CHANGING THE WAY BUSINESS THINKS ABOUT HEALTH CARE REFORM:

AN INTEGRATED APPROACH

APPWP
ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

Comprehensive Health Care Policy Adopted December 15, 1992
The APPWP believes the employment-based system of health care coverage is essential to ensuring the delivery of appropriate, high quality health care to all working Americans.

The APPWP policy calls for a Federal rather than state-by-state approach to health care system reform.

The APPWP supports a requirement that all employers provide and pay for a portion of the health care costs for their employees. Such a requirement would be coupled with tax credits and subsidies for low-income individuals and businesses with large numbers of low-income workers to ensure affordability.

The APPWP also supports an individual mandate to accept or acquire health care coverage. Thus, along with the employer mandate and public programs, all Americans (workers, nonworkers including those with low-incomes) must have essential health care coverage.

Managed care programs must be aggressively implemented throughout the private and public health care system, including Medicare, Medicaid, CHAMPUS and workers compensation. The practice of cost shifting from government to private payors of health care must end.

The tax exclusion to employees for employer-provided health benefits should be limited to the cost of providing an essential benefits package. The full deductibility of employers’ costs for providing health care coverage must be retained. Tax favored treatment of health benefits would be limited to the cost of the Health Maintenance Organization (HMO) Act of 1973’s package of benefits (or its actuarial equivalent).

The APPWP supports expenditure targets for overall health care spending to be met through aggressive implementation of managed health care programs. However, if after a specified period of time these targets are not met, the National Board would recommend appropriate measures such as all-payer rate regulation to meet the targets.
The APPWP is the first major business group to support a requirement that all employers provide and pay for a portion of the health care costs for their employees. Under the APPWP’s proposal, individuals would also be required by law to have health insurance. Both the employer and individual mandate are conditioned upon a system of tax credits and subsidies to make the cost of obtaining coverage more affordable. Because of our commitment to the employer-based system, the APPWP maintains that a mandate to provide a specified level of health coverage for all Americans is an essential component of health care reform.

Any mandate acceptable to the APPWP must limit the ability of Congress and the Executive Branch to micromanage employer benefits or to pre-empt design options as well as avoid, to the extent possible, specific requirements as to treatments, services, providers and cost-sharing requirements. Therefore, the mandate must provide inherent revenue disincentives so that policymakers will not easily expand the mandate. Tying the mandate to the tax exclusion cap would provide such a disincentive.

The APPWP proposal is based on a Federal rather than a state-by-state approach to health care reform and underscores the importance of ERISA protections for multi-state employers. The APPWP’s approach would preserve the employer-based system and provides a comprehensive, integrated plan that would achieve the objectives of access, quality and cost containment.

The APPWP plan includes stringent cost control mechanisms, defines the individual and employer mandates, provides a minimum benefit package based on those services found in the federal HMO Act of 1973 and assures universal coverage. Under the plan, all Americans would have health care protection one of three ways: most would receive coverage from their employer, others from public plans, or through a so-called “third pool.”

The “first pool” includes all those covered under the employer-based system where we think most Americans should get their care. Subsidies would be available for certain companies and individuals for whom the mandate would be an unreasonable burden. Almost all employers would qualify for some amount of credit under this proposal; however, employers with the largest low-wage work forces and small business would realize the greatest amount of credit. Employees with an annual family income below $20,000 would also be eligible for a tax credit equal to the lesser of the premium paid by the employee for employer-sponsored health insurance, or $1000. The credit would be reduced by $1 for every $10 of income between $20,000 and $30,000. A phase-out of the credit for these employees would be designed to be as simple as possible for employers to administer.

Employees who work more than 24 hours per week and their dependents would be covered by their employers. A level of contribution (but not a payroll tax) would be made by the employer on behalf of those employees who work 17.5 - 24 hours to secure basic coverage through a privately run “third pool.”

Employees would be allowed to exclude from their taxable income the value of the basic health plan (to be determined by the Secretary of Health and Human Services). However, employees would be required to include in their gross income the fair market value of coverage that exceeds the value of the basic plan, minus their contribution to such coverage.
Employers could continue to deduct the entire cost of all employee health care expenses but must maintain a plan that includes the services found in the HMO Act with the following design features:

- a minimum co-payment requirement of 70/30 percent;
- an employer contribution of no less than 60 percent of the basic plan costs;
- a requirement that deductibles not exceed $250 for individuals and $500 for families;
- a requirement that out-of-pocket expenses not exceed the greater of $3000 or 10 percent of compensation; and,
- alternatively, employers may offer a health plan that is at least actuarially equivalent to or greater than this minimum package;

The “second pool” would include public programs (e.g. Medicare, Medicaid, CHAMPUS, etc.) for which different populations are eligible. Critically, all public programs would be required to apply the same types of managed care efforts as private plans in order to curtail cost shifting to private payors.

Finally, the “third pool” would include those individuals self-employed, unemployed, early retirees without employer benefits, marginally-employed, those not eligible for government programs and part-time (i.e. work fewer than 24 hours per week) workers. COBRA would be eliminated. All third pool individuals would purchase their insurance through a private-sector pool administered by participating insurance companies and HMOs.

Pools would be set up at the state or substate level. Individuals would pay a monthly premium to the pool or be subject to an excise tax. The standard pool premium would be a uniform per capita amount determined by the pool to be the per-person allocation of 80 percent of the total experience of third pool individuals as a group. The pool would establish a standard benefit package equivalent to the minimum benefit package provided by employers. Individuals would be able to deduct the amount they pay in premiums for the standard benefit and would be able to exclude employer contributions and subsidies from income.

While supporting competition and having managed care as the primary cost containment feature throughout the health care system -- including public plans -- the APPWP supports developing the infrastructure to monitor expenditures and manage the spread of capital and technology. A new National Council would develop expenditure targets for overall health care spending and separate state targets would be set. However, if after a specified period of time these targets are not met, the Federal Board would recommend appropriate means to achieve targets such as all payor rate negotiations.

To help meet targets and contain costs, the APPWP recommends that Medicare methodology be applied to all treatments and services for the non-Medicare population. Physicians and hospitals would be required to publish their full range of fee schedules and display them as a percentage of Medicare fees. The National Council would also oversee the development of an electronic patient record system with treatment and outcomes data and review infrastructure and equipment purchases. In addition, the APPWP supports small group health insurance market reform and medical malpractice liability reform.

To achieve rationality and equity in the health system, all Americans must be guaranteed a similar level of basic health care coverage, whether covered by Medicare or Medicaid or a private employer plan. The APPWP plan would achieve this objective in a system driven by quality and cost containment.
**INTRODUCTION:**

The Association of Private Pension and Welfare Plans (APPWP) believes every American has the right to affordable health care. Because it is deeply concerned about the health care crisis, the APPWP’s Board of Directors, in September of 1991, charged its Health Care Issues Committee with the task of developing a health care policy which would reflect the needs of its membership -- principally plan sponsors of benefit plans -- and the nation as a whole. What ensued was fifteen months of deliberations by the Committee, the Board of Directors, and an open forum for all APPWP members. In December 1992, the APPWP Board of Directors, by consensus, adopted the following comprehensive and integrated health care reform proposal which would, if enacted, preserve and expand the employer-based system while meeting the objectives of providing access, quality and cost containment.

**I. BACKGROUND: THE VOLUNTARY NATURE OF THE EMPLOYER-BASED SYSTEM**

- The APPWP has long supported reform efforts that would expand access for all Americans but opposed any employer mandate. After much reflection, the APPWP became the first business group to endorse a requirement that all employers provide a minimum level of health care coverage (as outlined below) provided that the method for defining the required coverage minimizes political pressure to cover particular specialties, treatments or events, and provides for government encouragement and support of vigorous cost management programs. To achieve this end would require that:

  1) The mandate must include inherent disincentives to policy makers to expand the mandate’s scope.

  2) Cost management supported by the government be based on certain minimum criteria and safeguards so that the private market could be free to develop this concept over time.

- The role for the employer must be maintained. The employment-based system recognizes the important relationship between health, productivity and cost. Employers have established many wellness, prevention, and health education programs at the work place. Furthermore, employers now play a major role in developing, selecting and promoting managed care for their employees.

- The APPWP believes that a "play or pay" mandate would inevitably lead to a government-based social insurance system because the temptation to "pay" into a public plan and drop employer programs would increase, especially given the government’s open-ended ability to expand the mandate’s requirements. Therefore, we reject "play or pay" categorically.

- Thus, an employer mandate to preserve the private system must provide no "backdoor" escape for employers to opt out for a public plan. All employers should therefore be required, in a nationally-coordinated system, to provide employees (who work more than 24 hours per week) and their dependents with health care coverage, regardless of firm size or income.
Some appropriate level of contribution -- but specifically not a payroll tax -- would be made by the employer on behalf of employees who work 17.5 - 24 hours to secure basic coverage through a private "third" pool described below. Subsidies would be available for certain companies and individuals for whom the mandate would be an unreasonable burden, also described below. Appropriate penalties for employer noncompliance will be incorporated under ERISA in the third pool.

Dependent coverage would be determined according to a uniform methodology, i.e. "the birthday rule."

Providing universal access does not guarantee universal coverage. In addition to making standard coverage available and affordable, every American must obtain some identifiable coverage or be subject to an excise tax. An individual mandate would close coverage gaps and end cost-shifting that results from uncompensated care. When an employer offers coverage, the employee must accept. All others must attain coverage through Medicare, Medicaid, or through individual coverage in the third pool. Policy numbers would have to be disclosed for each family member on IRS forms to avoid imposition of the tax. Uninsured individuals would be enrolled in the third pool upon hospital admission. Parents would show proof of plan enrollment for children's annual admission to school.

A large new pool eligible for private, individual "basic coverage" would be developed and would include: nonpoor uninsured, the nonelderly with no attachment to the workforce, and those ineligible for the employer mandate -- the self-employed, unemployed nonpoor, and part-time (i.e. work fewer than 24 hours per week) workers. COBRA would be eliminated. (See Section III for description of the third pool.)

II. THE BENEFITS PACKAGE

To achieve rationality and equity in the health system, all Americans must be guaranteed a similar level of basic health care coverage, whether covered by Medicare or Medicaid or a private employer plan.

Any mandate acceptable to the APPWP must limit the ability of Congress and the Executive Branch to micromanage employer benefits, pre-empt design options as well as avoid, to the extent possible, specific requirements as to treatments, services, providers, and cost-sharing requirements. Therefore, the mandate must provide inherent revenue disincentives so that policymakers will not easily expand the mandate.

The mandated minimum standard plan should be based on the following principles:

1) The fundamental purpose of organized health care coverage, whether it is provided by government or by the private sector, is to protect individuals and families from heavy financial loss caused by illnesses and injuries, increase the health and productivity of the workforce, and limit the expense to society as a whole.

2) The minimum standard plan must create strong incentives to beneficiaries to choose the high quality, cost-effective health care...
providers. Choice and cost are linked; the American economy does not have the resources to cover every form of health care.

3) The basic health plan must contain strong cost containment measures in order to keep health inflation under control. Without adequate expense controls, the American health care system would have no choice but to reduce access to quality health care to assure the solvency of the system.

- Employers must provide their employees and dependents a health plan that includes the health care services found in the Federal HMO Act.

- Employers shall be required to contribute no less than 60 percent of the basic plan costs with minimum co-payments of 70/30 percent. At a minimum, the plan’s required deductibles could not exceed $250 for individuals and $500 for families, and out-of-pocket expenses could not exceed the greater of $3000 or 10 percent of compensation. However, the employer may instead offer a health plan that is at least actuarially equivalent to or greater than this minimum package. An actuarial equivalent would not eliminate any key mandated service.

- The employee exclusion from taxable income will be capped at the value of the basic plan. That value, set by the Secretary of Health and Human Services, would be calculated by averaging the three most cost-effective, qualified providers of the plan (with a reasonable demographic mix), in the five highest cost areas. The list of metropolitan areas will be expanded over time and the value adjusted annually consistent with adjustments in the expenditure targets (described in Section IV). All employees must include in gross income the fair market value of coverage that exceeds the value of the basic plan, minus their contribution to such coverage. This change is consistent with sound managed care principles of making beneficiaries sensitive to health program costs while driving down demand for less cost-effective care.

- Employers, however, could continue to deduct the entire cost of all employee health care expenses. This would fairly accommodate those situations where collectively-bargained and other negotiated benefits agreements result in health plans that exceed the value of the basic plan.

- Employees will be allowed to contribute toward the cost of the basic plan on a pre-tax basis. Employees may purchase supplemental health coverage -- such as dental and vision plans -- through an employer-sponsored plan only on an after-tax basis. Contributions by self-employed and others covered by the “third pool” (see Section III) will be considered qualified, above-the-line tax deductions consistent with the above restrictions.

III. ASSURING AFFORDABILITY

A. EMPLOYER-PROVIDED PLANS

- An across-the-board employer mandate must assure reasonable affordability for employers and employees.

- Affordability is especially critical in the small market, for it is here where the mandate would have largest impact both in terms of new coverage as well as in economic
costs, because many small businesses are marginal, and often their employees are “working poor.” Removing barriers of access in the small market will not go far enough, however, in lowering the cost barrier.

- An employer-based system assumes that employers have a self-interest in making good health care management decisions by reason of having to contribute to the costs of their plan and because they can share, within reasonable limits, in the underlying cost experience of their plan.

- Small case reforms must be enacted to remove market barriers. The APPWP supports such reforms as: guaranteed eligibility and renewability, strict limitations on pre-existing condition exclusions, limitations on premium variance between and within blocks of business, rating adjustments limited to age, sex or geography and applied consistently, and other reforms consistent with those advanced by the Health Insurance Association of America and the National Association of Insurance Commissioners. Experience rating should continue to be permitted, though limited, on smaller cases and prohibited only in plans with fewer than 50 lives. Purchasing co-operatives or corporations and acting on behalf of small companies to achieve greater economies of scale should be encouraged but not deemed exclusive agents within jurisdictions. APPWP supports extension of ERISA pre-emption protection to all employer plans.

- A refundable tax credit would be provided to employers on behalf of employees to offset premiums charged to them. Employees with annual family incomes below $20,000 would be eligible for a tax credit equal to the lesser of the premium paid by the employee for employer-sponsored health insurance or $1,000. The credit would be reduced by $1 for every $10 of income between $20,000 and $30,000. A phase-out of the credit for these employees would be designed to be as simple as possible for employers to administer.

- Employees who would be eligible on the basis of their salary or wages alone would be notified of their potential eligibility for the tax credit. Employees would have to declare their total expected household income and certify their eligibility to the employer. Employees would be responsible for notifying employers of changes in their status that would affect their eligibility. All attempts to simplify administration of the credit -- and shift as much of the responsibility as possible to the employee -- must be made. As far as possible, the credit should tie into current payroll practices. Employers would include the tax credit in their W-2 statements, and employees would declare the credit and make adjustments on their 1040 form when they file their taxes.

- Employers would reduce their periodic payments of withholding taxes by the amount of the credits and would apply the credit to reduce health insurance premium withholding for individual eligible employees.

- A refundable tax credit would be provided to companies equal to the “qualified health benefit costs” for low-wage workers in excess of 25 percent of their compensation. “Qualified health benefit costs” would be equivalent to the lowest area cost (as determined by the
Secretary of HHS) of the employer share of the standard benefit package for workers with wages or salaries below one-third of the Social Security taxable maximum ($57,600 in 1993). Employers could claim a credit for the amount by which “qualified health benefits costs” for these workers exceed 25 percent of their compensation. Retiree costs would not be considered.

- This credit would be available without regard for the employer’s overall workforce composition or profitability and would not be affected by the structure of the employer’s business (e.g., lines of business). The credit or subsidy is intended as a “circuit breaker.” Almost all employers would qualify for some amount of credit under this proposal -- but employers with the largest low-wage workforces would realize the greatest amount of credit. Every effort should be made to design the credit so as not to affect artificial compensation and hiring decisions.

B. THE THIRD POOL

- The new “third pool” is the health insurance location for everyone who is not covered in the first pool (mandated employer-provided health benefits) or the second pool (Medicaid and Medicare). Due to the employer and individual mandates, the third pool population is a precisely defined group -- it is not subject to adverse selection, and it cannot inadvertently expand since individual participation in the third pool is not voluntary.

- The third pool would contain non-employed and marginally-employed individuals not eligible for government programs. These include: early retirees without employer benefits, the unemployed, individuals not in the workforce, the non-Medicare eligible disabled; workers employed fewer than 24 hours a week by any one employer, and other workers with limited labor force attachment; and self-employed individuals. Part-time and other limited attachment workers receive contributions to the pool on their behalf from employers to subsidize their insurance. COBRA would be eliminated.

- All third pool individuals would purchase their insurance through a private-sector pool administered by participating insurance companies and HMOs. Pools would be set up at the state or substate area level. The pool would provide individuals with information on each of the participating insurers, and individuals would select an insurer at the pool office. Participating insurers and HMOs would be required to accept all applicants with no restrictions. Operating details on risk allocation will be resolved by participating insurance companies. Coverage under the pool is not limited to any particular plan design.

- Individuals would pay a monthly premium to the pool. The premium would vary depending on the insurer selected by the individual. Each premium would consist of a standard pool premium plus a variable insurer premium. The standard pool premium would be a uniform per capita amount determined by the pool to be the per-person allocation of 80 percent of the total experience of third pool individuals as a group. A variable premium would be set by each insurer or HMO to supplement the standard pool premium. The variable premium would reflect organization-specific costs and would encourage individuals to shop for low cost plans and encourage insurers and HMOs to manage costs.
An individual’s premiums would be reduced by the amount of any contributions, tax credits or subsidies credited to the pool for that individual. These would include employer contributions for employees working fewer than 24 hours per week or for other marginal employees, a voucherable individual tax credit, and government income-based premium subsidies for low-income individuals. Individuals would pay the pool the difference between the total premium and the total accumulated credits and subsidies held in their names.

For each individual enrolled in a particular insurance plan, the insurer or HMO would receive from the pool a per-capita payment adjusted for demographic and other characteristics of that individual (risk-adjusted), plus the variable insurer premium.

The pool would establish a standard benefit package equivalent to the minimum benefit standard provided under employer plans, which all participating insurers or HMOs would agree to offer without modification. Individuals could purchase supplemental benefits consistent with the limitations placed on individuals covered by employer plans.

Individuals would be able to deduct the amount they pay in premiums for the standard benefit and would be able to exclude employer contributions and subsidies from income.

IV. LIMITING HEALTH CARE SYSTEM COSTS

If everyone is covered, the demands of the U.S. health care system will increase dramatically. Even without a mandate, the need for cost containment in our system is critical. But with a mandate, cost containment must become an even more aggressive and firm public policy.

- Our cost containment objectives:
  1. End cost shifting
  2. Increase provider efficiency and quality of care
  3. Monitor and slow the growth in health care expenditures
  4. Control the spread of capital and technology
  5. Achieve immediate, measurable results
  6. Rely on competition and private sector efforts

- While supporting competition and having managed care as the primary cost containment feature, we should also develop the infrastructure to monitor expenditures, manage the spread of capital and technology; and, if competition and managed care fail to slow the growth in health expenditures, the APPWP might support implementing local all-payer rate negotiation or other appropriate devices.

- A new National Council would develop national expenditure targets and disaggregate them to state targets. The National Council would also develop a single national claims form with all claims data aggregated by locality and region and provided to state and national councils; work should continue to advance reforms like standard coding conventions and electronic claims submission.

- States would be required to establish state and regional/local councils to collect data on health claims, publish reports on health expenditures and causes of increases, and develop
annual health expenditure targets. These councils would provide equal representation of payors (with no health-related business interests) and providers, and include payor and provider subcouncils.

- Public health programs -- Medicare, Medicaid, CHAMPUS -- will be included in determining spending targets. Special incentives or requirements must be established to move these programs to pursue aggressively managed care arrangements, including use of networks in PPOs, EPOs, and HMOs, for their beneficiaries within four years -- e.g. 20 percent penetration per year, 80 percent coverage by four years.

- The National Council and local councils would determine whether and why targets were not being met by the fourth year after enactment, (to the three-year average of GDP increase plus 2%). The councils would recommend appropriate action to take to achieve target goals. One such mechanism might be all-payor rate negotiations, although other remedies may also be considered and implemented.

- An all-payor rate negotiation fallback plan might be implemented and would expand the role of existing local councils to negotiate with individual providers. (A year prior to enactment would be selected as the “base year” to overcome incentives for providers to expand care and treatment.) Negotiated rates would be designed to be compatible with managed care and to reward both providers and payors for efficiencies. Provider-specific negotiations would enable payors to influence the overall allocation of capital and technology in the community. Medicare and Medicaid would pay negotiated rates as long as the state met expenditure targets on average over three years. Integrated health systems (like HMOs) which provide members all health care for a single capitated premium would be exempt from negotiated rates. This is one remedy the councils might consider to meet spending targets.

- To help meet targets and contain costs, the APPWP recommends that Medicare methodology for provider fees be expanded to cover all treatments and services for the non-Medicare population. Physicians and hospitals would be required to publish their full range of fee schedules, to include displaying all fees as a percentage of Medicare fees. Balance billing to patients would be prohibited after publication of rates. Providers would be required to publish specific fees for each procedure as well as the range of their fees as a percentage of Medicare; they must also notify patients in advance of their rates. Medicaid must pay Medicare rates. Providers reimbursed under alternative risk-sharing methods would also be required to publish fees. Councils would publish fee range and average charges/revenues of every provider, as well as quality and cost-effectiveness data on providers as they become available.

- The National Council would oversee the development of a patient record system with treatment and outcome data and the development and dissemination of treatment guidelines. The Council would also provide statistical data and provider-specific data to local councils; local councils would provide payors with information on quality based on patient outcomes.
The APPWP supports strong managed care programs which require pre-emption of state anti-managed care laws. Putting regulation of commercial insurance and HMOs on a level playing field is also important. Currently, separate regulation blocks the efforts of commercial insurers to develop new managed care products; the distinguishing feature in regulation should now focus on products and services rather than organization. States should be required to support mandatory utilization review and case management in workers compensation medical claims and permit employers to direct employees to managed health care networks.

The National Council should develop national technology assessment capability in order to adopt a uniform standard for introducing new technology, including cost effectiveness analysis. Local councils should be required to review and approve local introduction of new procedures and plans for new equipment purchases and provide payors information on facilities and providers that have acquired material or procedures without approval. Local councils should identify “centers of excellence” by medical procedure -- either locally or elsewhere.

The National Council would oversee the development of a patient record system with treatment and outcome data and the development and dissemination of treatment guidelines. The Council would also provide statistical data and provider-specific data to local councils; local councils would provide payors with information on quality based on patient outcomes.

The APPWP supports promotion of wellness programs and emphasis on individual responsibility, appropriate lifestyle changes, and prevention. Such programs should be voluntary, but public education programs on healthy lifestyles and prevention should be expanded and supported by the federal government.

V. OTHER ISSUES

The APPWP supports reform of the medical malpractice system. Specific changes to the legal system to abate the practice of “defensive medicine” would help contain some unnecessary health care spending. Only by capping non-economic damages, reforming narrow legal doctrines such as the collateral source rule, providing for shorter statutes of limitations on claims, etc., will employers, as the largest purchasers and payors of health care, be able to reduce the high costs of health care.

APPWP supports enlarged public health funding for underserved populations in rural and inner city areas, particularly for improved primary care and emergency medical services for rural areas, expanding community health centers and school-based care in inner cities.

VI. CONCLUSION

The APPWP is the first major business group to support a requirement that all employers provide and pay for a portion of the health care costs for their employees. In December 1992, following fifteen months of deliberations, committee meetings and a forum for all APPWP members, the APPWP’s Board of Directors adopted by consensus this proposal to reform America’s health care system.
As comprehensive as this package of recommendations is, there are certain areas key to long-term, systemic health care reform that are not directly addressed. We wish to acknowledge that further study will be required for certain issue areas. For example, the APPWP did not determine the cost of our reform proposal or identify appropriate funding sources. We did not address the financing problems of early and post-65 retirees, especially in the FAS 106 era. We have not yet detailed the most appropriate way to redesign the medical infrastructure -- e.g. the kinds and numbers of doctors being educated, appropriate technology assessment, the future of the Veterans Administration hospital system, reallocating available vital resources, rescuing hospital emergency care, etc. We also did not address the question of how best to reform Medicaid and reallocate responsibilities between federal and state governments.

Finally, we wish to emphasize that the APPWP’s support of both an employer and individual mandate is premised on our trust and membership’s experience in providing health care benefits in an employer-based system. Our plan is based on a Federal rather than a state-by-state approach to health care reform and underscores the importance of ERISA protections for multi-state employers.

APPWP members are concerned that health care reform should preserve a strong role for private employers in the design and operation of health care -- not just the financing. We believe our proposal would achieve the objectives of access, quality and cost containment as well as preserve a true employer-based system.

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The APPWP is a nonprofit organization whose members include large and small plan sponsors and organizations providing support services to plans such as banks, insurance companies, consulting and actuarial firms, investment firms and other professional benefit organizations. APPWP members sponsor or provide services to pension and welfare plans covering over 100 million participants.