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September 17, 1996



# Health Financing Branch



Office of Management and Budget  
Executive Office of the President  
Washington, DC 20503

Please route to: Nancy-Ann Min  
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Mark Miller

Subject: *Revised* Response to Criticism  
of the Assistance to Workers  
Between Jobs Initiative

From: Parashar Patel

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Attached are a *revised* set of talking points in the form of Qs & As about the Assistance to Workers Between Jobs Initiative to address issues raised by the Majority Staff of the Senate Budget Committee in the September 9th issue of the Budget Bulletin.

The last sentence in the 2nd paragraph on page 1 has been revised to correct an earlier error. I apologize for any inconvenience this may have caused.

## **Assistance to Workers Between Jobs Initiative: Questions and Answers**

**Q. What is the initiative that the President has proposed?**

A. The Assistance to Workers Between Jobs Initiative is a carefully constructed, targeted, paid for program that the President proposed as part of the Fiscal Year 1997 Budget. The initiative builds on the Kassebaum-Kennedy law and will provide health insurance coverage for 3 million Americans, including 700,000 children. According to a recent Lewin Group, about half of the uninsured who lost their health insurance at some point between 1991 and 1993 lost coverage because either they or their parent/spouse lost their job.

Many of these people may have trouble paying their health insurance premiums. As recently reported in the Lewin study, the cost of COBRA coverage may present a barrier to coverage. The Lewin study estimates that in 1995, the average monthly premium for COBRA coverage was \$177 for individuals and \$464 for families. For families covered under the President's proposal, this represents about 20% to 30% of their average monthly income while they are unemployed.

- Builds on Kassebaum-Kennedy law. While Kassebaum-Kennedy helps provide access to health insurance, this initiative will help make health insurance more affordable.
- Provides premium assistance for those who previously had health insurance but are in-between jobs and may not be able to pay the full cost of coverage on their own.
- Limits coverage to only those previously insured. Coverage would not exceed six months.
- Costs about \$2 billion per year and is already paid for in the President's balanced budget.
- Helps Americans who truly need help paying for their health care coverage. About two-thirds of participants live in families with incomes less than \$30,000.
- Strengthens the safety net for middle income, working Americans in an increasingly mobile workforce.
- Provides states the flexibility to assure coverage in ways that make the most sense for each state. For example, states could provide coverage through COBRA continuation coverage, an insurance product in the private market, or alternative means of coverage (e.g., state high risk pools, Medicaid buy-in, etc.).

**Q. We think your program will cost more than you think. What were the assumptions used to develop your cost estimates?**

A. We developed our cost estimates using conservative assumptions about the level of participation in the program, individuals receiving unemployment benefits, and health care costs. In addition, the program is designed as a capped entitlement to states.

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question

If, for some unforeseen economic or other reasons, program costs are greater than anticipated, states have several choices. First, the proposal allows each state to accumulate a surplus fund from its share of the program's funding during good economic times. A state may use funds from its surplus account to meet any shortfalls. Second, the proposal sets aside a small portion of the program's appropriations which are placed into a federal loan fund. Any state may borrow from this loan fund to meet any shortfall. Finally, states have the authority to reduce the duration or extent of premium assistance.

**Q. Because you are providing a subsidy, won't the unemployed stay unemployed longer? And won't program costs be higher as a result?**

A. To assert that individuals will stay unemployed longer just to continue receiving some financial assistance to purchase health insurance is an exaggeration.

First, the vast majority of American workers, we believe, would rather start a new job as soon as possible, even if it means giving up the financial assistance to purchase health insurance, rather than risk remaining unemployed for a longer period of time. The current unemployment insurance compensation program shows that working Americans would rather work than receive a small government handout. In 1995, workers who received unemployment compensation received benefits for an average of about 4 months (17 weeks) even though they were eligible to receive benefits for about 24 weeks.

Second, we believe that the disincentive to find work is very limited because the financial assistance is temporary and limited. Our estimates show that families will receive assistance for an average of about 4 months and receive about \$240 per month while they participate in the program. We doubt many workers would give up a job that pays \$2,000 or \$3,000 a month just to get assistance for a couple more months.

However, just to be conservative, our cost estimates assume that a small number of individuals might stay unemployed longer just to continue receiving this assistance.

**Q. What happens if there is a recession?**

A. The proposal includes a provision that ties the level of available funds to the change in the average number of individuals receiving unemployment compensation. Therefore if there were a recession, the level of available funds would automatically increase. If the level of funding reaches the capped level and a state's funding is insufficient to meet its needs, the state has several choices. First, the proposal allows each state to accumulate a surplus fund from its share of the program's funding during good economic times. A state may use funds from its surplus account to meet any shortfalls. Second, the proposal sets aside, into a federal loan fund, a small portion of the program's appropriations. Any state may borrow from this loan fund to meet any shortfall. States' repayments are also placed into the federal loan fund. Finally, states have the authority to reduce the duration or extent of premium assistance.

**Q. How do you respond to the charges made recently by the Majority Staff of the Senate Budget Committee?**

A. I assume you are referring to the September 9th Budget Bulletin? We believe that the claims made in the Budget Bulletin are exaggerated and groundless.

*Claim:* "The President proposes to spend \$8.7 billion over four years to subsidize the purchase of health insurance for up to six months of unemployment. His proposal is expensive, inefficient, and would result in more unemployment and a smaller economy."<sup>1</sup>

*Claim:* Providing assistance to workers between jobs "will make unemployment less painful, but will also mean the unemployed will have less incentive to find a new job. This inefficient income transfer has real economic costs. It would raise the level of long-term unemployment, reduce the labor supply, and lower GDP. The Administration has proposed an almost perfect growth disincentive. The President may want to ask his advisors why unemployment is so high throughout Europe."

*Response:* To assert that the program "will result in more unemployment and a smaller economy" or that individuals "will have less incentive to find a new job" because they will receive some financial assistance to purchase health insurance is an exaggeration.

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<sup>1</sup>The Congressional Budget Office scored the President's proposal at \$8.6 billion over four years, not \$8.7 billion.

First, the vast majority of American workers, we believe, would rather start a new job as soon as possible, even if it means giving up the financial assistance to purchase health insurance, rather than risk remaining unemployed for a longer period of time. The current unemployment insurance compensation program shows that working Americans would rather work than receive a small government handout. In 1995, workers who received unemployment compensation received benefits for an average of about 4 months (17 weeks) even though they were eligible to receive benefits for about 24 weeks.

Second, we believe that the disincentive to find work is very limited because the financial assistance is temporary and limited. Our estimates show that families will receive assistance for an average of about 4 months and receive about \$240 per month while they participate in the program. We doubt many workers would give up a job that pays \$2,000 or \$3,000 a month just to get assistance for a couple more months.

Finally, while unemployment may be high in Europe, here in the U.S. the good news is that the rate of unemployment has fallen from 7.4% in 1992 to 5.1% in August 1996. We find it difficult to believe that a limited demonstration program would "result in more unemployment and a smaller economy" given the size of the American economy (projected to be over \$7 trillion in 1995).

*Claim:* "The Bulletin estimates that subsidizing health insurance for the full six months would cost taxpayers between \$15 and \$22 billion over six years."

*Response:* The attempt by the Budget Committee's Majority Staff to estimate the cost of providing benefits for six full months is irrelevant because the goal of the program is to provide assistance to *temporarily* unemployed workers and their families. In 1995 workers who received unemployment compensation, received benefits for an average of about 4 months (17 weeks) even though they were eligible to receive benefits for about 24 weeks. Also, by definition, once someone becomes employed, they are no longer eligible for the program. To continue providing assistance to these individuals would conflict with the goals of the program.

*Claim:* "The proposal mysteriously terminates in the year 2000, presumably because extending it to 2002 would push the President's budget plan even farther out of balance."

*Response:* The President's proposal is a *demonstration* program, the purpose of which is to determine if providing assistance to workers between jobs is a cost-effective method to assuring that such individuals and their families do not lose insurance coverage. Like all other demonstration programs (e.g., Medicare SELECT and Senator Domenici's recent mental health parity amendment), the program is intentionally designed to end at some point. If the program is successful, Congress and the President are free to extend the demonstration or continue it as a permanent program.

*Claim:* "If someone loses their job their income level drops, and they no longer have an employer providing and paying for health insurance. A provision in COBRA 1985 called 'continuation coverage' allows the unemployed to buy in to their former employer's health plan for up to 18 months while looking for another job. The problem, then, is not a loss of health insurance, but a loss of income."

*Response:* Under COBRA's continuation coverage provisions, firms with fewer than 20 workers do not have to provide access to health insurance to their former workers. For these workers, the problem *is* the "loss of health insurance". The President's program provides assistance to these workers.

For those workers who are eligible for COBRA but cannot afford coverage, the President's plan helps them as well. (States can choose to provide coverage through COBRA for these workers.)

*Claim:* "Why not just give the unemployed cash? If health insurance is needed, the cash can be used to pay for COBRA continuation coverage. If health insurance is available (maybe through a spouse), the cash could be used to pay for food, housing, education, or job training."

*Response:* The President's proposal provides states the flexibility to provide coverage through COBRA (for those workers eligible for continuation coverage), the purchase of private insurance, or through other means. The program was structured to address concerns about costs and minimize the inefficient targeting of limited dollars. In any case, if a state can show that they can provide cash to participants and still assure that participants have coverage, there is an avenue for the Secretary of HHS to approve the state's program.

Under the President's proposal, individuals that have access to insurance through a spouse whose employer contributes at least 50% of the cost of the premium are not eligible. Therefore, providing "cash" to these workers and their families would cost even more than what the President proposed.

*Claim:* "So the Administration proposes to tax workers (or increase deficits) to subsidize non-workers."

*Response:* The President's proposal is a part of his balanced budget proposal. As such, the costs are offset by savings in other programs. The Administration has not proposed to tax workers nor increase the deficit to pay for this program.

*Claim:* "The President's rhetoric may lead people to believe that he is promising they will have health insurance for six months if they lose their job. In reality, he says 'up to six months'."

*Response:* We are not sure how anyone can misinterpret the President when, as the Budget Bulletin acknowledges, he specifically says that workers can receive assistance for "up to six months".

# Small-employer co-ops pick up speed

*Offering the combined advantages of pooled purchasing and employee choice, health plan cooperatives are taking off.*

In late 1984, Health Choice in Portland, Ore., developed the nation's first small-employer health plan purchasing cooperative (HPC). A spin-off of a county Medicaid demonstration, the not-for-profit co-op gave employees a choice of four HMOs offering standardized benefits—an opportunity unheard of for small firms at the time. But it never took off. After a year-and-a-half, enrollment hadn't broken 1,000, far too little to cover administrative costs.

The reasons for its failure? For one thing, the co-op's initial benefit package proved too expensive for many small employers. For another, the organizers tried at first to reach prospective members without the help of agents. On top of that, the HPC lacked a fee-for-service plan, which many small employers preferred.

Fast forward to mid-1996, and zoom in on Associated Oregon Industries (AOI), which is on the brink of launching the country's newest HPC. Highly regarded by the business community, AOI will offer affordable benefits market-

BY RICK CURTIS  
AND KEVIN HAUGH

ed exclusively through agents and brokers and include options that extend to out-of-network providers. Little wonder that we expect it to fare far better than its long-ago predecessor.

Large employers' success in curbing costs has made it clear that purchasing cooperatives have much to offer small firms, which have had little chance to contract for defined panels of efficient physicians while offering their employees a choice. Nor have point-of-service plans been a viable solution, since many workers in the nation's smallest companies can't afford the higher cost-sharing and substantial balance-billing that comes with out-of-network care. That's where HPCs come in and why they're taking root.

A spate of initiatives followed the launch of the Health Insurance Plan of California in 1993, with co-ops cropping up in a variety of markets nationwide. In addition to those detailed in the table on pages 32 and 33, private HPCs are being developed in at least eight states, including Iowa, Illinois, Montana, Oregon and Texas. At the same

time, enrollment in other co-ops has rapidly taken off.

Colorado's Cooperative for Health Insurance Purchasing (CHIP), for example, exceeded its first-year projection of 500 employers and 10,000 covered lives in only six months of operation. Health Connections, the Connecticut Business and Industry Association's HPC, covered 45,000 lives a year-and-a-half after its inception.

The Health Insurance Plan of California had an enrollment of 40,000 soon after its launch, in part because its rates were about 15 percent below prevailing small-employer prices. The staff of the California group attributes its success to a combination of tough negotiating, stiff competition for enrollees in a price-sensitive, individual-choice environment and insurance market reform implemented just as the co-op got started. Its enrollment now exceeds 100,000, and its HMO rates have declined for the fourth year in a row.

In addition to such market-specific factors, HPCs' widespread appeal is not hard to understand: They combine the advantages of pooled purchasing and employee choice, directly represent purchasers and require every plan to

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## COALITIONS: HPCs

## HPC legislation nationwide

Repeated fictitious group law

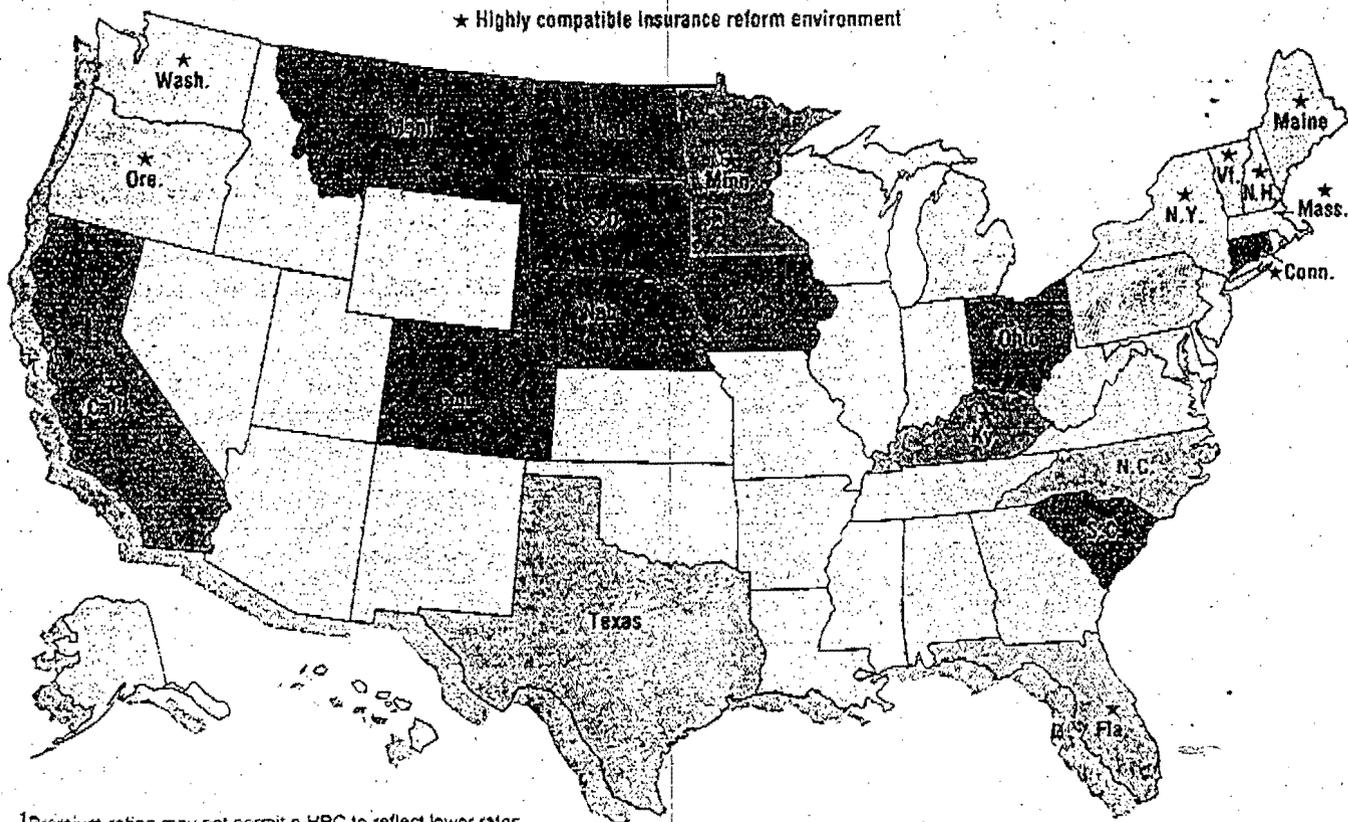
New rules for multiple employer purchasing groups

Certifies private HPCs

Initiated private HPC formation

State-run HPC

★ Highly compatible insurance reform environment



<sup>1</sup>Premium rating may not permit a HPC to reflect lower rates.

Source: Institute for Health Policy Solutions, Washington, D.C.

offer the same standardized benefits. But, unlike other multiple small-employer arrangements, HPCs do not bear insurance risk, pay individual providers or manage care.

#### INSURANCE REFORM IS CRUCIAL

While small-employer co-ops are intended to harness private market forces, state legislation created the supportive environment for the initial wave of HPCs. As the map above indicates, the construct varies. The California and

Kentucky co-ops are state-run, for instance, while Florida and North Carolina charter exclusive regional organizations and Iowa and Colorado set requirements for state certification of private purchasing cooperatives. The states shown as having a "compatible" environment guarantee small employers access to health plans and sharply limit rate variations based on health.

Small-group insurance reform—also addressed in the federal Kennedy-Kassebaum bill now in negotiation—is crucial to the

success of purchasing co-ops and their ability to promote competition based on both quality and cost. Because of the limited risk-spreading in small-employer groups, in any given year the burden is likely to fall heavily only on certain members. Without adequate reforms, health plans that devote their resources to providing value are often outflanked by those that spend heavily on marketing, underwriting and pricing aimed at attracting low-risk groups.

In states that allow carriers a

wide variation in small-employer premiums depending on health status or claims experience, a consumer-choice model HPC is extremely difficult to implement. That may be the most important lesson to be learned from the experience of the Texas Insurance Purchasing Alliance, which was determined to avoid becoming a high-risk dumping ground. TIPA not only found assessing the risks of each applicant group and adjusting

plans' prices quite cumbersome, but it also discovered that carriers were reluctant to be involved and unlikely to offer competitive rates.

Other equally poor options for a HPC: Allowing each plan it offers to assess the risks of each small employer and set prices accordingly, and setting itself up as the only source of small-employer coverage that offers the same price across-the-board. The former is expensive and precludes consumer-friendly

price comparisons, and the latter invites the kind of risk-selection death spiral that befell several Blue Cross-Blue Shield plans. Employer groups like one in Milwaukee have shelved plans for HPCs because inadequate state insurance reform would have forced them into such bad choices.

A HPC would be at a severe disadvantage, too, if it guaranteed issue of all its plans to all small-employer applicants while its competition only had to guarantee one or two state-specific benefit packages and could underwrite any other product. That's the conundrum created by the state law establishing North Carolina's Caroliance. Not surprisingly, Caroliance administrators were forced to accept high (non-competitive) rates and had only

### In the states: Small-group purchasing alliances

The table below is a partial list of small-employer groups, including both state-run and private co-ops. While the alliances featured here span a wide range of sizes—the largest has more than 17,000 employer groups, the smallest just 200—and structures, they have some common features: All offer employees standardized benefits and a choice of competing health plans, and all have employer representatives on their boards.

Alliance	Geographic area	Eligibility	Number of purchasing groups	Number of covered lives
California: Health Insurance Plan of California	Statewide (6 rating regions)	3 - 50 employees; trade associations	5,814	107,000
Colorado: The Cooperative for Health Insurance Purchasing	Statewide (8 rating regions)	No size restriction	544	11,000
Connecticut: Health Connections	Statewide (4 rating regions)	3 - 50 employees	2,800	46,000
Florida: Florida Community Health Purchasing Alliance	Statewide (9 CHPAs)	50-employee maximum	17,223	76,742
Kentucky: PlanSource	Statewide (7 rating regions)	Individuals; public employees; businesses with 2-50 employees	11,278	165,409
Minnesota: The Minnesota Employees Insurance Program (MEIP) Public Employees Insurance Program (PEIP)	Most of Minnesota	2-employee minimum (MEIP only)	352 (MEIP) 94 (PEIP)	5,000 (MEIP) 6,400 (PEIP)
New York: The LIA Health Alliance	Long Island	3 - 50 employees	500	6,000
North Carolina: Caroliance	Statewide (6 co-ops)	Self-employed individuals; businesses with fewer than 49 employees	200	1,000
Texas: Texas Insurance Purchasing Alliance	Statewide (7 rating regions)	3-50 employees	560	7,100
Washington: Employers' Health Purchasing Cooperative	Seattle area	4-employee minimum	225	8,000

Source: Institute for Health Policy Solutions, Washington, D.C.

COOPERATIVE HEALTH PLANS

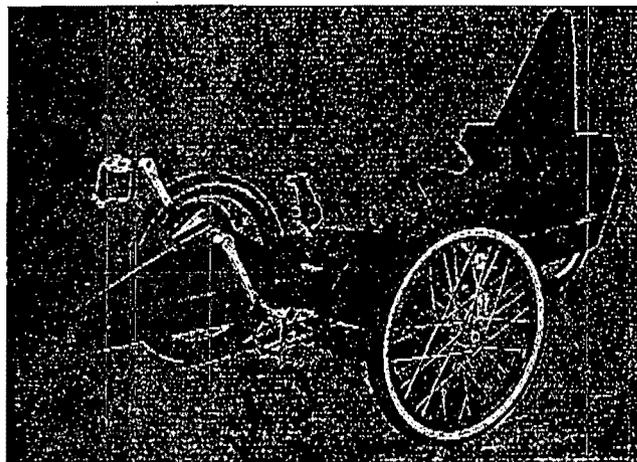
1,000 covered lives after seven months of operation.

**LEVELING THE PLAYING FIELD**

Even when state regulation is ideal, employee choice can exacerbate the potential for risk selection among competing health plans within a purchasing co-op. While standardized benefits level the playing field, offering a PPO alongside more tightly constrained HMO plans raises the possibility that the open-ended plans will be left with the higher risks. An employer-choice model, on the other hand, at least helps to ensure that some healthy workers enroll along with individuals at high risk.

HPCs have found a number of ways to address risk-selection concerns and to preserve employee

choice, however. Perhaps the most promising is the risk-adjustment mechanism the California cooperative developed with support from a Robert Wood Johnson Foundation grant. To determine the relative risk profile of each plan's enrollees, the co-op collects information on inpatient medical diagnoses as well as demographic characteristics of enrollees. Funds are collected from the plans with an enrolled population with a low-risk profile and paid to the plans with disproportionately high risk. The first-year experience in the California purchasing group confirms that a



practical way to address risk differences is indeed possible.

Risk adjustment in the small-employer market has another important purpose: By reducing plans' ability to compete on the basis of risk, it drives competition

Legal status	Selective contracting	Number of participating plans	Standardized benefits	Contact
State-run	✓	20 companies	High and low options	800-447-2937
Private cooperative	✓	4 companies	High and low options	303-333-6767
Private not-for-profit	✓	4 companies	High and low options	203-244-1900
State-chartered, private not-for-profit	No, all state-certified plans accepted	33	Basic and standard options, deductibles vary	800-469-2472
Independent state agency	✓	13	18 options	300-677-7323
State-run	✓	7	3 options	612-296-6251
Private not-for-profit	✓	13	18 options	516-493-3007
State chartered, private not-for-profit	No, all state-certified plans accepted	8	3 options	800-873-6464
Private not-for-profit	✓	19	3 benefit plans, high and low options	512-472-3956
Private cooperative	✓	3	3 benefit levels	206-646-4302

## COALITIONS: HPCs

based on value. In fact, it can provide the incentives plans need to develop innovations such as centers for excellence, knowing they won't be penalized for treating high-cost conditions. The problem is, risk adjustment is a tough and expensive undertaking for a fledgling HPC. Health plans are also likely to balk at the burden.

The California co-op has found another way to control risk selection and encourage value-based competition: Design sales compensation so that agents and brokers earn the same commission regardless of an employee's choice. A HPC can also ask each employer to select the benefit level or type of plan (for example, an HMO vs. a PPO) while the employees choose among plans of that kind. Colorado's new CHIP has adopted this approach, which prevents healthier and sicker employees from segregating themselves into different types of plans.

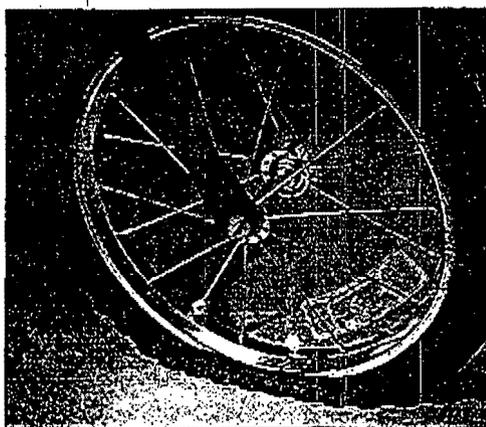
### THE DIFFERENCE SIZE MAKES

A HPC that combines large and small employers offers advantages to both groups, but, as with risk selection, designing an attractive product is difficult. Here, too, CHIP is one of several co-ops that's stepped up to the challenge.

The Colorado co-op has different pricing approaches to address risk issues for three groups: small (up to 50 employees), medium (51 to 200 employees) and large (over 200 workers). Up and running since last fall, CHIP is already highly successful in the small-employer market, but participation has been modest by medium-sized firms. And bigger companies apparently have been unimpressed by health plan bids under its large-employer pricing

strategy, which allows each participating plan to vary its (age-adjusted) rates for any given employer.

To attract big firms, CHIP executives say, they will likely change this component in the near future. They might try a method that a Topeka, Kan., HPC used with excellent results: It garnered highly competitive rates for its large-



employer members by adopting a one-price-for-all-comers (with demographic adjustments only) model.

The Community Health Purchasing Corp. in Des Moines, Iowa, uses a different approach. The co-op—which will phase in fully insured plans for small employers next year—has contracts with three integrated systems to provide coverage to larger employers. Most of these big firms purchase health coverage on a self-insured "target budget" basis copied from the model being piloted by Minnesota's Buyers' Health Care Action Group. If the claims target is exceeded, administrative payment to the integrated care systems is reduced.

### BOOSTING CONSUMER CHOICE

Small employers have more to gain than their larger counterparts from participation in a health

purchasing cooperative, especially when it comes to consumer choice. Without a co-op, small firms wishing to offer employees a selection of plans face significant complications. For one thing, carriers typically will not allow a small firm to offer competing plans. A more obvious problem is the administrative burden.

When small employers contract with single carriers, the carrier generally performs the full range of administrative functions, including enrollment, billing and general customer service. For many small firms, selecting, contracting and interacting with one carrier's billing and enrollment process is a challenge, never mind the difficulty of dealing with a number of plans. HPCs streamline the process by consolidating the enrollment, billing and premium collection functions and then giving their member employer a single bill.

Helping individuals maintain a relationship with their personal physicians is at the heart of employee choice and employer participation in a purchasing co-op, and new, low-cost technology is making that easier to do. PC-based software developed for Florida's Community Health Purchasing Alliances (CHPAs) and an on-line system developed by Health Partners in Minneapolis, for example, allow employees to easily identify which participating health plans (or group practices) include their doctors. Rather than wading through separate directories for each participating plan, an enrollee can simply ask the computer system which plans include, say, the pediatrician, gynecologist and general practitioner his or her family members prefer.

## COALITIONS: HPCs

### MARKETING MATTERS

One of the great truisms of the business world is that a bad product can be successfully marketed but even the best product will fail if it is not marketed well. HPCs are no exception. "Field of Dreams" notwithstanding, building an ideal ballpark does not ensure that the players will come.

Small employers typically have little time or resources to negotiate the health insurance system on their own, so the vast majority rely heavily on agents. The Long Island Association Health Alliance, a private health plan cooperative in New York, learned this the hard way. Its initial intent was to sell directly to employers. After suffering through very slow enrollment growth, the Alliance developed successful partnerships with agents. California's HPC took another tack: allowing employers to choose whether or not to use—and pay for—the services of

expectations. So they took away the option. As of July 1, all new enrollees pay the same premiums, which include agent commissions.

By a wide margin, the Connecticut Business and Industry Association (CBIA) has achieved the most rapid market penetration of any HPC to date. In a state with one-tenth the population of California, its enrollment approached 50,000 after less than a year-and-a-half of operation. While Health Connections, CBIA's strong offering, and the association's proven track record in serving employers clearly helped, CBIA officials attribute much of their success to their close relationship with the agent community. Like other successful cooperatives, CBIA's staff train, certify and pay agents to sell their product. Following a similar strategy, Colorado's CHIP offers credits toward the state's agent certification requirements.

Here, too, state rules and regulations can help or hinder. Florida's state-chartered Community Health Purchasing Alliances, for example, have been shackled by a statute that requires agent compensation to be set—and directly paid—exclusively by health plans. Such a regulation, which means different plans pay different commissions, clearly makes competition based on value and informed choice hard to achieve. The success of Florida's CHPAs—after two years their collectively enrollment exceeds 76,000—attests to their hard work and the attractiveness of the one-stop shopping and employee-choice option they offer the state's small employers. But enrollment would likely be much higher without the statutory constraints.

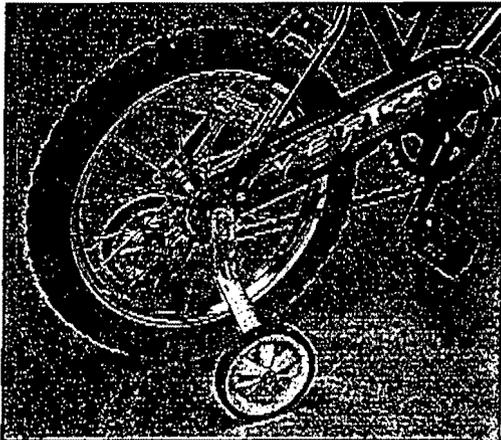
### ON THE NATIONAL FRONT

The Kennedy-Kassebaum bill includes measures to assure that

private HPCs meeting certain criteria can be implemented. The bill would allow them to negotiate price reductions even in states where community rating laws would otherwise preclude their doing so. However, HPCs would be authorized to negotiate savings from health plan efficiencies—but not from differences in risk status. The Senate bill would also preempt so-called "fictitious group" laws, state provisions that bar employers from coming together for the sole purpose of purchasing health insurance.

While the House version of the health reform bill shares the Senate's intent of giving small employers the kinds of deals their larger counterparts enjoy, its approach is fundamentally different: The House would simply provide broad ERISA preemption of state insurance law for some multiple-employer arrangements. Among other things, that would mean these small-employer groups would not be subject to state-mandated coverage for specified services and providers, insurance premium taxes and anti-managed care stipulations requiring freedom of choice of providers.

Regardless of the outcome of this year's federal legislation, both the impetus for its adoption and the concerns about specific provisions will doubtless generate debate and future laws. Small employers that want to provide health insurance have long been frustrated by a system that relegates them to the losing end of the cost-shift chain. Many experts and policymakers intent on solving this problem also want to ensure that employees get the health insurance protection they need. These forces portend both improved insurance market rules and continued growth of HPCs around the country. □



an agent or broker.

The result? Roughly two-thirds of its enrollees have come through agents. But the co-op's representatives say the knowledge that employers could bypass them (and their commission) stopped many agents from actively promoting their product. They also discovered that the time and expense involved in direct enrollment exceeded their

# A Comparison of Employee-Choice Small-Employer Purchasing Alliances

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	Health Insurance Plan of California	Health Connections	The Cooperative for Health Insurance Purchasing	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliances	PlanSource	The LIA Health Alliance	The Minnesota Employees Insurance Program and the Public Employees Insurance Program	Carolliance	Texas Insurance Purchasing Association	The Alliance-Chamber Health Insurance Program
<b>Contact, address, phone and fax number<sup>1</sup></b>	John Ramey Executive Director, Managed Risk Medical Insurance Board 818 K Street, # 200 Sacramento, CA 95814 916-324-4695 916-324-4878/fax	Nancy DeGroff V.P. of Insurance Marketing, Connecticut Business and Industry Association 370 Asylum St. Hartford, CT 06904 203-244-1900 203-278-8562 fax	Elisa Hamill Executive Director, The Colorado Health Care Purchasing Alliance 1033 E. First Avenue Suite 810 Denver, CO 80206 303-333-6267 303-322-3830 fax	Anita Boser Director of Operations, The Employers Health Purchasing Cooperative 401 2nd Avenue Suite 630 Seattle, WA 98104 206-343-2667 206-343-2282 fax	Florida Agency for Health Care Administration 904-922-6463 for general inquiries	Helen Barakauskas Executive Director, PlanSource 909 Leewood Drive Frankfort, KY 40601 502-564-4747	Fred Barba Executive Vice President/ Chief Operating Officer, LIA Health Alliance 80 Hauptpage Road Commack, NY 11725-4495 516-493-3097 516-499-2196 fax	Carole Ohnstein Manager of the MEIP Program, Employee Insurance Division, State of Minnesota 658 Cedar Street, 200 Centennial Bldg. St. Paul, MN 55155 612-296-2705 612-296-5445 fax	State Health Plan Purchasing Alliance Board 501 N. Blount Street Raleigh, NC 27604 919-715-4440 919-715-4429 fax	Clark Jobe Director, Texas Insurance Purchasing Alliance 1005 Congress Avenue Suite 550 Austin, Texas 78765 512-472-3956 512-474-2507 fax	Chris Quernm CEO, The Employer Health Care Alliance Cooperative P.O. Box 44365 Madison, WI 53744 608-276-6620 608-276-6626 fax
<b>Date coverage is or will be available</b>	July, 1993	January 1, 1995	October 1, 1995	March, 1994	June 1, 1994	July 15, 1995	February, 1995	November, 1993 (MEIP) 1989 (PEIP)	November 15, 1996	July 1, 1994 for the Gulf region (pilot project). Feb. 1, 1995 the other 6 regions.	Summer, 1996
<b>Legal structure</b>	Part of the Managed Risk Medical Insurance Board which is a state agency	Private, not-for-profit	Private, cooperative	Private, not-for-profit cooperative	State chartered, private, not-for-profit	Independent government agency	Private, not-for-profit	Part of the Department of Employee Relations, a state agency that also runs the state and local government employees purchasing programs.	State Chartered, Private, Not-for-Profit	Private, not-for-profit	Private, cooperative
<b>Governance structure</b>	Governed by a 5 member Board - the California Managed Risk Medical Insurance Board - appointed by the Governor, Speaker of the Assembly, and Senate Rules Committee.	Overseen by CBIA's Board of Directors.	Sponsored by the Colorado Health Care Purchasing Alliance which is a cooperative of self-funded employers. One Board and operating structure for the CHIP and existing services for self insured employers. 17 member board of directors made up of its members.	Board has 8 current members with the capacity to have up to 15. Members are elected by the membership <sup>2</sup> and are typically those members interested in serving.	Each governed by a 17 member Board of business and industry, consumer and state and local government representatives; appointed by the Governor, President of the Senate and Speaker of the House. None may have any health care conflict <sup>3</sup>	Governed by a 5 member Board appointed by the Governor and confirmed by the Senate. Certified and annually reviewed by the Health Policy Board.	9 person Board of Directors made up of 6 small employers, one bank, one accounting firm and the executive vice president. The Alliance was developed by the Long Island Association which is a business and civic association focused on improving the economic viability of Long Island.	10 person advisory committee made up of private sector employers chosen by the Commissioner of Employee Relations. The board meets quarterly and oversees both programs.	Each regional alliance is governed by an 11 member Board. The initial Board is composed of 6 appointments by the SHPPA Board, and 5 appointments by the Community Sponsor. Thereafter, all members elected by the membership.	Nonprofit organization governed by a 6 member Board of Trustees appointed by the Governor with advice and consent of the Senate. Board consists of employers, employees and a public representative.	Sponsored by the Employer Health Care Alliance Cooperative which is a cooperative of self-funded employers. The A-CHIP will be governed by the current member Alliance Board of Directors with one additional member to be added for Chamber of Commerce representation.

<sup>1</sup> Alliances on this chart have a Board of Directors with conflict of interest provisions and members who represent small employer consumers, offer a choice of multiple competing health plans, and have standardized benefits. All alliances meeting these requirements may not be included. Please contact Gina Young if you know of a small employer purchasing program that should be included.  
<sup>2</sup> Two membership classes exist: class A and class B. Class B members are supporting organizations and health plans and insurance carriers. Class A consists of non-provider organizations that obtain coverage through the cooperative. Only class A members may be Governing Board members.  
<sup>3</sup> Generally this means that they may not have a financial conflict of interest associated with a health carrier, provider or other similar health related organization or individual.

If you have any questions please contact Gina Young  
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P. 8

	Health Insurance Plan of California	The Connecticut Business Industry Association Health Connections	The Cooperative for Health Insurance Purchasing	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliances	PlanSource	The LIA Health Alliance	The Minnesota Employees Insurance Program and the Public Employees Insurance Program	Carollance	Texas Insurance Purchasing Association	The Alliance-Chamber Health Insurance Program
<i>Geographic area</i>	State of California	State of Connecticut	State of Colorado	Areas where contracted health plans have provider networks which is mostly the Seattle area.	Entire state of Florida is covered by 11 CHPAs.	State of Kentucky	Long Island	Most of the state of Minnesota	State of North Carolina	State of Texas	Plan will be offered in a 7 county area in Southwest Wisconsin
<i>Rating region</i>	6	4	8 as mandated by law.	1	11: one in each of the states health planning districts.	7	1	Rating regions are determined by the health plans service areas which are reviewed quarterly.	6	7	1
<i>Ability to selectively contract</i>	Yes. Entered in negotiations with 29 health plans; 19 contracts were signed. Negotiated a 6.3% reduction in premiums for second year and a 5.3% reduction for third year.	Yes. 10 RFPs were mailed out; 8 responses were received; 4 plans were chosen.	Yes. 11 of the 14 certified HMOs responded to RFP. 4 were chosen. <sup>4</sup>	Yes. 16 responses were received; 3 plans were chosen.	No. Health plans that wish to sell through the alliance must be certified by the state. 40 AHPs are certified.	Yes	Yes	Yes. 5 responses to the RFP were received; 4 carriers were chosen.	No. Health plans that wish to sell through the Alliance must be designated by the state. 13 Accountable Health Carriers (AHCs) have been designated.	Yes. 92 state qualified carriers; 19 carriers statewide offering 28 plans were chosen.	Yes. In process of evaluating health plan proposals.
<i>Number of participating health plans</i>	Currently, 20 insurance companies; 18 HMOs and 3 PPOs.	4 insurance companies each offering an HMO and a POS plan.	4 insurance companies each offering an HMO and POS plan.	3 POS plans with 3 plan designs are offered providing consumers with a choice of 9 plan options.	Statewide: 460AHPs offering 75 plan options.	13 health plans.	4 insurance companies each offering an HMO and POS plan.	4 HMOs and 3 indemnity plans. However, the indemnity plan is offered only in areas where 1 or no HMOs are available.	8	19 total: 13 insurance companies offer 20 plans with multiple plan options in Gulf region. <sup>5</sup> Across the other 6 regions, 11 carriers offer 15 plans.	NA
<i>Standardized benefits</i>	Yes. A high and low option for each option HMO and each PPO plan.	Yes. Each insurance company must offer a high and a low option HMO and a high and low option POS. Employees have a choice of 16 standardized insurance options.	Yes. Employers have a choice of three benefit levels: standard, basic, and standard with a POS option.	Yes. Each of the three plans are standardized.	A basic and a standard option. Different deductible levels are allowed; the state must certify each plan with a different deductible. The legislation states that other free standing plans are prohibited. Riders may be offered, but each CHPA must gain approval from the state.	Yes. 18 different plan options that vary in services, delivery model, and co-pay levels. Several standardized riders also available.	Yes. High and low HMO options, Value HMO option, and high and low POS options.	One benefit plan is offered for the HMO plans. The plan is comparable to the state employee plan and is more comprehensive than the minimum benefits plan mandated by the state.	Yes. Three benefit levels: Standard, Basic, and Select.	Yes. Three health benefit plans—preventive and primary care, in-hospital, and standard health plans defined under state law. May offer other plans as well. An HMO and a PPO is also offered with a high and low option for each. Learning from the Gulf pilot project, has adjusted plan benefits to closer reflect outside market.	Yes. Plans to offer high and low option plans, including an HMO, POS, and a standard plan.

<sup>4</sup> HMOs have a three year contract and other HMOs will not be allowed into the CHIP during that time period.  
<sup>5</sup> Learning from the Gulf pilot project, the TIPA will offer fewer carriers and thus plan choices in other regions to reduce the complexity of choosing.

	Health Insurance Plan of California	The Connecticut Business Industry Association Health Connections	The Cooperative for Health Insurance Purchasing	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliances	PlanSource	The LIA Health Alliance	The Minnesota Employees Insurance Program and the Public Employees Insurance Program	Carollance	Texas Insurance Purchasing Association	The Alliance-Chamber Health Insurance Program
<i>Minimum Employee participation requirements</i>	70% of eligible employees must participate.	70% of eligible employees must participate.	75% of eligible employees must participate in an Alliance plan <sup>6</sup> .	75% of eligible employees must participate.	70% of eligible employees must be insured either through the CHPA or through any public or private insurance.	80% of eligible employees must participate.	50% of eligible employees must participate.	75% of eligible employees must participate.	70% of eligible employees must participate.	75% of eligible employees must participate.	70% of eligible employees must participate.
<i>Size of employers</i>	3-50. Employers of any size if they obtain coverage through a trade association.	3-50	Any size	The minimum is 4 employees living in separate households. There is no maximum number of employees.	1 to 50 employee firms, potentially government employees, Medicaid, and Medicaid buy-in. Employers with more than 50 employees may participate to obtain information on AHPA.	2-50, individuals, and public employees. Mandatory for state employees. Voluntary for local units of government and universities.	3-50	2 or more employees for the MEIP. Larger employers may join, but to date none have expressed interest. For PEIP employer size is 1 or more.	Self-employed, individuals, and businesses with fewer than 49 employees.	3-50	1-99
<i>Employer or employee choice</i>	Employee	Employee	Employee (Employer chooses the benefit level and employee chooses the plan.)	Employer	Employers choose plans from which employees then choose. Firms of more than 30 employees must choose at least 3 health plans, firms w/ 30 or fewer employees must offer at least 2 health plans. <sup>7</sup>	Employee	Employee	Employee (Employer chooses the benefit level and employee chooses the plan.)	Employer must pay at least 50% of the lowest cost plan offered. Employers who pay 70% or more may choose only 1 plan.	Employee (Employer chooses the benefit level and employee chooses the plan.)	Employee
<i>Number of employer groups</i>	5,814. Average group size is 10 employees.	2800. Average group size is 8 employees.	439. Average group size is 10.	225	16,347 groups statewide	see below		352 groups for MEIP. 94 groups for PEIP.	200	560 groups. Average group size is 7 employees.	NA
<i>Number of covered lives</i>	105,200	43,000	8,450	8,000	73,786	Total is 317,000: 21,000 for small employer groups, 16,500 individuals and dependents, and 280,000 state/local employees.		4957 (MEIP) 6104 (PEIP)	1,000	7,066	NA

<sup>6</sup> Employees with over 50 employees may have employees in both insured and a self-insured plans.  
<sup>7</sup> Health plans with the same benefits, but different deductible levels are considered different health plans.

	Health Insurance Plan of California	The Connecticut Business Industry Association Health Connections	The Cooperative for Health Insurance Purchasing	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliances	PlanSource	The LIA Health Alliance	The Minnesota Employees Insurance Program and the Public Employees Insurance Program	Carollance	Texas Insurance Purchasing Association	The Alliance-Chamber Health Insurance Program
<i>Start up funding</i>	Loan from the state repaid with a surcharge on premiums.	CBIA Service Corporation, a for-profit subsidiary of CBIA provided start up funds.	A grant from the Hartford Foundation, other grants, and employer contribution. The CHIP is not funded with Alliance operating revenue.	Grants from the Hartford Foundation and the National Cooperative Bank as well as donations from member employers.	\$275,000 per alliance provided by the state.	State funding and grants.	Funding provided by the Association and participating insurers.	For MEIP: a loan from the state, repayment to begin in 1998. Appropriations from state are derived from a provider tax passed as part of the health care reform bill. For PEIP, a loan from the state that was repaid in 3 years.	Varies by region with a range of about \$196,500 - \$240,000 for annual operations and \$35,200 one time capital funds.	\$250,000 provided by the state.	Start-up funds provided by the Alliance with marketing costs shared by participating plans and Chambers.
<i>Source of ongoing funding</i>	Surcharge on premiums.	Current membership fees and a surcharge on premiums.	Surcharge on premiums and sign-up fee.	Membership dues range from \$50-200 depending on the number of employees. A sign up fee of \$10 per employee and a \$3 per employee per month fee. Donations and in-kind services from member companies.	For first year \$275,000 per alliance provided by the state. Second year \$138,636 provided by state. Ongoing: a membership fee and administrative fees.	Annual premium assessment of 1.25% paid by participating health plans.	Percentage of premiums: 1% to the Alliance to cover administrative expenses, telemarketing, and marketing expenses and 1% to outside ASO vendors to cover enrolling, billing, collection, and quality report card.	MEIP is currently using loan and a portion of administrative fees. For PEIP a surcharge on premiums.	Membership fees / dues and a monthly per member administrative fee.	Surcharge on premiums: \$4.63/employee/month	Surcharge on premiums.
<i>Agent commission</i>	Paid through a fee schedule based upon group size, fees are identified separately on billing statement and paid by the employer.	All employers must enroll through an agent. During the first year agents will receive 5% of premiums. During the second year agents may be paid on a capitated basis.	Commission based upon annualized premiums. Uniform for all health plans.	Agents are paid a commission of 3% for employers with less than 150 lives and may set any commission for groups over 150 lives. The 3% commission is noted on the plan proposals sent to employers.	Employers must enroll through an agent. AHPs (not the CHIPA) determine how agents are paid. In cases where AHP doesn't pay the commission, the CHIPA may pay commission.	5% of premium.	4% of premium	For MEIP, a set flat fee (per employee per month) is paid to agents that is equivalent to approx. 4% of monthly premiums. For PEIP no agents are used.	Employers must enroll through the use of an agent. AHCs determine commission.	7.5% of premiums; paid by employer	To be determined. Distribution through agents, brokers, and Chambers of Commerce.
<i>Quality measures</i>	Plans must report utilization and cost data to the state. Report cards and member satisfaction survey planned.	Will collect claim information and report trends. Report cards and member satisfaction survey planned.	A 2% health plan withheld for quality improvement based upon data collection and monthly report cards. Quality standards based upon clinical, service, and employee satisfaction measures.	4 report cards planned: Access to Qualified Providers, Accountability for Claims and Service, Consumer Satisfaction, and Medical Performance Measures.	AHPs must report quality indicators to the state.	All health plans must report some data to the state.	Will have quality performance report cards which include the member satisfaction surveys. Health plans must be certified by the National Committee on Quality Assurance by the end of 1997.	Much of the quality reporting has been done for the state employees program which uses some of the same plans as the MEIP and PEIP. Quality reporting specifically for MEIP is planned for next year.	AHCs are required to provide for the collection and reporting of information on the performance of AHCs regarding the effectiveness of outcomes in providing selected services.	Report cards and member satisfaction survey planned. Health plans must be certified by the National Committee on Quality Assurance by date to be determined.	Data will be collected from health plans in specified format. Performance indicators, including member satisfaction will be measured and evaluated.

	Health Insurance Plan of California	The Connecticut Business Industry Association Health Connections	The Cooperative for Health Insurance Purchasing	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliances	PlanSource	The LIA Health Alliance	The Minnesota Employees Insurance Program and the Public Employees Insurance Program	Carolliance	Texas Insurance Purchasing Association	The Alliance-Chamber Health Insurance Program
<i>Number of FTEs<sup>8</sup></i>	13 (All employees also work on 2 other programs.)	12		2	All CHPAs have 2 or 3 employees: an Executive Director and a clerical person; some CHPAs may also have an operations or a marketing person.	6	4	5 FTEs cover both MEIP and PEIP.	All Carolliance have between 2 and 4 employees.	2	SFTEs who also work for the Employer Health Care Alliance Cooperative.
<i>Services contracted out</i>	Enrollment, premium collection/ distribution, and marketing is contracted out to Employers Health Insurance; marketing contract is a separate contract. Actuarial services are contracted out to Cooper and Lybrand.	Enrollment, premium collection/ distribution, and claims reporting done in-house. Quality analysis done by Value Health Management.	Enrollment, and premium collection/ distribution, is contracted out to Network Management Services (NMS). All other services including marketing and data collection performed in-house.	None. The cooperative currently does not perform the functions of enrollment and premium collection/ distribution; the employers contract directly with the health plans. The coop may take on these functions in 1996.	For all CHPAs, enrollment and premium collection/ distribution; and marketing is contracted to Health Plan Services.	Enrollment, premium collection/ distribution, and marketing contracted out to Health Plan Services.	Enrollment and premium collection/ distribution is contracted out to Benefit Plan Administrators. The report card system is contracted out to Value Health Management. Marketing is directed by the alliance.	Enrollment and premium collection/ distribution is contracted out to Network Management Services (NMS), one staff person coordinates marketing with a local advertising firm. The brokerage house of Sedwick James handles quotes and sales. Defouie & Touche consults and provides actuarial services.	All Carolliance have signed a contract with Health Plan Services, Inc. for enrollment, premium collection and marketing functions.	Enrollment, premium collection/ distribution, and marketing is contracted out to Blue Cross of Texas. Actuarial services are also contracted out.	Enrollment, premium collection/ distribution is contracted out to Network Management Services. Marketing, data collection, and quality analysis will be conducted in-house and jointly with selected administrator.

<sup>8</sup> Full time employees for program only. When administration is contracted out the administrator uses many of its employees to perform functions for the alliance. Because they do the administration (enrollment and premium collection) themselves, the MEIP and PEIP programs have many more FTEs.

Now - signing, coop / Elotter → women  
purchase, ~~coop~~

- Leverage → not likely

- Administrative costs

- Local Better

- Blinded by unions → some poss. vs universal / Group vs. small group.  
vs compared

→ Big Government. Optional

- Absence of universal coverage, self solutions

- Address by separate parts, but it is unclear

whether own self effectively longer term

process vs Local understanding of differentials,

Leverage via would lead to unique problems.

Id all plan ~~doing~~ doing = 12-month wait, who is difference  
in program → in traditional plan + PETA/SP?

---

- Neton

- Get into to fall in Temp Unemployed.

- Get looking on Temp Unemployed - Ask Bar

- This next

- priority

**Purchasing Cooperatives  
Administration & Kassebaum/Kennedy Proposal**

	<b>Administration</b>	<b>Kassebaum/Kennedy</b>
1. Funding	<p>Grants: total of \$25 million/year for 5 years</p> <p>--state option</p> <p>--can be for state agency, non-profit, or for-profit if profits are shared on pro-rata basis</p>	No provision
2. Eligibility	<p>For grants: organization must be:</p> <p>--free of conflicts of interest</p> <p>--bear no insurance risk</p> <p>--small employers in coop area must be served on first- come, first-served basis</p> <p>--operating costs of coop based on reasonable fees</p> <p>--demonstrate financial viability in long-run</p> <p>--other criteria defined by Secretary of HHS.</p>	<p>Coops would be certified by state and register with Dept. Of Labor.</p> <p>Must:</p> <p>--not bear insurance risk</p> <p>--not be controlled or affiliated with insurance company</p> <p>--broad-based board of directors</p> <p>--contract with multiple, unaffiliated health plans.</p> <p>--small employers in coop area must be served on first- come, first-served basis</p> <p>--operating costs of coop based on reasonable fees</p>
3. State law overrides	No provision.	<p>1. Overrides state "fictious group laws" (which prevent employers purchasing insurance together)</p> <p>2. If state allows minimum benefit package (i.e., not all state mandated benefits required) for small employers, coop may also sell the product to small employers.</p>
4. FEHB Option	<p>--Governor must request (but OPM could decline if it considers option not feasible)</p> <p>--"Agents" chosen by OPM would be authorized to use FEHBP name in marketing. Could negotiate but not handle premium funds.</p> <p>--OPM could require FEHBP commercial carriers to sell its products through coop (and could terminate carrier in FEHBP if it did not comply)</p> <p>--This option funded with grant money</p>	No provision

THE WHITE HOUSE  
WASHINGTON

Purchasing coop  
file

August 19, 1996



# Health Financing Branch



Office of Management and Budget  
Executive Office of the President  
Washington, DC 20503

Please route to: Nancy-Ann Min  
Chris Jennings

Decision needed \_\_\_\_\_  
Please sign \_\_\_\_\_  
Per your request X  
Please comment \_\_\_\_\_  
For your information X

Through: Barry Clendenin  
Mark Miller *BC*

With informational copies for:  
HFB Chron.; HD Chron.; RD; JR

Subject: New Initiatives in the  
President's FY 1997 Budget

Phone: 202/395-4930  
Fax: 202/395-7840  
E-mail: patel\_pa@a1.eop.gov  
Room: #7001

From: Parashar Patel *PP*

Per a request from Chris, please find below a table which shows the cost of new health initiatives in the President's FY 1997 Budget. The table does not include additional spending proposals for Medicaid (new pools) and Medicare (new benefits) which are offset by a number of savings proposals in the respective programs.

## New Initiatives in the President's FY 1997 Budget

Fiscal Years; Billions of Dollars

	1996	1997	1998	1999	2000	2001	2002	97-02
Health Insurance for the Temporarily Unemployed	0.000	1.519	2.158	2.346	2.550	0.000	0.000	8.572
Grants for Health Insurance Purchasing Coops	0.000	0.025	0.025	0.025	0.025	0.025	0.000	0.125
<b>Total</b>	<b>0.000</b>	<b>1.544</b>	<b>2.183</b>	<b>2.371</b>	<b>2.575</b>	<b>0.025</b>	<b>0.000</b>	<b>8.697</b>

NECIDPC FL → self insured job  
(Firm jobs - right?)

## SELF-INSURANCE BY SIZE OF FIRM

FIRM SIZE	TOTAL NO. OF FIRMS (thousands)	FIRMS PROVIDING HEALTH INSURANCE (*)		FIRMS THAT SELF-INSURE		
		NO. (thousands)	% OF TOTAL FIRMS	NO. (**) (thousands)	% OF TOTAL FIRMS	% OF FIRMS PROVIDING HEALTH INS.
1,000 +	8	8	98%	6 - 7	74%	75%
500-999	8	8	97%	4 - 5	45%	46%
100-499	79	75	94%	25 - 37	33%	35%
50-99	110	96	86%	8 - 10	9%	10%
under 50	4,600	1,600	34%	166 - 200	4%	10%
All Sizes	4,900	1,900	40%	209 - 259	5%	13%

FIRM SIZE	TOTAL NO. OF EMPLOYEES (millions)	EMPLOYEES IN FIRMS PROVIDING HEALTH INSURANCE (*)		EMPLOYEES IN FIRMS THAT SELF-INSURE		
		NO. (millions)	% OF TOTAL EMPLOYEES	NO. (**) (millions)	% OF TOTAL EMPLOYEES	% OF EMPLOYEES IN FIRMS PROVIDING HEALTH-INS.
1,000 +	31	31	98%	19 - 23	73%	74%
500-999	6	5	97%	2 - 3	52%	54%
100-499	15	13	94%	3 - 5	31%	33%
50-99	8	7	86%	1 - 1	9%	10%
under 50	29	13	49%	1 - 2	6%	11%
All Sizes	89	69	77%	26 - 34	29%	37%

(\*) Firms providing health insurance include firms that provide health benefits through HMOs as well as through conventional or PPO plans.

(\*\*) Range estimate is necessary because data source intervals do not match.

Sources: Number of firms and employees by firm size from BLS ES-202 data on legal entities in U.S. private industry, 1992.  
Shares of employers who self-insure and of employees in firms that self-insure by firm size from 1991 HIAA health benefits survey, tabulated by Urban Institute.

Stacy - Pl. Sec. do  
Gary & Kim & Judy.

*self-insured*



November 7, 1994

MEMORANDUM TO CHRIS JENNINGS

FROM: MEREDITH MILLER

SUBJECT: HIAA and Foster Higgins Data on Self Insured Employers

The origin of the apparent disagreement is that in some 1992 data released by Foster Higgins they said that something greater than 60% of employers self-insured. This has evidently made its way into some of the literature and taken on a life of its own.

Foster Higgins did however publish recently the 1993 version of their survey which shows that self-insurance for employers sponsoring indemnity plans is 19% and for PPO's 6%.

The later data are roughly comparable to what we find in the HIAA tabulations that the Urban Institute did for us, which show that 13% of employers providing benefits are self-insuring. The earlier data I do not find to be at all credible and are probably a consequence of the nature of their survey which must not have been a very representative sample of employers. They have in fact greatly expanded the survey for 1993 and changed their sample.

An additional source of data is the EBS that is done by BLS. While they don't count employers they do show that in 1989 about 25% of workers with indemnity plans work for employers who reported that they self-insure. They corresponds reasonably well to the HIAA number of 37% of all workers (not employers) work for employers who self-insure.

Because the later Foster Higgins data, the BLS data and the HIAA reach findings that are quite similar I am not inclined to place much credence in the earlier Foster Higgins data. If 60% of employers self-insured and it was the largest 60% of employers this would mean that something like 80% of the population was in these plans. This is simply not feasible, there would not be enough left in the market to make insurance companies viable at the level that we know they exist, and it would mean there would be hundreds of thousands of ERISA plans that would be required to file with us.



DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS  
1500 PENNSYLVANIA AVENUE, NW  
WASHINGTON, DC 20220

Number of pages to follow: 3

Date: 6/10/95

To: Chris Jennings, NEC

Addressee's Fax Number: 456 7028

Addressee's Confirmation Number: 456 5560

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

Also sending to Mark Miller and Nang-Ana Min

NOTE: THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND/OR RESTRICTED AS TO OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. If the recipient of this message is not the addressee (i.e., the intended recipient), you are hereby notified that you should not read this document and that any dissemination, distribution, or copying of this communication except insofar as necessary to deliver this document to the intended recipient, is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone, and you will be provided further instruction about the return or destruction of this document. Thank you.

UNCLASSIFIED

50 percent deduction loses \$2.3 billion between FY 1995 and FY 2002 and \$4.2 billion between FY 1995 and FY 2005.

Under the slower phase-ins, the following phase-in schedules apply to the 100 percent, 80 percent, and 50 percent deductions:

For the 100 percent deduction -- 30 percent in 1995, 40 percent in 1996, 50 percent in 1997, 60 percent in 1998, 70 percent in 1999, 80 percent in 2000, 90 percent in 2001, and 100 percent in 2002 and thereafter;

For the 80 percent deduction -- 30 percent in 1995, 35 percent in 1996, 40 percent in 1997, 45 percent in 1998, 50 percent in 1999, 60 percent in 2000, 70 percent in 2001, and 80 percent in 2002 and thereafter;

For the 50 percent deduction -- 30 percent in 1995, 35 percent in 1996 and 1997, 40 percent in 1998 and 1999, 45 percent in 2000 and 2001, and 50 percent in 2002 and thereafter.

With discrimination rules, the 100 percent deduction loses \$5.4 billion between FY 1995 and FY 2002 and \$12.7 billion between FY 1995 and FY 2005. The 80 percent deduction loses \$3.1 billion between FY 1995 and FY 2002 and \$8.1 billion between FY 1995 and FY 2005. The 50 percent deduction loses \$1.4 billion between FY 1995 and FY 2002 and \$3.3 billion between FY 1995 and FY 2005.

The proposals only affect individual income tax receipts. As under current law, health insurance premiums do not reduce the SECA tax base. In addition, as under current law, the deduction cannot exceed earnings from self-employment and no deduction is allowed if the self-employed person is eligible for a plan with an employer contribution.

Attachment

cc: Jennifer Klein  
Mark Miller

Effect on Receipts

Several Options for Increasing the Self Employed Health Insurance Deduction  
 Additional Estimates of Self Employed Health Insurance Deduction  
 Phase In Complete 2002  
 and  
 Prior Estimates Phase In Complete 1998

Option	fiscal year											Total	Total
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	1995-2000	1995-2005
	(\$ millions)												
<b>1. Percent of self-employed health 1/</b>	<b>30.00%</b>	<b>40.00%</b>	<b>50.00%</b>	<b>60.00%</b>	<b>70.00%</b>	<b>80.00%</b>	<b>90.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>		
With discrimination rules	-	(39)	(217)	(422)	(660)	(958)	(1,314)	(1,771)	(2,230)	(2,421)	(2,628)	(2,296)	(12,659)
Without discrimination rules	-	(44)	(243)	(484)	(780)	(1,140)	(1,564)	(2,108)	(2,654)	(2,881)	(3,128)	(2,690)	(15,025)
<b>2. Percent of self-employed health</b>	<b>30.00%</b>	<b>50.00%</b>	<b>75.00%</b>	<b>100.00%</b>									
With discrimination rules	-	(79)	(461)	(985)	(1,476)	(1,636)	(1,793)	(2,007)	(2,230)	(2,421)	(2,628)	(4,637)	(15,716)
Without discrimination rules	-	(88)	(517)	(1,130)	(1,744)	(1,946)	(2,134)	(2,389)	(2,654)	(2,881)	(3,128)	(5,425)	(18,610)
<b>3. Percent of self-employed health</b>	<b>30.00%</b>	<b>35.00%</b>	<b>40.00%</b>	<b>45.00%</b>	<b>50.00%</b>	<b>60.00%</b>	<b>70.00%</b>	<b>80.00%</b>	<b>80.00%</b>	<b>80.00%</b>	<b>80.00%</b>		
With discrimination rules	-	(20)	(108)	(209)	(324)	(485)	(792)	(1,165)	(1,532)	(1,663)	(1,806)	(1,156)	(8,113)
Without discrimination rules	-	(22)	(121)	(240)	(383)	(589)	(942)	(1,386)	(1,823)	(1,980)	(2,149)	(1,354)	(9,635)
<b>4. Percent of self-employed health</b>	<b>30.00%</b>	<b>50.00%</b>	<b>65.00%</b>	<b>80.00%</b>									
With discrimination rules	-	(79)	(416)	(737)	(1,032)	(1,138)	(1,246)	(1,386)	(1,532)	(1,663)	(1,806)	(3,403)	(11,036)
Without discrimination rules	-	(88)	(466)	(844)	(1,220)	(1,355)	(1,482)	(1,649)	(1,823)	(1,980)	(2,149)	(3,973)	(13,057)
<b>5. Percent of self-employed health</b>	<b>30.00%</b>	<b>35.00%</b>	<b>35.00%</b>	<b>40.00%</b>	<b>40.00%</b>	<b>45.00%</b>	<b>45.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>		
With discrimination rules	-	(20)	(87)	(115)	(198)	(244)	(357)	(427)	(580)	(630)	(684)	(664)	(3,341)
Without discrimination rules	-	(22)	(97)	(133)	(234)	(290)	(425)	(508)	(680)	(750)	(814)	(776)	(3,962)
<b>6. Percent of self-employed health</b>	<b>30.00%</b>	<b>35.00%</b>	<b>45.00%</b>	<b>50.00%</b>	<b>60.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>60.00%</b>		
With discrimination rules	-	(20)	(130)	(304)	(401)	(439)	(479)	(528)	(580)	(630)	(684)	(1,292)	(4,193)
Without discrimination rules	-	(22)	(145)	(348)	(473)	(522)	(570)	(629)	(690)	(750)	(814)	(1,510)	(4,963)

Extend8 selfem95 Table sum3 06/08/95

1/ Percent of health insurance purchased by the self employed which would be allowed as an above the line deduction  
 Under the current law an above the line deduction of 30% of self employed health insurance is allowed.  
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Note: The receipts effect is entirely individual income tax.

JUN-10-1995 20:53  
 DHS IHS PULLY  
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**DEPARTMENT OF THE TREASURY  
OFFICE OF TAX ANALYSIS  
1500 PENNSYLVANIA AVENUE, NW  
WASHINGTON, DC 20220**

Number of pages to follow: 1

Date: June 12, 1995

To: Chris Jennings

Addressee's Fax Number: 456-7431

Addressee's Confirmation Number: 456-5585

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

Attached is the table with the 5-year phase-ins. See lines 3 (80%) and 5 (50%).

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**UNCLASSIFIED**

**Effect on Receipts Of Several Options  
to Increase the Percent of Health Insurance  
Purchased by the Self Employed  
Allowed as a Deduction**

Option	1995	1996	1997	1998	1999	fiscal year						Total 1995-2000	Total 1995-2001
						2000	2001	2002	2003	2004	2005		
	(\$ millions)												
<b>1. Percent of self-employed health 1/</b>	<b>30.00%</b>	<b>45.00%</b>	<b>60.00%</b>	<b>75.00%</b>	<b>90.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>		
With discrimination rules	-	(59)	(327)	(639)	(1,007)	(1,445)	(1,793)	(2,007)	(2,230)	(2,421)	(2,628)	(3,478)	(14,556)
Without discrimination rules	-	(66)	(367)	(733)	(1,190)	(1,720)	(2,134)	(2,389)	(2,654)	(2,881)	(3,128)	(4,076)	(17,260)
<b>2. Percent of self-employed health</b>	<b>30.00%</b>	<b>50.00%</b>	<b>75.00%</b>	<b>100.00%</b>									
With discrimination rules	-	(79)	(461)	(985)	(1,476)	(1,636)	(1,793)	(2,007)	(2,230)	(2,421)	(2,628)	(4,637)	(15,716)
Without discrimination rules	-	(88)	(517)	(1,130)	(1,744)	(1,946)	(2,134)	(2,389)	(2,654)	(2,881)	(3,128)	(5,425)	(18,610)
<b>3. Percent of self-employed health</b>	<b>30.00%</b>	<b>40.00%</b>	<b>50.00%</b>	<b>60.00%</b>	<b>70.00%</b>	<b>80.00%</b>	<b>80.00%</b>	<b>80.00%</b>	<b>80.00%</b>	<b>80.00%</b>	<b>80.00%</b>		
With discrimination rules	-	(39)	(217)	(422)	(660)	(958)	(1,246)	(1,386)	(1,532)	(1,663)	(1,806)	(2,295)	(9,928)
Without discrimination rules	-	(44)	(243)	(484)	(780)	(1,140)	(1,482)	(1,649)	(1,823)	(1,980)	(2,149)	(2,690)	(11,774)
<b>4. Percent of self-employed health</b>	<b>30.00%</b>	<b>50.00%</b>	<b>65.00%</b>	<b>80.00%</b>									
With discrimination rules	-	(79)	(416)	(737)	(1,032)	(1,138)	(1,246)	(1,386)	(1,532)	(1,663)	(1,806)	(3,403)	(11,036)
Without discrimination rules	-	(88)	(466)	(844)	(1,220)	(1,355)	(1,482)	(1,649)	(1,823)	(1,980)	(2,149)	(3,973)	(13,057)
<b>5. Percent of self-employed health</b>	<b>30.00%</b>	<b>35.00%</b>	<b>35.00%</b>	<b>40.00%</b>	<b>45.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>		
With discrimination rules	-	(20)	(87)	(115)	(223)	(355)	(479)	(528)	(580)	(630)	(664)	(800)	(3,700)
Without discrimination rules	-	(22)	(97)	(133)	(264)	(422)	(570)	(629)	(690)	(750)	(814)	(937)	(4,390)
<b>6. Percent of self-employed health</b>	<b>30.00%</b>	<b>35.00%</b>	<b>45.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>60.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>	<b>50.00%</b>		
With discrimination rules	-	(20)	(130)	(304)	(401)	(439)	(479)	(528)	(580)	(630)	(684)	(1,292)	(4,193)
Without discrimination rules	-	(22)	(145)	(348)	(473)	(522)	(570)	(629)	(690)	(750)	(814)	(1,510)	(4,963)

Extend7 selfem95 Table sum3 06/06/95

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Under the discrimination rule option discrimination rules would apply to the deduction in excess of the current law 30%.

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**DEPARTMENT OF THE TREASURY  
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WASHINGTON, DC 20220**

Number of pages to follow: 1

Date: June 12, 1995

To: Chris Jennings

Addressee's Fax Number: 456-7431

Addressee's Confirmation Number: 456-5585

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

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Comments/Special Instructions:

Attached is the table with the 5-year phase-ins. See lines 3 (80%) and 5 (50%).

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Effect on Receipts Of Several Options  
to Increase the Percent of Health Insurance  
Purchased by the Self Employed  
Allowed as a Deduction

Option	1995	1996	1997	1998	fiscal year							Total 1995-2000	Total 1995-2000	
					1999	2000	2001	2002	2003	2004	2005			
(\$ millions)														
1. Percent of self-employed health 1/ With discrimination rules	30.00%	45.00%	60.00%	75.00%	90.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	(3,478)	(14,556)
Without discrimination rules	-	(59)	(327)	(639)	(1,007)	(1,445)	(1,793)	(2,007)	(2,230)	(2,421)	(2,628)	(3,128)	(4,076)	(17,260)
2. Percent of self-employed health With discrimination rules	30.00%	50.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	(4,637)	(15,716)
Without discrimination rules	-	(79)	(461)	(985)	(1,476)	(1,636)	(1,793)	(2,007)	(2,230)	(2,421)	(2,628)	(3,128)	(5,425)	(18,610)
3. Percent of self-employed health With discrimination rules	30.00%	40.00%	50.00%	60.00%	70.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	(2,296)	(9,928)
Without discrimination rules	-	(39)	(217)	(422)	(660)	(958)	(1,246)	(1,386)	(1,532)	(1,663)	(1,806)	(2,149)	(2,690)	(11,774)
4. Percent of self-employed health With discrimination rules	30.00%	50.00%	65.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	(3,403)	(11,036)
Without discrimination rules	-	(79)	(416)	(737)	(1,032)	(1,138)	(1,246)	(1,386)	(1,532)	(1,663)	(1,806)	(2,149)	(3,973)	(13,057)
5. Percent of self-employed health With discrimination rules	30.00%	35.00%	35.00%	40.00%	45.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	(800)	(3,700)
Without discrimination rules	-	(20)	(87)	(115)	(223)	(355)	(479)	(528)	(580)	(630)	(684)	(814)	(937)	(4,390)
6. Percent of self-employed health With discrimination rules	30.00%	35.00%	45.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	(1,292)	(4,193)
Without discrimination rules	-	(20)	(130)	(304)	(401)	(439)	(479)	(528)	(580)	(630)	(684)	(814)	(1,510)	(4,963)

Extend7 selfem95 Table sum3 06/06/95

1/ Percent of health insurance purchased by the self employed which would be allowed as an above the line deduction  
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Under current law, there are in general no discrimination rules.  
Under the discrimination rule option discrimination rules would apply to the deduction in excess of the current law 30%.

Note: The receipts effect is entirely individual income tax.



DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C. 20220

June 9, 1995

MEMORANDUM FOR CHRIS JENNINGS  
NATIONAL ECONOMIC COUNCIL

FROM: ERIC J. TODER *Eric J. Toder*  
DEPUTY ASSISTANT SECRETARY (TAX ANALYSIS)

SUBJECT: Estimate of Phased-In Increases in Deduction for  
Health Insurance Costs of the Self-Employed

The attached table shows estimates by the Office of Tax Analysis (OTA) of the effect on Federal receipts of allowing the self-employed to deduct 100 percent, 80 percent, and 50 percent of health insurance premiums under phase-in schedules ending in 1998 and 2002. The effects on Federal receipts are computed relative to a baseline that includes recently enacted legislation that makes the self-employed deduction permanent at a 30 percent rate.

Some of the estimates assume that deductions in excess of 30 percent of health insurance premiums are subject to discrimination rules. Under these rules, the deduction is the greater of 30 percent of the premium or the percentage contributed to an equivalent plan for employees (up to the maximum available deduction for that year). Other estimates assume that discrimination rules do not apply. In all the estimates, the current law 30 percent deduction is not subject to discrimination rules.

Under the more accelerated phase-ins, the following phase-in schedules apply to the 100 percent, 80 percent, and 50 percent deductions:

For the 100 percent deduction --	30 percent in 1995, 50 percent in 1996, 75 percent in 1997, and 100 percent in 1998 and thereafter;
For the 80 percent deduction --	30 percent in 1995, 50 percent in 1996, 65 percent in 1997, and 80 percent in 1998 and thereafter;
For the 50 percent deduction --	30 percent in 1995, 35 percent in 1996, 45 percent in 1997, and 50 percent in 1998 and thereafter.

With discrimination rules, the 100 percent deduction loses \$8.4 billion between FY 1995 and FY 2002 and \$15.7 billion between FY 1995 and FY 2005. The 80 percent deduction loses \$6.0 billion between FY 1995 and FY 2002 and \$11.0 billion between FY 1995 and FY 2005. The



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Addressee's Fax Number: 456-7431

Addressee's Confirmation Number: 456-5585

From: Eric J. Toder  
Deputy Assistant Secretary (Tax Analysis)

Sender's Fax Number: 622-8784

Sender's Confirmation Number: 622-0120

Comments/Special Instructions:

Attached is the memo I sent you this weekend. 5-year phase-in numbers coming shortly.

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-2-

50 percent deduction loses \$2.3 billion between FY 1995 and FY 2002 and \$4.2 billion between FY 1995 and FY 2005.

Under the slower phase-ins, the following phase-in schedules apply to the 100 percent, 80 percent, and 50 percent deductions:

For the 100 percent deduction -- 30 percent in 1995, 40 percent in 1996, 50 percent in 1997, 60 percent in 1998, 70 percent in 1999, 80 percent in 2000, 90 percent in 2001, and 100 percent in 2002 and thereafter;

For the 80 percent deduction -- 30 percent in 1995, 35 percent in 1996, 40 percent in 1997, 45 percent in 1998, 50 percent in 1999, 60 percent in 2000, 70 percent in 2001, and 80 percent in 2002 and thereafter;

For the 50 percent deduction -- 30 percent in 1995, 35 percent in 1996 and 1997, 40 percent in 1998 and 1999, 45 percent in 2000 and 2001, and 50 percent in 2002 and thereafter.

With discrimination rules, the 100 percent deduction loses \$5.4 billion between FY 1995 and FY 2002 and \$12.7 billion between FY 1995 and FY 2005. The 80 percent deduction loses \$3.1 billion between FY 1995 and FY 2002 and \$8.1 billion between FY 1995 and FY 2005. The 50 percent deduction loses \$1.4 billion between FY 1995 and FY 2002 and \$3.3 billion between FY 1995 and FY 2005.

The proposals only affect individual income tax receipts. As under current law, health insurance premiums do not reduce the SECA tax base. In addition, as under current law, the deduction cannot exceed earnings from self-employment and no deduction is allowed if the self-employed person is eligible for a plan with an employer contribution.

Attachment

cc: Jennifer Klein  
Mark Miller

Effect on Receipts

Several Options for Increasing the Self Employed Health Insurance Deduction  
 Additional Estimates of Self Employed Health Insurance Deduction  
 Phase In Complete 2002  
 and  
 Prior Estimates Phase In Complete 1998

Option	fiscal year											Total	Total
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	1995-2000	1995-2005
	(\$ millions)												
1. Percent of self-employed health <sup>1/</sup>	30.00%	40.00%	50.00%	60.00%	70.00%	80.00%	80.00%	100.00%	100.00%	100.00%	100.00%		
With discrimination rules	-	(39)	(217)	(422)	(660)	(958)	(1,314)	(1,771)	(2,230)	(2,421)	(2,628)	(2,296)	(12,659)
Without discrimination rules	-	(44)	(243)	(484)	(780)	(1,140)	(1,564)	(2,108)	(2,654)	(2,881)	(3,128)	(2,690)	(15,025)
2. Percent of self-employed health	30.00%	50.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		
With discrimination rules	-	(79)	(461)	(985)	(1,476)	(1,636)	(1,793)	(2,007)	(2,230)	(2,421)	(2,628)	(4,637)	(15,716)
Without discrimination rules	-	(88)	(517)	(1,130)	(1,744)	(1,946)	(2,134)	(2,389)	(2,654)	(2,881)	(3,128)	(5,425)	(18,610)
3. Percent of self-employed health	30.00%	35.00%	40.00%	45.00%	50.00%	60.00%	70.00%	80.00%	80.00%	80.00%	80.00%		
With discrimination rules	-	(20)	(108)	(209)	(324)	(495)	(792)	(1,165)	(1,532)	(1,663)	(1,806)	(1,156)	(8,113)
Without discrimination rules	-	(22)	(121)	(240)	(383)	(589)	(942)	(1,386)	(1,823)	(1,980)	(2,149)	(1,354)	(9,635)
4. Percent of self-employed health	30.00%	50.00%	65.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%		
With discrimination rules	-	(79)	(416)	(737)	(1,032)	(1,138)	(1,246)	(1,386)	(1,532)	(1,663)	(1,806)	(3,403)	(11,036)
Without discrimination rules	-	(88)	(466)	(844)	(1,220)	(1,355)	(1,482)	(1,649)	(1,823)	(1,980)	(2,149)	(3,973)	(13,057)
5. Percent of self-employed health	30.00%	35.00%	35.00%	40.00%	40.00%	45.00%	45.00%	50.00%	50.00%	50.00%	50.00%		
With discrimination rules	-	(20)	(87)	(115)	(198)	(244)	(357)	(427)	(580)	(630)	(684)	(664)	(3,341)
Without discrimination rules	-	(22)	(97)	(133)	(234)	(290)	(425)	(508)	(690)	(750)	(814)	(776)	(3,962)
6. Percent of self-employed health	30.00%	35.00%	45.00%	60.00%	60.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%		
With discrimination rules	-	(20)	(130)	(304)	(401)	(439)	(479)	(528)	(580)	(630)	(684)	(1,292)	(4,193)
Without discrimination rules	-	(22)	(145)	(348)	(473)	(522)	(570)	(629)	(690)	(750)	(814)	(1,510)	(4,963)

Extend8 setlem95 Table sum3 06/08/95

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Retiree Health File

## HEALTH CARE FOR RETIRED WORKERS Pabst Brewery, Milwaukee

### ISSUE

On August 29, a federal court granted a temporary restraining order preventing Pabst Brewing Company from eliminating the health care benefits to more than 700 retired workers (who had been covered under the Collective Bargaining Agreement with Brewery Workers Local 9) on September 1. Pabst argued that it had the right to cut off retiree benefits while retirees asserted that Pabst had committed itself to pay retiree benefits for life. The Department of Labor filed an amicus brief that argued that retirees' health benefits should not be eliminated until additional information about the contract is evaluated. A hearing on the Motion for a Preliminary Injunction is scheduled on September 16.

The Milwaukee Journal-Sentinel (8/30/96) reports that Representative Kleczka will encourage the President to make Pabst's now-stalled plan part of the President's Labor Day agenda. The Department of Labor believes that the President's Milwaukee trip would be an excellent opportunity to highlight the Administration's involvement in retiree health protection issues.

### MEDIA COVERAGE

Pabst's actions have been widely reported by the local media. Secretary Reich is quoted in the Milwaukee Journal-Sentinel (8/30/96) as saying "from a legal point of view we think Pabst is wrong." He continued, "If Pabst promised lifetime medical benefits to its retirees, it will honor that commitment."

### CONGRESSIONAL INVOLVEMENT

Representatives Jerry Kleczka and Tom Barrett have been very involved in this issue on behalf of Pabst retirees and asked the Secretary of Labor to investigate the case and take action if appropriate. Both Congressmen recognized the Department of Labor's efforts in recent press releases (8/29/96).

### ADMINISTRATION HISTORY

The Secretary of Labor filed an amicus brief in a similar case to enforce the health benefit promise that General Motors made to its employees. On August 14, 1996, the court ruled in favor of the 84,000 non-union retirees.

### SUGGESTED ADMINISTRATION POSITION

The Administration has consistently defended the rights of workers who have been contractually promised long-term or permanent retiree health benefits. However, the extent to which this specific case explicitly meets this criteria is unclear. We would therefore suggest the following talking point:

**"If workers are promised retiree health benefits, those commitments should be upheld."**

Retiree Health RLG  
GM Case

## RETIREE HEALTH AND THE GENERAL MOTORS CASE

### BACKGROUND

Fewer and fewer workers receive from their employer the security of health care coverage in retirement. The percent of retirees covered by health insurance provided by a former employer dropped from 37 percent in 1988 to 27 percent (4.7 million retirees) in 1994.<sup>1</sup>

And of those who have received and relied on their employer's promise of health coverage, thousands of retirees have found that coverage was taken away after their employer decides to terminate the health plan.

To ensure that promises for health care security are kept, the Department of Labor has fought for retirees in important retiree health cases through its *amicus* brief program, including in General Motors v. Sprague. The Sixth Circuit recently agreed with the Department's position (and that of AARP in its *amicus* brief) that GM must honor its promise to 84,000 retirees for health care coverage in retirement. We have argued against legal technicalities used by employers to avoid honoring their commitment to retired workers.

### OUR POSITION

American workers deserve a secure retirement. If an employer has promised health coverage to its retirees, that commitment must be honored. After a lifetime of labor, American workers should be able to rely on promises from their employers for health security in retirement.

### NEXT STEPS

Two options are on the table. First, the Administration can assure AARP members that the Department of Labor will continue its efforts to protect retirees' promises of health security through the Department's *amicus* brief program.

Second, as you know, we have had discussions on the Secretary of Labor's idea for a Presidential directive to build upon the Department's efforts by using all available Labor Department resources to ensure that employers who have promised to provide health coverage for retirees keep their promises and that the Department will identify additional actions the Administration can take to make sure these promises are honored. A draft of the directive is attached.

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<sup>1</sup> According to the August 1988 and September 1994 Health Benefits Supplements to the Current Population Surveys.

RETIREE2.STM

Page 1

THE WHITE HOUSE  
Washington, September 10, 1996.

DRAFT

Memorandum of September 11, 1996

### Protecting Health Benefits of Retirees

#### *Memorandum for the Secretary of Labor*

A substantial number of firms, having promised to provide health benefits for their retirees, later reneged on these promises. Many of these retirees, especially those who are not yet eligible for Medicare, would not have left their jobs without the guarantee of employer-provided health coverage.

I would like to first congratulate you on the success of the Department of Labor's *amicus* brief program in protecting the health benefits of retirees. Thanks in part to friend-of-the-court briefs filed by the Labor Department, courts in three recent cases issued decisions preserving retiree health coverage that employers were attempting to terminate or reduce. One of the rulings protected the health benefits of 84,000 GM retirees; another prevented the Pabst Brewing Company from terminating the benefits of 700 former employees.

I direct you to build upon this effort by using all available Labor Department resources to ensure that employers who have promised to provide health coverage for retirees keep their promises. I further direct you to identify additional actions the Administration can take to make sure these promises are honored.

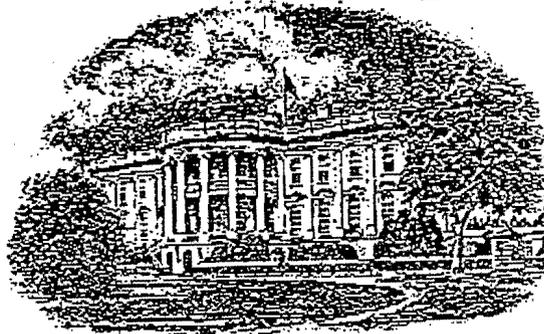
Protecting retiree health benefits is one part of this Administration's overall effort to ensure that workers, after a lifetime of labor, can enjoy a secure retirement. Honoring pledges of health coverage is the essence of corporate citizenship--taking into account people as well as profits.

You are authorized and directed to publish this memorandum in the *Federal Register*.

FAX COVER

Health and Personnel Division

Executive Office of the President  
Office of Management and Budget  
OEOB, Room 262  
Washington, D.C. 20503



DATE:

TO:

*Chris*

AGENCY:

FAX NO:

FROM:

Nancy-Ann Min  
Associate Director for Health and Personnel

Phone Number (202) 395-5178

Fax number (202) 395-9119

Number of pages (including cover) \_\_\_\_\_

COMMENTS:

S. 1107

**Retiree Continuation Coverage Act of 1995****Summary**

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This bill would allow early retirees (those under age 65) to purchase COBRA coverage through their former employer for themselves, their spouses, and dependents when the health care benefits sponsored by the retiree's former employer are eliminated or nearly eliminated. The retiree and covered dependents would remain eligible for COBRA coverage until they reach Medicare eligibility.

This legislation would enable the beneficiaries to purchase health insurance coverage at group rates until they become eligible for Medicare. Consistent with existing COBRA policy, the retirees would pay 102% of the premium, with the extra 2% added to cover the former employer's administrative expenses. The former employer is not required to contribute to the retiree's premium.

Without this legislation or other comparable reforms, early retirees who count on their employer-sponsored health care benefits may find themselves and their families unable to purchase affordable health insurance coverage when their former employers eliminate health care benefits. Furthermore, many are unable to purchase coverage at any price due to the presence of pre-existing conditions. In many cases, these individuals gave up other benefits (e.g., pay raises, pension benefits, etc.) in exchange for the promise of health benefits in their retirement.

---

*Rima Cohen*

224-2321

## U.S. Department of Labor

Assistant Secretary for  
Pension and Welfare Benefits  
Washington, D.C. 20210



AUG - 9 1996

MEMORANDUM FOR: CHRIS JENNINGS  
Senior Health Policy Analyst

FROM: OLENA BERG *Olena Berg*  
Assistant Secretary  
Pension and Welfare Benefits Administration

SUBJECT: Department of Labor Recommendations for  
Consumer Protection Reforms and Statement of  
Accomplishments Affecting Employee Health  
Benefit Plans

This memorandum is in response to your request for a short explanation of our recent accomplishments in health care related activities. In addition, you also requested that we transmit current ideas on health care initiatives that the Department is supporting. We have attached a document outlining those initiatives and one stating our recent accomplishments. I would like to emphasize that the Secretary is very interested in supporting initiatives increasing consumer protections in health care and increasing the availability of quality health care to small employers through state based group purchasing cooperatives.

**HEALTH CARE RELATED ENFORCEMENT ACCOMPLISHMENTS**

The Department's primary enforcement activity in area of health care since the beginning of this Administration has been to crack down on fraudulent MEWAs -- multiple employer welfare arrangements -- who promise inexpensive health, workers' compensation, disability and life insurance packages by setting artificially low insurance rates. To date PWBA has initiated 262 civil and criminal investigations and recovered more than \$54 million for workers and their families. In addition, criminal prosecutions have resulted in \$37.2 million in court-ordered restitution. More than 250,000 participants were covered by plans in which the Agency found fiduciary and criminal violations.

## CONSUMER PROTECTION INITIATIVES

### Consumer Grievance Process:

- Ensure consumer grievances about claims or covered benefits are addressed quickly and fairly, with access to a neutral dispute resolution system.
- ERISA Plans
  - ◆ Expand ERISA remedies to make people whole for economic losses suffered; no punitive damages; optional: add non-economic losses (pain and suffering).
  - ◆ Permit Secretary of Labor to impose civil penalties for failure to provide plan benefits without any reasonable basis. Alternative: make ERISA plans subject to existing state law remedies.
  - ◆ Health plans provide prompt notice of denial, delay or reduction in services and of a right to appeal.
  - ◆ Health plans provide expedited appeal procedures for pre-service denials and in urgent or emergency situations.
  - ◆ Trial courts review claims cases de novo, without deference to decision of administrator or fiduciary and to construe ambiguous terms in the plan contract against the drafter.

### Consumer Information:

- A summary description (not including proprietary information) of the procedures used to control utilization of services and expenditures, the practice guidelines used by the plan, and the financial incentives used by the plan (i.e., the amount of risk assigned to participating physicians).
- Health plan sponsors provide updated summary plan description (SPDs) for employee health plans every 3 years to DOL.
- Health plan sponsors distribute Summary of Material Modifications (SMMs) for changes other than material reduction in benefits at least 30 days before the earlier of the end of the plan year or the first date participants and beneficiaries may choose to decline coverage (open season).

Examples of such amendments include a decision to self-insure a plan that previously was insured without reducing benefits, or a change in plan administrator.

- o Insurance companies cannot lapse individuals' coverage under insured employee health plans lapse due to the plan administrator's nonpayment of premium, unless the insurer notifies these individuals at least 15 days before the coverage is to lapse.
- o Plan sponsors make the following disclosures to enrollees regarding their rights and remedies under an ERISA plan:
  - ◆ If a benefit claim is denied, any rights and remedies beyond the administrative appeal process come under federal law (ERISA), not state law.
  - ◆ Under federal law the remedies available are generally limited to recovery of the benefits under the terms of the plan and, at the court's discretion, reasonable attorneys' fees and costs of action but not expert witness costs.
  - ◆ Enrollees in ERISA plans generally may not recover compensatory, consequential or punitive damages that otherwise might be available under state law (e.g., out of pocket expenses and other costs incurred such as lost wages, pain and suffering and emotional damages).
- o Plan sponsors inform enrollees whether their health coverage is provided through insurance or from the general funds of the plan sponsor.
  - ◆ **Disclosure for self-insured plans:** The health benefits are provided by the plan sponsor (name) and not by an insurance company (the third party administrator could be named). The (TPA) is a claims processor and does not underwrite or insure any benefits under the plan. If the plan sponsor becomes generally unable to pay its bills, participants and beneficiaries may be responsible for outstanding bills. Because no insurance company underwrites the benefits, such unpaid claims are generally not eligible for reimbursement from a state guarantee fund that normally protects claims of failed insurance companies.
  - ◆ **Disclosure for fully-insured plans:** The health benefits are underwritten by the (name) insurance company. Should this insurance company experience financial difficulties, unpaid benefits may be eligible for reimbursement through a fund established by the

state, sometimes called a guarantee fund. Your rights however will vary from state to state and you should consult with your state insurance commissioner for further information.

**Quality:** The Department is very supportive of participants having access to objective information about the performance of their health plans. We would be interested in working with HHS and other groups to identify reliable sources of this information and develop methods for consumer access.

**Privacy and Confidentiality:** Guarantee the privacy of patient medical records.

- o Establish uniform confidentiality safeguards for all medical records, regardless of the form (paper or electronic).
  - ♦ The safeguards allows disclosure for payment of claims, investigation of health care fraud or abuse, and for specified public health reasons or in medical emergencies, by court order, by the subject's consent or to create anonymous aggregate data.
  - ♦ The safeguards ensures individual rights to inspect and modify his or her records in case of an error.
  - ♦ Adopt civil and criminal penalties for violations of confidentiality.

**Group Purchase Cooperatives/Multiple Employer Welfare Arrangements (MEWAs):**

- o Support state efforts to establish state-based purchasing cooperatives for employers (particularly small employers) to pool their purchasing power. This could be accomplished by states allowing the cooperative to have a separate pool within the state health plans for its employees or by the state certifying private cooperatives (see the original Senate version of Kennedy/Kassebaum).

- o Alternatively, as the Administration proposed before, if the state fails to set up a private or quasi-public cooperative, employers could buy into a separate state pool component of FEHBP.
- o Either of the above initiatives would help alleviate the current problems in unlicensed multiple employer welfare arrangements.

B:\CONSBILL\August 9, 1996 (11:59am)

Wt  
Bulletin  
Wed. 10/30

To Ann  
from  
Nancy - R

Meanwhile, estimates on the number of criminals amongst the more than 1 million citizens naturalized last year appear to be greatly varied. Republicans estimated earlier this week that as many as 100,000 could have been convicted criminals at the time of their naturalization. The Clinton Administration announced yesterday that its estimate, made by the Immigration and Naturalization Service, is closer to 1,300.

An INS official said today, "We believe 1,300 could warrant further investigation, but we also hold that it might be fewer than that who are criminal." Acknowledging that it could also be the case that "there may be more than 1,300" criminals in the group, the official added: "Some of them were let in by administrative errors. We need to determine whether these people were actually convicted, or they were just arrested on suspicion. ... We have to be careful who we say is a criminal. Remember, in this country, we are innocent until proven guilty."

The official said INS is reviewing naturalization applications submitted over the past year, as the House Government Oversight and Reform subcommittee continues its review of FBI files for approximately 50,000 of those new citizens. "We're going through a careful procedure to make sure that when we did the interview of the person who was naturalized, they were telling the truth and they didn't use fraudulent documents," the official said. Echoing comments made yesterday by INS Commissioner Doris Meissner, the official added: "If we find out they did have false documents, that is cause for revocation of naturalization." However, the official said those citizens would have an opportunity to appeal before being deported. "It's a process. Everyone has individual rights. Immigration affairs will hear their cases and decide whether they are deportable."

Administration considers next step for health insurance reform. Presuming a second term is on the horizon, the Clinton Administration is preparing for its next step in the area of health insurance reform. Labor Secretary Robert Reich is considering several options designed to protect health benefits for retirees, as he prepares to make recommendations in that area to President Clinton early next year.

Reich told the Bulletin that the Administration has "been litigating on behalf of retirees who allege that companies have promised them retirement health benefits and have either terminated or reduced those benefits unilaterally. We are entering court on the side of retirees when we find that their claims are justifiable. Unfortunately, we are beginning to see a pattern in which private employers are promising retirement benefits and then failing to deliver." Added Reich: "Employers are under no obligation to offer retirement health benefits to their employees, of course. But once they do, and employees rely upon that promise in their financial planning at that time, then removing that can cause quite a hardship."

Reich said the Labor Department is considering three possible ways to address concerns about retiree health benefits. "First of all, we are putting out an advisory to employees and retirees, suggesting that they look at their plan descriptions and employment

contracts to determine exactly what promises have been made with regard to retiree health care, the extent of those promises and how long those promises will last," Reich said, adding: "We're also warning employees and retirees to look for an escape clause often built into these contracts which gives companies the right to terminate or change the promises at any time. These clauses are often in fine print, but they make the difference between being assured of getting lifetime health care or not."

Secondly, Reich said his department is "looking also at some legislative options for next term -- assuming we are here. At the very least, it's important that employees who are promised health care in retirement get clear and full disclosure of what those promises entail so that they're not suddenly surprised when they retire and those promises are reneged upon. Clear disclosure would at least allow employees to plan on the possibility those promises would not be fulfilled."

The third option under consideration "would apply normal contract doctrine to employee agreements," according to Reich, who added: "So that if employees have reason to rely on them because the promises are clearly spelled out, the employer cannot escape responsibility merely to rely on a technicality." Reich said the change would be enforced through the courts. "Right now, courts don't apply normal contract principles to these employment contracts because the Employment Retirement Income Security Act -- ERISA -- preempts typical contract law. Thus the Federal courts will currently interpret these contracts extremely strictly and if the escape clause appears anywhere in the agreement, there is a possibility the courts may uphold employers' position to terminate or substantially reduce benefits."

At the root of the situation, Reich said, is the fact that "companies' earnings have suffered as a result of plans that provide health benefits for retirees. So, some companies have decided to reduce or eliminate retirement benefits, or at the very least, impose these escape clauses in their retirement benefit contracts, allowing them to terminate or amend at will." In addressing those concerns, Reich said the Administration "doesn't want to do anything that would deter employers from offering full retiree benefits in the first place. So we have to strike a delicate balance."

o FBI official pleads guilty to obstruction of justice in Ruby Ridge case. Senior FBI official E. Michael Kahoe pleaded guilty today to obstructing justice in destroying a report critical of the FBI's handling of the 1992 siege at Ruby Ridge. Entering the plea in US District Court in Washington, D.C. this morning, Kahoe agreed to cooperate with prosecutors investigating a possible coverup by other FBI officials. Under the terms of a deal agreed to last week, Kahoe admitted destroying an FBI critique of its role in the case and said he also ordered a subordinate to destroy his copies of the report as well as a computer disk that contained much of the information. Kahoe faces up to 10 years in prison and a fine of \$250,000.

o Administration responds to Schaefer on global climate change; Schaefer not satisfied. Two days ago, House Commerce Energy and Power subcommittee chairman Dan Schaefer asked officials of the



DATE: 9/10/96

TO: Chris Jennings

AGENCY: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ FAX: \_\_\_\_\_

FROM: **MEREDITH A. MILLER**  
*Deputy Assistant Secretary for Policy  
Pension and Welfare Benefits Administration  
U. S. Department of Labor  
200 Constitution Avenue, NW, Room S-2524  
Washington, DC 20210*

COMMENTS:  
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NUMBER OF PAGES INCLUDING COVER SHEET 3

Should you experience any problems receiving this transmission, please call  
(202) 219-8233.

September 10, 1996

**DRAFT**

## MEMORANDUM FOR THE SECRETARY OF LABOR

SUBJECT: Protecting Health Benefits of Retirees

A substantial number of firms, having promised to provide health benefits for their retirees, later reneged on these promises, leaving their former employees high and dry. Many of these workers, especially those who are not yet eligible for Medicare, would not have left their jobs without the guarantee of employer-provided health coverage.

I would like to first congratulate you on the success of the Department of Labor's *amicus* brief program in protecting the health benefits of retirees. Thanks in part to friend-of-the-court briefs filed by the Labor Department, courts in three recent cases issued decisions preserving retiree health coverage that employers were attempting to terminate or reduce. One of the rulings protected the health benefits of 84,000 GM retirees; another prevented the Pabst Brewing Company from terminating the benefits of 700 former employees.

I direct you to build upon this effort by using all available Labor Department resources to ensure that employers who have promised to provide health coverage for retirees keep their promises. I further direct you to identify additional actions the Administration can take to make sure these promises are honored.

Protecting retiree health benefits is one part of our overall effort to ensure that workers, after a lifetime of labor, can enjoy a secure retirement. Honoring pledges of health coverage is the essence of corporate citizenship--taking into account people as well as profits.

I look forward to receiving your suggestions as to additional steps we can take in this critically important area.

this ~~is~~  
memo will be on  
hold  
as of 9/9/96

sent out

~~DRAFT~~

## PROTECTING PROMISES OF HEALTH COVERAGE SECURITY IN RETIREMENT

American Workers <sup>deserve</sup> a secure retirement. It is crucial that employers keep their <sup>commitments</sup> ~~promises~~ of retirement health care security. ~~American workers who have worked their entire lives should be able to rely on promises from their employers.~~ I applaud Congressman Kleczka for his commitment to ensure that American workers do not find the path of retirement paved with broken promises. <sub>for</sub>

Too many retirees have relied on their employer's <sup>commitment to</sup> ~~promise~~ of health care coverage only to find that coverage is taken away after their employer decides to terminate the health plan. To ensure that promises for health care security are kept, the Department of Labor has fought for retirees in important retiree health cases, including Pabst and GM v. Sprague. We have argued against legal technicalities used by employers to avoid honoring their commitments to retired workers. We will continue to work with Congressman Kleczka and other Members to protect workers' health security in retirement.

**FAX TRANSMITTAL SHEET**  
**U.S. Department of Labor**  
**Office of the Chief Economist**



**DATE/TIME:**

**TO:** Gene Sperling / Chris Jennings

**FROM:** LISA LYNCH  
219-5109 x 156

**PAGE NUMBER ONE OF 3 PAGES**

**MESSAGE:**

Here are some draft statements  
for your review on health benefits  
for retirees. Let me know what you  
think.

**TRANSMITTER TELECOPIER: (202) 219-4902**  
**IF YOU HAVE QUESTIONS REGARDING THIS FAX CALL**  
**202-219-5108.**

September 10, 1996

**DRAFT**

MEMORANDUM FOR THE SECRETARY OF LABOR

SUBJECT: Protecting Health Benefits of Retirees

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I look forward to receiving your suggestions as to additional steps we can take in this critically important area.

DRAFT

## PROTECTING PROMISES OF HEALTH COVERAGE SECURITY IN RETIREMENT

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United States Department of Labor

**FAX****TO:***Chris Jennings***FROM:****Kelly L. Traw***Office of the Assistant Secretary**Pension and Welfare Benefits Administration**U.S. Department of Labor**200 Constitution Avenue, NW Room S2524**Washington, DC 20210**ph: 202/219-8233**fax: 202/219-5526**e-mail: ktraw@dol.gov***DATE:***9/10/96***NUMBER OF PAGES (including cover sheet):** *2***COMMENTS:***Attached is a proposed statement on retiree health*

**STATEMENT CONCERNING RETIREE HEALTH:**

We commend Congressman Kleczka for addressing how we can protect retired workers when their promise of health security in retirement is broken.

Retired workers who have relied on a promise from their employers for health care coverage should not find themselves with no coverage in their retirement, and we must continue to pursue measures to avoid such an alarming situation.

We look forward to working with Congressman Kleczka and other members of Congress on this important matter.

*This was not  
used - final version  
coming*

