- Standard benefit package = HSA-8%

- No mandate until January 1, 1999

- As of January 1, 1997, implement insurance reforms and standard benefit package rules. Subsidies available to employers according to retreat model 3 (3.5%-7.9%) for 50% share of standard benefit.

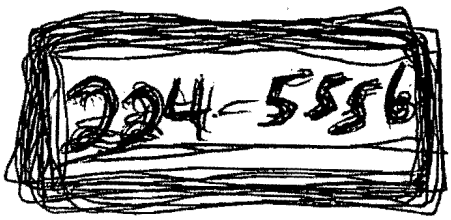
- As of January 1, 1997 provide subsidies to households according to HSA-like worker/non-worker schedules, based upon 50% share.

- As of January 1, 1999, implement 50% employer mandate on firms of >= 20 workers. Those below 20 workers have no mandate, but must pay a 1% of payroll assessment if they do not provide 50% coverage to their workers.

- Community rating for those at or below 500 workers; experience rating above 500 workers. No opt-in to community rate, and 1% assessment on those over 500.

- As of January 1, 1999, implement a Bradley-esque high cost plan assessment. The target will be set at HSA target plus 1% in each year (lagged to begin in 1997). Assessment will be on those plans bidding above the target in the community rating pool. Assessment will be on those bidding above target, taking into account the relative risk in the experience rated groups below 1000 workers.

FAX



DATE: _____ **TIME:** _____

TO:

RECIPIENT: Chris J.

ORGANIZATION: _____

FAX NUMBER: _____

FROM:

PERSON SENDING: Bob R.

ORGANIZATION: _____

NUMBER OF PAGES: ____
(including this one)

COMMENTS: _____

Ken Thorpe — 6 things

Target Govt money most efficiently

Govt spent per uninsured population scale

show a # of you only covered uninsured = $30 billion = 1 year

Voucher private insurance

(1) Choice subsidies to only under 75% of poverty & phase out at 150%
or. If uninsured for past 6 months your eligible for subsidies.

(2) increase Medicaid transitional payments for one year (?).
Labor concerns
- 6 million uninsured eligibles. Southern states, in particular, get a lot covered in charity hospitals. State concerns.

(3) Enforce nondiscrimination provisions. (Choice)

← (4) payroll tax - Taxes uninsured workers no matter where they work (excluding firms that offer & ring

(5) COBRA-like transitional pool. Federal funding of employer premium. Community rated pool offered to the uninsured.

(6) To firms that don't offer in last 6 months, guarantee a premium that does not ↑ more than 6% or 7% for 2 years & $1B - $5 - $10. Subsidies for firms that don't offer
Cost Containment: option to use Medicare fee schedule
insure

A MODEL WITH GREATER STATE ACCOUNTABILITY/RESPONSIBILITY

♦ In the HSA (and most other bills), a federal framework for health care financing and delivery is established, with the option for states to alter this framework if they so choose (the 'single payer' options). A model with greater state accountability and responsibility would reverse this approach, and allow states greater flexibility in designing a framework for health care financing and delivery, while giving them access to a federal 'back-up' framework if they so choose. Under such a model, states could be given three generic options:

OPTION I: Do nothing -- that is, do not act to provide universal coverage. However, as discussed below, states would be given strong financial incentives to avoid this option.

OPTION II: Within broad parameters, adopt their own financing and delivery rules. Under this option, states would receive a block grant equal in size to the subsidies they would have received under the HSA.

OPTION III: Adopt the health care financing and delivery rules specified in the HSA (e.g., employer/employee mandates, specified levels of financial protections for workers and non-workers, premium caps) and be guaranteed that the federal government will pay for subsidies.

Note: Without this option, state opposition to the proposal would be extremely strong -- i.e., states need an option for universal coverage that does not put them at financial risk.

Lunch
— 10:30
Please join me for
a great lunch w/
policy people & donor
policy — MAM, Lew, Kerr & Gang?

OPTION I: STATE DOES NOT ENACT UNIVERSAL COVERAGE

♦ States could choose not to enact universal coverage, but financial inducements to the states to accept the block grant offer would be strong:

- The federal government would increase the tobacco tax, eliminate federal DSH funding, cap federal contributions to acute care Medicaid, and enact Medicare savings nationwide. If a state does not act to enact universal coverage, it loses its share of the revenues generated by these measures. Like the Medicaid program in 1965, the federal government makes states an offer they are unlikely to refuse.

  As an alternative, this option might only be offered until some date (e.g., 2000). After that date, addtional financial levers might be used to encourage states to adopt reform.

OPTION II: STATE DESIGNS FINANCING AND DELIVERY RULES AND ACCEPTS BLOCK GRANT FUNDING

♦ The federal government gives a block grant to each state if the state operates a 'certified' system.[1]

♦ In order to receive this block grant, a state must file a state plan which demonstrates:

- All residents of the state are covered by health insurance providing a federally specified package of benefits;

- All residents, and particularly those from disadvantaged groups, receive quality health care; and

- The state provides federally specified encounter-level information on health care utilization.

♦ Within these parameters, states have broad flexibility to determine:

- How to raise money (e.g., employer/employee mandates, income tax financing, sales tax financing);

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[1] The size of the block grant would obviously be a hotly contested issue. As a starting point, assume that the block grant would be equal to the net federal subsidy if all of the provisions of the HSA were in place. That is, the level of block grant is determined by the number of employers and employees in the state eligible for subsidies under HSA subsidy rules (or some alternative subsidy rule), by the level of the premium target in each state, and by the state's required maintenance of effort for Medicaid recipients.

- How to spend money (e.g., managed competition with competing health plans; state-run analogue to Medicare Part C; direct budgeting of hospitals);

OPEN ISSUE IN OPTION II

♦ Federal tax treatment of health insurance: if current tax treatment of employer provided insurance is maintained, then tax expenditure is left exposed if states do not control costs. Further, if status quo is maintained, then states that want to shift from employer based financing to some other system (e.g., income tax or sales tax), would be discouraged from doing so.[2]

Alternative: The block grant could be adjusted to reflect the effects of changes in federal tax expenditures. For example, if a state chose to finance health care through a state income tax or sales tax, resulting in an increase in taxable wages and federal tax revenue, the state block grant should be increased. Conversely, if a state allows health care expenditures to rise faster than the rates of increase in the HSA and the federal government loses tax revenue, the block grant could be offset.

OPTION III: STATES ADOPT FEDERAL RULES AND AVOID FINANCIAL RISK

♦ Similar to the main scenario in the HSA and its alternatives, states could accept a federally defined system for employer/employee payment requirements, subsidy determination, health plan payments (including premium caps), and the federal government would guarantee the availability of revenues for subsidies.

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[2] One option would adjust the block grant for changes in federal tax expenditures. For example, if a state chose to finance health care through a state income tax or sales tax, resulting in an increase in taxable wages and federal tax revenue, the state block grant should be increased. Conversely, if a state allows expenditures to rise faster than the rates of increase in the HSA and the federal government loses tax revenue, the block grant could be offset.

ADVANTAGES AND DISADVANTAGES OF STATE ACCOUNTABILITY/RESPONSIBILTY APPROACH

ADVANTAGES

- Allows Congress to pass a law that makes universal coverage possible without imposing employer mandates or premium caps.

- Unites administrative and fiscal responsibility at the state level (option 2) rather than giving fiscal responsibility to the federal government while asking states to administer the system.

- Allows maximum flexibility to tailor state systems -- including financing -- to state circumstances.

- Provides incentives for states to implement cost containment, and more flexibility to states in devising methods to do so.

- To the extent that some states are slow to implement universal coverage, creates short term budget savings for the federal government.

DISADVANTAGES

- Unclear whether any major constituency groups would favor this proposal over the HSA or its cousins.

- If states can choose option I -- do nothing -- does not guarantee universal coverage.

- Degree of financial protection for low income persons may vary across states.[3]

- Precipitates ongoing state v. state and state v. federal disputes over initial premium targets, maintenance of effort payments, and allowable rates of growth.

- Unless the ERISA pre-emption is maintained, large multi-state employers will be subject to different rules in many states and are likely to be strongly opposed. If parts of the ERISA pre-emption are maintained, states must, at a minimum, be able to require large employers to provide insurance and must be able to equalize payments across community rated and self-insured pools (i.e., must be able to assess large

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[3] That is, some states may adopt more regressive financing systems than other states. Although the federal government could, in theory, require a minimum level of financial protection for individuals for their health insurance payments, unless the federal government approved every aspect of the state tax structure, it could not in practice provide equal financial protection to low income persons across states.

employers).

♦ The maximum flexibility option (block grants) leaves states financially at risk, and worried that the federal government witll increase benefits and/or cut back further on the rate of growth of the block grant. At a minimum, the legislation should require that if the federal government increases the guaranteed benefits package in the future, it must be required to increase the subsidy payments as well. A National Health Board would be required to provide an independent assessment of whether subsidies are adequately adjusted for benefit changes. Additional protections for states should be considered: for example, the ability to increase the deductible for upper income persons. Stronger protections, but ones that come at some federal cost, might:

- Tie the rate of growth of federal subsidy payments to the per capita rate of growth of Medicare expenditures.[4] This would provide some protection to state budgets against arbitrary cutbacks in subsidies (if the federal government is willing to take the heat from providers and constrain Medicare expenditure growth, then states should be willing to so so also).

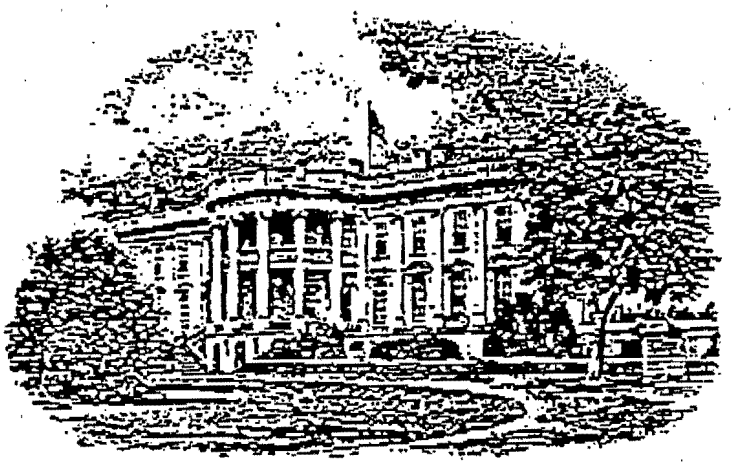
- Have the federal government share the risk of overruns with the states. If most states are over their premium target, then one might assume that the targets are too low and the federal share of the overrun might be relatively large. If only a few states are over the target, then one might assume that the states did a poor job of managing expenditures, and the federal share might be relatively low.

[4] The Medicare rate of growth should be adjusted for benefit changes (e.g., the addition of prescription drugs). Also, to make this budget neutral with respect to the HSA, the rate of subsidy increase might be specified as Medicare per capita minus X percent -- with the justification that with the advance of medical technology a greater percentage of expenditures should go the elderly.

DATE: 7/7
TIME: 7:45pm

THE WHITE HOUSE

WASHINGTON



FAX COVER SHEET

TO: Chris Jennings
c/o David Nexon

PHONE: ( )

FAX: ( ) 224-3533

FROM: Stacey

PHONE: (202) 456-5585

PAGES FOLLOWING COVER SHEET: 2

DRAFT July 7, 1994

ALTERNATIVE STRUCTURE FOR HIGH COST PLAN ASSESSMENT

- In general, health plans whose premium for the standard benefit package exceeds an annual target would pay an assessment.
  - For community-rated plans, the target would be the projected average premium (or some percentage above the average premium) of community-rated health plans in an area. *Alternatively, the target (and its rate of increase) could be established through a formula set in statute (similar to the HSA).* Health plans whose premium exceeds the average premium in an area would pay the assessment.
  - For experience-rated plans, the target would be the projected average annual rate of increase of health plans in an area. *Alternatively, the target rate of increase could be specifically established in legislation (similar to the HSA).* Health plans whose premiums in an area increased faster than the target rate of increase (based on a rolling average of increases over several years) would pay the assessment.
- Separate nationwide targets would be established for community-rated plans. *Alternatively, there could be no national targets.*
  - The nationwide target for community-rated plans would be the projected average premium of community-rated health plans nationally. The target would be adjusted for cost-of-living and demographic characteristics across community-rating areas.
  - Community-rated plans whose premiums were below the nationwide targets (regardless of the area target) would not be assessed).
- The area targets would be based on projections of the average premium and average annual premium increase in the each area. The nationwide targets would be based on national projections of premiums and annual premium increases. The projections would be made annually by the Secretaries of Treasury and HHS, pursuant to regulations. *Alternatively, the target formula and target rate of increase could be specified in statute, as in the HSA.*
- The targets and assessments would apply only to premiums for the standard benefit package. Experience-rated plans (including self-funded plans) would be required to establish separate premiums (or premium equivalents) for the standard benefits. Regulations would specify how the separate premiums would be calculated for experience-rated plans.
  - Targets would need to be adjusted for demographics characteristics of plan enrollees. For experience-rated plans, the adjustment would be based on change in enrollee characteristics between rating periods.

- The assessment would be made on the amount of premium that exceeded the target. The level of assessment would be specified in statute.

  - For experience-rated plans, the assessment would be based on the rolling average of premium increases over a specified period of years. The period would vary with the number of covered lives (smaller plans would be averaged over a longer period of years).

STATE FLEXIBILITY OPTION

GOAL: Maximize flexibility for states in both financing and delivery of health care. Under this approach states could either: adopt a federal reform plan, as in the HSA or Kennedy legislation, or design their own system of financing and delivery.

STARTING DATE: Under either option states would be eligible to enter the new system as of ..... States would have to choose Option 1 or 2 within two years of that date. (I.e., states could delay entry for two years, but would receive no federal subsidies during that time).

ERISA PREEMPTION: Under both options it is assumed that requirements for employers of over a specified number of full-time employees (e.g. 500) would be determined and enforced by the federal government.

OPTION ONE: THE FEDERAL TEMPLATE

Similar to the HSA or the Kennedy bill, states would adopt the reform scheme outlined in federal legislation. The federal template would define, among other things: employer/employee requirements to contribute, subsidy rules, cost containment provisions, insurance reforms, etc..

- Under this approach the federal government is responsible for subsidy payments to employers and families.

OPTION TWO: STATE FLEXIBILITY

Federal government provides funding to states when they enact an approved program. Amount of federal funding is equivalent to what state would receive under the subsidy formula in the federal template approach.[1]

- To receive federal funds, states must enact a plan in

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[1] Size of the federal grant could be a controversial issue. As a starting point assume it would be equal to the net federal subsidy if all the provisions if the Kennedy bill were in place. That is, the level of the block grant is determined by the number of employers and employees in the state eligible for subsidies under the Kennedy rules, by the level of the premium target in each state, and by the state's required maintenance of effort for Medicaid recipients.

which:

-- All legal residents are covered by insurance providing federally defined benefits.

-- There are assurances that all, especially vulnerable populations, will receive quality care.

-- Required payments from families are affordable. (Some flexibility must be allowed here, as states may chose a variety of financing mechanisms --e.g. sales tax-- in which capping family payments might be impossible).

-- Insurance is portable.

-- States collect quality and other data as required by federal law.

- States would have broad flexibility to determine:

  -- How to raise funds (e.g. employer/employee payment requirements, tax-based financing).

  -- How to spend money (e.g. managed competition, direct budgeting of hospitals, rate-regulation, Medicare Part C-type program, etc.).

  -- How to structure a delivery system (e.g., employer v. employee choice of plans, creation of alliances, etc.).

- The state would be responsible for payment of promised subsidies.

- To offer some guarantees to states, federal legislation would guarantee that should the benefits package be increased, federal subsidy payments would be increased as well. Levels of subsidy payments would also have to be guaranteed.[2]

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[2] Some means by which such guarantees could be offered would include: Require that the National Board provide an independent assessment of whether subsidies have been adequately adjusted for benefits changes; tie the rate of growth of subsidy payments to the per capita rate of growth of Medicare expenditures (i.e., make the federal government live with the same rates of growth it is mandating on states); have the federal share the risk of overruns with the states, especially when sizable numbers of states all fail to meet targets.

SOME OPEN QUESTIONS/OPTIONS RELATING TO OPTION TWO

Federal tax treatment of insurance:

- If current tax treatment of employer provided insurance is maintained then the federal tax expenditure is exposed by state programs that fail to contain costs. Additionally, if the current tax preference is maintained it will discourage states from adopting other funding mechanisms (e.g. sales tax) as states would not want their employers to lose the tax advantages of the present system.

  Therefore, the federal grant to a state could be adjusted to reflect the savings to the federal government should a state adopt a financing mechanism that reduces federal tax expenditures and/or increases federal revenues from other sources (e.g., higher income taxes). Conversely, the grant could be reduced if a state allows health care expenditures to rise faster than federal rules allow, causing higher tax expenditures by the federal government.

ERISA PREEMPTION ISSUES

Maximum state flexibility can be in conflict with the ERISA preemption. The smaller the threshold number for employers governed by federal rules the greater this conflict is likely to be. (I.e., exempting employers of over 5000 may still leave states with considerable flexibility. Exempting employers of over 100 employees may render state flexibility a less viable option).

The federal legislation would need to determine if:

- There were any circumstances under which a state could impose requirements on employers of over the threshold number (e.g., could a state enact a single payer system, including the large employers?).

- Employers above the threshold size would be eligible for subsidies and how those subsidies would be financed. (Presumably, directly by the federal government).

- Employers over the threshold size would be eligible to opt into the state run system, and under what rules.

- Whether or not employers over the threshold size could be assessed (by the federal government or states) to equalize payments across state run and federally regulated pools.

ADVANTAGES AND DISADVANTAGES OF THE STATE FLEXIBILITY APPROACH

ADVANTAGES

- Allows Congress to pass a law that makes universal coverage possible without imposing a mandate or premium caps.
- Offers states the option to unite administrative and fiscal responsibility rather than giving fiscal responsibility to the federal government administrative responsibility to the states.
- Allows maximum flexibility to tailor state systems -- including financing-- to state circumstances.
- Provides incentives for states to implement cost containment, and more flexibility to states in devising methods to do so.
- To the extent that some states are slow to implement universal coverage, creates short term budget savings for the federal government.

DISADVANTAGES

- It is unclear whether any major constituency group would favor this approach over the HSA or its cousins. This may be result, in part, because increased state flexibility leaves greater uncertainty as to what the final proposal will look like.
- The degree of financial protection for low income persons may vary across states.[3]
- Precipitates ongoing state v. state and state v. federal disputes over initial premium targets, maintenance of effort payments, and allowable rates of growth.
- Unless states are allowed to enact single payer systems including large employers single payer advocates would view this proposal as a big step backwards from the HSA.

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[3] Some states may adopt relatively regressive financing systems. This ~~probability~~ concern could be minimized by a requirement that the federal government approve state financing arrangements. But, in practice, that might require the federal government to undertake comprehensive reviews of the impact of various state tax systems.

Attachment 2

Issues

Self-Insurance

MEWAs

Solvency/Guaranty Fund

Remedies

Worker Protections

Definition of Employee

Early Retirees

Worker Training

Subsidy Administration

Role of States/ERISA Preemption

Workers Compensation

Small Business Carve Out

ERISA Technical Provisions -- Adequate Fiduciary Controls

DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY

JUN 28 1994

RECEIVED
1994 JUN 30 P 12: 20

MEMORANDUM FOR OLENA BERG

FROM: **Leslie B. Samuels** LBS

SUBJECT: **Definition of "Employee" Under the Health Security Act**

Under the Health Security Act (Act) as introduced, the Secretary of the Treasury would be authorized to promulgate regulations setting forth rules for determining whether an individual is an "employee" for employment tax, income tax, and, derivatively, health care purposes; and the Secretary of Labor would be responsible for enforcement of compliance with the health care requirements of the Act (such as payment of premiums). The purpose of this memorandum is to describe briefly our expectation regarding the scope of the Department of Labor's (DOL) participation in the development and implementation of the regulations.

Our expectations at this time are based on the Act as currently proposed. Thus, this discussion assumes that the Act will authorize (i) the Treasury Department to promulgate the regulations and (ii) DOL to enforce compliance with the health care requirements under the Act. If either of those aspects are altered substantially, we will have to consider the appropriate role of DOL based on the revised provisions.

Regarding the legislation itself, we believe, as I mentioned to you at our last meeting, that it would be counter-productive politically for DOL to have any formal or visible participation in the development of the tax provisions, and in particular the worker classification provisions. Our principal point regarding why it is reasonable to grant Treasury regulatory authority is that we do not expect that the regulations would result in substantial reclassification of workers relative to their proper classification under current law. We are very concerned that any visible participation by DOL in the enactment of the regulatory authority provision may be construed by opponents of the provision as evidence of an intent to reclassify independent contractors under current law as employees. We will, however, keep you apprised of legislative developments.

If the regulatory authority provision is enacted, we would expect the DOL to be involved in the development of the regulations to the same extent as with any other tax regulation that has significant ramifications for programs under the jurisdiction of DOL. Thus, we would expect that DOL, as an agency with considerable expertise and interest in the area of treatment of workers, would be consulted as proposed and final regulations are developed and promulgated. Again, however, we believe it would be counter-productive for DOL to have a more formal role than would be the case with other regulation projects of a similar nature, because that may be perceived as an indication that the regulations will attempt to recast independent contractors as employees.

Please feel free to contact me or my staff if you would like to discuss this matter further.

U.S. Department of Labor

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

MEMORANDUM FOR ROBERT B. REICH
Secretary of Labor

FROM: OLENA BERG
Assistant Secretary
Pension and Welfare Benefits Administration

GERI D. PALAST
Assistant Secretary
Office of Congressional and
Intergovernmental Affairs

SUBJECT: Legal and Policy Issues Relating to the Definition of Employee Under the Health Security Act

The purpose of this memorandum is to apprise you of controversial issues raised by the definition of the term "employee" in the Health Security Act. We believe it is important for you to focus on this issue for several reasons. First, the classification of an individual as an "employee" rather than as an independent contractor affects the individual and the employer's rights and responsibilities under many different labor and tax laws. Second, under the Act, this classification will determine whether an employer must pay the 80 percent share of the health care premium or whether the individual as an "independent contractor" is responsible for the entire premium and may now be eligible for government subsidies.

As you may be aware, Congressman Pat Williams of the House Education and Labor Subcommittee recently sent you a letter expressing his concern over the fact that, in the Administration's health reform legislation, it is the Treasury Department, and not the Labor Department, that has regulatory authority over the definition of "employee."[1] Other Congressional committees appear interested in the policy implications under labor law involved in the classification of individuals in the workplace, as well as the jurisdictional issues. The committees point out that, generally, where the Department has authority to enforce a statute, it also has

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[1] It is important to note at the outset that representatives from DOL were not present at an Administration meeting where the decision was made to utilize the Social Security definitions found in the Tax Code.

regulatory authority over key definitions. As for now, DOL has the responsibility to enforce the employer mandate under HSA.

This issue also has been a major longstanding substantive issue for interest groups such as unions who are more likely to be interested in how the classification of an individual as an "employee" under the Act might affect their ability to organize. Generally, unions are limited to organizing "employees" and may not organize "independent contractors". It is our understanding that the unions do not have a preference for whether it is the Treasury Department or the Labor Department with regulatory authority.

The following is a general explanation of how the term "employee" is defined in the Act for purposes of health care coverage. In addition, we have attempted to explain some of the history behind this issue and some of the policy consequences should the language remain unchanged. We have also made some recommendations about the regulatory authority the Department may wish to have concerning this issue.

The Health Security Act

The Act defines the term "employee" through incorporation by reference of the definition of employee under § 3121(d) of the Internal Revenue Code (the "Code"). This is the section that defines "employee" for purposes of collecting Social Security taxes (i.e., FICA tax).

The Code's definition of employee was selected for classifying workers under the Act for two primary reasons. First, it embraces the vast majority of workers who are not independent contractors. This would include workers ranging from domestic workers to corporate and many government employees. And second, it is a definition that employers already are or should be knowledgeable about to comply with existing employment tax requirements.

Section 3121(d) of the Code specifies four employee classifications with the largest, and arguably, the most important one, being "common-law employees."[2] This "common law employee" classification

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[2] The Act creates additional levels of analysis regarding the definition of employee in two relatively noncontroversial respects. First, it includes as "qualifying employees" those employees who perform 40 or more hours per month. A qualifying employee who performs 120 or more hours per month is treated as a full-time equivalent employee. A qualifying employee who performs 40 or more, but less than 120 hours per month is treated as the fractional equivalent of a full-time employee.

(continued...)

is also used in other employment tax provisions of the Code. The most significant change in the Act is that the Treasury is also being given additional authority to write new rules regarding who a common law employee is not only for the Social Security tax provisions and the Act, but also for other employment tax and income tax provisions of the Code that utilize this classification.

The rationale for granting this sweeping authority is based on the new employer mandates in the Act. As you know, the Act obligates employers to cover a significant share of their employees health insurance premiums. It also provides certain employers with discounts on the premiums they pay for their employees. Thus, it is critical that health care reform provide clear rules for determining the employment status of all workers for purposes of health care coverage.

In summary, the key controversy here has been triggered because the Treasury Department has turned this new regulatory authority into an opportunity to rewrite the classification section of worker rules for other employment tax and income tax provisions as well as the Act itself. The rationales for this are the greater incentive for manipulation with this new mandate and the fact that the classification rules in employment tax and income tax law are inconsistent and diverse. This confusion exists because this broad grant of regulatory authority given to Treasury in the Act has been explicitly prohibited by Congress in several laws over the past fifteen years.

Current Law and Its History

Under existing law, workers are generally classified as employees or independent contractors for employment tax purposes based on a common law facts and circumstances test employing approximately 20 factors.[3] This approach to employment classification is, by

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[2](...continued)

Second, it contains a special provision which allows the National Health Board to recognize as employees for coverage purposes those persons employed by the employer on a continuing basis as full-time employees based on the structure or nature of the employment in the relevant industry or industries.

[3] In 1948 the Treasury Department proposed regulations which would have replaced the common law test. The following year Congress rejected the proposed regulations by making the common law test retroactive to the date of enactment of the 1939 Internal Revenue Code and the Social Security Act of 1935. The statute was adopted over President Truman's veto.

definition, imprecise and unpredictable. In fact, its subjective nature invites the misclassification of workers by employers,[4] either intentionally or unintentionally, to avoid the payment of social security taxes or employee benefits.

Prior to 1979, the Service was apparently very aggressive in assessing major penalties against employers who misclassified employees as independent contractors including the imposition of retroactive income taxes and Social Security payments. The Service's actions in this area led Congress to enact § 530 of the Tax Reform Act of 1978 to protect employers from reclassification of workers by the Service by substantially prohibiting and otherwise restricting the Service's authority in this area. Section 530 was intended as a one-year measure presumably to give Congress an opportunity to develop its own guidelines for who is an employee. Absent such Congressional action, § 530 was made permanent in 1982 and endures today.

Section 530 prohibits the Service from issuing regulations or other rulings regarding the classification of workers for employment tax purposes. It also prohibits the Service from using the audit process to reclassify workers if the employer has (i) consistently treated all workers with substantially similar positions as independent contractors, (ii) filed all necessary returns consistent with that treatment, and (iii) a reasonable basis for that treatment. One safe-harbor applicable to the "reasonable basis" standard in (iii) is a reasonable reliance on a long-standing recognized practice of a significant segment of the industry in which the worker was engaged.

Given the difficulty of applying the current common law classification test, § 530 serves to insulate taxpayers from large retroactive assessments by the Service. However, in the context of health care reform, § 530 could also foster manipulation and abuse by employers of their responsibility to pay their 80 percent share of their employees health insurance premiums and the premium discount rules. It could also have a significant impact on the federal budget if individuals are treated as independent

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[4] For example, workers who are laid off and denied unemployment benefits because their former employers maintained that they were independent contractors frequently apply to the Service for a private letter ruling regarding their employment status. It is estimated that perhaps as many as nine out of every ten such requests result in a finding that the worker was an employee.

Also, a 1989 General Accounting Office study of 32,000 businesses found that approximately 38 percent of those businesses had misclassified five or more employees as independent contractors.

contractors by larger employers and are thus eligible for discounts as individuals or small business entities.

Changes Proposed in the Act

The Treasury Department had far greater regulatory authority in the October 1993 version of the Act. That version provided that such Treasury regulations would override all statutory and other rules pertaining to whether an individual is an employee for employment tax and income tax purposes.

In response to concerns expressed by a variety of persons and groups, Treasury's authority was cut back somewhat in the final draft of the Act. The Act now limits the scope of the Treasury's regulatory authority in several respects. It provides that any such regulations may modify existing rules, but must give "significant weight" to common law applicable to determining the employee-employer relationship and that any changes in worker classification will apply only on a prospective basis. In addition, they may not modify the definition of employee under § 3121(d) of the Code except for subsection (d)(2) regarding common-law employees. Nor may they modify certain other employment tax provisions.

Impact on the Department

Aside from concerns regarding the breadth of the proposed regulatory authority, vesting such broad authority in the Treasury Department will have implications not only for who is covered under the Act itself, but also for certain Labor Department programs. Issuance of regulations by the Treasury Department, combined with other interpretative guidance and the inevitable court decisions, will establish precedence regarding common law employees on which taxpayers will be entitled to rely. The sheer economic realities of how this issue gets decided for health care purposes will undoubtedly set a precedent and drive business and labor decisions regarding employment.

Such guidance and precedents will necessarily have some impact on Departmental programs that employ a common law definition of employee. For example, both the Employee Retirement Income Security Act ("ERISA") and the Fair Labor Standards Act (the "FLSA") employ the common law definition of employee that includes "any individual employed by an employer" (i.e., this is the same common law test utilized for Social Security purposes in § 3121 of the Code). Changes by the Service to the common law definition of employee will typically be driven by tax policy considerations. However, tax policy alone may not necessarily coincide with sound labor policy.

Another significant effect of this broad grant of authority to the Treasury Department would be termination of the "industry practice" safe-harbor (discussed above) under existing § 530 either when Treasury exercises its regulatory authority or otherwise issues guidance under the common law control test addressing workers in a particular industry.

This represents a major change which is, or likely will be, objectionable to most employers.[5] It will also likely be of great concern to small business entities that are more likely to rely on this exception to justify classification of certain persons as independent contractors. However, we understand organized labor to favor such reclassification as the Service generally finds more individuals to be employees rather than independent contractors as classified by their employers. Finally, this is an issue where the contingent workforce could be negatively affected if the regulatory provisions in this area are not properly crafted.

The Congressional Committees

The House Education and Labor Subcommittee on Labor-Management Relations is presently making changes to the Administration's health care legislation in an effort to write its own proposed bill. They will likely write a modified definition of "employee" that is similar to that contained in the Fair Labor Standards Act. By using that definition, the committee is also utilizing a definition that has been interpreted very broadly while assuring that the labor committees have jurisdiction over this important issue. The Senate Labor Committee is also very interested in this issue. At this time, however, they have not conveyed a position to us and are not scheduled to mark-up until mid-May.

MEMORANDUM FOR NANCY-ANN MIN

FROM: **Len Nichols**

RE: **Preliminary "Bottom Line" on Senate Finance Mark**

DATE: **7/6/94**

As you know, we received the language of the amendments to the Chairman's mark last night. OMB and Treasury staff have reviewed those amendments, and our very preliminary ballpark bottom line is:

$25 billion increase in the deficit between 1995-1999

$90 billion increase in the deficit between 1995-2004

By contrast, the Chairman's mark, sans employer mandate trigger, produced:

$80 billion decrease in the deficit between 1995-1999

$275 billion decrease in the deficit between 1995-2004

The salient differences between the final bill and the Moynihan mark are:

- HSA-like long term care program added ($158B 1995-2004)
- corporate assessment dropped ($150B)
- smaller tobacco tax increase ($20B)
- early and generous expansion for pregnant women and kids (Reigle amendment) added to subsidies ($22B)

The softest numbers, as always, are the subsidy estimates, especially the Reigle amendment subsidy estimates, since they are based upon assumptions about premiums and health insurance purchasing behavior in a voluntary yet partially reformed environment.

We will continue to refine these estimates as time and better information allows.

Final Finance Mark, 6:45 pm. 7/6

Preliminary!

	1995-1999	1995-2004
Long Term Care	19	158
Net Subsidies	211	772
Medicare Savings	(37)	(207)
Medicaid Savings	(121)	(559)
PHS/AHC Spending	40	120
Tobacco Tax*	(86)	(157)
Corporate Assessment	0	0
Net Other Revenues	(16)	(64)
Net Deficit Effect	22	87

All estimates preliminary and unofficial.

These estimates assume no changes in VA, DOD, FEHB, and other Federal health spending programs.

*Tobacco revenues are too high, and they are adjusted for in the Net Other Revenues line.

DATE: 7/6/94
TIME: 6:10 pm

Executive Office of the President
Office of Management and Budget
Health Policy

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FAX: (202) 395-3910 Voice: (202) 395-3844

To: Nancy-Ann Min; Chris Jennings; Ken Thorpe

FAX #: 5-7289; 6-7431; 401-7321

Voice #:

From: Linda Blumberg and Len Nichols

Notes:
Following is a second version of 50/50, including transitional measures outlined by Ken. Everything needs to be fleshed out, but we wanted to make sure that this is the general direction everyone is thinking about.

Number of Pages (including cover sheet): 3

- Standard benefit package = HSA-8%

- No mandate until January 1, 1999

- Transition period = January 1, 1997 through January 1, 1999
  Transition policies are as follows:

  - Implement insurance reforms and standard benefit package rules, including non-discrimination rules. No subsidies available to employers.

  - Provide 100% subsidies to households under 75% of poverty without current coverage. Phase-out percentage of premium subsidies between 75% and 150% of poverty. The same subsidies would be available to those losing their jobs that had insurance through their employment.

  - Provide a second year of Medicaid funding for those leaving welfare for work. Coverage continues through separate Medicaid program.

  - Provide constrained growth plan package to employers not currently offering insurance in the small group (< 25) market. Package would be solicited by the federal government from private sector insurers -- plans would agree to limit premium increases to 6-7% per year -- see Florida experience for details of how to do this. If employer contributed at least 50% of premium, worker 50% share would be subsidized on an income-based schedule).

  - 2% free rider assessment

  - Tobacco tax

  - 1% assessment on 500+, if provide (2% if don't provide).

- Mandate period -- January 1, 1999 and forward.

  - As of January 1, 1999, implement 50% employer mandate on firms of >= 20 workers; individual mandate on families. Those firms with fewer than 20 workers have no mandate, but must pay a 2% of payroll assessment if they do not provide 50% coverage to their workers.

  - Employers subsidized according to retreat model 3 (3.5%-7.9%) for 50% share of standard benefit.

  - Community rating for those at or below 500 workers; experience rating above 500 workers. No opt-in to community rate, and 1% assessment on those over 500.

  - Implement a Bradley-esque high cost plan assessment.

Community Rating Pool: Target is adjusted mean in the community rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997).

Experience Rated Group: Target is adjusted mean in the experience rated pool, with growth equal to HSA rates plus 1% (lagged to begin in 1997). Plan premium will be adjusted to take the pool's experience into account for firms of < 1000.

Rate is set such that revenue and subsidy losses due to growth in excess of targets is recaptured.

- Household subsidies available for 50% worker share for households up to 200% of poverty. Non-worker/Carve-out subsidies available for other 50% share to households up to 200% of poverty.

- Tax credit expansion for individual premium contributions.

- Tobacco tax

- 1% payroll assessment on the 500+ firms.

- Ricchetti meeting
- Nelson
- Tax meeting

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- o Transition period = January 1, 1997 through January 1, 1999
  Transition policies are as follows:

  - Implement insurance reforms and standard benefit package rules, including non-discrimination rules. No subsidies available to employers.

  - Provide 100% subsidies to households under 75% of poverty without current coverage. Phase-out percentage of premium subsidies between 75% and 150% of poverty. The same subsidies would be available to those losing their jobs that had insurance through their employment.

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