

Tax Incentives File

## Acceleration of Self-Employed Health Insurance Deduction

Under the proposal, self-employed individual would be able to deduct 100 percent of health insurance expenses as early as January 1, 1999. Under current law, this deduction is scheduled to phase up to 100 percent in the year 2007.

- In general, we support the principle of increasing the health insurance deduction for self-employed individuals to 100 percent.
- However, we do not support the provision in this context. The provision is very expensive and the Federal offset is needed for
  - health and other investments that have an focus on children.
  - research and public health investments that are critical for reducing tobacco use among children and for accelerating our success in developing diagnostic, treatments and cures associated with cancer and other diseases.
- Revenue loss (OTA) associated with the self-employed portion of the proposal is \$5.6 billion (FY1998 - FY2003) and \$7.9 billion (FY1998 - FY2008).

June 3, 1998

Sec. 934. BPA

	Current Law	BPA	COST
97	40%	40%	
98	45%	45%	
99	45%	45%	
00	45%	50%	\$ 39 m
01	45%	50%	\$ 120 m
02	45%	50%	\$ 224 m
03	50%	60%	\$ 604 m
04	60%	80%	\$ 882
05	70%	80%	
06	80%	90%	601
07	80%	100%	404
			604
			\$ 3,478 m
			98-02

To Do  
 Weekend Note to Specializing a Nucleic Mapping

## Impairment-Related Work Expenses of Handicapped Individuals June 2, 1998

### Rationale

- Recognize that disabled individuals incur additional costs in order to work and earn taxable income, and thus do not have the same ability to pay as taxpayers who do not incur such expenses.

### Current Law

- Allows itemized deduction for impairment-related work expenses of handicapped individuals. The deduction is not subject to 2 percent floor.
- For purposes of the deduction, a handicapped individual is defined as:
  - ▶ Any individual who has a physical or mental disability (including, but not limited, to blindness or deafness), which for such individual constitutes or results in a functional limitation to employment, or who has any physical or mental impairment (including, but not limited to, a sight or hearing impairment), which substantially limits one or more major life activities.
- Impairment-related work expenses are defined as expenses for attendant care services at the individual's place of employment and other expenses in connection with such place of employment which are necessary for such individual to be able to work.
  - ▶ Impairment-related work expenses must be ordinary and necessary and paid or incurred during the taxable year in carrying on any trade or business. (Depreciable capital items, which are not ordinary and necessary, are not included under the definition of impairment-related work expenses. These expenses, however, can be deducted as a miscellaneous employee expense. Unlike impairment-related work expenses, miscellaneous employee expenses are subject to the 2 percent floor.)

*only Available*

### Option: Replace Itemized Deduction for Impairment-related Work Expenses with Nonrefundable Credit

- The credit rate would be equal to 50 percent.
- The credit would be applicable to the first \$10,000 (in excess of a \$200 minimum) of qualifying expenses. Taxpayers must have at least \$200 of qualifying expenses to be eligible, and qualifying expenses cannot exceed earnings of handicapped individual.
- The maximum amount of qualifying expenses would be indexed for inflation, using a \$1,000 round-down rule.

- Same definition of handicapped individual as under the current law itemized deduction for impairment-related work expenses, but with two additional requirements:
  - ▶ Disability or impairment has lasted or can be expected to last for a continuous period of not less than 12 months.
  - ▶ Eligible individuals would be required to furnish such proof thereof (in such form and manner, and at such times) as the Secretary may require.
- Same definition of impairment-related work expenses, as under the current law itemized deduction for impairment-related work expenses, but with the following modifications:
  - ▶ Not restricted to ordinary and necessary.
  - ▶ Taxpayer must choose between expensing and depreciating a particular capital expenditure.
  - ▶ Credit applies only to depreciation for property placed in service after date of enactment.
  - ▶ For disabled taxpayers who work at home, expenses should be limited by the same rules currently applicable to home office deduction.
- No interaction with AMT or tentative tax.
- No carryforward of unused credit.
- Effective for tax years beginning after December 31, 2000.

**Very Preliminary Revenue Estimate:** Roughly \$150 million a year.

? %      30,000  
150,000

## QUALITY PROTECTIONS

- **PATIENTS' BILL OF RIGHTS.** There has been some movement on this issue on the Hill. (Daschle and Lott have agreed to bring the Republican bill up in June under time-limited debate and Dingell has filed a discharge position for his bill in the House). The Republican Leadership continues to offer a package that falls far short of giving patients the protections they need, which will provide yet another opportunity to clarify the important differences. There is a good chance that it will still not have passed by 2000.
- **COMPREHENSIVE MEDICAL PRIVACY PROTECTIONS.** There is some movement on this issue as the Senate Labor Committee just released their mark on this bill and some chance that legislation will pass this year. If this legislation does not pass, the Administration has been given the authority to implement these protections through executive action, although we do not have the authority to implement all the protections patients need. We recommend you continue to be visible on this issue throughout the debate this year.
- **ENDING GENETIC DISCRIMINATION.** This legislation to prevent health insurers and employers from discriminating on the basis of genetic information will not likely move on the Hill this year unless it is incorporated into the patients' bill of rights. This legislation is increasingly important as scientists complete the Human Genome Project and should be incorporated into your message on this issue. It is also popular the cancer community as well.
- **REQUIRING HEALTH PLANS TO COVER CONTRACEPTION.** This legislation, along with the increase in the Family Planning grants, is a top priority for the women's health community. The Administration has not formally endorsed this legislation, primarily because it lacks a conscience clause for those plans with religious objections to opt out (which most people agree is a reasonable exemption). We recommend that you talk publicly about the importance of this legislation but include in your discussion the need for a conscience clause.

## HELPING THE UNINSURED

- **MEDICARE BUY-IN.** This proposal is in the Administration's budget and is unlikely to pass unless it is part of a broader Medicare reform package. It is popular among aging advocates and can be discussed as part of your overall package to increase access to health care coverage to all Americans.
- **SAFETY NET.** The Administration's budget also includes \$1 billion over five years to help strengthen institutions that help the uninsured, such as public hospitals and community health centers. This proposal is popular among some liberals, including unions, and underscores our commitment to helping those who continue to be uninsured. This initiative will not likely pass.

## LONG-TERM CARE

Many components of the Administration's long-term care policy, including the tax credit and the National Family Caregiving Proposal, could be enacted this year depending on an overall agreement on the budget and use of the surplus for a tax credit. (Each component is on different legislative tracks). The proposal to allow Federal employees to buy private long-term care insurance has the best chance and will likely pass. It is unlikely that the Medicaid proposal to allow states move people into home and community-based services without a waiver will pass.

## IMPROVING PUBLIC HEALTH

- **RACE AND HEALTH.** The Administration's race and health initiative includes about \$100 million per year to help reduce disparities in several key areas, including diabetes and cancer. It is popular among minority public health groups and will likely get some funding in the appropriations process.
- **AIDS FUNDING (INCLUDING CBC AIDS PROPOSAL).** Funding for Ryan White, the Congressional Black Caucus initiative to fund stop the crisis of HIV in minority communities, and other AIDS prevention funding are all subject to the appropriation process. They are all likely to get some funding depending on what happens with the budget caps in the upcoming appropriations process.
- **FAMILY PLANNING.** Again this proposed increase is likely to get some funding subject to caps.

## REPUBLICAN IDEAS ON HEALTH CARE

- **TAX CREDIT FOR HEALTH CARE COVERAGE AND LONG-TERM CARE.** Some Republicans, such as Rep. Nancy Johnson and Rep. Bill Thomas are talking about a tax credit to help pay for coverage (possibly \$500 or \$1,000 credit). Republicans are also talking about a tax credit for long-term care similar to ours expect they would allow people to buy long-term care insurance. (Most people with three ADLs who are covered by our credit could not access private ltc insurance in the current market).
- **MEDICAL SAVINGS ACCOUNTS.** Republicans are still pushing to expand the availability of MSAs both for the Medicare population and the under-65 population that would cherry-pick the healthy populations, further segmenting the insurance market. In Medicare it would make for a sicker and weaker traditional program.

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- **HEALTH MARTS AND MEWAS.** These are Republican attempts to help the uninsured by enabling these arrangements to avoid state insurance regulation and any state mandates. These are opposed by consumers, providers, insurers, and states because they would cherry-pick the healthy and further segment the insurance market.

## BRADLEY'S IDEAS ON HEALTH CARE

Bill Bradley continues to talk about his goal of covering all Americans. However, he has yet to lay out a specific proposal for how he would achieve this goal.

## **Covering the Parents of Children**

### **Summary**

This proposal would expand the Children's Health Insurance Program to the parents of children (up to 200 percent of poverty) who are insured by Medicaid or CHIP. This would cost about \$30 billion over five years and cover an estimated 3.2 million uninsured parents, although it could probably be scaled back to about \$20 billion.

### **Background**

Most of the parents of uninsured children are themselves uninsured, as parents rarely cover themselves and not their kids. In fact, there are currently over 7 million uninsured parents whose children are eligible for, or enrolled in Medicaid or CHIP.

### **Policy**

This proposal would allocate Federal funds to states at the CHIP matching rate (which states like because it is higher than the Medicaid matching rate) to expand health care coverage to parents of children under 200 percent of poverty. Just like with CHIP, states would be required to offer benefits' package comparable to a commercial plan or some other benchmark plan. (States also prefer this to Medicaid because it provides more flexibility). Also similar to CHIP, parents with health care coverage would not be eligible for these programs.

This program would be a capped entitlement so states could cover as many parents as possible with their allotted funds. However, states would have the flexibility to cover parents up to 200 percent of the poverty level.

States would also be able to use their CHIP dollars for this purpose provided they have already covered children up to 200 percent of poverty and if they do not provide coverage for adults at a higher level of poverty than children.

### **Pros**

This proposal would be a meaningful coverage expansion for millions of uninsured adults. It would also have the indirect impact of having many children enroll in the CHIP or Medicaid programs because it holds families together allowing them to apply together for coverage. It would also end the current irrational policy that allows pregnant women coverage until their baby is born and would also be extremely helpful for fathers who are generally not in jobs that receive health care coverage.

CHIP has been popular in states with both Republican and Democratic Governors and in only a little over a year 47 states have applied for funding for this new program. Some states have clearly indicated an interest in expanding their proposals to the adult populations. This program builds on the strengths of the CHIP model in that it gives states flexibility to design programs that meet their needs, while assuring Federal accountability. Moreover, most health care validators would far prefer this incremental approach to health care coverage than a tax credit approach as they believe subsidies are far more effective at providing coverage.

## **Cons**

This program, like all incremental coverage policies, certainly will not lead to universal coverage. In fact, it would even leave millions of adults without children without access to affordable health care coverage. This policy builds on the CHIP model that leaves many of the design issues up to the states and gets further away from minimum Federal standards for coverage. There are, in fact, large variations in states in the area of coverage and this proposal would only further expand that trend. Moreover, the CHIP program has been, by some accounts, slow to get off the ground. There could be some criticisms that we are proposing to fund more state subsidies that do not prove to work.

## **Policy**

One option is to offer this program only to the states that provide coverage to parents up to 100 percent of poverty under the normal Medicaid matching rate. States already have the authority to cover these adults -- and those at higher rates of poverty -- although most have not chosen this approach. However, given the budget surplus and the money states will receive through the tobacco settlement, most have the funds to cover these populations if they want. Funding at only the Medicaid match up to 100 percent is probably better policy than providing a higher matching rate for adults that states already could and should be covering. It would also cost less money to cover more people since states would cover these adults at a lower Federal-matching rate.

The disadvantage of this approach is that fewer states would take up this proposal. It is not entirely clear that the option to cover their higher income populations (which they can already do under Medicaid) at a better matching rate would be enough of an incentive to expand in this area.

The alternative, which we recommend, is to extend the enhanced match for states that choose any expansions for adults. Even with this proposal, it is important to assure that states do not cover parents that are at higher poverty rates than other parents they have not chosen to cover.

## DRAFT: INSURING PARENTS THROUGH MEDICAID AND CHIP

### Eligibility

- 1.5 million uninsured parents have children enrolled in Medicaid
- 3.1 million uninsured parents have uninsured children eligible for Medicaid
- 2.7 million uninsured parents have uninsured children eligible for CHIP
  
- 7.3 million uninsured parents could be eligible

Source: Thorpe & Florence, 1998

### Potential Enrollment: Assuming all states participate

- 2.7 million parents in Medicaid  
(Assuming that 75% of parents with children already enrolled in Medicaid participate, and 50% of parents with children eligible but unenrolled participation)
- 1.6 million parents in CHIP (assuming same participation rate as we assume in CHIP (60%))
  
- 4.3 million uninsured parents total (note: assumes no crowd out)

### Potential Enrollment: Assuming 75% of people are in states that participate

- 2.0 million parents in Medicaid
- 1.2 million parents in CHIP
  
- 3.2 million uninsured parents total

### Costs:

Assuming CBO's 1999 adult per capita costs of about \$2,500 total in 2001 and 65% match rate:

	2001	2002	2003	2004	2005	TOTAL
CHIP	2.5	2.5	2.75	2.75	3.0	13.5
Medicaid	3.0	3.1	3.3	3.5	3.6	16.5
<b>Total</b>	<b>5.5</b>	<b>5.6</b>	<b>6.05</b>	<b>6.25</b>	<b>6.6</b>	<b>30.0</b>

Notes: For CHIP allotment estimate, assumes that all states participate  
Medicaid estimate in year one rounded to the nearest billion; trended by 5% in subsequent years.

## **Workers In-between Jobs**

### **Summary**

One incremental approach to helping provide health care coverage for the growing number of uninsured Americans is to subsidize health insurance for workers who are temporarily unemployed. This type of proposal would help a small but important portion of the uninsured -- those who have worked and played by the rules but are unable to afford health coverage while they are between jobs. However, in the past, this type of policy approach has not attracted much momentum or broad-based support.

### **Background**

Families who lose health insurance while they are between jobs are a small but important group of uninsured Americans. These Americans pay for health insurance for most of their lives, but go through brief periods without coverage when they are temporarily unemployed. If they experience a catastrophic illness during this transition, the benefit of their years worth of premium payments are lost. Worse, for families with an ill child or a worker with a chronic condition, the loss of health insurance while between jobs can make it financially impossible to regain coverage (as a break in coverage would preclude families benefiting from the Kassebaum-Kennedy portability protections enacted in 1996).

As health insurance is generally linked to employment (nearly 148 million Americans receive health insurance through an employer-based plan), changes in employment have important implications for the uninsured. A 1996 study showed that approximately 42 percent of workers with one or more job interruptions experienced at least a month without health insurance (as compared to 13 percent without job interruptions). Another study estimates that 58 percent of the two million Americans who lose their health care coverage each month cite some type of change in employment as the primary reason.

The 1986 Consolidated Omnibus Reconciliation Act (COBRA) allows most employees who lose or leave their jobs to purchase health care coverage from their former employer for up to eighteen month provided they pay the full cost of coverage. Although this can be quite expensive it is for many a better option than buying into an often more expensive individual market, particularly for those with pre-existing conditions. Currently, about 20 to 25 percent of COBRA-eligibles are electing coverage. However, cost clearly represents a significant barrier for those who are not choosing COBRA (only 15 percent of low-income Americans take up COBRA where 30 percent of the middle class do).

## **Policy**

There are different policy approaches to address this problem -- some more expansive than others. The approach the Administration proposed in 1996 gave grants to states to provide temporary premium assistance to eligible low-income families to partially subsidize families' premium payments for up to 6 months. This proposal covered Americans with incomes below 240 percent of poverty for workers who previously had health insurance through their employer. It provided states the flexibility to decide the way to best build on existing programs (e.g., subsidize COBRA or allow Americans to buy into Medicaid). This type of proposal costs about \$2.5 billion per year and is estimated to cover about 3 million Americans.

There are clearly more expansive approaches as well. For example, there does not have to be a six-month limit, as many Americans may well not be able to locate a job in this period of time (although some argue that an unlimited proposal would provide a disincentive to finding a new job). One could also remove the requirement that individuals must be coming from a job with insurance, as clearly some of those most in need may not have had coverage in the first place. Opponents would argue that offering it to those who had a job without coverage could give those incentives to leave their job for health insurance. Clearly these types of expansions would also increase the number of Americans who are covered as well as the cost of this proposal.

There are ways to limit this type of a proposal as well by constructing it as a demonstration that a limited number of states could apply for or by limiting the amount of the subsidy. Of course, as we ratchet it down less it clearly helps fewer Americans. For example, a demonstration of \$1 billion over 5 years would cover about 230,000 people; while a demonstration of \$2.5 billion would cover about 600,000.

## **Pros**

This is also a somewhat sympathetic group of uninsured in that it's workers have played by the rules and are suddenly left without health coverage. Many people who are in between jobs have trouble paying for their premiums. For the majority of workers who do not currently elect to use COBRA, the costs of coverage presents a significant barrier. In an increasingly mobile economy where more workers are changing jobs, this would provide peace of mind that a brief period of unemployment will not put one at major risk of being uninsured. It also will prevent some "job lock", as individuals may feel more comfortable changing jobs knowing this type of option is available.

This policy also helps both low-income and middle class workers as studies show that more than one-third of participants would come from families with incomes over \$31,200, for a family of four. Moreover, there are many incremental health coverage approaches that cover a high number of already insured Americans (sometimes in far greater numbers than cover those who are currently uninsured). This policy would subsidize some Americans that are already buying COBRA unsubsidized today or who have other coverage options, but more than many policies, it would help a group who has trouble getting coverage.

**Cons**

The downsides of this type of proposal are that it does not address a significant portion of the uninsured population. Some also argue that this is not the most compelling population, as we are subsidizing the unemployed while millions of uninsured workers have no access to affordable health coverage. Opponents would argue that this type of policy would encourage unemployment and discourage the unemployed from looking for a job -- although there is little data to suggest that Americans would pass up a job to keep health insurance that was scheduled to run out in six months.

Moreover, in the past, this policy has never attracted broad-based popular support. Even some of the constituencies who would think predisposed to such an approach, such as the labor community, have not been particularly invested in this policy. This may well continue to be the case, particularly in this type of economy where there are such low rates of unemployment.

## **More Affordable Health Insurance for Small Businesses**

### **Summary**

This initiative would encourage small businesses to offer health insurance to their workers by developing and/or joining voluntary coalitions for purchasing health insurance. It would: (1) provide a tax credit to small businesses who decide to offer coverage by joining coalitions; (2) provide seed grants to small businesses or other entities who want to get involved in these coops; and (3) potentially allow these policies to avoid the state mandates if they offer a policy equivalent to FEHBP. This proposal would cost in the range of \$250 million over five years.

### **Background**

Workers in small firms are less likely to have access to affordable, job-based health insurance. Although worker in firms with fewer than 25 employees make up about 30 percent of the workforce, they comprise nearly half of the uninsured. Over a quarter of private-sector workers in firms with fifty or fewer employees lack health insurance -- significantly more than the national average (about 17 percent of workers). Only one-third of firms with fewer than 10 employees and two-thirds of firms with 10 to 24 employees offer coverage compared to over 95 percent of large firms.

Small employers state that high premiums, the uncertainty in premium costs, and administrative costs are major reasons why they do not offer health insurance. Their administrative costs can be as high as 30 percent of premiums -- more than six times as high as many employers. As a result of this and other factors, small firms typically offer less generous benefits -- or do not offer coverage at all.

### **Proposal**

This initiative would encourage small businesses to participate in voluntary health purchasing coalitions that pool employees across firms to gain market power; negotiate with insurers over benefits and premiums; provide comparative information about available health plans; and administer premium payments made by small employers and their participating employees.

Despite these advantages, there are few small business health purchasing coalitions today. This, in part, reflects the lack of up front funding to develop coalitions. Small businesses are willing to pay membership fees to cover the ongoing operation of coalitions, but the startup costs -- hiring staff, developing a negotiating strategy, marketing to small businesses, etc. -- can be prohibitive. Additionally, coalitions that cannot quickly attract a large enough number of small firms to join them could find themselves without the bargaining power that they need to reduce costs and offer choice.

Eligible employers would receive a credit equal to twenty-five percent of their contributions to employee health plans, up to \$500 for a single policy and \$1250 for a family policy. This credit could be temporary (would begin to phase out at two years) since this policy is intended to encourage the one-time action of joining the coalition. The small business health plan credit would be treated as a part of the general business credit, and would be subject to the limitations of that credit.

A qualifying small business would have to have between 3 and 50 employees and purchase coverage through a qualified coalition. To target the credit to employers, who would not otherwise offer coverage, eligible employers could not have had an employee health plan during any part of 1997 or 1998. Employers would need to cover seventy percent of those workers who have wages (including deferred wages) in excess of \$10,000 and who are not covered elsewhere by a health plan.

This would also provide start up grants of about \$50 million to help encourage and develop these co-ops. One additional option is to have plans participating in these insurance models to be exempt from any state benefit mandates, which small businesses find extremely burdensome. Instead, they could choose to offer the benefits' package offered by the Federal Employees Health Benefits Proposal. They could also use the Office of Personnel Management, which runs FEHBP and has considerable experience in working with private plans, to help coordinate a bidding process negotiating benefits and premiums, and distributing consumer information. To help small business health purchasing coalitions do the same, it would provide any needed technical assistance to qualified coalitions, sharing its administrative experience.

## **Children's Health Insurance Outreach**

### **Summary**

One important aspect of reducing the number of uninsured Americans is to assure that families are using health insurance options that are currently in place. Many of the 11 million uninsured children are eligible for Medicaid or the new Children's Health Insurance Program. This proposal would use some of the funding in place for this program to launch an aggressive outreach effort to increase rapidly the number of children that are enrolled in these programs, by giving states and school districts that implement model outreach policies bonuses for the children they sign up.

### **Background**

There are over four million uninsured children that are eligible for the Medicaid program that are not enrolled. As states implement the Children's Health Insurance Program, there are likely to be even more children who are eligible for Federal/state health insurance programs that are not signed up. Moreover, there is evidence that the CHIP program is not currently spending all of its money, as these programs have been slower than anticipated to start up.

The Administration has taken steps to launch a major public-private outreach campaign to help enroll these kids, including a 1-800 number and involving consumer groups and private companies to help spread the message about this new program. While this campaign is in its beginning stages and we believe will be helpful, other strategies are clearly needed to help address this important problem.

### **Policy**

#### Bonuses to States

This proposal would provide bonuses to states that implement model outreach practices to sign kids up and who are aggressively enrolling eligible children. These states would receive a one-time bonus for each child that signs up for the program.

In order to be eligible for this program, states would have to implement a series of outreach activities that have proven to be quite effective, including: (1) a shortened eligibility form; (2) mail-in applications so that families don't have to go to welfare offices to sign up; and (3) places in schools, Head Start centers, and childcare centers where kids and their families can sign up for health care coverage; and specific outreach days where kids and families can sign up.

States that adopt these model outreach policies would be eligible for bonus grants for each child that signed up for these policies.

#### Bonuses for School Districts

School districts would also be eligible for these per child bonuses if they implement aggressive outreach strategies in their school districts, such as having programs to sign up efforts in the schools.

**Cost**

In the first year, this program would be paid for by the current funding within the Children's Health Insurance Program in the first year, and funding sources could be revisited after that time.

## **Analysis of Tax Credit to Provide Coverage for Uninsured Americans**

### **Summary**

One approach to providing health care coverage for the uninsured is to offer some type of a tax credit for those who purchase insurance. While using the tax code to help reduce the number of uninsured appears to be popular and may be a feasible way to expand coverage in the current environment, there are some concerns about this approach that need to be carefully considered and further explored. This memo provides some background information and outlines a few of the advantages and problems with this type of proposal.

### **Background**

The Census Bureau recently estimated that 43.7 million Americans are uninsured -- an increase of 1.7 million from 1996 and nearly 5 million more than in 1992. After initial efforts to expand coverage to all Americans, this Administration has continued to propose incremental reforms to provide more Americans access to affordable health care coverage.

We enacted the Kassebaum-Kennedy bill in 1996, making coverage more portable and increasing the tax deduction for the self-employed, and passed the Children's Health Insurance Program, providing subsidies to cover uninsured children. We have also proposed to allow Americans ages 55 to 65 -- the fastest growing group of uninsured -- to buy into Medicare and provided incentives to small businesses to join voluntary purchasing co-ops in order to expand access to coverage to their employees.

One way to expand coverage further would be to provide a targeted tax cut for health insurance. There are a variety of different approaches to using the tax system to provide health coverage, such as a fixed dollar tax credit, an income-related tax credit, or a credit for a percentage of actual health insurance costs. Some Republicans have already advocated for tax credits for the purchase of individual health insurance, as has Representative McDermott and some other Democrats.

### **Pros**

Given the fact that budget caps leave little room for additional investments on the spending side, the tax code may be the most viable way to provide significant relief for families buying health care coverage. Tax credits are not as vulnerable as other types of coverage expansions to criticisms of big government (e.g. Medicaid expansions). Another advantage of tax credits is that they appear to be extremely popular.

While many health care economists are skeptical that tax credits are an efficient way to increase coverage, insufficient resources are clearly an important barrier for more people interested buying health insurance. A tax credit may make the difference for some uninsured working class Americans such as the twenty percent of those between 100 and 200 percent of poverty who are uninsured and the 16 percent of those between 200 percent and 300 percent.

## Cons

### **Unclear whether significant numbers of uninsured would choose this benefit.**

Depending on its size, many of the uninsured may choose not to use a tax credit. Studies show that many uninsured individuals will only purchase health insurance if most or all of the costs are subsidized. Also, many uninsured Americans may not be able to afford up-front payment for premiums and out-of-pocket payments that would not be recovered until tax time. Economists believe that for many low and middle-income families, who make up the bulk of the uninsured, this would be a major barrier to participation.

Some academics believe it may be possible to design a benefit where people get the credit up-front. This could increase participation significantly, although there still would be a level of uncertainty that economists believe would affect behavior as people may end up owing something back at the end of the year. Also, it is important to note that many of the uninsured would not benefit from this type of a credit unless it was refundable, like EITC, as they are not currently working or do not pay enough taxes to benefit from a credit.

Moreover, the majority of uninsured workers (approximately 76 percent) are employed in firms that do not offer health insurance to their workers. This majority would have to use the credit to buy into the individual insurance market that is the least regulated, most expensive, most "cherry-picked" and most unstable insurance market in the nation. This would again preclude participation for many of the uninsured, particularly many of those with preexisting conditions. Still for the 24 percent of workers whose employer does offer coverage, a more modest tax credit could be quite useful.

### **Inefficient use of dollars**

The other problem with the tax credit approach is figuring out how to cover some of those who are currently uninsured without spending significant resources on those who already have coverage. Some who favor a tax credit have talked about offering a \$500 credit for all families that purchase health care coverage. This type of approach would require a significant Federal investment for a tax credit that would go to many people who already have health care coverage but may not prove to be enough of a subsidy -- particularly for those in the individual market -- to help many uninsured Americans get coverage. (It is also not clear that ultimately it would even provide relief for families with coverage because many employers may well use this as an excuse to lower their contribution to health insurance):

One possible approach to help avoid some of these problems is to offer this only to those who choose to buy into the individual market. This would mean that the vast majority of Americans who get their health care coverage through their employer would not be eligible for the credit unless they chose to go into the individual market. (Since this option would only help those who are buying into a more expensive individual market, the credit itself may well have to be more generous). The advantage of this approach is that it would target the large portion of the

uninsured who do not have access to an employer-sponsored plan and would not pay for the millions of Americans already with coverage.

The disadvantage is that some may choose to drop their employer plans for the tax credit but as most people prefer the notable advantages of the group market, economists think that few would choose this option over their existing health coverage. Also, some employers could potentially stop offering coverage arguing that their employees are better off in the individual market. If you choose this proposal, we may want to contemplate a way of giving states some types of incentives to bolster and improve this market to give these Americans better options in the insurance market.

### **Proposal**

One option would be to propose an \$1,000 tax credit for individuals who buy into the individual market. It would be open to anyone even to those with access to employer based coverage (so as not to encourage employers to drop coverage). A very preliminary model showed that this proposal would cost at least \$11 billion a year and would cover at most 6 million uninsured Americans per year (see attached estimates). This proposal would likely need to be accompanied by some insurance reforms in the individual market or state pools to buy into.

## Calculations on Cost of Tax Incentives

**Data:** March 1997 Current Population Survey - all data inflated to 1999.

**Price of Group and Non-Group Insurance:** We match to the CPS data from KPMG on group insurance premiums by firm size and region. To get non-group insurance costs, we simply take the group insurance costs on average for a region and increase them by a loading factor to get an average non-group cost for a typical individual. For a given person's non-group costs, we adjust this average non-group cost by age. We then aggregate individuals into health insurance units.

**Impact of Policy on Prices:** We divide the credit amount by the non-group policy cost for that health insurance unit to get the subsidy rate. That is, if the non-group policy cost for the family is \$5000, and there is a \$1000 credit, then the subsidy rate is 20%.

**Three populations of relevance:** (total non-elderly, non-Medicaid population: 194 million)

- 1) Uninsured (40.5 million): For those who are uninsured, we assume an elasticity of demand of -0.5. This means that a 20% subsidy rate would move 10% of the uninsured into insurance.
- 2) Existing Non-Group Insured (9.5 million): We assume that they all take-up the subsidy
- 3) Existing Group Insured (144.1 million): We assume that some of them will switch to non-group insurance when it is subsidized. We compare the employee share of the cost of group insurance to the cost of non-group insurance, post subsidy; if the latter is lower, we apply a switching elasticity of -0.4 (e.g. if non-group is 10% cheaper, 4% of group insured will switch).

**Results** (all figures in millions):

	\$1000 Credit	\$2000 Credit	\$3000 Credit
Total Cost (\$ billions)	\$11,034	\$33,030	\$49,851
Dollar Distribution			
Uninsured	\$5386	\$15,673	\$21,980
Non-Group Insured	\$5015	\$9592	\$13,067
Group Insured	\$633	\$7765	\$14,802
Number taking up			
Uninsured	6.83	11.77	14.28
Non-Group Insured	8.82	8.82	8.82
Group Insured	0.80	4.97	8.26

Notes

- All credits are available only to singles with income < \$75K and married with income < \$100K.
- Credit is fully refundable.
- All figures in millions

**What is Missing?**

- Firm dropping - likely to be important even if a small response, since firms provide the bulk of insurance
- Different assumptions on how much of the employer premium is paid by employees - employees may pay some of the employer cost in lower wages, leading to more switching
- Non-group premiums should reflect health status as well
- State insurance regulation will affect non-group premiums

## Safety Net

### Summary

This policy assumes that we will not eliminate the number of uninsured Americans and proposes to improve services for those Americans who lack coverage. This initiative has the potential to make substantial infrastructure investments in over 100 communities, deliver nearly 3 million primary care visits to a total of 700,000 uninsured people, and deliver over 1 million inpatient and outpatient mental health or substance abuse treatments to a cumulative total of more than 28,000 uninsured people. In addition to these direct impacts, the initiative will improve the efficiency and effectiveness of service delivery to uninsured patients and produce savings that can be used to expand the number of clients served.

### Policy

This policy builds on a current administration proposal and would propose to:

**Develop financial, information, and telecommunication systems.** It would fund Networks that could develop the financial, information, and telecommunication systems that are necessary to appropriately monitor and manage patient needs. This support will improve the efficiency and effectiveness of service delivery within the safety net, permitting more clients to be served with existing resources and strengthening the financial standing of the safety net providers by enhancing their ability to compete for business from Medicaid and commercial managed care arrangements.

**Provide additional services to the uninsured.** The initiative would also target substantial funding towards service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the focus will be on expanding access to primary health care and assuring that it is coordinated with other health care including mental health / substance abuse service needs.

**Award grants to those who prove effective at coordinating and delivering services.** Grants will be available to public or private entities. An important goal of the program is to encourage local public officials to work closely with providers of care to better coordinate service delivery and establish accountability within the system for assuring adequate patient care. Applicants will be expected to demonstrate how clients will be provided with a continuum of core health care services and link primary, specialty, and tertiary care. Applicants will also be required to document existing funding and resources and demonstrate that new funds will be used to supplement and not supplant existing resources.

**Cost**

This initiative invests \$250 million per year in comprehensive health care delivery systems that address the needs of the millions of Americans that are still without health insurance

## **National Family Caregiving Proposal**

### **Summary**

This proposal would fund a major expansion of the National Family Caregiving Proposal that you advocated for in the Administration's budget this year to be the centerpiece of your long-term care initiative. The vast majority of these funds would go to states to provide more home and community based care services, such as respite, adult day care services, and home care, to help Americans with long-term care needs receive the services they need in their communities. This program would also provide information for caregivers as well as training and support for caregivers, such as feeding tubes. The Administration's proposal cost is \$125 million. This expansion could be funded at any level (e.g. double, or \$500 million per year).

### **Background**

About 5 million Americans of all ages have significant limitations (cannot perform 3 or more activities of daily living without assistance) because of illness or disability and thus require long-term care services. Nearly 2 million live in nursing homes; the remainder live in the community and benefit from irreplaceable and uncompensated caregiving from countless relatives and friends. In addition, millions more Americans have chronic illnesses or disabilities that are less limiting but still require long-term care.

The sheer increase in number of elderly in the next century means there will be more chronic illnesses. The number of people age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older will grow even faster (from 4.0 to 8.4 million). By 2050, the number of older, disabled people could double.

### **Proposal**

This proposal would strengthen the informal long-term care support system and help Americans with long-term care needs get the support services they need to enable them to stay in their communities -- rather than having to seek institutional based care. It would provide funds for:

Increasing Home and Community-Based Care Services: The vast majority of this funding would go to states to provide home and community-based services to Americans with long-term care needs, including adult day care, respite care, and home care services. This would enable them to get the support needed in the community and delay or prevent them from having to go into a nursing home. For those Americans providing intense long-term care for a loved one, these services provide necessary, temporary relief from caregiving responsibilities, allowing them to restore balance to their lives that strengthens their ability to continue to provide assistance. At least 80 percent of the funding from this proposal would go for these types of services.

Connecting Families with Information on Caregiver Resources and Local Services: Caregivers often report that one of their most difficult challenges is finding quality day care centers or home care providers that can help their family members with long-term care needs. Often they do not fully understand the condition of their loved one and what type of care would be most appropriate. This program would serve as a resource center including detailed information on the condition affecting their relative; names and numbers of local home care and respite services that are proven to provide quality care, and volunteers, who can help them assure they get the range of services they need.

Assuring Quality Services for Americans with Long-term Care Needs: This program would only contract with those adult day care centers, home care workers, and others that have been certified as high quality.

Creating a National Long-Term Care Resource Center: Many Americans have family members with long-term care needs who live in other parts of the country. These Americans often have the most difficulty helping access and identify quality services. This center would serve as a national resource center for these families. It would include a 1-800 number for people to call that would help link them to quality services around the country. It could also help link people to volunteers or others where those services are located, as many caregivers are long-distance. Finally, it could collect and disseminate best practice approaches to help communities -- including faith-based organizations, schools, and employers -- to identify model approaches to improve support for Americans with long-term care needs and their caregivers, and to provide technical assistance for organizations who want to do more.

Establishing a Neighborhood Network to Connect Caregivers to Voluntary Organizations: As the baby boomers retire and the number of Americans with long-term care needs increases dramatically, no one program or policy will be able to address the nation's long-term care needs. All aspects of the private and public sectors, including faith-based organizations, employers, community-based organizations and others, are necessary to assure this support.

This proposal would require all caregiver programs to establish a coordinator that links Americans with long-term care needs or their caregivers with a range of other community organizations that can provide support and services, such as churches, senior centers, voluntary organizations, and employers. These coordinators would also work with organizations in the community to help encourage their involvement in promoting long-term care services.

#### **Cost**

The current funding is \$125 million and is estimated to help about 250,000 families per year. This proposal could fund \$500 million per year, helping more than one million families. Since this program is on the discretionary side, we would need to figure out a creative way to fund it.

## **Helping More Americans with Long-Term Care Needs Access Home and Community-Based Services in Medicaid**

### **Summary**

This policy proposes to give states grants and technical assistance to encourage them to expand their Medicaid programs to cover more home and community-based care services. This proposal is designed to continue to move away from the historical bias of the Medicaid program to only cover nursing home care and allow more Americans with long-term health care needs stay in the community.

### **Background**

Medicaid is the largest payer of long-term care in the nation. It covers two-thirds of nursing home residents -- many of whom become eligible for this income-related program because long-term care costs impoverish them. Nursing home costs average almost \$50,000 per year. About 80 percent of Medicaid long-term care costs are for nursing homes.

The remaining 20 percent of costs are for home and community-base long-term care services. The share of Medicaid long-term care spending going toward home and community-based services has more than doubled in the last 10 years. Ten years from now, Medicaid spending on these services is projected to equal spending on nursing homes. The Administration has encouraged the shift away from Medicaid's "institutional bias" by approving over 300 waivers for local home and community-based care programs and proposing to repeal the need for such waivers. States always complain about the amount of paper work involved in any Health Care Financing Administration (HCFA) process, but by and large agree that the HCFA waiver process in this area is not a burden or barrier to moving their Medicaid populations into home and community based care.

Notwithstanding these advances, not all Medicaid beneficiaries with long-term care needs have community-based options. States have been more aggressive in moving in the direction of home and community-based care for the non-elderly disabled population. But some states have been nervous about moving in this direction for the elderly population, particularly because they are worried about the "woodwork effect," the use of such services by those who would not have sought them if only nursing home care were available.

### **Policy**

This policy would provide \$100 million in grants to states to encourage them to move more of their Medicaid populations into home and community based care as a substitute for nursing home care. This will give more older Americans more flexible options to stay in the community. Such grants could also be used to encourage innovative programs that several states are now attempting.

## **Developing a New Eldercorps Program to Enlist Senior Volunteers**

### **Summary**

This proposal would create a national Eldercorps program to encourage 100,000 more older Americans to make a commitment to service and help fill the 'care gap.' This proposal would give grants to communities to develop service programs for the elderly to volunteer in schools, child care centers, or to assist those with long term care needs and their caregivers.

### **Background**

As we move into the 21st century and Americans are living longer healthier lives senior citizens are one of our most untapped national resources. In 1900, the average American could expect to live until 47; today, it is 76 years. (The addition of three decades to the American life span in less than 100 years exceeds the total change over the last 5,000 years). Moreover, seniors are a growing portion of the population. At the turn of the century there were ten times as many Americans under 18 as over 65. By 2030, the number of 65-year olds will exceed the number of 18-year olds.

Older Americans in retirement have more time to be caregivers than most other adults do. While the middle-age generation has a serious time crunch, studies show that retirement frees up on average 25 hours a week for men and 18 hours a week for women. The combination of early retirement and a longer life means that many Americans now at work will spend as long as one third of their life in retirement.

Studies also show that volunteering can be an extremely positive for seniors. A 25-year National Institutes of Mental Health study found that "highly organized" senior activity is – aside from smoking - the single strongest predictor of longevity and vitality. Local programs have also found that this is good for the children and Alzheimers' Association study found that seniors were an effective source of respite care.

There are currently some Federal programs – in addition to a host of local community-based programs – to promote senior volunteerism. These include a Foster Grandparents' Program that encourages older Americans to work with special needs kids and a Senior Companion Program that pairs low-income seniors with others. About 100,000 seniors are currently volunteering. However, some studies estimate that older Americans still volunteer less than any other age group in the country.

### **Proposal**

This proposal would call for a National Eldercorps initiative that would engage 100,000 more seniors to get involved in their local schools, child care centers, or to assist Americans with long-term care needs. This proposal would help fill the "care gap" that has emerged as a result of more Americans in the workforce who are working longer hours.

This would help older Americans work in:

- Elementary schools. A major component of this effort would be designed to bring seniors into schools throughout the country to help with a wide range of tasks including tutoring kids, promoting parent involvement, providing more personal attention to help kids with reading and learning, teaching assistance, mentoring, reading, cite manager within the schools.
- Child care centers. The prevalence of working parents and single-parent households creates burgeoning needs that could also be met by seniors. Seniors volunteering in child care centers would involve monitoring play, reading stories, leading games, and serving as drivers.
- Long-term care needs. There is also an enormous and growing number of Americans with long-term care needs. There are millions of caregivers who report being overburdened or depressed. Healthier and younger senior volunteer programs could provide relief to caregivers, provide companionship.

This proposal would enlist some volunteers to give serious time commitments (e.g. 15 hours per week). These volunteers would receive a \$1,000 stipend each year. They would also be reimbursed for expenses related to their volunteerism (\$100 per month). We would hope to get about 25,000- 30,000 of these volunteers to participate in this aspect of the program. Others would commit less time and would not be eligible for the stipend, but perhaps could receive some expense-related reimbursements.

#### **Cost**

This program would cost about \$250 million over five years and \$100 million a year when fully phased in.

## **Tax Credits to Develop Assisted Living Facilities**

### **Summary**

This proposal will provide tax credits to develop new assisted living facilities to help Americans with long-term health care needs stay in the community. It would require these facilities to get home-and-community based care waivers to assure Americans get the services they need in these facilities.

### **Background**

Assisted living is generally defined as a residential setting that provides or coordinates personal care services, 24-hour assistance, and some health-related services in a home like environment. Assisted living is generally much cheaper than nursing homes (\$72 average per day versus \$127 per day). Moreover many people prefer this type of arrangement because it provides far more autonomy than a nursing home.

However, assisted living is usually available for only higher income Americans. In 1997, the average annual income of residents was approximately \$31,000 and 86 percent of the residents received no other public or private financial assistance to help cover these costs. Recent studies have shown that there may be some market for assisted living that is for people with lower incomes. Some states have been working to develop more affordable assisted living to lower-income persons. For example, Massachusetts has financed affordable assisted living facilities for 1,000 residents.

### **Proposal**

This new program would help fund new assisted living facilities for elderly of moderate incomes. The new program would be basically the same as the Low-Income Housing Tax Credit, with a few variations to make it workable for assisted living facilities.

The Low-Income Housing Credit provides ten years of tax credits to investors for the construction or rehabilitation of rental housing occupied by tenants with incomes under 60 percent of area median income. In return for the federal subsidy, the housing must be targeted to eligible tenants based on income and the rent charged cannot exceed 30 percent of the tenant eligible income. Any services the tenant is required to pay are included within the rent limitation. Developers compete to get tax credit allocations from State housing finance agencies based on the degree to which the housing project satisfies the housing priorities of the State.

To make this program structure workable for assisted living facilities two main issues must be addressed. First, the income targeting should probably be different than the Housing Credit. Eligible household income perhaps should be raised to 80 percent of area median income or perhaps 100%. In rural areas where the feasibility of this kind of development is particularly difficult you may want to use the higher of area or statewide median income. The second

challenge has to do with the treatment of mandatory services, which are far greater in the context of assisted living than in regular housing. This is more difficult. If this proposal includes a limitation on rent, it will not be possible to include services within that limit the cost of services. There are all kinds of assisted living facilities across the nation but they typically provide 2 or 3 meals a day as a mandatory service for residents. Sometimes other services – such as laundry, dressing care, cleaning, etc. – are mandatory as well. It would be impossible to provide such services within the rent limitations that apply to the Housing Credit. The difficulty is that if you permit such services to be separately billed outside the rent limitation, it is easy to game the rules by hiding high rent charges in the cost of mandatory services.

One option we would recommend is to require these facilities to get a Medicaid waiver for home community-based care (for example, a 1915b waiver applies to local communities and would cover services such as aides and assistance). This would assure that for low-income elderly the services they need would be available.

Like the Housing Credit this would be a capped program based on the population of each State. Designated state agencies could establish elderly housing plans that would require developers to compete for credit allocations to build assisted living facilities.

**Cost**

This proposal would cost \$1 billion over five years.

## **Improving the Quality of Long-Term Care Services**

### **Summary**

This initiative would be a broad-based approach to improve the quality of long-term care. It would propose a higher level of regulation -- namely through training, certification, and registration -- of the over one million elderly aides and assistants who provide care and assistance to the elderly in non-nursing home settings. Specifically, it would fund grants to states to implement a range of quality protections for Americans in a range of long-term care settings, such as adult day care, assisted living and home health.

### **Background**

With the increasing number of older Americans with long-term care needs, more and more professionals are needed to care for them. However, there has generally been little oversight of these workers. As the elderly segment of the population continues to grow, federal and state government must take steps to assure that those who are supposed to help the elderly -- one of the most vulnerable segments of our population -- are qualified and trained to do so.

More older Americans receive assistance and care outside of nursing homes, a trend that is positive but poses challenges to assure these Americans receive quality care. State and federal agencies monitor nursing home workers and some home health services covered by Medicare, but they hardly regulate most of the people who work in home care, assisted living, and adult day care.

For instance, in some states, individuals with no formal training can become home health aides. From a quality perspective, the best case scenario is that Medicare, which requires certification although mostly they only need only to pass a competency test. Assisted living and adult day care facilities pose even more serious problems. The point of such facilities is that they are not nursing homes and that those who live in them don't need that level of care. However, under the current structure very little regulation is in place.

The cottage industry that has formed around caring for the elderly also poses a new set of regulatory challenges. What particularly concerns experts is the growing number of independent contractors who term themselves home health aides or nurses aides with no training or certification - or without even a background in this area.

Background checks are currently required for many positions (including Medicare-funded home care aides) but there is no national system for carrying them out and most local systems are incomplete and lack timely responses.

What makes this problem all the more pressing is that it is this kind of care - home health care and assisted living in the community- that should be encouraged as more Americans have

long term care needs. From both a quality of life and a financial perspective, the longer before an elderly person enters a nursing home the better. To make this policy work, we should work to insure that these facilities are safe and that their staffs are trained to do the jobs they must.

### **Policy**

This proposal would encourage a unified and comprehensive system of over-site, training, certification, and registration for the elderly aides and assistants who make this type of less intense care (home health, assisted living, and adult day care) possible. Such a program should:

- Assure that all of these workers undergo criminal background checks.
- Develop a national registry for aides practicing in all settings (home care, nursing home, assisted living, and adult day care). With proof of certification and a background check, an elderly aide or assistant will be entered into the registry.
- Develop and update a comprehensive list of the types and characteristics of elderly aides and assistants who work in all types of elderly facilities, and developing a unified training curriculum consist of classroom learning and on-the-job skill training for each of these positions. (For instance, training for home health aides would involve something like 75 hours of classes and 75 hours of skill training.)

This proposal would offer states grants to adopt this model of training, certification, and registration program. To be eligible for funding, states must:

- Require the complete battery of OAA training, certification, background check, and registration for elderly aides and assistants to work in any licensed elderly facility.
- Assure training and certification programs are regulated and approved by states or other accrediting institutions.
- Facilitate the registration process for elderly aides and assistants and will help facilities and the public confirm that their employees are in the registry.

### **Cost**

Fifty million annually or \$250 million over five years would be available in grants to states to enforce the provisions of the program. In addition, this program would fund these new national systems, such as the registry, at a cost of \$10 million.

## **Expanding Ombudsman Programs to Improve Quality of All Long-Term Care Services**

### **Summary**

This policy proposes to expand the Long-Term Care Ombudsman program both to better serve nursing home patients and to extend it to assisted living, adult daycare, home health, and respite facilities.

### **Background**

Concerns with the quality of nursing facilities and the Federal government's inability to regulate them adequately led to the creation of the LTC Ombudsman Program in the early 1970s. In contrast to regulators, ombudsmen are supposed to help the abuses that regulators often miss and resolve problems on behalf of residents, such as watching nursing home facilities, spotting mood or health changes in overlooked residents, or detecting Medicare fraud.

Today the LTC ombudsman program operates nation-wide with about 865 full-time, paid staff in the program and 6,750 volunteers. Funding for ombudsman programs totaled \$40.9 million in 1995. In 1993, LTC ombudsmen received more than 197,800 complaints by more than 154,400 people.

Despite the effectiveness of the ombudsman model, a 1993 Institute of Medicine study found a number of short-comings in the program's implementation. It found that the ombudsman program has trouble in many states covering all the nursing home facilities and that coverage of board and care homes has not been achieved in any significant way. The ombudsman program activities of too many states are focused primarily on responding to complaints that relate to individual residents of nursing facilities, according to the report. The Institute of Medicine report suggested a series of policy -- but not appropriations -- changes to help with these problems.

Compounding these problems are the lack of quality among new industries that have sprung up to care for the elderly: assisted-living, adult daycare, home health, and respite facilities. An increasing number of old people receive assistance and care outside of the nursing home industry, a trend which is positive but poses new regulatory challenges. The LTC Ombudsman Program has difficulty responding to the elderly's needs in the nursing home industry, not to mention these other facilities.

**Policy**

This policy would expand the LTC Ombudsman Program and send a clear message to the elderly that their long term care services are of the highest quality. The policy proposal would:

- Expand the LTC Ombudsman Program to cover a broader array of services and facilities that now serve the elderly, including board and care and for the first time ever assisted living, adult day care, home care, and respite facilities.
- Hire and train more professional ombudsman. Because the program works so effectively with volunteers, hiring one additional ombudsmen allows the program to bring in four to six additional volunteers. (Currently, there's a waiting list in many states to volunteer due to the lack of professional ombudsman to supervise them.)
- Increase accountability. With this increased funding must come a higher level of accountability. We should form an oversight group to supervise the state ombudsman programs and to ensure compliance with the goals of the program. The Administration on Aging should send each state information on its expectations for their performance as well as possible sanctions for their failure to meet these guidelines.
- Expand the National Long-Term Care Ombudsman Resource Center to improve coordination, disseminate best practices and tighten relationships between the ombudsman program and law enforcement and regulatory agencies.

**Cost**

The extra ombudsman funding would cost an additional \$40 million per year.

## **Improving Community Mental Health Services for the Severely Mentally Ill Through Medicaid**

### **Summary**

This policy proposes to give grants and technical assistance to encourage state Medicaid programs to cover a community mental health treatment model that would coordinate services for the severely mentally ill.

### **Background**

An estimated five million Americans suffer from severe mental illness. Many of these Americans do not receive the treatment they need. In particular, populations, such as the homeless mentally ill, people with co-occurring illnesses, such as mental health and substance abuse disorders and those who have spent significant time in a psychiatric facility, frequently do not receive the comprehensive array of services needed to improve their care. While many of these Americans are eligible for Medicaid, these services are often not well coordinated and do not provide the treatment to help these individuals. For example, one study estimated that 30 percent of the homeless population are comprised of people with mental disorders that have not been treated.

Some states have begun to implement Assertive Community Treatment (ACT) models that coordinate the delivery of community-based services for the severe mentally ill. These models assure that a range of services are provided including case management, psychiatric rehabilitation, hospital discharge planning, crisis residential services, and integrated treatment. Those who are at high risk for discontinuation of treatment or for repeated crises require an array of clinical rehabilitation and social services to address their needs. Coordination, integration, and continuity of services among providers over time can be substantially improved through ACT.

These models have been implemented in a few places, including Massachusetts and LA County, and have shown to lead to better treatment for those with mental illness, enhanced awareness about and use of community service; decreased homelessness (on average 3 days per month); and decreased use of both legal and illegal substances. The best and most concrete evidence of ACT's effectiveness come from the Schizophrenia Patient Outcomes Research Team (PORT) which developed comprehensive treatment recommendations for schizophrenia and demonstrated consistently the effectiveness of these programs in reducing inpatient use among such high-risk patients.

**Policy**

This proposal would encourage states to offer ACT for the severely mentally ill by enabling states to choose one benefit option that would cover the model, which includes a range of services including, intensive case management, psychiatric rehabilitation, integrated services for individuals with co-occurring mental illness and substance abuse disorders, crisis residential treatments, psychiatric support for services for individuals residing in supported housing facilities, hospital discharge planning, and medication education and management.

States currently have the authority to cover all of these services, although only a few of them do and those that do often don't offer the tightly integrated services ACT provides. This proposal would also provide technical assistance and seed money for states to implement this model. Some have also suggested offering a higher match for the ACT model, but we feel this is a bad idea because it would result in other groups (cancer, AIDS, etc.) requesting a higher match for their treatments.

**Cost**

We do not have a good sense of how much this model would score. However, this is a similar approach we took on the Kennedy-Jeffords legislation that would enable people with disabilities to buy into Medicaid so they can return to work. In this policy, we gave grants to states to encourage them to take up this option. This policy not only was scored at the cost of the grants, but also for the cost of additional states taking up the option. Similarly, we could get a score of several hundred million dollars for this policy.

## **Parity for Medicare**

### **Summary**

This policy proposes to equalize the Medicare co-payment that beneficiaries pay for treatment of mental illness. Under this proposal, Medicare would cover 80 percent of the cost of treatment for mental illness, as it does for all other outpatient services.

### **Background**

Currently, Medicare does not cover treatment for serious mental illness -- such as schizophrenia, bi-polar disorder, major clinical depression, obsessive-compulsive disorder, and panic disorder -- at as high a rate as it does other illnesses. Medicare covers 50 percent co-pay for outpatient services for mental health, but 80 percent for other services.

However, major clinical depression is widespread among Medicare's elderly beneficiaries and goes largely undiagnosed or under-treated. For example, older Americans have the highest suicide rate of any age group. The suicide rate for those over 65 is 17.3 compared to 11.6 for the entire U.S. population, according to the American Association of Suicidology. In fact, NIMH estimates that five million older Americans suffer from mental illness.

Moreover, many people who suffer from mental disorders are under 65, but on Medicare for disability. There are well over 1.25 million people certified disabled because of a mental disorder (other than retardation) under Social Security's Disability Insurance program, most of whom are on Medicare.

The mental health community believes that one reason mental illness often goes under-treated for older Americans is because of Medicare's insufficient benefit. This proposal would extend parity to the Medicare program (building on our previous successes in improving parity). As you know, the Mental Health Parity Act of 1996 required that health plans that provide mental health benefits provide equal lifetime and annual benefits coverage for mental health treatment as they do for physical. In addition, at the Mental Health Conference we will announce OPM's intention to extend parity for mental health to federal employees.

### **Proposal**

Medicare currently covers only 50 percent for outpatient treatments for mental illness. For all other outpatient services, Medicare covers 80 percent. This proposal would not bring Medicare into full parity as there is also a disparity in the Medicare's inpatient services -- a 190 day limit for mental health inpatient treatment and none for most hospital. This policy would bring down the 50 percent co-payment now imposed on outpatient treatment of mental disorders to the 20 percent charged to the beneficiary for other services.

**Cost**

This policy is projected to cost \$5 billion over five years. However, it is important to note that this proposal is scored on an old Medicare baseline, and could get a different score now. Phasing in the co-payment over time could reduce the five-year cost to approximately \$3 billion.

## Cancer

**EXPAND PREVENTION AND DETECTION FOR CANCER.** We need a national effort to assure that Americans are using the tools we have today to fight cancer, such as screening those at risk and preventing smoking. This new effort would include:

**Assuring older Americans get mammography, colorectal screening and other screening benefits that detect cancer early.** Many older Americans do not receive the prevention and screening tests currently available that could help detect and treat cancer early. For example, only 60 percent of older women receive regular mammograms and even fewer receive screening tests for cervical cancer -- one of the most treatable cancers when detected early. This proposal would eliminate all cost-sharing for Medicare cancer preventive benefits -- including the deductibles and coinsurance for colorectal and prostate cancer screening as well as coinsurance for mammography.

We could also launch a campaign to educate Americans to make sure they get the care they need and expand public health programs that provide screenings at low-cost, such as mammography, colorectal cancer, and cervical cancer. This campaign would cost about \$100 million per year.

**Renewing our commitment to stop children from smoking.** A recent report by the National Cancer Institute underscored that the unprecedented progress in the declines in cancer rates would be reversed if current tobacco rates continued. You could call for a renewed effort to stop the 3,000 children who start smoking every day -- the most preventable and leading cause of cancer and for more research to enhance tobacco prevention and tobacco control efforts for the 50 million Americans who smoke.

**Enhancing efforts to understand the relationship between the environment and cancer.** If we are going to prevent more Americans from getting cancer, then we need to understand the relationship between cancer and the environment. You could call for a new public health effort to enhance research in this area. (\$50 million per year).

**ENHANCE RESEARCH TO SPEED UP THE SEARCH FOR THE CURE.** Scientists have made significant progress in preventing, detecting, and treating cancer. By next year, scientists expect to complete the blueprint for the human genome project. With these advances in place, we must move quickly to use this new tool to meet our next challenge: to revolutionize the ways we detect and treat -- and one-day cure -- cancer. Our challenge is scientists is this:

**Identify every major gene that predisposes people to cancer in the next two years.**

The Cancer Genome Project, the historic effort that you announced in 1996 to unravel the genetics of cancer, has already more than doubled its original goals to identifying cancer related genes. Over the next two years, we should complete our goal of identifying every major human gene that predisposes people to cancer.

**Use the genetic revolution to develop blood tests for virtually every cancer in five years.**

We must use new knowledge about genetic information to revolutionize the way we detect cancer and even any early signs of gene alterations that indicate cancer. Today, we cannot detect many cancers early. Mammograms and cervical cancer screenings are able to detect cancers early, but many cancers are cannot be detected until it is too late. Our challenge is to use the genetic revolution to detect cancers

As a first step this fall, the National Cancer Institute will launch an Early Detection Research Network, designed to use new knowledge about genes to determine which ones help indicate early signs of cancer.

We are also challenging scientists that in the next five years we should use promising breakthroughs to develop blood tests that can detect virtually all cancers. These tests will be far more precise than almost any screening available today. They will be able to pinpoint genetic alterations that indicate an early sign of cancer or pre-cancer. Using this information we will be able to start treatment for those at risk far earlier.

**Develop treatments that can prevent cancer or treat it more effectively and safely.**

Finally we must reinvent the way cancer is treated. We can and must build on the preventive treatments that scientists are beginning to test for prostate and breast cancer (e.g. Tamoxifen, Taxol). The genetics revolution opens up the door to identify and treat those at risk long before they ever have cancer. Rather than the current toxic treatments of today, we are ready to move to genetically engineered cancer treatments. We are the cusps of a revolution in the way we treat and detect cancer. We must use this time to invest wisely in research so those at risk for cancer never get this disease

**DIAGNOSE EVERY MAJOR CANCER SOONER – SO TREATMENT CAN BEGIN IN ITS EARLIEST STAGES.** While some cancer is diagnosed early, too often it is diagnosed in later stages. About 60 percent of women diagnosed with ovarian cancer already have advanced stages. We need to develop tools to diagnose every major cancer early when we have a better chance of effective treatment. We are issuing a challenge to every scientist to develop diagnostic techniques for every major kind of cancer by the end of next year so we can catch cancer at its earliest and most preventable stages. Once we have these techniques, we should also take steps to assure that they are accessible to all patients.

**ASSURE PATIENTS ACCESS TO CUTTING EDGE TREATMENTS.** Only three percent of cancer patients currently participate in clinical trials. Many scientists believe that higher participation in clinical trials could lead to faster development of new therapies, as it often takes between three and five years to enroll enough participants in clinical trials to make them statistically meaningful. We need to assure cancer patients can choose to access cancer trials so they can get what are often the most state-of-the-art treatments and we can get answers about new therapies faster. We have taken steps by directing NCI to enroll patients on the spot, but now we must:

**Require all health plans to allow patients to participate in clinical trials.** Many managed care plans also do not reimburse the patient care costs for patients that participate in clinical trials. There are numerous stories of cancer patients who have been denied access to trials and some states have attempted to address this issue by passing protections, such as requiring coverage of bone marrow treatment. You could call on Congress to pass legislation that requires all health plans to cover patients who participate in clinical trials.<sup>1</sup>

**Enact legislation to assure Medicare patients can participate in clinical trials.** America's seniors make up half of all cancer patients, and are 10 times more likely to get cancer than younger Americans. Older Americans, however, frequently cannot participate in cutting-edge cancer clinical trials because Medicare does not reimburse patients who participate in experimental treatments. You could call on the Congress pass legislation to allow Medicare patients to participate in cancer clinical trials that is currently proposed by Senators Rockefeller and Mack.<sup>2</sup>

**Give patients have access to breakthrough medications.** Two years ago, we launched an historic effort to speed up the drug approval process at the Food and Drug Administration, while maintaining public health and quality. In just two years, we have more than doubled the number of approvals for new therapies. We must continue this commitment to cancer drugs while assuring high quality public health.

---

<sup>1</sup> This proposal is included in some versions of the patients' bill of rights currently on the Hill. We would recommend not proposing this as a stand-alone bill as it would undermine our patients' bill of rights strategy of getting comprehensive legislation rather than a piecemeal approach that some Republicans have proposed. But you still could talk about the importance of legislation that assures all health plans cover clinical trials, an issue that has not been highlighted by the Administration in the patients' bill of rights debate

<sup>2</sup> The Rockefeller-Mack proposal is more expansive than the Administration's policy as it covers all Medicare patients who participate in these trials. The Administration's proposal is a demo program that limited funds to \$750 million over three years due to concerns about the Trust Fund. The Mack proposal costs \$2.5 billion over five years. However, unlike last year, the cancer community is now committed to the Rockefeller-Mack approach. OMB has been resistant to endorsing their approach. However, the cancer community would be very appreciative)

## **GUARANTEE FAIRNESS FOR CANCER PATIENTS**

We must assure that cancer patients are treated fairly. They should have access to the doctors and specialists they need, and should not have to fear discrimination because they have cancer. We took steps to assure cancer patients could keep health insurance when they changed jobs. Now we must pass legislation that:

**Protects medical privacy.** Cancer patients should not worry about who will see their medical records. Congress should pass comprehensive privacy legislation. And if they don't pass it, we will do everything in our authority to implement these protections.

**Assures quality health care by passing a strong enforceable patients' bill of rights.** These protections that are critical to cancer patients because they assure those in the middle of chemotherapy, are not forced to stop treatment because their employer changes health plans; or cannot see a cancer specialist.

**Prevents genetic discrimination.** Studies have shown that a leading reason that women do not get the latest genetic breast cancer tests is that they fear these tests will be used to discriminate against them. We must assure that Americans do not avoid taking advantage of critical advances in cancer by passing legislation that prevents employers and health insurers from using genetic information to discriminate.

Individual Tax Deduction  
Health Plan

To Jerome

absence of insurance reform?

OK even if  
this doesn't  
make it in  
but would  
prefer it to  
IM

## ABOVE-THE-LINE DEDUCTION FOR INDIVIDUALLY PURCHASED HEALTH INSURANCE

### Current Law:

Under current law, employer-provided health insurance is deductible for an employer and is excludable from an employee's income for employment and income tax purposes. There is no deduction for individually purchased health insurance, except for self-employed individuals. Self-employed individual can deduct 45 percent of premiums in 1998 (45 percent in 1999, 50 percent in 2000 and 2001, 60 percent in 2002, 80 percent in 2003-2005, 90 percent in 2006, and 100 percent in 2007 and thereafter).

### Proposal:

Under the proposal, all individuals (including self-employed individuals) who are not eligible to participate in an employer-subsidized health plan maintained by an employer (or former employer) of the individual or the individual's spouse would be eligible for a deduction for health insurance. However, under the provision Medicare Part B premiums would no longer be deductible for self-employed individuals (nor for anyone else). The deduction would be effective January 1, 1999.

### Pros:

The proposal would increase equity.

- Currently individually purchased insurance does not currently receive favorable tax treatment. Providing an above-the line deduction for individually purchased insurance would be a step toward equal treatment.

### Cons

The tax system is not well-suited to providing subsidies aimed at expanding health insurance coverage. Furthermore, the increase in equity may result in some unintended bad consequences.

- **Coverage not substantially expanded.** An above-the-line deduction would not provide a big enough incentive to increase coverage to any significant extent. Subsidies in the neighborhood of 60 to 100 percent would be needed to substantially increase coverage for low-income individuals. An above-the-line deduction would provide at most a 15 percent subsidy for low-income individuals.
- **It is estimated that under 2% of uninsured individuals would be newly covered as a result of the proposal.**

- **Inefficient way to expand coverage.** It would be difficult to think of a less efficient way to expand coverage.
  - Dividing the total revenue loss by the number of newly insured individuals results in a \$10,000 revenue loss for each newly insured individual.
  - Fewer than five percent of the tax benefits would go to newly insured individuals.
- **Many uninsured ineligible.** About half of the uninsured have incomes too low even to pay taxes.
- **Subsidy not timely.** For moderate income individuals, a tax deduction would not provide help in a timely fashion. Premiums would need to be paid long before deductions could be claimed.
- **Higher income individuals gain most.** Among those who individually purchase health insurance, those in the highest tax brackets would gain the most from the proposal.
- **Erosion of employer-provided health insurance.** Providing an above-the-line income tax deduction to individually purchased health insurance would reduce the relative tax advantage of employer-provided health insurance compared with individually purchased health insurance, thus eroding the incentive for employers to provide health insurance. The smaller the tax advantage, the more likely that employers would cut back on contributions. Some employers would be encouraged to terminate health insurance coverage for their employees, other new or maturing firms might never chose to add coverage.
  - If only 2 percent of employers eliminate contributions, *the number of uninsured would increase* as a result of the proposal. Although there is great uncertainty in how many employers would eliminate contributions, many employers have a sizable portion of their workforce that would do better if employers eliminate contributions but increase wages in a way that holds employer costs constant.
  - If employers eliminate contributions, some employees would drop coverage because they would not be willing to pay the full premium. Recent evidence suggests that a small but growing number of employees are declining coverage, even when there is an employer contribution. Without an employer contribution, fewer employees would be covered.
  - The problem may be exacerbated for sub-groups of employees such as employees with family health plans and low-income employees. For example, employees with employer-provided family health insurance plans generally receive larger employer contributions than single employees. As a result, employees with family plans would be more adversely affected than single employees if employers eliminate contributions. Because of institutional factors in the current labor market, low-

income employees may be more adversely affected by employer cutbacks than higher income employees.

- Families with high risk factors and whose employers drop their health insurance plan altogether may face much higher premiums in the individual market.
- **Difficult to administer.** The Internal Revenue Service (IRS) would not be able to verify health insurance expenditures or most other eligibility criteria prior to payment of the credit or deduction, and may not be able to recapture erroneous payments to taxpayers in a cost-effective manner.
  - Under the proposal, individuals who are not eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer are eligible to claim a deduction. But it would be very difficult to verify who is eligible to participate in subsidized health plans.
- **Money needed elsewhere.** The provision is very expensive and the health of the public would be improved more by:
  - health and other investments that have an focus on children.
  - in particular, research and public health investments that are critical for reducing tobacco use among children and for accelerating our success in developing diagnostic, treatments and cures associated with cancer and other diseases.
- **Revenue loss.** The OTA preliminary estimate revenue loss for the proposal, including accelerating the phase-in of the self-employed health insurance deduction, would be \$25.3 billion (FY1998 - FY2003) and \$57.6 billion (FY1998 - FY2008).

June 3, 1998

## Acceleration of Self-Employed Health Insurance Deduction

Under the proposal, self-employed individual would be able to deduct 100 percent of health insurance expenses as early as January 1, 1999. Under current law, this deduction is scheduled to phase up to 100 percent in the year 2007.

- In general, we support the principle of increasing the health insurance deduction for self-employed individuals to 100 percent.
- However, we do not support the provision in this context. The provision is very expensive and the Federal offset is needed for
  - health and other investments that have an focus on children.
  - research and public health investments that are critical for reducing tobacco use among children and for accelerating our success in developing diagnostic, treatments and cures associated with cancer and other diseases.
- Revenue loss (OTA) associated with the self-employed portion of the proposal is \$5.6 billion (FY1998 - FY2003) and \$7.9 billion (FY1998 - FY2008).

June 3, 1998

## U.S. Department of Labor

Pension and Welfare Benefits Administration  
Washington, D.C. 20210

September 11, 1996

## MEMORANDUM FOR THE SECRETARY

THROUGH           MEREDITH MILLER  
FROM               KELLY L. TRAWNF  
RE                  RETIREE HEALTH COVERAGE

This memorandum is to provide information concerning retiree health coverage. This information reflects data on coverage trends, litigation trends, and public inquiries received by PWBA.

- 1) **Data:** A significant trend is the constant decline in the number of retirees who are not covered by health insurance. Between 1988 and 1994, the percentage of retirees covered by employer-provided health insurance dropped dramatically, from 37 percent to 27 percent. In September 1994, there were approximately 17.5 million private sector retirees, of whom 4.7 million (or 27%) were receiving health care benefits from their prior employer and 13 million were without employer-provided insurance.
- 2) **Litigation trends:** Over the past 15 years, doctrines based on contract law have developed in the case law on retiree health benefits that make it very difficult for retirees to establish that an enforceable promise of lifetime benefits has been made. A quick search revealed approximately 100 reported Federal court decisions in retiree health cases from 1979 to the present. The vast majority of these decisions have been issued since 1990, and we do not have information on pending cases. Although it is difficult to determine the final results of the reported cases, the majority of these decisions appear to have been against participants/retirees. The size of the retiree groups that brought these cases varied widely, from as few as seven retirees to as many as 84,000. When a court decision mentioned the number of retirees, it typically was in the hundreds or thousands. These findings on reported court decisions have severe limitations and almost certainly understate the degree of litigation involving retiree health benefits as well as the number of cases that might have been brought had the case law developed more favorably for retirees.
- 3) **Public inquiries:** PWBA has received relatively few public inquiries concerning retiree health coverage. From October 1, 1995 through August 31, 1996, PWBA customer service staff received 115,665 public inquiries; 41 percent, or 47,325, were inquiries regarding health benefits, of which 696 calls and letters concerned retiree health issues. Of those 696 inquiries, 224 related to terminated retiree health benefits.

# News

United States  
Department  
of Labor



Office of Information

Washington, D.C. 20210

## PENSION AND WELFARE BENEFITS ADMINISTRATION

CONTACT: GLORIA DELLA  
OFFICE: (202) 219-8921

USDL: 94-595  
FOR RELEASE: Immediate  
Mon., Dec. 12, 1994

### LABOR DEPARTMENT APPEALS JUDGMENT ON HEALTH BENEFITS FOR GM RETIREES

The U. S. Department of Labor has asked a Cincinnati federal appeals court to require that General Motors Corporation keep its promise to provide lifetime health benefits to 84,000 retirees.

Over the past 10 years, GM promised to pay almost the entire cost of lifetime health benefits for its retirees and their surviving spouses. Beginning in 1988, however, GM unilaterally reduced their health benefits by drastically raising the co-payments and increasing the monthly contributions of salaried employees.

Former employees sued GM in 1989 in *Sprague v. General Motors*, alleging that the company failed to comply with the terms of its health plan. The district court in Detroit ruled that health benefits for the general retirees did not vest based on the provisions of the general plan documents. The court also ruled against the retirees, saying that GM unambiguously reserved the right to amend the plan.

A separate court ruling in 1994, however, did allow the health benefit claims of those who retired under special early retirement agreements with GM.

In a friend-of-the-court brief, the department urged the appeals court to reverse the district court's dismissal of certain retirees' claims and to award them benefits. The department contends the court erred in dismissing their claims because the summary plan description provided to participants before they retired "unambiguously promised lifetime benefits without reserving GM's right to amend or terminate those benefits."

-2-

The department also argues that other retirees whose claims were dismissed should be awarded a trial. Furthermore, the department noted that the district court correctly awarded benefits to the early GM retirees who signed special agreements.

The amicus brief was filed Dec. 5 with the federal appeals court in Cincinnati.

# # #

Docket Nos. 94-1896, 94-1897, 94-1898, 94-1937

**PWBAnews**

Division of Public Affairs

Publication: Wall Street Journal

Date: 25 July 94

***GM Loses Another Ruling  
On Benefits for Retirees****By a WALL STREET JOURNAL Staff Reporter*

**DETROIT** — A federal judge has moved to protect a group of General Motors Corp. retirees as the auto maker appeals a February ruling giving them free medical benefits for life.

U.S. District Judge John Feikens ruled that GM is prohibited from altering the current benefits or co-payments of the early retirees during the appeals process. The ruling affects more than 45,000 GM salaried employees who took early retirement between 1974 and 1988.

Those employees sued in 1989, alleging the company broke its promise of lifetime medical benefits once it began charging them co-payments and other out-of-pocket expenses in 1988. In February, Judge Feikens ruled that GM did indeed make a promise that was legally binding, and so, it must honor it.

**PWBAnews**

Division of Public Affairs

Publication: BNA

Date: 14 September 94

**GENERAL MOTORS MUST PAY  
HEALTH COSTS PENDING APPEAL**

WASHINGTON (BNA) — General Motors Corp. has failed to convince a federal appeals court to stay a lower court's order requiring it to keep on paying a group of early retirees' health insurance costs pending a decision on whether GM can cut off the retirees' benefits (Sprague v. General Motors Corp., CA 6, No. 94-1896, 9/7/94).

In a one-page opinion, the U.S. Court of Appeals for the Sixth Circuit denied GM's petition for a stay of a July 25 injunction issued by the U.S. District Court for the Eastern District of Michigan (140 DLR A-1, 7/25/94). The injunction requires GM to keep paying the health insurance costs for 45,000 early retirees while the company appeals an earlier district court ruling on the merits of the case.

The district court ruled in February 1994 that GM violated the Employee Retirement Income Security Act when it stopped paying health benefits for approximately 45,000 early retirees (23 DLR AA-1, D-1, 2/4/94). The district court found that GM had made special promises of lifetime health coverage to induce early retirement and that GM could not go back on that promise.

In its opinion requiring GM to keep paying while it considers the substantive issues, the Sixth Circuit said it had considered four factors: whether GM has demonstrated a likelihood of success on the merits, whether GM would be irreparably injured absent a stay of the injunction, whether staying the injunction would substantially injure other parties in the dispute, and how the public interest would best be served. Based on those factors, GM has not shown the need for a stay, the Sixth Circuit said.

The unsigned opinion was issued by Judges David Nelson, Richard Suhrheinrich, and Eugene Siler.

**PWBA**news

Division of Public Affairs

Publication: BNA Daily Labor Report

Date: 13 December 94

**LABOR DEPARTMENT SAYS GM SHOULD PAY COSTS OF RETIREES' HEALTH INSURANCE**

The Labor Department Dec. 12 said it has taken the side of retired General Motors Corp. employees in their legal battle to regain free, lifetime health insurance benefits that the corporation began scaling back in 1988 (*Sprague v. General Motors*, CA 6, Nos. 94-1896, 94-1897, 94-1898, 94-1937, 12/5/94).

In a friend of the court brief filed Dec. 5 with the U.S. Court of Appeals for the Sixth Circuit, the department said the GM salaried workers were "unambiguously promised lifetime benefits" before they retired. GM had no "reservation of rights" clause or other language in required documents given to employees about their benefit plans by which it could later change promised benefits and begin charging retirees part of the cost, the department said.

The legal battle has broad implications not only for about 84,000 GM retirees, who could recover damages covering their out-of-pocket health care costs, but for other companies that may be considering modifications to retiree health benefits. A Labor Department spokeswoman said Dec. 12 that the department filed the brief not only because GM cut off benefits to retirees, but also because the case raises important questions about the validity of benefit plan documents required under the Employee Retirement Income Security Act, in this case the summary plan descriptions provided to GM employees.

In February, the U.S. District Court for Eastern Michigan ruled against GM's modifications for some 45,000 early retirees, rejecting the company's claim that the modifications were allowed because of a prominent "reservation of rights" clause in the summary plan description booklets (23 DLR AA-1, D-1, 2/4/94). GM appealed the ruling, but has been ordered to pay the retirees' costs while the case is pending (140 DLR A-1, 7/25/94).

Regular retirees have not seen fully paid benefits restored, however, since the district court dismissed their claims in July 1991. The Labor Department's brief urges these benefits be restored as well as those of early retirees. "The department contends the court erred in dismissing their claims because the summary plan description provided to participants before they retired 'unambiguously promised lifetime benefits' without reserving GM's right to amend or terminate those benefits," the department said in a Dec. 12 statement.

**PWBAnews**

Division of Public Affairs

Publication: New York Times

Date: 15 December 95

**G.M. TO MAKE \$161 MILLION IN PAYMENTS TO RETIREES**

The General Motors Corporation said yesterday that it would make lump-sum benefit payments of \$161 million today to about 350,000 retirees or their surviving spouses. The auto maker said eligible hourly and salaried retirees who left the company before Oct. 1, 1993, would receive up to \$570 depending on the number of years of credited service. Surviving spouses of eligible retirees will receive up to \$342. These payments come from G.M.'s operating income, not the hourly pension plan or salaried retirement program, the company said.

(Dow Jones)

## *GM Ordered to Pay Health Benefits To Early Retirees*

By NICHOLE M. CHRISTIAN

Staff Reporter of THE WALL STREET JOURNAL

DETROIT—A federal appeals court upheld a lower court's decision forcing General Motors Corp. to pay lifetime health benefits to 50,000 early retirees.

The decision was upheld yesterday in the U.S. Court of Appeals for the Sixth Circuit in Cincinnati. At issue in the case, which affects salaried employees who took early-retirement packages between 1974 and 1988, was whether GM was contractually obligated to pay lifetime medical benefits to its retiring workers.

The employees involved in the case argued that GM couldn't reverse a contractual promise and in 1989 sued the auto maker, claiming that GM was billing them for copayments. The appeals-court ruling was the latest of several challenges by GM to a federal-court judge's 1994 decision.

The case originally involved 84,000 employees, but the claims of 34,000 workers who retired at the normal retirement age were dismissed earlier by a federal court judge. However, the federal appeals court issuing yesterday's ruling ordered the claims of those individuals to be sent back to a lower court for further consideration.

A spokesman for GM said the auto maker was disappointed with the ruling and is considering a further appeal. He

## **President Clinton's Health Care Initiatives that Assist Children & Their Families**

### **Providing Health Care for Workers In Transition and Their Children**

- To respond to a rapidly changing economy in which workers frequently change jobs, the President proposed an initiative to address affordability of health care coverage for workers in transition from job-to-job. This proposal would provide premium assistance to temporarily unemployed workers and their families for up to six months of coverage. This provision would take the next logical step toward improving coverage to millions of working Americans and their families are at risk of not being able to afford coverage. In so doing, it would assure that individuals retain the continuous health care coverage necessary to receive portability benefits under the Kennedy/Kassebaum health insurance reform bill.

This program would provide assistance to approximately 3 million Americans, **including 700,000 children**. It would cost about \$2 billion a year paid for in the context of the President's balanced budget.

### **Protecting New Mothers and Their Babies**

- The President endorses reforms that will guarantee mothers the quality of care they need when they have had a baby. Over the past two decades, the average length of stay for an uncomplicated childbirth has declined sharply. Today, a growing number of insurance companies are refusing to pay for anything more than a 24-hour stay, and as few as 8 hours. Premature discharge can lead to serious health consequences for both mothers and children.

Because he believes that beneficiaries should be guaranteed coverage for needed health services, President Clinton strongly supports initiatives to allow all new mothers a minimum of 48 hours of care following most normal deliveries and 96 hours following most cesarean sections. Decisions about medical care for newborns and their mothers should be left with doctors, nurses, and mothers themselves, not insurers.

FAX COVER SHEET

Sunday, June 11, 1995 03:07:13 PM

To: CHRIS JENNINGS  
Fax #: 18005147823,,1,,67431

From: LARRY LEVITT  
Fax #: 5106010568  
Voice: 5106010568

Fax: 1 page and a cover page.



Note:  
Gave a copy to Gary, also. Take care.

## **SUGGESTED POLICY ASSUMPTIONS FOR HEALTH CARE FOR THE UNEMPLOYED PROGRAM**

- ◆ Eligibility for benefits:
  - Insured when working (including non-group).
  - Income under 200% of poverty (defined monthly, including UI).
  - No coverage through an employer with at least 50% contribution available.
  - Eligible for UI.
  - Not eligible for Medicaid.
  - Have not received benefits under the program for more than x months.
  
- ◆ States are assumed to administer the program (though they are not required to). The federal government administers the program if a state does not.
  
- ◆ Eligible individuals are guaranteed (i.e., entitled to) benefits. However, the level of the benefits can be adjusted.
  
- ◆ Federal program funding is capped at the national and state levels.
  
- ◆ Caps at the state level are based on UI caseload and health care costs. Variations due to health care costs are reviewed periodically.
  
- ◆ States determine benefit levels and/or delivery mechanism. (Note: It would seem that state flexibility is necessary if program funding is capped at the state level.) One option is for states to provide a voucher for COBRA.

## **Who are the Participants in the Temporarily Unemployed Program?**

---

- In 1997, an estimated 3.8 million people will be covered by the Temporarily Unemployed Program.
  - o Over 50% of the participants are in families with married parents and children. Another 6% of participants are in single-parent families. About one in four participants are single people, and almost 25% of people covered are children.
  - o About one-third of the subsidies go to middle class people who are in between jobs.

**Distribution of Temporarily Unemployed, 1997**

<b>AGE</b>	<b>&lt;18</b>	<b>18-24</b>	<b>25-34</b>	<b>35-49</b>	<b>50-65</b>	<b>TOTAL</b>
Number of Participants (100,000s)	931	377	925	1,034	489	3,756
Percent	24.8%	10.0%	24.6%	27.5%	13.0%	
<b>FAMILY STATUS</b>	<b>Individual</b>	<b>Married Couple</b>	<b>Unmarried w/Kids</b>	<b>Married w/Kids</b>	<b>Other</b>	<b>TOTAL</b>
Number of Participants (100,000s)	993	552	223	1,977	12	3,756
Percent	26.4%	14.7%	5.9%	52.6%	0.3%	
Subsidies (billions, full calendar year)	0.6	0.2	0.1	0.8	0.0	1.7
Percent	34.3%	13.1%	5.9%	46.6%	0.2%	
<b>FORMER FIRM SIZE</b>	<b>&lt;25 Employees &gt;25 and Unknown</b>					<b>TOTAL</b>
Number of Participants (100,000s)	888	2,868				3,756
Percent	23.7%	76.3%				
<b>INCOME QUINTILES</b>	<b>1st</b>	<b>2nd</b>	<b>3rd</b>	<b>4th</b>	<b>5th</b>	<b>TOTAL</b>
Number of Participants (100,000s)	184	896	1,355	1,061	260	3,756
Percent	4.9%	23.9%	36.1%	28.2%	6.9%	
Subsidies: Percent	10%	35%	33%	17%	4%	

June 14, 1995

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION  
OFFICE OF HEALTH POLICY



PHONE: (202) 690-6870 FAX: (202) 401-7321

From: Leanne

Date:

To: Vicky Feder  
GARY CLAYTON

Phone: (202) 690-  
(202) 690-6870  
FAX: (202) 401-7321

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

Number of Pages (Including Cover): \_\_\_\_\_

Comments: Temp. Unemployed

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June 14, 1995