage cannot meaningfully be extended to all Americans. We recommend that the subsidies be made into an entitlement. (The issue of whether this entitlement program should be capped is discussed below.)

Agree ✓ Disagree _____ Let's discuss _____

B. An uncapped entitlement program, together with what are likely to be viewed as uncertain sources of funding (savings in Medicare and Medicaid, increased income tax receipts, etc.), may lead to unacceptable increases in the Federal deficit. A reasonable cap can serve as assurance that, if the estimates understate the actual cost, the total deficit exposure would be limited and the program would have to be re-examined. Although it would be clear that the cap could be raised legislatively after such re-examination, the cap would make fiscal control easier.

However, the existence of a cap could make firms and individuals worry that their full subsidies might not be paid. Moreover, legislative intervention can always be taken to protect against increasing the deficit, regardless of whether the entitlement is capped or not. While this is a difficult issue, on balance, we recommend that the entitlement be capped if at all possible.

Agree LWB Disagree _____ Let's discuss _____

II. Should the subsidies be paid out of a single account (which would not have trust-fund status) or a trust fund?

A. We recommend a single account, not a trust fund. Since health care reform is funded through many sources, none of which are expressly dedicated for this purpose, a trust fund does not appear appropriate. Moreover, the establishment of a trust fund would place the issue under the jurisdiction of the Ways and Means committee. As you know, the White House thinks jurisdiction belongs elsewhere.

Agree LWB Disagree _____ Let's discuss _____

B. A separate issue is whether other new health-related Federal expenditures, such as those for administrative costs, should be merged into a single account with the new subsidies. This should only be done if separate sub-accounts remain for each expenditure. Separate sub-accounts would ensure that the fiscal effect of each part of the program could be separately analyzed. Similarly, if any sources of funds are earmarked for new expenditures, they must be assigned to specific sub-accounts unless we have agreement on how to allocate the funds among the new outlays. Accordingly, we recommend separate sub-accounts.

Agree LWB Disagree _____ Let's discuss _____

III. Should various sources of funding be expressly earmarked for health care subsidies?

We are against such earmarking, especially in case of savings from Medicare (which would imply that some Medicare funds would be used for the non-elderly). The Federal contribution to health care reform is expected to be funded through savings in Medicare and Medicaid, though increased tobacco taxes, and though increased income and payroll taxes. Yet no mechanism exists by which the Medicare savings (which may merely prolong the solvency of the HI trust fund), Medicaid savings, or the anticipated increase in tax revenues, are to be dedicated to paying for health care reform. In fact, no such mechanism is needed; the monies for the subsidies can all come out of the General Fund (as is the case for Medicaid). On the

other hand, there may be political advantage in earmarking to show that they are all being used for their anticipated purpose. In addition, some Medicare savings might be specifically dedicated to pay for the cost of adding prescription drug benefits to this program.

Agree LWB Disagree _____ Let's discuss _____

IV. Should the subsidies be paid to the states or to the alliances, and should they be paid as block grants or only when premiums are due?

We recommend that payments be made directly to the alliances on a "when-due" basis. Because very large amounts are being transferred, direct payment to the alliances on the "due date" will allow Treasury to keep the money longer, and reduce the interest cost. If the funds were first transferred to the States they could hold them for some time before transferring them to the alliance (where they are needed). Likewise, making payments in block grants allows the funds to be held by the alliance for some period before they are needed.

Agree LWB Disagree _____ Let's discuss _____

V. Should the long-term care and prescription drug benefits be included as Part A Medicare benefits?

While this issue is not directly related to the health care subsidies, because it touches upon your responsibility as managing trustee of the Social Security Trust Funds we wanted to bring it to your attention. The cost-saving effects of health care reform are expected to increase the size of the HI Trust Fund (which funds Part A Medicare benefits) in the near term; such a buildup of revenue may create pressure to lower payroll tax rates. Politically, including these new programs in the HI Trust Fund would be very difficult (Cong. Waxman feels strongly that the benefits should be treated as Part B Medicare benefits). Nevertheless, the fact remains that, as a fiscal policy matter, both programs should be included in Part A. Moreover, there may be political advantages to having the HI trust fund appear to be paying for benefits for the elderly. Should we discuss this issue with HHS? yes

Agree _____ Disagree _____ Let's discuss _____

VI. Are the compliance mechanisms relating to the subsidies adequate?

We are quite concerned about the laxity of compliance envisioned in the September 7 draft. In most respects, we are leaving to the States the determination of the specifics of subsidy administration, including subsidy application, information update, and reconciliation procedures; delivery mechanisms (such as premium discounts and rebates); coordination of State agency, employer, and alliance functions (such as periodic eligibility determinations, employee paycheck withholdings effected by employers, and alliance billing and accounting); and enforcement (including collection of amounts due and penalties for fraud or other noncompliance). This may not be the best system, and will be criticized, but it is dictated by the White House's desire to make this a State-alliance level program as much as possible.

These specifics are part of the plan for implementation of health reform that each State submits to the National Health Board (and must be satisfactory to the Board, in consultation with other Federal agencies), but such limited oversight leaves much to be desired for a system that will provide subsidies to millions of Americans. Although HHS and DOL will audit the subsidies provided to ascertain the extent of noncompliance in each State, we believe that there is insufficient audit/monitoring/incentives to prevent significant misuse of funds at the State, alliance, employer, and provider levels. Moreover, the September 7 draft does not require the States to audit the alliances to ensure that administrative expenses are reasonable and necessary.

In order to provide some accountability, we propose that States bear all or a major portion of the risk of noncompliance with the subsidy eligibility requirements and of errors and defaults in the subsidy scheme. The States could not make up the shortfall by raising premiums or imposing employer-based taxes; revenues would have to come from other sources. We have heard from the Health Task Force staff, however, that the Administration has promised the governors that the States would bear no risk (and, therefore, potentially no responsibility for improper subsidies being provided). We also recommend that health subsidy information be made available to the IRS, so that information flows in both directions.

Agree ✓ Disagree _____ Let's discuss _____

93- 126588

THE DEPUTY SECRETARY OF THE TREASURY

WASHINGTON

October 13, 1993

Memorandum for Secretary Bentsen

From: Roger Altman

Subject: Health Care Numbers

Both OMB and Treasury have completed their re-estimates on health care reform. There has been $67 billion of slippage over the 1995-2000 period. In other words, the September 7 plan would have reduced the pre-reform deficit by $80 billion and the new estimates have that figure at $13 billion. The variances are widely distributed. At a meeting this afternoon with Ira, Leon and others, a few directions emerged for coping with these changes.

There is a general sense that we should restore much of the lost deficit reduction. Otherwise critics will claim this is just the first slippage in a plan which ultimately will cost the taxpayers a ton. agree

The goal of getting back to $70 billion of deficit reduction was discussed. This could be done any number of ways but the main ones include:

- delay the beginning point of the phase-in from January 1995 to October 1995 OK
- go with a higher tobacco tax, e.g., adding 90 cents instead of 75 cents agree
- delay the early retiree provision by one year agree
- impose a temporary premium surcharge on larger employers probably

There is also a series of "smaller-money" options. All of these are being costed out and should be available over the next 48 hours. At that point, there will be an NEC meeting and the options will be presented.

cc: Les Samuels
Alicia Munnell
Marina Weiss

93-126450

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

OCT 15 1993

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Alicia H. Munnell
Assistant Secretary for Economic Policy

SUBJECT: The Medicare Experience in Projecting Health Care Costs

Skeptics of the budget forecasts in the President's health care reform plan often point to the experience of the Medicare program. When the Medicare legislation was enacted in 1965, the program's long-range cost estimate was that hospital insurance (HI, or Part A) benefit payments would be about $9 billion in 1990. Actual 1990 benefits were more than $66 billion, about 7.5 times the predicted amount.

To a great extent, this criticism is exaggerated and unfair. Some of the reasons for the forecasting error are economically insignificant, or were unforeseeable in 1965. One reason is that overall U.S. inflation has been much more severe since 1965 than the forecast assumed it would be. A second reason is that conscious decisions were made to expand the Medicare program, particularly in 1972 when legislation extended coverage to the disabled and those with chronic kidney disease.

Adjusting for economy-wide inflation and Medicare program expansion reduces the proportional forecast error from 7.5 to about 3. However, this smaller error is still cause for concern. Unexpectedly high utilization and costs in Medicare's startup years led to almost immediate upward revisions in the forecast. Subsequently, large increases in the relative price of hospital care caused a continuing divergence between predicted and actual benefits. Although it is reasonable to expect that our tools and methods of forecasting have improved greatly since 1965, the sobering lesson of history is that the new health care system might have costs that are greater than we predict.

Discussion

Simple comparison of the $66.239 billion in 1990 Hospital Insurance benefit payments to the $8.797 billion forecasted when the original Medicare legislation was enacted in 1965 exaggerates the significance of the forecast error. For example, the 1965 forecast projected hospital costs largely on the basis of an assumed 3 percent annual growth in nominal earnings. Actual nominal earnings growth between 1965 and 1990 averaged 6.4 percent, primarily as a result of unexpectedly high inflation in the overall U.S. economy. Another important reason for the increase in benefit payments was the 1972 legislation that extended HI coverage to non-elderly persons who were disabled or

who suffered from end-stage renal disease. These persons now account for more than one-ninth of HI benefits.

Unexpected inflation caused an underestimate of 1990 benefits in nominal, but not in real, terms. Moreover, it did not jeopardize the financial viability of the Medicare system, since revenues are a function of nominal earnings. Similarly, Medicare's expansion to new beneficiary groups was a result of conscious decisions made after 1965, and should not be counted as a forecast error. Increasing the 1965 prediction for both earnings growth and program expansion yields an adjusted forecast of about $22.3 billion in 1990 benefits. Dividing this value into $66.239 billion gives 3.0, not 7.5, as a more appropriate ratio of actual to predicted benefits.

Robert Myers, the former Chief Actuary of the Social Security Administration, has suggested a different approach to evaluating Medicare's forecasting record, focusing on the projection of program costs as a percentage of taxable payroll. The 1965 forecast was that program costs, including both benefits and administrative costs, would equal 1.61 percent of taxable payroll in 1990. However, the 1965 forecast was very conservative in projecting the taxable earnings base. In particular, the maximum amount of annual taxable earnings was assumed to stay at $6,600 throughout the forecast period. According to Myers, had this maximum been assumed to rise with overall wage growth, the projected cost as a percent of taxable payroll would have been only 1.1 percent. The taxable earnings cap has, in fact, increased *more* rapidly than wages since 1965, raising the proportion of earnings that are subject to tax. If we adjust the 1.1 percent figure downward to reflect this change, and upward to reflect coverage of the non-elderly disabled and those with chronic kidney disease, we obtain an adjusted forecast that Medicare costs would equal about 1.02 percent of 1990 covered earnings. The actual ratio of costs to taxable payroll was 2.71 percent in 1990, so by this measure the actual cost was about 2.7 times the projection. This provides rough verification for the 3.0 ratio obtained above by a different method.

These results demonstrate that the errors in the early Medicare projections were due in large part to innocuous factors. However, serious forecasting errors remain after those factors are taken into account. In Medicare's startup years, hospital prices and utilization were both well above expectations, and skilled nursing expenditures were also higher than expected. As a result, by 1968 the forecast of 1990 benefits had already been nearly doubled, from $8.797 billion to $16.830 billion. Subsequently, even this latter forecast was outstripped as the price of hospital care continued to rise much faster than prices in general.

A set of talking points on this issue follows below.

TALKING POINTS
Medicare Cost Projections

Skeptics of the budget forecasts in the President's health care reform plan often point to the experience of the Medicare program. When the Medicare legislation was enacted in 1965, the program's long-range cost estimate was that hospital insurance (HI, or Part A) benefit payments would be about $9 billion in 1990. Actual 1990 benefits were more than $66 billion, about 7.5 times the predicted amount. [Adjusting for inflation and program expansion, a more fair ratio of actual to predicted would be about 3 to 1.]

- This criticism is exaggerated and unfair.
  - Much of the divergence between the actual and projected dollars in benefit payments has nothing to do with health care: the general price level is simply much higher than anyone would have predicted in 1965.
  - Another reason that the prediction was too low is that the Medicare program has been broadened. For example, non-elderly disabled persons and those with chronic kidney disease are now covered. Failure to predict these new expenditures is not a forecast error.
- Times have changed, and our ability to forecast has improved.
  - The people who are preparing the budget estimates for health care reform have more data and better computers than their counterparts had in 1965.
  - We also have accumulated almost three decades of experience in projecting Medicare and Medicaid expenditures.
- At the same time, we recognize the difficulty and importance of getting the numbers right.
  - Treasury and other agencies are making every effort to make our budget projections accurate.
  - We have even called in outside experts to review the estimates.

Office of Economic Policy, October 15, 1993

TREASURY CLEARANCE SHEET

NO. 93-126450
Date 10-15-93

MEMORANDUM FOR: ☐ SECRETARY ☐ DEPUTY SECRETARY ☐ EXECUTIVE SECRETARY
☐ ACTION ☐ BRIEFING ☐ INFORMATION ☐ LEGISLATION
☐ PRESS RELEASE ☐ PUBLICATION ☐ REGULATION ☐ SPEECH
☐ TESTIMONY ☐ OTHER _____

FROM: Alicia Munnell, Assistant Secretary for Economic Policy
THROUGH: _____
SUBJECT: The Medicare Experience in Projecting Health Care Costs

REVIEW OFFICES (Check when office clears)

- ☐ Under Secretary for Finance
  - ☐ Domestic Finance
  - ☐ Economic Policy
  - ☐ Fiscal
    - ☐ FMS
    - ☐ Public Debt
- ☐ Under Secretary for International Affairs
  - ☐ International Affairs
- ☐ Enforcement
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  - ☐ Customs
  - ☐ FLETC
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  - ☐ Scheduling
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  - ☐ Savings Bonds
- ☐ Other _____

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
John Greenlees	JG	10-15-93	Economic Analysis	2-2020
REVIEWERS				

SPECIAL INSTRUCTIONS

☐ Review Officer _____ Date _____

☐ Executive Secretary _____ Date _____

DO F 80-02.1 (04/89)

Roger D. Mahun

Edward S. K...

DEPARTMENT OF THE TREASURY 93-126655
WASHINGTON

October 19, 1993

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Marina L. Weiss

SUBJECT: Health Reform Subsidies as a Capped Entitlement

ACTION FORCING EVENT: Opposition from House Democrats

RECOMMENDATION: That you instruct staff to work with HHS and OMB on some options for a contingency plan if the President and Congress fail to act to raise the cap if subsidy funds run out.

OPTIONS:

_____Staff to work with OMB and HHS on contingency plans

_____Let's discuss

_____Other:

BACKGROUND/ANALYSIS: Apparently Congressman Waxman has been told of the "capped entitlment" discussion that took place at the meeting with the President on Monday. I am advised that Mr. Waxman is very upset and that the White House is concerned he will not cosponsor the Administration's bill unless the entitlement to subsidies is open ended.

Majority Leader Gephardt's office has reported that, without Waxman's support, the Black Caucus and other liberals will not support the initiative.

The crux of Congresman Waxman's concern is that if the estimates are wrong and the cap is reached, low income people [and small businesses] will lose their subsidies. He worries, in the face of last week's debate over extending unemployment benefits, that the Congress may not act to avert a crisis.

Clearly, if the Federal government limits its liability for the subsidies through a cap, and the President and Congress fail to act in the event of a shortfall, something undesirable will happen. Among the options are:

1. Alliances raise premiums charged other businesses and individuals;

2. States will have to make up the shortfall;

3. low income individuals and small businesses have their subsidies reduced or lose them altogether;

4. A blended response which includes all of the above.

HHS has suggested that a small group of staff from HHS, OMB and Treasury get together to develop some options for consideration by the Secretaries, the First Lady and the President if necessary.

The question they would like to try to answer is what the Administration's preferred outcome would be under a "doomsday" scenario; and whether it would be desirable to write a contingency plan into the legislative language or whether it is preferable to be silent on the issue in the legislation.

The question of who bears the ultimate financial risk has been discussed throughout the development of the legislation, though there was never any clear indication from Ira as to how he thought the dilemma should be resolved.

In my judgment, this may be the single most important issue [both political and financial] surrounding this legislation, and I was frankly surprised that it was so quickly disposed of at the meeting earlier this week.

Congressman Waxman's reaction offers an opportunity to focus greater attention on the issue to ensure that everyone is comfortable with the decision -- and prepared to defend it.

Assuming the decision stands, and the entitlement will be capped, staff will need some guidance for drafting purposes.

DEPARTMENT OF THE TREASURY
WASHINGTON

126917

October 26, 1993

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Kevin Varney
Scheduling Office

SUBJECT: Presentation of Health Care Legislation to Congress

Date & Time: Wednesday, October 27, 1993

Location: H-204 Speaker's Office (Cabinet holding room)

PARTICIPANTS:

Secretary Bentsen
Secretary Shalala
Secretary Jesse Brown
Secretary Riley
Erskine Bowles
Laura Tyson
Leon Panetta

President Clinton
Vice President Gore
Mrs. Clinton

PRESS: Yes

SCENARIO:

10:30 am — Meet the President and other Cabinet Secretaries in H-204.

10:40 am — Cabinet Secretaries will proceed to VIP seating in Statuary Hall.

10:45 am — Speakers on health care:
President Clinton
Vice President Gore
Mrs. Clinton
Senate Majority Mitchell
Speaker Foley
Majority Leader Gephardt

12:00 pm — Secretary Bentsen departs for Treasury. (The President will be hosting a lunch following his speech for Cabinet Secretaries and selected members of Congress in the Madison room. We have arranged to have you leave at the conclusion on the President's speech).

93-127139

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

November 3, 1993

MEMORANDUM FOR: SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Alicia Munnell
Assistant Secretary for Economic Policy

SUBJECT: The National Health Care Proposals of Presidents Truman and Nixon

This memo provides background on proposals for national health insurance by the Truman and Nixon Administrations.

Truman

Background. In a November 19, 1945 message to Congress, President Truman described five major problems with the U. S. health care system: the unsatisfactory distribution of health care providers, inadequate public health services, the need for more medical research and professional training, the high cost of medical care, and the loss of income from prolonged illness. Private health insurance coverage was spreading rapidly, however. For example, the number of people with some hospital insurance coverage rose from under 6 million in 1939 to about 75 million (about 50% of the population) in 1950. However, only about 3-4% of the population had comprehensive health insurance coverage in 1950.

Health Care Proposal. In his November 19th message President Truman called on Congress to pass a national program that would assure every American citizen the "right to adequate protection from the economic fears of sickness." To address these problems he proposed adoption of a comprehensive and modern national health program that would:

(1) provide federal grants for construction of hospitals and other health centers;

(2) expand public, maternal and child health services;

(3) provide grants for research programs and medical education;

(4) protect against wage loss due to accident or sickness; and

(5) provide workers and their dependents comprehensive medical services paid for through social security taxes.

Outcome. Truman was a fervent advocate of compulsory national health insurance in which employers would be required to offer and help pay for the health insurance of their

employees. He was the first president to explicitly support such a program and he repeated his message in a 1949 address to Congress. Truman's national compulsory health insurance plan was highly controversial and, as a legislative item, it never even cleared a committee. Intense and successful opposition was mounted by the American Medical Association, which was given credit for defeat of Truman's national insurance health plan. By 1950, the attention of the Truman Administration turned to Korea, mitigating any further effort to pass national health insurance.

The expansion of private health insurance around the time of the Truman Administration, noted above, also inhibited the push for national health insurance. As a fringe benefit, private health insurance was tax-favored and exempt from the wartime freeze on wages.

Nixon

Background. Rising health care expenditures were of much concern during the late 1960s. National health care expenditures as a share of GNP rose from 5.9% in 1965 to 7.1% in 1970. A background report prepared by the Ways and Means Committee in 1971 described the following problems with the U. S. health care system: maldistribution of physicians and facilities (physicians were increasingly engaging in research, locating in metropolitan areas, and becoming specialized), fragmentation of the delivery of medical care resulting in much inefficiency, and inadequate financial access to health insurance (the poor had little health insurance protection and the unemployed relied on government programs). In the late 1960s, Senator Kennedy was pushing strongly for a national health insurance program.

Health Care Proposal. On February 18, 1971, President Nixon announced a comprehensive national health insurance program. The program had three main parts:

(1) National Health Insurance Standards Act to require employers to provide basic health insurance coverage to employees and their families. Employers would pay 75% of premium amounts.

(2) Family Health Insurance Plan to replace Medicaid for the poor and near-poor with children, financed partially by premiums paid by enrollees and graduated by income class (no premiums paid by the lowest class). Coverage would be less generous than employer-based plans.

(3) a proposal to encourage establishment of Health Maintenance Organizations (HMOs). According to Nixon, "such organizations provide a strong incentive for better preventive care and for greater efficiency."

Outcome. The third part of Nixon's program was the only one to see Congressional action. Eventually, the Health Maintenance Organization Act was passed in 1973. This Act provided for grants and loans to develop new HMOs, and required employers with more than twenty-five employees to offer an HMO option in their health benefit plan if a

qualifying HMO were located within the vicinity.

In 1974, Nixon approved a national health insurance plan similar to but more generous (no difference in the minimum benefits between employer-provided plans and a plan for the non-employed population) than the 1971 proposal. However, other political events became dominant.

Similarities and Differences in the Health Care Plans of Presidents Clinton, Truman, and Nixon

Truman promoted the "economic bill of rights" initiated under President Roosevelt which included the right to adequate medical care. Expansion of health insurance coverage was a primary goal of his administration. In his 1945 message to Congress, Truman stated that "Our new Economic Bill of Rights should mean health security for all, regardless of residence, station, or race - everywhere in the United States." Health care costs were regarded as less of an issue to Truman, who said that medical care "absorbs only about 4 percent of the national income. We can afford to spend more on health."

During the Nixon Administration, rising health care costs had become a problem which increased the receptability for a national health insurance program such as the one then being pushed by Senator Kennedy.

Both Truman and Nixon proposed health care reform plans that would build on the employer-based insurance system that grew dramatically during the 1940s and 1950s. Employers would be required to offer and help pay for the insurance coverage of their employees and families. Both proposals sought to achieve universal coverage, though neither included an individual responsibility to enroll in a health care plan.

President Clinton stresses the health security concept of President Truman. Clinton also faces the problem of rising health care costs. As in the case of Truman and Nixon, Clinton proposes to build on the employer-based system but goes further toward achieving the goal of universal coverage by combining an employer mandate to offer and contribute toward insurance coverage with an individual mandate to enroll in a health plan.

TREASURY CLEARANCE SHEET

NO. 93-127139
Date 11/3/93

MEMORANDUM FOR: ☒ SECRETARY ☒ DEPUTY SECRETARY ☐ EXECUTIVE SECRETARY
☐ ACTION ☐ BRIEFING ☐ INFORMATION ☐ LEGISLATION
☐ PRESS RELEASE ☐ PUBLICATION ☐ REGULATION ☐ SPEECH
☐ TESTIMONY ☐ OTHER _____

FROM: Alicia Munnell
THROUGH:
SUBJECT: The National Health Care Proposals of Presidents Truman and Nixon

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- ☐ Under Secretary for Finance
  - ☐ Domestic Finance
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INITIATOR(S)				
James Duggan	JD	11/3/93	Economic Policy	622-2010
REVIEWERS				
Alicia Munnell	AM	11/3/93	Economic Policy	622-2200

SPECIAL INSTRUCTIONS

☐ Review Officer Date ☐ Executive Secretary Date

DO F 80-02.1 (04/89)

93-129011

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

December 23, 1993

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Marina L. Weiss

SUBJECT: Health Care Reform

ACTION FORCING EVENT: Request from the White House

RECOMMENDATION: That preliminary contacts be made at the staff level to ascertain information about issues of concern to the Member or CEO. In the case of Members of Congress, inquire about how you could be of most help in educating their constituents on the specifics of the President's plan. That you then use this information to converse by telephone with the Members and CEO's to obtain the information requested by the White House and to offer your assistance personally.

OPTIONS:

✓ Agree with staff recommendation, staff contacts to be made as quickly as possible

_____ Prefer that no preliminary staff contact be made, will place calls myself

_____ Other:

BACKGROUND/ANALYSIS: As you know, the White House has asked you and other Members of the Cabinet to "target" members of Congress and the Senate for special outreach during the congressional recess. You have been assigned 10 individuals [Congressmen Pickle, Andrews, Tauzin, Roemer, Green of Texas, Chapman of Texas, Stenholm, and Senators Boren, Johnston, and Nunn].

In addition, the White House has asked that you and other Cabinet Members take responsibility for communicating with certain CEO's on a regular basis [a minimum of once per month is recommended]. The purpose of the communication is to: "educate them on changes in the plan; receive their input on recommended changes; and to take the general pulse of the business community." You have been assigned two CEO's -- Pete Silas of Phillips Petroleum and Michale H. "Mike" Walsh, President and CEO of Tenneco. Both of these individuals are characterized by the White House as "undecided" on the President's plan. Assume Silas would be against - a rock conservative

Information you obtain from these contacts is then to be given to the White House office of Congressional Affairs and/or the Office of Business Liaison for use in modifying the legislation as it is considered by the Congress.

I would recommend that an initial contact be made at the staff level to provide you with background information from which to speak to the Member/CEO. Calls to Member offices would be coordinated with Treasury's office of Legislative Affairs, calls to the CEO's with Treasury's Public Liaison.

93-12 9553

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

very interesting + helpful!

December 30, 1993

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Marina L. Weiss

SUBJECT: Health Care Reform

ACTION FORCING EVENT: Post-Christmas return to Washington.

BACKGROUND/ANALYSIS: To enable you to "hit the ground running," I thought you might like to have a chance to review some recently released health reform materials at your leisure and prior to your return to D.C. Attached for your purusal are the following items:

- A pictorial account of one of the earliest recorded attempts to encourage the use of "managed care."

- Recently released Department of Commerce statistics on the rates of growth in the health care industry and in national health care spending.

  I have also included not yet released data from the HCFA actuaries on the 1993 rates of growth in Medicare spending. [As you know, the most complete and accurate Federal health spending data relates to Medicare...so this information will weigh heavily in cost estimates prepared by the Administration actuaries and by CBO].

- A chart developed by the staff of Senator Arlen Specter. The staff describe the effort as a "serious attempt to diagram the Administration's health reform plan -- the purpose of the chart was to serve as a visual aid in explaining the plan to the Senator." The chart has had some limited coverage in the print media. Not well done

- A paper written by former Treasury employee Michael Graetz, one of the major architects of President Bush's health reform proposal. I've included Mike's paper in this packet so that you can see what kind of advice is being given to Senator Chafee. As you know, there are serious operational problems associated with an individual mandate -- chief among them are the upheaval that would occur in the current employer based system, the difficulty that individual's would face in evaluating and purchasing insurance, and the cost and complexity of a tax credit/deduction structure. agree

- A copy of a speech given by Bob Stone [Associate general Counsel of IBM] to Fortune 100 representatives who attended a

some valid concerns

special meeting of their benefits trade association held earlier this month to review the Administration's health reform proposal. I also include the Executive Director's cover letter to me so that you can see the list of companies represented on the association's Board of Directors.

- A WASHINGTON POST article on the latest twist in the FOIA litigation over the Health Care Reform Task Force internal memoranda.

- Finally, you should be aware of the status of two on-going efforts.

  First, the health care Quantitative Analysis group, [generally staff associated with NEC member agencies] are trying to pull together a state-by-state analysis of the impact of the President's health reform proposal. The available data is, in a word, awful. But we're giving it a go.

  Second, Treasury staff met with staff from the Federal Office of Personnel Management [OPM] in an effort to move ahead on the development of a health reform brochure for distribution to Departmental staff. We are approaching the project with the hope that Treasury can be the prototype for a government wide effort to inform Federal workers of the impact of the President's proposal on the Federal Employees Health Benefits Plan [FEHBP]. Our objective is to produce a generic brochure which includes a letter of introduction from the Secretary -- that way, the brochure which we develop here at Treasury can be used by other Departments [with appropriate modifications to accommodate a greeting from other Cabinet Secretaries to their employees]. The White House is, of course, fully informed about our interest in taking the initiative on this project. Apparently the War Room expressed some interest in doing a similar project earlier but had to abandon the plan due to lack of sufficient funding.

- HAPPY NEW YEAR !!!

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

94 130097

January 25, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Marina Weiss
Andy Rittenberg

SUBJECT: Health Care Reform

Action Forcing Event:

The White House has requested that we prepare a statement for you to release.

As you know, Senator Gramm is expected to introduce as early as today a health insurance reform bill similar to your proposals of 1991 and 1992. The health care "Delivery Room" (as contrasted with earlier "War Rooms") has requested that you release a statement when and if Senator Gramm introduces the proposal. A draft statement is attached for your review and comment.

Approve as drafted LSB

Approve with noted edits _____

Other _____

In 1991-1992 in my former post as Chairman of the Senate Committee on Finance, I introduced four bills that, taken together, were designed to address some of the most egregious problems of the American health care system. At the time, it was the most that could be achieved in my judgment.

Today, we have a President who is enthusiastic about taking the lead and doing what is necessary to guarantee health security to every American. We have all the ingredients to make history in this country. Universal coverage is essential both because it will enable us to contain costs and because it is long overdue. I can only say that it would be tragic if we were to miss this opportunity when the American people so clearly want us to join together in a bipartisan effort to reform our nation's health care system.

to: _____

room: _____ date: _____

Department of the Treasury

Office of the Executive Secretary

1/25/94

CLOSE HOLD DOCUMENT

Do not distribute to anyone without permission from Ed Knight or Roger Martin.

Roger Martin

room 3413
phone 622-0064

TREASURY CLEARANCE S[redacted]

[redacted]D. _____

Date _____

MEMORANDUM FOR: ☒ SECRETARY ☐ DEPUTY SECRETARY ☐ EXECUTIVE SECRETARY

☐ ACTION ☐ BRIEFING ☐ INFORMATION ☐ LEGISLATION

☐ PRESS RELEASE ☐ PUBLICATION ☐ REGULATION ☐ SPEECH

☐ TESTIMONY ☐ OTHER _____

FROM: Michael Levy, Assistant Secretary

THROUGH: _____

SUBJECT: Budget Act Treatment of New Revenue Souce for Superfund

REVIEW OFFICES (Check when office clears)

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  - ☐ Secret Service
- ☐ General Counsel
- ☐ Inspector General
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NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
Robertson	AR	1/25	Legislative Affairs	622-1920
REVIEWERS				
Levy	AR	1/25	Legislative Affairs	622-1900
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SPECIAL INSTRUCTIONS

☐ Review Officer _____ Date _____

☐ Executive Secretary _____ Date _____

DO F 80-02.1 (04/89)

94-131604

DEPARTMENT OF THE TREASURY
WASHINGTON

LM13

INFORMATION

ASSISTANT SECRETARY

March 14, 1994

MEMORANDUM FOR: SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

THRU: Frank N. Newman FNN
Under Secretary of the Treasury
Domestic Finance

FROM: Gerald Murphy
Fiscal Assistant Secretary

SUBJECT: Health Care Reform Issues of Concern to Treasury

The attached memorandum highlights a number of issues, three of which I would like to bring to your attention:

(1) The potential for unlimited liability created by the Secretary of Labor's full guarantee of payment to corporate alliance providers.

(2) The potential of a health care problem similar to that faced with failed S&Ls, created by the Secretary of Labor's ability to assume open-ended trusteeship of an insolvent corporate alliance in order to get it back on sound financial footing.

(3) The disincentive a full guarantee of benefits creates re: providers collecting their own receivables.

In reference to Item (1), while Treasury staff was successful in limiting our exposure in terms of borrowing authority from Treasury to pay guaranteed corporate alliance provider benefits, a second reading by our attorneys indicates that the Secretary of Labor's guarantee is probably backed by the full faith and credit of the United States. It appears that while the borrowing authority is capped, the obligation to pay all defaulted self-insured corporate alliance provider benefits may not be.

In reference to Item (2), Treasury staff strongly protested this provision in the draft document, and was told that it would be removed. The Secretary of Labor's role as receivership to insolvent corporate alliances could expose the Government to:

(a) Expensive and time-consuming litigation with allegations of premature and unwarranted intervention, as with the S&Ls.

(b) Questionable chances of success in turning around the financial condition of these alliances.

(c) Requests for large emergency appropriations from Congress, as the insolvency fund finances both trustee operations, and the defaulted provider benefits mentioned above.

We recommend that Treasury continue to vigorously oppose this provision.

In reference to Item (3), fully guaranteeing payment of all provider services gives the provider less incentive to function in a business-like manner to collect amounts due the provider - particularly delinquent debts which take a disproportionate amount of effort to collect.

cc: Munnell
Samuels
Weiss

DEPARTMENT OF THE TREASURY
WASHINGTON

2 March 1994

MEMORANDUM TO: Marina Weiss
Deputy Assistant Secretary
(Economic Policy)

THRU: Gerald Murphy (Initialed) GM
Fiscal Assistant Secretary

FROM: Diane Dogan Hilliard DdOH
Office of the Fiscal Assistant Secretary

SUBJECT: Corporate Alliance Guaranteed Benefits

In the proposed "Health Security Act," Senate Bill 1757, the Secretary of Labor guarantees the payment of benefits to providers of corporate alliances with self-insured sponsors. It appears that we may have an unlimited liability here. In pertinent part, the proposed Act provides:

> **"The Secretary of Labor shall guarantee the payment of all benefits** under a corporate alliance health plan which is a self-insured plan while such plan is under the Secretary's trusteeship..." S.1795, 103rd Cong., 1st Sess, Sec. 1396(a) (1993) [emphasis added]

and

> "The Secretary shall not cease to guarantee benefits on account of the failure of a designated payor to pay any assessment when due." Sec. 1397(f)

Based on a presumption, historically reflected in opinions of the Attorney General, see 6 U.S. Op. Off. Legal Counsel 262 (1982), that federal agency obligations are supported by the full faith and credit of the United States, unless the statute authorizing such obligations expressly provides otherwise, these provisions raise the likelihood that Labor's guarantee is backed by the full faith and credit of the United States. This result is very likely even if the restraints earlier added at the suggestion of Treasury, such as the $500 million cap on the borrowing authority of the Corporate Alliance Health Plan Insolvency Fund, Sec. 1396(c)(3, remain intact.

Against the background of this concern that we have informally verified with legal counsel, the following proposals are presented that, if adopted, would contribute further to controlling the potential for unlimited obligations.

Proposal #1. Modify the provision which allows the Secretary of Labor to become trustee of an insolvent self-insured corporate alliance under Section 1395 to exclude assisting an insolvent corporate alliance to get back on a sound financial footing.

Sec. 1395(a) states:

"Whenever the Secretary of Labor determines that a corporate alliance health plan which is a self-insured plan will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of the Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint the Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the enrolled individuals or health care providers or to avoid any unreasonable deterioration of the financial condition of the plan or any unreasonable increase in the liability of the Corporate Alliance Health Plan Insolvency Fund. The trusteeship of the Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated."

Comments:

a. Adopting a system that contemplates an indefinite open-ended Government role in helping an insolvent self-insured employer get back on sound financial footing is a high risk proposition.

b. Particularly in a single employer alliance, the Secretary of Labor cannot become trustee without impacting the operations, management, and possibly the reputation of the sponsor firm. If the trusteeship is successful, an additional subsidy will have been given the sponsor firm, at the expense of employers whose assessments funded the Insolvency Fund, and the Federal Government. If it is unsuccessful, it is possible that corporation whose alliance was taken over will accuse the Government of early and destructive intervention which caused the corporation to fail, flounder and/or lose the confidence of and credit in the marketplace. Consider S&L litigation where the Federal Government was charged with premature and/or unwarranted intervention. Litigation requires disproportionate quantities of Government and company time and money.

c. The goal is to establish a system which will provide individuals with uninterrupted health care, and providers with a

safety net. This may not require operating an alliance. We are not in the business of saving companies. Intervention of this type is premature, expensive, inappropriate, and runs a high risk of being unsuccessful.

d. The current plan allows the Secretary of Labor to serve as trustee until the hazardous financial conditions are remedied. How many years will that be? Indefinitely? How many times can the Secretary become Trustee to the same employer/alliance? This open-ended intervention could merely prolong the inevitable, at added expense to the Guarantee Fund contributors and the Government, not to mention the negative publicity the Government will receive. Any Government intervention in the operations of a corporate alliance should be well defined, and limited in time.

e. DOL intervention as a trustee in the operation of a corporate alliance is appropriate at the point when DOL revokes the status of a corporate alliance, and transfers covered employees to regional alliances.

f. The role of trustee may turn out to be a morass. This role, combined with fully guaranteed provider benefits, could have DOL applying to go to Congress for huge emergency appropriations - a health care RTC.

g. Business might be more amenable to a plan whereby the right to have a corporate alliance is terminated if the sponsor doesn't live up to the conditions specified by the Government, rather than having DOL running a troubled alliance.

<u>Proposal #2.</u> Modify Sec. 1396 whereby the Secretary of Labor shall guarantee <u>all</u> benefits of the self-insured plan. Guarantee only somewhere between 80% to 95% of the benefits. It is important to retain sufficient incentives for providers to operate in a business-like fashion.

a. Much can be gained by only partially guaranteeing benefits of a self-insured plan. If the providers were only assured of 80% or even 90%, they would be much more assiduous in pursing amounts due them, and sending out signals when there were signs of alliance weakness, not to mention assessing up-front risk.

b. Fully guaranteeing provider benefits gives the provider less incentive to function in a business-like way to collect amounts due the provider - particularly delinquent debts, which take a disproportionate amount of time and effort to collect.

c. Does the Government really want to fully guarantee a self-insured plan? What incentive system does this create? Are we trying to get more employers to adopt a self-insured plan?

d. The goal is to provide a safety net for providers and employees - not a womb. Partially guaranteeing benefits would allow the market place to work more naturally.

e. The Government has had a great deal of experience with fully guaranteed loans - most of it unfavorable.

f. This is both a cost reduction and a risk reduction measure.

Proposal #3. Should an alliance default, do not pay the providers immediately if there are no funds in the Insolvency Fund. If possible, wait until employer assessments can be collected.

a. Anyone in business, by definition, assumes some degree of risk.

b. The providers will still get paid - just not as soon and not as frequently from funds borrowed from the Government.

c. Eliminating the borrowing and payback steps would streamline the operational requirements. It would not eliminate the Government's ultimate guarantee.

Proposal #4. Identify trigger events that will initiate well-defined Department of Labor (DOL) intervention in the operations of a corporate alliance for each employer category. e.g.,:

Partially self-insured single employer
Fully insured multi-employer - union mandated

Process:

1. Focus on what the Government is attempting to do.
   The goals appear to be:
   (1) To provide uninterrupted service to individuals, and
   (2) To provide a safety net for the participating providers.
2. Focus on the optimal time to intervene, e.g.,:
   (a) Before the benefits to be paid are too great.
   (b) At the time the employees premiums/ provider benefits can no longer be supported by the corporate alliance.

Summary:

(1) Modify the provisions fully guaranteeing the payment of benefits to providers.

(2) There is no need for DOL to intervene as trustee in the

operation of a corporate alliance for lengthy periods of time, at much risk and cost. DOL need not intervene as trustee until it is determined that a corporate alliance cannot turn its financial situation around.

(3) The key is to minimize losses by revoking corporate alliance status promptly when an alliance does not meet the terms under which it was granted this status, e.g., not paying their premiums and/or providers.

(4) Action should be quick to minimize the liability to the Insolvency Fund and the Federal Government. At the point of intervention as trustee, DOL should be prepared to immediately enroll employees in a regional alliance.

(5) The measures being considered to assess insolvency should focus on the critical event, i.e., is the corporate alliance promptly paying its premiums (if insured) or providers (if self-insured), or paying at all? Delinquent payments could be the focus of a DOL early warning system.

Mr. Altman

TREASURY CLEARANCE SHEET

NO. _____

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MEMORANDUM FOR: ☒ SECRETARY ☐ DEPUTY SECRETARY ☐ EXECUTIVE SECRETARY

☐ ACTION ☐ BRIEFING ☐ INFORMATION ☐ LEGISLATION

☐ PRESS RELEASE ☐ PUBLICATION ☐ REGULATION ☐ SPEECH

☐ TESTIMONY ☐ OTHER _____

FROM: Gerald Murphy (Signed) Marcus W. Page

THROUGH: Frank Newman, Under Secretary for Domestic Financc

SUBJECT: Health Care Reform Issues of Concern to Treasury

REVIEW OFFICES (Check when office clears)

- ☐ Under Secretary for Finance
  - ☐ Domestic Finance
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NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
Diane Dogan Hilliard	DD	3/9/94	OFAS	2-0560
REVIEWERS				
Mark Page	[illegible]	3/9/94	"	" "

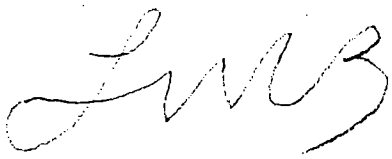
SPECIAL INSTRUCTIONS

☐ Review Officer Date ☐ Executive Secretary Date

94-132800

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

MEMORANDUM



TO: Secretary Bentsen and Deputy Secretary Altman
FROM: Mark Iwry
THROUGH: Les Samuels
DATE: April 13, 1994
SUBJECT: Health Care Reform: Ira Magaziner Comments at White House Meeting With Five Major Corporations

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SUMMARY -- This memorandum summarizes a number of comments made by Ira Magaziner to representatives of Ford, Eastman Kodak, Procter & Gamble, TRW, and Xerox at a recent health care meeting at the White House.

ACTION -- This is for your information only.

DISCUSSION -- The five corporations listed above comprise what the White House calls the "joint consultative team", an ad hoc group of companies that has commented on health care reform issues of particular concern to major corporations. These companies are generally representative of the group of employers that are most likely to support health care reform.

After submitting position papers to Ira Magaziner on a number of issues raised by the Administration's Health Security Act, the ad hoc group was asked to meet with Ira and other White House staff. At the meeting (which Marina Weiss and I also attended, together with Department of Labor representatives), Ira commented briefly on some of the concerns the companies had raised. His comments included the following:

- benefit package: In response to the companies' criticism of the Administration's benefit package as too costly, Ira said that CBO had characterized the cost of the benefit package as being comparable to the 52nd percentile of Fortune 500 corporate plans. He indicated that this was about where the Administration had wanted to be, "so the benefit package is pretty well pitched."

- repeal of tax-favored treatment of health care in cafeteria plans: One of the corporate representatives also serves as President of the Employers Council on Flexible Compensation (an organization dedicated to promoting cafeteria plans). He asked Ira whether there might be any hope for cafeteria plans. Ira observed that, according to Administration estimates, repeal of tax-favored treatment for cafeteria plans would raise a great deal of revenue, but

that CBO had scored it as raising far less. He speculated that the amount CBO estimated might not be worth fighting for, and said he therefore suspected Congress might preserve cafeteria plans.

• corporate alliances: Ira agreed with the companies that some of the impediments to formation of a corporate alliance should be removed, but disagreed with the companies' recommendation that the 1% assessment on corporate alliance employers be eliminated in favor of an alternative "broad-based" tax.

• regional alliances: The business representatives expressed concern about the amount of regulation contemplated for the regional alliances. Ira responded that community rating could be achieved through either voluntary or mandatory alliances, but opined that it could not be done without some degree of regulation.

• ERISA preemption of state regulation: Ira said he agreed with the companies that too much state-by-state variation in the requirements imposed on health plans was not desirable, but said that the state-by-state single-payer option should be retained and that, in general, the role of the states was an issue on which "we'll just have to disagree".

• claims for benefits and related legal remedies: Ira expressed general agreement with the companies' concerns in this area. He added that some of the provisions of the Health Security Act relating to these matters may have been "inadvertent" and that the provisions of the bill "probably were too specific".

• premium caps: Ira expressed disagreement and puzzlement at the companies' criticism of the premium caps as interfering with the competitive market and fostering inefficiencies.

Although Treasury staff were asked to attend and to participate in this meeting, Treasury was informed of the meeting by accident. Papers prepared by the ad hoc corporate group were only made available to Treasury three weeks after receipt by the White House, and then not through official channels. It would be helpful if some procedure were implemented to ensure Treasury access to business reaction to the proposal and involvement in all relevant meetings of this nature.

TREASURY CLEARANCE SHEET

NO. 94-132-800
Date April 13, 1994

MEMORANDUM FOR: ☒ SECRETARY ☐ DEPUTY SECRETARY ☐ EXECUTIVE SECRETARY
☐ ACTION ☐ BRIEFING ☒ INFORMATION ☐ LEGISLATION
☐ PRESS RELEASE ☐ PUBLICATION ☐ REGULATION ☐ SPEECH
☐ TESTIMONY ☐ OTHER _____

FROM: J. Mark Iwry
THROUGH: Les Samuels
SUBJECT: Health Care Reform

REVIEW OFFICES (Check when office clears)

- ☐ Under Secretary for Finance
  - ☐ Domestic Finance
  - ☐ Economic Policy
  - ☐ Fiscal
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- ☐ Under Secretary for International Affairs
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  - ☐ Customs
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- ☐ General Counsel
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NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
J. Mark Iwry	JMI	4/13/94	Tax Policy, BTC	622-1357
REVIEWERS				
Randy Hardock	RHM	4/12/94	DO/XLB	622-0170
Marina Weiss	[illegible]	4/9/94	DO/EH	622-0090

SPECIAL INSTRUCTIONS

☐ Review Officer Date

☐ Executive Secretary Date

DO F 80-02.1 (04/89)

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

133342

April 15, 1994

MEMORANDUM SECRETARY BENTSEN

FROM: Staff working on health reform. Memo regarding outsourcing and subsidies by Eric Toder; Pay-go rules changes by Alan Cohen and Marina Weiss; cover memo and update on miscellaneous issues by Marina Weiss.

SUBJECT: Health Reform

ACTION FORCING EVENT: Status report on several health reform issues of interest to Treasury.

BACKGROUND/ANALYSIS: Attached are 4 memoranda intended to provide you with backround information on a number of health reform issues. The items are as follows:

1. A description of work underway in Tax Policy on modifications to the subsidy provisions of the Health Security Act as submitted to Congress. In addition to the review of alternative ways to structure the subsidies, the memo outlines the state-of-play with regard to the difficult issue of outsourcing and its impact on the estimates of the cost of the subsidies.

2. Staff is deeply concerned about the erosion of funding for the plan. Using material developed by the Office of Tax Analysis plus information from CBO and the Ways and Means Subcommittee staff, we have developed a "scorecard" of what we believe to be a rough approximation of the current deficit in financing. That deficit is attributable to several factors, the most significant of which are listed below.

   a. CBO's re-estimate of the Health Security Act concludes that the Administration's bill would add $74b to the deficit over the years 1994-2000.

   b. It is widely assumed by the committees of jurisdiction that the level of savings from Medicare and Medicaid proposed by the Administration exceeds what Members of Congress are willing to support. Thusfar, only the Ways and Means Health Subcommittee has taken action on cuts in Medicare, reducing the level of available "savings" by $8b in the year 2000. No estimate has been made of the 5 year effect of this less aggressive cut in the rate of growth in Medicare spending.

   c. The "premium cap" cost containment provisions of the Health Security Act were scored by CBO as 100% effective.

Other proposals for savings, however, may not be viewed by the estimators as foolproof. For example, the Ways and Means Subcommittee "global budgets/maximum payment rate" limits are presumed to be only 50% effective. Of course, there are virtually no savings associated with the managed care provisions of the Cooper bill.

d. Finally, there is reason to believe that some of the revenue provisions proposed by the Administration may be modified, phased-in more slowly or dropped altogether.

3. As you are aware, the Budget Resolution now under consideration in Congress would modify the year by year portion of the pay-go rules for mandatory spending and revenues. This is good news for health reform and Alan Cohen has provided for your review a status report on the Congressional negotiations over this initiative as well as an explanation of how the change could impact the health reform bill.

4. Finally, we have included an update on recent developments in health reform, with particular emphasis on the Senate Democrats' weekend retreat, the NFIB job-loss study, and the new Cooper bill estimates.

DEPARTMENT OF THE TREASURY
WASHINGTON

April 15, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: ERIC TODER
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: **Effects of Outsourcing on Employer Subsidies Under HSA**

SUMMARY -- Under the Health Security Act (HSA), a firm's required contributions for the comprehensive benefit package would be capped at 7.9 percent of its payroll. This approach ensures that no firm in the regional alliance would pay more than 7.9 percent of its payroll for the costs of the comprehensive benefit package. Employer subsidies will generally be provided only to lower-wage firms.

At the Presidential meetings last summer, Treasury supported an individual wage cap over a firm payroll cap. During the past month, other Administration officials and Hill staff have expressed interest in replacing the firm payroll cap with an individual wage cap. In large part, this renewed interest in individual wage subsidies is based on CBO's analysis that the firm payroll cap may raise employer subsidy costs by as much as 23 percent, in the long-run, because of the effects of outsourcing.

On April 12, Marina Weiss and I, along with representatives from OMB and HHS, met with John Hilley of Senator Mitchell's staff to discuss options which will be presented at the Senate Democratic retreat. These options included replacing the 7.9 percent firm payroll cap with a 12 percent individual wage cap. Senator Kennedy's staff have also raised questions with Treasury staff about the effects of an individual wage cap.

In addition, the interagency health reform policy group (under the chair of Alice Rivlin) requested a presentation by Gillian Hunter, of the Office of Tax Analysis, comparing the effects of a firm payroll cap and an individual wage cap. Copies of the preliminary analysis were also provided to OMB staff with the approval of Deputy Secretary Altman. The analysis used a methodology similar to CBO for predicting the impact of outsourcing on the costs of employer subsidies in the long-run. The principal findings are:

- Using the CBO estimates of the costs of the comprehensive benefit package, a 7.9 percent firm cap could be replaced with a 10 percent individual wage cap for roughly the same budget costs.

- An 8 percent individual wage cap could be combined with a reduction in the benefit package. For example, a scaled-back benefit package could be designed

- to cost as much as the Administration's estimates of the current benefit package. Using the lower premiums, an 8 percent individual wage cap would cost as much as the 7.9 percent firm payroll cap with CBO's higher premium estimates.

- With the 7.9 percent firm cap, the costs of the subsidies are roughly the same regardless of the firm size cut-off for joining regional alliances. The effects of outsourcing largely offsets the effect of reducing the size thresholds for firms eligible to join the regional alliance and obtain subsidies

BACKGROUND -- At the Presidential meetings last summer, Treasury argued in favor of an individual wage cap instead of a firm payroll cap. An individual wage cap can better mitigate the effects of an employer mandate on low-wage workers. In response to an employer mandate to provide health insurance, firms will likely reduce the wages of their workers who are currently uncovered or receiving less costly benefit packages. For low-wage workers, these reductions may be significant as a share of their total income. An individual wage cap would ensure that firms pass on only a portion of the costs of the employer mandate to their low-wage workers. In contrast, a firm payroll cap does not provide any subsidy for firms with high average wages. Consequently, a firm cap of 7.9 percent could still cause some low-wage workers to suffer a wage reduction of more than 7.9 percent.

A firm cap may also cause high-wage firms to reorganize in order to obtain the benefits of the HSA's employer subsidies. For example, a firm could spin off their low-wage workers into a separate entity. Alternatively, they may contract (or "outsource") with a low-wage firm to do the work their less skilled workers once did, or they may purchase intermediate products rather than producing the products in-house with low-wage workers. Although low-wage workers will remain employed, they may find it more difficult to advance in a firm which specializes in low-skilled labor. Moreover, the segregation of low-wage workers in low-wage firms could cause them to lose pension coverage and other benefits typically provided by large firms with a diversified workforce.

An individual wage cap will generally be more expensive than a firm payroll cap, unless the individual wage cap is higher than the firm payroll cap. But some firms would pay more than 7.9 percent of their payroll for health insurance with, for example, a 9.5 percent individual wage cap. The prospect that some low-wage firms would pay more than 7.9 percent of payroll for health insurance under an individual wage cap was a critical factor in the President's decision to support a firm payroll cap.

Three events are causing a reconsideration of the individual wage cap. First, Congressional staff have expressed interest in an individual wage cap. Second, the Chamber of Commerce, reportedly the original promoter of the 7.9 percent firm payroll cap, did not support the Clinton plan. Third, new estimates of the effects of alternative subsidy approaches on outsourcing lower the budgetary savings from using a firm payroll cap instead of an individual wage cap and highlight the potential economic and social disruptions from policies that encourage outsourcing.

Financing Shortfalls to Date

($ Billions)

	2000	1994 – 2000
CBO's Reestimate of HSA's Effect on Deficit 1/	10	74
50% Effectiveness Rating on Premium Caps 2/	14	31
Medicare Changes in Stark Bill	8	n.a.
Tobacco Tax 3/	3	37
Total	35	142+

April 15, 1994

Notes:

1/ According to Administration's estimates, HSA would have reduced the deficit by $58 billion between FY 1994 and 2000. In contrast, CBO estimates that HSA will increase deficit by $74 billion over the same period.

2/ Assumes that Congress passes HSA with its premium caps but eliminates some of the enforcement tools contained in the Administration's bill. Further assumes that CBO would give the enforcement mechanisms a 50 percent effectiveness rating.

3/ Assumes that Congress enacts a 50 cent increase in the tobacco tax which is phased – in over five years.

BUDGET ACT PAY-GO RULES AND HEALTH REFORM

Under the pay-go rules currently under discussion in the Congress, legislation must be deficit neutral in the first year, over five years, and over the second five years.

There is some possibility that the requirement for deficit neutrality for the second five years will be further liberalized. Under such liberalization, the legislation would need to avoid causing a significant increase in the deficit, rather than being precisely deficit neutral. However, such liberalization may not occur in the final language for the point of order in this year's conference report on the budget resolution.

In addition, it is worth noting that unlike the situation in previous years, it will no longer be a requirement to have the legislation be deficit neutral year by year.

These modifications in the year-by-year scoring of pay-go provisions are critical to enactment of health reform, as it is highly unlikely that the final bill will be perfectly deficit neutral in each year of the phase-in. The current thinking is that the tobacco tax increase may make it possible to meet the first year deficit neutrality requirement [in fact, CBO and Administration estimates suggest that the Health Security Act would actually reduce the deficit in 1995 by about $10 to $11b], but that the plan will not be deficit neutral in each of the subsequent years.

UPDATE ON HEALTH REFORM

Retreat: Majority Leader Mitchell is scheduled to make a health reform presentation at the Senate Democratic retreat in Williamsburg this weekend. The presentation was characterized by Pat Griffin's office as covering the "levers for modifying the Health Security Act." Griffin's office also indicates that an effort will be made to have Chairmen Kennedy and Moynihan sit at the table with Mitchell while he makes his remarks. Both the President and First Lady are expected to attend a portion of the retreat.

Specifically, Mitchell is said to be prepared to discuss alternative subsidy schemes, with particular emphasis on approaches that target subsidies to firms on behalf of actual wages paid to individuals as opposed to the structure under the HSA which targets subsidies to firms based on average wages paid. This is the same issue that was debated before the President last year, and there is a growing concern in the Congress over the approach incorporated in the Administration's bill.

Mitchell will also present some deficit reduction options to address Members' desire that the Senate bill include budget savings -- at least in the out-years of the 10 year estimating period. OMB indicates that the savings options under consideration include reduced subsidies; a downsized benefit package; more revenues from the 1% corporate assessment -- by reducing the 5,000 threshold to 1,000. Also under discussion among some Members is an increase in the tobacco tax, though it is not clear that Mitchell will introduce a tobacco provision as part of his list of options.

You might be interested to know that Mitchell had wanted to present an option to reduce the employer contribution under the mandate to 50% [instead of the 80% proposed in the President's bill], but Ira Magaziner told Mitchell's staff that the Administration would prefer he not present that option -- however, if it came up as part of the discussion then the Administration would not oppose Mitchell's offering some comments on it. Treasury has not been provided paper describing these proposals, though it is clear that White House and OMB staff were involved in developing the options.

NFIB Study: We are scheduled to receive a copy of the full NFIB study this afternoon, and will provide you with a more complete review early next week. According to NFIB staff, the study was the second in a series done for NFIB by CONSAD, a private estimating firm that uses county level data to estimate the number of individuals/firms eligible for subsidies and the cost of the subsidies. NFIB staff also report that independent reviewers of the CONSAD assumptions [including former CBO staff] concluded that the estimates of subsidies and the job loss figures are "reasonable."

Cooper Bill Estimates: CBO has not released its final estimate of the Cooper bill, but Cooper's office has been told that the target for public release is next Wednesday. Copper staff say the Congressman is bracing for what he expects will be a "terrible" week, though after last year's CBO estimate showed a $70b over 5 year deficit increase with enactment of the Cooper bill, he added $40b in Medicare cuts, altered the Medicaid baseline, and jawboned CBO to alter the estimating assumptions about the scope of the benefits package.

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

133334

April 21, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Marina L. Weiss

SUBJECT: Health Reform

ACTION FORCING EVENT: DSCC Speech/Q and A's

BACKGROUND/ANALYSIS:

I have just learned that you may take some Q and A's after your noon speech to the DSCC on health reform. The list of attendees suggests that most will be from the Washington lobbying community, therefore I would expect questions on the state-of-play for congressional action. The following questions strike me as most timely:

1. Question: Mr. Secretary, Senator Mitchell last weekend floated a possible compromise on the employer mandate that would lessen the employer's contribution from the 80% of premium proposed by the Administration to 50%. Mitchell's proposal could be adapted for the smallest employers only or applied to the entire employer population. What is the Administration's reaction to the Leader's plan...weren't you involved in preparing the plan for his presentation to the Democratic retreat?

Draft Response: The Administration proposed an 80/20 split on the premium because we wanted to be sure that individuals and families were not overly burdened by the cost of their insurance premium. However, you are correct, Senator Mitchell and others have been looking at variations on the 80-20 split, with simultaneous adjustments in the individual subsidies. Of course, the Administration has taken the position that we will not comment on isolated issues under discussion on the Hill -- we'll need to look at the entire bill proposed by the Senate. As your point about the Administration helping Senator Mitchell prepare information for the weekend retreat, that is correct. We are trying hard to be responsive to the Leadership -- including Committee Chairs -- when they ask for technical help. Our assistance should not be viewed as an endorsement of any particular proposal.

[Mr. Secretary, Stan Greenberg has done some polling that shows the 50-50 plan to be very unpopular with the American public. The results of that poll were known to Mitchell when he made the weekend presentation -- but he went ahead anyway. The White House is adamant that the Administration not reveal it has done polling on this issue.]

2. Question: Mr. Secretary, Chairman Dingell has floated a plan to exempt altogether from the mandate employers of 10 or fewer; with employers of 11-20 given a choice as to whether they offer insurance or pay a 1% payroll tax [pay or play]; and employers of 21-25 or 29 given a choice with a 2% payroll tax. What is your view of this proposal? Won't Treasury and CBO be concerned about "outsourcing," that is, restructuring of businesses to take advantage of the opt out for firms of fewer than 10?

Draft Response: Again, we are not taking a position on any particular proposal. Chairman Dingell, like the President, is trying to soften the impact on small business of guaranateed private insurance.

Treasury is concerned about incentives for outsourcing, and we intend to work with the Congress to do the best we can to eliminate or keep to a minimum such incentives. I am advised by staff that the premiums as calculated by CBO take into account expected outsourcing under the Administration's plan -- suggesting we may well be able to reduce the cost of the compromise plan if we address that problem.

[A way to address it, of course, is to target subsidies to individuals -- a technique under consideration by Mitchell, Rostenkowski and others.]

3. Question: Mr Secretary, Pat Williams [D-Montana], Chairman of one of the Education and Labor Subcommittees in the House was scheduled to begin to mark up today. He is described as considering a strategy under which he reports out two bills -- a single payer proposal similar to H.R. 1200, the Mc Dermott plan, and a bill that resembles the White House proposal but is more generous with women's health coverage [mammograms] and preventive services. Do you know how he plans to pay for these add-ons? What do you think of his 2 bill strategy?

Draft Response: I haven't seen a copy of his proposed modifications to the Administration plan -- of course we would all like to see the most comprehensive package of benefits possible, but paying for coverage is essential. We made some tough choices when we put together the President's plan, and I trust Congressman Williams will pay for his proposal as well. On the issue of 2 bills, having been a Chairman, I can understand his need to develop a strategy tailored to his Committee -- the Education and Labor Committee has many members who favor single-payer, and I'm sure that is a factor.

4. Question: Mr. Secretary, Senator Conrad and others who are flirting with the Jackson Hole managed competition concept are floating an idea that would have the legislation include a "trigger" so that, initially, there would be no employer mandate or cost control on private spending. If certain levels of coverage were not reached by some date [percent of uninsured is reduced], then a mandate would "trigger" on. And in the case of

cost containment, some mechanism would trigger if costs got out of hand. What is your reaction to that approach, especially since it seems to have some currency with Senator Moynihan.

Draft Response: Jackson Hole has appeal for a number of Members, and again, I am sure that different variations of phase-ins will be given the closest attention in the mark-up process.

But, without some form of compulsion -- an individual mandate, an employer mandate or a large public program -- it is difficult to see how one can reach universal coverage, that could be a problem for millions who would be left out in the cold.

Also, without some form of cost containment, it is not clear to me that CBO and the Actuaries will give managed competition the savings we need to make this system work.

I'd say we're interested, but we have questions.

5. Question: Mr. Secretary, who on the Hill will handle the taxes in this bill? We understand that the Energy and Commerce Committee and perhaps the Labor Committees as well intend to write premium and corporate assessment provisions -- even under the Administration's rhetoric the premium has a 1.5% set aside that is considered a tax; and of course the corporate assessment is undeniably a tax. What is your view on the rationale for taxes being handled by the Energy and Commerce and Labor committees?

Draft Response: It is my understanding that the Ways and Means and Energy and Commerce Committees were sent the entire Administration bill, while the Education and Labor committee was given specific portions of the bill. They'll have to sort out their respective plans when they get to the Rules committee -- but if I know Chairman Rostenkowski, he will see to it that Ways and Means handles the tax features of this bill...and maybe even a little more.

6. Question: Will Chairman Dingell begin mark-up next Tuesday as advertised?

Draft Response: I don't think Chairman Dingell has set a specific date, he is working with his Members to develop a majority, that takes time and effort. If I know John Dingell, he'll go to mark-up when he's ready, and not a moment sooner.

135312

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

June 19, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Linda Robertson
Marina Weiss

RE: Health Care Reform

ACTION FORCING EVENT: TONIGHT'S MEETING WITH THE PRESIDENT, FIRST LADY, AND OTHER ADMINISTRATION PRINCIPALS

BACKGROUND/ANALYSIS: We understand that Harold Ickes was principally responsible for setting up this evening's health care reform strategy meeting with the President, First Lady, and other Administration principals. The purpose of the meeting is to address "next steps" with respect to health care. This memo attempts to provide some background for the meeting and the latest developments with respect to health care. Marina Weiss will also call you about 5:30 p.m. to discuss this in person.

MEETING AGENDA: We understand there are three primary questions that the group will address: a) what is the "bottom line" on universal coverage (i.e., can we accept a delayed trigger approach and, if so, can it be a "soft trigger"); b) what is the role of the President and his legislative team (as you know there is not a unified position with respect to the question of the President's role); and c) what happens if the Senate Finance Committee is unable to report legislation.

DIVISIONS WITHIN ADMINISTRATION: As you are well aware, there is a very lively debate within the Administration as to our current health care strategy. In one camp, Mac McLarty and David Gergen argue that it time to cut a deal with Republicans, to admit that something less than full universal coverage is acceptable. A second camp, largely dominated by the President's media advisers and consultants, argues that we should draw a bright line, that a hard trigger is the very least that is acceptable. It appears the President, the First Lady, and Ira fall into the second camp. We understand that both camps perceive your role in this meeting as being the one person who is both a senior adviser with in depth knowledge of the Senate and an acurate understanding of Senator Moynihan. Given your experience with Chairman Moynihan and that "you alone know what's on his mind", both camps are likely to give your suggestions considerable weight.

CURRENT DEVELOPMENTS:

a) Ways and Means. On Friday, the Ways and Means Committee adopted three amendments to the Chairman's health care mark. By unanimous consent, the Committee adopted an amendment by Rep.

Jacobs exempting the Amish and Mennonite congregations from coverage. Also adopted by UC was an amendment by Reps. Jefferson and Kopetski to assure that educational employees who work less than 35 hours per week in the classroom nonetheless require an 80 percent employer contribution. The most significant amendment, however, was a substitute by Rep. Neal which had the effect of lowering from 250 in the Chair's mark to 100 the size of firm allowed to self-insure. As you may recall, in the Chairman's mark firms with 250 or more employees were allowed to self-insure; under this amendment the limit was lowered to 100. It was adopted 36-2 after Republicans unsuccessfully tried to lower the limited even further.

b) Moynihan on Meet the Press. This morning Chairman Moynihan appeared on Meet the Press. When asked if the President would be sent a bill which provides universal coverage, Chairman Moynihan said that he hoped they would produce a bill which substantially achieves this objective. He said that he and Senator Packwood met with the President Tuesday, and then re-read the statement given after that meeting, i.e., that there is not now a majority in the Senate Finance Committee supporting any bill. He said that he would work on a bipartisan basis to produce a bill which would eventually cover most Americans.

He said the White House fails to recognize how positive some of the alternatives are: for example, he cited, the Breaux/Durenberger bill would subsidize over 100 million individuals, while Chafee would subsidize about the same amount. He said his mark would subsidize about 110 million individuals. The program then replayed the veto message segment of the State of the Union Address. The Chairman said that an approach with triggers would go a long way toward the goal of "guaranteeing every American" health insurance. He said that with insurance reforms and subsidies very significant progress would be made. He noted that when social security was passed in 1935 only 60 percent were covered. Not until 1939 were spouses and survivors added to the social security program. He observed that there was no chance we would get immediate universal coverage.

In response to a question from David Broder, Chairman Moynihan noted that a trigger approach with fast track authority at a time certain would be an acceptable process. When pressed, he noted that a time certain would be 2002 or 2004. The Chairman noted that the President, to date, is not willing to accept something less than universal coverage. But the Chairman was hopeful by the President's willingness to explore a bipartisan track in the Senate. Broder then asked about the fact that Chairman Moynihan's mark drops the seniors' drug benefit. Among other items, the Chairman noted the provisions for academic health centers would benefit seniors.

Lisa Meyers asked if a bill which provides only 91 percent coverage is a failure. Moynihan said no. He then noted that the Breaux/Durenberger approach went a long way toward universal

DEPARTMENT OF THE TREASURY

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PAGE 1 OF 18 PAGE(S)

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June 17, 1994

Mr. Secretary:

Your Sunday HEALTH CARE MEETING at the White House HAS BEEN CHANGED to 7:30 PM, rather than 6:00 pm as originally scheduled.

The meeting will be held in the Map Room in the Residence, and is set to last an hour and a half.

thank you,

robin

DEPARTMENT OF THE TREASURY
WASHINGTON

136271

June 28, 1994

MEMORANDUM FOR DEPUTY SECRETARY ALTMAN
MARINA WEISS

FROM: George Muñoz
Assistant Secretary (Management)/
Chief Financial Officer

SUBJECT: Health Care Estimates

Two weeks ago, the White House asked that we review the cost implications to Treasury of the health care reform proposal developed by the House Ways and Means Committee. The Congressional Budget Office (CBO) had scored total start up and administrative costs for the bill at $90.5 billion over ten years, but admitted that their estimating techniques were fairly gross. The White House believes the CBO estimates were excessive.

We have worked closely with officials from Health and Human Services (HHS) and the impacted Treasury bureaus over the past two weeks to develop a more refined estimate of the costs. Last Friday we notified you that our estimate was around $3.7 billion but could increase as IRS estimate for years before FY 1998 had not been developed. We have now revised the IRS estimates based on the IRS Commissioner's review of the costing and added some funding for information systems using the assumption that IRS Tax Systems Modernization may not be funded. In addition we added additional enforcement personnel to deal with the possibility that employers will have more incentive to misclassify employees as independent contractors in order to lower their health care costs. Attached are our current estimates for Treasury, which shows a ten year cost at slightly over $5.1 billion. HHS estimated their costs to be $43.9 billion over the same period for a combined total of $49 billion - well below the CBO estimate.

OMB has asked that we share our numbers and backup data with them for review. With your concurrence, we will do so.

Agree: _____ Disagree: _____ Let's Discuss: _____

Attachment

HOUSE WAYS AND MEANS COMMITTEE HEALTH CARE PLAN

PRELIMINARY COSTING, JUNE 1994

	FY 1995		FY 1996		FY 1997		FY 1998		FY 1999		FY 2000		FY 2001		FY 2002		FY 2003		FY 2004		Total	
	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)
Bureau of Alcohol, Tobacco and Firearms	-	-	20	2,800	20	2,800	20	2,800	20	2,800	20	2,800	5	325	5	325	5	325	5	325	120	15,300
Departmental Offices	-	-	3	200	3	200	3	200	3	200	3	200	3	200	3	200	3	200	3	200	27	1,800
Financial Management Service	-	-	5	300	5	300	5	300	5	300	5	300	5	300	5	300	5	300	5	300	45	2,700
Internal Revenue Service	109	148,630	201	213,839	1,040	271,667	5,383	301,541	12,586	714,388	12,104	641,488	12,191	660,227	12,347	684,117	12,510	708,289	12,689	733,729	81,160	5,077,915
Treasury Total	109	148,630	229	217,139	1,068	274,967	5,411	304,841	12,614	717,688	12,132	644,788	12,204	661,052	12,360	684,942	12,523	709,114	12,702	734,554	81,352	5,097,715

Note: As of 3:00 PM, June 28, 1994.

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HOUSE WAYS AND MEANS COMMITTEE HEALTH CARE PLAN

PRELIMINARY COSTING, JUNE 1994

Internal Revenue Service

	FY 1995		FY 1996		FY 1997		FY 1998		FY 1999		FY 2000		FY 2001		FY 2002		FY 2003		FY 2004		Total	
	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)	FTE	Amount ($ 000s)
Returns Processing *	-	-	-	-	-	-	2,635	90,867	2,826	99,971	2,134	79,475	2,264	84,638	2,406	91,122	2,556	97,978	2,720	105,425	17,540	649,476
Tax Forms, Publications and Communications *	-	-	-	-	29	1,305	57	7,805	57	8,047	57	8,296	57	8,554	57	8,819	57	9,092	57	9,374	428	61,292
Taxpayer Service *	-	-	-	-	-	-	587	32,240	587	33,239	587	34,270	587	35,332	587	36,428	587	37,557	587	38,721	4,109	247,787
Chief Counsel	-	-	59	4,425	88	6,600	117	8,775	117	9,047	117	9,327	117	9,617	117	9,915	117	10,222	117	10,539	966	78,467
Document Matching *	-	-	-	-	-	-	50	1,500	500	17,310	750	24,980	750	25,754	750	26,552	750	27,375	750	28,224	4,300	151,695
Examination *	-	-	-	-	400	24,000	600	36,000	3,168	195,972	3,168	202,048	3,168	208,311	3,168	214,769	3,168	221,427	3,168	228,291	20,008	1,330,817
Collection *	-	-	-	-	-	-	300	18,000	4,036	199,885	4,036	206,082	4,036	212,470	4,036	219,057	4,036	225,847	4,036	232,849	24,516	1,314,190
Criminal Investigation	-	-	-	-	-	-	45	3,375	45	3,480	45	3,587	45	3,699	45	3,813	45	3,932	45	4,053	315	25,939
EP/EO	-	-	25	1,500	50	3,000	111	6,660	111	6,866	111	7,079	111	7,299	111	7,525	111	7,758	111	7,999	852	55,687
Information Systems *	100	147,000	100	206,000	387	223,220	437	26,220	100	6,186	100	6,378	50	3,288	50	3,390	50	3,495	50	3,603	1,424	628,779
Support (RM, HR, IS)	9	540	17	994	86	5,152	444	26,668	1,039	62,354	999	59,966	1,007	60,397	1,019	61,168	1,033	61,976	1,048	62,861	6,701	402,075
Unallocated Indirect Support	0	1,090	0	920	0	8,390	0	43,430	0	72,030	0	0	0	870	0	1,560	0	1,630	0	1,790	0	131,710
IRS Total	109	148,630	201	213,839	1,040	271,667	5,383	301,541	12,586	714,388	12,104	641,488	12,191	660,227	12,347	684,117	12,510	708,289	12,689	733,729	81,160	5,077,914

Note: IRS Costing as of 3:00 PM, June 28, 1994.
* = Data supplied by IRS otherwise costed with percentages from 1987 Tax Reform Costing.

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MANAGEMENT CLEARANCE SHEET

FOR: Roger Altman/Marina Weiss
FROM: George Muñoz
THROUGH:
SUBJECT: Health Care Estimates

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
Tracy Pierrot	AP	6-28-94	Office of Budget	622-0730
REVIEWERS				
John Murphy	JM	6/28/94	Office of Budget	622-0730
Edwin Verburg	EV	6/28/94	Director, FSD/DCFO	622-0750
W. Scott Gould			DAS, (Deptl Finance & Mgt)	622-2400

COMMENTS:

MANAGEMENT CLEARANCE SHEET

FOR: Roger Altman/Marina Weiss
FROM: George Muñoz
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COMMENTS: