



DEPARTMENT OF THE TREASURY
WASHINGTON

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ASSISTANT SECRETARY

July 18, 1994

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Alicia Munnell

SUBJECT: Health Care Briefing for Economic Team in
Preparation for Wednesday, July 20, 1994
Press Briefing

Date and Time July 19, 1994, at 11:30 a.m.

Location Roosevelt Room, White House

PARTICIPANTS:

Treasury Secretary Bentsen
Deputy Secretary Altman
Alicia Munnell
Marina Weiss

Others Commerce Secretary Brown
Labor Secretary Reich
Robert Rubin
Laura Tyson
Alice Rivlin
Erskine Bowles
Gene Sperling
Others TBD

BRIEFING: TAB A - Overview
TAB B - Profile of the Uninsured - Myth vs.
Reality
TAB C - Draft Comments for Wednesday Press
Briefing
TAB D - Sample State/District Summary Sheets
TAB E - Questions and Answers

Overview

One hour press events are being planned for Wednesday and Thursday for Secretary Bentsen, Bob Rubin, Laura Tyson and Alice Rivlin to discuss about health care issues. A pre-briefing is scheduled for Tuesday at 11:30 am in the Roosevelt Room.

The format of the press events will be as follows;

- o Secretary Bentsen will welcome the press and introduce the speakers
- o Each speaker will talk for approximately 7 minutes.
 - Laura Tyson -- insurance reform.
 - Alice Rivlin -- cost containment.
 - Secretary Bentsen -- characteristics of the uninsured.
 - Robert Rubin -- workforce issues.
- o A half - hour question and answer session will follow the presentations.

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PROFILE OF THE UNINSURED: MYTH VS. REALITY

As health reform reaches a critical stage in Congress, fashioning the right solution requires having a clear understanding of the characteristics of the uninsured. Contrary to popular myth, the uninsured are not all poor, elderly, or otherwise vulnerable. In fact, over half of the uninsured live in families where at least one spouse is a *full-year, full-time* worker. Roughly 84 percent come from families whose head works at least part of the year. In addition, while even short exposures without insurance put people at significant financial and health risk, being uninsured is predominately a long-term problem. Finally, those who do purchase insurance, and taxpayers as a group, bear much of the burden of the uninsured -- through both "cost shifting" to private insurance premiums and increased spending on public programs.

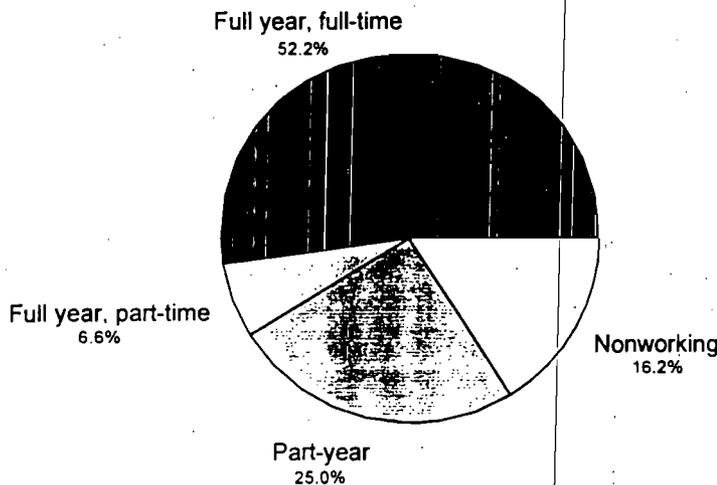
Myth #1: *The uninsured are unemployed.*

Reality: The uninsured are working Americans.

The vast majority of the uninsured -- 83.8 percent -- belong to working families. Federal programs already cover most of the non-working population. Medicare provides near-universal coverage for those over 65, and Medicaid covers 50 percent of those in poverty and 25 percent of those just above the poverty line.

As a result, large numbers of the uninsured are clustered in working families with moderate incomes, who do not qualify for Medicaid. Insurers in general charge higher rates to the self-employed and small businesses, which makes it difficult for them to obtain affordable coverage.

Job Status of the Uninsured



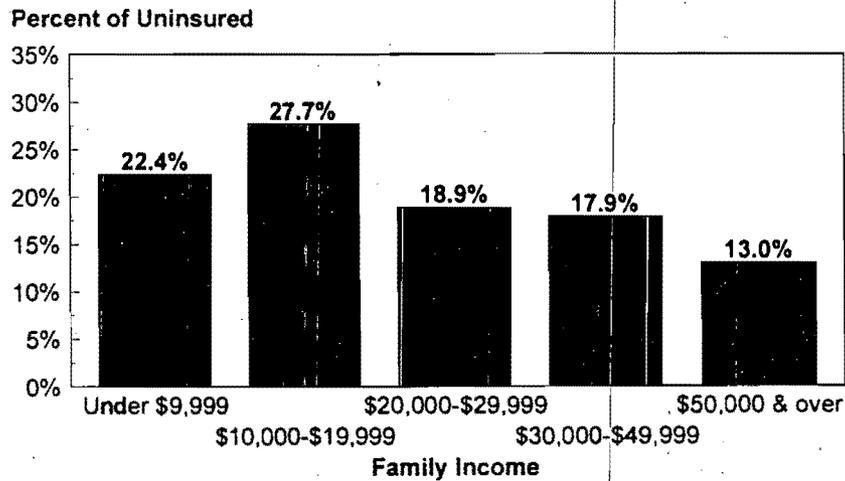
Myth #2: *The uninsured are poor.*

Reality: The bulk of the uninsured have moderate incomes; many are middle-class.

The vast majority of the uninsured -- 72 percent -- have incomes above the federal poverty threshold. While the average uninsured American family is a lower-income family, it is far from being in poverty.

The bulk of the uninsured are in hard-working families for whom health insurance is unaffordable. Because small businesses and the self-employed have difficulty obtaining affordable insurance, almost one in three of the uninsured is a member of a family making more than \$30,000 a year.

Family Income of the Uninsured

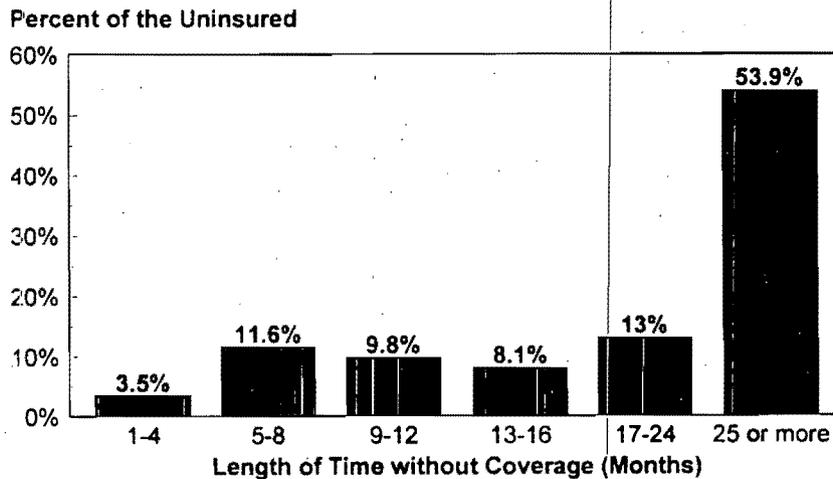


Myth #3: *For most of the uninsured, being without health insurance is a short-term, rather than a long-term, problem.*

Reality: 54 percent of those uninsured today will be uninsured for more than two years. 75 percent will be uninsured for more than a year.

Some have suggested that being uninsured is a short-term problem, not a long-term condition. Even short periods of time without insurance do put people at significant financial and health risk. But being without health insurance is not a short-term problem. A researcher from the University of Missouri reports that nearly 75 percent of uninsured Americans are "chronically" uninsured, and will remain uninsured for longer than one year. Less than one in twenty out of those uninsured today will obtain health coverage before they have been uninsured for five months.

Distribution of Uninsured, by Time without Coverage

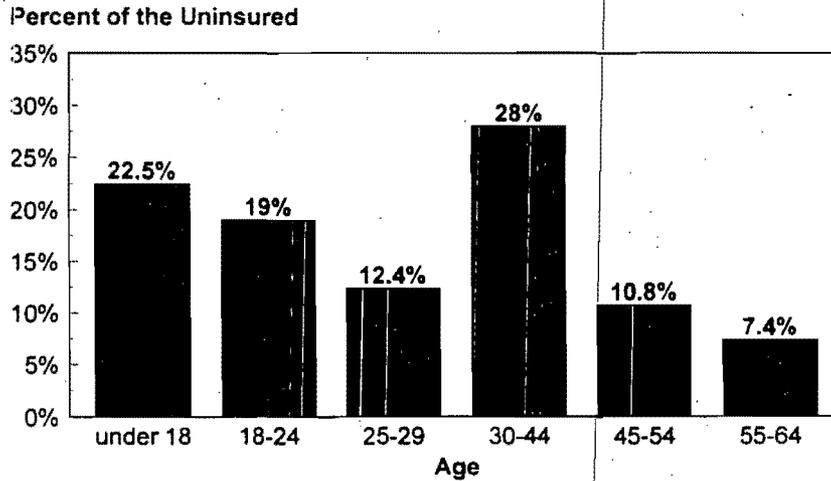


Myth #4: *The uninsured are mainly young and healthy; they choose not to buy insurance.*

Reality: Almost one quarter of the uninsured are children. Nearly half of the uninsured are over 30. Less than 30 percent of the uninsured are between 18 and 30 years of age.

While a disproportionate share of the uninsured are young, this is the result of low incomes and poor access to affordable insurance.

Age of the Uninsured



Myth #5: *I have health insurance--the uninsured do not affect me.*

Reality:

- Americans who lose their jobs may well become uninsured.
- Private insurance costs are high because of the uninsured.
- Taxes are higher because of high Federal health costs.

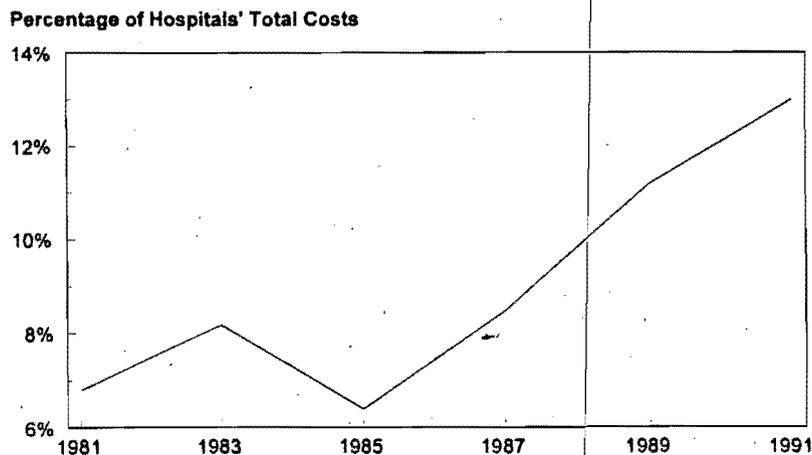
Nine out of ten Americans with private health insurance receive insurance through employers. Those who lose their jobs for an extended period of time may well lose their health insurance.

In addition, the uninsured place a large direct burden on those who do have insurance -- through higher taxes and through higher private insurance premiums. The effects of a large uninsured population go well beyond the individuals without coverage. The uninsured do receive health care -- often in emergency rooms, at very high costs. Hospitals and doctors raise the fees they charge those who have private insurance in order to cover the bill for the inefficient, high-cost services received by the uninsured.

The lack of private health insurance for some raises taxes for all. Some say the obvious solution is to cut, or "cap," federal health care spending. But cutting Medicare and Medicaid puts pressure on doctors and hospitals to raise the fees they charge those with private insurance. As the government pays less, everyone else pays more.

According to the Congressional Budget Office, unreimbursed costs for hospitals alone totaled over \$28 billion in 1991. As a result, private payers are charged substantially more by hospitals than the actual cost of their services.

Hospitals' Unreimbursed Costs, 1981-1991



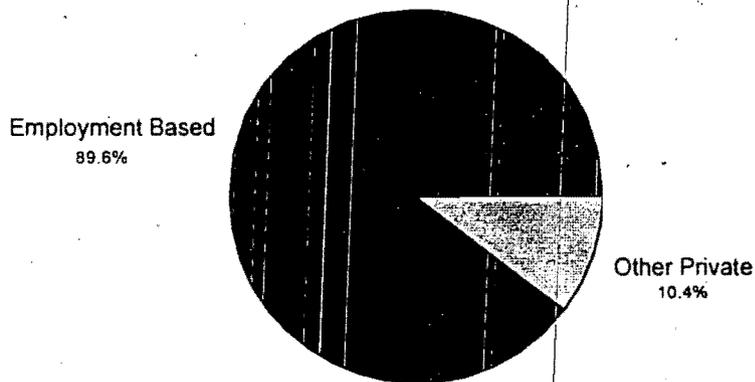
Myth #6: *An employer mandate is not necessary to fix the health care system, or to decrease the number of uninsured.*

Reality: The United States has an employment-based health care system. The major cause of increasing numbers of uninsured is employers dropping coverage.

According to the March 1993 Current Population Survey, nine out of ten of the nonelderly who purchase private insurance obtain it through the workplace.

Recent increases in the number of uninsured can be attributed to a decline in the number of employers who offer coverage. The share of the nonelderly population with employment-based coverage declined from 66.8 percent in 1988 to 62.5 percent in 1992. This fall was partly offset by a rise in the number of nonelderly Americans with publicly-financed health insurance -- from 12.4 percent to 15.1 percent. Even with this boost in publicly-financed coverage, the share of the non-elderly who are uninsured grew from 15.9 percent of the population in 1988 to 17.4 percent in 1992.

Source of Private Health Insurance, 1992



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Conclusion

For millions of Americans with health insurance, the fear of losing their health coverage is a constant source of insecurity: over 38 million Americans were uninsured at some point in time in 1992.

Universal coverage is a universal issue. It is not simply about the unemployed, the poor, and or the young and healthy. Hard-working Americans are disadvantaged by today's health care system, and have the most to gain by reform that includes universal coverage. Today, the statistics show that the poor and elderly are covered by government programs, while millions of working Americans and their families are uninsured. Universal coverage is essential to strengthen the link between work and security.

It makes sense to build on the employer-based system. Most people today with private insurance obtain it through their employer -- it is a system that works for the vast majority of Americans. With universal coverage, small business will pay the same rates for the same coverage as do large businesses, and those who purchase insurance will no longer pay for those who do not.

NOTES

Unless otherwise indicated, all numbers come from the March 1993 Census Population Survey. All CPS numbers refer to the non-elderly population (less than 65 years of age).

1. *Whither the Health Care Crises? Misinterpretations of Chronically Uninsured Estimates*, Timothy McBride, University of Missouri-St. Louis, April 1994.

- **WELL, I DON'T THINK WE'LL PRODUCE ANY HEADLINES TODAY. THE HEADLINE WILL BE IN A FEW WEEKS: "CONGRESS PASSES HEALTH CARE REFORM." BUT BETWEEN NOW AND THEN, YOU'LL BE FLOODED WITH COMPLEX -- AND CONTRADICTORY -- INFORMATION. SO, WE WANT A CANDID DISCUSSION.**
- **TODAY'S AGENDA IS THIS: IN THE FIRST HALF HOUR, DR. TYSON WILL DISCUSS INSURANCE REFORM ... DR. RIVLIN,**

COST CONTAINMENT ... I'LL SHARE
INFORMATION DEVELOPED BY TREASURY ON
THE DEMOGRAPHICS OR CHARACTERISTICS
OF THE UNINSURED ... AND BOB RUBIN
WILL REVIEW WORKFORCE ISSUES.

THEN WE'LL OPEN IT UP FOR QUESTIONS
AND COMMENTS.

- LET ME SAY ONE THING BEFORE LAURA
STARTS. MOST OF YOU KNOW WHEN I WAS
IN THE SENATE, ALONG WITH CHAIRMAN
ROSTENKOWSKI, I AUTHORED AN

INCREMENTAL BILL -- TO CREATE
VOLUNTARY ALLIANCES; ADDRESS
INSURANCE ISSUES LIKE CHERRY PICKING
AND PORTABILITY; ADD PREVENTIVE
BENEFITS TO MEDICARE; AND MAKE
PREMIUMS FULLY DEDUCTIBLE FOR THE
SELF-INSURED. MY BILL PASSED THE
SENATE -- TWICE -- BUT IT DIDN'T MAKE
IT INTO LAW. NOT BECAUSE OF
SUBSTANCE, BUT BECAUSE OF POLITICS.

- I WROTE AN INCREMENTAL BILL, BECAUSE I FELT IT WAS THE BEST WE COULD GET THROUGH -- AT THE TIME. PRESIDENT CLINTON FEELS -- AND I CONCUR -- WE CAN DO BETTER NOW. THE TIME IS RIGHT, AND WE HAVE A PRESIDENT WHO IS FULLY COMMITTED. IT'S DIFFERENT ON THE REPUBLICAN SIDE, TOO. WHEN IN YOUR WILDEST DREAMS DID YOU THINK BOB DOLE WOULD PROPOSE A BILL CALLING FOR \$100 BILLION IN SUBSIDIES?

**INTRODUCE LAURA
INTRODUCE ALICE**

- **I WANT TO DISCUSS THE CHARACTERISTICS OF THE UNINSURED. WITH THE HELP OF THREE CHARTS, I'LL GO OVER THREE MYTHS, AND THE REALITIES.**

SLIDE 1

- **THERE'S A MYTH THAT UNINSURED ARE UNEMPLOYED. THE REALITY IS, THEY'RE WORKING AMERICANS. THE VAST MAJORITY**

-- ALMOST 85 PERCENT -- ARE IN WORKING FAMILIES.

- THIS CHART SHOWS THE JOB STATUS OF THE UNINSURED. 52 PERCENT WORK FULL YEAR, FULL-TIME ... 7 PERCENT, FULL YEAR, PART-TIME ... 25 PERCENT PART-YEAR ... WHICH LEAVES ONLY 16 PERCENT NOT WORKING.
- AMERICANS YOU'D EXPECT TO BE UNINSURED -- THE POOR, THE ELDERLY OR THE DISABLED -- ALREADY HAVE COVERAGE

THROUGH MEDICAID, MEDICARE, AND OTHER PUBLIC PROGRAMS, SUCH AS VA. SO, THAT LEAVES MOSTLY MIDDLE-INCOME WORKING FAMILIES AS THE ONES WITHOUT INSURANCE.

- AND THESE UNINSURED ARE NOT POOR. THREE-FOURTHS HAVE MODERATE INCOMES -- ABOVE THE POVERTY THRESHOLD. ONE IN THREE IS A MEMBER OF A FAMILY MAKING MORE THAN \$30,000 A YEAR.

SLIDE 2:

- **THE SECOND MYTH IS THAT THE UNINSURED ARE ALL YOUNG, HEALTHY PEOPLE WHO CHOOSE NOT TO BUY INSURANCE. THE REALITY IS, 44 PERCENT ARE OVER THE AGE OF 30.**
- **YOU CAN SEE FROM THE CHART THAT ONE QUARTER ARE CHILDREN. THAT'S CAUSED BY A COMBINATION OF LOW INCOMES AND HIGH INSURANCE PREMIUMS. BUT LOOK AT THE 18 TO 24 YEAR OLDS AND THE 25 TO**

29 YEAR OLDS. TOGETHER, THEY COME TO ONLY 30 PERCENT.

- THIS SAYS TO ME, THAT MOST PEOPLE WHO ARE UNINSURED EITHER HAVE AN EMPLOYER WHO DOESN'T PROVIDE COVERAGE, OR THE WORKER CANNOT AFFORD TO BUY IT WITHOUT SOME HELP WITH THE COST OF THE PREMIUM.
- AND FOR MOST OF THE UNINSURED, BEING WITHOUT INSURANCE, IS A LONG TERM, NOT A SHORT-TERM PROBLEM.

THE UNIVERSITY OF MISSOURI CALCULATES THAT NEARLY 75 PERCENT OF UNINSURED WILL REMAIN UNINSURED FOR AT LEAST A YEAR.

SLIDE 3

- THE THIRD MYTH: THERE ARE THOSE WHO THINK THAT IF "I HAVE INSURANCE -- THE UNINSURED DO NOT AFFECT ME." THE REALITY IS THEY AFFECT YOU -- A LOT.

- **INSURANCE COSTS ARE HIGHER ...
TAXES ARE HIGHER BECAUSE OF HIGHER
FEDERAL HEALTH COSTS ...
AND AMERICANS WHO LOSE THEIR JOBS MAY
WELL JOIN THE UNINSURED.**
- **YOU CAN SEE FROM THE CHART, IN 1981,
ABOUT 7 PERCENT OF A HOSPITAL'S COSTS
WERE UNREIMBURSED COSTS. IN 1991
(THOSE ARE THE MOST RECENT NUMBERS WE
HAVE), IT'S 13 PERCENT. CAN YOU
IMAGINE IF 13 PERCENT OF YOUR READERS**

DON'T PAY THEIR SUBSCRIPTION. IF 13 PERCENT OF YOUR ADVERTISERS DON'T PAY UP. YOU WON'T BE IN BUSINESS LONG, OR YOU MAKE UP THE LOSSES BY CHARGING OTHER CUSTOMERS MORE.

- ACCORDING TO THE CONGRESSIONAL BUDGET OFFICE, UNREIMBURSED COSTS FOR HOSPITALS ALONE TOTALED MORE THAN \$28 BILLION IN 1991. AS A RESULT, PRIVATELY INSURED PERSONS PAY

SUBSTANTIALLY MORE TO HOSPITALS THAN
THE ACTUAL COST OF THEIR SERVICES.

- WHEN THE GOVERNMENT PAYS LESS,
PRIVATE PATIENTS PAY MORE.
THE HOSPITALS AND OTHER PROVIDERS
SHIFT COSTS TO PERSONS WITH PRIVATE
INSURANCE.
- LET ME CONCLUDE BY SAYING UNIVERSAL
COVERAGE IS ESSENTIAL -- TO PROTECT
THOSE WHO HAVE NO INSURANCE, THOSE
WHO MIGHT LOSE IT, OR THOSE WHO PAY

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HIGHER PREMIUMS THAN THEY WOULD IF EVERYONE WAS COVERED. IT MAKES SENSE TO BUILD ON THE EMPLOYER-BASED SYSTEM, SINCE MOST PEOPLE TODAY OBTAIN THEIR INSURANCE THROUGH THEIR EMPLOYER. AND WE NEED TO MAKE SURE HEALTH CARE IS AFFORDABLE TO BOTH EMPLOYERS AND EMPLOYEES.

- AS THE PRESIDENT AND THE FIRST LADY SAY: UNIVERSAL COVERAGE IS ABOUT MIDDLE-INCOME WORKERS AND THEIR

FAMILIES. IT'S NOT ABOUT THE
UNEMPLOYED. NOT ABOUT THE POOR.
NOT ABOUT OLDER AMERICANS.
THE WORKING FAMILY IS THE ONE MOST AT
RISK UNDER TODAY'S HEALTH CARE
SYSTEM, AND IT'S THE ONE WITH THE
MOST TO GAIN BY REFORM.

- INTRODUCE BOB.
- OPEN IT UP TO QUESTIONS.

CLOSE

- THANK YOU FOR COMING. BETWEEN NOW AND THE END OF THIS CONGRESSIONAL SESSION, I THINK THE MOST IMPORTANT STORY YOU'LL WRITE IS THE HEALTH CARE ONE.
- I HOPE YOU GAINED SOME NEW INFORMATION AND PERSPECTIVE AS THIS MOVES ALONG.

Alabama

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Sonny Callahan	102	80	79.0
2	Terry Everett	97	78	79.7
3	Glen Browder	102	81	79.0
4	Tom Bevill	101	80	79.4
5	Bud Cramer	91	73	80.2
6	Spencer Bachus	85	68	80.6
7	Earl F. Hilliard	116	90	77.5
<i>Total</i>		694	550	79.3

Alaska

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Don Young	84	76	90.5

Arizona

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Sam Coppersmith	86	80	93.3
2	Ed Pastor	129	113	87.3
3	Bob Stump	78	71	90.6
4	Jon Kyl	77	72	93.3
5	Jim Kolbe	84	75	90.1
6	Karan English	87	77	88.6
<i>Total</i>		479	416	86.8

Arkansas

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Blanche M. Lambert	126	109	86.1
2	Ray Thornton	114	100	87.6
3	Tim Hutchinson	118	104	87.6
4	Jay Dickey	120	104	86.1
<i>Total</i>		5,937	5,052	85.1

Colorado

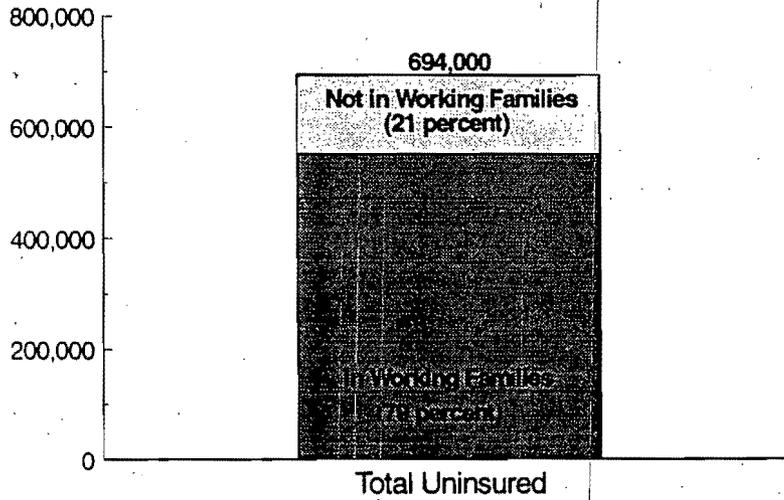
District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Patricia Schroeder	80	66	81.6
2	David E. Skaggs	63	53	85.3
3	Scott McInnis	79	65	82.1
4	Wayne Allard	76	64	83.3
5	Joel Hefley	58	48	82.3
6	Dan Schaefer	55	48	86.0
<i>Total</i>		412	343	83.3

Connecticut

District	Representative	Total Uninsured (000's)	Uninsured in Working Families (000's)	Proportion of Uninsured in Working Families
1	Barbara B. Kennelly	46	37	80.0
2	Sam Gejdenson	41	33	80.4
3	Rosa L. DeLauro	44	36	80.4
4	Christopher Shays	43	35	80.2
5	Gary A. Franks	40	33	81.6
6	Nancy L. Johnson	39	32	82.3
<i>Total</i>		255	206	80.8

694,000 PEOPLE IN ALABAMA DO NOT HAVE HEALTH INSURANCE, INCLUDING 542,000 IN WORKING FAMILIES

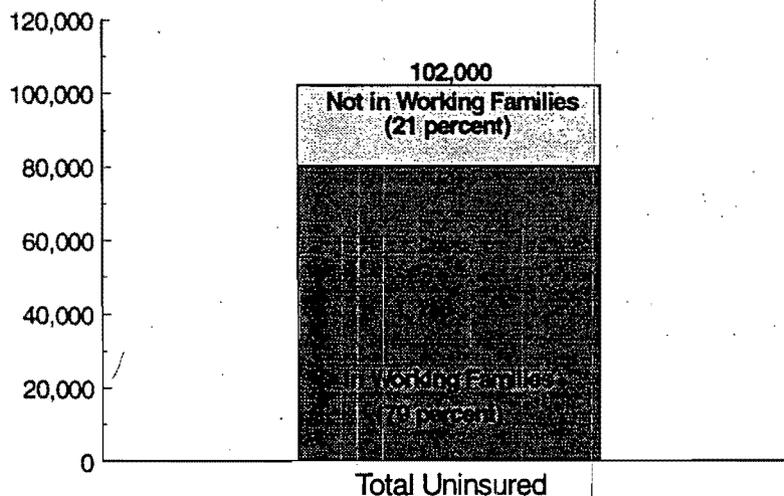
Number of Uninsured in Alabama



- The uninsured are exposed to major health risks and financial insecurity.
- People *with* insurance in Alabama pay higher premiums to cover the costs of caring for the uninsured.
- Without universal coverage, thousands of hard working people in Alabama will remain at risk of losing their health insurance.
- 542,000 (79 percent) of the 694,000 uninsured in Alabama are in working families.

**102,000 PEOPLE IN ALABAMA'S FIRST DISTRICT
DO NOT HAVE HEALTH INSURANCE,
INCLUDING 80,000 IN WORKING FAMILIES
(Representative Sonny Callahan)**

Number of Uninsured in Alabama's 1st District



- **The uninsured are exposed to major health risks and financial insecurity.**
- **People *with* insurance in Alabama's 1st District pay higher premiums to cover the costs of caring for the uninsured.**
- **Without universal coverage, thousands of hard working people in Alabama's 1st District will remain at risk of losing their health insurance.**
- **80,000 (79 percent) of the 102,000 uninsured in Alabama's 1st District are in working families**

DISTRIBUTION OF UNINSURED

Question:

Your data suggest that the uninsured are not equally distributed across States. Does that mean that a health reform bill that achieves "universal coverage" will be more beneficial to residents of certain States?

Answer:

Your observation is right, residents of States with large numbers of uninsured stand to benefit substantially from universal coverage...but it is not correct to assume that persons who live in States with small percentages of uninsured won't also benefit. Let me explain.

In order to protect against loss of insurance as workers and their families move across State lines, it is important to extend insurance to every family. Moreover, many individuals and families in States with relatively smaller numbers of uninsured do not have adequate coverage. A comprehensive standard benefit package will both assure portability and upgrade coverage for millions.

Office of Economic Policy
July 18, 1994

COSTS TO SMALL BUSINESSES

Question:

It strikes me that there is a "flip" side, if you will, to your argument that certain States with large numbers of uninsured will benefit most from universal coverage. Doesn't that also mean that small businesses in those States -- where many working uninsured are concentrated -- will have to bear a disproportionately large financial burden under the employer mandate?

Answer:

Well, it is certainly true that under the President's plan, all businesses -- including small firms -- are expected to help pay for the cost of providing employer based coverage. And to the extent that they did not already do so, these businesses would have to make a contribution. But, it is very important to point out that small, low wage firms would be heavily subsidized through a system of discounted premiums. Moreover, small, medium and large firms that do offer insurance in those States would benefit significantly in that they are currently carrying a very substantial cost-shift burden [paying for the cost of caring for the uninsured]. Since small firms suffer most under the current system, these firms would be especially well-served by a better distribution of the cost of providing care.

Like the President, the committees dealing with this issue have acknowledged the need for a well-structured system of subsidies, and while the actual configuration of the subsidy is still evolving, I feel sure that at the end of the day we will be able to come together on a plan for helping individuals, families and firms make this change.

Office of Economic Policy
July 18, 1994

RELIABILITY OF DATA

Question:

How good is this data once it is broken down into substate regions like Congressional districts? For example, is it fair to assume that communities with large numbers of uninsured do not provide adequate coverage through public health clinics -- services available to families but not captured in the insured data?

Answer:

You're right, data is always better when it is aggregated -- that is, when you're dealing with data sets this large, you tend to be more accurate at the macro level. However, I am confident that the methodology used to arrive at the Congressional district breakdown is sound...and I don't think you'll find any better breakdown than what the Treasury staff has assembled.

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July 18, 1994

SOURCE OF DATA USED

Question:

Is there anything new here, Mr. Secretary? My impression is that the data you have included in this report is well known and already widely available. What should we look for here?

Answer:

You are right, much of the health coverage data has been produced for years by various agencies, organizations and university based researchers. But given the complexity and texture of this debate, we thought you would appreciate having the most recent information about the uninsured assembled in one place. In addition, what is new here is the breakdown of information by Congressional district.

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July 18, 1994

CONGRESSIONAL SUPPORT BY REGION

Question:

Looking at the distribution of the uninsured by State, Mr. Secretary, it occurs to me that the final debate in Congress -- assuming you can get past the rhetoric of the last few weeks and months -- is likely to break down by region rather than by party. That is, Members from the southern and western States may either support universal coverage because there is such a great need for it among their constituents -- or oppose it because the burden on the businesses in those States is excessive.

Likewise, Members from the northeast, far west and midwest may either support universal coverage because it secures benefits that workers already have -- or oppose universal coverage because it is not such a serious problem in their States yet residents of those regions will have to bear a large portion of the cost of the subsidies. Am I right?

Answer:

I think your point about the non-partisan nature of this debate is well taken. Both Democrats and Republicans represent districts and States where there are serious gaps in coverage, and even if coverage appears to be reasonable, there is the insecurity associated with losing your health coverage if you change or lose you job. For different reasons -- to secure existing benefits, to control costs, to extend benefits, to obtain subsidies -- we will all benefit from enacting a comprehensive health reform bill.

Office of Economic Policy
July 18, 1994

UNIVERSAL COVERAGE AND MANDATES

Question: If we can get close to universal coverage without mandates doesn't that make more economic sense than a system that even the Chair of the CEA admits may cost 600,000 jobs?

Answer:

- o First, you can't get close to universal coverage without a mandate of some kind or without going to a single payer system. Neither the Dole plan, nor the Senate Finance plan, nor the Cooper plan achieve the coverage targets they claim to achieve. Let's examine exactly what CBO said about Cooper.
- o On the one hand, CBO said that Cooper's bill could achieve 91 percent coverage if the subsidies were fully funded; but CBO also said that Cooper's bill underfunded the subsidies by \$30 billion a year and that its' mechanism for providers to simply absorb a subsidy shortfall is untenable.
- o Similarly, Lewin based its conclusion that Cooper would get to 91 percent coverage on this faulty assumption. CBO found that the Cooper plan has a \$30 billion a year financing hole in this plan, which will increase the deficit and leave 20 to 25 million people -- most of whom will be middle class -- uninsured.

DEFINE UNIVERSAL COVERAGE

Question: The President has made it clear that he will veto a bill that doesn't achieve universal coverage but he has never defined the term "universal coverage." What would be an unacceptable time frame to get to universal coverage?

Answer: Universal coverage means that every citizen will have affordable comprehensive health benefits. Of course there will be people who fall through the cracks, but everyone will be able to obtain health care without fear of being bankrupted. The President deliberately made the time line flexible for achieving universal coverage and has always said that he would be willing to work with Congress on defining an acceptable phase in time. However, that date must be clear, and it must be in the foreseeable future.

DEFINE UNIVERSIAL COVERAGE-FOLLOW UP

Question: By all indications the date for universal coverage is going to be well into the future, and certainly not before 1998. Doesn't that leave you with many of the problems of an incremental transition against which you are campaigning so heavily now? If the health care coverage and cost crisis is now, isn't a bill with a slow phase-in unacceptable?

Answer: Yes, the coverage and cost problem in health care are real, and we believe they need to be addressed in a comprehensive and timely way. At the same time, we are talking about an enormous industry that today constitutes one seventh of the economy. We're not about to rush a new system into place. The important thing is to be clear with consumers, providers and payers about the fact that we will achieve universal coverage within a reasonable length of time.

TRIGGERS

Question: Would a more market-oriented bill based on managed competition with a hard to meet the President's bottom line goal? What about a soft trigger in which a commission would make recommendations to Congress if coverage targets weren't achieved?

Answer: I would first remind you that the President's proposal is built around market forces as the chief mechanism for controlling costs, with a backup of limits on how fast premiums can rise. It would be premature to speculate about what Senator Mitchell and Congressman Gephardt will prepare to their respective chambers. I can only reiterate what the President has said all along. He will only sign a bill that achieves universal coverage, but that he wants to work with Congress in developing a compromise bill on how to get there. The administration would certainly consider a bill with triggers, but only if we are confident that it can achieve universal coverage and significant cost control.

STATE FLEXIBILITY OPTION

Question: How far is the Administration will to go with allowing States maximum flexibility to design their own health care systems? There are rumors that the Administration is considering allowing States to design completely new reform system -- beyond the single payer option specified in the Health Security Act. Would the Federal government merely make block grants to States for subsidies? Wouldn't this maximum flexibility policy put already stretched State budgets even more at risk? What is the Administration's position on the California ballot initiative to go to a single payer system?

Answer: ERISA is the Federal law that covers pensions, health plans and other employee benefits. ERISA was enacted in 1974. I helped push the bill through the Senate Finance Committee. I was there when the President signed the bill in the Rose Garden, 20 years ago this Labor Day. The provision in ERISA preempting State laws governing benefits has done some good over the years in protecting multistate employers from having to deal with 50 different State laws.

But the balance here is allowing the people closest to the ground -- those back home in the states, counties and cities -- to have some flexibility to adapt their health system to meet their needs, while at the same time providing enough national uniformity to make sure that health plans don't have to deal with 50 different State laws and thousands of local laws. Every issue must be looked at with an eye toward finding the best mix of national uniformity and local flexibility. We are continuing to work with the business community and the State and local governments to get the right balance.

DEFENDING THE MANDATE

Question: All of your arguments for universal coverage are really arguments for a mandate on businesses and individuals to purchase insurance. You yourself once argued as a senator for a more incremental reform -- one that wouldn't achieve universal coverage but would make the purchase of health insurance more affordable and accessible. Could you envision a scenario in which the President would sign a bill with no mandates? In other words, could there be a bill that achieves universal coverage without any mandates?

Answer: We in the Administration believe the best way to achieve universal coverage is through a system of shared responsibility between employers and individuals. I think we've seen some examples of problems with passing incremental reforms in the absence of universal coverage; in New York State last year when small group reform was enacted, young, healthy people stayed out of the system, leading to higher premiums for everyone else in the small group community rate pool. We are concerned that the incremental reforms now being debated will not achieve the coverage levels they claim (91 to 94 percent) and if enacted they could worsen the situation by increasing cost of purchasing insurance which could cause some individuals and families to forgo coverage. In other words, there is potential for increasing the number of uninsured.

SUBSIDY STRUCTURE

Question: Your chief complaint against the incremental plans is that the plan subsidies are insufficient and would cause perverse economic incentives for businesses. But the President's plan faces many of these same issues; the cap on Federal spending for subsidies leaves subsidies availability for eligible recipients in doubt. Also, firms have a large incentive to rearrange themselves to maximize subsidies under the HSA. How should a Mitchell/Gephardt bill deal with these questions?

Answer: With regard to the availability of government subsidies for businesses and individuals, I think it's clear that incremental reforms could cost the government much more than a system of universal coverage, since these nonuniversal reforms present employers with such a powerful incentive to drop coverage thereby increasing the amount government would have to devote to individual subsidies. Secondly, we are working with Majority leaders Mitchell and Gephardt on the issue of target subsidies; as you know many of us have thought for some time that individual-based subsidies involve fewer economic distortions than firm-based subsidies and I think there is interest in congress in that type of structure. But the first decision you need to make is whether you are going to go to a system of universal coverage or not. Everything else flows from that.



DEPARTMENT OF THE TREASURY
WASHINGTON

July 19, 1994

INFORMATION

ASSISTANT SECRETARY

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN ✓

From: Alicia Munnell *AM*
Economic Policy

Subject: EMPLOYMENT IMPACT OF HEALTH CARE REFORM

A new economic study, distributed by the National Bureau of Economic Research, finds that those Canadian provinces that introduced universal coverage first saw faster, not slower, employment growth than either the same provinces before coverage or other provinces that had not yet established the system. Universal coverage and national health insurance did not destroy jobs, but created jobs--and not at the price of lower wages.

The study, by Harvard Assistant Professor Jon Gruber and Princeton Assistant Professor Maria Hanratty, calculates that the implementation of universal coverage in a Canadian province appears to have permanently boosted employment by between 1.3 and 2.6 percent, and wages by between 1.4 and 4.2 percent. The authors write that the "hypothesis...most consistent with our findings" is that national health insurance boosted employer demand for workers in all sectors of the Canadian economy.

They speculate that reduced "job lock" allowed employees to go where their skills were more valuable, boosted the productivity of the workforce, and thus boosted wages. They also speculate that productivity may have been higher because of a healthier workforce. ✱

very interesting
LSB

Edward S. Knight

TREASURY CLEARANCE SHEET

NO. 44-136226
 Date July 19, 1994

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

FROM: Alicia Munnell

THROUGH: _____

SUBJECT: Employment Impact of Health Care Reform

REVIEW OFFICES (Check when office clears)

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| <input type="checkbox"/> Under Secretary for Finance
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<input type="checkbox"/> Economic Policy
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<input type="checkbox"/> Under Secretary for International Affairs
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<input type="checkbox"/> Legislative Affairs
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<input type="checkbox"/> OCC | <input type="checkbox"/> Policy Management
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NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S) De Long, Brad	<i>BD</i>	7/19/94	DAS for Economic Policy	2-0563
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date



ASSISTANT SECRETARY

DEPARTMENT OF THE TREASURY
WASHINGTON
July 19, 1994

94-137419
BRIEFING

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Joan Logue-Kinder ^{ONE}
Assistant Secretary for Public Affairs

SUBJECT: White House Press Conference on Health Care

DATE AND TIME: Wednesday, July 20, 1994, 11:00 am

LOCATION: White House Briefing Room

PARTICIPANTS:

Treasury: Secretary Bentsen
Chris Peacock

Reporters: White House Press Corps and Health Care Reporters

BRIEFING: To release report: Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District.

SCENARIO: You will give several minutes of remarks and walk the reporters through the report. Then you will open the briefing to Q&As.

ATTACHMENTS: Tab A - Talking Points on Crime Bill
Tab B - Tax Refund Fraud Task Force
Tab C - IRS Issues

ADDITIONAL BRIEFING MATERIALS TO BE PROVIDED SEPARATELY

LMB -- 7/20/94 -- White House Press Corps -- 11:00 a.m.
draft 1 -- 4.5 minutes (prepared by Ilene)

2

**I'M OFTEN ASKED: WHO ARE THESE
AMERICANS WITHOUT HEALTH INSURANCE?**

**WE TRIED ANSWERING THAT IN A STUDY
TREASURY JUST COMPLETED. WE DID AN
ANALYSIS BY STATES AND BY CONGRESSIONAL
DISTRICTS ESTIMATING HOW MANY AMERICANS
HAVE NO HEALTH INSURANCE -- AND WHO THEY
ARE. ARE THEY YOUNG? DO THEY HAVE
JOBS?**

**THE BOTTOM LINE: THE UNINSURED ARE
YOUR MIDDLE-INCOME WORKING NEIGHBORS.**

2

**LET ME ILLUSTRATE WITH THE
CONGRESSIONAL DISTRICT THAT INCLUDES MY
NEIGHBORHOOD. THEY BLEW UP THE PAGE ON
TEXAS FROM THE REPORT. I HOPE YOU TAKE
A LOOK AT YOUR STATES AND CONGRESSIONAL
DISTRICTS, LIKE I'M DOING FOR TEXAS.**

CHART: TEXAS

**IN THE 15TH DISTRICT OF TEXAS ...
ON THE MEXICAN BORDER ... THE DISTRICT I
REPRESENTED IN CONGRESS, AND KIKA DE LA
GARZA REPRESENTS NOW ... THERE ARE**

173,000 UNINSURED ... ALMOST 82 PERCENT OF THEM ARE IN WORKING FAMILIES... AND 58,000 ARE UNINSURED CHILDREN.

IN TEXAS, THERE ARE 3.8 MILLION PEOPLE WITH NO INSURANCE ... 84 PERCENT ARE IN WORKING FAMILIES ... AND 972,000 ARE CHILDREN.

THINK ABOUT THAT: ALMOST A MILLION CHILDREN IN TEXAS HAVE NO INSURANCE. CHILDREN DON'T HIRE LOBBYISTS. THEY DON'T HAVE ANYONE TO SPEAK FOR THEM

IN THIS DEBATE, BUT THEY'RE THE ONES MOST VULNERABLE. NOW YOU KNOW WHY AS A SENATOR FROM TEXAS, I SPENT SO MUCH TIME WORKING ON IMPROVING HEALTH CARE COVERAGE FOR CHILDREN. NOW WE HAVE A CHANCE TO COMPLETE THE JOB.

THERE'S A SENSE IN THIS COUNTRY THAT UNINSURED ARE POOR, OR DISABLED, OR ELDERLY. NOT TRUE. MOST OF THOSE INDIVIDUALS ALREADY HAVE COVERAGE

THROUGH MEDICAID, MEDICARE, AND OTHER PUBLIC PROGRAMS.

BY FAR, MOST OF THE UNINSURED ARE MEMBERS OF MIDDLE-INCOME WORKING FAMILIES.

THE TREASURY STUDY SHOWS THERE ARE 37 MILLION UNINSURED, 84 PERCENT ARE IN WORKING FAMILIES, AND 8.3 MILLION ARE CHILDREN.

AND THESE PEOPLE AREN'T POOR. ONE IN THREE IS A MEMBER OF A FAMILY MAKING MORE THAN \$30,000 A YEAR.

MOST UNINSURED EITHER HAVE AN EMPLOYER WHO DOESN'T PROVIDE COVERAGE, OR THE WORKER CAN'T AFFORD TO BUY IT WITHOUT HELP. AND FOR MOST OF THE UNINSURED, BEING WITHOUT INSURANCE, IS A LONG TERM, NOT A SHORT-TERM PROBLEM.

IF YOU HAVE INSURANCE, IT'S EASY TO SAY: "THE UNINSURED DON'T AFFECT ME. THAT'S THEIR PROBLEM."

BUT IT'S YOUR PROBLEM TOO, BECAUSE INSURANCE COSTS ARE HIGHER ... TAXES ARE HIGHER BECAUSE OF HIGHER FEDERAL HEALTH COSTS ... AND AMERICANS WHO LOSE THEIR JOBS MAY WELL JOIN THE UNINSURED.

LET ME CONCLUDE BY SAYING UNIVERSAL COVERAGE IS ESSENTIAL. IT MAKES SENSE TO BUILD ON THE EMPLOYER-BASED SYSTEM,

SINCE THAT'S HOW MOST PEOPLE TODAY OBTAIN THEIR INSURANCE. AND WE NEED HEALTH CARE TO BE AFFORDABLE TO BOTH EMPLOYERS AND EMPLOYEES.

THIS IS IMPORTANT TO EVERY ONE OF US. EVERY ONE OF US CAN TELL A STORY ABOUT A FAMILY MEMBER, A CO-WORKER, A NEIGHBOR WHO'S RUN INTO TROUBLE WITH THE CURRENT SYSTEM. THAT'S WHAT WE'RE TALKING ABOUT -- FIXING THESE PROBLEMS.

SO, WHO'S FIRST

Texas

District	Representative	Total Uninsured (000's)	Uninsured in Working Families		Uninsured Children (000's)
			(000's)	Percent	
1	Jim Chapman	114	96	83.8	28
2	Charles Wilson	117	96	82.4	28
3	Sam Johnrison	90	79	88.0	17
4	Ralph M. Hall	110	94	85.5	26
5	John Bryant	129	108	84.2	31
6	Joe Barton	94	83	87.9	18
7	Bill Archer	100	88	87.6	20
8	Jack Fields	104	90	85.9	22
9	Jack Brooks	112	95	84.7	26
10	J. J. Pickle	125	107	85.3	24
11	Chet Edwards	121	99	82.1	29
12	Pete Geren	122	104	85.1	29
13	Bill Sarpalius	130	109	83.8	33
14	Greg Laughlin	128	108	84.3	33
15	E. de la Garza	173	141	81.7	58
16	Ronald D. Coleman	164	134	82.0	49
17	Charles W. Stenholm	122	103	83.8	31
18	Craig A. Washington	137	113	82.6	32
19	Larry Combest	121	103	85.5	30
20	Henry B. Gonzalez	158	130	82.3	43
21	Lamar S. Smith	105	91	86.0	23
22	Tom DeLay	107	92	86.6	23
23	Henry Bonilla	158	130	82.8	49
24	Martin Frost	130	111	85.4	34
25	Michael A. Andrews	124	106	85.7	29
26	Dick Armey	102	90	87.9	19
27	Solomon P. Ortiz	162	134	82.5	50
28	Frank Tejeda	161	133	82.4	49
29	Gene Green	178	148	83.1	55
30	Eddie Bernice Johnson	141	118	84.0	34
Total		3,839	3,233	84.2	972

Talking Points on Crime Bill

- * The House and Senate Conferees are scheduled to meet today to work out the remaining details in the Crime Bill. I applaud their efforts and encourage swift enactment of this critical piece of legislation.
- * From across the nation, we have heard calls for a stop to the violence that is plaguing our cities, towns and rural areas. Key to stopping the violence is the ban on assault weapons which has passed both the House and the Senate. Assault weapons are preferred by criminals over law abiding citizens 8 to 1.
- * Now, I know guns. These weapons are not sporting or hunting firearms. These are the first cousins of machine guns. They are tools of war. You can't go into a store and buy an anti-aircraft missile -- you shouldn't be able to buy an assault rifle loaded with 20 or more rounds either.
- * Now, a lot of people don't know that Treasury does law enforcement, but we have about a third of Federal law enforcement agents in our Treasury bureaus. The crime bill is important to us in that it will provide important new crime fighting authorities and new resources.
- * We need to reform the licensing system for gun dealers. The regulations are too lax -- we can't even require that a dealer comply with state and local laws and ordinances. We have too few inspectors -- 240 to cover nearly 280,000 gun dealers. And, the fee does not cover the cost of administering the license. Senator Simon's Federal Firearms License Reform provisions go a long way in improving the regulatory system, and I strongly encourage their inclusion in the crime bill.
- * Violent crime involving juveniles increased 57 percent from 1983 to 1992. During 1992, there were 809 juvenile gang related killings -- nearly 95 percent involved firearms. This tragedy must be stopped. We need to enact the juvenile handgun ban which is being discussed by the conferees.
- * Our Bureau of Alcohol, Tobacco and Firearms deals with gangs. The Crime Bill will provide resources to expand ATF's successful gang prevention program, as well as resources for ATF law enforcement to target gangs and other violent criminal groups that use firearms.

QUESTIONS ON THE ASSAULT WEAPONS LEGISLATION

as passed by the House

Q: Why are the firearms listed in the bill as "assault weapons" any different from other firearms? Why should they be treated any differently?

A: These weapons are modeled after military firearms which are designed for battle. They are made for war, not for hunting, target-shooting, or self-defense. You cannot buy a grenade launcher, or a tank, or a machine gun, because they are serious military weapons. The semi-automatic assault weapons in the bill belong in that same category.

The bottom line is that these weapons are extremely deadly. There are too many examples of gruesome and tragic shooting rampages with assault weapons. A gun that has to be reloaded after several shots gives its victims a fighting chance.

Q: What features make these firearms different from hunting or other "legitimate" firearms?

A: No single feature makes a firearm an "assault weapon" -- it is a combination of characteristics, such as a folding stock, a large capacity magazine or detachable magazine, a silencer or threads for a silencer, a bayonet mount, a pistol grip, a flash suppressor, or a grenade launcher. These features are designed either for combat or to conceal possession or use of the weapon.

Q: How many firearms will actually be affected by this ban?

A: Actually not very many. The legislation specifically bans 19 firearms. Included in that list is the Streetsweeper rapid-fire shotgun, which was recently reclassified, through an administrative action, as a "destructive device" -- the same classification as a machine gun.

The legislation also refers to certain characteristics which in combination would require a firearm to be considered as an assault weapon -- the list of prohibited characteristics is meant to prevent the development of future models of assault weapons. Finally, it lists nearly 700 semi-automatic rifles, handguns and shotguns as legitimate firearms.

Q: If these firearms are as bad as machine guns, why can't you just reclassify them as destructive devices?

A: There is a very strict statutory definition of destructive device. While these firearms are essentially the same as many of the fully automatic destructive devices, the simple change from fully automatic to semi-automatic takes them outside of the destructive device definition. The recent Treasury ruling on Streetsweepers and USAS-12's was possible because they are both shot-guns with large bores.

Congress enacted a ban on the importation of firearms with the exception of those firearms which meet a "sporting purpose" test. ATF has developed "sporting purpose" criteria to ban the import of certain firearms, while ensuring that firearms with a variety of legitimate uses are available to law-abiding Americans. Although Congress has recognized the need to ban these weapons from import, current law still allows the domestic production and distribution domestically.

Q: How prevalent is the use of these weapons in crime?

A: Although these firearms constitute only one percent of all firearms in America, based on firearms trace data, they account for eight percent of firearms used in crime. [ATF conducts over 50,000 firearms traces per year of guns recovered in crimes. Only 25% of recovered firearms are traced.]

Q: Doesn't the Brady Act already ensure that assault weapons can't be purchased by criminals?

A: At present, the Brady Law only covers transactions of handguns in licensed dealerships. It does not cover any longarms, nor does it cover private transactions. In five years, however, when the "instant check" provision becomes effective, it will cover all firearms transactions at licensed dealerships.

Moreover, the Brady Act does not ban any firearms.

Brooks' Assault Weapons Ban Alternative

- * **Chairman Brooks' proposed substitute to the House and Senate passed Assault Weapons Ban undermines the objectives of the legislation and is an unacceptable alternative.**

- * The "compromises" in every area of the legislation gut the critical features of the bill. Changes that Brooks would make include:
 - Removing the AR-15 from the list of banned weapons. This is one of the most popular assault weapons used in violent crime. Because it is the only domestically produced assault *rifle* on the list, it is the only one which is not and cannot be banned administratively.

 - Removing the application of the "features test" provisions from rifles and shotguns. The features test would only apply to handguns. The only assault rifles that would be prohibited would be those 8 which are specifically named; any future rifles or shotguns with the same features would not be prohibited.

 - Changing the restriction on large capacity feeding devices from a maximum of 10 rounds to a maximum of 20 rounds. Common sporting rifles use magazines of 5 rounds. The Long Island Railroad massacre involved a 15 round clip.

 - Removing from the definition of "large capacity ammunition feeding device" parts from which such a device can be assembled. Without this language, such parts will continue to be readily available for easy assembly.

 - Diluting the "features test" by eliminating the threaded barrel feature, which is designed to accommodate silencers, flash suppressors, and other non-sporting attachments.

SECRETARY'S BRIEFING MATERIALS ON TAX REFUND FRAUD TASK FORCE

- Tax refund fraud, particularly relating to electronically filed returns, has been an increasing problem in recent years. Often, this fraud involves taxpayers improperly claiming Earned Income Tax Credits. Congress has been deeply interested in this area.

- Last February, the Oversight Subcommittee of the House Committee on Ways and Means had hearings on tax refund fraud.

- On Tuesday, July 19, the Senate Government Operations Committee heard testimony from IRS Commissioner Richardson and the GAO on this issue.

I am committed to working with Congress to solve the problem of tax refund fraud.

- In April, 1994, in response to concerns expressed by the House Committee on Ways and Means, I formed a Task Force to study the tax refund fraud problem. The chair of the Task Force is Under Secretary (Enforcement) Ronald K. Noble; the vice-chairs are General Counsel Jean Hanson and Assistant Secretary (Tax Policy) Les Samuels.

- The Task Force Director is George Washington University law professor Stephen A. Saltzburg. Professor Saltzburg is a former Deputy Assistant Attorney General for the Criminal Division of the Justice Department. The Task Force Manager is Joyce J. Walker, a former Deputy Associate Director of OMB. The Task Force staff will be drawn from Treasury, IRS, Justice, OMB, other federal and state government agencies, as well as experts from the private sector. The Commissioner of the IRS, along with representatives of OMB and the Justice Department are part of an advisory committee assisting the Task Force.

- Although the Task Force study will rely in part on the expertise of the IRS, the Task Force will issue independent conclusions and recommendations.

- The Task Force has issued an organizational charter, which I am sending to the leadership of Ways and Means Committee. NOTE: The package containing the transmittal letters will be sent to the Executive Secretary on July 19, 1994.

- The Task Force will report to the senior Treasury Department officials and we will, in turn, report to the Committee on Ways and Means. We anticipate that the Task Force review will last approximately six months. Representative Pickle's Oversight Subcommittee of the Committee on Ways and Means has indicated that it may hold hearings on this issue in the fall. I also understand that Senator Roth may hold hearings on Earned Income Tax Credit fraud.

- The Task Force is seeking broad input from parties in both government and the private sector. The Task Force has been working closely with the IRS to study past, present, and possible future refund fraud practices. The Task Force is also examining the IRS's anti-fraud programs. IRS Commissioner Richardson is fully supportive of the Task Force effort.

BRIEFING NOTES -- IRS ISSUES

Commissioner Richardson appeared before the Senate Governmental Affairs Committee (Sen. Glenn) on Tuesday, focusing on two issues: refund fraud and computer security.

REFUND FRAUD

- Fraud is not unique to IRS or to government -- as public agencies and private companies have automated their systems, perpetrators of fraud have followed.
- Treasury's Tax Refund Fraud Task Force is in process.
- IRS has studies under way, including a three-year contract with the Los Alamos National Laboratory to improve fraud detection methods.
- IRS made changes this past year to enhance fraud detection, and will make more next filing season -- Commissioner Richardson announced two of these Tuesday:
 - expanding the suitability check on Electronic Filing Program applicants, and
 - delaying refunds on claims lacking proper social security numbers.
- The IRS is pursuing a four-part fraud reduction strategy: understanding, prevention, detection and enforcement.
- Timely implementation of IRS' Tax Systems Modernization (TSM) program is the key to identifying and stopping fraud.

COMPUTER SECURITY (safeguarding taxpayer files from unauthorized access by IRS employees)

- Commissioner Richardson announced over a year ago that no violation of taxpayer privacy will be tolerated. The IRS has taken a number of steps to reinforce among its employees the importance of taxpayer privacy.
- The systemic solution to better privacy protection is timely implementation of TSM.
- The IRS has appointed a Privacy Advocate who will implement the privacy strategy and integrate it into the development of TSM.
- The IRS has automated the research of computer audit trails at each service center to enhance the detection of improper employee access to taxpayer records.
- Computer misuse is limited to a very small portion of IRS employees with access to the system -- about 0.5 percent of users in the past year.



DEPARTMENT OF THE TREASURY
WASHINGTON

July 26, 1994

ASSISTANT SECRETARY

MEMORANDUM FOR SECRETARY BENTSEN
DEPUTY SECRETARY ALTMAN

FROM: Alicia Munnell
Economic Policy

SUBJECT: BUDGETARY IMPACT OF HEALTH CARE REFORM

SUMMARY:

Health reform that is deficit-neutral over the next decade does not achieve long-term control over the federal deficit.

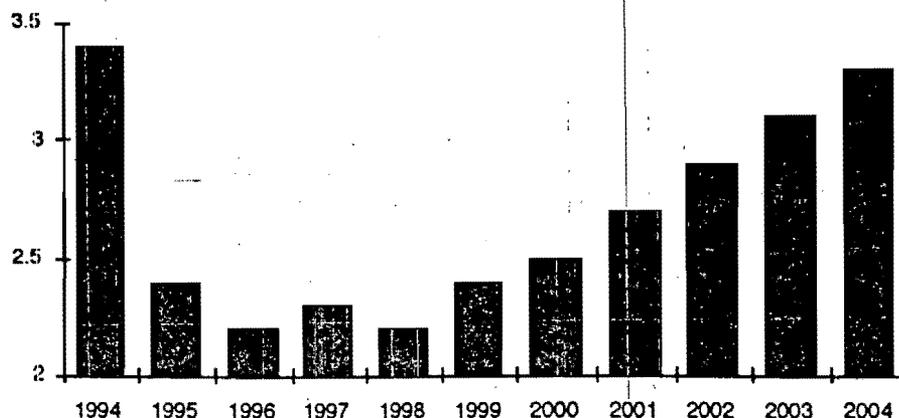
DISCUSSION:

As you know, in late 1993 this Administration argued that health care reform was essential to reduce the deficit in the out-years after 1999. By 2004 Medicaid and Medicare were projected to amount to 6.3 percent of GDP (compared to 3.7 percent of GDP today).

If we want health-care reform to stabilize the deficit at \$200 billion through 2004, then we require 10-year net budgetary savings from health care reform of approximately \$463 billion. If we want health care reform to stabilize the deficit at 2.3 percent of GDP through 2004, then we require 10-year net budgetary savings from health care reform of approximately \$318 billion.

A health reform plan that is merely deficit-neutral over the next ten years does not fulfill the Administration's commitment to use health care reform to gain long-term control over the federal deficit. It leaves the federal government with a projected deficit of \$365 billion in 2004--3.3 percent of GDP.

Federal Deficit as a Percentage of GDP (CBO
January 1994 Projections)





DEPARTMENT OF THE TREASURY
WASHINGTON

August 8, 1994

ASSISTANT SECRETARY

INFORMATION

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Alicia Munnell
Marina Weiss

SUBJECT: Health Care Delivery Room State/District Study

This morning at 11 AM Secretaries Shalala, Babbitt, Reilly, and Cisneros released a Health Care "Delivery Room" study, "Why America Needs Health Care Reform: A State-by-State, District-by-District Profile." The Delivery Room study regularly cites a previous Treasury analysis on the uninsured by Congressional District.

Treasury staff have a number of concerns with the study's use of the Treasury analysis; these concerns, which are outlined in the attached page, involve incorrectly attributing estimates to the Treasury analysis as well as factual errors which serve to exaggerate the number of uninsured.

You should know that Treasury staff were not aware of the existence of the Delivery Room study until this morning after copies of the study had already been sent to members of Congress. As a result, Treasury staff did not have the opportunity to comment on the study before its release. In addition to Treasury, HHS also was not given the opportunity to comment on the Delivery Room study, and, following a telephone call from Marina Weiss to Ken Thorpe, HHS is currently reviewing the study for the portions that cite their estimates.

Since we have had a chance to look at the study, we have made attempts to contact the Delivery Room to share our concerns. Specifically, Marina Weiss spoke with Greg Lawler, who is in charge of Delivery Room operations, and Josh Steiner spoke with Gene Sperling. Both Marina and Josh also have a call in to Harold Ickes.

Attachment

Edward S. Knight

Comments
"Why America Needs Health Care Reform:
A State-by-State, District-by-District Profile"

Statement: "3,233 thousand working families in Texas have no health insurance--a 27.56% increase since 1988"

Comments:

1. This statement should read, "3,233 people in working families in Texas." By claiming that 3,233 thousand **families** are uninsured, as opposed to **individuals**, the Delivery Room statement exaggerates the number of uninsured. Note that this mistake is repeated on more than one page for each state (and attributed to the Treasury analysis), while in other parts of the document the figure is correctly phrased.
2. The 27.56% increase since 1988 is incorrectly attributed to the Treasury study, which did not estimate the number of working uninsured in 1988. In fact, for some states the percentage increase is implausibly large; for example, the page for Virginia claims that there has been a 66% increase in the number of uninsured in working families since 1988.

Statement: "920,214 children are without health coverage (in Texas)"

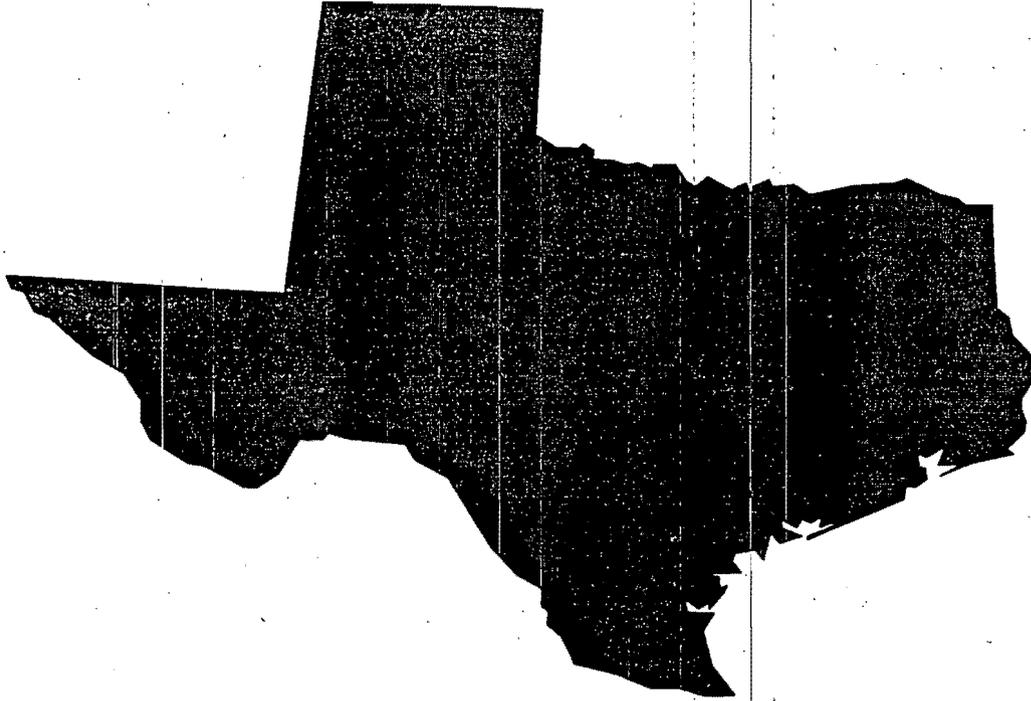
Comments:

1. This number, taken from a study by Senators Rockefeller and Daschle, is not consistent with the Treasury Department analysis, which states that 972,000 children in Texas are uninsured. While the Delivery Room project does not use the Treasury number for the states, the document does use the Treasury number of uninsured children for each Congressional district, making the document itself inconsistent.

Note: There are a number of other less significant errors in the state/district study related to the use of the Treasury analysis; for example, the percent of uninsured in working families for each Congressional district is slightly different than the Treasury estimate.

Also note that the above comments only concern the parts of the study which cite the Treasury analysis.

***Real* Health Care Reform**
TEXAS



Why Texas Needs Universal Coverage:

Under the current system...

- **175,000** people in Texas lose their insurance each month. [Lewin-VHI estimates, 1993. Families USA, "How Americans Lose Their Health Insurance," April 1994.]
- **3,233 thousand working families** in Texas have no health insurance -- a **27.56% increase since 1988**. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94; 1988, 1993 CPS]
- Of the **3,839 thousand** people without health coverage in Texas, **3,233 thousand** are in **working families** -- that's **84.21%** of all the people without coverage in Texas. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]
- **920,214** children are without health coverage. [Senators Jay Rockefeller and Tom Daschle, "America Without Universal Coverage," 6/16/94. Calculated from March 1993 CPS and 1990 Census data]
- **14.2%** of family income is spent on health care each year -- an average of **\$7,547** per family. [Lewin-VHI estimates. Families USA, "Skyrocketing Health Inflation," December 1993.]
- **21.2%** of the state budget is spent on Medicaid. [1992 State Expenditure Report -- National Association of State Budget Officers]

Why Texas Needs Universal Coverage:

With UNIVERSAL COVERAGE...

- **Every middle-class family** earning between \$20-75,000 will save, on average, \$622.71 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 3,335,910 families in Texas. [Catholic Health Association of the United States, "Coverage, Premiums, and Household Spending Implications of Health Reform," 7/18/94.]
- **3,233 thousand working families** in Texas will no longer go without coverage. [Department of Treasury, "Estimates of the Uninsured in Working Families and Uninsured Children by Congressional District," 7/19/94.]
- **920,214 children** will no longer go without coverage. [Senators Jay Rockefeller and Tom Daschle, "America Without Universal Coverage," 6/16/94. Calculated from March 1993 CPS and 1990 Census data]
- **5,452,062 people** with pre-existing conditions will no longer be at the mercy of insurance companies. [United States Department of Health and Human Services estimate]
- **2,726,342 people** will no longer have life-time limits on their coverage. [US DHHS estimate]
- **As much as \$2.6 billion** will be saved by doctors and hospitals when care is fully compensated. [Senators Jay Rockefeller and Tom Daschle, "America Without Universal Coverage," 6/16/94.]
- **As many as 9,393,000 people** will receive mental health benefits. [Lewin-VHI estimates. Families USA, "Better Benefits," December 1993.]
- **As many as 167,644 two-year olds** will have improved coverage for immunization. [US DHHS estimate]
- **As many as 4,690,085 women** will have improved coverage for mammograms. [US DHHS estimate]
- **As many as 1,120,000 Medicare recipients** gain prescription drug coverage. [Lewin-VHI estimates. Families USA, "Better Benefits," December 1993.]
- **As many as 174,000 people** will be able to get help with home and community based care. [Lewin-VHI estimates. Families USA, "Better Benefits," December 1993.]

Why Texas Needs Universal Coverage:

Texas can't afford *Non-Universal reform...*

- **105,000** people in Texas will continue to lose their insurance each month. [Lewin-VHI estimates. Families USA Special Report, "The Phony 91% Solution," 6/17/94.]
- Under non-universal reform, **every middle-class family** earning between \$20-75,000 will be forced to pay, on average, \$622.71 more each year on insurance premiums than they would under universal reform-- that's **3,335,910 families** in Texas. [Lewin-VHI for the Catholic Health Association of the United States, "Coverage, Premiums, and Household Spending Implications of Health Reform," 7/18/94.]
- **\$4,182,067,296** in additional costs will be shifted to Texas's state budget under a Dole-style Medicaid cap by the year 2003. [American Federation of State, County and Municipal Employees and Citizen Action, "Squeezing the States," 7/15/94.]

Texas Wins With *Shared Responsibility...*

- Without shared responsibility that ensures universal coverage, **2,231,180 families** in Texas will have to pay as much as **\$3,900** more each year if they want insurance. [1993 CPS; "Families and National Health Reform," Kaiser Commission on the Future of Medicaid, 5/94.]
- With shared responsibility, Texas businesses that now provide insurance will save as much as **\$1.9 billion** in premium costs for their employees each year -- an average of **\$290 per worker**. [U.S. Department of Health and Human Services, "State-by-State Analyses: Health Security, The President's Health Care Plan," March 1, 1994. Estimates for the year 2000.]
- Workers employed by firms that offer insurance will save as much as **\$2.9 billion** and earn **\$1.5 billion** in higher wages. [U.S. Department of Health and Human Services, "State-by-State Analysis Health Security, The President's Health Care Plan," March 1, 1994. Estimates for the year 2000.]
- Texas will save as much as **\$3.3 billion**. [U.S. Department of Health and Human Services, "State-by-State Analysis Health Security, The President's Health Care Plan," March 1, 1994. Estimates for the year 2000.]

State Data Profile

16,986,510	Total state population [1990 Census]
11.34%	Medicare recipients [U.S. Department of Health and Human Services, HCFA unpublished data]
11.92%	Medicaid recipients [HHS, HCFA]
812,848	Persons with disabilities [Area Resources File, 9/93. people between the ages of 16-64]
33,846	Doctors total [Area Resource File, 9/93.]
2	Doctors per 1000 people
60,074	Nurses [Area Resource File, 9/93]
882	Hospitals [American Hospital Association]
42	Community and Migrant Health Centers [HHS, Health Resources and Services Administration]
18.7%	Population underserved [HHS, Health Resources and Services Administration]
101	National Health Service Corps members [HHS, Health Resources and Services Administration]
28	National rank of infant mortality rate per 1000 births [Area Resources File, 9/93. Five year average infant mortality rate, 1984-1987.]

TREASURY CLEARANCE SHEET

NO. 94-136775
Date 8-8-94

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

FROM: Alicia Munnell - and Marina Weiss

THROUGH: _____

SUBJECT: Health Care Delivery Room State/District Study

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) Andy Rittenberg	<i>AR</i>	8/8/94	Economic Policy	2-1521
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date



ASSISTANT SECRETARY

DEPARTMENT OF THE TREASURY
WASHINGTON
August 11, 1994

BRIEFING

94-137401

MEMORANDUM FOR SECRETARY BENTSEN

FROM:

mlk
for Joan Logue-Kinder
Assistant Secretary (Public Affairs)

SUBJECT:

Cabinet Caravan for Health Care

DATE AND TIME:

Friday, August 12, 1994, 8:45 a.m.

LOCATION:

White House/Capitol Hill

PARTICIPANTS:

Treasury:

Secretary Bentsen

Others:

Michael Levy
Joan Logue-Kinder
Marina Weiss
Cabinet Secretaries
The President's Economic Team
The Congress
Open Press

BRIEFING:

To urge Congress to pass the health care bill.

SCENARIO:

8:45 a.m. President meets with all Cabinet Secretaries and his Economic Team
9:15 a.m. Weekly economic briefing in the Oval Office
9:30 a.m. Cabinet caravan leaves the White House for Capitol Hill
9:45 a.m. Photo-op on steps of the Capitol with other Secretaries
10:00 a.m. You go to the Senate Floor for meeting with Senator Moynihan

ATTACHMENT:

Tab A - Memo re Health care



DEPARTMENT OF THE TREASURY
WASHINGTON

August 11, 1994

MEMORANDUM FOR SECRETARY BENTSEN

FROM: Marina L. Weiss

SUBJECT: Health Reform

ACTION FORCING EVENT: Cabinet visit to the Senate

BACKGROUND/ANALYSIS:

Purpose of Hill Visit:

o As you know, you will be joining other Members of the Cabinet on a trip to the Capitol to lobby Senators to support Majority Leader Mitchell's efforts to preserve the triggered employer mandate provision of his health reform bill. Your assigned Member is Senator Moynihan, but you are encouraged to lobby others informally if you wish. To recap briefly, the 50/50 mandate would go into effect only if, in the year 2000, less than 95% of the population is insured. If the mandate were to be triggered, it would be implemented no sooner than 2002, and only in those states where the number of uninsured exceeds the permissible threshold.

o The purpose of your visit is to discuss health reform and to encourage Chairman Moynihan to support the Leader when the motion to strike the mandate is offered. This assignment should not be difficult as the Chairman supported a stronger employer mandate offered by Mitchell during the Finance Committee mark-up and is expected to vote with the Leader on this issue.

You might want to use this opportunity to get the Chairman -- who has been co-managing the bill with Senator Kennedy -- to give you an update on the situation in the Senate. You should be aware that Moynihan has been effusive in his praise of Senators who have spoken on behalf of bipartisanship, and it is clear that Packwood and Dole are eager to maintain a cordial relationship with Moynihan even as the debate becomes testy on the floor. In addition, if you wish to discuss other non-health issues with the Chairman, this is an opportunity to do so.

Status of Health Reform Debate:

o Votes are tight, but given that the employer mandate is included in the Mitchell plan and removing it will be a motion to strike Mitchell can afford to lose up to 7 Democratic votes if, as

expected, Senator Jeffords continues to be supportive. Timing of the vote is not clear, largely because the House situation is fluid [therefore, the House Leadership is not sure it will be able to take advantage of a good Senate vote or to stem the tide if the Senate vote is negative]. You should be aware that Mitchell is in the process of revising his plan a third time and will release the revisions within the next 24-36 hours.

o Senator Baucus yesterday afternoon delivered good news on the mandate issue by saying he would vote against a motion to strike.

However, Baucus also made clear his intention to oppose the overall bill as currently written because it does not achieve cost containment and it includes excessive funding for academic health centers [the only provision Moynihan is determined to preserve]. Baucus' staffer reports that Senators are increasingly "nervous" about the Mitchell bill, largely because the Republican attacks, coupled with poor press coverage, are taking a toll.

o Yesterday, Senator Hollings held a press conference to announce his opposition to the Mitchell mandate, making him the 5th Senator to state publicly his opposition [others are Bob Kerrey, Boren, Shelby, and Nunn].

o Today, Senators Kohl, Bob Kerrey and Boren went to the Senate floor to encourage the Leaders to work together to craft a bipartisan plan. Meanwhile, Senator Daschle delivered a very strong critique of the Dole/Packwood bill which was rebutted by Senator Dole.

o I am advised that the situation in the House is deteriorating, with the Leadership unable to muster sufficient votes to pass the Gephardt plan. The developments in the Senate have persuaded enough Members that it would be foolish to lend their support to an 80/20 mandate, and there is growing concern about the "excessive regulation" included in the Leadership bill as well as the inevitable "big government" associated with the Medicare C portion of the plan.

o At the moment, the most promising activity seems to be occurring within the reconstituted "Mainstream" group in the Senate. According to staff with Breaux and Danforth the Members participating in this group include but are not limited to: Breaux, Chafee, Danforth, Durenberger, Boren, Jeffords, Feinstein, Bond, Bradley, Bob Kerrey, Lieberman, Gorton, and Hatfield. Members on the House side as well as other Senators are watching and waiting for the group to come to closure around both a series of provisions and a process for their consideration on the Senate floor.

In addition to process questions [whether to offer an entire substitute or simply targeted amendments], principal issues under debate in the Mainstream group include:

1. The high cost plan assessment -- Bradley and Danforth are in

the process of revising the proposal in a way that reduces the revenue but moves the provision in the direction of a tax cap. While the policy outcome is clearly more acceptable to the technicians, it is likely to generate opposition from both organized Labor and conservative anti-tax Members.

2. The failsafe -- Danforth and Kerrey, in their role as entitlement reformers, are seeking changes in the failsafe mechanism to include Medicare and Medicaid as programs whose spending would be reduced if spending on subsidies grew too rapidly [the Mitchell bill applies the failsafe only to spending for new programs]. They are also suspicious that the OMB will "play games" in setting the baseline against which new spending would be measured, and are therefore looking for ways to better control the determination of the baseline.

3. Remedies and dispute resolution -- Jeffords and many others are deeply upset by the Labor Committee provisions relating to remedies and dispute resolution. Wholesale changes in Title I of the Mitchell bill are being sought.

4. Malpractice reform -- the Mitchell bill is viewed as too lenient to the Trial Lawyers Association, and the group is working to return to the provision approved in the Finance Committee mark-up.

5. Medicare Integration -- the insurance industry is seeking a provision that would allow Medicare beneficiaries to enroll in private plans and several Senators are trying to persuade the others that the proposal should be accepted. The downside of expanding consumer choice in this way, however, is that the elderly and disabled would choose private plans when they are fairly healthy but be encouraged toward the government funded plan when they are older and sicker, thereby driving up government costs and protecting the private plans.

PROFILE #: 94-136972

CREATE DATE: 08/12/94

ADDRESSEE: Bentsen, Lloyd M.
Secretary

AUTHOR: Lew, Jack
White House

SUBJECT: Meeting With House Members On Health Care

ABSTRACT: Meeting with House Members on Health Care.

RM 3419 TO REVIEWERS
IN:

TO EXECUTIVE SECRETARY
IN:

TO THE SECRETARY
IN:

OUT:

DISTRIBUTION: NONE

EXECUTIVE SECRETARIAT

AUGUST 12, 1994 10:23 AM

THE WHITE HOUSE
WASHINGTON

August 9, 1994

MEETING WITH HOUSE MEMBERS ON HEALTH CARE

DATE: August 10, 1994
LOCATION: HC 8, The Capitol
TIME: 4:00-5:00 PM
FROM: Jack Lew



I. PURPOSE

To present the economic case for comprehensive health care reform to a group which is largely freshman Members. The group includes a number of Members who are undecided or leaning no, and a number who are supportive but need to be shored up with economic arguments that they can use with confidence. The meeting should emphasize a positive approach to the House leadership bill and not focus on the Mitchell bill.

II. BACKGROUND

For the past several weeks the House has been engaged in a largely internal process to define the House leadership bill as a new approach. During this period there has been relatively little Administration involvement, and contacts with Members have been low profile. Beginning on Monday, we resumed more aggressive Administration efforts with House Members. The President met with a group of eleven House Members, several of whom are also invited to this meeting. He will be meeting with another group of Members this afternoon.

At the Monday meeting with the President, a recurring theme was the preference of many members for the Mitchell approach compared to the Gephardt approach. Since the rule in the House may or may not provide for a vote on Mitchell, the important message to Members is that it is critical to vote for the House leadership bill to get to conference and to get the strongest possible bill out of conference.

This morning's Washington Post story on business concerns with both the Mitchell and the Gephardt bills will further raise concerns which Members already have about the impact of health care reform on business. We need to use this meeting as an opportunity to arm Members with arguments that they can use in response to these concerns.

III. SEQUENCE OF EVENTS

The meeting will begin with brief presentations, followed by questions and discussion.

IV. ISSUES FOR DISCUSSION

(1) Effect of health care reform on premiums.

Both the Gephardt and Mitchell bills will significantly reduce, or eliminate, uncompensated care. As businesses look at the impact of various provisions which cost them money, they also need to look at the other side of the ledger and give credit for the provisions which save them money. Businesses which currently insure will pay less than they presently do when uncompensated care is removed from premiums.

(2) Effect of the mandate on employment.

Gephardt has argued extensively with Members that the mandate is like a one time increase in the minimum wage, and that since Congress will not be legislating a minimum wage as well, the mandate will have a very modest impact on employment.

The CBO analysis of the Mitchell bill supports this analysis. CBO concluded that the effect of the mandate, "would be quite small because the mandate would not be implemented until 2002. Market wages for low-income workers will rise over time, reflecting general inflation and, probably, some share of the nation's real economic growth. As a result, few workers will be earning the current minimum wage by 2002. If the Congress did not raise the minimum wage, loss of jobs from this mandate would likely be very limited."

Since the Gephardt bill delays the employer mandate for firms of 100 and less until 1999, and provides subsidies for small low wage firms, the CBO analysis should be very similar.

(3) Impact on small business.

The Gephardt bill provides subsidies of up to half the premium for small low wage firms. Community rating and reductions in administrative costs will reduce premiums for these firms, and will make it possible for them to provide insurance at rates which are competitive with the larger firms that presently benefit from experience rating.

We expect that business subsidies will be phased out after ten years, as they were in the Ways and Means bill. While Members have not yet focussed on this phase out, there may be a question regarding the long term impact on small business.

In the long term, cost containment is the real benefit for small business. The Gephardt bill has serious cost containment provisions, which in the long run will limit the premiums that small businesses pay. The Medicare Part C option offers a cost constrained option to firms of 100 or less as soon as the mandate takes effect.

(4) Deficit impact and cost containment.

Cost containment is the key to achieving real long term savings in both public and private health care spending. The House bill has strong cost containment provisions which are critical.

(5) Limits of incremental reform.

Incremental reform which does not eliminate uncompensated care or provide cost containment will not control premiums or end cost shifting.

V. PARTICIPANTS

[LIST OF MEMBERS ATTENDING]

Rep. Ben Cardin, Maryland
Rep. John Lewis, Georgia
Rep. Peter Barca, Wisconsin
Rep. Leslie Byrne, Virginia
Rep. Bob Clement, Tennessee
Rep. Sam Farr, California
Rep. David Mann, Ohio
Rep. Tim Roemer, Indiana
Rep. Lynn Schenk, California
Rep. Maurice Hinchey, New York
Rep. Carolyn Maloney, New York

Secretary Bentsen
CEA Chair Laura Tyson
Administrator Bowles
Gene Sperling

CONGRESSMAN PETER BARCA (D-WI):

Congressman Barca now holds former Secretary Aspin's seat but may have some trouble retaining it. He won by less than one percent in the special election and the same opponent is running again. Although Barca has been publicly supportive of the health care effort, he has not cosponsored any of the major health reform bills. Barca campaigned against new taxes and for controlling health care costs while expanding access. He has said that health reform must make the purchase of health insurance possible for all Americans and include coverage of preexisting conditions. He supports provisions calling for everyone to pay something towards coverage.

Barca served in the state legislature and was also a teacher of emotionally disturbed children and a job training specialist for people with disabilities. A Catholic, he said he would support the Freedom of Choice Act.

Recent Developments:

At a meeting with the President on Monday, August 8th, Barca said that people in Wisconsin are scared. He is not prepared to say what he will vote for but he wants to do the right thing. He feels people want more gradual steps. He is also concerned that there is not enough time after the vote to go back to the people and show the positive effects as with the Budget.

In another recent meeting, Barca told an Administration representative that he has still not decided how he will vote. He would like to get to universal coverage but does not like the employer mandate in Majority Leader Gephardt's bill. He also noted that he wants time to review the bill in its entirety, especially noting its effect on the deficit. Barca would not mind putting off a vote until January, then having reform phased in before the next election. He does not want a tough vote on something that would not be effective until 1999.

Votes:

FOR:

Budget Reconciliation

AGAINST:

NAFTA

Why the 1st district needs health care reform:

- **44 thousand** people in working families in Rep. Peter Barca's district have no health coverage.
- 89.80% of all people without health coverage in Rep. Peter Barca's district are in working families.
- **12 thousand** children in Rep. Peter Barca's have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$630.95 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 127,202 families in Rep. Peter Barca's district.

8/8/94

CONGRESSWOMAN LESLIE BYRNE (D-VA):

Freshman Congresswoman Byrne barely won her seat in 1992 with 50% of the vote and Roll Call considers her one of the top 25 incumbents most in jeopardy this November. She has not cosponsored any of the major bills but in a Washington Post article on her and Rep. Moran on July 29, she was portrayed as optimistic that the leadership would produce something she can support: "To Byrne, failing to pass a health care plan before the November elections would be a political disaster." The Post described health care as a major plank in her 1992 election, and she said: "I don't want to hurt or help the president if it hurts the constituency."

Byrne's two major issues are reproductive rights and federal employees. She does not want to see federal employers and retirees end up with lower benefits and higher costs. She signed the DeFazio-Schroeder letter supporting inclusion of abortion in the benefits package. She has told the Administration she will support the Gephardt bill if she is satisfied with the reproductive rights provisions. She is also protective of the seniors in her district and is opposed to any Medicare cuts. She has no problems with triggers and the goal of universal coverage, or the caps on premiums as long as they are in accordance with COLAs. She said that she and many of her House colleagues with tough races want the Senate to vote first on the mandates. Last year she was one of the 25 co-signers of a letter urging caution in the imposition of tobacco excise taxes.

Of her constituents he says "There are two levels of anxiety. One is about the current system going down the tubes. The other is people feeling they're one illness away from bankruptcy."

<i>Votes:</i>	<i>FOR:</i>	<i>AGAINST:</i>
	Family and Medical Leave	NAFTA
	Budget Reconciliation	
	National Service	

Why the 11th district needs health care reform:

- 53 thousand people in working families in Rep. Byrne's district have no health coverage.
- 85.48% of all people without health coverage in Rep. Byrne's district are in working families.
- 8 thousand children in Rep. Byrne's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$629.73 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 125,272 families in Rep. Byrne's district.

8/8/94

CONGRESSMAN BOB CLEMENT (D-TN):

A former political "boy wonder," college president and real estate executive, Congressman Clement is a Cooper and Rowland cosponsor. At a July meeting with Administration officials, Clement said that as a small businessman himself, he has small business concerns. He could see a hard trigger, or at least a delayed effective date, but not a straight mandate. He noted that he told the lead sponsors of the Cooper and Rowland bills that he wanted to help the President on health care reform if he could. With either a hard or soft trigger, he is prepared to help, but is concerned about voting on the employer mandate before the Senate acts. While ostensibly pro-choice, he does not want any government money involved. Clement co-signed the letter last year condemning the tobacco excise.

He is a member of the Veterans Affairs Committee, Rural Health Care Coalition and Mainstream Forum. He represents Nashville and is said to have considered running for Governor, a post once held by his father.

Recent Developments:

At a meeting with the President on Monday, August 8th, Clement said that he hears more good things back home about the Mitchell bill than he does about the Gephardt bill.

Votes:

FOR:

Family and Medical Leave
NAFTA
National Service

AGAINST:

Budget Reconciliation
Assault Weapons Ban

Why the 5th district needs health care reform:

- 61 thousand people in working families in Rep. Clement's district have no health coverage.
- 82.43% of all people without health coverage in Rep. Clement's district are in working families.
- 13 thousand children in Rep. Clement's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$624.39 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 127,361 families in Rep. Clement's district.

8/8/94

CONGRESSMAN SAM FARR (D-CA):

A former state legislator, Congressman Farr now holds Chief of Staff Panetta's seat. He was appointed to the Agriculture, Natural Resources, and Armed Services Committees. The district is one which includes the Monterey Peninsula, agricultural land, and a nearly one-third Hispanic constituency.

Farr is a McDermott cosponsor and has a very large number of single payer advocates among his constituents. In July, he cosigned the DeFazio-Schroeder letter to the Speaker on abortion coverage.

He campaigned for increased emphasis on women's health issues and support for the Freedom of Choice Act. Both in the state legislature and his run for Congress, Farr had very strong support from women's groups. In meetings last year, Farr advocated folding in the health portion of workers compensation and auto insurance.

<i>Votes:</i>	FOR:	AGAINST:
	National Service	
	Budget Reconciliation	
	NAFTA	

Why the 17th district needs health care reform:

- 100 thousand people in working families in Rep. Farr's district have no health coverage.
- 84.75% of all people without health coverage in Rep. Farr's district are in working families.
- 27 thousand children in Rep. Farr's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$626.83 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 118,904 families in Rep. Farr's district.

8/8/94

CONGRESSMAN MAURICE HINCHEY (D-NY):

A former state assemblyman, freshman Congressman Hinchey is a HSA and McDermott cosponsor. Hinchey's popularity in his legislative races in a heavily Republican area helped him win this seat with 50% of the vote. He is nominally favored to win this fall. The district includes small cities and parts of the Hudson Valley. It will continue to be hurt by IBM and defense layoffs which will in turn hurt his reelection chances. Hinchey sits on the Banking and Natural Resources Committees.

Hinchey campaigned for national health care reform and continues to prefer the single payer system. Hinchey wants to insure that any overhaul of health care removed the inequities in New York's Medicaid reimbursements. Local groups report that he wants the employer percentage at 80%, feels there needs to be premium containment, supports comprehensive benefits, and opposes taxation of benefits. In the Assembly he was a strong supporter of women's issues, including abortion rights. Hinchey cosigned the DeFazio-Schroeder letter on abortion benefits. He also sponsored a bill bringing more family practice physicians to his area, and maintained its success at reducing prenatal and infant mortality rates.

Votes:

FOR:

Family and Medical Leave
Budget Reconciliation
National Service

AGAINST:

NAFTA

Why the 26th district needs health care reform:

- 59 thousand people in working families in Rep. Hinchey's district have no health coverage.
- 81.94% of all people without health coverage in Rep. Hinchey's district are in working families.
- 13 thousand children in Rep. Hinchey's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$625.04 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 125,889 families in Rep. Hinchey's district.

8/8/94

CONGRESSMAN JOHN LEWIS (D-GA):

Chief Deputy Whip Lewis has been unfailingly supportive of the Administration's efforts on health care reform. An HSA and McDermott cosponsor, Lewis is a freshman member of the Ways and Means Committee and serves on its subcommittee on health. He is president of Americans for Democratic Action which has endorsed the President's plan.

Lewis is concerned about access to substance abuse and mental health programs and long-term care. He strongly opposes tobacco and favors raising excise taxes. Lewis has found the compromises on the tobacco tax particularly difficult. He cosigned the DeFazio-Schroeder letter on abortion benefits. He has a number of hospitals in his district and wants to be sure that inner city and rural citizens have equal access to universal quality health care.

Whip Count: Yes

Votes:

FOR:

Family and Medical Leave
Budget Reconciliation
National Service

AGAINST:

NAFTA

Why the 5nd district needs health care reform:

- **96 thousand** people in working families in Rep. Lewis's district have no health coverage.
- 80.00% of all people without health coverage in Rep. Lewis's district are in working families.
- **31 thousand** children in Rep. Lewis's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$620.33 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 115,078 families in Rep. Lewis's district.

8/8/94

CONGRESSWOMAN CAROLYN MALONEY (D-NY):

Freshman Congresswoman Maloney now represents what was once the "Silk Stocking" district of New York City. A member of the Banking and Government Operations Committees as well as the Caucus for Women's Issues, she is a McDermott cosponsor. Maloney won with a slim majority over a popular Republican. While her district is now overwhelmingly Democratic, she faces a stiff re-election. She was targeted by the Republicans after her vote for Budget Reconciliation -- earlier she had surprised many by voting against the budget.

Maloney cosigned the letter to Chairman Moynihan and Rep. Rangel concerning the effect of the HSA on New York State. She is particularly worried about the bill's impact on New York hospitals. She has said that some New York unions want to opt out of the alliances. A strong supporter of women's rights, Maloney cosigned the DeFazio-Schroeder letter on abortion benefits.

Whip Count: Leans Yes

<i>Votes:</i>	FOR: Family and Medical Leave Budget Reconciliation National Service	AGAINST: NAFTA
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Why the 14th district needs health care reform:

- 52 thousand people in working families in Rep. Maloney's district have no health coverage.
- 83.87% of all people without health coverage in Rep. Maloney's district are in working families.
- 5 thousand children in Rep. Maloney's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$628.99 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 163,39 families in Rep. Maloney's district.

8/8/94

CONGRESSMAN DAVID MANN (D-OH):

Freshman Congressman Mann is a former Cincinnati councilman and mayor - a liberal who campaigned as a fiscal conservative. Mann has not cosponsored any of the major health care bills. He told the administration in July that there is a lot of opposition in his district to employer mandates and that he prefers the Senate Finance bill. He believes a moderate incremental plan would be best. He fears the CBO numbers may be soft and wants the Senate to act first. Politically, Mann is worried about supporting the President and being labeled a "Clinton Clone." At the same time he recognizes the danger of doing nothing, demonstrating gridlock and being caught in a movement to "throw the rascals out."

In the past he has said, "The problem with the Cooper plan is that it doesn't provide universal coverage." He feels the Administration is on the right track, but employer mandates are a problem. Mann is pro-choice and has a child who is hearing impaired.

Mann won a difficult primary in this open seat and then was elected with 51% of the vote, suggesting a serious challenge this year. His vote in favor of NAFTA alienated labor to some degree -- they supported his opponent in this year's primary. However, Mann won the primary rather handily. Mann is a member of the Judiciary and Armed Services Committees.

Recent Developments:

At a meeting with the President on Monday, Mann said that people in Ohio think costs will go up and quality will go down. They believe access will improve but feel we should move more gradually. Mann is concerned that cost containment seems to have been forgotten.

<i>Votes:</i>	<i>FOR:</i>	<i>AGAINST:</i>
	Family and Medical Leave	Budget Reconciliation
	NAFTA	
	National Service	

Why the 1st district needs health care reform:

- 59 thousand people in working families in Rep. Mann's district have no health coverage.
- 81.94% of all people without health coverage in Rep. Mann's district are in working families.
- 18 thousand children in Rep. Mann's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$625.88 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 120,535 families in Rep. Mann's district.

8/8/94

CONGRESSMAN TIM ROEMER (D-IN):

Congressman Roemer has not cosponsored any of the major bills but he has told his constituents that he doesn't trust government to solve the problem. He is a member of Education and Labor, the Mainstream Forum and the Conservative Democratic Forum. A tough moderate vote, he voted for the Education and Labor mark to move the process along. He has told Administration representatives that the mandate would have to be reworked significantly for him to support it on the floor. In committee, he sought unsuccessfully to decrease to 500 the threshold for companies to self-insure with experience rating. He would prefer a "responsible" trigger mechanism that would also address small business concerns.

He is concerned about cost controls and changes to Medicare and their impact on seniors. He has a number of Eli Lilly employees and retirees in his district. Senator Bennett Johnston is his father-in-law.

Recent Developments:

At a meeting with the President on Monday, Roemer noted that he voted for the HSA in Committee and wants to vote for reform. However, even liberal groups in his district are telling him to go slow. He feels the Mitchell bill would put things in clearer focus between Democrats and Republicans and that we will have to go to the Mitchell bill in conference.

<i>Votes:</i>	FOR: Family and Medical Leave National Service	AGAINST: NAFTA Budget Reconciliation
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Why the 3rd district needs health care reform:

- 53 thousand people in working families in Rep. Roemer's district have no health coverage.
- 86.89% of all people without health coverage in Rep. Roemer's district are in working families.
- 12 thousand children in Rep. Roemer's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$628.08 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 125,109 families in Rep. Roemer's district.

8/8/94

CONGRESSWOMAN LYNN SCHENK (D-CA):

Other than Chairman Dingell, no Energy and Commerce Committee member has gotten more press on the health care deliberations than freshman Rep. Schenk. She told Secretary Reich in July that while the Dingell package solved her breakthrough drug and small business problems, it's now a whole new ball game. She doesn't like the Ways and Means language on breakthrough drugs and is concerned about the mandate. She suggested a carve-out based on profits or a phase-in based on size and profits with large businesses included first. While she signed the DeFazio-Schroeder letter supporting abortion coverage in the benefits package, she sees why we might have to be flexible and allow for religious exemptions, but she doesn't want every business suddenly having religious objections. She also doesn't like an opt-in as a solution. She feels the Ways and Means provisions on "any willing provider" undermine managed care and are therefore problematic to her.

Her Republican opponent is Rep. Bilbray's cousin.

<i>Votes:</i>	<i>FOR:</i> Family and Medical Leave National Service Budget Reconciliation	<i>AGAINST:</i> NAFTA
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Why the 49th district needs health care reform:

- 85 thousand people in working families in Rep. Schenk's district have no health coverage.
- 84.16% of all people without health coverage in Rep. Schenk's district are in working families.
- 13 thousand children in Rep. Schenk's district have no health coverage.
- Every middle-class family earning between \$20-75,000 will save, on average, \$623.48 each year on insurance premiums compared to a non-universal reform -- that's substantial savings for 137,487 families in Rep. Schenk's district.

8/8/94



MEMORANDUM

TO: DEPUTY SECRETARY NEWMAN
FROM: RANDY HARDOCK
DATE: NOVEMBER 10, 1994
RE: HEALTH CARE FINANCING

Assistant Secretary Samuels indicated that you were interested in a summary of the more likely health reform financing options. The attached summary provides a very brief analysis of the major revenue sources that might be available. In reviewing these materials you may want to keep in mind that many of the items discussed will be characterized as tax increases and, consequently, could have little chance of passing a Republican-controlled Congress. The Administration will have to carefully weigh whether the potential political fallout from each particular tax increase is warranted.

SUMMARY -- POSSIBLE HEALTH CARE REVENUE SOURCES

• Tobacco Taxes -- Increases in tobacco taxes were a major source of new revenue for most of the Democratic health care bills proposed in the last Congress. The Administration's Health Security Act (HSA) proposed an immediate 75 cent-per-pack increase in the current 24 cent-per-pack cigarette tax. This raised about \$107 billion over ten years. All of the other major Democratic health care proposals (Mitchell, Gephardt and Mainstream) included a 45 cent-per-pack increase phased-in over 5 years, raising about \$57 billion over ten years. We believe that this reflects an agreement that was worked out with Democratic members from tobacco states. Significantly, none of the major Republican health care plans included any tobacco tax increase, and many of the tobacco state delegations have swung further to the Republican side (e.g., the only remaining Senators from the six tobacco states are Ford (KY), Robb (VA), Nunn (GA) and Hollings (SC)).

It will probably be difficult for the Administration to propose a larger tobacco tax increase than the 45 cents-per-pack that was agreed to in the legislative process earlier this year. In addition, it is worth emphasizing that it is unlikely that the Republicans will support even that level of tax increase.

• Medicare Part B Subsidy Recapture -- Currently, 75% of Medicare Part B benefits are subsidized by the Federal government. The HSA proposed recapturing that subsidy on income tax returns for couples with income above \$115,000 and individuals with income above \$90,000. This proposal raised about \$18 billion over ten years. Most other health care proposals (including some Republican proposals) incorporated this concept. Since this proposal will probably be included in the Kerrey-Danforth Commissions recommendations, we believe that it will be possible to include it in the Administration's health care reform proposal. You should note, however, that the proposal is controversial with certain senior citizen groups.

• Extend HI Tax To All State and Local Government Employees -- Currently, certain State and local government employees are exempted from the HI portion of FICA taxes. The HSA proposed extending the HI tax to these employees. The proposal would have raised \$13 billion over ten years. State and local government employees in some states, including Ohio, Massachusetts and Texas strongly oppose this proposal. Nonetheless, it was included in the major Democratic health care bills and was included in a number of Reagan and Bush budgets. It was not included in any of the Republican health care reform proposals. On balance, we believe that this proposal is one of the better options for health care financing.

• Cafeteria Plans/Flexible Spending Accounts/Tax Caps -- A wide variety of options have been raised in connection with the tax treatment of employer-provided health care. Revenue estimates of these proposals are highly dependent upon other elements of the package. They will also be very controversial. The HSA contained a repeal of cafeteria plans and flexible spending accounts that we continue to believe is good tax policy. In addition, the HSA contained a very modest tax cap beginning in 2004. Although it is very difficult to determine without knowing the other elements of the package, the Office of Tax Analysis (OTA) believes that changes can reasonably be expected to raise between \$35 and \$55 billion over ten years if a decision is made to include proposals in this area.

• Revenue Impact of Increased Subsidies -- Under most proposals to increase subsidies to low income individuals, employers would be able to reduce their contributions for health care for some of their employees. Under scoring conventions, this would result in an increase in taxable income. The amount of revenue raised depends on the structure and generosity of the new subsidies. Recently prepared OTA ten year estimates of subsidy proposals range from a gain of about \$6 billion to \$44 billion.

SUMMARY -- REASONABLY AVAILABLE REVENUE SOURCES
(in \$ billions)

	<u>10-YEAR</u>
TOBACCO TAXES	\$ 57
PART B RECAPTURE	18
STATE & LOCAL GOVERNMENT MEDICARE TAX	13
CAFETERIA PLANS/FLEXIBLE SPENDING ACCOUNTS/TAX CAPS ..	45
REVENUE IMPACT OF SUBSIDIES (ROUGH)	<u>20</u>
 SUBTOTAL	 153
 MEDICARE CUTS	 ?



DEPARTMENT OF THE TREASURY
WASHINGTON

MEMORANDUM

TO: SECRETARY BENTSEN
FROM: RANDY HARDOCK AND MARINA WEISS
DATE: NOVEMBER 18, 1994
RE: NEC/DPC MEETING ON ERISA AND HEALTH CARE REFORM

SUMMARY -- You are scheduled to attend a meeting of the NEC/DPC on Monday, November 21st at 11:00. The main topic for discussion will be ERISA issues. Drafts of the materials to be passed out at the meeting are attached under marked tabs. This memorandum provides some background and talking points on the issues to be discussed.

DISCUSSION -- Three issues will be considered (time permitting):

- A. Multiple Employer Welfare Arrangements (MEWAs)
- B. ERISA Preemption of State Law
- C. Expansion of ERISA Remedies

A. MEWAs

Background -- A MEWA is any arrangement that offers health benefits to the employees of two or more employers. Since 1983, ERISA has expressly provided that states could regulate the financial solvency of MEWAs, generally under their laws governing insurance arrangements. The Department of Labor was given the authority to ensure that MEWAs comply with ERISA fiduciary standards. A number of MEWAs have been ignoring state insurance laws. When they go bankrupt, premium payers have been left without health insurance and with unpaid bills to providers. In addition, when States do take MEWAs to court, the MEWAs have argued (generally unsuccessfully) that they were ERISA plans and that the state could not regulate them. However, the delay in winning this litigation has often resulted in a further erosion of the MEWAs assets.

Initiative -- The Department of Labor would like to confirm that states can regulate MEWAs under current law. In addition, they want to create a new Federal requirement that any MEWA would be required to provide copies of materials showing compliance with state insurance laws. The DOL could require any MEWA that failed to meet this reporting requirement to cease its operations. They believe that this reporting will make it easier for them and the states to act more quickly in shutting down "fly-by-night" MEWAs.

Discussion/Talking Points -- You should be aware that in the past some small business associations have argued for the ability to form national or state specific MEWAs that allow small employers to band together in providing health insurance. These associations do not want to be subject to the solvency requirements of even one state, much less all fifty. For this reason, some Republican health care reform bills have proposed applying very loose Federal solvency standards to MEWAs and then exempted them from state regulation. Consequently, the DOL approach, in confirming the continuing role of state insurance commissioners to regulate MEWAs and in expanding Federal paperwork requirements, could well be criticized.

Nonetheless, from a policy perspective, MEWAs are insurance companies and should probably be regulated as such in order to protect the individuals buying those policies. In addition, there have been a number of documented cases of abuse in this area. Consequently, we feel that you should not oppose the DOL proposal on this issue, albeit with the understanding that a Republican Congress may well move towards a much less stringent Federal standard.

B. ERISA Preemption

Background -- General -- ERISA preempts any state law that relate to employee benefit plans. However, state laws regulating insurance are not preempted. In very general terms, courts have interpreted these provisions to preempt state laws from applying to self-insured employer provided health plans. A main justification for the ERISA preemption clause was to ensure that nationwide employer-provided health insurance plans were not subject to a "patchwork quilt" of 50 different state laws that would make plan administration overly burdensome.

In the past, states (and the National Governors Association (NGA), in particular) have complained that the ERISA preemption of state law effectively precludes them from implementing meaningful reform. The NGA has requested substantial changes in the ERISA rules to expand the authority of governors to regulate all plans on issues like: (1) coverage expansion/financing (e.g., ability to implement pay-or-play or single payor systems that apply to self-insured plans; ability to tax self-insured plans); (2) application of cost containment initiatives to all plans in the state (e.g., state established provider rates); (3) application of insurance reforms to self-insured plans (e.g., minimum benefit packages); and (4) application of state administrative requirements to self-insured plans (e.g., reporting requirements on utilization, cost and quality of care; uniform claims procedures; participation in purchasing pools).

General Discussion/Talking Points --The ERISA issues to be discussed at the NEC/DPC meeting involve a debate over the relative Federal and state roles in regulating health insurance. Some former advocates of a strong Federal role now see significant

Federal reform as unattainable in the near term and want to open the door to more extensive state authority to regulate all plans. They hope that these state experiments will act as demonstration projects for nationwide reform. In addition, they believe that having failed in achieving meaningful reforms at the Federal level, we should at least allow the possibility of universal coverage at the state level. Some may also believe that most states will not do anything significant if given the power, but that the President might be able to argue that he "delivered" on the campaign pledge on health care reform.

On the other hand, substantial ERISA preemption changes could eliminate any chance (however slim) of getting business support for an Administration proposal. The national uniformity issue was perhaps the most important issue for big business last year. Perhaps more importantly, small business (NFIB, etc.), having won the debate on mandates at the Federal level, can be expected to fight vigorously against opening the door to mandates at the state level. They will not want to fight this issue in every state one at a time. Finally, it can be argued that emphasizing state based reform will undercut the scope of what we may be able to achieve at the Federal level in this Congress.

In considering this issue generally, you may want to keep the following points in mind:

- Cutbacks on the ERISA preemption of state law will be very controversial and the President should be made fully aware of the potential fallout from a decision to proceed in this area.
- The President should not stake out a position on this issue until we have a better feel for who will support it.
- Since the Republicans now control the NGA (there are at least 30 Republican governors), we must anticipate that the NGA's position on ERISA issues could well change (see attached article). They announced yesterday that they are reevaluating the health care positions that they have previously taken, including ERISA. That may mean that the constituency for changes in ERISA preemption is even smaller than last year, especially on issues like allowing states to increase taxes.
- As with all issues in the health care debate we must decide where to fight and where to back off. We don't want to waste our energy on fights like this one that we won't win or that won't do that much good if we do win.

Background -- Specific Issues To Be Discussed -- The ERISA issues can be analyzed first by determining which items will be addressed by Federal regulation (whether direct or through a Federal mandate of state action) and then determining the extent to which each individual state's authority to regulate specific issues will be expanded beyond these Federal minimums.

Three general "objectives" will be presented at the NEC/DPC meeting:

1. Retain Status Quo
2. Expand minimum Federal rules, while allowing states to expand regulation of small plans.
3. Allow states to implement comprehensive reforms affecting all plans.

As a general observation, the three objectives being presented at the NEC/DPC meeting create the impression that decisions must be made on the appropriate Federal/state role on a global basis. In actuality, we believe the correct policy analysis is to examine each specific issue on the basis of whether the Federal or state government is best equipped to regulate any particular activity. For example, an analysis of expanding state power to regulate hospital rates paid by self-insured plans in order to contain costs has a distinctly different political dimension than expanding the power of states to tax or impose mandated benefits packages on those self-insured plans.

Discussion -- Specific Issues

1. Retain Status Quo -- The discussion on this option will probably be brief. As noted, this is probably the least controversial course.

2. Expand State Authority to Regulate Small Plans

Initiative A -- Expand Federal Role -- Many of the insurance reforms can be implemented best within the context of an overall Federal structure. For example, preexisting condition exclusions will only work fully if adopted on a national basis. Otherwise, someone who moves from one state to another could lose coverage for a preexisting condition. We believe that most of the participants will agree that certain issues should still be dealt with at the Federal level.

Initiative B -- Allow States to Regulate Small Plans -- ERISA's preemption clause allows states to regulate insurance, but are preempted from regulating self-insured employee benefit plans. Courts in interpreting the scope of the ERISA preemption clause have generally defined it fairly broadly, preempting the application of state laws in most cases where there was any self-insurance present. In order to avoid the application of state laws (e.g., mandated benefit laws), there has been a substantial increase in the number of self-insured health plans (sometimes called "ERISA plans") even among very small employers since ERISA was enacted in 1994.

The Department of Labor staff have proposed eliminating the current self-insured/insured distinction. It would be replaced by a rule

that said states could regulate all plans, except those of large employers (i.e., those with more than 5000, 1000, or 500 employees) operating in more than one state. This is generally consistent with the approach adopted in the Health Security Act (HSA) where employers with over 5000 employees could form Corporate Alliances and avoid some state regulation, while smaller employers were forced to join Regional Alliances that were subject to state regulation. In addition, this is arguably consistent with the original intent of ERISA, since in 1974 only large employers self-insured. In analyzing this proposal, you may want to keep the following points in mind.

- Some changes in ERISA preemption may be necessary to implement state-based insurance reform and, to the extent that those reforms are targeted at small employers, this type of approach may make sense. However, the expansion proposed by the DOL staff would be substantially broader than insurance regulation and would encompass the broad array of state options including the imposition of employer mandates.
- As noted in the general talking points, small business groups can be expected to strongly oppose this type of legislation. Moreover, even though large employers would be exempted from some requirements it is unlikely that they would support a proposal along these lines since they will be worried that they will be subjected to more and more state regulation as happened on specific issues in the HSA and in other Democratic health care reform bills.

3. Expand State Authority to Regulate All Plans -- The materials present possible initiatives permitting individual states to request ERISA preemption waivers that would allow them to regulate all health plans within the state. These waivers could be limited in a number of ways. The NEC/DPC materials present three possible models:

- (i) exemption for state cost containment laws (e.g., Maryland hospital rate setting);
- (ii) exemption for state financing laws (e.g., New York taxes on health plans);
- (iii) exemption for state laws providing "comprehensive health care reform": (e.g., pay-or-play or mandates like Washington and former Massachusetts models).

The materials also note that the waivers could be limited to a small number of states and be granted for only a limited period of time and that state-by-state waivers could expressly be limited to small employers.

In reviewing these proposals you may want to keep the following additional thoughts in mind:

- Is it appropriate for the President of the United States to be suggesting that certain named states will effectively be

given favored treatment. Although this type of activity is not unusual when dealing with spending programs, it is not common when dealing with laws of general applicability.

- You supported the exemption for Hawaii when in Congress. The Hawaii example is distinguishable, however, given the long history of exemption and the fact that no large multi-state employers have a significant number of employees in Hawaii.
- If the Secretary of HHS is given authority to grant waivers, specific guidelines for the exercise of discretion should be provided.

C. ERISA Remedies

Background -- Under ERISA, a participant's remedies against a health care plan are generally limited to recovery of the benefit and, in some cases, court awarded attorneys' fees. The Supreme Court has determined that the ERISA remedies are the exclusive remedy for all employer-provided plans, whether insured or self-insured. These very limited remedies create a situation where a plan can be fairly aggressive in denying benefits claims.

Initiative -- The Department of Labor staff (and Democratic Labor Committee staff) have argued for a number of years that ERISA remedies and procedural protections need to be expanded. The DOL will suggest a variety of options to achieve this end. Among the options will be:

- Mandatory award of attorney fees, expert witness fees and costs;
- Compensatory and consequential damages, e.g., lost wages that result from not getting timely treatment; loss of home because of inability to make mortgage payments;
- Non-economic damages (e.g., emotional distress; pain and suffering);
- In the case of a pattern of "abusive" denials, a Federal civil penalty;
- Creation of new mechanisms for resolution of claims disputes.

Discussion/Talking Points -- As we have indicated to you in the past, we believe some expansion in the scope of ERISA remedies and procedures is justified and we supported some changes in this area during consideration of the HSA. Nonetheless, we continue to believe that the broad expansion of remedies and the imposition of additional procedures that the DOL staff would like to implement can be expected to increase the amount of litigation under the new system and will increase the cost of coverage. It will also make it substantially more difficult for employers to manage care since the cost of the denied procedure will often be less than the cost of litigation.

AGENDA
November 21, 1994

3:00 or
3:30

- I. BACKGROUND ON ERISA
- II. THE PROBLEM
- III. THE PROBLEM WITH THE PROBLEM: POLITICS
- IV. POSSIBLE OPTIONS
- V. RECAP AND CONCLUSION

ERISA

I. BACKGROUND

II. THE PROBLEM

- A. INSURANCE REFORMS CANNOT BE EXTENDED TO SELF-INSURED PLANS
- B. ENROLLEES IN MEWAS ARE INSUFFICIENTLY PROTECTED
- C. ERISA AS A POTENTIAL ROADBLOCK TO REFORM
- D. REMEDIES MAY BE INSUFFICIENT

III. THE PROBLEM WITH THE PROBLEM: INTEREST GROUP POLITICS

IV. POSSIBLE OPTIONS

OPTION 1: To continue the present structure of having federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

POSSIBLE INITIATIVES

RETAIN CURRENT ERISA PREEMPTION: STATUS QUO

OPTION 2: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.
(NOTE: Administration-wide staff agreement on this matter -- as was the case in almost every bill last year; no consensus on appropriate state role beyond minimum standards, however.)

POSSIBLE INITIATIVES

- A. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD NOT BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON ANY PLANS.
- B. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON FULLY-INSURED PLANS.
- C. APPLY MINIMUM FEDERAL HEALTH INSURANCE REFORM TO ALL HEALTH PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON PLANS BELOW A CERTAIN THRESHOLD NUMBER OF EMPLOYEES (i.e., 5000, 1000, 500, etc.)
- D. APPLY FEDERAL INSURANCE REFORMS AND REQUIRE STATES TO REQUEST WAIVERS TO IMPOSE FURTHER REQUIREMENTS ON PLANS BELOW THE THRESHOLD NUMBER

OPTION 3: To facilitate state and federal enforcement of existing regulations of MEWAs.

POSSIBLE INITIATIVES

CLARIFY EXISTING LAW AND, IN ADDITION, REQUIRE MEWAS TO FILE COPIES OF THEIR STATE LICENSES WITH THE DEPARTMENT OF LABOR (NOTE: Administration-wide staff agreement on this compromise initiative).

OPTION 4: To allow states to implement their own health care reforms by promoting express legislative waivers of ERISA preemption.

POSSIBLE INITIATIVES

- A. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED EXCEPTION FOR STATE LAWS ON COST CONTAINMENT
- B. RETAIN CURRENT ERISA PREEMPTION WITH AN EXCEPTION FOR CERTAIN STATE LAWS RELATING TO FINANCING AND COST CONTAINMENT
- C. RETAIN CURRENT ERISA PREEMPTION WITH BROAD LEGISLATIVE EXCEPTION FOR STATES THAT ENACT LAWS WITH EXTENSIVE COVERAGE EXPANSION
- D. RETAIN CURRENT ERISA PREEMPTION BUT GRANT A LIMITED NUMBER OF INDIVIDUAL STATE WAIVERS THROUGH A LEGISLATIVE OR ADMINISTRATIVE PROCESS

OPTION 5: To enhance the remedies available to enrollees in ERISA plans.

POSSIBLE INITIATIVES

- A. EXPAND FEDERAL REMEDIES AVAILABLE TO PARTICIPANTS FOR "BAD FAITH" CLAIM DENIAL
- B. PROVIDE FOR FEDERAL CIVIL PENALTIES FOR CASES OF BAD FAITH DENIALS
- C. MAKE STATE LAW REMEDIES AVAILABLE TO ERISA PLAN PARTICIPANTS

AGENDA
November 21, 1994

- I. BACKGROUND ON ERISA
- II. THE PROBLEM
- III. THE PROBLEM WITH THE PROBLEM: POLITICS
- IV. POSSIBLE OPTIONS
- V. RECAP AND CONCLUSION

ERISA

I. BACKGROUND

II. THE PROBLEM

- A. INSURANCE REFORMS CANNOT BE EXTENDED TO SELF-INSURED PLANS
- B. ENROLLEES IN MEWAS ARE INSUFFICIENTLY PROTECTED
- C. ERISA AS A POTENTIAL ROADBLOCK TO REFORM
- D. REMEDIES MAY BE INSUFFICIENT

III. THE PROBLEM WITH THE PROBLEM: INTEREST GROUP POLITICS

IV. POSSIBLE OPTIONS

OPTION 1: To continue the present structure of having federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

POSSIBLE INITIATIVES

RETAIN CURRENT ERISA PREEMPTION: STATUS QUO

OPTION 2: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.
(NOTE: Administration-wide staff agreement on this matter -- as was the case in almost every bill last year; no consensus on appropriate state role beyond minimum standards, however.)

POSSIBLE INITIATIVES

- A. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD NOT BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON ANY PLANS.

- B. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON FULLY-INSURED PLANS.

- C. APPLY MINIMUM FEDERAL HEALTH INSURANCE REFORM TO ALL HEALTH PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD BE PERMITTED TO IMPOSE ADDITIONAL REGULATIONS ON PLANS BELOW A CERTAIN THRESHOLD NUMBER OF EMPLOYEES (i.e., 5000, 1000, 500, etc.)

- D. APPLY FEDERAL INSURANCE REFORMS AND REQUIRE STATES TO REQUEST WAIVERS TO IMPOSE FURTHER REQUIREMENTS ON PLANS BELOW THE THRESHOLD NUMBER

OPTION 3: To facilitate state and federal enforcement of existing regulations of MEWAs.

POSSIBLE INITIATIVES

CLARIFY EXISTING LAW AND, IN ADDITION, REQUIRE MEWAS TO FILE COPIES OF THEIR STATE LICENSES WITH THE DEPARTMENT OF LABOR (NOTE: Administration-wide staff agreement on this compromise initiative).

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We have, in the past, recommended that the remedies for compensatory damages be limited to specifically stated items and that recovery for emotional distress, pain and suffering not be allowed. As a practical matter, however, the chances of further expanding ERISA remedies at this point, even to the more limited extent we feel might be appropriate is problematic at best. It will draw substantial criticism from the business community and has only a very limited constituency. Consequently, we do not believe that this is the best time to propose expanded remedies. We have reason to believe that others (including the First Lady) feel that this is an issue that is not worth fighting at this time.

GOP Gains in Congress, States Cast Doubt on State Reforms

After the 103rd Congress' failure to pass a health reform bill, it appeared inevitable that the federal government would take up legislation allowing states to pursue their own solutions. But last week's GOP electoral sweep cast doubts on whether the incoming Republican governors will push as vigorously for state flexibility as their Democratic predecessors did or whether incoming GOP congressional leaders will grant that flexibility. Reform of the 20-year-old Employee Retirement & Income Security Act (ERISA), which exempts self-insured companies from state regulation, is anathema to the majority of large, multi-state businesses. Although Republicans favor giving states more freedom, the GOP also has traditionally been more sympathetic to the concerns raised by big business when it comes to easing ERISA rules. State interest in pushing ERISA also is less clear. Republican candidates won 24 of 34 gubernatorial contests Nov. 8 — with the outcomes in Maryland and Alaska still uncertain — so Republicans now control at least 30 governorships. Consequently, states "are not expected to be too aggressive" on ERISA waivers, says corporate lobbyist Lawrence Atkins. "It's not clear if anyone wants" ERISA reform after the elections, he adds.

Washington state already is bracing for some major changes to its health plan. House Speaker Thomas Foley (D-WA), voted out last week, had promised to help the state get an ERISA waiver. But the outcome of last week's election dashed those hopes. Newly elected conservative state legislators will attempt to strike the controversial employer mandate and eliminate the need for a federal waiver. Still, two bipartisan state groups, the National Governors' Assn. and the Reforming States Group, will continue to seek some form of ERISA modifications. A Labor Dept. subcommittee last week approved one potential political compromise. The Employee Welfare and Pension Benefits Advisory Group Nov. 10 advocated ERISA protection for self-insured firms that voluntarily abide by state health care regulations such as mandatory benefits. The advisory document is set to be delivered to Congress in early 1995 by Labor Secretary Robert Reich, but corporate representatives say it may carry little weight with the new GOP Congress. Another alternative for dealing with ERISA: establishing an administrative, rather than legislative, process for reviewing ERISA waiver requests. The Labor document suggests that waivers be granted only when states have comprehensive state reform initiatives under way. Two House proponents of ERISA reform about to cede their gavels to Republicans on Jan. 4, Reps. Ron Wyden (R-OR), whose home state needs an ERISA waiver, and Pat Williams (D-MT) will co-chair an ERISA hearing Nov. 30 to hear testimony from state, labor, and business representatives. In the Senate, GOPers Mark Hatfield (OR) and James Jeffords (VT) have experience on this issue and could take the lead on crafting a solution acceptable to corporate and labor lobbies when their party takes control in 1995.

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Washington state already is bracing for some major changes to its health plan. House Speaker Thomas Foley (D-WA), voted out last week, had promised to help the state get an ERISA waiver. But the outcome of last week's election dashed those hopes. Newly elected conservative state legislators will attempt to strike the controversial employer mandate and eliminate the need for a federal waiver. Still, two bipartisan state groups, the National Governors' Assn. and the Reforming States Group, will continue to seek some form of ERISA modifications. A Labor Dept. subcommittee last week approved one potential political compromise. The Employee Welfare and Pension Benefits Advisory Group Nov. 10 advocated ERISA protection for self-insured firms that voluntarily abide by state health care regulations such as mandatory benefits. The advisory document is set to be delivered to Congress in early 1995 by Labor Secretary Robert Reich, but corporate representatives say it may carry little weight with the new GOP Congress. Another alternative for dealing with ERISA: establishing an administrative, rather than legislative, process for reviewing ERISA waiver requests. The Labor document suggests that waivers be granted only when states have comprehensive state reform initiatives under way. Two House proponents of ERISA reform about to cede their gavels to Republicans on Jan. 4, Reps. Ron Wyden (R-OR), whose home state needs an ERISA waiver, and Pat Williams (D-MT) will co-chair an ERISA hearing Nov. 30 to hear testimony from state, labor, and business representatives. In the Senate, GOPers Mark Hatfield (OR) and James Jeffords (VT) have experience on this issue and could take the lead on crafting a solution acceptable to corporate and labor lobbies when their party takes control in 1995.

ERISA PREEMPTION

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ERISA OVERVIEW

- ◆ ERISA applies to all private employment related group health plans, of which there are currently more than 3 million covering over 120 million Americans. ERISA does not apply to church plans, governmental plans and most worker's compensation plans.
- ◆ ERISA contains extensive rules for pension plans but few substantive requirements for health plans. Remedies generally provide for only the benefit denied.
- ◆ ERISA has no eligibility or funding rules for health plans. The discrimination rules for health plans are not as comprehensive as the rules for pension plans.
- ◆ The limited reporting and disclosure rules do not provide for timely notice of pertinent plan changes. Currently ERISA only requires that enrollees be notified of material changes within 210 days of the end of the plan year.

BACKGROUND ON PREEMPTION: WHAT PURPOSE HAS IT SERVED?

- ◆ ERISA allows states to regulate health insurance carriers and the group health policies they sell to employers but prevents states from regulating self-insured employee benefit plans.
- ◆ When ERISA was enacted in 1974, states regulated a far larger share of their health insurance market because more employers bought health insurance from state licensed insurers and it was primarily only the largest companies that were self-insured.
- ◆ ERISA preemption was intended to aid large multi-state business and labor organizations by protecting them from being subject to as many as 50 different state regulatory schemes.
- ◆ The roadblock to health care reform at the state level lies with single-state small and medium size employers who self-insure and use ERISA preemption to avoid state mandates and other state requirements. According to a 1991 HIAA survey on self-insurance it is estimated that 76% of all firms that self-insure have less than 500 employees and 67% have less than 100 employees. These are not the type of large multi-state plans ERISA preemption was intended to protect from state regulation.

RECENT PREEMPTION/WAIVER DEVELOPMENTS

- ◆ This year Washington, New York, Oregon, Maryland and Minnesota sought legislation to exempt their individual states from ERISA preemption. Hawaii has sought to have its waiver expanded.
- ◆ At the end of the last legislative session several proposals contained ERISA waivers for a number of individual states along with an administrative process through which DOL could grant additional state waivers.
- ◆ The Administration has participated, through an amicus brief, in the Traveler's Insurance Co. case which was granted certiorari by the U.S. Supreme Court on October 7, 1994. This case involves the application of three separate surcharges added to hospital rates by the New York State legislature. The Second Circuit Court of Appeals held all three surcharges were preempted. The Administration's position in its brief is that the surcharges are not preempted as applied to insurance carriers and the policies they sell to employers. Preemption as applied to self-insured plans is not explicitly at issue in this case, although the Court may nevertheless express its view on the subject. This case may not be heard by the Court until June 1995.

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ERISA ISSUES FOR INSURANCE MARKET REFORM

► **REQUIRE MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs) [i.e., ASSOCIATION PLANS] TO FILE COPIES OF THEIR STATE LICENSES WITH THE FEDERAL GOVERNMENT.**

What Are MEWAs?

- ◆ A multiple employer welfare arrangement (MEWA) is defined by ERISA as an arrangement offering health benefits to employees of two or more employers.
- ◆ Small employers, who often find it difficult to secure affordable health insurance for their employees, find MEWAs attractive because the premiums are comparatively inexpensive.
- ◆ A 1983 amendment to ERISA allows states to regulate the financial solvency of MEWAs while at the same time permitting DOL to have oversight with respect to fiduciary standards.

Why There Are Problems With MEWAs

- ◆ These arrangements can lack financial stability since they often do not have a stable funding source, maintain inadequate reserves and charge actuarially unsound contribution levels. However, the insurance market has not served small businesses well, and, in many places, self-funded MEWAs (sponsored by stable trade associations) are an important alternative source of coverage.
- ◆ Some of these arrangements experience rapid growth and it is in this expansion phase that they begin to resemble a ponzi scheme with more premiums coming in but benefits not being paid out.
- ◆ Such MEWAs do not comply with state law and when caught challenge the state's authority in federal court, using ERISA preemption as a defense. This period of non-compliance and then time consuming litigation is sufficient for the MEWA to enroll thousands of participants, collect large amounts of premiums and then abandon the operation.
- ◆ Minimum federal reporting requirements would fill time gap and prevent the current abuses.

Example of Problems Involving MEWAs

- ◆ According to a 1992 GAO Report MEWAs were operating in 46 states. The report estimated that from 1988 to 1991, unpaid claims by MEWAs totalled over \$123 million and affected almost 400,000 enrollees.
- ◆ In addition to being left with unpaid bills and no health coverage when a MEWA goes out of business, enrollees may be precluded from purchasing coverage elsewhere if they have any pre-existing conditions.
- ◆ The Department of Labor is currently investigating 70 MEWA civil cases and 36 criminal cases. Since the Department began its nationwide criminal MEWA effort in the late 1980s, it has obtained 77 criminal indictments and 70 convictions.

The Solution

- ◆ This initiative would require that MEWAs provide copies of their state licenses to federal authorities prior to beginning operation. This information would then be shared with the states to help them ensure compliance with their laws.
- ◆ New federal authority to allow the federal government to cease the operations of a MEWA that did not file the required license would enable federal authorities to prevent abuses before the MEWA's operations became widespread.
- ◆ This is the least intrusive federal solution. Essentially, it allows regulators to enforce current law by providing a mechanism to notify them that a MEWA exists while there is still time to prevent the damage an insolvent MEWA could cause. (Currently, the authorities are often unaware of a MEWA's operation until they begin to receive complaints from employees covered by the MEWA.) The new requirement will enable authorities to identify arrangements that are not licensed and act quickly to force them to comply or cease operations.
- ◆ Legitimate association plans may complain that they cannot meet state requirements. This, however, is already required under the current law and has been for 10 years. Under the suggested solution states and associations would continue to be free as they are now to work out any special arrangements to accommodate certain associations that may be less financially risky.
- ◆ Existing MEWAs that are complying with state solvency requirements would not be significantly affected by this new requirement.

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STATE FLEXIBILITY / ERISA

November -- , 1994

OUTLINE OF POSSIBLE OPTIONS

The three possible options for dealing with the issue of increasing state flexibility to regulate employment-based health insurance, in order of increasing flexibility, are:

OPTION 1: To continue the present structure of having federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

POSSIBLE INITIATIVES

► **RETAIN CURRENT ERISA PREEMPTION: STATUS QUO**

In this scenario states would continue to regulate health insurance companies but self-funded plans would remain subject only to ERISA's limited requirements. In this system states are limited in achieving reform as employers have the option of choosing to self-insure, thus escaping state regulation entirely.

OPTION 2: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.

POSSIBLE INITIATIVES

A. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS

State laws in these areas would continue to be preempted but new federal insurance reform could help to expand coverage and reduce costs thus solving some of the problems states currently suffer. This initiative, however, does not solve the problem of an increasing number of employers self-insuring to escape state mandates nor will it satisfy every state's individual needs for consumer protection (e.g., additional ERISA reforms including expanded remedies, timely and uniform claims procedures and expedited review for urgent requests).

B. MINIMUM FEDERAL HEALTH INSURANCE REFORM APPLIES TO ALL HEALTH PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD ALSO BE ALLOWED TO IMPOSE ADDITIONAL REGULATIONS ON PLANS BELOW A CERTAIN THRESHOLD NUMBER OF EMPLOYEES (i.e., 5000, 1000, 500, etc.)

This initiative essentially resolves the issue whether only federal rules apply according to the criteria of plan size; currently the determining factor is whether the plan is fully-insured or self-insured.

C. ADOPT THE FEDERAL INSURANCE REFORMS BUT REQUIRE STATES TO REQUEST WAIVERS TO IMPOSE FURTHER REQUIREMENTS ON PLANS BELOW THE THRESHOLD NUMBER

Under this initiative states would only be able to regulate small employers by requesting an administrative waiver from the federal government. This initiative may accomplish more uniformity among state programs by requiring states to meet certain criteria before a waiver is granted.

OPTION 3: To allow states to implement their own health care reforms by promoting express legislative waivers of ERISA preemption.

Many of the initiatives discussed below would permit states to institute laws concerning the financing of health care. It is important to remember that in any such ERISA waiver approach, the waiver could be structured in a way that would make it more acceptable to the affected parties. For example, the permissible financing options could be limited to specific mechanisms -- e.g., provider taxes but not mandates. Alternatively, certain sized firms could be exempted altogether from state financing regulations as long as the firms provided a suitable benefit package for their employees.

POSSIBLE INITIATIVES

A. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED EXCEPTION FOR STATE LAWS ON COST CONTAINMENT

This initiative is limited and thus would cause less disruption of the current market. It will, however, also be less effective in expanding coverage and other reforms. Financing will be improved only to the extent that cost savings are used to extend coverage.

B. RETAIN CURRENT ERISA PREEMPTION WITH AN EXCEPTION FOR CERTAIN STATE FINANCIAL LAWS RELATING TO FINANCING AND COST CONTAINMENT

Under this initiative state laws financing health care and promoting cost containment would apply to plans whether self-insured or fully-insured. This would allow states to do financial regulation to contain costs, expand coverage, raise revenue or achieve other health care reform goals. This initiative alone does not advance insurance reform or administration issues.

C. RETAIN CURRENT ERISA PREEMPTION BUT GRANT A LIMITED NUMBER OF INDIVIDUAL STATE WAIVERS THROUGH A LEGISLATIVE OR ADMINISTRATIVE PROCESS

Under this initiative specific statutory criteria would need to be established against which the states seeking waivers would be measured. Granting individual state waivers could be done on a limited basis, such as for a certain number of states for a period of 5 years. The waivers could be granted as part of a research or demonstration project and an executive branch interagency commission could be established to grant the waivers.

D. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED LEGISLATIVE EXCEPTION FOR STATES THAT ENACT LAWS WITH BROAD COVERAGE EXPANSION

This initiative would allow states to enact more comprehensive reforms (e.g., "pay or play" taxes, single-payer systems, etc.). This initiative essentially exempts from ERISA preemption state laws that are part of a comprehensive reform system that would not be exempt under the more limited exceptions for cost containment and financing listed in initiatives 3(A) and 3(B).

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STATE FLEXIBILITY / ERISA

November -- , 1994

The three possible options for dealing with the issue of increasing state flexibility to regulate employment-based health insurance, in order of increasing flexibility, are:

1. Status Quo: To continue the present structure of both federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

2. Insurance Reform: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.

3. State Waivers: To allow states to implement their own health care reforms by promoting express legislative waivers of ERISA preemption.

Note: This paper outlines several initiatives involving state flexibility on health care issues and ERISA preemption of state law. It is important to recognize that more than one initiative may be chosen as several of these efforts could work well together. This paper does not deal with Medicaid waivers or other federal laws where state flexibility might also be increased.

For the past several years the National Governors' Association (NGA) has adopted a policy promoting ERISA reform in order to allow states to implement their own health reforms to improve access to quality and affordable care. The NGA has stated that they are aware of the concerns of large multi-state employers and that they are looking for solutions that balance the needs of the states and the business community.

The NGA has identified the following four major considerations where state flexibility is important to them: Coverage Expansion/Financing, Cost Containment, Insurance Reform and Administration. Provided below is a general discussion of these four considerations as presented in a recent NGA report and how state laws could address them under each of the three options:

Coverage Expansion/Financing

States could attempt to expand coverage through employer mandates and taxes on employers (including payroll taxes), plan contributions and/or health care providers.

Cost Containment

States could set provider rates (either uniform or varying) and require all health plans to participate in overall spending limits.

Insurance Reform

States could limit pre-existing condition exclusions, impose other market reforms and create reinsurance pools for high risk cases. States could also be allowed to require self-funded plans to comply with open enrollment and community ratings, risk adjustment mechanisms and assessments.

Administration

States could require self-funded plans, in the same manner as insured plans, to:

- ◆ Report services utilized, cost and quality information
- ◆ Use uniform claims procedures
- ◆ Participate in purchasing pools
- ◆ Meet quality review organization standards for fair review

RECENT DEVELOPMENTS:

- ◆ This year, Washington, New York, Oregon, Maryland and Minnesota sought legislation to exempt their individual states from ERISA preemption. Hawaii has sought to have its waiver expanded. As many as 26 other states may also be considering requesting exemptions from ERISA preemption.
- ◆ The Administration has participated, through an amicus brief, in the Traveler's Insurance Co. case which was granted certiorari by the U.S. Supreme Court on October 7, 1994. This case involves the application of three separate surcharges added by the New York State legislature on hospital rates. The Second Circuit Court of Appeals held all three surcharges were preempted. The Administration's position in its brief is that the surcharges are not preempted as applied to insurance carriers and the policies they sell to employers. Preemption as applied to self-insured plans is not explicitly at issue in this case, although the Court may nevertheless express its view on the subject. This case may not be heard by the Court until June 1995.

OPTION 1: To continue the present structure of having federal and state regulation of health insurance bought from insurance companies and only federal regulation of self-insured employment-based health plans.

POSSIBLE INITIATIVES

A. RETAIN CURRENT ERISA PREEMPTION: STATUS QUO

In this scenario states would continue to regulate health insurance companies but self-funded plans would remain subject only to ERISA's limited requirements. In this system states are limited in achieving reform as employers have the option of choosing to self-insure, thus escaping state regulation entirely.

Considerations:

Coverage Expansion/Financing

Under this initiative states would continue to be generally barred from imposing taxes, mandates, premium assessments, etc. on any ERISA plan whether self-insured or fully-insured.

Cost Containment

It is unclear whether states can presently set provider rates. States are prohibited from setting global budgets for self-funded plans.

Insurance Reform

States insurance reform measures would continue to have limited effect as they would only apply to insurance companies and employers who purchase insurance but would not apply to self-insured health plans.

Administration

States would be able to continue to require insurance carriers to report data, etc. but they could put no requirements on self-insured plans.

OPTION 2: To apply minimum federal insurance reforms to all health plans with options for additional state regulation.

POSSIBLE INITIATIVES

A. APPLY HEALTH INSURANCE REFORMS THROUGH FEDERAL REQUIREMENTS FOR ALL HEALTH INSURANCE PLANS, INCLUDING SELF-INSURED PLANS

Examples of possible reforms:

- ◆ Prohibit pre-existing condition exclusions
- ◆ Require guaranteed issue and renewal of insurance
- ◆ Prohibit disease specific caps

Considerations:

Coverage Expansion/Financing, Cost Containment

State laws in these areas would continue to be preempted but new federal insurance reform could help to expand coverage and reduce costs thus solving some of the problems states currently suffer.

Insurance Reform

In this initiative federal reforms would help with some basic rules and states would be free to add requirements on insurance companies. This initiative does not solve the problem of an increasing number of employers self-insuring to escape additional state mandates.

Administration

Federal insurance reforms may solve some of the problems in this category but it may not satisfy every state's individual needs for consumer protection (e.g., additional ERISA reforms including expanded remedies, timely and uniform claims procedures and expedited review for urgent requests).

B. MINIMUM FEDERAL HEALTH INSURANCE REFORM APPLIES TO ALL HEALTH PLANS, INCLUDING SELF-INSURED PLANS. STATES WOULD ALSO BE ALLOWED TO IMPOSE ADDITIONAL REGULATIONS ON PLANS BELOW A CERTAIN THRESHOLD NUMBER OF EMPLOYEES (i.e., 5000, 1000, 500, etc.)

This initiative essentially resolves the issue whether only federal rules apply according to the criteria of plan size; currently the determining factor is whether the plan is fully-insured or self-insured.

Considerations:

- ◆ This option would allow the states to move ahead with reform efforts and also protect national uniformity of plan administration for medium and larger business and labor organizations. The higher the threshold cutoff, the greater amount of state flexibility results.
- ◆ This structure has an arguable policy basis as it seeks to balance the goal of national uniformity of structure for those larger plans that need it most and increases state flexibility by expanding state regulation over smaller plans.

Coverage Expansion/Financing, Cost Containment

Would allow states to extend requirements to small employers (e.g., an employer mandate, a "pay or play" tax, etc.) that would increase the number of enrollees covered through their employers or give the states a larger base for obtaining revenue to operate their own programs to provide coverage. The impact of this new flexibility will vary according to the number of small versus large employers in each state.

Insurance Reform

This initiative would allow the states to regulate employers below the threshold level who are presently self-insuring.

Administration

This initiative will permit states to require better data collection and higher quality standards from a larger group of employers which should produce a more level playing field for participants.

C. ADOPT THE FEDERAL INSURANCE REFORMS BUT REQUIRE STATES TO REQUEST WAIVERS TO IMPOSE ADDITIONAL REQUIREMENTS ON PLANS BELOW THE THRESHOLD NUMBER

Under this initiative states would only be able to regulate small employers by requesting an administrative waiver from the federal government. This initiative may accomplish more uniformity among state programs by requiring states to meet certain criteria before a waiver is granted.

OPTION 3: To allow states to implement their own health care reforms by promoting express legislative waivers of ERISA preemption.

This option could be achieved with or without federal insurance reform. If federal reform is adopted then the states, including those granted waivers, would not be allowed to drop below the federal minimum standards.

Many of the waiver approaches discussed below would permit states to institute laws concerning the financing of health care. It is important to remember that in any such ERISA waiver approach, the waiver could be structured in a way that would make it more acceptable to the affected parties. For example, the permissible financing options could be limited to specific mechanisms -- e.g., provider taxes but not mandates. Alternatively, certain sized firms could be exempted altogether from state financing regulations as long as the firms provided a suitable benefit package for their employees.

POSSIBLE INITIATIVES

A. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED EXCEPTION FOR STATE LAWS ON COST CONTAINMENT

This initiative is limited and thus would cause less disruption of the current market. It will, however, also be less effective in expanding coverage and other reforms.

Considerations:

Coverage Expansion/Financing, Cost Containment

This initiative improves financing only to the extent that cost savings are used for those specific purposes.

Insurance Reform, Administration

This initiative does not expressly advance insurance reform or administration considerations although if cost savings are achieved other reforms may follow.

B. RETAIN CURRENT ERISA PREEMPTION WITH AN EXCEPTION FOR CERTAIN STATE FINANCIAL LAWS RELATING TO FINANCING AND COST CONTAINMENT

Considerations:

Coverage Expansion/Financing, Cost Containment

Under this initiative state laws financing health care and promoting cost containment would apply to plans whether self-insured or fully-insured. This would allow states to do financial regulation to contain costs, expand coverage, raise revenue or achieve other health care reform goals.

Insurance Reform, Administration

This initiative does not advance insurance reform or administration considerations.

C. RETAIN CURRENT ERISA PREEMPTION BUT GRANT A LIMITED NUMBER OF INDIVIDUAL STATE WAIVERS THROUGH A LEGISLATIVE OR ADMINISTRATIVE PROCESS

Under this initiative specific statutory criteria would need to be established against which the states seeking waivers would be measured. Granting individual state waivers could be done on a limited basis, such as for a certain number of states for a period of 5 years. The waivers could be granted as part of a research or demonstration project and an executive branch interagency commission could be established to grant the waivers.

Consideration:

- ◆ Any state receiving a waiver would be able to regulate all health plans in that state to the extent allowed under the statutory criteria, including in the areas of coverage expansion/financing, cost containment, insurance reform and administration. Those states not receiving a waiver would remain in the same position as they are today.

D. RETAIN CURRENT ERISA PREEMPTION WITH A LIMITED LEGISLATIVE EXCEPTION FOR STATES THAT ENACT LAWS PROVIDING FOR COMPREHENSIVE HEALTH CARE REFORM

This initiative would allow states to enact more comprehensive reforms (e.g., "pay or play" taxes, single-payer systems, etc.). This initiative essentially exempts from ERISA preemption state laws that are part of a comprehensive reform system that would not be exempt under the more limited exceptions for cost containment and financing listed in initiatives 3(A) and 3(B).

► REQUIRE ALL INSURERS (INCLUDING SELF-INSURERS) TO ADHERE TO ENHANCED UNIFORM BENEFIT CLAIMS PROCEDURES AND REMEDIES

Current Problem Involving Remedies

- ◆ The only remedy for enrollees in ERISA plans (whether self-insured or fully insured) whose benefit claims are denied in bad faith is recovery of the initial cost of the benefit denied.
- ◆ Thus, unlike other legal relationships, no other additional recovery is allowed even where the bad faith denial resulted in further medical harm, economic loss or even death.
- ◆ Under current law, insurers, including managed care organizations and self-insurers, may have a financial incentive to deny claims because even if they lose in court they will be liable only for the original benefit and possibly some costs, even if the denial was in bad faith and resulted in further medical harm.

Current Problem Involving Benefit Claims Procedures

- ◆ ERISA's existing timeframes and standards for benefit claims review are not timely for health care benefits and give deference to any decisions made by the plans. For example, enrollees need only be notified of material modifications to the plan within 210 days after the end of the plan year.

Possible Options

- ◆ Expand remedies available to participants for "bad faith" claim denial:
 - Permit recovery for economic losses (e.g., lost wages);
 - Permit recovery for non-economic damages (e.g., pain and suffering);
- Alternative dispute resolution procedures could be offered or required.
- ◆ Provide for federal civil penalties for cases of bad faith denials.
- ◆ Make state law remedies available to ERISA plan participants.
 - Could be applied to insured plans regulated by states or to all ERISA plans.

◆ Apply new federal requirements and/or remedies to all ERISA plans (insured and self-funded).