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001. letter	George Kargianis to Mande re meeting (partial) (1 page)	09/15/1997	b(6)

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P1 National Security Classified Information [(a)(1) of the PRA]
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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Jerold Mande -- OSTP -- Box #4 Tobacco

Folders

Labor Issues and Suits (Kargianis)
Tobacco Budget
Koop/Kessler Report and Letter
Harkin FDA Funding Amendment
VP/Conrad Event
State Settlements -- FL, MS, TX
Medicaid NGA Letter
Q&A
DES Commerce Cmte Q&A
Radioactive Ingredients
Limits on Liability
Harkin Bill
Gleitsman
Minnesota
Minnesota -- Industry FDA Document
Tobacco News Articles and Clippings

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**ALSO ADMITTED IN CALIFORNIA
***ALSO ADMITTED IN WISCONSIN

October 8, 1997

Mr. Jerold Mande
Senior Advisor to the Director
OSTP, Room 436
Old Executive Office Buiiding
Washington, D. C. 20502

re: **Proposed Tobacco Settlement**

Dear Mr. Mande:

Thank you for coming on the line the other day. As you know our chief concern with the settlement as originally proposed was that with the granting of immunity to the tobacco companies, it was too high a price to pay for what the nation was receiving in return. I would agree with the President that the consist of the any settlement or solution has to be totally revised if, in fact, a just and equitable solution to the problems presented by tobacco is to be reached.

As you are well aware, the proposed settlement had left out and had not made arrangements for compensation for a number of deserving constituents and victims which would include, among others, the labor health funds, tobacco farmers, and others. The proposed increase in the price of tobacco of $1.50 per package would raise additional funds that would be used to compensate various deserving constituents as well as the victims of tobacco usage. I am enclosing for your consideration the excellent statement presented by Mr. Victor Van Bourg.

I look forward to visiting with you again on this most important issue and should any settlement discussion be recommenced, we would appreciate an opportunity to participate and to present our views. Thanking you once again, I remain

Very truly yours,

George Kargianis
GK:jj
J:\CLIENTS\6\06476\001\MANDE.2LE

cc: President William J. Clinton
Bruce N. Reed
Paul Stritmatter
Robert Connerton
Victor Van Bourg

J:\CLIENTS\6\06476\001\MANDE.2LE

George Karganis

COALITION FOR WORKERS
HEALTH CARE FUNDS

1920 L STREET, N.W
FOURTH FLOOR
WASHINGTON, D.C. 20036 5004

PRESENTATION BEFORE THE DEMOCRATIC TOBACCO TASK FORCE

UNITED STATES SENATE

SEPTEMBER 24, 1997

BY

VICTOR VAN BOURG, ESQ.

VAN BOURG, WEINBERG, ROGER & ROSENFELD

OAKLAND, CALIFORNIA

ON BEHALF OF

THE COALITION FOR WORKERS' HEALTH CARE FUNDS

Mr. Chairman and Members of the Committee, I want to thank you for providing us with the opportunity of appearing before you this afternoon and testifying on such an extremely important matter.

My name is Victor Van Bourg. I am the senior partner in the law firm of Van Bourg, Weinberg, Roger & Rosenfeld, headquartered in the San Francisco Bay Area of Northern California. I have been representing workers, trust funds and unions for approximately 41 years. Our firm represents unions in the construction, industrial, service and public sectors of the economy, and we represent many health and welfare and pension trust funds.

I am appearing today on behalf of the Coalition for Workers' Health Care Funds, and I am proud to be a member of the Executive Committee of that group.

The trust funds are joint labor-management trust funds which provide and have been providing health care benefits since Congress enacted the Labor-Management Relations Act of 1947 known as the Taft-Hartley Act. That law required that monies negotiated in collective bargaining agreements, which were ear-marked to pay medical bills for workers and their families, be spent through jointly trusted trust funds represented equally by labor and management. Such benefits could no longer be provided directly through union treasuries which could no longer accept employer contributions directly to such labor organizations. Such trust funds became known as Taft Hartley, jointly trusteed health plans or funds, and are sometimes referred to as multiemployer trust funds.

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) which placed our trust funds and their trustees directly under the regulatory control of the Department of Labor and the Internal Revenue Service. ERISA codified the fiduciary obligations of trustees mandating that, as a matter of federal law, trustees must engage in such legal actions as necessary to secure or obtain funds for the benefit of the worker participants whenever legally possible and feasible.

Thus, these trusteed funds are actually required by law to pursue the tobacco industry for reimbursement for past, present and future expenditures which have burdened and will continue to burden these trusts to defray medical costs brought about by the use of tobacco products.

The Taft-Hartley labor-management, multiemployer health and welfare funds for which we speak, provide workers with direct medical benefits and with insurance to pay their medical and hospital bills.

My firm filed the first workers' health care fund class action law suit in the country against the tobacco industry.

The workers' funds and their participants, are at the very heart of the problem before us. If that sounds like an extravagant statement, Mr. Chairman just bear with me for a moment and I will explain.

There are some 2,500 workers' health care funds in the 50 states, Puerto Rico and the District of Columbia. They provide medical coverage for approximately 30 million Americans: workers, retirees and members of their families, including children.

The men and women these funds cover are, for the most part, blue-collar workers. The percentage of this group who smoke is greater than any other segment of our society - in fact it is more than double the national average. Worse, our members are heavier smokers by far than other segments of society. Fully 20 percent of the American smoking population is covered by our health funds. Unlike every other segment of the American population, the percentage of our workers who smoke has not precipitously declined in the last 20 years.

By the time the children covered by these trust funds reach the age of 18, 43% of them smoke -- more than double the national average. We estimate that 43% of new smokers are recruited from our ranks.

The results are horrifying: lung cancer, throat cancer, emphysema and heart diseases, are frighteningly prevalent among our covered population. Treating these tobacco-related diseases consumes far too much of our scarce resources - fully 10%, or more than $3 billion each year of the $33 billion plus these funds spend annually on medical claims.

Our funds are collectively bargained. This means that every dollar spent paying for a tobacco-related claim is a dollar that would otherwise have gone into a workers' pay check or benefits package to expand his or her health coverage.

None of this has come about by accident. The tobacco companies have coldly and methodically targeted our workers with specially designed promotional and advertising campaigns, unfortunately with devastating success.

These trust funds have filed class action lawsuits against Big Tobacco in some 27 states. Our goal is simple. We want our money back - the money we have spent on tobacco-related diseases. Currently, that figure runs to more

than $3 billion a year. Part of the money we get will pay for smoking cessation and prevention programs.

As soon as we learned that the tobacco industry was negotiating to achieve immunity from trust fund lawsuits, while cynically insisting in the settlement agreement that trust funds must continue to provide health benefits for people who are sick from the use of these products, we wrote to all 50 attorneys general putting them on notice that they had no right to barter away our rights to recover reimbursement from the tobacco companies, and that they had no right to speak for us without giving us a seat at the table so that we could negotiate our own reimbursements.

Unlike the States, every penny awarded to our funds will go to pay for health claims and smoking reduction programs.

We are preparing to create and implement a nationwide smoking prevention and cessation program aimed directly at our family groups with a particular focus on teenagers. (A copy is attached.)

The Taft-Hartley funds have a long and distinguished history in the realm of workplace safety programs, as exemplified by their efforts in the fields of building and construction.

The original proposal drafted by the attorneys general and the tobacco industry and submitted to Congress for codification would have extinguished our lawsuits leaving us high and dry.

Attorney General Hubert H. Humphrey, III testified before the Senate Judiciary Committee that his fellow AGs had informed him the language in the proposal that would have extinguished class action suits, was aimed directly at our funds on the grounds that they couldn't afford the extra financial burden.

This claim is patently untrue. A number of studies have shown there is ample money to pay our claims -- the most recent coming earlier this week from the Federal Trade Commission. The FTC report was only the latest in a string of such documents which pointed out that the true cost of the proposed settlement to the tobacco industry would be no more than some $100 billion in today's dollars -- not the $368.5 billion the industry would have us believe. In addition, all these studies have shown that one effect of a settlement would be to substantially increase tobacco industry profits over the next 25 years by several hundred billion dollars.

Their proposal would have had the effect of closing the door on a lot of constituencies in addition to ours. There are the cities and counties of

America, many of whom have already filed class action suits to recoup the costs of treating tobacco-related illnesses. There are veterans groups, and others, represented by agencies of the federal government. The list goes on but it clearly encompasses at least 100 million Americans.

Imagine, two parties entering a room, closing the door and then working out a deal that affects not only themselves but also, other parties not privy to their negotiations.

To add insult to injury, an examination of the deal, reveals that it would pay the states damages for monies spent by state-sponsored state employee health plans to treat tobacco-related diseases. Those plans are identical in every respect save one to our own (which were to be excluded); they had a lawyer in the room when the deal was made.

Such a procedure is clearly unconstitutional and raises a host of other legal issues.

What judge would stand by and allow parties similarly situated to be treated in such widely disparate fashion?

And that, Mr. Chairman is the heart of our complaint.

We are outraged that an industry that makes its money by selling poison that sends 400,000 Americans a year to an early grave; and plots vigorously to ensnare the flower of our youth as grist for their mill, should seek to insulate itself from the justice that every American has a right to seek, and try to keep us from pursuing our law suits.

Surely, Mr. Chairman:

- if any segment of American society has a legitimate grievance against the tobacco industry, it is our workers;
- if any segment of American society has a right to go into court to seek justice from this industry, it is our funds;
- if any segment of American society has demonstrated its dedication to the health and safety of working men and women, and their families, it is our funds; and
- if any segment of American society has established a track record when it comes to producing effective solutions to workers' health and safety problems, it is our funds.

President Clinton, in his announcement from the oval office, said he wanted to see those who have suffered most from the ravages of tobacco included among those seated at the table when the new tobacco deal is worked out.

Clearly this means us. We agree fully with the five principles he enunciated and we stand ready, willing and able to join with those of you in the Congress who will refashion this fatally flawed agreement. And, we want to make sure that the President's vow to protect the livelihood of the tobacco farmers extends to those workers employed in the tobacco industry.

And now, Mr. Chairman, with the Committee's permission, I would like to submit the remainder of my statement for inclusion in the record.

Table XX
Estimated Size of Multi-employer
Health & Welfare Fund Community

Population	Number of funds	Number of participants	Estimated number of covered lives	Total payments ($1,000)
Sample	440	1,789,500	5,726,400	5,813,000
Extrapolated to all of U.S.	2547	10,358,764	33,148,044	33,649,341,000

Source: Sample is extracted from *1997 Group Insurance Plans, Entity C File.* Washington D.C.: Judy Diamond Associates Inc. This file covers Taft Hartley Funds labeled as "Multi-employer plan" based on their most recent submission of Form 5500 to the Internal Revenue Service "Covered lives" means the total number of participants and dependents for whom the funds pay health benefits. These data cover the year 1995, and includes all funds in the following states: AL, AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD The estimated total number of funds in the U S is derived from *Characteristics of Multiemployer Plans, Second Quarter, 1996.* Chicago: International Foundation of Employee Benefit Plans, 1996, which found that 68% of the 3746 welfare plans reported in the U.S provide health care benefits.

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JACK CURRAN†
LEGISLATIVE DIRECTOR

†NOT A MEMBER OF THE BAR

October 10, 1997

Jerold Mande, Senior Advisor to the Director,
Office of Science and Technology Policy
Executive Office of the President
Room 436
The Old Executive Office Building
17th Street and Pennsylvania Avenue, N.W.
Washington, D.C. 20502

Re: **Proposed Tobacco Settlement**

Dear Mr. Mande:

I am writing to follow up on our meeting of September 16th. At that meeting George Kargianis and I presented to you the concerns of The "Coalition for Workers' Health Care Funds" regarding the effect the proposed global tobacco settlement would have on lawsuits filed by labor-management health and welfare funds throughout the United States. As you may recall, Mr. Kargianis represents a number of health and welfare funds in the State of Washington, and I and my law partners serve as national counsel to the coalition of funds which have brought class action law suits in 27 states to recoup damages from the tobacco industry for treating the tobacco-related illnesses suffered by their members and families.

I would like to thank you again for meeting with us, and also wish to reiterate to you the devastating affect the proposed global tobacco settlement, as agreed to by the State Attorneys General and the tobacco industry, would have on our claims against the tobacco industry. The Coalition for Workers Health Care Funds represents some 30 million individuals - union workers, their families, and retirees. We estimate that these funds comprise nearly one quarter of all employment-based health coverage in the U.S. The claims brought by the coalition funds are based on the same legal theories as those brought by the States to recoup medicaid expenses, and the costs of tobacco-related health care for their own state employee health plans. Private sector health and welfare funds deserve to be treated the same as the health and welfare plans providing coverage to state employees. Yet the agreement between the tobacco industry and the Attorneys General would extinguish our legal rights while reimbursing the tobacco-related health care costs of the state plans. Furthermore, the agreement also would eliminate lawsuits filed by cities and counties and forclose the rights of other third-party payors, such as the federal government, to bring suit against the tobacco industry. This is not only extremely unfair, but we believe it is also constitutionally suspect, and we will soon be releasing our analysis of the serious

problems such legislation would face in satisfying the due process and equal protection clauses of the Constitution.

We were very pleased to see that President Clinton has chosen to seek important improvements in the proposed settlement before endorsing any particular tobacco control legislation. The Coalition for Workers' Health Care Funds strongly supports the public health proposals of the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health, and urges that the President also endorse their recommendation that "all currently available avenues of litigation, both civil and criminal, must be fully preserved" under any settlement. Our organization is prepared to work towards a resolution that embraces our claims, and the claims of others who were not party to the secret negotiations that lead to the proposed settlement, but only if we are included in the process. If it is not possible to come to such a resolution then we simply want to preserve our right to litigate our cases.

I have enclosed some additional information about the Coalition for Workers Health Care Funds and the impact on us of the civil liability provisions in the proposed settlement. In particular I would like to highlight the information on the role of multiemployer health and welfare funds in the nation's health care system, and the potential for these funds to make a substantial contribution to smoking cessation and prevention efforts. Any reimbursement that the funds ultimately recoup from the tobacco industry will go entirely to defraying the increasing health care costs borne by these funds and to institute and expand tobacco cessation and prevention programs for their participants and beneficiaries. Please also note that the labor-management health and welfare funds represented by the Coalition for Workers' Health Care Funds are *not* insurance companies. These non-profit funds operate in a very different manner than private insurers in how they provide and pay for health care for the individuals they cover.

As the national counsel to 2,500 health and welfare funds representing 30,000,000 affected Americans, we would like to meet with you at the earliest opportunity to discuss our positions and to respond to any questions you might have. We are prepared to assist the President in meeting his objectives and we look forward to continuing to work cooperatively with the Administration and with Congress in the coming weeks and months in pursuit of the best possible national tobacco control legislation. Thank you very much for your consideration.

Sincerely,

Robert J. Connerton

Enclosures
RJC/jth tobacco\1686.00\correspo\mande.o10

COALITION FOR WORKERS
HEALTH CARE FUNDS

1920 L STREET, N.W.
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WASHINGTON, D.C. 20036-5004

PRESENTATION BEFORE THE DEMOCRATIC CAUCUS TOBACCO WORKING GROUP

UNITED STATES HOUSE OF REPRESENTATIVES

OCTOBER 8, 1997

BY

ROBERT J. CONNERTON, ESQ. CHAIRMAN OF THE EXECUTIVE COMMITTEE

AND

DAVID L. MALLINO, LEGISLATIVE DIRECTOR

COALITION FOR WORKERS' HEALTH CARE FUNDS

Good afternoon Mr. Chairman. My Name is Robert J. Connerton. I am the Chairman of the Executive Committee of the Coalition for Workers' Health Care Funds. I am accompanied today by Mr. David L. Mallino, our legislative director. The workers' health care funds are the so-called "Taft-Hartley" labor-management, multiemployer health and welfare funds that provide approximately 32 million Americans: workers, retirees and their families with medical insurance.

I would like to begin by thanking you for this opportunity to appear before you today and testify on this most important issue.

There are some 2,500 workers' health care funds in the 50 states, Puerto Rico and the District of Columbia. They have filed class action lawsuits against the tobacco industry in some 27 states and we expect more to be filed in the next few months.

THE PROBLEM

We have filed these suits because the workers' health care funds and their participants are at the very heart and soul of the tobacco problem this nation faces. If that sounds like an extravagant statement, Mr. Chairman just bear with me for a moment and I will explain.

There has been a lot of talk about the smoking menace since the proposed "global" settlement was first unveiled last June but no one, and I do mean no one, has addressed the issue that is at the very core of the problem -- the hard core smokers: those who have smoked the longest; smoke the most and are furthest removed from smoking cessation efforts.

Mr. Chairman, failure to address the problem of the hard core smokers means failure to address the problem of smoking in America in a meaningful way – it is as simple and uncomplicated as that.

And the population that contains this element of hard core smokers is our population. The men and women covered by our funds are, for the most part, blue-collar workers and previous efforts to reduce their smoking have met with failure.

The percentage of this group who smoke is greater than any other segment of our society – in fact it is more than double the national average. And that statistic, Mr. Chairman, applies to *both* women and men.

The majority of these women are of child-bearing age and most of them continue to smoke throughout pregnancy posing an enormous risk to the health of their unborn children.

In the last 20 years every segment of the American population has experienced a decline in the percentage of smokers save one -- ours. Not only has the percentage stayed rock solid, but, in the last five years it has begun to increase – the only segment to do so.

When we say that our population consists of hard core smokers, we not only refer to the percentage of smokers; we refer to the amount they smoke. The fact is they smoke far more than any other grouping of smokers.

The workers in our funds purchase more than 25 percent of the cigarettes sold each year in the United States. And, sadly, the heaviest smokers of all are the minority males in our population.

These statistics are just the beginning – it gets worse. Consider: by the time the children in our population reach the age of 18, a staggering 43% of them smoke -- more than double the national average. And most of those remain hooked for life.

We estimate that no less than 42% of all new smokers in the United States are recruited from our ranks.

Perhaps the most devastating statistic of all, Mr. Chairman is the one which shows that, once the habit is picked up, a smaller percentage by far of our workers later gives up smoking than in any other segment of society.

If you look at where in society the gains in smoking cessation are made it is typically in the middle class, white-collar families. They were lighter smokers to begin with; they drop the habit easier; and the risks from smoking are relatively low among these individuals.

Contrast this with our workers: They start at an earlier age; smoke more; stay hooked in greater numbers; and suffer more from smoking-related diseases.

The results are horrifying: lung cancer, throat cancer, emphysema and heart diseases are frighteningly prevalent among our covered population. And, I might add Mr. Chairman, that fully 20 percent of the American smoking population is covered by our health funds.

Treating these tobacco-related diseases consumes far too much of our scarce resources – fully 10%, or more than $3 billion each year of the $33 billion plus these funds spend annually on medical claims.

That Mr. Chairman is the problem as it affects 30 million working class Americans.

THE SOLUTION

The Coalition for Workers' health Care Funds is in the process of devising a public health strategy to deal with the hard core smoking problem that bedevils our membership. Our aim is twofold: smoking prevention and smoking cessation.

While we applaud and support the public health goals outlined in the proposed settlement agreement signed by the attorneys general, our plan differs in two important respects:

- First, our strategy is population specific. We cannot address the needs of all people but, we do address that segment of the population that is most caught up in smoking – the hardest of the hard core smokers.
- Second, we will place our program in the context in which this population lives and works. We will address the synergy of race and smoking. We will address the disgracefully high rates of smoking among women in general, and women during pregnancy in particular. And we will address the social structures in which childhood smoking behaviors are acquired and reinforced.

As I stated earlier, these are areas that the proposed settlement agreement does not address and which are at the very heart of this nation's tobacco problems.

To accomplish our objectives, we recognize that a long-term strategy spanning the next two generations – at least 30 years in duration – will be required.

Our approach is rooted in the local communities and social structures of our workers. We will use the more than 2,500 health and welfare funds of our membership as the main vehicle for implementing and maintaining our programs.

Mr. Chairman, lest anyone think that we are newcomers to this process, I would point out that the Taft-Hartley funds have a long and distinguished history in the realm of workplace safety and health programs, as exemplified by their efforts in the fields of building and construction. And that history includes working closely with the relevant public health and governmental agencies to achieve our goals.

With your permission, Mr. Chairman, I will submit a detailed copy of our Working paper "Strategy for Smoking Prevention and Cessation for Workers and Their Families" for inclusion in the record.

THE BOTTOM LINE

The bottom line, Mr. Chairman is this:

- The tobacco industry has caused this problem by coldly and calculatingly targeting our workers with their sophisticated and devastatingly effective advertising campaigns.
- The tobacco industry is at the table now for one reason and one reason only – class action lawsuits.
- The tobacco industry must not be allowed to succeed in their plan to persuade Congress to outlaw our class action suits both present and future.
- If they succeed then not only will we fail to make progress against smoking in America – it will get progressively worse with no one to pick up the public health tab except the American taxpayer.
- If Congress stands up for our workers and maintains our right to sue then major progress will be made.

If that happens then the tobacco industry will have two choices: negotiate with our healthcare funds to pay for these smoking cessation and prevention programs or face a series of juries of their peers to have the matter decided by the American system of civil justice.

I might add that, regardless of the scenario, unlike the situation with tobacco money going to the states, every penny that goes to the workers' health care funds must, by law, be spent directly on health care programs that benefit the workers.

Attorney General Hubert H. Humphrey III testified before the Senate Judiciary Committee that his fellow AGs had informed him the language in the proposal that would have extinguished class action suits, was aimed directly at our funds on the grounds that the tobacco industry couldn't afford the extra financial burden.

Mr. Chairman this claim is not merely patently untrue it is absurd. A number of studies by distinguished national experts have shown there is ample money to pay our claims. The most recent coming only last month from the Federal Trade Commission.

The FTC report was only the latest in a string of such documents which pointed out that the true cost of the proposed settlement to the tobacco industry would be no more than some $100 billion in today's dollars – not the $368.5 billion the industry would have us believe. Even then, the industry would be able to write off one-third of that in taxes and collect the rest from its insurance companies.

In addition, all these studies have shown that one effect of a settlement would be to substantially increase tobacco industry profits over the next 25 years by several hundred billion dollars.

In other words, under the proposal now before Congress: they pay nothing, reap enormous profits and enjoy immunity from lawsuits calling them to account for their deeds.

Their proposal would have had the effect of closing the door on a lot of constituencies in addition to ours. There are the cities and counties of America, many of whom have already filed class action suits to recoup the costs of treating tobacco-related illnesses. There are veterans groups, and others, represented by agencies of the federal government. The list goes on but it clearly encompasses at least 100 million Americans.

To add insult to injury, an examination of the deal, reveals that it would pay the states damages for monies spent by state-sponsored state employee health plans to treat tobacco-related diseases. Those plans are identical in every respect save one to our own (which were to be excluded); they had a lawyer in the room when the deal was made.

Such a procedure is clearly unconstitutional and raises a host of other legal issues.

What judge would stand by and allow parties so similarly situated to be treated in such widely disparate fashion?

We are outraged that an industry that makes its money by selling poison that sends 400,000 Americans a year to an early grave; and plots vigorously to ensnare the flower of our youth as grist for their mill; should seek to insulate itself from the justice that every American has a right to seek, and try to keep us from pursuing our law suits.

Surely, Mr. Chairman:

- if any segment of American society has a legitimate grievance against the tobacco industry it is our workers
- If any segment of American society has a right to go into court to seek justice from this industry it is our funds
- If any segment of American society has demonstrated its dedication to the health and safety of working men and women, and their families, it is our funds
- And, if any segment of American society has established a track record when it comes to producing effective solutions to workers' health and safety problems it is our funds.

President Clinton, in his announcement from the oval office, said he wanted to see those who have suffered most from the ravages of tobacco included among those seated at the table when the new tobacco deal is worked out.

Clearly this means us. We agree fully with the five principles he enunciated and we stand ready, willing and able to join with those of you in the Congress who will refashion this fatally flawed agreement. And, we want to make sure that the Presidents' vow to protect the livelihood of the tobacco farmers extends to those workers employed in the tobacco industry.

And now, Mr. Chairman, with the Committee's permission, I would like to submit the remainder of my statement for inclusion in the record

COALITION FOR WORKERS
HEALTH CARE FUNDS

1920 L STREET, N.W.
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WASHINGTON, D.C. 20036-5004

A Working Paper[1]

Strategy for Smoking Prevention and Cessation for Workers and Their Families

Oct. 7, 1997

[1]Note: This is a work in progress which we will continue to develop in the months to come. Additional analysis and refinement will likely result in changes in details both in terms of findings and conclusions; however, these are not likely to change the overall analysis presented. For additional copies or more information, please contact the Coalition for Workers' Health Care Funds, 1920 L Street, N.W., 4th Floor, Washington, DC 20036. Tel 202-293-1735. Fax 202-634-6759.

1. The Issue.

The workers[2] we represent and their families smoke at a rate that is more than twice the average rate in the U.S. and almost four times as much as in white collar professional populations (fig 1). While smoking among other population segments has declined significantly in the last 20 years, smoking among blue collar workers has not declined much. In fact, has *increased* in the last five years (fig. 2).

Fig. 1: Smoking by Educational Attainment--Age 25 and Over

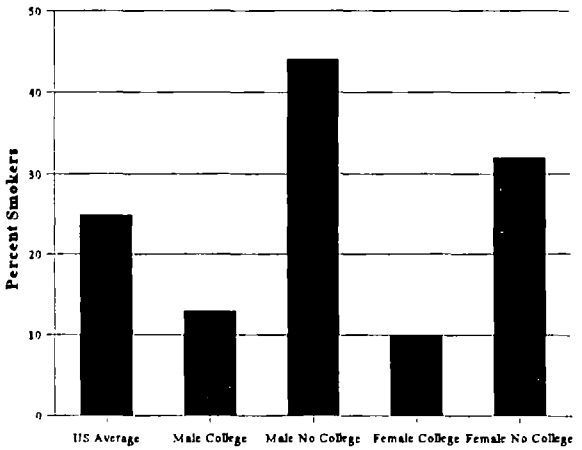
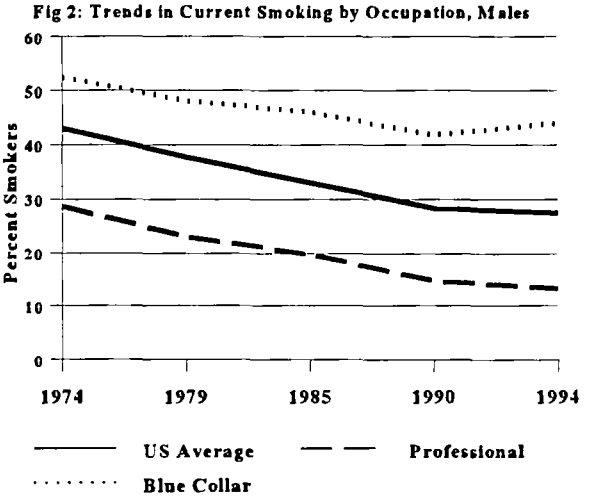


Fig 2: Trends in Current Smoking by Occupation, Males



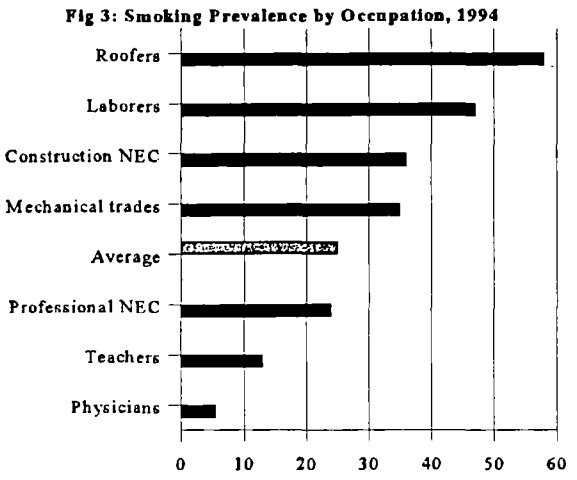
Source: *Health United States 1996-97.* Atlanta: USDHHS, CDC, July 1977

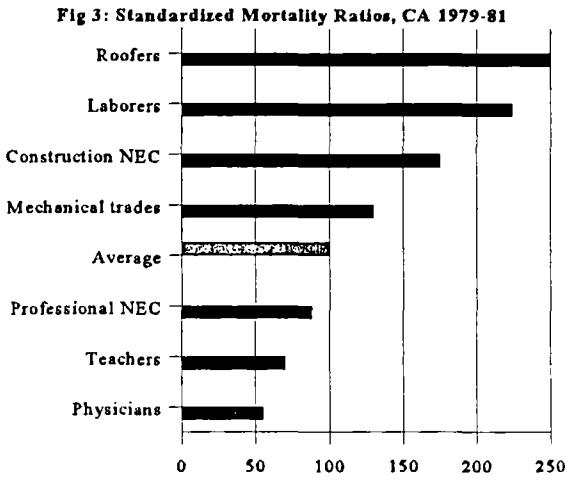
The rates of smoking are reflected in the mortality pattern of these workers. The most extensive study on occupational mortality has been done in California[3]. It shows that blue collar workers have overall mortality rates that are 2-3 times higher than the average in the general population and as much as 4-5 times higher than in professional occupations like physicians or teachers, and that these workers face a host of threats to health (figs. 3 and 4). Smoking-related diseases stand out as being

[2]The workers and their families referred to in this paper are participants in multi-employer health and welfare plans. While these workers are generally considered "blue collar," they work in a wide range of occupations and industries, including building and construction, transportation, retail, food and commercial establishments, health care, apparel, maritime, arts and entertainment, etc.

[3]*California Occupational Mortality 1979-81.* Sacramento: California Department of Health Services, 1987.

significant to the overall higher mortality.[4]





Source: Nelson DE et. al. Cigarette smoking prevalence by occupation. *Journal of Occupational Medicine* 36:516-525, 1994; : ***California Occupational Mortality 1979-81.*** Sacramento: California Department of Health Services, 1987

1a. The Special Problem of Teen Smoking.

Most smokers start when they are in their teens. It comes as no surprise that smoking among the children of smoking parents is much higher than smoking among children of non-smoking parents. Just as smoking levels among adult workers has remained high over the past twenty years, so has smoking among their kids. And young people who seek or are recruited into blue collar occupations are more likely to be smokers than those who seek other careers.[5] Thus, unless we attack the problem of youth smoking in *all* social strata, we are not likely to have an impact. Unless we can gradually make blue collar occupations smoke-free, and unless we can also find ways to reduce the smoking prevalence among adult workers, it will be difficult to be effective in attacking youth smoking in *our* environment.

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[4]Singleton JA, Beaumont JJ. COMS II: California Occupational Mortality 1979-81 Adjusted for Smoking, Alcohol and Socioeconomic Status. Sacramento: California Department of Health Services, 1989.

[5]Approximately 40% of these youths become smokers in their teens. *Healthy People 2000 Midcourse Review and 1995 Revisions*, Objective 3.5a. Atlanta, USDHHS, Centers for Disease Control, 1995.

1b. The Outline of a Solution.

In spite of the high rate of smoking in working populations, most research and demonstration programs directed at smoking prevention and cessation have been directed at other issues. It is not uncommon to hear researchers say the reason for this neglect is that, "... it is so hard to reach these populations."

This concept paper aims to provide an initial outline of a strategy to redress this problem. In basic terms the strategy would use the following approach:

- Develop approaches that recognize that effective prevention and cessation programs must be grounded in the social context in which this smoking takes place.
- Use the structures already available to reach these workers on health-related matters to implement the programs.
- Seek the resources needed to carry out a massive program from the agents that have caused the problem--the tobacco industry.
- Design evaluation methods that can determine which approaches work best.

2. The Market Share For Smoking

The crux of the cigarette smoking problem resides in the segment of the population we represent because of three factors:

- It has the highest proportion of smokers of any population segment.
- On average, these smokers smoke more than other smokers.
- The number of new smokers from this population is disproportionately high.

2a. The Size of Our Population

Table 1 summarizes the key features of multi-employer plans in the U.S. as a totality. There are more than 2,500 funds which serve an estimated 33 million people and have over $33 billion in annual expenditures. They represent approximately 25% of the total private employment-related health care market in the U.S.

Table 1
Estimated Size of Multi-employer
Health & Welfare Fund Community

Population	Number of funds	Number of participants	Estimated number of covered lives	Total payments for benefits
Sample	440	1,789,500	5,726,400	5,813,000,000
Extrapolated to all of U.S.	2547	10,358,764	33,148,044	33,649,341,000

Source: Sample is extracted from *1997 Group Insurance Plans, Entity C File.* Washington D.C.: Judy Diamond Associates Inc. This file covers Taft Hartley Funds labeled as "Multi-employer plan" based on their most recent submission of Form 5500 to the Internal Revenue Service. The term "covered lives" means the total number of participants and their depdendents who are covered by the funds. These data cover the year 1995, and includes all funds in the following states: AL, AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD. The estimated total number of funds in the U.S. is derived from *Characteristics of Multiemployer Plans, Second Quarter, 1996.* Chicago: International Foundation of Employee Benefit Plans, 1996, which found that 68% of the 3746 welfare plans reported in the U.S. provide health care benefits.

2b. Estimated Number of Smokers

We estimate that the Funds we represent cover 33 million lives, of which 20 million are over the age of 18. Of these, we conservatively estimate that 40% are current smokers,. As shown in fig. 5, we estimate that these funds account for 19% of the 42 million current smokers in the U.S.for a total of 8 million current smokers Given that these 19% smoke more than the average smoker, it is not unlikely that they account for as much as 25% of all cigarette sales in the U.S. (Fig 6).

Fig 5: Workers as Percent all Smokers

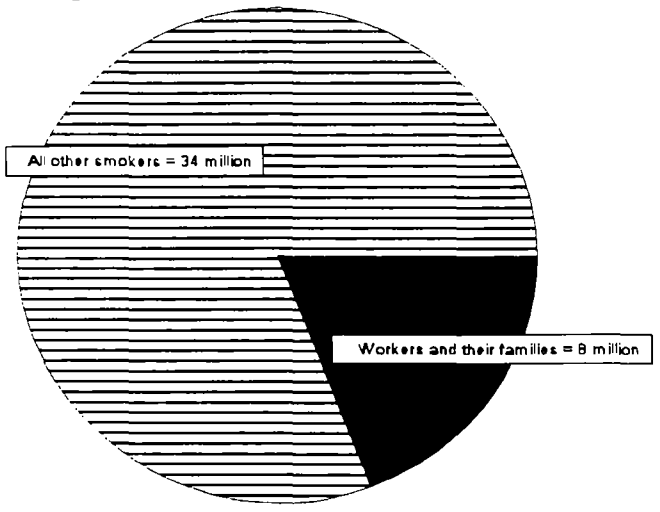
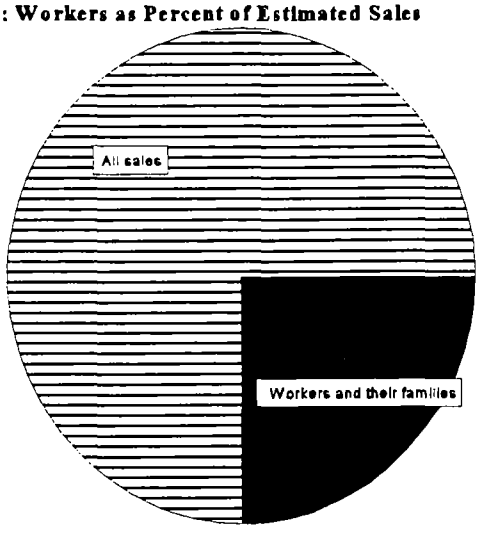
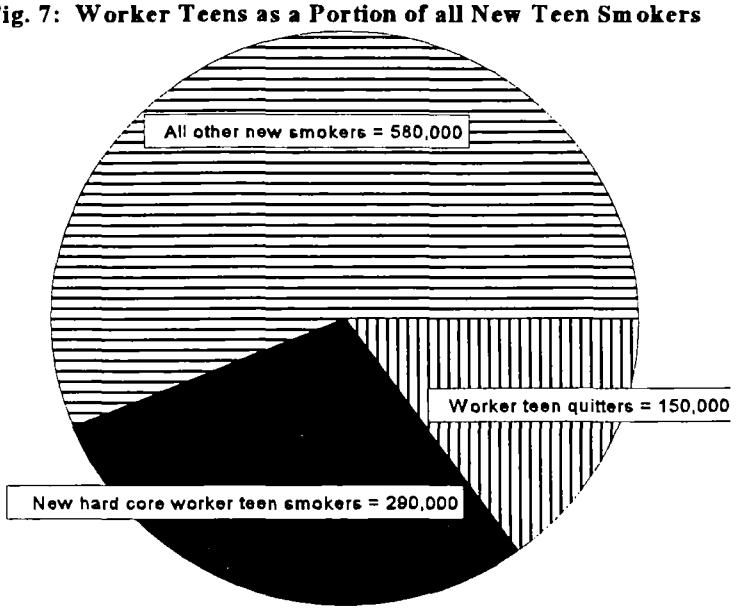


Fig. 6: Workers as Percent of Estimated Sales



2c. Youth Smoking

Fig. 7: Worker Teens as a Portion of all New Teen Smokers



Obviously, the most serious problem is the recruitment of young people into this smoking culture. Assuming that 40% of dependents under age 18 become smokers, we estimate that this population yields 290,000 new hard-core smokers each year and an additional 150,000 who smoke for some time As shown in fig. 7, of the 1.01 million new teen smokers in the U.S. each year[6], our populations contribute a total of 430,000 new young smokers or 42.6 percent of all new smokers.

It therefore is little wonder that in the last twenty years the tobacco industry has shifted more and more of its advertisements towards the population we represent.[7] It provides a steady stream of new smokers.

2d. Synergy With Race

Beyond occupation as a determining factor of high smoking prevalence, race is the second important demographic factor that we need to address. The populations that we represent generally have a higher than average minority participation, in part as a result of educational attainment. Most participants in our health plans have completed education of high school or less. Table 2 shows smoking prevalence for blacks and whites by educational attainment. Typically, smoking prevalence among black males is 6-8 percentage points higher than for white males.

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[6]Pierce JP, Fiore MC, Novotny TE, et.al. Trends in cigarette smoking in the United States: Projections for Year 2000. *Journal of the American Medical Association* 261:61-65, 1989.

[7]Warner KE, Goldenhar LM. Targeting of cigarette advertising in US magazines, 1959-86. *Tobacco Control* 1:25-30, 1992.

Table 2
Smoking Prevalence among Blacks and Whites by Educational Attainment. In percent.

Educational Attainment	Male		Female	
	Black	White	Black	White
Less than high school	51.6	42.6	30.1	33.0
High school	37.1	31.7	22.5	28.4
College	N\R*	12.7	11.3	10.8

Source: Health United States 1996-97. Atlanta: US Department of Health and Human Services, The Centers for Disease Control and Prevention, July 1997. *Not reliable due to small survey sample size. However, it is likely that the difference in smoking prevalence for college graduates is similar to the difference in other educational categories.

2e. Smoking Among Women

Smoking among women during childbearing age is a major concern to public health, which becomes critical when women continue to smoke during pregnancy. As can be seen in table 2, smoking among women with a high school degree or less is triple the smoking prevalence among women with a college degree. Most of the adult women in our funds are in the high risk group, and place not only their own lives in danger, but also the lives of the unborn children.

2f. Estimated Smoking-Related Costs

Studies of smoking-related costs that have been conducted for the general population have found that 7.1 percent of all medical costs can be attributed to smoking.[8] Adjusting this figure for the significantly higher prevalence of smoking in our populations, we can estimate that smoking-related medical costs in our funds amount to approximately 10 percent of total medical costs. This means that the annual cost of providing medical care for smoking-related illnesses among participants and their dependents in our funds amounts to $3.3 billion per year.

[8]Bartlett JC, Miller L, Rice DP, Max WB. Medical care expenditures attributable to cigarette smoking, United States 1993. *MMWR* 43:469-471, 1994. For a lay-person's guide to estimating costs see *Measuring the Medical Costs of Smoking*. Berkeley, CA: Berkeley Economic Research Associates, 1997.

3. The Social Context of Public Health.

The public health model uses a triangular design to finds the best ways to focus on a particular problem. The three corners of the triangle are:

- The agent, which causes the disease. In this case it is tobacco.
- The vector, which transmits the disease to and between humans. In this case the vector is tobacco production and marketing.
- The host, which in this case is the smoker.

In the history of public health there have been few effective programs that have not addressed all of these, but often it has been emphasis on the vector that proved most effective. To prevent cholera it meant providing safe sources of drinking water; to stop malaria it meant eliminating the mosquitos. For maternal mortality it meant addressing poverty in the urban tenements.

Yet when it comes to tobacco, the emphasis has been mainly on the host alone, apparently assuming that people will act on the information outlining the hazards, perhaps with a small added pharmacological aid of nicotine patches or gum for the hard core smokers. The vector--the tobacco industry and its marketing prowess--has been given a free reign. This approach has bypassed most workers. Why is this the case?

Systematic smoking prevention and cessation programs began to be developed approximately twenty-five years ago. That coincides with the start of the declining standard of living for workers. It is interesting that today, wages for workers are where they were in 1973 when adjusting for inflation. Thus, the advent of smoking cessation and prevention programs, which relied on great self-motivation and personal strength, began at the very time when the prospects of workers looked most bleak. As smoking prevention and cessation picked up steam, life for blue collar workers became only bleaker. Those population segments that have experienced declining smoking rates also have experienced exceptional economic gains during this period, while workers were left behind, both in terms of economics, and in this case, public health.

It is no coincidence that workers have become more and more alienated from society at large, which is reflected in all kinds of aberrant behavior. It is this social

context that the public health community finds it hard to deal with, but which the tobacco companies recognized almost immediately. While middle class, white collar market segments for cigarettes began to decline, the tobacco companies switched emphasis to other segments, in particular white working class men and women, and their children. It obviously has worked. The symbolic emphasis on rugged individualism, the association with power sports and hunting, all have the same meaning. Smoking gives the appearance of being in control of oneself and/or in defiance of authority.

This same context applies to the children of these workers. It is not a coincidence that smoking among young people from families is much higher than for other population segments.

4. The Social Context for Workers.

To be effective in attacking problems in working populations is no different than in other populations. We must find a strategy that is rooted in their social context, which they will take ownership of. With smoking prevention and cessation, where do we find this context?

The health and welfare funds that serve many working populations are likely to be the most effective vectors for smoking prevention and cessation. These funds were established by the workers to provide economic security in illness. They are the source to which workers turn when they need medical care. The main contact that these funds have with a worker often is through the worker's family, usually through the spouse.

5. The Health and Welfare Funds as Context.

The funds grew out of World War II, when employment-based health insurance coverage began to gain momentum. A particular problem was finding ways to provide the insurance to workers in industries with high degree of mobility in employment, such as construction, performing arts, the long shore trades, transportation, etc., and to sectors characterized mostly by smaller employers, like retailers. The solution came through collective bargaining over several years and emerged in somewhat different forms in different local areas and different

industries. But they all had some things in common. They were trusts, and had to comply with the Taft Hartley Act. They therefore had a board consisting equally of representatives for the workers and the employers, the board defined the benefits to be provided workers covered by the trust, the employers paid a contribution sufficient to cover the benefits and the administration of the trusts. The contribution was defined and enforced contractually by being included in the collective bargaining agreements. The trust then either provide the benefits directly or they contract on behalf of the population they serve with a health insurance company, which then pays for the benefits, etc.[9]

Over the years these funds have proven to have many excellent features: they are democratic in terms of decision-making structure and hey typically are local and therefore close to the population they serve. As a result they tend to be more involved with their clients and more responsive to the clients' needs than might be the case with more impersonal, large insurance companies. Over the years they have set many examples to support what is being proposed here.[10]

5.1 The Funds as Vehicles for Public Health

In the mid-1950s, the Cannery Workers' Trusts in cooperation with the California State Health Department mounted the first large-scale multi-phasic health screening programs for their members and families, and this type of preventive medicine gradually spread. It seems like misguided policy today, placing too great expectations in medical care, but then it was highly advanced.[11]

Throughout the years much emphasis has been placed on defining more broadly what a health benefit is, to take this concept beyond medical care to health promotion in general. A second step came in the 1970s, when much was done to work with researchers to detect asbestos-related diseases among construction workers and other trades. It was in the context of those programs that smoking

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[9]Ringen K et al. Health insurance and workers' compensation: the delivery of medical and rehabilitation services for construction workers. *Occupational Medicine: State of the Art Reviews* 10:435-444, 1995

[10]See also National Coordinating Committee for Multiemployer Plans. *Multiemployer Health and Welfare Plans: An overview of their Operations, Regulations and Concerns*. Presented to the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry. September 10, 1997

[11]Breslow L. Personal communication. School of Public Health, University of California at Los Angeles.

cessation became recognized. For people with advanced obstructive lung disease caused by exposure to asbestos, there was not much more medicine could do than counsel smoking cessation.

With the recognition that health protection on the job had been inadequate, many new programs were instituted in the 1980s to monitor the health of workers. Cooperating with Federal agencies like the Centers for Disease Control and the Department of Labor, new forms of employment-specific medical examinations were made mandatory for workers in certain types of employment. In the course of conducting these examinations it became further evident that half the workers were active smokers, and often very heavy smokers.

As part of this effort, the funds began to analyze their data to understand better the health patterns of their members and families, and to address them. Gradually, new types of health programs emerged. In many trades, the funds formed national organizations to promote health, and it may be worth looking at one program in particular.

The safety and health experience of the construction trades has been poor throughout history. In the U.S. alone it was common to have 2,000 deaths and over 300,000 serious injuries each year. This was a need that everyone could agree to focus on. The workers needed better protection. Because the injuries were becoming a major cost factor, employers and organizations paying for construction begin to place a much greater emphasis on safety. In the late 1960s a fund in New York, with cooperation from the state, set up a group insurance plan for employers and the unions to work together on safety and workers compensation. They saw a decline in injuries and significant reductions in costs. They attributed the success to one simple design: all the interested parties working together towards a common objective. In other words, the success derived from the program being tied to those making decisions. It was grounded in the industry, the local community and it had the support and active involvement of the government agencies.[12]

By 1990, many unions, in cooperation with the employers had large organizations with dozens of experts focused on improving safety and health. They obtained the

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[12]Harley JR, Rosenfeld SS. Negotiating workers' compensation: the success of management and labor at Local 3. *In Workers' Compensation Success Stories*. Cambridge MA: Workers' Compensation Research Institute, 1995.

active support of the agencies that are ultimately responsible, like the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health. And the payoff has been excellent. Since 1990, there has been a 34 percent decline in serious injuries in construction and now the number of deaths are down to approximately 1,000 per year. More needs to be done, but much has already been done in a short period of time, largely because these programs were grounded in the social contexts that drive construction.[13] Much the same can be done for smoking.

6. The Strategy Against Smoking among Workers and Their Families.

When nicotine patches and gum first became available with a physician's prescription, one fund in Washington state redesigned its benefits to allow coverage of this type of treatment. It then sent information on this new benefit to the participants. The response was overwhelming, with twenty percent of all adult participants taking advantage of it in the first couple of months. About eight months later the fund did a survey of those who had taken advantage of the benefit. Of those, one third has remained quitters for at least three months, but more importantly, over 95 percent of those who had relapsed said they desired to quit, but needed more help.

It was at this time that many funds started to discuss ways in which they could create more effective programs dealing with a range of health issues, including addiction to tobacco. They began to analyze their data to determine how much smoking-related illness there could be and how much these illnesses might cost.

As a result of this, over twenty-five state-wide class action law suits against the tobacco companies have been filed by health and welfare funds seeking compensation for the costs of providing medical care for the illnesses brought on by smoking. These suits have two aspects that are important to the public health strategy against smoking among workers and their families:

- It is from settlements recommended in these suits that the funds should be

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[13] *Construction Safety and Health: Five Years of Progress and Proposals for the Future.* Washington D.C.: The Center to Protect Workers' Rights, 1996

provided by the tobacco companies to finance long-term public health programs directed at smoking cessation for workers and their families.

- The role of the tobacco companies cannot be excluded from the anti-smoking program. Unless the tobacco companies are included and held accountable, they will overwhelm the anti-smoking effort. The only way to include the tobacco companies is to force them, and the only way to accomplish this is through litigation. The only incentive that can change the tobacco companies' behavior is financial. The more they are forced to pay for the development and implementation of large-scale programs to prevent and stop smoking, the less likely they are to continue using countervailing strategies that keep these populations hooked on smoking.

6a. Organization of the Public Health Strategy

The structure proposed to develop and implement the public health strategy is outlined in table 2. A Leadership Organization will be established using proceeds from this litigation as the endowment. The Leadership Organization will: 1) Be governed by the interested parties as agreed to in litigation; 2) have a scientific board of nationally recognized public health experts; 3) provide financial grant support to local organizations rooted in the workers' communities that would implement programs; 4) work with government agencies on the federal, state and local levels and interested voluntary organizations; 5) conduct and sponsor research on the prevalence of smoking and the prevention of smoking; and 6) finance smoking prevention and cessation programs; and 7) conduct large scale ongoing evaluations of the impact of the program.

The Leadership Organization will work through 10-20 national safety and health organizations that already are in place and that serve different segments of the working populations to coordinate the implementation of these programs, and these in turn will contract with the 2,500+ local health and welfare funds that are the implementation arm of this program.

Table 3
Organizational Structure

Leadership	Coordination	Implementation
		◗Health & Welfare Fund
	◗National Organizations	
		◗Health & Welfare Fund
Leadership	◗National Organizations	
Organization		◗Health & Welfare Fund
	◗National Organizations	
		◗Health & Welfare Fund

The smoking prevention and cessation programs will have certain key requirements:

- **They will be specific to workers and their families**. They will emphasize the contexts of family and work that have been effective in the past.
- **They will be administered by the health and welfare funds**. This ensures that the four factors most effective in terms of implementation are included: the programs will be local, they are run by organizations already entrusted by the workers with their health, they have the ability to obtain the buy-in of the key decision-makers that will need to change the social context the smoking takes place, and they can be held accountable. And, each of these 2,500+ funds will make their own decisions about which approaches work best for the populations they serve.
- **There will be accountability**. A carefully designed evaluation protocol that sets baselines and establishes performance benchmarks will be developed.

Ultimately, the key to this strategy is involving the health and welfare funds. They are in every local community in the U.S. and they have very close ties to their populations. They have fifty years of experience serving these populations and involvement in their communities. But the most important aspect of their role in this program has to do with the following: the participants they cover include the most heavy smokers in our society, and the bulk of those participants are in the child-rearing age groups. Through these funds it is possible to address simultaneously adult and childhood smoking, and this is important since they are closely linked.

6b. A Long-Term Commitment

The smoking problem did not arise over-night and is now so deeply embedded in our culture that a long-term, concerted effort, carried out over the next two generations will be required to make a significant dent in hard-core smoking among workers and their families. This means that from the start, we will need to commit ourselves to a time frame of thirty years or more in order to have a major and lasting impact.

6c. Relationship of Strategy to *National Objectives*

In an effort to better direct the Nation's public health activities, the US Department of Health and Human Services has established performance goals to be achieved by the year 2000.[14] To reduce smoking prevalence among people aged 18 and over, objective 3.4 identified a number of special populations to target. Table 4 lists these targets and how our strategy might impact on them:

[14]The goals are known as *Healthy People 2000*. In 1994, the Assistant Secretary for Health conducted a progress review and issued midcourse revisions. These highlighted the problems we are attempting to address in this strategy. Washington, DC: US Department of Health and Human Services, 1988.

Table 4
Relationship of our strategy to *National Objectives*

Objective No.	Population	1987 Prevalence Baseline	How Strategy Applies
3.4a	**High school of less education**	34%	This applies to the majority of our population
3.4b	**Blue collar workers**	41%	This is our main population focus
3.4c	**Military personnel**	42%	Most discharged veterans enter the trades
3.4d	**Black males**	30%	Our populations have a high Black representation
3.4e	**Hispanic adults**	24%	Our populations have a high Hispanic participation in select locations
3.4f	**Native Americans**	42-70%	The unions are actively organizing Native Americans
3.4g	**Southeast Asian males**	55	Their participation in the trades is increasing
3.4h	**Women of reproductive age**	29%	Because our funds cover people during their working years, most adult females are in this category
3.4i	**Pregnant women**	25%	Smoking during pregnancy is disproportionately high
3.4j	**Women using oral contraceptives**	36%	We have no data on oral contraception use, but in all likelihood it is about average for all women

Source: Healthy People Midcourse Review and 1995 Revisions. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, 1995. 1987 Baseline Prevalence means the percentage of the particular population segment who were smokers in 1987.

In short, the health and welfare funds cover disproportionately all of these target populations, and the ability to impact on all of these simultaneously strengthens the potential impact of the strategy we have proposed.

8. Economic Blackmail of Tobacco Workers

There are approximately xx workers employed in the production of cigarettes and other tobacco products. Historically, the tobacco companies have enlisted the workers and their unions in their campaigns to promote smoking and prevent effective anti-tobacco activities. This alliance is forged around economic blackmail against the tobacco workers which goes like this: if big tobacco is challenged too much in the U.S. it will move its production overseas where labor is cheap and focus on foreign markets, which unlike the market in the U.S., are growing rapidly. Most recently, this threat was related to the suits that the multi-employer funds have

filed.[15]

It seems likely that even if tobacco consumption in the U.S. ended right now, the stockholders and management of the tobacco companies would do just fine. The workers and the tobacco farmers, however, would not fare well. For this reason, we believe that an effective anti-smoking strategy must provide for indemnification of these groups.[16]

8. Why is This Different from the Proposed Settlement.

This strategy is very different from the proposed settlement between the states attorneys general and the tobacco companies in terms of two specific issues.

First, this strategy is population-specific. We will not attempt to address all needs of all people. But, we will address the population segments that are most exposed to smoking. We aim to address the core of hard core smoking in America.

Second, we will place this program in the context in which this population lives and works. We will address the synergy of race and smoking. We will address the high rates of smoking among women in childbearing ages and pregnancy. And we will address the social structures in which childhood smoking behaviors are reinforced. To accomplish these objectives, we recognize that a long-term strategy spanning the two next generations —at least 30 years in duration — will be required.

Our approach is rooted in the local communities and social structures of workers. We will use the more than 2,500 health and welfare funds that administer health benefits for these populations as the main vehicle for smoking prevention and cessation.

The proposed settlement would make this strategy impossible. It would prohibit

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[15]At the AFL-CIO Executive Committee meeting in Chicago in August, 1997, representatives for the tobacco companies stated that if a any funds beyond those agreed to in the proposed settlement would be required to settle additional complaints, the companies would move their production overseas. Lobbyists for the tobacco companies have made similar statements to members of Congress.

[16]In his September 16, 1997 comments on the proposed settlement between the State Attorneys General and the tobacco companies, President Clinton called for full indemnification of tobacco farmers. We urge that tobacco production workers be included in this context.

any recoveries by the funds, and thus obviate the financial foundation of this strategy. As important, it would preclude workers' funds from forcing through litigation the tobacco companies to recognize the overwhelming problem of smoking in working populations.

The proposed agreement says nothing about workers and their families and would in all likelihood perpetuate the kind of benign neglect that has been given to this problem in the past. The tobacco companies would like this, because they would in effect protect their largest domestic market segment from being targeted.

While the agreement speaks to childhood smoking it does not speak to one of the most important factors that we are concerned about in our populations, which is that children mimic parents and if the smoking prevention and cessation effort is not placed in a family context we will not see a decline in smoking among youths for generations to come.

The agreement fails to take into account the special population targets that the Public Health Service has identified in its *National Objectives: Health People 2000.* We believe that any effort to address the tobacco problem in the U.S. has to be consistent with the established public health philosophy of the nation, with the aim of reinforcing it.

Finally, while the agreement secures the financial base for stockholders and management, it does not in any way protect the future of tobacco farmers and tobacco production workers. Until a way is found to protect them economically in the face of a concerted decline in smoking in the U.S., they will continue to be pawns for the tobacco companies and their threats of economic blackmail.

COALITION FOR WORKERS
HEALTH CARE FUNDS

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TOBACCO-RELATED HEALTH CARE REIMBURSEMENT CLAIMS OF WORKERS' HEALTH CARE TRUST FUNDS:

UNLIKE INSURANCE COMPANIES, WORKERS' FUNDS HAVE NOT RECOUPED THEIR TOBACCO-RELATED HEALTH CARE COSTS

Introduction

Labor-management, multiemployer health care trust funds ("workers' health funds") in more than 25 States have filed class action lawsuits against the tobacco companies to recover reimbursement of the costs incurred by these funds for health care provided to workers, retirees and dependents suffering from tobacco-related disease. These lawsuits are modeled after the lawsuits filed by the various State Attorneys General against the tobacco companies to recover reimbursement of the costs of health care provided under State employee health plans and Medicaid programs to public employees and their dependents and to public assistance recipients suffering from tobacco-related disease.

The State lawsuits are the subject of a "global" settlement agreements which is being reviewed by Congress. Under that agreement, the States would receive reimbursement of the tobacco-related health care costs incurred by their public employee health plans and Medicaid programs.[1] However, workers' health funds would receive no reimbursement under the agreement. Moreover, the intended effect of the agreement would be to throw the health funds' reimbursement lawsuits out of court.

Workers' health funds were not invited to participate in the negotiations that led to the "global" settlement agreement. The unique nature of workers' health funds was not taken into consideration.

Now, called to account for the settlement agreement's ill-treatment of workers' health funds, proponents of the agreement are rationalizing their efforts to kill the funds' reimbursement claims by arguing that the funds are just like insurance companies and that the insurance companies have already recouped their tobacco-related costs from policyholders (*e.g.* employers) through premium increases. This argument is as inaccurate as it is self-serving. Workers' health funds are not insurance companies.

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[1] The States of Mississippi and Florida have reached separate settlements of their health care reimbursement lawsuits with the tobacco companies during the pendency of the "global" settlement agreement in Congress. These agreements provide for reimbursement of health care costs to the States.

The funds have not recouped their tobacco-related health care costs. They have no one but the tobacco companies from whom to recoup their tobacco-related health care costs, just like the State employee health plans and Medicaid programs.

Unique Nature of Workers' Health Funds

Workers' health funds are non-profit trust funds established through collective bargaining between labor and management for the purpose of providing medical and other health care benefit for workers represented by the sponsoring union, retired workers, and their dependents.[2] These funds are governed by the Labor Management Relations ("Taft-Hartley") Act of 1947 and the Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these federal laws require that the funds be operated as trusts for the exclusive benefit of the workers, retirees and family members covered by the funds. Each fund must be governed by a board of trustees composed of representatives of the covered workers and the contributing employers whose conduct is regulated by ERISA's fiduciary standards. Those fiduciary standards of conduct require that the trustees use their fund's assets for only two purposes: to pay benefits to eligible individuals, and to pay the reasonable expenses of administering the fund.[3]

The health funds are simply pools of workers' money. They are financed by the labor of the covered workers. Pursuant to collective bargaining agreements negotiated between the workers' union and their employers, a dollars-and-cents contribution is made to the health fund for each hour of work by a covered worker. These collectively bargained contributions are substitute wages. That is, the contributions are money that would be included in the paychecks of the workers if the collective bargaining agreements did not require it to be paid into the health fund to finance coverage for the workers and their dependents.

> Take, for example, the building and construction industry whose organized workers and their families depend on workers' health funds for payment of their hospital and doctor bills. During negotiations between a building trades union (say, the Iron Workers Union) and employers toward a collective bargaining agreement, the employers typically agree first to a gross hourly labor rate which rate is then allocated by the negotiators

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[2] See generally "Multiemployer Health & Welfare Plans: An Overview Of Their Operations, Regulation And Concerns," National Coordinating Committee for Multiemployer Plans, Washington, D.C. 1997 (prepared for President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry)

[3] See ERISA Section 404(a)(1), 29 U.S.C. Sec. 1104(a)(1).

among cash wages, health fund contributions, pension fund contributions, and other benefit plan contributions. If a portion of the gross rate were not allocated for health fund contributions on behalf of the iron workers, that money would have been included in the workers' wages or contributed to the pension fund or to another benefit program for the workers.

The collectively bargained contributions received for all covered workers are pooled in the fund and invested. It is from this pool of workers' money, and from no other source, that the health care benefits and the expenses of fund administration are paid. To the extent that the health fund is "self-funded" (as most of the health funds are), benefit payments and expenses are paid directly from the fund's trust account. To the extent that the fund provides some or all of its health benefits through an insurance contract with an insurance company (as a minority of the funds do), the insurance premiums are paid from the fund's trust account. In either case, the bills are paid from the pool of workers' money.

If the health fund's costs increase--due to increases in the need for health care or increases in the cost of care--the fund's trustees must meet these increases by either drawing down any fund reserves, requiring the bargaining parties to negotiate an increase in the contribution rate, or reducing benefits. In any event, it is the workers who pay for the increases because the fund is composed of their money.

The health funds accept into coverage all workers covered by a collective bargaining agreement, and their dependents, without regard to the health status of any individual. The collectively bargained contribution rate is the same for all workers covered by an agreement, without regard to the health status of any individual.

Accordingly, the costs incurred by a health fund for the health care provided to covered workers, retirees, or dependents suffering from tobacco-related disease are borne by all of the covered workers without distinction between smokers and non-smokers.

In sum, a workers' health fund is established and maintained in trust to provide health care benefits for a particular group--for the workers represented by the sponsoring union, retired workers, and their dependents--and the fund's assets consist only of the workers' money. The fund exists to serve the health care needs of that particular group of workers and their families. It has a long term commitment to the health of those workers and families.

Contrast With Insurance Companies

In contrast to workers' health funds, insurance companies are typically for-profit businesses. Insurers merely pass through health care costs to their premium payors

(*e.g.* employers). They set premium rates at a level that they expect will cover the cost of claims and administration plus produce a profit for the insurer and its owners. If costs are higher than projected, the insurer increases the premium rate to recoup the excess costs.

Moreover, an insurance company is not established and maintained to provide for the health care of a particular group of workers; rather, it is a commercial enterprise that gains and loses customers in the normal course of business.

Most importantly, an insurance company is not a pool of workers' money that can be used only for the benefit of the covered workers and their families.

Recognizing the distinction between workers' health funds and insurers, Congress treated these two types of entities very differently in the regulatory scheme for health benefit programs. For example, as provided in ERISA, workers' health funds are regulated exclusively by federal law, whereas insurers are subject to extensive State regulation.[4]

Like The State Reimbursement Claims

Under the "global" settlement agreement, as well as under the Mississippi and Florida settlements, the States will be reimbursed by the tobacco companies for the tobacco-related health care costs of the States' public employee health plans and Medicaid programs. The reimbursement claims of the workers' health funds are quite like the States' claims.

While the tobacco-related health care costs of the State plans and programs have been borne heretofore by the employees and taxpayers of the States, the tobacco-related health care costs of workers' health funds have been borne by the workers covered by these plans. For the funds are nothing more or less than the workers' money. And, like State employees and taxpayers, workers have no one else to pass the costs on to, except the tobacco companies whose actions caused the funds to incur the costs.

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[4] See ERISA Section 514(b)(2)(A) and (B), 29 U.S.C. Sec. 1144(b)(2)(A),(B). Compare also 29 U.S.C. Secs. 1191b(a) and (b)(distinguishing between group health plans and health insurance coverage and insurance issuers).

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HEALTH CARE FUNDS

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WHAT IS A MULTIEMPLOYER HEALTH & WELFARE PLAN?

How 30 Million Workers, Retirees, and their Dependents Obtain Health Coverage

INTRODUCTION

Among the proudest achievements of collective bargaining is the decades-old, nationwide system of labor-management, multiemployer health and welfare plans that provide millions of American workers, retirees, and their families with medical, hospital, sickness, disability, death, and related benefits.

Workers covered by multiemployer plans are employed throughout the Nation in industries as diverse as building and construction, retail, food, clothing, textiles, transportation, mining, services, entertainment, maritime, hotel and restaurant, and manufacturing. But for multiemployer plans, most of these millions of American would lack employment-based health care coverage and would be dependent upon government programs for their medical treatment or face financial ruin in the event of accident or illness in the family. The intermittent and mobile employment patterns of these industries would prevent the workers from obtaining health benefit coverage absent a central pooled trust fund through which portable coverage is provided to workers as they move from employer to employer. Moreover, most employers in these industries are small and would not maintain their own employee health plans, particularly for transient workers.

In sum, multiemployer plans are a critical component of the Nation's voluntary, employment-based health care system. This paper provides a general overview of how multiemployer health plans operate. This overview will assist policymakers to understand exactly what a multiemployer plan is, and to appreciate the significant role multiemployer plans can play in confronting the national public health crisis of tobacco-related illness.

"Multiemployer plan" is a term of art; a term defined by federal statutes. The Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code define a multiemployer plan as an employee pension, health or welfare benefit plan--

(1) to which more than one employer is required to contribute, and

(2) which is maintained pursuant to one or more collective bargaining agreements between one or more labor organizations and more than one employer.[1]

Workers' Trust Fund

The hallmark of a multiemployer plan is the involvement of the worker's representatives in the creation and operation of the plan. The mere fact that multiple employers create or contribute to a single plan does not make the plan a multiemployer plan. For example, a "multiple employer welfare arrangement" or "MEWA" is not a multiemployer plan.[2] The unifying force of a multiemployer plan is the labor union which sponsors the plan and represents the covered workers.

Because a multiemployer plan is co-sponsored by a labor union, the plan can accept employer contributions only if it complies with the structural requirements of the Labor Management Relations ("Taft-Hartley") Act of 1947[3], a federal statute that pre-dated ERISA by more than 25 years. That is why multiemployer plans are often referred to as "Taft-Hartley plans" or "Taft-Hartley funds."[4]

The Taft-Hartley Act requires that a multiemployer plan:

- be established and maintained in the form of a trust fund, legally distinct

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[1] See ERISA Section 3(37), 29 U.S.C. §1002(37); Section 414(f) of the Internal Revenue Code, 29 U.S.C. §414(f).

[2] See ERISA Section 3(40)(A); 29 U.S.C. §1002(40)(A)(excluding collectively bargained plans from the MEWA definition).

[3] Section 302(c) of the Act (29 U.S.C. §186) prohibits employer payments to unions and to organizations in whose administration union representatives participate, with certain specified exceptions. Among the exceptions are pension and health care plans that meet the structural requirements described herein.

[4] A single employer plan may also be subject to the mandates of the Taft-Hartley Act if a labor union or its representative participates in the plan's administration. However, single employer Taft-Hartley health plans are rare. An employer may collectively bargain with its employees' union over the content and operation of the company's employee health plan, but rarely does an employer agree to involve the union's representatives in the administration and control of the plan. In contrast, multiemployer plans typically are established at the behest of a union.

from the sponsoring union and the contributing employers, for the sole and exclusive benefit of the covered employees, retirees, and their families;

- provide for equal representation of the covered employees and the contributing employers in the trust fund's administration (*i.e.* a joint board of labor and management trustees must govern the plan);
- not commingle pension and health plan assets in a single trust;
- be maintained pursuant to a detailed written agreement with the employers specifying the basis for contributions;
- provide only certain types of benefits (which include medical and other health care benefits);
- provide for arbitration of disputes between labor and management trustees; and
- undergo an annual financial audit and disclose the audit results to interested parties.[5]

These statutory mandates are enforceable under civil and criminal provisions of the Taft-Hartley Act.[6] Contributions to plans that do not comply with these statutory requirements may constitute a federal crime and are enjoinable by the federal district courts.[7]

As a practical matter, a multiemployer health plan is established normally by a labor union and employers of the employees represented by the union agreeing to establish such a plan to provide health benefits to the employees and their families. The union, the employers, and individuals designated as labor and management trustees enter into an "agreement and declaration of trust" or "trust indenture" which creates the trust fund and defines the rights and responsibilities of the trustees with regard to the management of the fund. The union and the employers also enter into one or more collective bargaining agreements obligating the employers to contribute to the plan for all employees in the bargaining unit at certain rates for a set period of time

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[5] Taft-Hartley Act Section 302(c)(5), 29 U.S.C. §186(c)(5).

[6] Taft-Hartley Act Section 302(d), 29 U.S.C. §186(d).

[7] Id.; Local 144 Nursing Home Pension Fund v. Demisay, 508 U.S. 581 (1993).

(usually the term of the agreement, which may be one to three years or longer)[8].

Over the years that follow the plan's founding, the union and the original employers periodically renegotiate and enter into new collective bargaining agreements requiring contributions to the plan. Additional employers may be negotiated into the plan under the same or different collective bargaining agreements. A single employer may be obligated to contribute to the plan pursuant to multiple collective bargaining agreements (e.g., separate agreements cover employees at different plants or project sites). An employer may be permitted to obtain coverage under the plan for its non-bargaining unit (i.e., not union-represented) employees as well as its union-represented employees.[9]

Some plans have grown to include hundreds of employers contributing pursuant to hundreds of different collective bargaining agreements on behalf of thousands of workers in multiple States. Some plans are national in coverage. Some cover workers in multiple States in a region. Some are statewide. Some cover the workers of relatively few employers in a local area.

In some cases, more than one union representing workers in the same industry will jointly establish a multiemployer plan with a group of employers (e.g., various building and construction trades unions in an area may form a multi-union, multiemployer plan covering workers represented by all of those unions in the area).

Pooled Fund: Portability & Economies of Scale

All of the collectively bargained employer contributions to the multiemployer health plan are pooled and invested. It is from this pool that all of the plan's expenses of operation are paid. It is also from this pool that benefits are paid to covered workers, retirees and their dependents ("participants" and "beneficiaries," as defined in ERISA[10]) to the extent that the plan is self-funded, and from which premiums are paid to the extent that the plan's benefits are insured through contracts with insurance companies or benefits are delivered through managed care organizations.

This pooling characteristic of multiemployer plans provides workers with true portability of health coverage. A covered worker who changes jobs from one

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[8] Multiemployer plans accept all employees covered by the collective bargaining agreement as they are, subject to uniform eligibility rules. They do not "cherry pick" the good risks in a bargaining unit and exclude the bad risks.

[9] Coverage of non-bargaining unit employees is often in response to an employer's concerns that cost-effective health plan coverage would not be available for these employees if they are separated from the union-represented group.

[10] ERISA Sections 3(7), (8); 29 U.S.C. §§1002(7), (8).

contributing employer to another maintains seamless coverage under the plan despite frequent changes in employment. The plan continues to receive contributions for the worker, just from a different employer.

This portability is essential for workers in industries characterized by mobile and intermittent patterns of employment, such as building and construction, entertainment, clothing, longshore, maritime, and transportation. For example, a building tradesman may be employed by a particular employer for only a day, a week, a month, or a few months to work on a specific project, and then move on to work on another employer's project for a time, and then another, etc. Between jobs, the worker might be off work for a day, a week, a month, or longer, depending on the availability of work. A building tradesman might work for scores of different employers over his working life, with varying periods of unemployment in between. In another industry, a longshoreman may work for several employers in a single day.

Moreover, many multiemployer plan industries are characterized by small employers[11] which would not maintain a separate health plan for their employees, particularly transient workers because of the costs involved. Participation in a multiemployer health plan enables these employers to provide benefit coverage for their workers by simply making contributions and without the burdens of administering or designing a plan.[12]

For several decades, multiemployer plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to workers as they move from one contributing employer to another. In effect, all of the contributing employers — scores, hundreds, or even thousands of employers — are treated as a single employer for purposes of providing health and welfare benefits coverage to workers and their families.

Beyond this internal plan portability, many multiemployer health plans have reciprocal arrangements with other multiemployer plans sponsored by affiliates of the same union(s). Reciprocal arrangements help workers who take employment outside of the geographic area of one multiemployer plan to maintain health plan coverage if their new jobs are with employers which contribute to another multiemployer plan covering workers represented by affiliates of the same union(s). So, for example, a laborer who participates in a Laborers Union health fund covering the Northern California-Nevada area may maintain health plan coverage even if he accepts a job in

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[11] For example, in the construction industry, 82% of contractors have fewer than ten employees. *The Construction Chart Book: The U.S. Construction Industry & Its Workers,* Center to Protect Workers' Rights, February 1997.

[12] In the construction industry, virtually all union-represented workers have health coverage through multiemployer plans. In contrast, few non-union workers receive health care coverage through their employment.

Albany, New York with an employer which contributes to the Laborers' multiemployer plan that covers the Albany area, depending on the terms of the reciprocal arrangement between the plans.

Even in the absence of a formal reciprocal agreement, arrangements are made by many plans to accept contributions on behalf of participants working outside of the plan's jurisdiction. Through these arrangements, "traveling" participants can maintain coverage for themselves and their families under their "home plans."

Multiemployer plans also enjoy economies of scale in administration and enhanced purchasing power with health care providers, insurers and managed care organizations not available to individual employers, particularly small employers. Multiemployer plans are prototype purchasing cooperatives.

Workers' Money

Multiemployer plans are financed by the covered workers through their labor; that is, through collectively-bargained contributions. While the law considers these to be "employer contributions," the workplace reality is that these collectively bargained contributions are substitute wages for labor received. Instead of putting this money into the workers' paychecks, the employer agrees to pay it into the multiemployer health plan to finance coverage for the workers and their families.

The basis for the collectively bargained contributions varies by industry according to the nature of employment patterns, cash flow, and financial structures of the industry. In many industries, like building and construction, the contribution is dollars-and-cents per hour of work or pay. In other industries, the contribution is based on units of production, weeks of covered work, or earnings. Who is responsible for making these contributions (i.e., who is the "employer") is the subject of special industry rules designed to maximize the collection of contributions. For example, in building and construction, a general contractor is often responsible for guaranteeing payment of plan contributions owed by subcontractors. In the garment industry, manufacturers or jobbers, who have greater financial stability, typically are required to make the contributions even though separate firms (contractors) are the covered workers' direct employers.

In a single employer plan setting, it is common to distinguish between the employer's share and the employee's share of the health insurance or plan premium. Cost-sharing and cost-shifting from employers to their employees are matters of concern. In contrast, multiemployer plans normally do not think in terms of employer's share versus employee's share. All of the contributions are workers' money. Employers do not pay anymore than they would otherwise pay in wages.

Because they pay the full cost, the workers are well aware of the cost of health care coverage. The nature of collective bargaining in most multiemployer plan

industries is that the union and the employers negotiate total compensation package cost; a total per hour labor cost. The workers, through their union, decide how to allocate the total monetary rate among cash wages, pensions, health and welfare, apprenticeship and training, and other benefits programs. Given the fixed compensation pie, an increase in the contribution rate needed to finance the health plan means lower cash wages, or a reduction in the pension plan contribution rate or in some other benefit.

During the past decade, many workers did not receive increases in their cash wages because health care cost inflation had driven health plans to demand higher contribution rates to maintain benefits.

From the plan's perspective, collectively bargained contributions are the life-blood; plans cannot pay benefits unless they receive contributions to finance the coverage.[13] Financing depends primarily on two factors: the amount of covered work that generates the contributions and the contribution rate. A plan generally receives contributions only for work that is covered by a collective bargaining agreement requiring contributions to the plan. If the level of covered work declines, plan income declines. So, for example, if union construction work in the area of a carpenters health plan is slower than expected, the plan will receive less in contributions because the covered carpenters will not be working as many hours in covered employment.

On the expense side of a plan's budget are benefit payments (e.g., hospital and doctor bills) for participants and beneficiaries, or premium payments, and costs of administering the plan. These expenses are affected by a variety of factors including health care costs, utilization of plan benefits and regulatory costs.

Over the years, the labor-management boards of trustees[14], with professional assistance,[15] have designed health and welfare programs that balance the benefit needs and wants of the covered workers with the financing that can be provided by the collectively bargained contributions. In so balancing the income and expense sides of the budget, trustees have developed various eligibility rules, benefit packages, and operational practices for the particular circumstances of the plan, its participants, and the industry.

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[13] This essential link between multiemployer health plan coverage and receipt of contributions has been recognized by Congress in formulating legislation affecting plans. See, e.g., *Report on the Family and Medical Leave Act of 1993*, Committee on Labor and Human Resources, U.S. Senate, S. Rep. No. 103-3, 103d Cong., 1 st Sess. 32-34 (1993).

[14] In a few situations, like the mining industry, the bargaining parties, rather than the trustees, design the plan.

[15] Boards of trustees typically hire actuaries and consultants, attorneys, auditors, and investment advisors among other professionals.

For example, plans have developed various systems for benefit eligibility that are designed to maximize coverage given the employment patterns in the industry and the financing needs of the plan. Some systems require a worker to work a minimum number of hours in a period (e.g., month or quarter) to earn eligibility for the following period (e.g., the next month or quarter). Some systems include "hours banks" arrangements under which a worker's covered work hours in excess of a set level are "banked" and used to obtain benefit eligibility during future periods of unemployment or underemployment.

So, too, do the benefit packages vary from plan-to-plan according to circumstances. Given that the plan is financed by the workers and that one-half of the plan's board of trustees are labor representatives (usually elected union officers), the tendency is for a board to adopt the most generous benefit package that the plan can reasonably afford. The trustees are accountable to the covered workers.

A number of plans offer multiple levels of benefit packages at different contribution rates. These plans enable the bargaining parties to select a specific benefit package at a cost that fits their financial circumstances, and to obtain better benefits over time as they are able to negotiate increases in contribution rates.

The trustees' budget balancing may be upset by unexpected declines in contribution income or increases in cost. At times, a plan may experience both; for example, an economic recession in the industry may cause a reduction in covered work and, therefore, contribution income, and may also cause an increase in benefits utilization by the idled workers. Plans normally take steps to protect against economic adversity, such as maintaining reserves, obtaining stop-loss insurance, or insuring some or all of the plan's benefits.

However, these protective devices may not be appropriate or sufficient in some circumstances such as hyper-inflation of health care costs or prolonged economic recession. Trustees have traditionally relied upon other tools to maintain the plan's viability in times of economic adversity. These tools include adjusting eligibility rules (e.g., requiring more covered employment for benefit eligibility), reducing benefit levels, increasing out-of-pocket charges, and eliminating types of benefits.

Trustees may also request the bargaining parties to negotiate an increase in the collectively bargained contribution rate. It may take months or even years to effectuate such an increase, particularly where the contribution rate is fixed for the term of the collective bargaining agreement and where the plan receives contributions pursuant to many collective bargaining agreements with differing expiration dates and terms. Some bargaining agreements provide for mid-term adjustments in the allocation of the compensation package so that the union and employer(s) may agree to reallocate a portion of the wage rate to increase the rate of contribution to the health plan. Or, they may agree to reduce the rate of contributions to the pension plan and redirect the amount of the reduction to the health plan. Or, they may agree that a scheduled wage

increase will be foregone in favor of an increase in the health plan contribution rate.

In short, unlike a single employer corporate-type plan, a multiemployer plan cannot simply dip into the corporate treasury when funding falls short of, or expenses exceed, expectations. The trustees need flexibility to use a combination of tools to innovatively adapt to changing circumstances and maintain the plan's financial soundness. Multiemployer plans have been successfully doing so for decades.

Delivery of Benefits

A plan's board of trustees, typically, is authorized by the plan's trust agreement to decide all questions regarding the types and levels of benefits that the plan will provide, how the plan will provide the benefits, and the eligibility requirements for benefits. And, as noted, these decisions are based on the balance between available funding and the needs and wants of the covered workers and their families.

Among these decisions is whether the plan will "self-fund" some or all of the benefits, will insure all or some of the benefits, or will contract with a managed care organization (e.g., health maintenance organization) to provide all or some of the benefits.

Most multiemployer plans, and virtually all large plans, are "self-funded" in whole or in part. That is, the benefits — e.g., payment of hospital and doctor bills — are paid directly from the plan's assets in the trust fund, whether paid to the provider or reimbursed to the participant or beneficiary. Some plans are fully insured; that is, the trustees purchase policies of insurance from insurers which pay the benefits due under the policies to or for the plan's participants and beneficiaries. The cost of the insurance policies (the premium) is paid by the plan from its trust fund. Some plans self-fund part of their benefits and contract with insurers to provide other benefits (particularly "welfare" benefits like life and disability insurance. And, some plans may contract with managed care organizations to provide some or all of their health benefits.

Whatever the arrangement for providing the benefits, the plan is the trust fund entity governed by the board of trustees. An insurer or managed care organization with which the plan contracts are merely means by which the plan delivers its benefits to participants and beneficiaries.

The benefits provided by a plan are set forth in plan documents adopted by the board of trustees and distributed to participants. To the extent that a plan insures benefits, the contract or policy issued to the plan by the insurer will reflect the terms of the plan documents and may be incorporated into those documents. To the extent that a plan contracts with a managed care organization, the contract will reflect the terms of the plan. The terms of these contracts and policies with insurers and managed care organizations are subject to renegotiation by the board of trustees. For example, if the board wishes to make improvements in the insured benefits, it so advises the insurer

and negotiates with the insurer over the amount, if any, that the improvement will increase the plan's premium cost. For the insurer's part, it may negotiate with the board to increase premiums for the current benefit levels if the claims payment experience has been worse than anticipated.

Self-funded plans often control the risk of unexpected benefit claims experience by purchasing "stop-loss" insurance for the plan. Such coverage typically requires the insurer to compensate the plan if the benefit claims submitted to the plan in a particular period of time exceed a certain amount, or if a particular claim exceeds a certain amount. The stop-loss carrier has no obligation to pay benefits to participants and beneficiaries; rather, its obligation is to reimburse the plan upon certain events. Accordingly, it is not considered "health insurance." The cost of this stop-loss coverage is paid by the plan.

Administration

As noted above, all multiemployer plans are governed by labor-management boards of trustees.[16] The individuals who serve as labor trustees and management trustees on these boards are typically unpaid volunteers.[17] Yet, the performance of their plan-related duties is subject to the standards of fiduciary conduct set by ERISA, which are among the highest standards known to the law. Violations of these standards may subject the offending trustees to personal liability for any losses to the plan, as well as to the removal from his plan position, among other penalties. Indeed, a plan trustee may be personally liable for plan losses caused by another trustee or plan fiduciary under certain circumstances (e.g., failure to take reasonable steps to correct a breach of fiduciary duty by another trustee).[18]

ERISA prohibits plans from indemnifying trustees against personal liability for breaches of fiduciary duty.[19] Plans are permitted to purchase errors and omissions liability insurance for the trustees, provided that the insurer has recourse against any trustee for whom it pays a claim.[20] However, insurance policies available on the market provide limited coverage in terms of their liability limits and their exclusions of certain

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[16] Under ERISA, the board of trustees of a multiemployer plan is typically the"named fiduciary," "plan administrator," and "plan sponsor." See, ERISA Sections 3(16)(A), (B), 402(a)(2); 29 U.S.C. §§1002(16)(A), (B), 1102(a)(2).

[17] ERISA prohibits use of plan assets to compensate trustees who are full-time employees of the sponsoring union or contributing employers. See ERISA Sections 406(a) and 408(c)(2); 29 U.S.C. §§1106(a), 1108(c)(2).

[18] ERISA §405; 29 U.S.C. §1105 (co-fiduciary liability).

[19] ERISA Section 410, 29 U.S.C. §1110.

[20] Id.

types of liability.

Attracting and retaining responsible, competent individuals to serve as trustees, particularly employer representatives, has become more difficult in the fact of increased regulatory burdens and legal responsibility. Many are concerned about good faith judgments resulting in personal liability based on retrospective application of vague legal standards. Yet, multiemployer plans cannot legally exist without management as well as labor trustees. If responsible employer representatives are no longer willing to volunteer was plan trustees, the plans will die.

While the board of trustees is ultimately responsibility for the plan's management, the plans hire administrators to conduct the plan's day-to-day operations. Some plans, particularly large plans, establish their own administrative offices and hire a staff (which arrangement is referred to as in-house administration or self-administration). Other plans contract with administrative services companies which perform the plans' day-to-day administrative functions through the companies' (or insurers) offices (which arrangements are referred to as third-party administration). And, there are variations and combinations of these two general types of administrative arrangements.

Whatever the administrative arrangements, the administrator is required to perform its functions in accordance with the plan's governing documents and with the rules and policies set by the board of trustees. The administrator is responsible to and overseen by the board. Typically, the board meets periodically to receive and review reports from the administrator (and the plan's other professional service providers) concerning the plan's operations. The reports include matters such as contributions received, delinquent contributions, reserves, investments, benefit payments, benefit denials, and appeals from benefit denials.

In the case of a plan whose health benefits are insured, a representative of the insurer will report to the board of trustees on the benefit claims received, paid, and denied by the insurer. So, too, where the plan contracts with a managed care organization to provide some or all of the health benefits, a representative of that organization will report to the plan's board of trustees on care provided and care denied, among other matters regarding implementation of their contract with the plan.

Benefit claims are submitted to the plan's administrative office, as are eligibility questions. To the extent that the plan is self-funded and self-administered, claims and questions are handled in the first instance by the administrative staff. Appeals from the administrative staff's decisions are taken to the board of trustees in accordance with procedures set forth in the plan documents. The board may, as appropriate, use medical advisors when considering appeals based on medical issues rather than issues of plan interpretation or application.

To the extent that a plan is insured, it may rely on the insurer to make the initial

decision on benefit claims and eligibility, or the plan's administrative staff and the insurer may jointly make the initial determinations. So, too, the managed care organization with which the plan has contracted may make the initial determination on a questions of eligibility or a benefit claim, or may make the determination jointly with the plan's administrative staff. But, generally, appeals from these determinations are made to the labor-management board of trustees. Even where a managed care organization may have an internal appeals or grievance procedure, the multiemployer plan's board of trustees retains authority to review the organization's conduct.

Retiree Coverage

Many multiemployer plans provide health benefits coverage for workers and retire from covered employment, particularly if the retiree is receiving retirement benefits from a multiemployer pension plan sponsored by the same union and group of employers. This retiree coverage reflects a philosophy on the part of plan trustees and the bargaining parties that the workers have earned a secure retirement without fear of financial ruin if they become sick or injured without health benefits coverage.

Retiree coverage is particularly important for workers who retire before the Medicare eligibility age of 65 years. In several multiemployer plan industries, pre-Medicare eligibility age retirements are the norm. Many covered workers are engaged in heavy physical labor that wears down their bodies and drives them from the workforce earlier than the average worker. But for their multiemployer plan coverage, these workers would be without health care coverage for 5, 10, or even more years before becoming eligible for Medicare.

Most plans require the retirees to pay for plan coverage, but the charge is typically less than the plan's true cost of providing the coverage. In other words, the plans subsidize the retirees' coverage from the contribution income generated by the labor of the active workers covered by the plan.

Accordingly, the plans' ability to provide affordable retiree coverage is affected by fluctuations in the covered work that generates the collectively bargained contributions. Retiree coverage is also dependent upon the continued willingness of the active workers to allow a portion of the contributions they generate to be used to subsidize the retirees.

Health care for retirees is generally more costly. The cost pressures on the plan are increased by various factors including earlier retirements, longer life expectancy, and cost-shifting by the Medicare program to private sector plans.

Purchasing Alliances

Multiemployer plans, by their nature, are group purchasers of health care services. The plans receive collectively bargained contributions from multiple

employers and thereby have more market power than any of the individual employers.

Voluntary mergers of multiemployer plans is one approach to gaining even more market power and further economies of scale in operating expenses, and some plans take this approach.

Another approach to gaining greater purchasing power is a coalition or alliance of multiemployer plans. Several coalitions have been formed by multiemployer plans in various areas around the country.[21] The prime motivation for the formation of coalitions has been health care cost containment, including concern that other groups' discounts from health care providers are being offset by higher prices to non-discount groups. But, as costs come under control, the quality of care and accountability become important factors ("value purchasing").

Typically, each multiemployer plan that joins a coalition retains autonomy, including control over its own benefit design and administration, and the right not to participate in particular programs of the coalition or to deal with particular providers. The coalition provides each member plan with access to special arrangements with providers, and leaves the decision whether to accept the arrangements with the plan's board of trustees.

Activities of multiemployer plan coalitions include:

- negotiating discounts with health care providers, including hospitals, physicians, dentists, and providers of prescription drugs, vision care, and mental health/substance abuse care;
- negotiating with managed care organizations;
- forming custom-designed preferred provider organizations;
- developing or negotiating with utilization review and case management programs;
- evaluation of vendors/providers;
- gathering and exchanging cost data and other information;
- health and wellness promotion programs;

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[21] For example, Basic Crafts Health Care Consumer Coalition (California), Health Care Cost Containment Corporation of the Mid-Atlantic Region (District of Columbia, Virginia, Maryland), Affiliated Health Funds (California, Arizona, Nevada), Connecticut Coalition of Taft-Hartley Funds, the AFL-CIO Employer Purchasing Coalition (Michigan), and the Mid-Hudson Labor Health Care Alliance (New York).

- government relations; and
- dispute resolution.

Coalitions have not yet become widespread for a variety of reasons. Some relate to plan concerns about loss of autonomy and competition among the union and management sponsors. Other reasons include legal and regulatory concerns (e.g., antitrust law, tax exemption for coalition).

NEWS:

FROM THE COALITION FOR WORKERS' HEALTH CARE FUNDS

For Immediate Release

Contact: David A. Jewell (202) 293-1735

WORKERS HEALTH CARE FUNDS APPLAUD CLINTON STAND ON TOBACCO; PLEDGE TO HELP EFFORTS TO RESHAPE AGREEMENT

Washington, Sept. 17 --The Coalition for Workers' Health Care Funds, representing 30 million Americans, today congratulated President Clinton on his historic pronouncement on the proposed tobacco settlement.

The President's recognition that, among its other shortcomings, the proposed settlement failed to address the suffering of tobacco's victims, is the theme that has been at the heart of a campaign waged in Congress by the Coalition for Workers' Health Care Funds for the past two months," said Robert J. Connerton, counsel to the coalition.

"We represent the single most tobacco-targeted segment of the American public — blue collar workers — whose ranks have been penetrated by tobacco addiction at more than double the national rate, and we think the President's statement today puts our workers, and the nation on the right track to dealing with the tobacco menace."

"Coalition members have filed class action suits against the tobacco industry in some 27 states to recover billions of dollars paid out by member funds to treat tobacco-related diseases. The tobacco industry has intentionally, and with devastating success, targeted America's blue collar workers with special promotional and advertising campaigns. Federal statistics show blue collar workers smoke at more than double the national average. For the past 20 years, while the percentage of smokers in other segments of American society has dropped, it has remained steady among our workers," said Connerton.

"The so called 'global' settlement between the attorneys general and the tobacco industry was not global at all," said Connerton. "It was parochial, hatched by people with narrow interests who tried to make it binding upon the entire American populace who were without representation when the deal was negotiated," he said.

"We welcome and accept the President's invitation to affected parties such as ourselves to work with him and the Congress in fashioning a new agreement which provides justice for America's working men and women.

(MORE)

"We look forward to working with the appropriate figures in Congress, the Administration and the public health community in the months ahead to achieve this worthwhile goal,," said Connerton.

"For instance, we represent some 2,200 Taft-Hartley workers' health care funds in the 50-states, the District of Columbia and Puerto Rico. These funds cover more than 30 million workers, retirees and their dependents, a population with the highest percentage of smokers in America. No one consulted us when these negotiations were going on. What about our rights?" he added.

Prior to the pronouncement of President Clinton there was a possibility that Congress might accede to the tobacco industry's frantic request for quick passage of a bill codifying the agreement as written into law. Had that happened the workers' health care funds class action suits would have been extinguished and it would have been impossible for them to take such actions the future.

"We are not the only segment of the American population the tobacco companies sought to disenfranchise in this way," said Connerton. "In addition there are any number of cities (San Francisco, Chicago, New York) and counties who have suits virtually identical to ours who are equally outraged at the prospect of having their right of access to the courts of this nation taken away."

"The irony of our situation is that the proposed agreement addressed the needs of state employee health care funds, in exactly the same position as our own, while denying those of is the private sector and those employed by cities and counties, the right to even go to court for similar relief.

"The President placed great emphasis on the reduction of smoking among America's youth. This is an area in which our workers' funds can make an enormous contribution.

"We are ideally situated to develop and implement comprehensive and sustained programs of smoking cessation and prevention aimed at our workers and their families. Such programs will have a major impact on teen smoking among those families. There is scientific proof that, where parents don't smoke, there is a sharply reduced chance that children will take up the habit. We will focus on the family context of teen smoking," Connerton said.

-30-

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January 15, 1998

Jerold Mande, Esq.
Office of the President
The White House
Washington, D. C. 20510

re: **Tobacco Litigation**

Dear Mr. Mande:

It was a pleasure talking to you the other day. As I advised you, the Federal Court in Seattle certified our class action against the tobacco companies, thus assuring representation on behalf of some 500,000 union members and their families in the State of Washington.

I am enclosing a copy of the Seattle Post-Intelligencer article under date of Thursday, December 25, 1997, on this class certification.

I direct your attention to the last two paragraphs of said article, specifically as it pertains to the current language of the tobacco settlement which would prohibit lawsuits like our suit in the State of Washington. I further call your attention to the position of Senior Assistant Attorney General John Hough who indicated a willingness to request Congress to modify the settlement to enable the Health & Welfare Funds to participate in the proposed settlement.

We would appreciate the assistance and support of The White House in requesting that the Union Health & Welfare Funds be given a place at the table and that we be allowed to directly share in any settlement funds.

Your comments and observations would be appreciated. I remain,

Very truly yours,

George Kargianis
GK:jj
J:\CLIENTS\6\06476\001\MANDE3.LE

INSIDE: Stolen baby Jesus figure is returned to its manger. **B3**

■ Lottery **B2** ■ Funerals **B13**
■ Weather **B13**

Union members granted role in tobacco lawsuit

By SCOTT SUNDE
P-I REPORTER

A federal judge in Seattle agreed yesterday to include 500,000 union members in Washington state in a groundbreaking lawsuit against tobacco companies that could end up seeking hundreds of millions of dollars in damages.

The ruling by U.S. District Court Judge William Dwyer also could have implications beyond the state. Thirty-two of the lawsuits on behalf of so-called health and welfare funds that pay for medical care have been filed in 32 states, said Michael Withey, a lawyer representing the funds in the Seattle suit. But Dwyer's ruling marks the first time any judge has granted class-action status to one of the lawsuits, he said.

Wrong number for U S West

■ The state Supreme Court rejects company's request to increase its telephone rates. **Page B2**

"It's a real boost to health and welfare funds nationally," Withey said.

At the same time, Congress also is considering a $360 billion settlement that several attorneys general, including Washington's Christine Gregoire, reached with the tobacco companies. That settlement would ban class-action suits such as the one Dwyer has before him.

Dwyer's ruling and perhaps similar orders by other federal judges could present a constitutional question of whether Congress can stop what has taken place in the judicial branch of government, Withey said.

John Phillips, lead attorney for the tobacco companies in the Seattle lawsuit, expressed disappointment yesterday at Dwyer's ruling. He said he and other attorneys representing the cigarette makers will spend the holidays considering whether to appeal to the 9th U.S. Circuit Court of Appeals in San Francisco.

"It is a case without precedent and a (class) certification without precedent," Phillips said.

But the attorney did find something to hearten him in Dwyer's ruling: language that Phillips believes invites the tobacco companies to ask the judge to dismiss the suit.

Withey and other attorneys representing the funds do not intend to introduce evidence showing how each union member got sick because of smoking. Instead, they plan to introduce more general information on smoking and health.

"Defendants (the tobacco companies) contend that any such method of proving damages

See **SUIT**, *Page B4*

Suit: Health, welfare funds affected

From Page B1

will be insufficient as a matter of law," Dwyer wrote. "Whether it is or not will have to be decided when the appropriate motions are filed."

The lawsuit was filed in May on behalf of two health and welfare funds that pay for benefits for union carpenters, masons and other laborers. Employers and workers pay for the funds, which provide health care as well as other benefits to the workers and their families.

Dwyer's ruling means that the 60 funds in the state, which comprise a half-million union members, will be included in the lawsuit, Withey said.

The funds claim that the tobacco companies wrongly shifted the costs of paying for the care of those who became sick from smoking away from the cigarette makers. The lawsuit contends that the tobacco companies did that by suppressing evidence about smoking's damage to health.

The lawsuit and others like it could run afoul of the tobacco settlement before Congress. The settlement would prohibit lawsuits like the one in Seattle and even suits filed by individual health and welfare funds on behalf of its members, Phillips said.

The state attorneys general did not favor the prohibition, said John Hough, a senior assistant attorney general in Washington state. But he said the tobacco companies insisted on it to agree to the settlement.

But Hough said Gregoire and other attorneys general might be willing to ask Congress to modify the settlement. That could mean ensuring that the health and welfare funds get part of the $360 billion settlement.

■ P-I reporter Scott Sunde can be reached at 206-448-8331 or scottsunde@seattle-pi.com

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September 22, 1997

Mr. Jerold Mande
Senior Advisor to the Director
OSTP, Room 436
Old Executive Office Building
Washington, D. C. 20502

Re: **Tobacco Settlement Proposal**

Dear Mr. Mande:

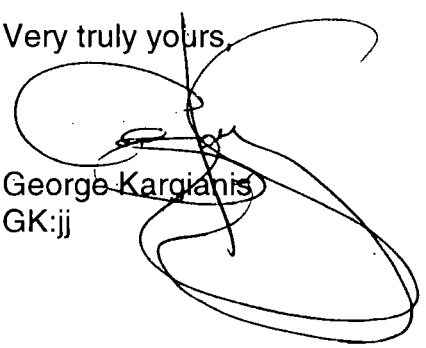
Once again, I wish to thank you for taking the time to meet with Paul Stritmatter, Robert Connerton, and myself, with regards to the President's position on the tobacco settlement proposal.

Your comments and observations were most helpful and instructive.

As we advised you, we remain committed to the legitimate interests and claims of the collectively bargained health trust funds that provide medical benefits for the millions of union employees and their families and dependents covered by these plans. As we have previously observed, the proposed settlement sponsored by the tobacco industry and the various Attorneys General would have effectively eliminated said claims and the right of said funds to recover billions of dollars in medical costs necessitated by smoke related diseases and illnesses.

We applaud and agree with the President that a new and a different approach is needed to address the problems associated with tobacco usage in this society. To that end, we look forward to working with you in the future and in providing you with such further and additional information and input as may prove helpful. Once again, I thank you for your courtesies and remain

Very truly yours,



George Kargianis
GK:jj

cc: President William J. Clinton
Senator Patty Murray
Mr. Bruce N. Reed
Mr. Robert J. Connerton
Paul L. Stritmatter

J:\CLIENTS\6\06476\001\MANDE.LE

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Facsimile Transmission

To :	Jerold Mande Executive Office of the President
Facsimile No. :	(202) 456.2883
From :	Richard Piccioni for George Kargianis
Date :	September 15, 1997
Subject :	Tobacco Litigation
Pages:	7, including cover page
Comments :	Please see attached materials re Tuesday 16 September 1997 meeting with Paul Stritmatter, Victor Van Bourg and George Kargianis

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	George Kargianis to Mande re meeting (partial) (1 page)	09/15/1997	b(6)

COLLECTION:
Clinton Presidential Records
Office of Science and Technology Policy
Jerold Mande
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FOLDER TITLE:
Tobacco: Kargianis/Labor Suits [1]

2008-1524-F
kc1224

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P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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September 15, 1997

Jerold Mande
Executive Office of the President
The White House
Washington, DC

Dear Mr. Mande:

Enclosed for your ready reference is information we and co-counsel have forwarded to the President regarding the impacts of the proposed tobacco settlement on health and welfare trust funds.

The following people will be meeting with you:

Paul L. Stritmatter

Victor Van Bourg

George Kargianis

(b)(6)

I understand that our meeting is scheduled for 12:00 noon, Tuesday 16 September 1997.

Very truly yours,

George Kargianis
Enclosures

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August 6, 1997

President William J. Clinton
The White House
Washington, D. C. 20502

Re: Proposed tobacco settlement provisions —
negative impact on labor health care trust funds

Dear President Clinton:

We are counsel for various labor union health care trust funds and their trustees, covering union family members in Washington State. We feel their interests have been adversely affected by certain provisions of the proposed tobacco settlement. We are requesting an opportunity to meet with you (and your advisers Messrs. Bruce Reed and Bruce Lindsey) to explain our concerns so that you may take them into account in your ongoing review of the proposed tobacco settlement.

By way of background, some thirty million Americans rely on labor-management health care trust funds for health care coverage. These collectively bargained for trust funds pay for all medical care and health services received by covered workers, retirees and dependents. These collectively bargained trust funds pay the hospitals, doctors, and other health care professionals who provide medical care, prescription drugs, and health services to workers, retirees and dependents. Federal law created these pooled, non-profit trust funds in order to ensure employment-based health care for working families. These funds typically covered workers in multi employer or transient-employment work patterns, such as the building trades, trucking, maritime, and service industries. Typically, the workers in these industries have far higher-than-average rates of smoking.

These trust funds have incurred billions of dollars in health care costs for individuals suffering from tobacco-related disease. These costs are ultimately borne by the covered workers and their families, who see a growing share of their compensation package absorbed by health care contributions.

In Washington, the Northwest Laborers-Employers Health & Security Trust Fund and the Carpenters Health and Security Trust of Western Washington and their trustees commenced a class action claim against the tobacco industry, under date of May 21, 1997 (No. C 97-849 WD, U.S. District Court, Western District of Washington). The Washington-Idaho Carpenters-Employers Health & Welfare Trust, and the Washington-Idaho Operating Engineers Health and Welfare Trust Fund, and their trustees, also have joined this suit. The suit is a class action on behalf of all labor union health care trust funds in Washington. We are attorneys representing such trust funds and trustees in this action.

Similar actions in upwards of 20 other states have been filed, involving trust funds covering tens of millions of Americans. These trust funds claimants seek reimbursement of health care costs for tobacco-related diseases. Reimbursement would allow the trust funds to provide smoking prevention and cessation programs and well as reduce the cost burdens of tobacco-related disease on the funds. Any recovery would inure to the benefit of the trust fund beneficiaries. At a time when health care benefits are a crucial cost item for employers and are the subject of intense bargaining by labor, any recovery of such trust funds ultimately would benefit both sides of the collective bargaining table.

The trust funds' claims are essentially the same as the reimbursement claims asserted by the 40 or so States that have filed suit against the tobacco companies. The State suits seek reimbursement of tobacco-related costs incurred by the States' employee health plans and Medicaid programs, in providing health care to government employees and public assistance recipients.

The settlement agreement negotiated between the States' Attorneys General and the tobacco companies provides for reimbursement to the States' employee health plans and Medicaid programs, as well as relief for certain private lawsuits brought by attorneys who were parties to the settlement negotiations. The labor health care trust funds, which were not represented in the negotiations, do not receive reimbursement under the settlement as currently written.

The settlement agreement proposal as currently written would severely limit access to the courts and the relief available for all private claimants not included in the settlement, including the labor health care trust funds in Washington and other states (referred to in the proposed settlement as "third party payor" claimants). These restrictions and limitations would legislatively settle these suits. For example, the proposal prohibits class actions, restricts the availability of punitive damages (arguably restricting availability of treble damages), and makes other changes in procedures and substantive rules of law for the labor health care trust fund suits and other private lawsuits against the tobacco companies. The proposed settlement applied these limitations and restrictions against the labor union health care trust fund claims, without any input and without compensating the trust funds for the billions of dollars they have expended in health care costs for beneficiaries suffering from tobacco related diseases.

We are enclosing a copy of the resolution passed July 11, 1997 by the Washington State Labor Council, opposing "any" legislation implementing the tobacco settlement that fails to recognize labor's right to access to the courthouse and right to share equitably in all settlement proceeds.

We understand that representatives of the Attorneys General, the tobacco industry and tobacco growers have met with you regarding the proposed settlement. We would like the same opportunity to meet with you, and to bring our clients and labor representatives to such a meeting, so that the voice of labor and the joint employer-employee health care trust funds also may be heard with regard to certain provisions in the proposed settlement.

Thank you in advance for your consideration of our request for a meeting at your earliest possible convenience. We look forward to hearing from you soon.

Sincerely,

George Kargianis

Paul L. Stritmatter

Lembhard G. Howell

Lembhard G. Howell

Cleveland Stockmeyer

Enclosures

cc: Members of the Washington State delegation
Trustees of the Northwest Laborers-Employers Health & Security Trust Fund,
the Carpenters Health and Security Trust of Western Washington,
the Washington-Idaho Carpenters-Employers Health & Welfare Trust, and
the Washington-Idaho Operating Engineers Health and Welfare Trust Fund.
Rick Bender, President, Washington State Labor Council

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DAVID L. MALLINOT
MICHAEL BARRETT

JENNIFER M. ROOF
JACK CURRANT
LEGISLATIVE DIRECTOR

† NOT A MEMBER OF THE BAR

June 19, 1997

The Honorable William J. Clinton
The White House
Washington, D.C. 20500

Re: **Tobacco Settlement/Workers' Health Care Trust Funds**

Dear President Clinton:

Thirty million Americans--workers, retirees, and their family members--rely on labor-management, multiemployer health funds and union-sponsored health funds for health care coverage. You recognized the vital role of these funds in the Nation's health care system in your historic proposal to comprehensively reform that system. But for these portable health funds, a great many more workers and their families would have to depend on government programs for health care coverage.

These health funds have incurred billions of dollars in health care costs for individuals suffering from tobacco-related disease; costs borne by the covered workers who have seen a growing share of their compensation package absorbed by the health fund contributions needed to keep pace with inflation. These funds have claims for reimbursement from the tobacco companies that are essentially the same as those asserted by the 40 or so States that have filed lawsuits. The States seek reimbursement of the tobacco-related health care costs incurred by their public employee health plans and Medicaid programs.

However, the settlement being negotiated between the States and the tobacco companies would provide upfront reimbursement only for the States' health plans. Multiemployer and union-sponsored funds would receive no such reimbursement under the settlement because representatives of these funds were not permitted to participate in the negotiations. Reimbursement would greatly assist the funds in providing smoking prevention and cessation programs for the workers, retirees and dependents that they cover, as well as help to reduce the cost burdens of tobacco-related disease on the funds and the covered workers.

These funds have been left with no choice but to file their own reimbursement lawsuits. Class actions have been filed in ten States; at least ten more class actions will be filed shortly. These lawsuits are modelled on those filed by the States.

The funds have also formed a coalition–the **Workers' Health Care Coalition**–to inform the Congress about the settlement's omissions and to urge that the funds and the working families they cover be extended equal treatment with the States' health plans with respect to reimbursement.

We urge you to oppose any settlement between the States and the tobacco companies that does not extend to multiemployer and union-sponsored health funds equal treatment with the States' health plans with respect to reimbursement. We urge you to insist on equal treatment for workers' health care funds.

Respectfully,

Robert J. Connerton

cc Dr. C. Everett Koop
Dr. David A. Kessler

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July 23, 1997

The Honorable Patty Murray
111 Russell Senate Office Building
Washington, D.C. 20510

Re: Proposed Tobacco Settlement Opposed By Washington State Labor Council

Dear Sen. Murray:

We are seeking your assistance in ensuring that the voice of half of a million unionized workers and their families in Washington State is heard by the White House in connection with the proposed tobacco settlement.

We are enclosing a copy of the resolution passed July 11, 1997 by the **Washington State Labor Council,** opposing "any" legislation implementing the tobacco settlement that fails to recognize labor's right to access to the courthouse and right to share equitably in all settlement proceeds. (Also enclosed is a copy of our prior letter to your office concerning the impact of this proposed settlement on labor.)

The resolution notes the proposed settlement was *negotiated without any input from employer-employee health care trust funds,* even though it targets and imposes onerous conditions on their lawsuits against the tobacco industry. These conditions effectively shut the courthouse door on these claims. There is no provision for the trust funds to share in any settlement proceeds.

The targeted lawsuits include a pending class action lawsuit on behalf of all labor union health care trust funds in Washington. We are attorneys in the Washington action, which covers trust funds benefitting some 500,000 Washingtonians. Similar actions in some 20 other states would benefit some 30 million Americans -- if those actions are not foreclosed by the settlement. These trust funds seek the same relief the Attorneys General sought for Medicaid funds -- reimbursement for smoking-related health care costs which the tobacco industry justly should pay.

cc mailed PA 8/6

These trust funds are funded through employer contributions according to collective bargaining agreements. Any recovery would inure to the benefit of the trust fund beneficiaries. At a time when health care benefits are a crucial cost item for employers and are the subject of intense bargaining by labor, any recovery of such trust funds ultimately would benefit both sides of the collective bargaining table.

Thirty million Americans--workers, retirees, and their family members--rely on labor-management, multi employer health funds for health care coverage. That is, these collectively bargained trust funds pay the hospitals, doctors, and other health care professionals who provide medical care, prescription drugs, and health services to workers, retirees and dependents.

These funds have claims against the tobacco companies for reimbursement of their health care costs for tobacco-related diseases. Reimbursement would enable the funds to provide smoking prevention and cessation programs for covered individuals, as well as reduce the cost burdens of tobacco-related disease on the funds.

Tobacco growers, the tobacco companies and the attorney generals have now been heard by the White House. The multi employer fund representatives have not had this opportunity and time is growing short. We urgently request your assistance in helping us arrange a meeting with the President and/or President's advisers on the tobacco settlement, Messrs. Bruce Reed and Bruce Lindsay, so that the voice of labor and the employer-employee health care trust funds also may be heard.

We would appreciate an opportunity to discuss this matter with you at greater length.

Sincerely,

George Kargianis

Lembhard G. Howell

Paul L. Stritmatter

Cleveland Stockmeyer

Enclosures
cc: Bruce Reed

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Executive Office of the President

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From : George Kargianis
Paul Stritmatter

Date : September 5, 1997

Subject : Proposed Tobacco Resolution

Pages: 7, including cover page

Comments :

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September 5, 1997

The Honorable Patty Murray
111 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Murray:

Thank you for the opportunity to discuss the "Proposed Resolution" ("PR") of claims against the tobacco industry. We thought we would follow up, by summarizing and supplementing the points we discussed.

We look at the proposal in terms of (1) public health, (2) industry payments and (3) restrictions on access to justice ("protecting" the industry from other claims).

I. Public health/teenage smoking.

A. Background: Like cocaine, nicotine changes the structure of the brain, creating cell growths that hunger for nicotine, and produce symptoms of sickness when deprived of nicotine. Most adult smokers are addicted as youths; relatively few smokers start as adults. Recently-discovered industry documents show the industry designs the product to addict people and recruits teenage smokers. Recently, the FDA ruled cigarettes are "drugs," finding that manufacturers know they change the human body and are used for pharmacological effects. The industry currently is appealing this ruling.

B. Goal of PR: reduce teenage smoking/give FDA restricted jurisdiction to regulate.

C. **Problems:**

1. The PR is not needed to give FDA jurisdiction; FDA will have full jurisdiction under its Act if the appeals court (or the Supreme Court) upholds FDA ruling. Health agencies/local governments are regulating tobacco and do not need the PR to do so.
2. PR restricts FDA power to regulate nicotine, prevents FDA from banning nicotine for 12 years.
3. PR's smoking reduction goals do not address current teenage smokers or adults -- just attempt to limit number of *new* teenage smokers.
4. Goal to reduce teenager smoking rate 40% in ten years "allows" other 60% to be recruited as new smokers.
5. There is no real penalty if the goal is not met.
   a. Penalty is $80 million for each percentage short of goal, but is 75% refundable if manufacturer shows it has obeyed laws.
   b. Penalty arbitrarily capped at $2 billion.
   c. Profit stream from "allowed" new smokers is $2.4 billion every year, making any penalty easily payable out of profits from new recruits. (Penalty of $80 million is described as the "lifetime profit" on each 1% percent of teenagers who smoke in a given cohort; $80 million times 60 (for the 60 % allowed smokers) is $2.4 billion).
   d. Industry is already using new teenage marketing (red "Kamels," psychedelic Camel billboard ads, etc.)

II. Financial Obligations of Tobacco Industry

A. **Background:** Attorneys General and other claimants (including our clients) have sued to recover smoking costs imposed on health care trust funds.

B. **Goal of PR:** Make tobacco industry reimburse part of costs, to allow money to be used for health purposes.

C. **Problems:**

1. The $368 billion figure that is widely quoted is inaccurate. There is only a stream of contingent payments (about $10 billion/year for states and $5 billion/year for private claimants; see section III below). The present value of this stream is only about $190 billion. The present cost to tobacco of creating this stream is $190 billion

minus the recent deductions in the budget bill and *minus* tax savings because payments are tax deductible.

2. The cost to tobacco (which is well under $190 billion) is a cheap settlement of claims for all tobacco-related health care costs since 1953; tobacco-related health care costs are estimated to be $50-100 billion *every year.* Industry will feel no pain; stock prices rose after PR announced; payments can be recouped with price increase of 60 cents/pack.
3. Payments not guaranteed.
4. Amounts of payments tied to future level of sales.
5. Payments end if FDA bans nicotine, or sellers leave U.S. market.
6. Payments stream gives States a direct interest in high sales levels. (Washington's share, $100 million/year, is 5% of health care authority budget).
7. State Legislatures can re-direct the funds out of health care (or cut health care budgets to achieve same result); no guarantee payments to States will be used for health.
8. No provision for payments for federal employees or federal Medicaid trust funds, or for union health care trust funds; under the PR the only compensated health care trust funds are State portions of Medicaid and State employees.

III. Restriction on Private Claims.

A. Background:

Until recently, industry always "won" lawsuits. Now, recently-discovered industry documents give claimants needed evidence of historic outrageous wrongdoing. The industry settled Mississippi case for $4 billion, and Florida for $11 billion. In early 1997, before the PR was announced, union health care trust funds began to sue the industry in class actions. The trust funds are authorized under ERISA and labor laws and labor agreements; they pay expenses of doctors, hospitals, etc., out of employer contributions which otherwise would be part of wages. Class actions representing funds with 30 million beneficiaries have been filed in 20+ states. These trust funds were denied participation in the PR. The Washington State Labor Council and councils in other states oppose the PR as anti-labor.

B. Goal of PR: Stated goal is to allow private lawsuits to continue. Actual result is to prevent any such lawsuit.

C. Problems:

1. PR destroys claims of private parties.
   a. PR states a trust fund cannot sue industry unless suit was filed before June 9, 1997. (Only exception is for "subrogated" claims, meaning where the trust fund stands in the shoes of an individual smoker; this precludes trust funds claims for damages to trust fund itself, or trust fund claims under antitrust law, RICO, etc.) This provision would prohibit all claims asserted in our lawsuit for all union trust funds in Washington except for the Laborers and Carpenters trust funds' claims since they filed prior to June 9, 1997.
   b. PR disallows suits against co-conspirator that is not a manufacturer, immunizing industry lawyers and others.
   c. PR does not allow punitive damages. This seems to preclude treble damages under antitrust and racketeering laws.
   d. PR bans class actions, which are necessary to resolve in one case claims of many parties, and to level the playing field.
   e. PR requires private parties to sue one-by-one; must prove the same facts (smoking causes cancer) over and over; cannot join as plaintiffs (even a husband and wife) and must sue each defendant in separate suits. This ties the hands of federal or state court judges, telling them how to rule on procedure and evidence questions.
   f. PR limits recoverable damages. PR provisions for annual aggregate cap and annual payment cap on successful parties limit total industry liability to private claimants to $5 billion/year. If claims exceed this, claimants receive only $1 million each, with excess rolling over into next year, without interest. If verdict is in the tens of millions, trust fund will never catch up.
   g. There are many constitutional problems in the PR. It is unconstitutional to abrogate claims based on a cut off date or race to the courthouse; to deny a certain group access to courts, or to make grave inequalities in claims (the Medicaid trust funds get all rewards; private sector trust

funds are barred from proceeding) for no rational reason.

h. Bad precedent to give one industry protection from justice system.

Conclusion

The benefits of the PR are largely illusory, since government agencies do not need the PR to assert their jurisdiction. Attorneys General do not need the PR to obtain funds to reimburse Medicaid trust funds -- Mississippi and Florida have settled, and Texas is expected to settle soon. Only the industry really needs the PR -- to obtain protection from regulation and protection from being held accountable in private lawsuits. These protections are unprecedented in our history, for an industry that provides no social value whatsoever.

If the provisions protecting the industry from private lawsuits are incidental, then there can be no objection to deleting them from the legislation. If they are important to the industry, then it is unfair and unconstitutional to allow the industry to buy this protection through payments that do not go toward compensating the private parties. The restrictions are so onerous that no individual person or trust fund has any ability to sue.

Overall, in our view the PR also may hurt public health efforts. It makes public health agency budgets dependent on tobacco sales. The protections from being held accountable in court give up one of the strongest tools we have to force the industry to change its conduct. Indeed, litigation has been the only tool that has ever been effective. As a result of litigation, the industry has given up on Joe Camel and has conceded cigarettes are harmful. Now, for the first time, the industry is finally changing its conduct and making concessions, due only to the litigation pressure of suits by the attorneys general. Why should we free the industry from the continued pressure created by class actions of union health care trust funds and others, who merely seek their day in court against the industry ? The changes to the civil justice system amount to surrendering the first tool that has ever worked, just when it is starting to bring results.

Moreover, there may be a concern that Congress would not be able to change tobacco legislation once it is enacted. The terms of the global settlement are to be tied to consent decrees in Attorney General cases; the industry will be in a position to argue that its agreements with the Attorneys General are contracts that may not constitutionally be impaired by future legislative action. This would provide the industry with one final immunity granted to no one else in this nation -- immunity from future democratic legislative action.

Please do not hesitate to call if you or your aides have any questions.

Sincerely,

George Kargianis

Paul Stritmatter

cc: John Engber, Ann Grady
Bruce Reed, Bruce Lindsey

Keith Kessler, Lembhard G. Howell
Michael E. Withey, Cleveland Stockmeyer

Rick Bender, President, Washington State Labor Council
The Northwest Laborers-Employers Health & Security Trust Fund
The Carpenters Health and Security Trust of Western Washington
The Washington-Idaho Carpenters-Employers Health & Welfare Trust
The Washington-Idaho Operating Engineers Health and Welfare Trust Fund

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PASSED BY LABOR COUNCIL 7/11/97

IN SUPPORT OF TAFT-HARTLEY HEALTH & WELFARE PLANS' LEGAL RIGHTS AND REMEDIES AGAINST THE TOBACCO INDUSTRY

Resolution #30 - AMENDED

Submitted by Washington State Labor Council Executive Board

WHEREAS, Taft-Hartley Health and Welfare Plans ("Plans") provide important benefits and protects union members and their dependents; and

WHEREAS, such Plans have paid out hundreds of millions of dollars in health care claims for beneficiaries who have incurred medical expenses for smoking-related health care illnesses, such as lung cancer, emphysema and heart disease; and

WHEREAS, the tobacco industry has for decades sought to shirk their legal responsibility to compensate its many victims for the medical costs of their smoking-related diseases and impose the responsibility for such costs on the Plans; and

WHEREAS, in May of 1997, the Northwest Laborers and Carpenters Plans initiated a state-wide class action lawsuit against the tobacco industry to recover reimbursement for the smoking-related health care costs incurred by these plans; and lawsuits on behalf of other Plans have been filed in numerous other states, seeking similar reimbursement; and

WHEREAS, on June 20, 1997, the tobacco industry and forty state attorneys-general (without the involvement or input from any Plans) announced a proposed comprehensive settlement of all tobacco litigation and have sought the approval of Congress and the President for this settlement; and

WHEREAS, although the proposed settlement has numerous positive features, it proposed, in exchange for providing billions of dollars of reimbursement to the states for Medicare payments, to severely and unfairly restrict the same full access to the civil justice system by the Plans which the state attorneys general utilized. The proposed settlement:

- Bans all class actions and any consolidations and joinders of the Plans' lawsuits;
- Requires that any of the Plans' lawsuits brought after June 9, 1997 be brought solely for subrogation (i.e., requiring the plans to proceed on an individual basis to recover health care costs for individual beneficiaries); and
- Outlaw the triple damages remedies (or other forms of punitive damages) for anti-trust and consumer protection violations that are currently allowed by law; and
- Imposes other onerous conditions which severely restrict the ability of the Plans

to proceed to obtain legal remedies.

NOW, THEREFORE, BE IT RESOLVED, that the Washington State Labor Council go on record in support of the right of all Taft-Hartley Health and Welfare Plans to share equitably in all settlement proceeds; and, be it further

RESOLVED, that all Taft-Hartley Health and Welfare Plans have full right of access to justice, including all legal rights and remedies, both substantive and procedural, that existed prior to the proposed settlement agreement; and, be it further

RESOLVED, that the Washington State Labor Council oppose any legislation that fails to recognize these rights; and, be it finally

RESOLVED, that the Washington State Labor Council send this resolution to all affiliates, Congressional representatives and Senators, Attorney General Christine Gregoire, President Clinton, and appropriate media.

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Referred to the Health & Safety committee.