

**THE BUSINESS-SPECIFIC ELEMENTS OF THE  
PROPOSED KERRY – EDWARDS HEALTH PLAN:  
ENDANGERING WORKERS’ JOBS AND BENEFITS**

Commissioned by:

*The Associated General Contractors  
The National Association of Wholesaler-Distributors  
The National Federation of Independent Business  
The National Restaurant Association  
The National Retail Federation*

BRUCE SCOTT LEVINSON  
JIM J. TOZZI

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**THE CENTER FOR REGULATORY EFFECTIVENESS  
11 DUPONT CIRCLE, N.W.  
WASHINGTON, DC 20036  
[WWW.THECRE.COM](http://WWW.THECRE.COM)**

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**Executive Summary**

- < In an effort to increase the health care coverage available to American workers, the Kerry campaign designed a highly complex health care plan that imposes numerous new regulatory mandates on businesses in exchange for the promise of certain benefits.
- < To gain some specific benefits such as tax credits and insurance premium reductions, businesses would have to comply with numerous regulatory requirements including providing health coverage to all of their workers (including part-time, seasonal, temporary and contract workers) and adopting disease management programs.
- < The proposed Kerry-Edwards Health Plan (pKEHP) fails to address the key reasons why smaller businesses are less able to offer their employees health insurance: the administrative burdens and costs associated with offering health insurance.
- < Instead, the pKEHP would likely increase the administrative and regulatory burden on many employers, particularly those utilizing part-time, temporary and seasonal employees, the net effect of which could be to reduce overall employee benefits and possibly employment opportunities, by smaller businesses.
- < The business-specific elements of the pKEHP would, conservatively, impose at least 225 regulatory mandates on businesses that participated in the plan. These mandates would be in addition to the uncounted number of additional regulatory mandates inherent in other aspects of the pKEHP.
- < Each mandate in the pKEHP could potentially translate into a vast array of specific regulations. For example, one sentence in the Health Insurance Portability and Accountability Act of 1996 (Sec 264 of Public Law 104-191) concerning patient privacy, resulted in 93 pages of regulations in the *Federal Register*.

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## **THE BUSINESS-SPECIFIC ELEMENTS OF THE PROPOSED KERRY – EDWARDS HEALTH PLAN: ENDANGERING WORKERS’ JOBS AND BENEFITS**

### **I. Overview**

- < A key goal of the proposed Kerry–Edwards Health Plan (pKEHP) is to encourage employers to provide health insurance to American workers who lack such coverage.
  - The pKEHP sets a goal of health care coverage for 95% of Americans.<sup>1</sup>
  - One key mechanism for increasing health coverage is to “encourage small businesses to cover their employees.”<sup>2</sup>
- < To attain increased coverage, the pKEHP proposes a number of direct and indirect benefits to businesses to encourage them to offer coverage to all of their workers. However:
  - The benefits offered by the proposed Plan do not address many of the key underlying reasons why many workers are not offered health plans; and
  - The new regulatory burdens placed on business by the pKEHP could well reduce the ability of employers to provide benefits to their employees.
- < Because small businesses bear a disproportionately high administrative burden in providing health care benefits, employees of small businesses participating in pKEHP could be:
  - Particularly hard hit by burdens resulting from new regulatory mandates; and
  - Forced to cut back employee benefits as a result of the higher regulatory burdens inherent in the pKEHP.
- < This analysis will examine:

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<sup>1</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American,” [http://www.johnkerry.com/issues/health\\_care/health\\_care.html](http://www.johnkerry.com/issues/health_care/health_care.html).

<sup>2</sup> “Cutting Costs and Increasing Coverage vs. Rising Premiums and Shrinking Coverage,” [http://www.johnkerry.com/issues/health\\_care/compare.html](http://www.johnkerry.com/issues/health_care/compare.html).

1. The benefits, direct and indirect, promised businesses by the pKEHP;
  2. The new regulatory mandates that businesses would need to comply with in order to receive those promised benefits; and
  3. The particular burdens that employers of contingent workers and small businesses would experience in adhering to the proposed new regulatory mandates.
- < All source materials and assumptions used in this analysis are clearly stated. Information regarding the pKEHP is current information from the JohnKerry.com website, the official website of the Kerry-Edwards campaign. Wherever practical, government studies and data are utilized in evaluating the proposed health plan and related health insurance issues. This analysis does not attempt to quantify the cost that businesses would incur as a result of the pKEHP.
- This analysis also does not attempt to detail or otherwise analyze the regulatory burden and costs that would be incurred by governments, including possibly State and local governments, as a result of the pKEHP.
    - In that the pKEHP would impose specific mandatory regulatory requirements on States, these governments would also incur administrative and regulatory costs as a result of the Kerry Health Plan.
    - For example, the pKEHP states, “...Senator Kerry would require states to make available nonbinding mediation in all cases before permitting plaintiffs to proceed to trial on any medical liability claim.”<sup>3</sup>
  - The Kerry Health Plan does not indicate whether the benefits and regulatory mandates would apply only to the domestic workers of American companies or also to any or all of their foreign employees. Since applying the pKEHP to foreign workers would substantially magnify the costs and regulatory burdens associated with the Plan, this analysis, to be conservative, will assume that the Kerry Health Plan would apply only to domestic workers.
  - The Plan does not provide any estimate of the personnel or other resources that would be required for States or the Federal government to carry out their regulatory mandates under the pKEHP.
  - This analysis does not attempt to address the various other major components of the pKEHP, including those extensive provisions that apply to issues ranging from Medicare to foreign policy.

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<sup>3</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American.”

## II. Why Some American Workers Lack Health Insurance

- < Most American workers are covered by health insurance. However, a small but significant minority of workers do not have health insurance.
- < Availability of health insurance coverage is strongly correlated with the size of the employer. According to a recent study commissioned by the U.S. Small Business Administration's Office of Advocacy, 47% of employers with fewer than 50 employees offer health plans "while 97% of all firms with 50 or more employees offer health plans. (MEPS data for 2000)."<sup>4</sup>
- < Contingent workers are "slightly less likely" to receive health benefits than other workers.<sup>5</sup> Contingent workers are described in a study prepared for and disseminated by the SBA's Office of Advocacy, as those workers who do not perceive themselves as having an explicit or implicit contract for long term employment.
  - The study further explains that contingent workers are those "who, for example, are in projects or activities of limited duration, have fixed term employment contracts, or are temporarily filling in for permanent workers."<sup>6</sup> The study stresses that contingent workers may be full-time or part-time, hired from a temp agency or on an independent contract basis. Thus, seasonal, on-call and many part-time employees fit the definition of "contingent" workers.
  - The study also emphasizes the value of contingent workers to the economy stating, "The importance of contingent workers is the flexibility they provide firms in managing their work force in response to changing business conditions and skill needs."<sup>7</sup> Large firms are more likely to hire contingent workers than are smaller firms. However, small businesses hire about 40% of all contingent workers.<sup>8</sup>

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<sup>4</sup> "Study of Administrative Costs and Actuarial Values of Small Health Plans," Actuarial Research Corporation, Reston, Virginia for SBA Office of Advocacy, January 2003, p. 1.

<sup>5</sup> "Labor Shortages and Related Issues In Small and Large Businesses: Part B: Contingent Workers in Small and Large Firms. Final Report, Presented to the Office of Advocacy, U.S. Small Business Administration," Joel Popkin and Company, November 2, 1999, p. 17.

<sup>6</sup> Ibid., p. 1.

<sup>7</sup> Ibid., p. 2.

<sup>8</sup> Ibid., p. I.

- < The Federal government has made clear that lack of access to health care plans is not the reason why employees of smaller firms are less likely to be offered health insurance. A Small Business Research Summary published by SBA stated that there were “a variety of state laws designed to make coverage available.” The Research Summary also noted that no study participant “expressed a concern that their small business lacked access to health insurance or HMO coverage.”<sup>9</sup>
- < Federal studies also make clear that the parsimony by smaller firms is not the reason why their employees are less likely to be covered by health insurance. In fact, just the opposite is true. An SBA-published study states that, “It is notable that small firms were more likely to pay the premium in full than large firms for either contingent workers or non-contingent workers.”<sup>10</sup>
  - According to a poll conducted by the National Federal of Independent Business (NFIB), an organization that represents small and independent businesses, 55% of small businesses “offering health insurance required no employee premium contributions for single coverage; one-third did not require them for family coverage. Respondents indicated that they require little or no premium-sharing in order to offer a competitive insurance program.”<sup>11</sup>
- < There are two key reasons why small business are less likely than large firms to offer health insurance:
  1. The cost of the premiums; and
  2. The administrative costs associated with offering health insurance.
- < Another key reason why smaller companies have difficulty in obtaining affordable health care coverage are various state insurance laws that may set a number of potentially difficult to meet requirements, such as minimum enrollment rates. Furthermore, small company insurance plans may well have difficulty in obtaining reinsurance that could further boost the rates paid by both employers and workers.
- < An SBA-sponsored study noted that, “Price is the major factor affecting small firms’ ability to offer health insurance. Small health plans have higher administrative expenses

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<sup>9</sup> US Small Business Administration, Office of Advocacy, “Small Business Research Summary No. 202, Small Business and Access to Health Insurers, Particularly HMOs,” October 2000.

<sup>10</sup> “Labor Shortages and Related Issues In Small and Large Businesses: Part B: Contingent Workers in Small and Large Firms,” p. 19. Emphasis added.

<sup>11</sup> Morrissey, Michael A, Ph.D., NFIB National Small Business Poll, “Health Insurance,” Volume 3, Issue 4, 2003, Executive Summary.

than larger employers in the form of higher brokerage commissions, underwriting expenses and other expenses related to operating a health plan."<sup>12</sup>

- < The SBA study goes on to explain that, "Combining small employers into larger 'groups' (e.g., through associations or trusts) only reduces administrative costs if the cost per employer is significantly reduced."<sup>13</sup> Furthermore, the study notes that "The cost of some administrative functions is increased for small firms. For example, the cost to collect premiums that reflect the exact composition of the enrollment each month and the cost of plan booklets, underwriting applications and renewals have economies of scale."<sup>14</sup>
  - The types of administrative costs discussed in the study (determining the exact composition of enrollment, distributing plan booklets, etc.) would indicate that firms which are relatively dependent on contingent, i.e. seasonal and/or temporary workers, would be particularly hard hit by higher pKEHP-related administrative costs regardless of the size of the company.
- < The SBA study also examines, based on published studies and data, the cost of administering health benefits plans for large companies. The study estimated that "administrative costs of health benefits in-house were \$250 per covered employee or about 6% of premiums (range of 1% for the largest firms to 8% for the midsize firms). There are no comparable figures for smaller firms."<sup>15</sup>
- < Thus, the administrative, non-premium costs of administering health benefits is a significant cost for all companies with substantially higher burdens on all but the very largest companies.
- < The pKEHP includes provisions intended to reduce the premiums paid by employers. However, in order to gain these lower premiums, firms would need to comply with an extensive series of regulatory mandates that would likely increase administrative costs. Although the pKEHP includes provisions designed to lower administrative costs, such as requiring electronic medical records, these are plan elements that, even if they were to function as intended, would reduce administrative costs on insurers and the government, not employers.
- < Increasing the availability of health care coverage for American workers would require ensuring moderation in premium levels and reducing the administrative burden on employers, particularly smaller employers, for offering health insurance. If the pKEHP

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<sup>12</sup> "Study of Administrative Costs and Actuarial Values of Small Health Plans," p. 1.  
[emphasis added]

<sup>13</sup> Ibid., p. 9.

<sup>14</sup> Ibid., p. 10.

<sup>15</sup> Ibid., p. 19.

increases the administrative burden on employers, especially on smaller firms that are currently less likely to offer health insurance, the Kerry plan could have the unintended consequence of raising the costs and reducing the availability of employee benefits.

### **III. Benefits for Businesses Promised In the pKEHP**

- < There are five benefits promised to businesses in the business-specific version of the pKEHP.<sup>16</sup> The specific promised business benefits, using the language contained in the pKEHP, are:
  - Cut Premiums By Up To \$1,000 For America's Workers;
  - Taxes Credits To Cut The Cost Of Health Insurance By Up To 50 Percent;
  - Cut Administrative Costs By Eliminating Waste, Fraud And Abuse;
  - Reduce Medical Malpractice Premiums; and
  - Improve The Efficiency And Quality Of Care To Cut Administrative Costs.
- < The goal of cutting administrative costs contains three specific sub-goals:
  - Ensuring that all Americans have secure, private medical records by 2008;
  - Giving health providers technology bonuses; and
  - Require insurers doing business with the federal government to use advanced systems.
- < Although a number of these goals and sub-goals would not directly go to businesses, with the possible exception of certain representatives of the health care industry, the goals could potentially contribute to the overall aim reducing the resources necessary to provide quality health care.
- < It should be noted that many of the benefits enumerated in the pKEHP for businesses are not unique to the business community. Other pKEHP sub-plans tailored to various interest groups contain mixes of the benefits promised to a number of specific constituencies. For example, the promise to cut premiums by up to \$1,000 and the

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<sup>16</sup> "A Plan For Stronger, Healthier Businesses."  
[http://www.johnkerry.com/issues/health\\_care/business.html](http://www.johnkerry.com/issues/health_care/business.html)

promise to reduce medical malpractice premiums, also appears in the Kerry campaign's "Plan For Stronger, Healthier Families And Children."<sup>17</sup>

- The appearance of the same promised health care goals in different sub-plans should not be viewed as a flaw in the pKEHP since, if the many of the Plan's goals were achieved, they could benefit diverse stakeholders and constituencies.

#### **IV. Paying for the pKEHP**

- < Both the business-centric version of the pKEHP and the more detailed campaign document, "John Kerry's Plan To Make Health Care Affordable To Every American," discuss a variety of potential cost savings from implementation of the pKEHP. However, neither document discusses how the costs of the Plan would be paid for or by whom.
- < The more detailed Kerry health plan document states that the Plan has been estimated to "cost \$653 billion over 10 years."<sup>18</sup>
  - An estimate of the cost of the pKEHP published by prepared by the American Enterprise Institute has estimated that over "the ten-year period between 2006 and 2015, the Kerry plan would increase federal outlays by about \$1.5 trillion...."<sup>19</sup>
- < However, irrespective of how much the pKEHP would cost, the Plan itself provides no indication as to how the money would be raised. Therefore, although higher taxes on business and individuals are a possibility, analysis of the funding for the Plan is outside the scope of this analysis since the pKEHP does not provide information on this issue.

#### **V. Regulatory Mandates on Businesses Contained In the pKEHP**

- < Milton Friedman famously observed that "there is no free lunch." Mr. Friedman's truism applies as much to health care benefits as it does to noontime nourishment. Thus, in addition to promising businesses a number of health care related benefits, the pKEHP would also impose a number of regulatory requirements on businesses in order for them to be eligible to receive the benefits. To this end, the pKEHP notes that "John Kerry believes that all parts of the health care system - insurers, providers, lawyers, employers

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<sup>17</sup> "A Plan For Stronger, Healthier Families And Children," [http://www.johnkerry.com/issues/health\\_care/family.html](http://www.johnkerry.com/issues/health_care/family.html).

<sup>18</sup> "John Kerry's Plan To Make Health Care Affordable To Every American."

<sup>19</sup> Antos, J, et. al., "Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact," American Enterprise Institute, September 13, 2004, p. 1.

and patients -- have a responsibility to help make the health care system more affordable.”<sup>20</sup>

- Furthermore, each explicit regulatory mandate often encompasses a number of sub-mandates that businesses would need to comply with in order meet the proposed regulatory requirement.
- < This analysis will detail, to the extent practical, the regulatory mandates that would be imposed on business through implementation of the pKEHP. The analysis does not attempt to provide a comprehensive list of all mandates that could result from the Plan since, given the paucity of detail contained in the pKEHP, many regulatory mandates that could be imposed on business as a result of the Plan are, at this point in time, speculative. Instead, to be conservative, this analysis seeks to describe only those regulatory mandates that would most likely be imposed on businesses if the pKEHP were enacted.
- As previously noted, this analysis does not address the regulatory mandates that would be placed on Federal and State governments by the pKEHP.

**A. *Decreasing Family Premiums by Up to \$1,000 Annually***

- < A key component of the pKEHP for reducing health insurance premiums is for the government “to create a ‘premium rebate’ pool that will make health care more affordable for employers and employees by helping out with certain high cost health cases.”<sup>21</sup> The Plan goes on to explain that, under the proposal, “the pool would reimburse private and public employer and group health insurance plans that meet certain qualifications for a portion of catastrophic costs. ‘Catastrophic costs’ would be defined as the annual claims for an individual that exceed a certain threshold.”<sup>22</sup>
- < However, in order to be eligible for the reimbursement, i.e. reinsurance pool, business would have to comply with three separate regulatory requirements, each of which has a series of sub-requirements. Specifically, in order to participate in the reinsurance pool, employers would have to:
- Provide health coverage to all of their workers;
  - Adopt disease management and care coordination programs to improve quality and lower costs; and

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<sup>20</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American.” [emphasis added].

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

- Share savings with workers.
- < It is also important that the pKEHP document tailored to the business community does not delineate these regulatory requirements necessary to achieve the potentially lower insurance premiums. Instead, the obligation side of the proposed policies is contained in a separate, more detailed document.<sup>23</sup>
- < Because each of these regulatory mandates is a complex, multi-faceted requirement, each deserves its own brief analysis to make a first-cut determination as to the minimum specific regulatory mandates inherent in each sub-element.

### **1. Provide Health Coverage to Workers**

- < The text of the pKEHP makes clear that health insurance would need to be provided not only to some workers, such as year-round workers or full-time workers. Instead, the Plan strongly indicates that companies would need to make health insurance available to all of their workers, including part-time, temporary and seasonal help.
- Specifically, the text of the plan states, that many “companies work to provide quality coverage to all their workers. However, some companies have stringent rules that prevent some workers from obtaining affordable health care. To receive the premium rebate, employers would have to provide insurance coverage to their employees.”
    - Thus, the clear implication of the Plan is that health insurance would have to be made available to all workers in the companies seeking to participate in the reinsurance program.
    - Since the text of the pKEHP uses the both the term “worker” and the term “employee,” it could be assumed that the regulatory requirement would apply not only to a company’s employees but also to independent contractors and other non-employees who may work in the facility.
    - The regulatory requirement for universal worker health care coverage for participating companies contains no exemptions for small businesses. In fact the Plan specifically states that small business and the self-employed are less likely to have health insurance.<sup>24</sup>

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<sup>23</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American.”

<sup>24</sup> Ibid.

Therefore, it appears that the pKEHP health coverage requirements would apply to even the smallest businesses, including those that may utilize only or two employees. It also appears that the pKEHP requirements could also apply to the self-employed, a topic addressed in the Kerry plan.

- One essential issue not addressed in the pKEHP, except with regard to tax credits, is the share of the health care premiums that would need to be paid by employers. Should the pKEHP require that private employers pay the share of premiums comparable to those paid by the federal government, over 70%, the result could mean that many employers would either not be able to participate in the pKEHP or would have to make cutbacks in other areas, such as employment.
    - Another key issue that is mentioned but not highlighted by the pKEHP is that private sector employers would be in a separate risk pool than federal employees. To the extent that federal employees are healthier than other workers, pKEHP participants, both employers and workers, could well end up paying premiums significantly higher than those in the FEHB.
  - One oddity in the text of the pKEHP is the requirement for companies to “provide,” not simply offer or make available, health care coverage. Thus, if read literally, companies need to provide health care coverage to their workers even if those same workers are already covered by a health care plan through a family member or whom choose, for whatever personal reasons, to decline coverage.
- < Offering health insurance to workers is not a simple one-step process that allows workers to obtain coverage simply by the employer and/or worker writing a check. Instead, providing health care coverage requires the employers to go through a series of time-consuming administrative steps ranging from research to contract negotiation to recordkeeping and reporting.
- < Some of the burdens associated with health insurance administrative work, such as negotiating contracts, are largely fixed, i.e., it may take roughly a similar amount of work to negotiate a health insurance contract somewhat irrespective of the number of employees to be covered. However, the burden associated with other mandated work items, such as record keeping, will increase directly with the number of employees.

- Furthermore, these administrative burdens associated with providing health care coverage would substantially increase with employee turnover. Thus, companies which significantly rely on temporary and/or seasonal employees could bear a disproportionately large administrative burden in providing health care coverage.
  - Since these businesses that are relatively reliant on short-term, seasonal and/or temporary workers would bear a relatively larger administrative cost of providing health insurance, these companies could be placed at a competitive disadvantage with firms that enjoy a greater reliance on longer-term employees.
- < The primary information source for determining the regulatory mandates incumbent on employers who participate in the reinsurance pool is taken from the “Federal Employees Health Benefits (FEHB) Handbook.”<sup>25</sup> This government source is being utilized in this analysis for two reasons:
  1. It is the primary federal information source for government health benefits; and
  2. The pKEHP has stated that allowing public access to the federal health care benefits system, a.k.a. the so-called Congressional Health Plan, is a major goal of the Plan.<sup>26</sup>
- < The following is a list mandates in the FEHB Handbook most relevant to the private sector. The list is intended to provide a conservative assessment of the key regulatory burdens that would fall on business as a result of enactment of the pKEHP, not a comprehensive list of every regulatory burden that may be imposed on businesses. It should be noted that the FEHB provides a far more detailed set of regulations than is contemplated in this analysis.
- < The first main element in the 233 page FEHB Handbook is Laws & Regulations. The FEHB Handbook cites both the Public Law that created the program, P.L. 86-382, and also the relevant implementing regulations found in:

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<sup>25</sup> Office of Personal Management, “Federal Employee Health Benefits Program Handbook,” <http://www.opm.gov/insure/handbook/fehb00.asp>.

<sup>26</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American.”

- Part 890 of title 5 of the Code of Federal Regulations (CFR); and
  - Chapter 16 of title 48 of the CFR.
- a. *Relevant Federal Regulations Applicable to Providing Health Benefits.*
- < Not all federal FEHB regulations would be directly relevant to the private sector businesses. However, many of the specific regulatory requirements involved in providing such insurance would likely be relevant whether the providing entity is the federal government or a private business operating under a new regulatory regime. Furthermore, because the federal government already has an extensive infrastructure in place to manage the enrolment of the new employees, private companies not currently offering health insurance plans may need to develop their own new procedures, compliant with applicable federal regulations to implement the pKEHP. The following mandates are adopted and adapted from Part 890 of Title 5 of the CFR.
  - < The following are the key regulatory mandates, specific to initiating a provision of health insurance coverage, that we assume, based on the best available current information, would result from implementation of the pKEHP.
    - i. Definitions of eligibility. The company, whether large or small, would need to define a list of eligible participants in the health coverage plan. The definition would need to be consistent with whatever implementing regulations were developed in response to the pKEHP. Possible eligible members could include: workers, former workers (COBRA), spouses, former-spouses, dependent and non-dependent children, and any surviving family members following the death of the eligible worker.
    - ii. Definition Conformity. The company, either directly or through a consultant and/or attorney, would need to make sure that the eligibility definition conformed to the relevant regulatory definition.
    - iii. Coverage. The company would need to contact one or more insurance brokers to obtain potential insurance coverage plan(s).

- iv. Company Plan Analysis. Based on the proposals received from the insurance brokers, the company would need to evaluate the offerings in light of:
  - iv.a. The cost of each proposed plan;
  - iv.b. The costs of the proposed plans relative to the financial position of each company;
  - iv.c. The benefits associated with each proposed plan;
  - iv.d. The costs and benefits of each proposed plan relative to the offerings likely provided by competing employers<sup>27</sup>;
  - iv.e. The need to comply with regulatory requirements for health coverage established by the federal government in implementation of the pKEHP.
- v. Plan Selection(s). Based on the analysis conducted in steps iv.a-e, the employer would select one or more health coverage plans to provide to workers and/or their families.
- vi. Cost Sharing. Based on consultations with their financial staff, workers (particularly in the case of a partially or fully unionized workforce) and an assessment of the firm's competitive position in the marketplace, each company would need to develop a cost-sharing formula that splits premium costs between workers and the company. In the cases of retirees, former workers, surviving spouses, union contracts and other factors, it may be necessary for some companies to develop multiple cost sharing arrangements.
- vii. Worker Education. Once one or more health coverage plans are available to a company's workers, it is incumbent on the business to provide the workers with salient information about the available health insurance plan(s). Although much of this information would likely be provided by the insurance carrier(s), the companies still would have specific information communications duties.
  - vii.a. Obtaining Health Plan Information. Although most if not all health plans provide information about

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<sup>27</sup> The NFIB National Small Business Poll demonstrated the need for many small business to offer competitive health insurance plans.

their plans, including costs, benefits, exceptions, procedures and other relevant information, it would be the duty of the company to: obtain and store the required information prior to distribution to workers as well as to retain additional copies of the information for new workers.

- vii.b. Translating Health Plan Information into Appropriate Languages. Many companies, including those that utilize non-skilled labor, hire diverse work forces, many of whose members may not speak English as a first language and may have limited knowledge of English. Companies may well have the duty to translate health plan information into relevant languages such as Spanish, Arabic, Russian, Korean and many other languages.

The requirement that companies provide translation service is not merely theoretical. On August 11, 2000, President Clinton signed Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." Among the provisions of the Executive Order is the requirement that, "Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations."<sup>28</sup>

Since companies that participate in the pKEHP could well be construed as receiving a federal benefit, it would seem likely that the companies

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<sup>28</sup> Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," August 11, 2000, Sec. 1.

may well be bound by the requirements and procedures of Executive Order 13166.

- vii.c. Executive Order 13166 Consultation Process. Under the Executive Order, it is not sufficient to simply translate insurance company materials into the required languages.

Instead, the Order requires that companies engage in a consultation process with employees and their representatives, in order to determine their communications needs. Specifically, the Order states, that in “carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. ... This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.”<sup>29</sup>

- vii.d. Final Development of Health Insurance Materials. Based on the input from the consultation process and on a determination of the linguistic and related needs of workers, the company will prepare, in appropriate languages/formats, information about the company’s available health care program(s).
- vii.e. Federal Approval of Materials. Once the final health care materials have been developed, they will likely be subject to federal approval to ensure they comply with all applicable regulations. This approval could take one of two forms:

- Providing sample copies to the relevant federal agency and await approval; or
- A self-certification process.

In either case, the company would need to maintain records demonstrating that their health insurance

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<sup>29</sup> Ibid., Sec. 4.

information materials were in compliance with federal regulations.

- vii.f. Distribution/Communication of Health Insurance Materials. Once the health coverage materials have been prepared, they need to be distributed and/or otherwise communicated. Because some workers may have special communications needs, the materials may need to be translated into Braille or read, in the appropriate language, to each employee. Of course, since the translators would be working on a temporary basis for the company, they too may be eligible for the health insurance program.
- vii.g. Comparison Tool. Due to the complexities inherent in many health care plans, the company may need to develop and/or purchase a comparison tool allowing workers to compare key benefits, drawbacks and costs among the plans. The precedent for this requirement is OPM's decision to make health care coverage comparison tools, prepared by third-parties, available to federal employees. As OPM explains, "Several Federal departments and agencies have contracted with PlanSmartChoice and Consumer's CHECKBOOK to make their plan comparison tools available to their employees through Employee Express and other methods."<sup>30</sup>
- viii. Worker Acknowledgment of Receiving Health Care Information. To document that all workers, including part-time, seasonal, and others have received the required health care coverage information materials, they will need to sign or otherwise complete a form acknowledging their receipt and understanding of the materials.
- ix. Health Care Information Distribution Recordkeeping. Companies will need to maintain copies of the worker acknowledgments of receiving the health care information.
- x. Updating Health Care Information Distribution Records. Records regarding distribution of health care information will need to be updated each time a worker enters or leaves the employ of the company.

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<sup>30</sup> "How to Choose the Plan that is Best for You."  
<http://www.opm.gov/insure/04/html/choose.asp>

- xi. Distributing Health Care Application Forms Virtually every health care plan requires that workers complete application forms which often include at least some personal medical information. Companies will need to distribute the language and carrier appropriate application forms to all workers, including those workers who labor off-site, such as at construction projects.
- xii. Collection of Health Care Application Forms. Companies will be required to collect the health care application forms to ensure that they all workers have completed the necessary paperwork. Because such forms may contain individually identifiable health information, the forms may be subject to some or all of the provisions of the Privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The HIPPA's Final Rule for Standards for Privacy of Individually Identifiable Health Information<sup>31</sup> totals 93 pages in the *Federal Register*. Although companies may be subject to many or all of the HIPPA privacy provisions, the regulatory mandates associated with HIPPA privacy compliance far exceeds the scope of this analysis.
- xiii. Correction of Errors. Section 890.103 of Title 5 of the CFR is entitled, "Correction of Errors." According to the federal regulation, the "employing office may make prospective corrections of administrative errors as to enrollment at any time." Furthermore, the regulation sets conditions for making "retroactive corrections of administrative errors..."
- Therefore, each company would need to establish, in coordination with their workers, a set of procedures for correcting current and retroactive information in company files.
- xiv. Employer Responsibilities for Rejected Claims. Health care claims by workers are to be filed with the health care carrier, as explained in Section 890.105 of Title 5 of the CFR. Should the carrier deny the claim, the worker has the right to ask the carrier for reconsideration of their claim.

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<sup>31</sup> 67 FR 53181, et seq.

However, if the carrier affirms its rejection the claim, “the covered individual may ask OPM to review the claim.”<sup>32</sup>

Thus, under the pKEHP, employers may well find themselves adjudicating health care insurance claims rejected by the insurance carrier. Specific OPM duties with regard to reviewing health insurance claims, under the regulation, that could be borne by each company could include:

- iv.a. Request that the covered individual submit additional information;
- iv.b. Obtain an advisory opinion from an independent physician;
- iv.c. Obtain any other information as may in its judgment be required to make a determination; or
- iv.d. Make its decision based solely on the information the covered individual provided with his or her request for review.
- iv.d. Within 90 days after receipt of the request for review, the company, based on the existing OPM regulation, would either: (i) Give a written notice of its decision to the covered individual and the carrier; or (ii) Notify the individual of the status of the review.
- xiv.e. The company, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.
- xv. Litigation. After a covered individual exhausts both carrier and employer appeal mechanisms, federal regulations allow the claimant to seek judicial review, i.e. go to court, on the denied claim.<sup>33</sup>
- xvi. Judicial Review and Company Legal Expenses. Section 890.107 “Court Review,;” details the specific regulations governing judicial review of health care claims. In addition

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<sup>32</sup> Section 890.105, Title 5, Code of Federal Regulations, (a)(1).

<sup>33</sup> Ibid.

to covering a number of legal issues, the regulation specifically states, “A covered individual may seek judicial review of OPM’s final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier’s subcontractors.”<sup>34</sup>

Therefore, if the pKEHP regulations parallel the existing OPM regulations with the private companies standing in the place of OPM, the private employers are:

1. Subject to being sued by employers and other workers for health care claims denied by the insurance carrier; and
2. The insurance carrier nor any of their subcontractors that denied the claim are a party to the lawsuit.

xvii. Reporting Requirements. The federal regulatory requirement to provide all workers with health insurance would result in substantial reporting requirements. These record keeping and requirements would likely be particularly onerous on employers who utilize transitory and/or seasonal employees.

Section 890.110 “Employment Reconciliation” requires that “Each employing office must report to each carrier or its surrogate on a quarterly basis the names of the individuals who are enrolled in the carrier’s plan in a format and containing such information...”

Thus, each employer must not only prepare quarterly reports on each employee, but those employers who offer a choice of health plans must prepare different reports for each insurance carrier.

xvii.a Reconciliation Requirements. After each carrier receives their quarterly report from each employer, they are required to “compare the data provided with its own enrollment records. When the carrier finds in its total enrollment records individuals whose names do not appear in the report from the

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<sup>34</sup> Section 890.107, Title 5, Code of Federal Regulations, (c).

employing office of record, the carrier must request the employing office to provide the documentation necessary to resolve the discrepancy.”

Thus, following the filing of each quarterly report with each insurance carrier, the employer may need to engage in a reconciliation process. The process is likely to be more detailed and complex for companies which experience relatively high levels of employee turnover, such as those firms which make greater use of temporary and/or seasonal employees or for those companies where high turnover levels are inherent in the nature of the business, such as in the fast food industry.

- xviii. Plan Standards. Federal regulations set minimum standards for health care plans. The OPM standards for health care plans are quite detailed and may be found in Sec. 890.201, “Minimum standards for health benefits plans.” Two key aspects of the regulation, 1) OPM must initially approve the health care plan as meeting minimum standards; and 2) the health care plan needs to continue to meet the minimum standards.
  - xviii.a. Employers, therefore, would need to ensure that health care plans under consideration meet with applicable federal regulations for minimum standards.
  - xviii.b. Employers would have an ongoing obligation to ensure that selected carrier(s) continue to meet federally required minimum standards.
- xix. Carrier Standards. In addition to setting minimum standards for health plans, federal regulations also set minimum standards for health insurance carriers. The minimum standards for health carriers are detailed in 48 CFR subpart 1609.70. The minimum standards requirements include, “Timely and accurate adjudication of claims or rendering of medical services.” and having a “system for accounting for costs incurred under the contract, when required, which includes segregating and pricing FEHB medical utilization and allocating indirect and administrative costs in a reasonable and equitable

manner.” Other standards pertain to fiscal responsibility and integrity.

Although these minimum carrier standards may not directly impact employers, the employers would likely have an implicit fiduciary responsibility to ensure that health insurance plan(s) they offer are from carrier(s) meet at least meet minimum federal standards so as to avoid the risk of losing coverage should their carrier(s) be disbarred. Federal regulations<sup>35</sup> set the procedures for health benefits plans and carriers to be excluded from those that are eligible to provide coverage.

xx. Family Coverage. Federal regulations (Section 890.302) provide extensive discussion of family members who are eligible and not eligible for coverage. However, since the pKEHP, at this point in time, only appears to require coverage of all workers but not necessarily their families, these provisions may or may not apply to the proposed Kerry health care plan.

xxi. Continuation of Enrollment. Federal regulations require that health care coverage be continued “without change” when a worker “moves from one employing office to another, without a break in service of more than 3 days, whether the personnel action is designated as a transfer or not.”<sup>36</sup>

Thus, an employer would not likely to be able to suspend or discontinue coverage when a worker changes locations, even if that change is precipitated by disciplinary issues.

xxii. Discontinuation of Enrollment. FEHB regulations generally place the last date of enrollment in the coverage as the “last day of the pay period in which he/she is separated from the service other than by retirement...” Additional regulations apply to employees who are furloughed or for “temporary employees, under certain circumstances, whose pay “is insufficient to pay the withholdings for the plan...”

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<sup>35</sup> Sec. 890.204, “Withdrawal of approval of health benefits plans or carriers,” Title 5 CFR.

<sup>36</sup> Sec. 890.303, “Continuation of enrollment,” Title 5 CFR.

- xxiii. Coverage for Former Spouses. The federal regulations governing the FEHB include regulations specific to, in some instances, covering former spouses of employees. For example, the regulations applicable to employers state that, the “employing office will set up a method for accepting applications for enrollment informing the former spouse what documents to submit and where to submit them for an eligibility determination, and collecting premium payments. The method will include procedures for verifying the eligibility requirements...”<sup>37</sup>
- xxiii.a. Employer Obligations to Former Spouses. The federal regulations set up a series of paperwork and related requirements that employers must carry out with regard to at least certain former spouses. For example, the “employing office will send the former spouse notice, in writing, of its decision. When an employing office informs a former spouse of his or her eligibility to enroll, it will identify the documents on which it based its decision and will include a premium payment schedule and statement of the requirements for continued enrollment...”<sup>38</sup>
- xxiii.b. Appeal Rights for Former Spouses. The regulations set appeal rights for certain former spouses to maintain their health care coverage through their husband’s/wife’s former employer. Specifically, the regulations state that if “the former spouse does not qualify for health benefits coverage, the employing office must give the former spouse a reconsideration right under Sec. 890.104.”
- xxiv. Employer Duties to Maintain and Provide Information to Employees and Their Families About Their Rights. Federal regulations require employers to undertake specific information dissemination procedures. This information

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<sup>37</sup> Sec. 890.808, “Employing office responsibilities,” (b)(2), Title 5 CFR.

<sup>38</sup> Sec. 890.808, “Employing office responsibilities,” (b), Title 5 CFR.

has to include not just data about the health care plans but also set “forth their rights...”<sup>39</sup>

The duties set forth by the regulations are not merely *pro forma* information about the health coverage plans but would also require employers to “establish procedures for notifying the former employees, child, or former spouse about his or her eligibility to enroll, including what documents are needed to determine eligibility, and for accepting enrollment registrations.”<sup>40</sup>

Thus, it appears that the pKEHP would require employers to not only maintain records, including contact information, about current workers, but also to maintain and update contact about the workers’ current and former family members. By way of example, it appears that, if a firm were to hire someone to play Santa Clause for a few weeks, the company would be under the obligation to maintain records for the foreseeable future on contact information regarding the worker’s spouse, former spouse(s), and children and to contact them about their potential eligibility for health benefits.

The same situation would seem to apply to summer employees at retail stores, fast food restaurants, contractors and other workers. There does not appear to be any provision in the regulations for either, former workers who have not provided forwarding contact information or who may not know (or care to divulge) the location(s) of their children and/or former spouse(s).

**2. Adopt Disease Management and Care Coordination Programs to Improve Quality and Lower Costs**

- < In an effort to reduce the cost of medical care, the pKEHP states that innovative “programs targeting patients with chronic conditions have illustrated that both the human and cost consequences of chronic diseases can be alleviated through hands-on medical management. Employers and

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<sup>39</sup> Sec. 890.1111, “Employing office responsibilities,” (a), Title 5 CFR

<sup>40</sup> Sec. 890.1111, “Employing office responsibilities,” (b), Title 5 CFR

their insurers must adopt model programs to receive the premium rebate.<sup>41</sup>

- < The disease management provision of the pKEHP is, potentially, the most personally intrusive, privacy-invading aspect of the Kerry plan. At a minimum, a potentially effective program could involve employers collecting highly personal health information about their workers. The information that employers may need to collect in order to develop appropriately-tailored wellness plans could range from the mundane, such as height, weight and blood pressure. Furthermore, the wellness information employers may be required to provide to their workers could range from dietary guidance to recommendations regarding lifestyle choices such as smoking, drinking, exercising, and practices with sexual partners.
- < It would seem likely that employers would be required to adhere to the stringent federal HIPPA privacy regulations with regard to all information collected and distributed under the wellness program.
- < Although there a wide range of wellness programs. For the purposes of this analysis, the “model” wellness program is based on one described by the US Office of Personnel Management.<sup>42</sup>
- < Among the basic information included in the OPM wellness guide are statements such as:
  - “the workplace is a logical place for employees to receive preventive health services.”
  - “It is essential that employees have convenient healthcare opportunities and the information they need to spend their time wisely. Providing such services at the Federal worksite can be an effective way of meeting that need, and many of these services can be accessed without charge to leave”
    - It appears, therefore, that under the wellness provisions of the pKEHP, employers could be required to make preventative health services available to all of their workers free of charge.

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<sup>41</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American.”  
[emphasis added]

<sup>42</sup> “A Federal Workplace Guide To Preventive Health Services,”  
<http://www.opm.gov/ehs/health3.asp>.

- < The OPM document covers a range of preventative health issues. For the limited purposes of this analysis, the only section of the document that will be discussed in the one entitled, “What Preventive Health Strategies Can Agencies Develop for Their Employees?”
- < The OMB manual lists five specific preventative, i.e. wellness, strategies for employers. In the absence of more detailed information from the Kerry campaign as to what elements would be included in a mandatory wellness campaign for employers, the current OPM guide will serve as a proxy document for this analysis. The five basic wellness mandates for employers discussed in the OMB document are:
  - Educate Employees;
  - Offer Preventive Health Screenings at the Worksite;
  - Provide Follow-up Feedback;
  - Offer Intervention Programs; and
  - Launch a Marketing Campaign
- < OPM provides a series of detailed sub-steps for each of these five wellness program components.
  - a. *Educate Employees*
    - < OPM explains that, “Agencies can provide information to help employees understand their risks for disease and the tools for making healthy lifestyle choices.”
    - < OPM also details a series of specific steps that employers could engage in to support wellness education among their employees. Since the pKEHP envisions wellness programs as being mandatory for employers in order to reduce health insurance premiums, it could be reasonably presumed that the following steps, or analogs of these steps could well be regulatory mandates on employers.
      - i. Distribute health education brochures and pamphlets on a variety of preventive health topics.
        - Thus, employers would either have to draft or, more likely, purchase brochures and pamphlets, in appropriate languages, for distribution to employees. The employers would also need to allocate storage space for the materials and to set up

an inventory control system for each brochure/pamphlet so as to know when they need to order more copies. It is also possible that the employer would need to establish a forms-based system so that they could document to federal officials that all workers had received the required materials.

- Since a diverse workforce will have differing physical and psychological needs, employers may need to obtain wellness materials specifically appropriate for workers with varying physical conditions, such as limited mobility, diabetes, heart disease, visual impairment, etc. It is because of the potential need to tailor the wellness materials to specific groups that employers could be required to conduct the initial health assessment discussed in Section V.A. 2. of this document.
- ii. Distribute an employee health newsletter with a regular feature about preventive health services.
- Thus, a firm would be required to either assign a (hopefully) qualified worker to the task of writing a health news letter or spend the money to purchase such a newsletter from a commercial service.
- iii. Create a web page with links to other important screening information.
- This requirement involves multiple steps including:
    - Retaining the services of a qualified web designer, or reassigning an in-house web programmer from other duties; and
    - Researching appropriate health materials for inclusion in the newsletter;
    - Ensuring that any material used in the newsletter are in compliance with copyright restrictions; and
    - Providing management coordination to ensure success of the project.

- iii. Offer “lunch and learn” sessions on preventive health issues.
- Fulfillment of this potential regulatory mandate would require that the employer retain the services of a qualified health care professional able to provide useful information on preventative health care issues.
    - To the extent that employers offer flexibility in when their workers take lunch breaks, it may be necessary for employers to schedule multiple educational sessions.
    - Employers who have workers who perform their duties off-site, i.e. delivery drivers, technicians who work at client sites, etc., it may be necessary to schedule special sessions, at company expense, for off-site employees.
    - Employees with special needs, hearing or visual impairments may require special aids.
- iv. Conduct health risk appraisals or other types of risk questionnaires. Assessing the state of employee health was discussed earlier in this document.
- Some employees may be very reluctant to cooperate in providing sensitive and/or potentially embarrassing information to their employer.
  - The employer would likely need to retain the services of a highly skilled expert in order to appropriately assess employee health.
  - Information gleaned from the assessment would likely subject the employer to having to comply with the detailed and potentially expensive requirements of the HIPPA privacy regulation.
  - Workers may resent be counseled, though newsletter, company websites, etc., on the potential need for them to modify their lifestyles in areas ranging from diet to exercise to practicing safer sex.

v. Make videos and reading materials available through a lending library.

- This potential regulatory mandate would require employers to, at a minimum:
  - Establish space within the office for the lending library;
  - Select appropriate health care books and videos;
  - Ensure that the books and videos encompass the linguistic needs of the company's workforce; and
  - Create a check-out system for lending the wellness materials.

*b. Offer Preventive Health Screenings at the Worksite*

- < This regulatory mandate would require that workplaces become, at least on a temporary basis, health clinics. Although it is possible that final pKEHP regulations could scale back the program requirements, there is no such indication in the materials provided by the Kerry campaign.
- < The OPM materials states, that agencies, i.e. employers, “can make it convenient for employees to receive health screenings by offering them on-site.”
  - No indication is provided as to how much such screening would cost or who would bear the economic burden.
  - Popular screening suggested by the OPM materials include, body fat, cholesterol and blood pressure measurements, health risk appraisals, and cardiac risk profiles.
    - Of course, all health information gleaned from such screening would be subject to the HIPPA privacy protection regulations.
- i. Screening and related wellness health care services suggested, but not mandated, by OPM include:

- i.a. Bring screenings to the employee with mobile health screening vans or conduct screenings such as a blood pressure measurement at the employee's work station.
- i.b. Establish an annual health fair and offer preventive screenings and health information on a variety of topics. Use this checklist to make health fair planning as easy as possible. Check with other agencies to gather health fair ideas.
- i.c. Obtain agency permission before proceeding with any plans.
- i.d. Determine if and when employees can be excused from work to attend.
- i.e. Consult with and involve local union representatives.
- i.f. Organize and plan the fair at least eight weeks prior to the actual date. Stay organized.
- i.g. Identify goals and audience.
- i.h. Develop a theme to attract participants.
- i.i. Make sure fair theme is not too broad.
- i.j. Consider audience's needs.
- i.k. Select a fair date and time.
- i.l. Select a day in the middle of the week.
- i.m. Avoid scheduling around a major holiday.
- i.n. Check that no other agency events are scheduled that day.
- i.o. Get approval of the schedule and secure building space from building services.

- i.p. Ensure that space is accessible to employees with special needs.
- i.q. Send a letter to building services about the event.
- i.r. Inform building services of any changes in the schedule.
- i.s. Make security arrangements.
- i.t. Notify building security of all fair plans.
- i.u. Hold meetings with building security to discuss their concerns.
- i.v. Discuss movement of vendors in and out of the building.
- i.w. Notify building security of planning changes.
- i.x. Develop a list of health fair activities.
- i.y. Offer non-traditional activities such as seated massage to draw a wider audience.
- i.z. Prepare a list of organizations to invite to the fair.
- i.aa. Include national and local groups.
- i.ab. Consider available space for table set up.
- i.ac. Contact vendors.
- i.ad. Invite organizations by phone.
- i.ae. Mail a formal written invitation to all parties.
- i.af. Ask organizations that cannot attend to send materials.
- i.ag. Use a tracking form to record important information about the vendors.

i.ah Construct a floor plan, assigning each organization and activity to a particular table.

- < It should be noted that although a wellness program would be mandatory under the pKEHP, it may not necessarily have to be as detailed as described in the OPM plan.
- < However, even if conducted in an abbreviated fashion, the OPM document illustrates the substantial management and staff time and expenses that would be required to conduct wellness education and screening events.

c. *Provide Follow-up Feedback*

- < In addition to providing workers with health care screenings, and the results of their tests, it is also important, according to OPM, to encourage “employees to share results of screenings with their health providers. Health services provided at the worksite should not be a substitute for the regular source of care employees have through their healthcare provider.”
- < Therefore, OPM recommends that the health screenings should:
  - i. Conduct health risk appraisals that include an individual evaluation of the results.
  - ii. Make arrangements for a professional to share the results of the screening tests and offer healthy solutions.
  - iii. Provide one-to-one counseling or group education opportunities.
- < On one hand, the medical advice provided on this section appears to be sound and beneficial. On the other hand, the recommendations are likely to involve both significant time and expense by either management and/or specialty consultants. For example, one-to-one counseling or group education activities by qualified personnel are not likely to be budget priced, particularly for companies that are smaller and/or experience lower profit margins.

d. *Offer Intervention Programs*

- < OPM recommends that employers “should look at ways to encourage positive behavior change. Agencies can offer intervention activities such as smoking cessation classes or nutrition counseling.” The agency goes on to explain that it is important for employers “to evaluate whether workplace policies, practices, and physical environment support these measures.”
- < OPM provides a series of recommended steps for intervention programs. As with other OPM recommendations, it is not clear that all of the recommendations are appropriate or would be required for all employers. However, the breadth and scope of the recommendations clearly indicates that the government is seeking substantive, not simply *pro-forma* intervention actions by employers. The specific intervention programs recommended by OPM include:
  - i. Provide a variety of opportunities for employees to learn about, or to make, healthy behavior changes through classes, videos and self-help materials.
  - ii. Choose health topics that meet Healthy People 2010 goals, a broad-based initiative led by the U.S. Public Health Service to improve the health of Americans.
  - iii. Provide a variety of opportunities for employees to learn about, or to make, healthy behavior changes through classes, videos and self-help materials.
  - iv. Survey employees to develop programs around their interests.
  - v. Develop policies that allow flexible work schedules to permit participation in health activities.
  - vi. Stock the cafeteria, snack bars and vending machines with healthy food choices.
  - vii. Provide a shower or locker room for those who exercise at work and a bike rack for those who ride a bike to work.
- < Although the suggested intervention methods may prove beneficial, there is no discussion as to the cost burden on employers of providing even some of these measure. For example, for many employers, the cost of installing shower and locker room

facilities could well be prohibitive. Furthermore, even if a company were to provide such facilities, in that resources are finite, they would likely have to make cut back in other areas such as health and safety training, continuing education for employees and, possibly, reduced pension fund contributions.

- < Ultimately, the real problem with the OPM recommendations is not that they are themselves bad or harmful but rather that they appear to be developed by persons who have absolutely no experience in operating a business and making payroll. Ivory tower suggestions as to how to improve the health of the American workforce may well prove useful for publishing academic papers or campaign documents but have little practicality in improving the health of American workers.

*e. Launch A Marketing Campaign*

- < In order to promote the government's wellness campaign, OPM has developed a detailed set of recommendations for promoting the wellness program.
- < Specific federal recommendations include:
  - i. Agencies should find effective ways to promote their preventive health programs.
  - ii. Begin with communicating the purpose of the program and the agency's commitment to the program.
  - iii. Assure that personal health information will be kept confidential and make special efforts to encourage those less likely to participate.
  - iv. Make the programs accessible and enjoyable for employees.
  - v. Keep the program visible and continue to find ways to make it better.
  - vi. Use a wellness committee to get marketing ideas and to help promote the program.
  - vii. Use technologies such as email, voice mail and Internet and Intranet web pages.

- viii. Look at the entire year's events in order to schedule activities at the most convenient and effective times.
- ix. Coordinate activities with national health observances. Health observances are special months, weeks or days devoted to promoting particular health concerns, and many health organizations have free or low cost promotional materials to go along with the observance.
- x. Look for opportunities on the agency's calendar to schedule activities. For example, schedule a health screening or educational session at a supervisory training session, coordinate a fun run at the annual picnic, or introduce the employee health program at new employee orientations

< Although the government's wellness campaign marketing program is divided into a number of specific steps, it needs to be understood that each and every one of those steps requires a series of resource-intensive activities. For example, a relatively simple item such as vi, "Use a wellness committee to get marketing ideas and to help promote the program." This step, at a minimum, involves:

- Developing an organization-wide communication campaign to solicit members to serve on the committee;
- Organizing the committee, (selecting a Chair, detailing assignments etc.);
- Developing agendas;
- Developing and testing communications messages;
- Carrying out marketing activities;
- Preparing progress reports;
- Holding meetings; and
- Refining activities to improve message communication efficiency.

< Similarly, a relatively small task, such as "Use technologies such as email, voice mail and Internet and Intranet web pages" also involves an extensive amount of work from skilled personnel. For example,

- An organizing committee needs to be convened;
- Multi-media (internet, voice, etc.) messages would need to be developed and approved by the responsible committee;
- Web programmers would need to secure permission to post the materials on the company's website;
- Hyperlinks would need to be created with established websites in order to promote access to the new materials.
- Phone banks would likely need to be established and manned in order to communicate the verbal messages;
- E-mail messages would need to be developed;
- A series of relevant e-mail addresses would need to be compiled and made available to the organizing committee; and
- Legal counsel should be sought to ensure that transmission of the unsolicited e-mail messages does not violate federal and/or state anti-spam ordinances

< In short, even if a business were to engage in only a small handful of the recommended wellness activities, small and medium-sized firms would need to devote substantial resources to the project. Thus, the companies would need to either:

- Retain additional personnel (whom would be entitled to health benefits); or
- Redirect existing personnel away from their regular duties in order comply with the regulatory mandates inherent in the Kerry health plan.

< However, since the wellness plan and other requirements of the pKEHP are only mandatory on employers participating the program, employers may choose to opt out of the program by not offering/ceasing to offer health insurance to their workers.

### 3. Share Savings With Workers

- < The final set of regulatory mandates employers would be required to adhere to in order to potentially qualify for the reduction in health care premiums is to “share savings with workers.”<sup>43</sup>
- < As was the case for the other regulatory mandates necessary for businesses to comply with in order to potentially obtain the lower premiums, the specific regulatory requirements to share cost savings with workers are not contained in the business-specific version of the pKEHP, “A Plan For Stronger, Healthier Businesses,” but instead are included in the more detailed “John Kerry’s Plan To Make Health Care Affordable To Every American.”
- < The Kerry Plan initially assumes that health insurance saving from reducing catastrophic coverage costs would be passed to workers through “higher wages, maintain[ing] benefits, and mak[ing] investments that help employers and workers alike.”<sup>44</sup> The pKEHP goes on to state that health “economists predict that these savings will automatically be passed onto workers in the form of higher wages and/or other forms of compensation.”<sup>45</sup>
- < However, if the expected health care insurance saving are not seen as being passed on to workers, the pKEHP calls for instituting a regulatory regime to force to employers to pass the alleged saving on to employees through multi-agency regulatory program. Specifically, the pKEHP states that if “employees do not share in the savings, the Secretary of Health and Human Services and the Secretary of Labor would develop policy options to ensure that employers do share these savings with workers.”<sup>46</sup>
- < The pKEHP does not delineate the specific regulatory mandates that would be imposed on business to ensure that health insurance savings were passed on to employees. Nor does the Plan indicate the minimum share of any savings that would be need to be passed on to workers, the time-frame for determining when those saving occurred and when they would need to be shared with workers or the algorithm for calculating any health insurance savings.

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<sup>43</sup> “John Kerry’s Plan To Make Health Care Affordable To Every American.”

<sup>44</sup> Ibid.

<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

- < However, based on a number of existing regulatory programs, there are some common regulatory elements that would likely need to be included in the Kerry regulatory program
- i. Federal determination of the minimum quantity of savings to be passed to workers.
  - ii. An interagency task force, likely supplemented with outside medical and economic experts, would need to convene one or more meetings to determine the threshold value for minimum insurance savings to be passed to workers.
  - iii. A *Federal Register* Notice of Proposed Rule Making (NPRM) would need to be published which provides not only the proposed cost savings plans but also a series of mechanisms, such as record retention and forms to be provided to the agencies by employers on a regular basis, to help ensure that any final rule contains appropriate enforcement mechanisms.
    - iii.a. In that the rule would likely be construed as a major rule under Executive Order 12866, the proposed rule would need to undergo review by the White House Office of Management and Budget. The proposed rule would also be subject to scrutiny under the other “good government” laws such as the Regulatory Flexibility Act, the Unfunded Mandates Reform Act, and the Data Quality Act
    - iii.b. The agencies would need to fully evaluate the proposed rule in light of all comments received by stakeholders. The agencies would then be required to respond to the comments when crafting the final regulations.
    - iii.c. Once a final rule has been developed and published in the *Federal Register*, it is potentially subject to protracted litigation.
  - iv. Recordkeeping. Companies would need to create and maintain detailed records documenting that they have passed the required share of insurance premium savings on to employees in an acceptable fashion.
    - iv.a. Each company would need to develop a recordkeeping mechanism with their insurance carrier(s) to document that savings have been achieved as a result of the pKEHP.

- iv.b. Each company would need to document that the share of those savings that have been passed along to employees in an acceptable form, i.e. higher wages, benefits, etc.,. Since many companies already have union contracts or other incentive programs in place to regularly raise employee compensation, each company would need to develop a mechanism for passing along insurance savings in a discreet form distinct from other employee benefits.
- iv.c. Grievance Procedures. In that it is possible that at least some workers will feel that they are not getting their fair share of the insurance cost savings, companies may need to set up grievance procedures to adjudicate disputes. Should these procedures not prove sufficient in at least some instances, litigation may, at times, prove necessary.
- v. Paperwork/Form Preparation. To ensure that companies are appropriately sharing insurance cost saving with workers, they would likely need to prepare federal forms which:
  - v.a Detailed the actual insurance savings; and
  - v.b Explained how the required saving were passed on to workers.
- vi. Form Filing. Companies may need to file their worker-sharing plans with the appropriate agencies on a regular schedule.
- vii. Record Retention. Companies would likely need to maintain copies of all forms filed with the government, as well as all backup materials, in event of either a government audit or a dispute with one or more disgruntled worker and/or e-workers.

#### **4. How The Pool Would Operate**

- < The pKEHP states that it “proposes to create a "premium rebate" pool that will make health care more affordable for employers and employees by helping out with certain high cost health cases. Under this proposal, the pool would reimburse private and public employer and group health insurance plans that meet certain qualifications for a portion of catastrophic costs. ... The resulting savings would decrease family premiums by up to \$1,000 annually.”
- < Thus,

1. There is no promise that all employers would benefit from the rebate pool. Since the only potential beneficiaries appear to be those with catastrophic claims, it is possible, depending on exactly how the pool is structured, that many employers would not be eligible for the reduced premiums even, even if they comply with all of the applicable regulatory requirements.
2. There is no timetable, estimate or goal in the pKEHP as to when the pool would become operational. Therefore, it is possible that it could take years before an employer received any benefits from the pool.
3. The pKEHP contains no indication as to the regulatory/bureaucratic apparatus that would need to be constructed in order to: 1) establish and maintain the pool; and 2) establish the recordkeeping, paperwork, and other regulatory requirements that employer would need to go through in order to potentially gain a benefit from the pKEHP pool.

< Therefore, it appears at this point in time that the reinsurance pool associated with the pKEHP contains a number of specific regulatory mandates on employers but is rather more vague as to what, if any, benefits they could expect to receive from the system.

***B. Taxes Credits To Cut The Cost Of Health Insurance By Up To 50 Percent***

1. Overview of the Tax Credit Plan. Under Senator Kerry's "Plan For Stronger, Healthier Businesses," "small businesses will receive tax credits to help them provide health insurance for their low and moderate-income employees. The tax credit will cover up to 50 percent of the cost of the employers' share of the premiums."

< However, the discussion of tax credits contained in "John Kerry's Plan To Make Health Care Affordable To Every American," states that "Refundable tax credits for up to 50 percent of the cost of coverage will be offered to small businesses and their employees to make health care more affordable."

- Thus, based on the two Kerry health plan documents, it is not clear whether the tax credits would apply only to small business' low and moderate income workers (as stated in the Kerry campaign's Business-centric proposal) or to all small business employees regardless of their income, as implied by the more detailed Kerry health plan.

- To be conservative, this analysis assumes that the tax credits would apply only to low and moderate income workers.
- < Several key questions arise as to how the proposed Kerry tax credit plan would operate. Key questions include:
- i. Definitions of what constitutes a small business. In that SBA maintains a set of small business definitions, this should not be a difficult issue.
  - ii. Definition of low and moderate employees. This has the potential to be a highly contentious issue since:
    - ii.a Wages have significantly different purchasing power in various parts of the country;
    - ii.b Wages vary greatly based on the skill level(s) of the workers; and
    - ii.c There is no indication as to whether benefits would be considered as part of the employees compensation package. Given that benefits packages are often part of union contracts or other employer compensation agreements, it is not clear how or if benefits, including retirement benefits, would be considered for determining which workers constituted low or medium income workers.
  - iii. The situation could potentially arise where employees could have their health and/or retirements benefits reduced in order for the employer to qualify for the tax credit.
- < Establishment of the low and moderate worker income cut-offs that would apply in order for workers to qualify for the tax credits would likely need to be established through a federal rulemaking process. Given the magnitude of economic impact of the rulemaking, it would probably need to go through OMB review.
- i. It should also be noted that all forms, paperwork and recordkeeping requirements associated with the pKEHP would also be subject to OMB review and approval. Such review and approval would provide the opportunities for the separate submission of public comments to both the relevant agencies and to OMB.
  - ii. All data and models used to determine low and moderate worker income cut-off points for access to the reinsurance pool would be

subject to the Data Quality Guidelines of both the Department of Health and Human Services and the Department of Labor.

- ii.a In that such data and models would be likely considered as “influential” financial and statistical information, they would be subject to the more rigorously robust tests that apply to such information. Affected parties would have the right to petition for correction of information not meeting the Data Quality Standards.
- ii.b Should affected parties not receive a favorable response in reply to any Data Quality petitions, they would have the right of appeal.
- iii.c It is possible, although not certain, that affected parties may be able to seek redress in courts for agency decisions regarding the use of data and models that may not comply with applicable Data Quality standards.

## 2. Regulatory Mandates Required to Participate in the Proposed Tax Credit Program

The Kerry Health Plan sets two specific regulatory mandates on small businesses in order for their workers to be eligible to participate in the tax credit program:

- i. Small businesses would, apparently, have to offer their workers access to the proposed “new Kerry-Edwards Congressional Health Plan...”<sup>47</sup> Although mandatory participation in the so-called Congressional Health Plan, as opposed to any other private sector health insurance plan, is not explicitly stated, it is implicit in the text of the Plan since no other option other than the Congressional Health Plan is mentioned.
  - The extensive regulatory mandates that small businesses would need to comply with in order to offer such health insurance have already been summarized in this analysis.
- ii. Small business seeking to obtain the proposed tax credit would “have to pay at least 50 percent of the health insurance premium.”<sup>48</sup>
  - It is not clear from the text of the pKEHP for businesses whether the insurance premium coverage would have to cover only the workers or also their families. Should family coverage be mandated by the Kerry Plan, it could give businesses an

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<sup>47</sup> “A Plan For Stronger, Healthier Businesses.”

<sup>48</sup> Ibid.

unintended and unfortunate incentive to discriminate against workers with families.

- Should small business not be in a financial position to afford to pay at least 50% of the Congressional Health Plan premiums, those business may be forced to either:
  - Opt out of the pKEHP; or
  - Not provide any health insurance options for their workers.

### ***C. Cut Administrative Costs By Eliminating Waste, Fraud And Abuse***

#### ***1. Overview of the Cost Cutting Plan.***

- < The pKEHP for businesses discuss the benefits from eliminating waste, fraud and abuse. For example, the Plan states, the “about 25 percent of the annual cost of health care goes towards non-medical costs - mainly paperwork and other costs associated with preparing, submitting, calculating, and paying bills.”<sup>49</sup> No data source is provided for this information.
- < Although eliminating, or at least reducing, waste fraud and abuse, would clearly have macro economic benefits for the economy, it is not clear how or when these benefits would translate to specific tangible gains for businesses, except, perhaps, for businesses that are health care practitioners.
- < The pKEHP has already promised premium reduction of up to \$1,000 for businesses that participate in the Plan. It is not clear whether any reduced premiums resulting from elimination of waste, fraud and abuse would be in addition to those premium reductions or are subsumed in the estimate of reduced premiums.
- < Although the business-centric pKEHP lists three specific mechanism for cutting administrative costs, it is not at all clear how these mechanism apply to employers who are not in the health care industry. For example, the three administrative cost cutting mechanisms listed in the “Plan For Stronger, Healthier Businesses,” are:
  - i. “Ensuring that all Americans have secure, private medical records by 2008, which will eliminate unnecessary tests and reduce serious medical errors by as much as 88 percent.” No data source is provided by the pKEHP for the statistical information.

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<sup>49</sup> Ibid.

- ii. “Giving health providers technology bonuses to simplify and streamline their paperwork - allowing patients to spend more time with doctors and less time filling out forms.”
  - iii. “Require insurers doing business with the federal government to use advanced systems.”
- < Although all three of these regulatory mandates for improving administrative efficiency may potentially have benefits, as well as costs, to some businesses in the health care industry, their relevance to the great majority of businesses is, at best, uncertain. For example, it is not at all clear what relevance requiring insurance providers doing business with the government to use advanced technologies has for auto part manufacturers, retailers, construction companies, barbers, tavern owners and the plethora of other businesses which make up the backbone of the American economy.
- < The only apparent explanation for including these regulatory mandates in the business-centric version of the pKEHP is that a future Kerry Administration intends to rely, on part, on a “trickle down” theory of health care costs whereby the benefits given by the government to large health care providers eventually make their way down to smaller businesses.
2. Regulatory Mandates Required to Participate in the Administrative Cost Cutting Plan
- < One specific series of regulatory mandates that would apply to health insurers under the pKEHP is for private insurers to “have to use this simplified technology standard as a condition of doing business with the Federal government (Medicare, Medicaid, and the Federal Employees Health Benefit Program).
- < Thus, in addition to the mandates on the government to develop specific definitions of simplified technology standards, along with implementing timetables, applicable businesses, at a minimum have to:
- Learn the new federal regulatory mandates and understand how they apply to the specific business;
  - Identify applicable technology standards;
  - Obtain bids from competing vendors for required technologies/services and/or processes;
  - Negotiate with competing bidders to obtain the most advantageous business arrangements for the equipment and/or services;
  - Arrange financing for the new equipment/services;

- Arrange for employee training in the use of the new equipment and/or services;
- Arrange for service contracts to maintain/update the new equipment and/or services;
- Integrate the new equipment/services and/or processes into existing business practices;
- Maintain records demonstrating that the company is complying with all applicable new federal regulatory mandates; and
- Prepare and file forms with federal agencies demonstrating compliance with the new, more efficient, regulatory requirements.

#### ***D. Reduce Medical Malpractice Premiums***

##### **1. Overview of Reducing Malpractice Premiums**

- < One of the goals of the pKEHP enumerated in the campaigns plan for stronger healthier business is to reduce medical malpractice premiums
  - Doctors leaving the practice of medicine as a result high malpractice insurance rates has been well documented.<sup>50</sup>
- < The pKEHP includes a number of provisions to discourage frivolous malpractice suits including sanctions against lawyers who repeatedly file such suits.
- < The pKEHP provides no estimations or approximations of how much employers and/or workers could expect gain from the promised reduction in malpractice rates over any given period of time.

##### **2. Regulatory Mandates**

- < Although medical malpractice portion of the pKEHP business plan does not promise any tangible benefits for businesses, except perhaps for the medical practice and insurance industries, thus portion of the plan does require new regulatory mandates.
- < Specifically, the pKEHP requires “that a qualified specialist certifies a medical malpractice case's merit before it is allowed to move forward.”

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<sup>50</sup> Taylor, James M, and Meier, Conrad F., “Jury Awards Forcing Doctors off the Job,” Health Care News, March 1, 2003, The Heartland Institute.

- < Although the pre-qualification requirement for medical malpractice cases may, potentially, have merit, they raise a host of question not addressed by the pKEHP. Specifically:
- Who would organize the system under which specialists would pre-screen potential malpractice cases? Options could include:
    - Taxpayers, business and personal through federal, State and/or local governments;
    - State or federal Bar associations;
    - Business organizations; and
    - Non-Governmental Organizations (NGOs).
  - Who would set the qualifications for individuals to serve on the pre-screening board(s)?
  - Who would nominate qualified members to serve on the pre-screening board(s)?
  - Who would select qualified members to serve on the pre-screening board(s)?
  - Would there be an appeal process in event one or more stakeholders considered that a selected board member may be biased?
  - How would the regulations be developed for the pre-qualification board(s) operations?
    - By government agencies through an Administrative Procedures Act (APA) Notice and Comment process?
    - By a third-party not subject to APA processes and protections?
  - Who would pay for the ongoing operations of the pre-screening review board? Options could include:
    - Taxpayers, business and personal through federal, State and/or local governments;
    - Physicians;
    - Lawyers;

- Insurance companies;
  - Plaintiffs;
  - Defendants; and/or
  - A fund supported by multiple stakeholders.
- Who would pay for the case-specific operations of the pre-screening review board? As with the case of ongoing board operations, options could include:
  - Taxpayers, business and personal through federal, State and/or local governments;
  - Physicians;
  - Lawyers;
  - Insurance companies;
  - Plaintiffs;
  - Defendants; and/or
  - A fund supported by multiple stakeholders.
- Would there be an appeal process for the pre-screening board(s)' decisions?
- Who would establish the appeal procedures, if applicable?
- Who would serve on any appeals board to ensure that they were independent of the initial decision-making body?
- Would the pre-screening board provide a simple yes/no decision on whether the malpractice case should proceed, or would they draft an explanatory document?
- Could a court view an initial decision by a pre-screening panel to allow a case to proceed as prejudicial against the defendant?
- Could any written record/decision from a pre-screening panel be admitted into evidence in court?

- Could a defendant who was wrongly accused of malpractice seek damages from the plaintiff?

***E. Improve The Efficiency And Quality Of Care To Cut Administrative Costs***

1. Overview: Improving Efficiency of Care

- < Based on an Institute of Medicine Study, the pKEHP states that “between 44,000 and 98,000 people die of medical errors every year.”<sup>51</sup>
- < The vast majority of the injuries are “not caused by negligent doctors or hospitals, but because of outmoded practices, habits and systems that fail to adequately protect patients from harmful errors.”<sup>52</sup>
- < The pKEHP does not indicate any specific benefits that most businesses or their workers could expect from the Kerry campaign’s plan for reducing medical errors. However, it is reasonable to infer that businesses and/or their employees could eventually enjoy some trickle-down benefit from the Plan if it were successful.
- < However, some businesses in the health care profession may be eligible to receive a “quality bonus” that would enable “purchasers and providers to use upfront capital to upgrade quality and reduce errors to improve outcomes.”
- < It is not clear from the pKEHP which parties would be eligible to receive the quality bonuses. However, since the proposal is geared to the health care profession, it appears that both the bonuses and any administrative cost savings would be realized by the health care industry, not the vast majority of employers.

2. Regulatory Mandates

- < There are a number of regulatory mandates associated with the Kerry plan to cut administrative cost through improved efficiency and quality. However, these mandates appear to be somewhat vague, if laudable.
- < Specifically, the pKEHP would require that “health care organizations and physicians that invest in advanced information technology are rewarded with financial incentives, including the funds needed to install computerized prescribing systems, which can reduce medication errors by 80 percent or more.”

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<sup>51</sup> “A Plan For Stronger, Healthier Businesses.”

<sup>52</sup> Ibid.

- < This regulatory mandate calling for greater use of advanced technology raises a substantial number of important technical, regulatory and administrative issues that would need to be address before the proposed could be implemented. Specifically, and at a minimum, the following issues would need to be addressed:
- What organization would establish the “advanced information technology” standards that would be required in order to comply with the mandate and, potentially, qualify for a qualifying bonus..
    - Would the organization with lead responsibility be a federal entity with standards experience, such as the National Institute of Standards and Technology (NIST);
    - A private standard setting and certification body such as the American National Standards Institute (ANSI); or
    - A third party entity which may or may not be certified by ANSI.
  - Any federally-related standard setting exercise, whether utilizing consensus or market-driven consortia standards, would need to comply with the applicable procedures contained in the National Technology Transfer and Advancement Act as well as OMB Circular A-119.
- < What body would be organized and/or charges with assessing standards compliance, i.e. whether the advanced technologies installed by various health care establishments are in compliance with duly formulated standards?
- < What records would businesses need to maintain in order to demonstrate compliance with the new technology-based regulatory mandates?
- < What, if any, forms would health care providers need to send to the government or other applicable entity to demonstrate compliance with the technology mandates?
- < What staff training and related exercises would companies need to engage in to ensure that new information technologies were being properly implemented and utilized?
- < What company business processes would need to be changed to take advantage of the new information technologies?
- < What forms and supporting documents would relevant companies need to provide to the government in order to qualify for the “funds needed to install computerized prescribing systems....”?

- < How would businesses finance any portions of equipment, training and related expenses not covered by government funding?
- < What metrics would be applied to companies to determine whether the new information services achieved their goals of reducing medical errors?
- < What information would businesses need to maintain and provide to the government in order to determine the relative success, or failure, of the new information technology program in reducing medical errors?
- < What Data Quality pre-dissemination review procedures would federal agencies apply to the medical error information prior to dissemination?
- < What business and/or individuals are ultimately going to pay the expenses associated with the proposed advanced medical information technology program?

## **Conclusions**

- < In an effort to increase the health care coverage available to American workers, the Kerry campaign designed a highly complex health care plan that imposes numerous new regulatory mandates on businesses in exchange for the promise of certain benefits.
- < To gain some specific benefits such as tax credits and insurance premium reductions, businesses would have to comply with numerous regulatory requirements including providing health coverage to all of their workers (including part-time, seasonal, temporary and contract workers) and adopting disease management and care coordination programs.
- < The proposed Kerry-Edwards Health Plan (pKEHP) fails to address the key reasons why smaller businesses are less able to offer their employees health insurance: the administrative burdens and costs associated with offering health insurance.
- < Instead, the pKEHP would likely increase the administrative and regulatory burden on many employers, particularly those utilizing part-time, temporary and seasonal employees, the net effect of which could be to reduce overall employee benefits and possibly employment opportunities, by smaller businesses.
- < The business-specific elements of the pKEHP would, conservatively, impose at least 225 regulatory mandates on businesses that participated in the plan. These mandates would be in addition to the uncounted number of additional regulatory mandates inherent in other aspects of the pKEHP.

- < Each mandate in the pKEHP could potentially translate into a vast array of specific regulations. For example, one sentence in the Health Insurance Portability and Accountability Act of 1996 (Sec. 264 of Public Law 104-191) concerning patient privacy, resulted in 93 pages of regulations in the *Federal Register*.