[COMMITTEE PRINT]

INSURING THE UNINSURED: OPTIONS AND ANALYSIS

PREPARED FOR THE

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

AND THE

SUBCOMMITTEE ON LABOR STANDARDS

OF THE

COMMITTEE ON EDUCATION AND LABOR

AND THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

AND THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

BY THE

Congressional Research Service
Library of Congress

OCTOBER 1988

Education and Labor Serial No. 100-DD
Energy and Commerce Serial No. 100-BB
Special Committee on Aging Serial No. 100-O

[COMMITTEE PRINT]

INSURING THE UNINSURED: OPTIONS AND ANALYSIS

PREPARED FOR THE

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

AND THE

SUBCOMMITTEE ON LABOR STANDARDS

OF THE

COMMITTEE ON EDUCATION AND LABOR

AND THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

AND THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

BY THE

Congressional Research Service
Library of Congress

OCTOBER 1988

Education and Labor Serial No. 100-DD
Energy and Commerce Serial No. 100-BB
Special Committee on Aging Serial No. 100-O

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1988

90-441 ⇆

For Sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, D.C. 20402

90-441 O - 88 - 1

COMMITTEE ON EDUCATION AND LABOR

AUGUSTUS F. HAWKINS, California, *Chairman*

WILLIAM D. FORD, Michigan
JOSEPH M. GAYDOS, Pennsylvania
WILLIAM (BILL) CLAY, Missouri
AUSTIN J. MURPHY, Pennsylvania
DALE E. KILDEE, Michigan
PAT WILLIAMS, Montana
MATTHEW G. MARTINEZ, California
MAJOR R. OWENS, New York
CHARLES A. HAYES, Illinois
CARL C. PERKINS, Kentucky
THOMAS C. SAWYER, Ohio
STEPHEN J. SOLARZ, New York
ROBERT E. WISE, JR., West Virginia
TIMOTHY J. PENNY, Minnesota
BILL RICHARDSON, New Mexico
TOMMY F. ROBINSON, Arkansas
PETER J. VISCLOSKY, Indiana
CHESTER G. ATKINS, Massachusetts
JAMES JONTZ, Indiana
— —

JAMES M. JEFFORDS, Vermont
WILLIAM F. GOODLING, Pennsylvania
E. THOMAS COLEMAN, Missouri
THOMAS E. PETRI, Wisconsin
MARGE ROUKEMA, New Jersey
STEVE GUNDERSON, Wisconsin
STEVE BARTLETT, Texas
THOMAS J. TAUKE, Iowa
RICHARD K. ARMEY, Texas
HARRIS W. FAWELL, Illinois
PAUL B. HENRY, Michigan
FRED GRANDY, Iowa
CASS BALLENGER, North Carolina

SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS

WILLIAM (BILL) CLAY, Missouri, *Chairman*

WILLIAM D. FORD, Michigan
DALE E. KILDEE, Michigan
CHARLES A. HAYES, Illinois
MAJOR R. OWENS, New York
JAMES JONTZ, Indiana
AUSTIN J. MURPHY, Pennsylvania
THOMAS C. SAWYER, Ohio
AUGUSTUS F. HAWKINS, California
(Ex-Officio)
— —

MARGE ROUKEMA, New Jersey
RICHARD K. ARMEY, Texas
HARRIS W. FAWELL, Illinois
CASS BALLENGER, North Carolina
THOMAS E. PETRI, Wisconsin
JAMES M. JEFFORDS, Vermont
(Ex-Officio)

SUBCOMMITTEE ON LABOR STANDARDS

AUSTIN J. MURPHY, Pennsylvania, *Chairman*

PAT WILLIAMS, Montana
TIMOTHY J. PENNY, Minnesota
ROBERT E. WISE, JR., West Virginia
TOMMY F. ROBINSON, Arkansas
AUGUSTUS F. HAWKINS, California
(Ex-Officio)

THOMAS E. PETRI, Wisconsin
STEVE BARTLETT, Texas
JAMES M. JEFFORDS, Vermont
(Ex-Officio)

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
AL SWIFT, Washington
MICKEY LELAND, Texas
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. (BILLY) TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
DENNIS E. ECKART, Ohio
WAYNE DOWDY, Mississippi
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
GERRY SIKORSKI, Minnesota
JOHN BRYANT, Texas
JIM BATES, California
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
TERRY L. BRUCE, Illinois
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
DON RITTER, Pennsylvania
DAN COATS, Indiana
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
SONNY CALLAHAN, Alabama

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

JAMES H. SCHEUER, New York
DOUG WALGREN, Pennsylvania
RON WYDEN, Oregon
GERRY SIKORSKI, Minnesota
JIM BATES, California
TERRY L. BRUCE, Illinois
MICKEY LELAND, Texas
CARDISS COLLINS, Illinois
RALPH M. HALL, Texas
WAYNE DOWDY, Mississippi
JOHN D. DINGELL, Michigan,
(Ex Officio)
EDWARD R. MADIGAN, Illinois
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
DAN COATS, Indiana
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
NORMAN F. LENT, New York,
(Ex Officio)

SPECIAL COMMITTEE ON AGING

JOHN MELCHER, Montana, *Chairman*

JOHN GLENN, Ohio
LAWTON CHILES, Florida
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota
J. BENNETT JOHNSTON, Louisiana
JOHN B. BREAUX, Louisiana
RICHARD SHELBY, Alabama
HARRY REID, Nevada
JOHN HEINZ, Pennsylvania
WILLIAM S. COHEN, Maine
LARRY PRESSLER, South Dakota
CHARLES E. GRASSLEY, Iowa
PETE WILSON, California
PETE V. DOMENICI, New Mexico
JOHN H. CHAFEE, Rhode Island
DAVE DURENBERGER, Minnesota
ALAN K. SIMPSON, Wyoming

COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515

TELEPHONES
MAJORITY—(202) 225-4527
MINORITY—(202) 225-3725

October 14, 1987

Mr. Joseph E. Ross, Director
Congressional Research Service
Library of Congress
Washington, D. C. 20540

Dear Mr. Ross:

Public and private institutions now provide health insurance to the majority of the nation's population. In general, most employed working-age persons and their dependents are covered through employer-provided insurance. The elderly and disabled are covered by the Federal government's Medicare program and about two-fifths of the poor receive insurance through the Federal/State Medicaid program. However, a sizeable minority (estimates run as high as 37 million) have no health insurance even though most of these are employed. Furthermore, some 10 million people in poverty are not covered by Medicaid and have no health insurance.

Various means to extend health insurance coverage to those who do not have it have been proposed in the past, and although some improvements have been made, the largest part of the problem still remains. This Committee is interested in further efforts to extend coverage to those who do not now have it, and we are writing to you to solicit the assistance of the Congressional Research Service in analyzing options for doing so.

In particular, the Committee is interested in options for extending minimum health benefits to those who do not have health insurance as part of compensation for employment. This might be by providing incentives to employers, by mandating coverage, or some other means. In addition, the Committee is interested in options for providing insurance to those who are either unemployed, are uninsurable through current practices, or who are poor and yet do not qualify for Medicaid.

We recognize this to be a difficult task and are in need of high quality analysis to assist us. Accordingly, we are requesting the CRS to provide the Congress with analysis on the costs of the various options for mandating health insurance, on individuals, on businesses, and on other public and private institutions. In addition, we request that the analysis include consideration of some of the administrative issues associated with options for extending health insurance to those who do not have it.

We thank you for your support.

Sincerely,

Austin Murphy
Chairman
Subcommittee on Labor
Standards

Augustus F. Hawkins
Chairman

William L. Clay
Chairman
Subcommittee on Labor-
Management Relations

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
2415 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
PHONE (202) 225-4952

March 30, 1988

Mr. Joseph Ross, Director
Congressional Research Service
Library of Congress
Washington, D.C. 20540

Dear Mr. Ross:

I understand the Congressional Research Service is prepared to undertake a major study related to health insurance and the uninsured population in the U.S.: Who is Uncovered, what role private health insurance can play in providing coverage to the uninsured, options for extending that health insurance coverage, and the effects of a program to achieve this end.

I am aware that the Committee on Education and Labor has worked with you on the design and plan for the study. With their agreement, I would like to request that you also consider the Committee on Energy and Commerce as a requester of the study, include us in the study development, and provide us with your results.

My staff has already discussed the study plan in some detail with Royal Shipp and Janet Kline. We look forward to continuing to work with them as the study progresses. I believe it will provide great assistance to the Committee in its consideration of the Minimum Health Benefits bill, and will make an important contribution to our long-term understanding of and solution to the problem of the uninsured.

With every good wish, I am,

Sincerely,

Henry A. Waxman

HENRY A. Waxman
Chairman, Subcommittee on
Health and the Environment

HAW:kna

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

October 21, 1987

Joseph E. Ross
Director
Congressional Research Service
Library of Congress
Washington, DC 20540

Dear Mr. Ross:

Public and private institutions now provide health insurance to the majority of the Nation's population. Most employed persons and their dependents are covered through employer-sponsored insurance plans. Persons age 65 and older and disabled persons are covered by the Federal Government's Medicare program, and about two-fifths of the poor receive insurance through the Federal/State Medicaid program. Unfortunately, a sizeable minority (estimates run as high as 37 million) have no health insurance. While most of these are connected to the workforce, many are retirees under age 65 or others who have no current workforce connection. Ten million of those not covered live in poverty, but are ineligible for Medicaid.

Various means to extend health insurance coverage to those who do not have it have been proposed in the past, and although some improvements have been made, the largest part of the problem still remains. This Committee is interested in further efforts to extend coverage to those who do not now have it, and we are writing to you to solicit the assistance of the Congressional Research Service in analyzing options for doing so.

In particular, the Committee is interested in options for extending minimum health benefits to those who do not have health benefits as part of compensation for employement. This might be by providing incentives to employers, by mandating coverage, or some other means. In addition, the Committtee is interested in options for providing insurance to those who are either unemployed, are uninsurable through current practices, or who are poor and yet do not qualify for Medicaid.

We recognize this to be a difficult task and are in need of high quality analysis to assist us. Accordingly, we are requesting the Congressional Research Service to provide the Congress with analysis on the costs of the various options for mandating health insurance, on individuals, on businesses, and on other public and private institutions. In addition, we request that the analysis include consideration of some of the administrative issues associated with options for extending health insurance to those who do not have it.

We thank you for your support.

Sincerely,

JOHN HEINZ
Ranking Member

JOHN MELCHER
Chairman

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

LETTER OF SUBMITTAL

October 24, 1988

Honorable Augustus F. Hawkins
Chairman, Committee on Education and Labor
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This report, "Insuring the Uninsured: Options and Analysis," is the second of a three-part study of health insurance for the uninsured by the Congressional Research Service (CRS). This study was requested by the Committee on Education and Labor and by the Senate Special Committee on Aging in letters dated October 14, 1987 and October 21, 1987, respectively. The House Committee on Energy and Commerce later joined in requesting the study.

Upon receipt of your letters, a team of CRS analysts began meeting, and in consultation with members of committee staffs, developed a plan for a comprehensive study. The foremost priority was to produce a study that would help the requesting committee, and the entire Congress, understand the advantages and disadvantages of the various approaches for extending health insurance to the uninsured, if the Congress decides to take such action.

The first report of the study, "Health Insurance and the Uninsured: Background Data and Analysis," was released on June 9, 1988. The third report, "Costs and Effects of Extending Health Insurance Coverage," released concurrently with this one, develops and analyzes estimates of the costs of health insurance premiums and the effects of specific approaches to extending coverage to the uninsured.

This second report, "Insuring the Uninsured: Options and Analysis," presents and analyzes a comprehensive range of options for providing additional health insurance coverage, including public programs, tax incentives, and private employer-based plans.

We hope this report will be of use to your Committee and to the Congress as you consider options for insuring the uninsured.

Sincerely,

Joseph E. Ross
Director

PREFACE

This report is the second of a three-part study by the Congressional Research Service (CRS) on the issue of extending health insurance to people who lack it. The study was initially requested by the House Committee on Education and Labor and the Senate Special Committee on Aging. Subsequently, the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce wrote to CRS expressing interest in the study and asked to be included as a sponsor.

A CRS team was formed to carry out this health insurance study. The team, which began meeting in the fall of 1987, developed a work plan, a detailed outline, and an analytic framework for the study. After meeting with Committee staffs requesting the study, the work on the study began, producing first a report titled "Health Insurance and the Uninsured: Background Data and Analysis," which was released on June 9, 1988. This first report provides background information, data, and analysis on: (1) the health insurance business, (2) government regulation of health insurance, (3) the number and characteristics of the uninsured, (4) exposure to health care out-of-pocket costs by people who have insurance, and (5) a comparison of the utilization and financing of health care services between the insured and the uninsured.

The third report, released concurrently with this one, is titled "Costs and Effects of Extending Health Insurance Coverage." It concentrates analysis mainly on employer-based health insurance. An actuarial model was developed with assistance from Hay/Huggins Company, Inc., under contract with CRS. The model provides estimates of the level and sensitivity of health insurance premiums for the currently insured and the potentially insured populations. This report also analyzes the effects of four illustrative plans for extending health insurance on (1) the number and characteristics of those affected, (2) out-of-pocket expenditures for health care, (3) changes in overall health care expenditures, (4) the health insurance industry, (5) private sector employers, and (6) on the fiscal status of the Federal and State governments. Data on these estimated effects were provided through a computer-based micro-simulation model developed by Lewin/ICF under contract with CRS.

This second report, titled "Insuring the Uninsured: Options and Analysis," discusses a comprehensive range of options for providing health insurance and making it more readily available to those who lack it, including public and private options. The report discusses the theory and practice of health insurance, including the issue of adverse selection, the problems of small employers, and insurance underwriting and ratesetting. The report goes on to identify and analyze various possible means of increasing health insurance coverage through public programs, tax incentives, private employer mandates, and other measures. A final section of the report

discusses ways to encourage wider availability of affordable health insurance, especially for individuals and small employers. Emphasis is given to various "pooling" arrangements, whereby small companies could join together to enjoy some of the insurance benefits of larger employers or insurers could join together to spread the risk of insuring high-risk groups.

This second report was written by Beth Fuchs and Mark Merlis. Other members of CRS's health insurance team, Vicki Freedman, Janet Kline, Janet Lundy, Michael O'Grady, Dennis Snook and Jim Storey, provided assistance regarding the study's structure and concepts. P. Royal Shipp was the project manager. Under contract with CRS, Edwin Hustead, Michael Carter, Larry Bobbitt, J. Alan Lauer, and Michael Schaefer of Hay/Huggins Company, Inc., worked with the team to provide actuarial and other technical assistance. The entire team reviewed drafts of the report.

In addition, the report was reviewed by the following outside experts who provided helpful comments:

Gerard F. Anderson, The Johns Hopkins Medical Institutions
Jim Cantwell, General Accounting Office
Jill Eden, Office of Technology Assessment
Lynn Etheredge, Consolidated Consulting Group
Kevin Haugh, Health Insurance Association of America
Stanley B. Jones, Consolidated Consulting Group
Mary Nell Lehnhard and Diana Jost, Blue Cross and Blue Shield Association
John Luehrs, National Governors' Association
Patricia Neuman, The John Hopkins Medical Institutions
M. Michael Schiffer, CIGNA Corporation

CONTENTS

CHAPTER 1. INTRODUCTION

CHAPTER 2. THE THEORY AND PRACTICE OF HEALTH INSURANCE

CHAPTER 3. NATIONAL HEALTH INSURANCE

CHAPTER 4. PUBLIC PROGRAMS

CHAPTER 7. EXPANDING THE AVAILABILITY OF INSURANCE

LIST OF TABLES

LIST OF CHARTS

CHAPTER 1.—INTRODUCTION

This report analyzes a broad spectrum of potential public and private initiatives to extend health insurance coverage to the 37 million uninsured Americans. It builds on a companion report, *Health Insurance and the Uninsured: Background Data and Analysis,* published in June 1988, which reviewed the history and current status of health insurance in the United States, the extent of health coverage, the reasons so many people are not covered, and the consequences for them and for the society. For readers without access to the earlier report, its findings are summarized in the first section of this introduction. The second section discusses the structure and contents of this report and provides a road map to guide the reader through the many different policy alternatives to be considered.

I. Background

A. Evolution of the American Health Insurance System

The United States provides health insurance through a combination of private initiatives and public programs. The United States health insurance system evolved gradually beginning in the late 19th century. Health insurance plans offered by direct providers of health care, such as physicians and hospitals, grew into the Blue Cross/Blue Shield systems in the 1930s. Commercial insurers began offering health insurance policies around the same time. By the end of World War II, increasing numbers of employers were offering health insurance as a fringe benefit, while individuals with the means could buy coverage on their own. Concern that health insurance was still unavailable to many Americans led to a series of Federal attempts to fill the gaps in private coverage, culminating in the 1965 enactment of the Medicare program for the aged (and later the disabled and persons with end-stage renal disease) and the Medicaid program for certain categories of the poor. Still, private insurance, chiefly employment-based, remains the primary source of health coverage for most Americans.

The nature of private coverage has changed as the insurance industry has grown. At one time, the plans offered by Blue Cross/Blue Shield programs differed from those offered by commercial insurers in at least three key respects. First, the Blues offered "service benefits," paying in full for covered services; commercial insurers offered "indemnity" coverage, paying a fixed amount for each service and leaving the enrollee to pay any uncovered balance. Second, the Blues used "community rating," under which premium amounts were based on expected costs for all policyholders; low-cost individuals or groups helped to pay for the participants requiring more expensive services. Commercial insurers used "experience rating," under which the rate for each employer group was based

on historic costs for that specific group. Third, most of the Blues practiced a policy of "open enrollment," permitting any individual or group to purchase coverage. Commercial insurers adopted underwriting practices comparable to those traditionally used in their other lines of insurance business, such as life insurance. That is, applicants perceived to be high risk might be charged higher rates, or be denied coverage (temporarily or permanently) for problems already diagnosed at the time the policy took effect. Applicants with costly chronic conditions might be denied coverage altogether.

The differences between the practices of the Blues and commercial insurers have diminished over time. "Indemnity" coverage is increasingly rare, especially in employment-based plans. Most of the Blues now use experience rating for large employer groups, and many—though not all—have modified their enrollment policies, using underwriting to limit their risks.

Meanwhile, new forms of competition have entered the insurance market. These include health maintenance organizations (HMOs), which directly provide or arrange for the services used by their enrollees and seek to reduce unnecessary care, and preferred provider organizations (PPOs), which give their enrollees financial incentives to use the least expensive hospitals and physicians. Traditional insurers are also taking steps to control the use of services and reduce costs; for example, they may require prior authorization or second opinions before certain services are furnished. Finally, many large and medium-sized employers have sought further cost-savings by "self-insuring," covering the costs of their employees' health care directly instead of purchasing insurance from an outside firm.

These changes all have had a potential impact on the ability of individuals and small employer groups to obtain and pay for health insurance. Some of the effects of current insurance practices are discussed in chapter 2 of this report. While the operation of the private health insurance market has affected the extent of coverage in the United States, other factors have also played a role.

B. EXTENT AND ADEQUACY OF HEALTH INSURANCE COVERAGE

As of 1986, 85 percent of all Americans had some form of health insurance coverage during at least part of the year.[1] Of those aged 65 and over, 99 percent were covered, chiefly through Medicare. Of those under 65, 83 percent were covered; of these, over three-quarters were covered through their own employment or that of another family member. The rest were covered by a mix of Medicaid, Medicare, CHAMPUS (the health program for armed services personnel and their dependents), individually purchased private policies, and other health insurance sources.

However, an estimated 37 million persons had no coverage at any time during 1986; all but 300,000 were under age 65. More than half of the uninsured were employed during at least part of the year. Younger and lower-paid employees, and those who worked part-time or for only part of the year, were more likely to

[1] Data in this section are derived from a CRS analysis of the March 1987 Current Population Survey.

be without coverage from their own employment. Employer-based coverage was least common for employees in certain sectors of the economy, such as agriculture, personal/household services, and retail trade, and most common for those in manufacturing, mining, or public administration. Small firms were much less likely than larger ones to provide coverage.

The share of the nonaged population lacking health insurance has grown from 14.6 percent in 1979 to 17.5 percent in 1986. The most significant change appears to have been in dependent coverage. Fewer people are obtaining insurance through another family member's employment. Two factors appear to have contributed about equally to this change. First, coverage rates for spouses and children have declined. Second, demographic shifts have occurred. For example, children under 18 made up a smaller part of the population in 1986 than in 1979; older children in the household may not be eligible for coverage under their parents' policies.

C. EFFECTS OF INADEQUATE HEALTH INSURANCE COVERAGE

Those who lack health insurance may face significant financial barriers in obtaining needed health services. According to the 1986 Health Interview Survey, the uninsured see a physician two-thirds as often as the insured, and spend three-fourths as many days in the hospital. They are less likely to obtain care for certain kinds of health problems and are more likely to rely on emergency rooms for routine services. Differences in the use of health services by the insured and uninsured exist even after taking age and income into account.

When the uninsured do obtain services, they must pay for their own care or rely on some form of subsidy. The subsidy may be direct, as when a local government supports the operations of a public hospital, or indirect, as when a provider increases its charges to insured patients to help cover the costs of care for patients who cannot pay. There is concern that as the number of uninsured persons grows the ability of providers to spread the costs for their care to other payers declines. Both public and private insurers have become increasingly price-conscious. New forms of insurers, such as HMOs and PPOs, restrict their members to less costly providers or negotiate discounts from the providers' usual charges. The resulting financial pressures may further reduce access to care for the uninsured.

Even persons with health insurance plans are at risk for having to pay much of the cost of their own care. Virtually all private health insurance plans require enrollees to make some contribution, in the form of deductibles and coinsurance payments, to the cost of their own care. Most plans have some limit on the cost-sharing amounts an enrollee could be required to pay in the course of a year, but 17 percent of the plans offered by large and medium employers in 1987 had no such limit, and an additional 24 percent had limits in excess of $1,000 for an individual enrollee.[2] Insurance

[2] Data on provisions of health insurance plans are from the 1987 Hay/Huggins Benefits Survey of nearly 900 employers.

purchased on an individual basis was more likely to have no limitation on an enrollee's potential expenditures for covered services. Enrollees also may be liable for services excluded from a plan (most often prescription drugs or mental health care) or for costs in excess of a lifetime benefit limit imposed by the plan. Fourteen percent of plans offered by medium and large employers had lifetime limits of $250,000 or lower, possibly less than the cost of some kinds of catastrophic episodes. As a result of these coverage limits and enrollee cost-sharing requirements, an estimated 15.3 percent of all insured families had 1987 health expenses (not counting insurance premiums) greater than 5 percent of their family income; 3.7 percent had expenses greater than 25 percent of their family income.

D. CURRENT REGULATION OF HEALTH INSURANCE AND HEALTH BENEFITS

Responsibility for regulation of health benefits and health insurance is divided between the States and the Federal Government. Regulation of all forms of insurance has traditionally been the province of the States; State primacy in this area was confirmed by the McCarran-Ferguson Act of 1945. However, the right to regulate employee benefits, including health benefits, was reserved by the Federal Government in the Employee Retirement Income Security Act of 1974 (ERISA). ERISA established uniform national standards for employee benefit plans and preempted State regulation of these plans. States can still regulate the companies selling health insurance and the content of the policies they sell. However, States cannot directly regulate the benefit plans offered by employers. An employer that "self-insures" (covers employees' health expenses directly instead of buying insurance from an outside company) is exempt from any State regulation. One of the reasons large employers increasingly choose to self-insure is to avoid State regulations, such as mandated coverages in health insurance policies or taxes on insurance premiums.

In comparison to the regulation of pensions and other retirement benefit plans, direct Federal regulation of employee health benefits has been minimal. No employer has been required to furnish health coverage, but employers who do choose to provide coverage have been subjected to certain requirements. The Health Maintenance Organization Act of 1973 requires most employers who provided health benefits to offer employees the option of joining an HMO as an alternative to the employer's basic plan. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) requires an employer to allow employees and dependents to continue to participate in the employer's health plan, at their own expense, for up to 18 months (or in some cases, 36 months) after an event that would otherwise cause them to be dropped from the plan, such as loss of a job or a change in marital status. Finally, the Tax Reform Act of 1986 requires employers to ensure that their health plans do not discriminate in favor of highly compensated employees. Plans that continue to discriminate are subject to the loss of favorable tax treatment for higher compensated employees.

II. Organization of This Report

This report has seven chapters, of which this introduction is the first. *Chapter 2* provides an overview of the fundamental principles of health insurance, both in theory and in practice. In addition to providing general background, the objective is to focus on those characteristics of private health insurance that play an important role in determining the availability and price of coverage for individuals and for groups. The chapter examines such basic insurance concepts as risk and probability, and then discusses how health insurance differs from other kinds of insurance, contributing to the very costs against which it affords protection. The chapter moves on to review rate setting and underwriting practices and considers the critical problem of adverse selection.

The remainder of the report is devoted to policy options. Although the focus is chiefly on alternatives for Federal legislative action, some of the options presented could be acted on by State or local government, while others might be undertaken through private sector initiatives with little government intervention or assistance. Some of the Federal options to be considered have been embodied in legislative proposals, either in the 100th Congress or during earlier periods of congressional interest in health insurance; others have not. The purpose of this report is not to summarize legislation, but to provide a technical analysis of the widest possible variety of approaches: how they might be implemented and what effects they might be expected to have. For the most part, no attempt has been made to estimate the economic impact of a given alternative or the number of uninsured persons who might be assisted.[3] Where possible, information is provided on factors that may affect the overall effectiveness or feasibility of a particular approach.

Charts 1.1 and 1.2 provide road maps of the options to be considered in chapters 3 through 7 of this report (more detailed road maps appear at the start of some of the chapters). The report distinguishes between *coverage options,* which focus on the individuals or groups to be insured, and *availability* options, which focus on insurance mechanisms and on ways of making insurance more available or affordable. Another way of speaking of the distinction is that coverage options address *who* is to be insured, while availability options address *how* insurance coverage might be provided. Under this scheme, for example, a proposal to provide Medicaid coverage as an entitlement to all poor families is a coverage option; a proposal to allow those families to purchase Medicaid coverage as they might purchase coverage from a private insurer is an availability option. This classification is sometimes arbitrary and should be regarded merely as a way of sorting out the many alternatives to be considered.

---

[3] Estimates for several illustrative plans are provided in the third report in this series. Congressional Research Service, Costs and Effects of Extending Health Insurance Coverage. 1988.

Chart 1.1

Coverage Options

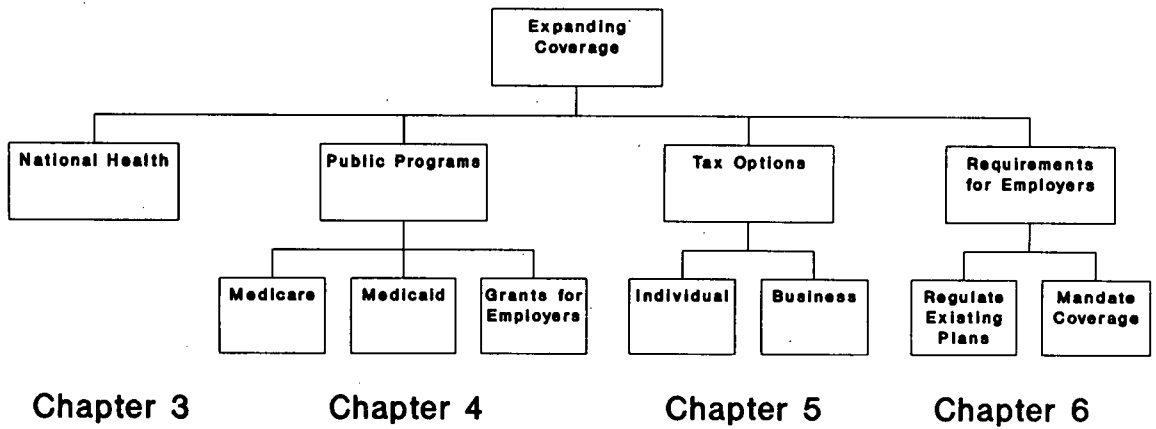
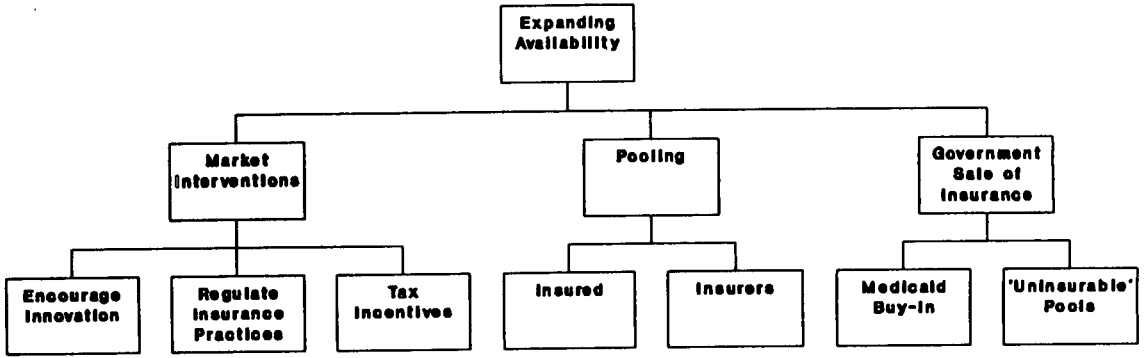


Chart 1.2

Availability Options



Chapter 3 considers proposals for a comprehensive *national health insurance* plan. Although such proposals currently receive little attention, in the 1960s and 1970s they were at the center of the health insurance debate. These proposals are reviewed here both as a matter of historical interest and as a way of setting the stage for the more piecemeal or incremental approaches considered in the remainder of the report. The proposals discussed are of two kinds: social insurance programs like Canada's system, which finances services furnished by independent health care providers, and health service systems like that of the United Kingdom, in which the government actually furnishes medical care through its own facilities and employees. The chapter concludes with a discussion of proposals that would combine a number of public and private coverage initiatives into a universal or nearly universal coverage system, fitting the components together like pieces of a jigsaw puzzle. The individual components are the subject of the remainder of this report.

Chapter 4 addresses options for expansion of the major *public programs,* Medicare and Medicaid. Proposals to expand the public insurance programs are of two basic types. First, persons not presently eligible to participate could be given coverage as an entitlement. Second, persons not entitled to coverage could be allowed to "buy in" to one or the other of the programs. The discussion in this chapter is confined to options for expanding eligibility for Medicare or Medicaid as an entitlement. (The buy-in options, under which the Federal or State government sells insurance to individuals or groups, are discussed in chapter 7.) The chapter concludes with a brief discussion of another possible use of direct public funding to expand coverage: grant programs for employers.

Chapter 5 considers ways in which current Federal or State tax law might be modified to help more individuals purchase insurance or to encourage more employers to provide group health plans. Among the options discussed are refundable health insurance tax credits, modeled on the earned income tax credit (EITC) for low-income workers, and modifications of the tax treatment of employer expenditures for health care.

Chapter 6 discusses more direct options for improving employer-based group health insurance or for requiring that some or all employers provide health coverage. The first section of the chapter considers requirements that might be placed on existing health plans that are provided by employers voluntarily or as a result of labor negotiations. These might include specific benefits or plan provisions that all plans would have to include, or extension of the continued coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272).

The second part of the chapter, and the longest section of this report, considers in detail the technical issues involved in implementing a proposal for mandatory employer coverage. The space devoted to this option does not reflect any policy preference, nor does it stem solely from the fact that employer mandates are currently the subject of widespread discussion. For this option, perhaps more than for any of the others, resolution of the technical problems is a central policy consideration. Decisions on such seem-

ingly minor details as the coordination of coverage for families with two working parents could have significant economic effects.

Finally, *Chapter 7* considers possible interventions in the insurance market that might help make coverage more accessible and affordable for potential purchasers. Some of the options would seek to modify the logic of the private insurance market by changing the rules or incentives under which it operates. Others would have government assume the role of selling insurance directly, through Medicaid or a distinct program, to persons unable to obtain it in the private sector. Between these two extremes are proposals to form insurance pools, with or without government assistance. Pooling proposals are of two broad types. Pools of insureds combine individuals or small groups into one large group in order to obtain some of the purchasing advantages large groups have in the current insurance market. Pools of insurers combine to spread the risk of covering potentially costly applicants. Both types of pooling are considered.

CHAPTER 2.—THE THEORY AND PRACTICE OF HEALTH INSURANCE

I. INTRODUCTION

This chapter examines some of the theory and practices of private health insurance. In addition to providing general background, the objective is to focus on those characteristics of private health insurance that play an important role in determining the availability and price of coverage for individuals and for groups.

The diversity in the health insurance industry makes this a difficult task. Health insurance is provided by a vast and highly complex assortment of entities, including commercial insurance companies, Blue Cross and Blue Shield Plans, preferred provider organizations (PPOs), and prepaid arrangements such as health maintenance organizations (HMOs). Each insuring entity is in some way unique, and the nature and practices of the insurance industry are constantly evolving. Increasingly, large and medium-sized companies are self-insuring, that is, directly assuming the risk of health care costs for their employees, and may use insurance companies only to cover catastrophic expenses and/or provide administrative services. Such variation and change make it difficult to characterize the health insurance industry; the following discussion necessarily masks differences in the way individual health insurers operate.

This chapter first examines the building blocks of insurance: the concepts of risk and probability. It then considers how health insurance differs from other kinds of insurance. There is a discussion of the interplay between health insurance and health care costs, and of some of the ways that employers and insurers are attempting to reduce those costs. The chapter moves on to review ratemaking in the abstract and the development of rates for individual and group health insurance policies. While self-insured plans are also addressed, most of the discussion focuses on the more traditional health insurance arrangements, that is, individual and group indemnity and service plans. Ratemaking for PPOs and prepaid arrangements differs from traditional arrangements in a number of ways, but is not covered except where specifically indicated.[4] The next sections of this chapter look at adverse selection and underwriting practices, especially as they affect small employers. Underwriting of multiple employer trusts (METs) is also discussed.

[4] On deriving premium rates for PPOs, see Handley, Thomas L. Developing Premium Rates for a Preferred Provider Organization (PPO). Transactions, Society of Actuaries, vol. xxxvii, 1985. pp. 187-200.

II. Principles of Health Insurance

A. THE CONCEPT OF RISK

Insurance is a response to risk, to uncertainty about specific outcomes, and to the possibility that those outcomes will be unfavorable. An individual may try to reduce or avoid risk, but it is not always possible to assure a favorable outcome. The risk of illness, for example, can be reduced by exercising and maintaining a good diet, but it cannot be entirely eliminated. A healthy person might decide that the risk of an expensive illness is so low that it makes no sense to buy health insurance, and might choose instead to pay out-of-pocket for whatever medical expenses come along (in effect, to self-insure). Most people, however, choose to transfer the risk of a financially costly illness to an insurer (or comparable third-party payer). In this way, insurance provides an economic device whereby a person substitutes a certain payment (a premium) for the uncertain financial loss that would occur in the event of an uninsured accident or illness.

The fundamental principle of insurance is, in fact, to minimize the losses of one or a few individuals by spreading the risks (of their medical expenses) among many. In its ideal form, insurance provides a mechanism by which losses can be spread on an equitable basis to all members of the group.

B. PROBABILITY AND THE LAW OF LARGE NUMBERS

For insurance to operate, there has to be a way to predict the likelihood or probability that a loss will occur as a result of a specific outcome. Such predictions in insurance are based upon probability theory and the law of large numbers. According to probability theory, "while some events appear to be a matter of chance, they actually occur with regularity over a large number of trials." [5] By examining patterns of behavior over a large number of trials, it is therefore possible for the insurer to infer the likelihood of such behaviors in the future.

The classic illustration of probability theory is the coin toss. The chance or probability of obtaining "heads" from any one coin toss is 50 percent. If the coin is tossed 10 times, however, there is no certainty that "heads" will turn up five times. But if the coin is tossed 10,000 times, the probability is that heads will turn up close to 5,000 times. Applied to insurance, probability allows the insurer to make predictions on the basis of historical data. In so doing, the insurer ". . . implicitly says, 'if things continue to happen in the future as they happened in the past, and if our estimate of what has happened in the past is accurate, this is what we may expect.'" [6]

Losses seldom occur exactly as expected, so insurance companies have to make predictions about the extent to which actual experience might deviate from predicted results. For a small group of insured units, there is a high probability that losses will be much greater or smaller than was predicted. For a very large group, the

[5] Vaughan, Emmett J. Fundamentals of Risk and Insurance. 4th Edition. New York. John Wiley and Sons, 1986. p. 22.
[6] Ibid., p. 27.

range of probable error diminishes, especially if the insured group is similar in composition to the group upon which the prediction is based. Thus, to predict the probability of a loss, insurers seek to aggregate persons who are at a similar risk for that loss. The larger the number of similar units, the more accurate the prediction. This is why insurance companies set rates for groups of individuals, even when each of those individuals is contracting directly for his or her insurance.[7] For some rating purposes, the "group" may exist only statistically. For example, a Medicare supplemental (Medigap) policy may be rated on the basis of what is known about the characteristics of the purchasers of such policies, even though those purchasers do not constitute a group in the same sense in which the employees of a firm are a group.

C. INSURABLE RISKS

In theory, all probabilities of loss can be insured. Insurance could cover any risk for a price. As the probability of loss increases, however, the premium will increase to the point at which it approaches the actual potential pay-out.

To keep premiums competitive, there are in practice some risks that insurers will not accept. In general, insurable risks must meet the following criteria: [8]

- There has to be uncertainty that the loss will occur, and that the loss must be beyond the control of the insured. Insurers will not sell hospital insurance to a person who is on his way to a hospital, nor fire insurance to someone holding a lit match. The law of large numbers can only inform predictions about future losses if it can be reasonably assumed that the future will approximate past experience. Losses must therefore occur randomly.
- The loss produced by the risk must be measurable. The insurer has to be able to determine that a loss has occurred and that it has a specific dollar value.
- There must be a sufficiently large number of similar insured units to make the losses predictable. As noted above, while an insurer cannot predict whether any one person will be hospitalized in a given year, it can determine that, of 100,000 persons of a certain age, a predictable number will be hospitalized.
- Generally, the loss must be significant, but there should be a low probability that a very high loss will occur. A person does not need to insure against a trivial loss. However, it would not be prudent for an insurer to accept a risk in which there is a high probability that an expensive loss will occur to a large percentage of the insured units at the same time. Thus, insurers generally do not cover damage that results from acts of war, and insurers often refuse life and health insurance to individual applicants known to be suffering from a costly illness or condition.

---

[7] Ibid, pp. 27-28.

[8] This section is drawn largely from: A Course in Individual Health Insurance. Health Insurance Association of America. Chicago. 1983. p. 2-4, and Vaughan, Emmett J. Fundamentals of Risk and Insurance. 1986. p. 29.

In practice, the sale of insurance sometimes involves deviations from these textbook rules. For example, insurance is sometimes written for unique risks, despite their lack of predictability; Lloyd's of London is celebrated for such policies. Moreover, many people do buy insurance for losses that are highly probable and financially insignificant. This is the case, for example, when people obtain coverage for routine dental care. Nevertheless, the principles enumerated are fundamental to most types of insurance and continue to play an important role in health insurance, particularly insurance for individuals and small groups. In some ways, however, health insurance is very different from other kinds of insurance. The next section explores these differences and discusses how they have affected the overall cost of health insurance and the kinds of health insurance being offered.

D. THE CASE OF HEALTH INSURANCE

As the previous section suggested, one of the basic principles of most kinds of insurance is that a risk is insurable only if it is beyond the control of the insured. The possibility that an insurer may have to pay a claim for a loss deliberately precipitated by the insured is known as "moral hazard," as distinguished from "normal hazard." Normal hazard consists of risks governed by the laws of probability. Moral hazard consists of risks governed, at least in part, by the behavior of the policyholders. Traditionally, the concept of moral hazard was applied to cases in which the insurer was actually uncertain of the insured's honesty. In health insurance, however, normal hazard and moral hazard are not so easily separable. The loss being insured against is seldom wholly beyond the control of the insured.[9]

Table 2.1 illustrates the special nature of health insurance by comparing it to a type of insurance that more closely adheres to classical insurance models, fire insurance.

The *normal* hazard in both cases is more or less random: fire or sickness can strike anyone unpredictably. However, certain insurance applicants are more at risk than others. Insurance underwriters attempt to classify applicants for coverage according to the level of risk they present. In the case of fire insurance, underwriters might distinguish between a wooden building and one built of brick. Health insurers also practice underwriting for individual and small group policies. The extent of this practice and the variety of risk categories used will be reviewed later in this chapter. Underwriters also, in the case of fire insurance, consider whether the applicant has taken certain steps to limit the risk of loss, such as installing smoke alarms or sprinkler systems. In turn, applicants for fire insurance may actually modify their behavior in response to underwriting and rating practices. They might remodel their building or adopt fire prevention practices. Efforts by the insured to control the risk of loss are known by the broad term "risk management." Large businesses now have risk management depart-

[9] An early elaboration of the role of moral hazard in health insurance may be found in Arrow, Kenneth J. Uncertainty and the Welfare Economics of Medical Care. American Economic Review, 53:5 (Dec. 1963). p. 941-973.

ments, which seek to reduce a company's insurance claims and hence the cost of insurance.

TABLE 2.1.—Comparison of Fire Insurance and Health Insurance

	Fire	Health
Normal hazard	Random risk of fire.	Random risk of sickness.
Insurer control of normal hazard.	Underwriting.	Underwriting.
Insured's control of normal hazard.	Risk management.	Lifestyle changes.
Moral hazard	Arson.	Use of unnecessary or excessive health services.
Insurer control of moral hazard.	Underwriting.	a. Benefit provisions that discourage use of services. b. Direct insurer controls over use of services.
Insured's control of moral hazard.	Complete.	Limited.
Nature of loss	Value of property destroyed (fixed).	Value of health services consumed (variable).
Purchaser of insurance	Property owner.	Usually third-party, sometimes individual.

At this time, health insurance underwriters generally do not consider steps that applicants might take to prevent illness. Some individual policies may provide credits for non-smokers, and some insurers will grant a small rate reduction to employers who establish "wellness" programs for their workers.[10] There is a growing debate over proposals that health insurers consider the effects of "lifestyle" on the incidence of illness. One major corporation recently announced that its (self-insured) health plan would no longer cover certain diseases related to lifestyle; it has since dropped this proposal pending further study. It is possible that in the future health insurers will give greater emphasis to lifestyle. Employers may respond by practicing risk management. They might prohibit smoking in the workplace or, more controversially, control their risks by refusing to hire persons who are obese or have high blood pressure.

The *moral* hazard in fire insurance is the risk that the insured will commit arson. The insurer may seek to control this risk during the underwriting process by considering the applicant's history, the financial stability of the applicant's business, or other factors. The moral hazard in health insurance is very different. Insurers are not concerned that some applicants will deliberately become sick.[11] Instead, the moral hazard is that the insured, whatever his or her condition, will use unnecessary or excessive health services.

[10] One controversial use of lifestyle in underwriting is the effort by some insurers to determine the sexual orientation of applicants for individual coverage, in order to screen out persons potentially infected with the AIDS virus. Although the National Association of Insurance Commissioners has recommended that States prohibit this practice, 30 percent of commercial insurers and Blue Cross/Blue Shield Plans responding to a survey by the Office of Technology Assessment reported that they considered sexual orientation in individual underwriting, as did 25 percent of HMOs. U.S. Congress. Office of Technology Assessment. AIDS and Health Insurance: An OTA Survey. Washington. Feb. 1988. p. 15–23.

[11] However, when many health insurance policies excluded coverage of care related to pregnancy, one argument for the exclusion was that pregnancy was under the control of the insured and therefore not an insurable risk.

While other types of insurance cover the value of the loss being insured against, health insurance covers the value of the actions (medical treatments) taken in response to the loss (sickness). In effect, the medical treatments are the loss, not the sickness underlying them.[12] The value of a fire insurance policy is fixed. Even a replacement cost policy covers only the expected cost of replacing the specific building insured; the policyholder may not build a palace where a garage once stood and expect the insurer to pay. The value of a health insurance policy is generally not fixed, although there may be limits on the total benefits. There is no firm connection between the nature or severity of an individual's illness and the cost of the services the individual obtains. Someone with a headache may take an aspirin and never seek medical treatment at all, or may seek medical care and receive a series of expensive diagnostic tests.

Moreover, the extent to which the insured uses health services is only partly under the control of the insured. The moral hazard in fire insurance is completely under the control of the insured: the policyholder does or does not start a fire. In health insurance, the insured individual generally initiates medical care but may have little influence on the subsequent course of that care. Instead, the physician often determines the type and quantity of the services to be furnished.

Finally, fire insurance is ordinarily purchased by the owner of the property being insured. The insured has a direct interest in the cost of the insurance and has an incentive to take steps that will reduce that cost. Most private health insurance, on the other hand, is paid for partially or fully by employers. The covered employees may have little interest in controlling the costs. Even if the employees are required to contribute to health insurance premiums for themselves or their dependents, the fact that they are insured as members of a group means that each individual's behavior has a limited effect on costs. One member of the group has no incentive to reduce his or her use of services when other members' use of services may still result in increased premium rates.

The health care providers are even further insulated from the effects of their own behavior. So long as insurance payment is available, cost is not a consideration in deciding what services to provide or order. On the contrary, other factors may encourage providers to furnish more services than a particular patient requires. For example, concern about malpractice litigation may lead to the practice of "defensive medicine," performing superfluous tests or procedures for fear that the failure to perform them might be raised in a lawsuit. Some providers who have purchased an expensive piece of equipment, such as a CAT scanner, might use the equipment more often than necessary because the resulting fees will help pay for it.

Health insurance, then, encourages both the insured and health care providers to use more services. The growth of health insurance coverage during this century is generally acknowledged to

[12] One exception to this rule is the so-called "dread disease" insurance policy, which provides a fixed benefit if the insured contracts a specific illness, such as cancer. However, such policies account for only a tiny share of the private health insurance market.

have been a central factor in rising health care costs. To a considerable extent, services have become available because insurance was ready to pay for them. This is not to say that insurance is the only source of cost increases in medical care. The development of new medical technologies may be equally important. The aging of the American population and general price inflation also result in increased medical expenditures.

Still, the steady increases in medical care costs have led insurers, as well as employers providing group health coverage, to look for ways of limiting or reversing the financial incentives for excessive use of services that are inherent in health insurance.

E. COST CONTROLS IN HEALTH INSURANCE

Insurers and employers seeking to reduce the costs of health insurance may focus either on the use of medical care, the volume and intensity of the services insured persons obtain, or on the price of those services.

The latter approach, obtaining discounts from health care providers, has been common almost since the birth of the health insurance industry. Blue Cross Plans, for example, have often negotiated reduced rates from participating hospitals; the hospitals grant the discounts in return for assured patient volume and guaranteed payment. A more recent development is the PPO, which receives discounts from a network of contracting physicians and/or hospitals. Individuals insured under a PPO arrangement are given financial incentives to obtain care from the PPO's affiliated providers, rather than from more costly providers outside the network. (PPOs are discussed further in section IV of this chapter.)

Price reductions do not, however, affect the basic incentives created by health insurance. Providers who furnish services at reduced rates can maintain their income by increasing the number of services they provide or by furnishing more complex, expensive services. For this reason, efforts to reduce the cost of health insurance have increasingly focused on controlling the use of services. Two broad approaches are common: enrollee cost sharing, which shifts some of the costs of care to the insured individual, and managed care, which seeks to modify the behavior of health care providers.

The first approach, *cost sharing,* involves provisions in health insurance policies for deductibles, coinsurance, and copayments. A deductible is a fixed amount the insured must pay for covered services during a given period before the insurer will assume liability. Coinsurance provisions require the insured to pay a certain percentage of each claim, usually up to a specified annual out-of-pocket limit. Copayment provisions require the insured to pay a fixed dollar amount for each service, rather than a percentage of the cost of the service.

Cost-sharing requirements not only shift part of the financial responsibility for health care to the enrollee, but may also deter the enrollee from using services. An enrollee with "first dollar" coverage—insurance with no deductible requirement—has an incentive to seek medical care for any complaint, no matter how trivial. An enrollee who must pay the first $100 of his or her medical bills

during a year is more likely to consider the cost before obtaining services.

In controlled studies, cost-sharing requirements have been found to affect the likelihood that individuals will obtain care at all for a particular problem, but not the course of the care once the individual has begun medical treatment.[13] Once treatment has been initiated, patients obtain the services that providers regard as necessary.

For this reason, there is increasing interest in the second major approach to limiting the use of services, *managed care.* Although the phrase is used to describe a variety of insurance provisions or arrangements, it generally covers efforts to control the provision or ordering of services by health care providers. Among the control mechanisms in use are requirements that all non-emergency hospital stays be approved by the insurer in advance or that a second opinion be obtained before elective surgery is performed. Some insurers are now practicing "case management," arranging necessary medical and social services in order to expedite the discharge from the hospital of very costly patients.

The prototypical managed care program is the HMO. An HMO not only practices the control mechanisms described, but also requires that each enrollee's overall care be managed by an assigned primary care physician or other provider. The primary care provider must authorize visits to specialists or hospital admissions, and is expected to reduce the provision of duplicative or unnecessary services. In many HMOs, physicians may share in the savings if they succeed in reducing overall costs; sometimes the physicians are also at risk for cost overruns.

The growth of managed care is seen by some analysts as having modified the basic relationship between the insurer and the insured. In a traditional insurance system, the insurer sells a policy, the policyholder incurs losses, and the insurer pays the policyholder's claims. The insurer has no direct interest in the volume or dollar amount of the claims incurred, so long as the policyholder is willing to pay premiums sufficient to cover the losses. Managed care involves the insurer directly in ongoing efforts to control health services. Health insurers may now compete on the basis, not of price, but of their relative ability (whether actual or perceived) to limit costs. This trend may be expected to continue as employers becoming increasingly concerned about the rising costs of their health benefit plans.

The remainder of this chapter focuses on current health insurance underwriting and rating practices, because they are important in the analysis of many of the policy options considered later in this report. The final chapter (chapter 7) specifically addresses possible ways of achieving reductions in the cost of insurance by modifying these insurance practices. In conclusion, however, it

---

[13] "Cost-sharing reduced outpatient medical use principally by deterring people from seeking any care at all. It did not decrease the intensity or 'size' of an episode of care for a given diagnosis, measured by the number or amount of services provided per episode once people entered the medical care system. Physicians evidently did not adjust their practice patterns to their patients' insurance status." Lohr, Kathleen N., et al. Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial. Medical Care, 24:9 (Supplement, Sep. 1986), p. S78.

must be emphasized that *health insurance is costly because health care is costly.* Even for the largest groups, health insurance is expensive for reasons so far largely beyond the control of insurers or employers.

III. RATEMAKING

A. INTRODUCTION

Ratemaking is the "process of predicting future losses and future expenses and allocating those costs among the various classes of insureds." [14] The outcome of the ratemaking process is a "premium" or price of the policy.[15] The premium is made up of expected claims against the insurer and the insurer's "administrative expenses." The term "administrative expenses" is used to mean any expense that the insurance company charges that is not for claims (including reserves for potential claims). These expenses are frequently referred to as "retention" because these amounts are retained by the insurance company, in contrast to claims that are paid out to plan enrollees or to providers. In the case of employer group coverage, a third part of the premium is set aside in a reserve held against unexpected claims. This reserve is often refundable to the employer if claims do not exceed expectations.

B. THE RATEMAKING PROCESS

In the textbook descriptions of ratemaking for health insurance, insurers predict losses on the basis of predicted claims costs. This prediction involves an assessment of the likely morbidity (calculated in terms of the number of times the event insured against occurs) and severity (the average magnitude of each loss) of the policyholder or group of policyholders. In addition, co-payments and deductibles have to be factored into the calculation to determine the amount that the insurer will actually be paying. In writing policies for groups, such as employer plans, the actuary determines the probabilities of loss for more than one insured person.

While the following discussion largely focuses on group health insurance, it is also helpful to look at insurance practices affecting individual subscriber policies. For some Americans, individual policies are the only form of health insurance available. There are several important differences between individual and group policies:

- Selection of risks—The foremost difference involves the "group" rather than the "individual" selection of risks. With the exception of very small groups, group insurance is issued without medical examinations or other evidence of the insurability of the individual members of the group. For individual policies, the insurer will generally require evidence of insurability. The issue of selection of risks is considered further in the discussion of underwriting, below.
- Single contract—For group policies, the members of the group are covered under a single contract. The persons insured under the group contract are not parties to the contract, since legally

[14] Vaughan, 1986, p. 91.

[15] Used in this context, "premium" and "rate" are the same thing, that is, the final price per unit of insurance paid by the insured individual or group.

the contract is between the insurer and the group policyholder, usually an employer.

- Cost of coverage—Group policies provide the possibility for economies of scale for such activities as premium collections and record-keeping. In addition, the costs of obtaining business (acquisition costs) are lower per enrollee for groups than for individual policies.
- Duration of contract—A group insurance contract may last long beyond the lifetime or membership of individual members of the group. New persons are added all the time; others leave the group. However, it is relatively uncommon for the insurer to discontinue coverage of the group, although the group may change its insurers or benefit arrangements. In the individual market, there may be less stability. Insurers may discontinue coverage of an individual when the contract ends. (This practice may be restricted by State laws requiring that contracts be noncancellable or guaranteed renewable.)

The process of developing rates for group plans is illustrated below. What is described is the textbook model of ratemaking, in which an actuary constructs a table of probabilities and expected payments. As discussed later, the method employed in practice is substantially different.

Table 2.2 shows for a hypothetical plan the expected expenses for claims falling into six categories, according to the probability that a claim will be made. Thirty-nine percent of the insureds will not have claims that exceed $200 for the year (in a plan where the deductible is $100). Twenty-five percent will have minor claims that will average $200 for the year. Fifteen percent will have claims averaging $500, and so on down the table.

TABLE 2.2.—Development of Estimated Claims Cost for a Hypothetical Insurance Plan

Probability of claim (percent)	Amount of claim	Expenses paid by insurer	Expected value
39	$0	$0	$0
25	200	80	20
15	500	320	48
12	1,000	720	86
7	10,000	7,920	554
2	25,000	19,920	398
Total expected expenses			1,106

Once the probabilities and expected claims are determined, the actuary calculates how much of each claim will be paid by the insurer. The third column, expenses paid by the insurer, was calculated for a plan that applies a $100 deductible and 80 percent coinsurance to each type of claim. For example, the amount of the $1,000 claim that is paid by the insurer is $720, determined as 80 percent coinsurance of the $900 remaining to be paid after the $100 deductible is subtracted.

The last column, expected value, is the probability of a claim multiplied by the expected expense. For a $25,000 claim, the ex-

pected value of $398 is determined by multiplying $19,920 (the insurer's portion of a $25,000 claim) by the 2 percent probability that a claim of this size will be made. The total of all lines is the expected average claims cost of the total plan.

In this illustration, the actuary would develop a set of probability factors for each type of coverage. Therefore, if hospital and surgery claims were paid in full by the insurers but all other claims had coinsurance applied after the deductible, there would have to be at least three probability tables. The plan premium would be the sum of the premiums for hospital, surgical and other claims.

The textbook method of developing a premium from individual expected claims is seldom used in practice. Instead, the actuary will update a premium based on the previous year's rate for the policyholder, adjusted for certain "change" or trend factors such as the rate of inflation for health care costs and technology changes. The probability distributions like those illustrated above are implicit in the base, but the actuary does not recalculate the premium according to cost and utilization components.

There are different approaches to determining rates. In health insurance, the most frequently used approaches are "experience rating" and "community rating."

Under *experience rating,* the past experience of the group to be insured is used to determine the premium. For employer groups, experience rating would take into account the company's own history of claims and other expenses. Thus experience rating is "the process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience." [16] This type of rating is used for groups that meet certain size requirements. It is not used where experience is likely to be unreliable, as in the case of individuals or very small groups.

When an insurer first covers a group, the insurer's actuary will set a premium using the past experience of the prior insurer, adjusted for change factors such as inflation and increases or decreases in utilization. If the group has not had health insurance before, the insurer will start with an average premium for similar groups derived from a rate manual, which is a book of rates compiled on the basis of predicted costs for an individual or group with various characteristics. For group insurance, the manual rates are computed from basic experience tables developed for moderate-sized groups in non-hazardous occupations. The insurer then adjusts the manual rate for factors specific to the group to be covered, such as dependent coverage, age of employees, geographic area, and type of industry. (This practice is sometimes known as "manual rating.") The initial rate is tentative and is often designed to attract business rather than to produce a profit from the group in the first year.[17]

The advantage of experience rating is that it adjusts the cost of insurance for a specific group in a manner more commensurate with the expected cost of that particular group than is possible

---

[16] Health Insurance Association of America. 1986–1987 Source Book of Health Insurance Data. Washington, 1987. p. 85.

[17] Dickerson, O.D. Health Insurance. Third edition. Homewood, Illinois. Richard D. Irwin, Inc., 1968. p. 590.

through the exclusive use of manual rates.[18] In addition, the increasingly competitive environment among insurers demands that each one "make every effort to retain groups with favorable experience. Unless an insurer can provide coverage to such groups at a reasonable cost, it runs the risk of losing such policyholders to another insurer which more closely reflects the expected costs of their programs in its rates." [19]

Under *community rating,* premium rates are based on the allocation of total costs to all the individuals or groups to be insured, without regard to the past experience of any particular subgroup.[20] The term is related to "class rating," which refers to the practice of computing a rate for a policy that applies to all applicants possessing a given set of characteristics, such as sex, age or locale.[21] Community or class rating has the advantage of allowing an insurer to apply a single rate or set of rates to a large number of people, thus simplifying the process of determining premiums.

In order to be federally qualified, HMOs are required to use community or class rating.[22] Community rating also has been historically associated with the Blue Cross and Blue Shield Plans. In the past, the Blues "made little attempt to relate the rate for a group to its own loss probability. Except for differences due to variations in coverage and the presence or absence of dependent coverage, all groups were charged the same." [23] For policies for individuals, the Blues would construct similarly broad-based rates, reflecting broad averages over a large number of insureds. As a result, through community rating the premiums were based on the experience of more than one group or employer. For instance, the community could be all of the individually insured people or all of the small employers in a metropolitan area or State. In the past, the Blues used community rating to subsidize high-risk, disadvantaged groups and individuals in order to make hospital protection available to all at a reasonable rate. However, the pressure of market competition has increasingly encouraged the Blues to experience rate larger employers; small group and individual policies are still generally community rated.[24] Many employers have also urged that the community rating requirement for federally qualified HMOs be eliminated.[25]

Table 2.3 shows the individual premiums for nine hypothetical employers and the community rate that results from combining the employers into a community for rating purposes. The individual rates range from $750 for employer A to $20,000 for employer J. The community rate would be $970 per employee if all the employ-

---

[18] Health Insurance Association of America. A Course in Group Life and Health Insurance. Part A. Washington. 1985. p. 236.

[19] Ibid.

[20] U.S. Congress. Office of Technology Assessment. AIDS and Health Insurance: An OTA Survey. Staff Paper. Washington, U.S. Govt. Print. Off., Feb. 1988. p. 57.

[21] Vaughan, p. 93.

[22] Federally qualified HMOs are those certified by DHHS as meeting standards set forth by the Public Health Service Act. An HMO so certified may take advantage of the Act's requirement that an employer who offers a health insurance plan must also offer an HMO option if a federally qualified HMO in its area asks to be offered to employees.

[23] Dickerson, p. 327.

[24] See U.S. Congress. General Accounting Office. Health Insurance: Comparing Blue Cross/Blue Shield Plans with Commercial Insurers. July 11, 1986. [GAO-HRD-86-110]

[25] Under legislation passed in the 100th Congress, P.L. 100-517, HMOs will be permitted to use a form of "adjusted community rating" that may closely resemble experience rating.

ers were to join the group (total cost, $2,143,625, divided by the total number of employees).

TABLE 2.3.—Experience Rating Versus Community Rating—An Illustration Applied to Employer Group Health Plans

Employer	Number of employees	Cost per employee	Total cost
A	25	$750	$18,750
B	1,000	850	850,000
C	100	900	90,000
D	25	950	23,750
E	5	975	4,875
F	1,000	1,000	1,000,000
G	25	1,000	25,000
H	25	1,250	31,250
J	5	20,000	100,000
	2,210	970	2,143,625

An insurer who had a monopoly would have no problem charging the community rate of $970 to all nine employers. However, in a market environment, insurers competing for employer B's business will offer a rate much closer to B's actual experience, $850. B will then drop out of the community, raising the rate for the remaining employers to $1,069. Now employer F, whose real cost is $1,000 and who was saving money at the $970 rate, also finds it preferable to obtain an experience rate. With employer F gone, the rate for the remaining seven employers rises to $1,398. None of the remaining groups is large enough to be experience rated (although C might be), and nearly all are now being charged a rate higher than their actual costs. Many insurers would have established underwriting rules that would exclude employer J from the community. This exclusion allows the insurer to offer a more competitive rate to the remaining six plans.

A large employer is a self-contained community. If all 2,210 employees represented in table 2.3 worked for one employer instead of many, an insurance company would readily insure the entire group since the cost of the very expensive risks would be absorbed into the lower costs for the large number of average and low risks.

C. SELF-INSURED PLANS

Many large employers use one of several forms of self insurance, directly covering the costs of services used by employees and their dependents. In a fully self-funded plan, the employer may use an outside administrator or an insurance company to process claims, but the outside entity assumes no financial risk and is not paid on a premium basis. Some employers purchase "stop-loss" coverage, insurance against very high, unanticipated claims. Others may enter into a "minimum premium" arrangement with an insurer; this is essentially a combination of outside claims administration and stop-loss coverage.

While there are benefit design and tax reasons for selecting self insurance, there is little difference between the financing of a self-insured plan and the financing of a fully experience-rated plan

through an insurance company (except that the insurer's charges include some profit).

An employer with a self-insured plan estimates the expected cost of insurance using actuarial projection methods similar to those used by insurance company actuaries. This amount is usually budgeted through payments to a trust fund and reimbursement of health claims are made from the trust fund. If the claims and administrative expenses are greater than expected, the employer must pay the difference to the fund. If the claims and expenses are less than expected, the employer often uses the gain to offset the cost of future health care inflation.

In contrast, for a fully experience-rated insured plan the insurer estimates the cost of health claims and expenses, and bills the employer for that cost. If funds are deficient, the employer makes a payment for the difference through an increase in future premiums. A gain can either be paid to the employer or used to reduce future premiums. In either case, the premium is predetermined and budgeted. Any gain or loss is credited to the employer. Excess funds not needed for current claims and expenses are invested, and interest is credited to the employer.

D. CATEGORIES OF ADMINISTRATIVE EXPENSES[26]

Administrative expenses fall into the following general categories:

- claims administration;
- general administration;
- interest credit;
- risk and profit charge;
- commissions; and
- premium taxes.

Following is a description of these categories.

1. Claims Administration

Claims administration expenses are all those related to claims payment, including charges for claims processors, supervisors, and related computer and overhead expenses. As a percentage of claims, these charges decline as account size grows, due to economies of scale.

2. General Administration

General administration expenses include all expenses of operating the health insurance plan other than the expenses of paying the claims. Some of these expenses are about the same dollar amount for each plan, while others increase with the size of the group (though not necessarily proportionately). Per capita administrative expenses therefore decline as the size of the plan grows. General administrative expenses include:

- sales and marketing
- contract, and legal staff work;
- underwriting;

---

[26] For estimates of the amount of administrative expenses and their variation by firm size, see U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988. Chapter 2.

- employee communications materials (summary/plan descriptions/booklets);
- billing activities;
- accounting and data reports and analysis;
- research and advice concerning laws and regulations;
- plan design advice and plan revision implementation;
- problem resolution and general account servicing; and
- overhead (personnel, accounting, management, facilities, etc.).

3. Interest Credit

Conventionally insured plans hold reserves for claims that are incurred but not yet paid, to prevent extreme fluctuations in premiums, and for other purposes. The insurance carrier earns investment return on these reserves and, in turn, credits interest to the account. (Conversely, the insurer may charge interest for deferred premium payments.) The result is to lower the total retention amount.

As noted above, most large employers and many medium-sized employers operate under some form of self insurance. While the employer may use an insurance company to process claims, the insurer does not hold reserves and there is thus no interest credit. However, since the employer is able to invest the funds that would otherwise have been held by the insurer, the employer may receive a return at least as great as the interest credit would have been.

4. Risk and Profit Charge

Claim costs for a group are subject to some degree of unpredictable fluctuation. Over a long enough period, premiums would be expected to be at least equal to claims and other expenses. At any given time, however, a group may be in deficit: the pay-out in the current period (or cumulatively) has exceeded revenues. If the group terminates its contract while in a deficit position, the insurer has no opportunity to make up the deficit through future surpluses. Insurers have found that more accounts terminate in a deficit than a surplus; they therefore impose a "risk charge" on all accounts to make up for the net loss on some of those accounts. The risk charge is a higher percentage for smaller accounts than for larger accounts because smaller accounts experience greater claim fluctuation and are hence more likely to cancel in a deficit position.

The risk charge is also the source of the insurer's profit or surplus. (Stockholder insurers operate to make a profit, while mutual or nonprofit insurers operate to have a "surplus" or "reserve" to ensure the financial health of the organization.) Some people therefore speak of the "risk and profit charge," although this is not the terminology used by the industry.

5. Commissions

Almost all small insured plans, other than those sold by some Blue Cross/Blue Shield Plans, are purchased through, and serviced by, an insurance agent or broker. Agents and brokers are compensated by commissions. Due to economies of scale, commissions are a larger percentage of plan costs for smaller plans than for larger

plans. Commissions are generally higher for the first year of a policy than for renewals.

Most large employers and some medium-size employers do not use brokers. As a result, there is no commission charge in their plan's retention. But many such plans will receive ongoing assistance from a consulting firm that bills directly for its services (and that may be a broker for smaller accounts).

6. Premium Taxes

States assess a premium tax against insurers for group health coverage. This tax is then included in retention. In a majority of States, this tax is 2 percent of premiums. Many large plans do not use conventional funding and, as a result, pay little or no State premium taxes. Under a "minimum premium" approach, premium taxes approximate only 0.2 percent of claims, one-tenth that of conventional plans. A fully self-funded plan would pay no premium taxes at all. In addition, many States exempt Blue Cross/Blue Shield Plans from premium taxes. In some of these States the plans may be required to make some contribution to the costs of the State's insurance regulation activities.

7. Comparison of Retention for Various Funding Arrangements

Almost all plans under 200 employees are conventionally insured. Most plans over 1,000 employees are not conventionally insured. Medium-sized plans are heavily represented in both categories.

Table 2.4 shows how the elements of retention in alternate funding arrangements compare to the elements in conventional funding.

TABLE 2.4.—Relationship of Alternate Funding to Conventional Funding Retention Elements

	Funding approach		
	Conventional	Minimum premium	Self-funded
Typical plan size	Small and some medium	Some medium and many large	Few medium and many large
Claims administration	Included	Included	Included.
General administration	Included	Included	Included.
Interest credit	Included	None	None.
Risk & profit charge	Higher	Lower	Lowest.
Commissions	Included	Included	None.
Premium taxes	Higher	Minimal	None.
Total retention	Higher	Lower	Lowest.
Investment return	None	Yes	Yes.
Consulting fees	None	None	Yes.
Total cost	Higher	Lower	Lowest.

IV. ADVERSE AND FAVORABLE SELECTION

If everyone in the society purchased health insurance, and if everyone opted for an identical health insurance plan, then insurance companies could adhere strictly to the models of prediction and rate-setting described above. However, everyone does not buy insur-

ance, nor do all the purchasers of insurance choose identical benefits. People who expect to need health services are more likely than others to purchase insurance, and are also likely to seek coverage for the specific services they expect to need. That is, people are not coins being tossed, but independent economic actors.

Insurers use the term "adverse selection" to describe this phenomenon. Adverse selection is defined by the health insurance industry as the "tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than do persons with average or better health expectations." [27]

Over time, adverse selection itself would be expected to become predictable. If purchasers of health insurance were consistently sicker than non-purchasers, the level of increased risk could be assessed using historical data, and premium rates could be adjusted accordingly. However, market and other factors limit the insurer's ability to correct for expected losses resulting from adverse selection.

Adjusting premiums for adverse selection results in further adverse selection. As the price of insurance goes up, healthier people are less likely to want to purchase insurance. Each upward rate adjustment will leave a smaller and sicker group of potential purchasers. If there were only a single insurance company, it would serve a steadily shrinking market paying steadily increasing premiums. However, because multiple insurance companies are operating in the market, each company may strive to enroll the lower cost individuals or groups, leaving the higher cost cases for its competitors. In this market, adverse selection consists (from the insurer's point of view) of drawing the least desirable cases from *within the pool of insurance purchasers.* "Favorable" selection occurs if the insurer successfully enrolls lower risk clients than its competitors.

It is thus necessary to distinguish between the more traditional use of "adverse selection," as a term to describe the differences between people who do and do not buy insurance, and the sense in which the term is often used today, to describe the differences among purchasers choosing various insurers or types of coverage. This second type of adverse selection can occur within an insured group, if the individuals in that group are permitted to select from among different insurance options.

Insurers are still concerned about the more traditional type of adverse selection. They use underwriting rules, described in the next section, to exclude or limit the worst risks. Some insurers may also attempt to limit adverse selection by careful selection of where they market and to whom they sell a policy. For example, a company offering a Medicare supplement (Medigap) plan might be more likely to advertise its plan in senior citizen recreation centers, where the patrons tend to be relatively young and healthy, than in nursing homes, where the residents are probably older and have chronic health conditions. Thus, from the perspective of the individual or group applying for insurance, the insurer's attempts to avoid adverse selection may result in lack of availability of cover-

[27] Health Insurance Association of America, 1987. p. 83.

age, denial of coverage, incomplete coverage or above-average premiums.

Adverse selection within insured groups is a newer phenomenon, and insurers' techniques for controlling it are less highly evolved. The nature of the problem may be seen in the following example.

Employer A offers its employees a choice between a "low option," basic health benefit plan and a "high option" plan that provides more comprehensive coverage. Employer A pays the entire premium for workers choosing the low option plan. Those choosing the high option plan must pay the difference in cost between the two plans. Workers who expect to need expensive health services are willing to pay the difference in price and choose the high option plan. Those who do not expect to need services choose the free, low option plan. Over time, the total cost of the high option plan rises in relation to the cost of the low option plan. The selection effect continues in the cyclical manner described above. Healthier workers shift to the low option plan. The high option plan serves a steadily smaller group of enrollees, and the difference in cost between the two plans increases every year.

Factors other than benefits and price may affect the employees' decisions. Perhaps the most important of these is provider selection. Under conventional insurance plans, the enrollee chooses what hospitals, physicians, and other health care providers to use. The plan's benefits for any specific service are the same regardless of the enrollee's choice of provider. New arrangements, such as HMOs and PPOs, limit this choice.

An HMO will cover only services furnished by a limited group of providers who have entered into a contractual relationship with the HMO. The HMO will not pay for services furnished by a non-affiliated provider, except in a medical emergency or if the use of the outside provider has been approved in advance. The ability to control an enrollee's use of services allows the HMO to manage the enrollee's overall care and possibly achieve savings, some of which may be passed on to the enrollee in the form of reduced out-of-pocket costs or more comprehensive coverage.

A PPO also has contracts with a limited group of providers, but is less restrictive. The enrollee may use outside providers, but is given a financial incentive to use the PPO's affiliated providers. For example, the PPO might pay in full for services furnished by its contracting physicians, while paying only part of the bill for other physicians' services. The PPO does not control the use of services, but negotiates discounts from its affiliated providers' usual rates. Some of the resulting savings may also be passed on in the form of reduced costs to the enrollee.

Employers and outside observers have argued that, when workers are given a choice between a conventional insurance plan and an HMO, the older or less healthy employees choose the conventional plan, while the younger or healthier ones choose the HMO alternative. The contention is that the sicker enrollees have established ties to their own physicians or other providers and are unwilling to change to the HMO providers. Healthier enrollees will accept the provider limitations in exchange for lower costs. HMOs respond that the reverse is true, that sicker enrollees may be more likely to choose the HMO because it offers more comprehensive

benefits at lower cost than the conventional plan. While conclusive evidence is not available, most research supports the view that HMOs do experience some degree of favorable selection, enrolling individuals who use fewer health services than those enrolled in the conventional plans with which the HMOs are in competition.[28] (No evidence is yet available on PPOs.)

Whatever the basis for enrollees' choices, some degree of adverse/favorable selection can be expected to occur within groups when individuals are able to choose from among multiple health plan options. In order to understand why this is a matter for concern, it may be helpful to consider further the case of Employer A, which offers a high option and low option plan, with the high option plan more attractive to enrollees who use more services. In theory, this trend should make no difference to Employer A, since the employees choosing the high option plan are themselves paying the extra costs for this plan. In practice, however, some of these costs may eventually be passed on to the employer. This can happen in several ways.

First, Employer A may face pressure, through collective bargaining or because of a tight labor market, to increase its contribution to the high option plan. Second, if the two plans are offered by different insurers (as is the case when one of the plans is an independent HMO), the rates for the low option might not be reduced to reflect the fact that healthier employees have chosen it.[29] Third, even when both plans are offered by a single insurer, selection creates uncertainty. As was discussed earlier, when a large group is enrolled in a single insurance plan, the insurer may be able to assume that future costs will resemble those experienced in the past. When the same group is split into several smaller groups, with enrollees shifting from one to another unpredictably, the insurer may face some of the same underwriting or rating problems that characterize the small group market. The insurer's inability to fully predict the effects of adverse/favorable selection may result in losses, which will be passed on to the employer.

V. Underwriting

A. Introduction

Underwriting is the selection and rating of risks that are offered to an insurer. Selection is key because it implies that not all risks will be accepted and issued an insurance policy. The outcome of underwriting is risk classification and exclusion. While the general underwriting approach for insurers is similar, variations are found in the classifications of specific medical conditions.

Underwriting is best understood as it is applied to different populations seeking insurance. When writing coverage for individuals,

---

[28] For a review of the research, see Hellinger, Fred J. Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence. Health Care Financing Review. 9:2 (Winter 1987), p. 55–63. Hellinger notes that HMO enrollees are not necessarily in better health than those choosing conventional plans, but may have a lower "propensity to consume health services given a specific health state." p. 61.

[29] Under current regulations, employers are required to make the same premium contribution to a Federally qualified HMO that they make to a non-HMO plan. Thus, even if the total HMO premium is lower than that of the indemnity plan, the costs to the employer are identical. This "equal contribution" rule will be relaxed by P.L. 100-517, the 1988 HMO amendments.

the underwriter evaluates each individual risk, looking at state of health, medical history, occupation, habits and other insurance the person might have. In group insurance, there is usually no investigation of individual group members, although very small groups and late applicants are an exception. The cost of above-average risks in the group (also referred to as "substandard risks") is built into the rate automatically. The size of the group helps to balance poor risks with good ones. (See the above discussion of the law of large numbers.)

B. UNDERWRITING INDIVIDUAL POLICIES

Insurance companies look at a number of factors in evaluating an individual who has applied for coverage.[30] Normally, they will require either a health statement or, in rare cases, a medical exam. On the basis of this evaluation, the insurer will classify the individual as a standard risk, a substandard risk, or uninsurable. A person determined to be insurable on a standard basis will generally be able to purchase insurance without extra premiums or special limitations. A person determined to be insurable on a substandard basis will be charged a rated (higher) premium or receive an exclusion waiver in the policy. This waiver "may temporarily or permanently exclude a medical condition from coverage. The exclusion may be for a specific condition, such as gallstones, or for an entire organ system, such as reproductive disorders. Permanent waivers usually exclude from coverage chronic conditions that are moderately costly and without life-threatening implications. Temporary waivers generally involve acute conditions that are short-term in nature, such as fractures or some minor surgery." [31]

An insurer may deny coverage completely to people with serious preexisting health conditions, or who fall into other high risk categories such as "dangerous health habits (e.g., drug abuse), illegal or unethical behavior (e.g., criminal business practices), age, and occupation." [32] Other factors, such as financial status, the area in which the person lives, and sexual preference may also contribute to an insurer's decision to deny coverage.[33]

Table 2.5 (Risk Classification by Commercial Health Insurers) illustrates the Office of Technology Assessment's (OTA) findings from a recent survey of insurers regarding the common medical conditions requiring a higher premium, exclusion waiver, or denial. Table 2.6 shows the extent to which commercial insurers surveyed by OTA considered non-medical factors in their individual underwriting practices.

---

[30] For information on the variations among insurers in the use of sources of medical information (e.g., attending physician statements), see Office of Technology Assessment, 1988. p. 22-30.
[31] Ibid., p. 11.
[32] Ibid., p. 14.
[33] Ibid., p. 16.

TABLE 2.5.—Risk Classification by Commercial Health Insurers: Common Conditions Requiring a Higher Premium, Exclusion Waiver, or Denial

Higher premium	Exclusion waiver	Denial
Allergies	Cataract	AIDS
Asthma	Gallstones	Ulcerative colitis
Back strain	Fibroid tumor (uterus)	Cirrhosis of liver
Hypertension (controlled)	Hernia (hiatal/inguinal)	Diabetes mellitus
Arthritis	Migraine headaches	Leukemia
Gout	Pelvic inflammatory disease	Schizophrenia
Glaucoma	Chronic otitis media (recent)	Hypertension (uncontrolled)
Obesity	Spine/back disorders	Emphysema
Psychoneurosis (mild)	Hemorrhoids	Stroke
Kidney stones	Knee impairment	Obesity (severe)
Emphysema (mild-moderate)	Asthma	Angina (severe)
Alcoholism/drug use	Allergies	Coronary artery disease
Heart murmur	Varicose veins	Epilepsy
Peptic ulcer	Sinusitis, chronic or severe	Lupus
Colitis	Fractures	Alcoholism/drug abuse

Source: Office of Technology Assessment, 1988.

According to OTA, Blue Cross and Blue Shield Plans use similar criteria in underwriting individual policies. One difference is that some of the Blues (24 out of the 77 plans) provide for regular open enrollment, in which the plan will write coverage for all who apply. However, while the plans providing open enrollment do not classify applicants by risk in the way described above, they often provide fewer comprehensive benefits. They may also require open enrollment subscribers to pay higher premiums than other applicants for identical coverage. Like some other forms of coverage, open enrollment plans usually require waiting periods before initial benefits may be paid for preexisting conditions. Preexisting conditions may be excluded altogether.[34]

TABLE 2.6.—Individual Underwriting by Commercial Health Insurers—The Importance of Non-Medical Factors

Underwriting factor (n=61) [1]	Very important [2]		Important		Unimportant		Never used	
	Number	Percent [3]	Number	Percent	Number	Percent	Number	Percent
Age	23	38	29	48	6	10	3	5
Type of occupation	18	30	29	48	18	3	5	
Avocation (e.g., race car driving)	9	15	39	64	9	15	4	7
Financial status	10	16	26	43	20	33	5	8
Health endangering personal habits (e.g., drug abuse)	57	93	3	5	0	—	1	2
Health enhancing personal behavior (e.g., non-smoking)	6	10	34	56	9	15	12	20

[34] Ibid., p. 16.

TABLE 2.6.—Individual Underwriting by Commercial Health Insurers—The Importance of Non-Medical Factors—Continued

Underwriting factor (n=61) [1]	Very important [2]		Important		Unimportant		Never used	
	Number	Percent [3]	Number	Percent	Number	Percent	Number	Percent
Illegal or unethical behavior	44	72	13	21	2	3	2	3
Place of residence	3	5	13	21	21	34	24	39
Sexual orientation	1	2	4	7	13	21	43	70

[1] One company did not respond to this question.
[2] Definitions:
Very Important—Critical to underwriting process; can affect acceptance/rejection.
Important—Always considered but will never by itself affect acceptance/rejection. It may, however influence coverage limits (e.g., exclusions or waiting period) and/or premium.
Unimportant—Rarely affects acceptance/rejection, coverage limits, or premium—unless in conjunction with other more important factors.
Never used—Never considered.
[3] Row percentage may not total 100 due to rounding.

Source: Office of Technology Assessment, 1988.

The OTA survey found that, of 2.1 million applications in one year to commercial health insurance companies for individual health insurance, 20 percent (or over 412,500) of the applicants received a substandard risk classification that produced an above-average premium or a preexisting condition exclusion. (See table 2.7.) 1Of the 401,475 applications to the Blues for individual coverage, 9 percent (close to 40,000 applicants) received a substandard risk classification, leading to either a preexisting condition exclusion or above-average premiums. Another 8 percent (about 33,000 applicants) were denied coverage.[35] (See table 2.8.)

TABLE 2.7.—Commercial Health Insurers: Estimate of Industry-Wide Risk Classification of Individual Applicants

Risk classification	Total number of applicants per year (n=33)[1]	Percent of total [2]
Standard	1,525,472	73
Substandard	412,505	20
Exclusion waiver	(270,373)	(13)
Rated premium	(108,293)	(5)
Waivered and rated up	(33,839)	(2)
Denied	164,317	8
Total applications	2,102,294	100

[1] Data were not provided by 8 of 61 insurers.
[2] The percentages in column 2 were derived by dividing column 1 by the total number of applications. Percentages may not total to 100 due to rounding.

Source: Office of Technology Assessment, 1988, p. 14.

[35] Ibid., p. 11-19.

TABLE 2.8.—Blue Cross/Blue Shield Plans: Estimate of Industry-Wide Risk Classification of Individual Applicants

Risk classification	Total number of applicants per year [1] (n=53)	Percent of total
Standard	331,560	83
Substandard	36,949	9
Exclusion waiver	(23,660)	(6)
Rated premium	(13,289)	(3)
Denied [2]	32,966	8
Total applications	401,475	100

[1] Data were not provided by one continuous open enrollment plan.
[2] Denials occur only at non-open enrollment plans; on average, these plans reject 19 percent of their applicants.

Source: Office of Technology Assessment, p. 19.

Federally qualified HMOs are "restricted to either accepting non-Medicare [individual] applicants at a community rate or denying membership altogether. Exclusions, rated premiums and waiting periods are prohibited. Some States have similar requirements. However, HMO underwriting does reflect traditional practice with respect to medically underwritten conditions." [36] Of 57,869 individual applications, 73 percent were enrolled on a standard basis. Only two HMOs (13 percent) reported enrolling individuals on a substandard basis. There were twelve responding HMOs that refused membership to approximately 13,653 applicants (24 percent of their self-pay applicants). (See Table 2.9.) [37]

TABLE 2.9.—Health Maintenance Organizations: Estimate of Industry-Wide Risk Classification of Individual Applicants

Risk classification	Total number of applicants per year (n=53) [1]	Percent of total [2]
Standard	42,401	73
Substandard	1,815	3
Ridered	(1,815)	(3)
Denied	13,653	24
Total applications	57,869	100

[1] Data were not provided by three HMOs.
[2] The percentages in Column 2 were derived by dividing column 1 by 57,869.
[3] Percentages do not total to 100 due to rounding.

Source: Office of Technology Assessment, p.22.

C. UNDERWRITING GROUP POLICIES

Insurers also examine groups to determine whether they present acceptable risks. Acceptability depends on such factors as: the permanency of the firm; the reasonableness of the benefit package (there should be controls on utilization and costs, such as coinsurance and deductibles); adequacy of enrollment (for example, insurers prefer that a substantial majority of employees elect coverage

[36] Ibid., p. 19.
[37] Ibid., p. 19–22.

and that a steady flow of new hires keeps the average age of insureds down); centralized administration facilities; substantial employer contributions; automatic collection of employee contributions; no (or very limited possibility of) adverse selection; and satisfactory credit.[38]

Some groups present questionable risks to insurers and are covered only if the group pays an additional premium. For example, some groups experience seasonal employment. In such groups, medical care utilization often peaks just before layoff, or dependents seek medical care just after the employee goes back to work. Seasonality is characteristic of such industries as restaurants, hotels, laundries, contractors, canneries and vacation resorts. Also certain industries and occupations are denied coverage because of the special risks they present. These include industries in which there is a high risk of occupational illness or accidents, such as mining, logging, oil exploration, bridge construction and explosives manufacturing. Finally, some companies (such as small restaurants) pose credit risks because they are in a line of business with a high failure rate.

Table 2.10 illustrates the classification of industries into those considered ineligible for insurance or eligible only with restrictions.[39] As evident from this illustration, insurers vary in respect to the industries they exclude.

> . . . The existence and use of somewhat disparate 'ineligible' industry lists indicates that there is no fully agreed-upon, scientific base of actuarial data concerning which industries are in fact risky. . . . On the whole, this lack of consensus works in favor of employers seeking insurance, because groups denied coverage from one insurer can usually get it from another. On the other hand, industry exclusion practices can lengthen an employer's search process, limit the number of insurer options available to any particular employer, or raise premium costs. At some point, raising premium costs for a group is tantamount to denying true group coverage, because the premiums are at rates more commonly found in individual policies.[40]

---

[38] Health Insurance Association of America. A Course in Group Life and Health Insurance. 1985. p. 155–157.

[39] American Hospital Association, 1988. p. 28–29.

[40] Ibid., p. 27.

TABLE 2.10.—Industries Ineligible for Health Insurance Coverage Under Three Selected Insurer Plans

Insurer A

Industry eligibility

Some activities create special hazards which cannot be included in the underwriting of group insurance, particularly under Master Trust programs.

Also, it is often not practical to give in-depth consideration to a particular prospect because our major function is to extend our service to as many employees as possible. Therefore, the following industries are ineligible.

Ineligible industries	Industries with special consideration
Any group with known uninsurable risks	Auto Dealers—New [2]
Auto dealers—Used	Auto Repair Shops [1 2]
Aviation Personnel	Barber Shops and Beauty Parlors [1 2]
Bars or Taverns	Church-Related Groups [5]
Car Washes and Parking Lots	Hotels, Motels, Lodges [1 2 3 4]
Commercial Fishing	Landscaping [1 2 4]
Construction Workers (using heavy equipment, or at heights)	Light Construction [2 4]
Divers	Local Transit (taxis, buses) [1 2]
Drilling, Oil and Gas Wells (or repair or maintenance)	Local Trucking [2]
Entertainment, Amusement or Athletic Groups	Real Estate Agencies [1 2]
Explosives	Restaurants [1 2 3]
Exterminators	
Gas Stations	
Hospitals and Nursing Homes	
Junk Dealers, Salvage Yards, and Refuse Collection	
Leather Tanning	
Longshoremen	
Logging	
Mining or Extraction (minerals or fuel)	
Moving Companies	
Personal Services (e.g., domestic help)	
Public Employee Groups	
Security Guards	
Trucking Firms (long distance-overnight)	
Window Washing	

Insurer B

Certain types of groups present hazards which cannot be accepted within the Trust underwriting guidelines. A partial listing of such groups would include the following:

Aviation	Taxi Operations
Amusement Parks	Farming & Ranching
Auto Dealers and Service Stations	Parking Lots
Bars & Restaurants	Non-profit Organizations
Beauty Salons and Barber Shops	Mobile Home Sales, R.V. Dealers
Car Wash Operations	Marine Enterprises
Hospitals	Religious Groups
Manufacturing of Dangerous Products	Nursing and Rest Homes
Convenience Stores	Motels
Political Subdivisions	Unions, Fraternals
Entertainment	Liquor Stores
Logging or Mining Operations	Scrap Collectors/Dealers

Insurer C

Ineligible Industries

	Medical-Life
Construction Companies (involved in building 4 or more stories)	R
Country Clubs, Health/Sport Clubs, Athletes	X
Entertainment Groups, Artists, Authors	X
Explosives Companies—Manufacturing or Transport	X
Exterminators	X
Foundries	X
Gambling—Related Businesses	X
Garages	X
Garbage/Trash Collection Companies	X
Gas Stations	X
Government Agencies (with long-range financing)	X
Grocery Store	X
Hospitals, Clinics, Nursing Homes and Health Care Facilities	[6] X
Hotels and Motels	X
Insurance Agencies	X
Janitorial Services	X
Junk Dealers and Scrap Dealers	X
Liquor Stores and Dealers	R
Logging and Lumbering Operations	X
Massage Parlors	X
Medical Practitioners	[6] X
Mining, Quarry and Drilling Operations	X
Motion Picture Theaters	X
Moving Companies	X
Municipalities, Political Subdivisions	X
Parking Lots	X
Pawn Shops/Collection Agencies	X
Petroleum Producers (drilling operations	X
Pilots and Flight Personnel	X
Property Management/Development Companies	R
Real Estate Sales Offices	X
Restaurants, Drive-Ins and Catering Services	R
Salesmen working on a commission basis only	X
Schools and School Districts	X
Security Guards/Watchmen Services, Detectives	X
Social, Vocational Counseling Services	R
Truckers—Long Haul only	X
Vending Machine Companies	X
Firms which have more than 50% of its employees related by blood or marriage	R
Firms with no employer/employee relationship	X

[1] Mandatory 3-month waiting period.
[2] No disability income.
[3] Management only.
[4] Only if clearly a year-round operation.
[5] Only those engaged in full-time employment, such as a church-affiliated school.
[6] Eligible for life only benefits.
X=Not eligible for benefit plan.
R=Eligible on restricted bases, need home office approval.

Source: American Hospital Association, 1988, pp. 28-29.
The lists come from insurer training manuals, 1986-1987.

1. Underwriting Small Groups

In underwriting very small groups (usually defined as less than ten "lives"), the insurer may use special underwriting rules. One approach involves the use of ratings for the *individuals* in the group. The insurer will often require nonmedical questionnaires from employers and, in some instances, attending physician statements or medical examinations. This information is used to assign numerical ratings to each employee. When added together, if the

ratings of the group's members average below the cutoff for acceptability, the group is accepted for insurance. Employees with higher ratings may be excluded if those remaining do not have ratings that are favorable enough to permit the group averaged together to meet the acceptability index. Dependents usually are accepted without evidence of insurability if the employee is accepted. Insurers may also limit their loss exposure by limiting the benefits in the insurance package to standard rather than more comprehensive plans, and by applying pre-existing condition limitations or exclusions that restrict coverage for some period (typically one year) for a condition treated immediately before the effective date of the insurance coverage.[41]

For these very small groups, participation requirements usually are very high, ranging from 85 to 100 percent of employees. The insurer may require the employer to pay the full premium to ensure full participation. Businesses with poor persistency (that is, low rates of policy renewal), accident hazards and other high-risk features will often be denied coverage by the insurer.[42] Insurers may offer coverage to the small group but only on a "non-guarantee issue" basis, meaning that the insurer makes no guarantee that it will offer the same policy to the group when the contract expires.[43] Also, insurers that sell coverage in the small group market may use "durational rating," in which a newly insured group will be given a cheaper rate than renewals (unless the groups to be renewed provide new evidence of insurability). For this and other reasons, small groups that are considered good risks will often move around from insurer to insurer, which means that renewals are concentrated among what the insurers consider to be poorer risks. In the words of one insurer:

> We have chosen to durationally rate the business. That is, as business ages, rates increase over the new business rates. At a select point in time, though, we give the groups an opportunity to reenter. If the group provides us with new evidence of insurability, it reverts to the new business rate. This forces a selection between bad business and good business. We keep the healthy groups that otherwise would leave and we isolate and concentrate our resources on watching the bad business. Bad business is isolated from the rest of the business, so we can take renewal action on it as needed.[44]

In a report on catastrophic illness, the Department of Health and Human Services found that the availability of insurance for smaller employers may be declining as a result of insurers' using "aggressive" underwriting policies to sell relatively inexpensive coverage to some groups and more costly coverage to the rest:

---

[41] Health Insurance Association of America. A Course in Group Life and Health Insurance. 1985. p. 160.

[42] According to the health insurance industry, the lapse rate for policies is highest during or at the end of the first year. Since first-year expenses are greater than those in later years, a low persistency rate can be costly. See Health Insurance Association of America, 1983. p. 118-119.

[43] Society of Actuaries. Record. Medical Coverage for Groups of Two to Fourteen. Panel at the San Francisco Meeting. Apr. 1-2, 1985. vol. 11. no. 1. p. 33-51.

[44] Ibid., p. 41. This is a quotation from one of the panelists, Mr. Bolnick.

This process 'skims' small employers with healthy workforces out of the general market, leaving employers with less healthy workforces to maintain the coverage they have or to enroll in Blue Cross/Blue Shield. Local Blue Cross/Blue Shield Plans, in part because of tax advantages they enjoy as non-profit companies, turn down applicants substantially less frequently than do commercial insurers. The result is to reduce the number of healthy enrollees over whom the risk of insurance is spread. Because renewal premiums are consequently likely to rise rapidly (the healthy groups leave, and the insurance experience of the remainder becomes increasingly worse as a result), employers with employee groups found by potential insurers to represent excess risk will find coverage progressively hard to secure and afford.[45]

2. Small Employer Pools and METs

It is often suggested that a feasible way for small employers to reduce their health insurance premiums is through small group pools, such as multiple employer trusts (METs).[46] However, some small employers find that they cannot purchase coverage under these arrangements, even when they are willing to pay high premiums. If the pool is open to all applicants, enrollment by high-risk employers drives up premiums for the pool as a whole. This creates a spiral of adverse selection whereby the better risks leave the pool to seek less expensive coverage, leaving the higher risks in the pool. In cases where the pool works actively to avoid adverse selection, many employers are unable to obtain coverage.

For example, in Oregon, Healthchoice (a nonprofit organization that specializes in projects designed to increase health insurance coverage of workers employed in small businesses) ran a pilot project in which it attempted to market prepaid health plan options exclusively to small firms. To minimize the possibility of adverse selection, standard health insurance techniques were adopted: (1) minimum participation requirements (for firms with less than 10 workers, 100 percent participation was required unless a worker was covered under another policy, while firms with more than 10 workers had to meet a 75 percent participation requirement); (2) certain categories of businesses were excluded; (3) the firm had to have been in business for at least one year; and (4) all employees and their dependents were subject to medical screening.[47] Healthchoice discovered that the medical screening requirement discouraged some firms from participating in the program, once they were informed that an employee would be excluded because of a preexisting medical condition.[48] Low employer enroll-

[45] Department of Health and Human Services. Office of Health Policy. Assistant Secretary for Planning and Evaluation. Insuring Catastrophic Illness for the General Population. [Washington] 1987. pp. 1-18, 1-19.

[46] For a basic definition and description of METs, see U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured. 1988. Chapter 3. The treatment of METs by State and Federal regulation is treated in this report in chapter 7.

[47] Alpha Center. Health Care for the Uninsured Program. Quarterly Report. Washington. July 1987. p. 2.

[48] Ibid.

ment forced Healthchoice to lower premiums and change the marketing strategy. Even with these changes, however, enrollment was insufficient to make the plan financially solvent.[49] Among the lessons learned from this project was that while medical underwriting helps to keep premiums affordable, it excludes a vulnerable population from obtaining insurance coverage.

The experience with METs has been similar. To keep rates low enough to attract enrollees, a MET has to screen for bad risks, exclude them, or charge them higher premiums. As a result of the screening or underwriting process, many businesses are automatically rejected because of the nature of the firm, its credit risk, or because they are believed unlikely to participate for long. The good-risk firm usually can find less expensive insurance in the existing market.

Information on the underwriting practices of METs can be drawn from the experience of the Council of Smaller Employers (COSE) in Ohio, and the various METs being organized by the Robert Wood Johnson Foundation. COSE keeps premiums down by imposing medical underwriting for companies with fewer than 10 employees (they report rejecting less than 5 percent of companies that apply). It also uses age rating and substandard rating to "apportion costs more fairly through our entire group. . . ." [50] These practices reportedly have raised rates "dramatically" for employers with elderly workers or above-average utilizers.[51]

Robert Wood Johnson (RWJ) projects have been funded in a number of areas to assist in the development of METs to sell insurance to small employers. To attract employers, these METs have to reduce the price of insurance far below market levels. To accomplish such reductions, a variety of approaches are being tried, including PPO-like arrangements with providers in which the designated hospitals and physicians accept reduced payments. However, the RWJ METs also limit which employers can enroll in the plan. For example, in Memphis, eligibility in the MET (Medtrust) is restricted to companies that have not offered coverage in the last three months. In companies with 10 or fewer employees, 100 percent participation is required. For larger firms, 80 percent of eligible employees must enroll. For companies with 20 or more employees, individual health information is not requested. For smaller firms, employees have to answer a medical questionnaire, which is then followed by a progression of evaluations.

> If no individual is identified as being at-risk . . . the entire group will be enrolled. In those circumstances where one or more individuals are identified as being at-risk, additional assessments will be conducted. First, individuals considered at-risk will be evaluated within the context of the entire enrollment of that firm. If the perceived risk is offset by the better health status of the remaining workers, the entire group will be enrolled. If the Medtrust

[49] Ibid., p. 3.

[50] Testimony of John J. Polk, executive director, Council of Smaller Enterprises, in U.S. Senate Committee on Small Business, Hearing to examine the cost and availability of health care benefits for small businesses and proposals for federally mandated health benefits, 100th Congress, 1st session, April 23, 1987. p. 154.

[51] Ibid.

assessment concludes that the entire group still constitutes too high of a risk, another evaluative step will occur. This assessment will combine the high risk group with MedTrust's entire enrollment. If there are an adequate number of enrollees from firms with low risks to offset the at-risk group, the latter group will be enrolled. If there is not a sufficient offset to create an overall acceptable risk, enrollment will be delayed. The group will be enrolled from a waiting list when an adequate number of additional low risk groups join MedTrust.[52]

These examples suggest that as long as enrollment is voluntary, METs are not going to be very effective in expanding availability of affordable coverage. They help to reduce some of the administrative costs of covering small groups, but as long as they operate in the same way as insurance companies do to minimize risk, they are unlikely to significantly reduce the number of uninsured linked to small employers.[53]

[52] The Alpha Center. Health Care for the Uninsured Update. July 1988. p. 2.

[53] See chapter 7, in which ways to improve the effectiveness of small employer pools are described.

CHAPTER 3.—NATIONAL HEALTH INSURANCE

I. Introduction

In the 1970s, substantial legislative activity at the Federal level was directed at the creation of a national health insurance program. While the legislation took a variety of forms, the general thrust of the proposals was to make basic health insurance available to all Americans, so that access to health care would not be contingent upon a person's ability to pay. Although the specifics of the proposals varied, they shared a common goal of establishing universal entitlement to insurance for Americans of all ages.

In today's political and budgetary environment, such comprehensive proposals are receiving less attention. The emphasis is on encouraging or mandating more extensive access to private employer coverage, expanding the Medicaid program, and creating Federal or State pools to provide health insurance to specific populations such as the medically uninsurable. Consequently, expanded access to insurance coverage may result from a series of political decisions in which responsibility for financing coverage is spread among health care consumers, employers and the public sector. Under such a piecemeal or incremental strategy, it is possible to envision a point at which most Americans will be able to obtain access to health insurance at a price they can afford, although the scope, quality and cost of that coverage and the program(s) through which it is obtained may vary significantly. The U.S. could, in effect, achieve national health insurance by an aggregation of public and private sources of coverage at both the State and Federal levels. This uniquely American approach has been described as "slouching toward national health insurance." [54]

In the absence of significant change in the economic and political climate, this incremental approach to coverage seems likely to continue. It is also apparent that many lawmakers believe that access to coverage can be expanded in this country only in a step-by-step fashion. Thus, increasingly the incremental strategy is being explicitly articulated in government as well as academic circles. It is also reflected in a variety of congressional proposals that provide for Federal program changes and new initiatives that stop short of comprehensive system reform.

For example, a new study by Anderson, Lave, Russe and Neuman [55] proposes a five-part plan that could be implemented gradually, and that would draw on State and Federal authority, to increase access to health insurance:

---

[54] Morone, James, and Andrew Dunham. Slouching Toward National Health Insurance: The New Health Care Politics. Yale Journal of Regulation, 2:2. 1985.

[55] Anderson, Gerard, Judith Lave, Catherine Russe and Patricia Neuman. No Free Lunch. Baltimore, MD, Johns Hopkins University Press, forthcoming.

- treat all employer contributions for health insurance as taxable income;
- offer all families a uniform refundable tax credit adjusted for family size;
- offer government subsidies to poor and near-poor persons for the purchase of health insurance;
- require all States to make health insurance available to all persons, including the uninsurable (States would retain their flexibility to design and finance individual programs, but the Federal Government would define the minimum level of benefits and maximum copayments); and
- eliminate the existing adjustments under Medicare and Medicaid for hospitals serving a disproportionate share of low-income patients. (Eventually all subsidies to public hospitals could be eliminated.) [56]

Numerous examples of this strategy exist in pending legislation, although it is a question of definition as to whether these proposals are most appropriately characterized as "national health insurance through aggregation" or a "mixed public/private scheme which results in national health insurance." If the criterion for the former is one of providing gap-fillers rather than universal coverage, then most of the current bills would fall under this category. They would include recent initiatives such as: (a) those to increase coverage under the Medicaid program by severing the connection between Medicaid and welfare eligibility (S. 1139 in the 100th Congress); (b) the Access to Health Care proposals of the 99th Congress (S. 2402, S. 2403, and H.R. 4742), which would have provided for increased coverage through requirements on employers to provide continued benefits to laid-off workers and their dependents, and on the States to create programs to finance indigent care; and (c) the various employer mandate bills introduced in the 100th Congress (S. 1265/H.R. 2508, H.R. 4951), which would fill the major gaps in coverage of the working uninsured but leave the remaining uninsured population uncovered.

While approaches of this nature are more politically feasible than the national health insurance proposals of the 1970s, they may not help to reduce the administrative waste, cost shifting and inflationary features that many people believe characterize the current patchwork system.[57] For example, under a piecemeal approach, there is likely to be duplication of administrative agencies and the accompanying red tape associated with operating programs. Also probable is duplication of effort in the areas of quality assurance, such as licensure, certification and peer review. At the same time, there are likely to be vast variations in such administrative functions as eligibility determinations, billing, and reporting of information. These factors not only add to the cost of cover-

[56] At full implementation of the tax credit and subsidy, Anderson et al. estimate that the maximum expenditures for these proposals would be $28 billion in FY 1989. Much would depend on the generosity of the subsidy, a component of this plan that would be subject to political negotiation. Some of this expenditure would eventually be offset by savings from reducing subsidies for uncompensated care.

[57] For an analysis of the administrative costs of the existing system, see Himmelstein, David, and Steffie Woolhandler. Cost Without Benefit. Administrative Waste in U.S. Health Care. New England Journal of Medicine, vol. 314, no. 7, Feb. 13, 1986.

age but also to difficulties and confusion for providers and consumers who must navigate through the maze of different eligibility criteria, benefit packages, and reimbursement rules. Also made more complicated is the task of coordination of benefits among the various sources of coverage. The more complex the design for providing coverage, be it multiple layers of government, mixed sources of financing, and/or the lack of uniform eligibility standards, the higher the likely costs for administration.

Coupled with administrative waste is the more general problem of rising health care costs. In the absence of a centralized budget and coordinated cost controls that typify comprehensive approaches to reform, inflation in health care prices may continue to be a significant problem. The U.S. cost containment experience so far suggests that efforts to constrain expenditures by applying restraints on one part of the health care system tend to lead to ballooning costs in other parts.

On the other hand, the piecemeal or incrementalist approach may be the most appropriate for the U.S. Given the size and complexity of our current system of financing and delivering health services, small steps with room for adjustment may make more sense than sweeping system-wide reforms. After all, the national health insurance systems in Europe and Great Britain did not spring forth overnight but instead evolved over many years. In Great Britain, for example, the National Health Service was created in 1948, but it followed on the heels of a medical insurance program begun in 1911 for much of the nation's workforce.

There are other possible arguments for an incremental and pluralistic approach. A system that builds upon private insurance preserves freedom of choice for consumers and autonomy for providers. Pluralism can also encourage innovation, encouraging program improvements and new solutions that might not be found in a centralized, more static system.

Nevertheless, it is possible that lawmakers may decide that universal coverage is most effectively and efficiently achieved through a comprehensive approach. Such an approach could take at least one of three basic forms: social insurance, the creation of a national health service, or a public-private mix. The following pages provide illustrations of each of these approaches.

II. Models of National Health Insurance

A. SOCIAL INSURANCE MODEL

This model is characterized by compulsory universal coverage, generally within the framework of Social Security, and financed by employer and individual contributions to nonprofit insurance funds. Typically, these proposals provide for a mixture of public and private ownership of the factors of production such as hospitals, physicians and ancillary services.[58] They therefore differ from national health service models, in which the direct delivery of care becomes a function of government.

---

[58] Schieber, George J. Financing and Delivering Health Care. Social Policy Studies No. 4, OECD, 1987. p. 24.

Many of the prominent national health insurance proposals of the 1970s were of this nature. For example, the Health Security Act, introduced by Senator Edward Kennedy and Representative James Corman in the 94th Congress (S. 3, H.R. 21) would have established a universal national health insurance program financed by a Federal payroll tax on employers and employees, a tax on unearned income, and Federal general revenues. Providers would have had to meet specified standards of participation (e.g., to accept Federal payment as payment-in-full and not charge patients for covered services). Hospitals would have been paid on a reasonable cost basis from a predetermined budget. Physicians, dentists and other professionals would have been paid on a fee-for-service, capitation, or salary basis. The bill included provisions designed to reorganize the delivery of health services, improve health planning, and increase the supply of health care personnel and facilities.[59]

A more recent example of a social insurance proposal is the U.S. Health Program Act, introduced by Representative Edward Roybal (H.R. 200 in the 100th Congress). The bill would replace Medicare and Medicaid with a comprehensive national health insurance program covering all U.S. citizens and legal aliens. Everyone would have access to a basic health benefits package (similar to the Medicaid "categorically needy" package), and would be protected from the cost of catastrophic illness, once beneficiaries paid up to $500 per year (indexed for future years) for health care, skilled nursing home and home health costs, and $1,000 (indexed) for nonskilled, long-term care costs. The bill would provide for subsidization of the cost of coverage for low-income beneficiaries. The program would be financed by a tax on employers, beneficiary cost sharing, an increase in the excise tax on cigarettes, State revenues, and a surcharge on corporate and personal income taxes. The program would be administered by an independent agency in the executive branch.

B. NATIONAL HEALTH SERVICE MODEL

Far less common are proposals that are modelled after Britain's National Health Service. These are characterized by universal coverage, Federal financing derived from progressive taxes, and national ownership and/or control of the factors of production.[60]

An example of this approach is legislation sponsored by Representative Ronald Dellums that was first introduced in 1977 and has been introduced in each successive Congress. In the 100th Congress, the U.S. Health Service Act (H.R. 2402) would establish a Health Service that would provide free medical, dental, and mental health care and additional supplemental services to all individuals while within the U.S. and its territories. The program would be administered by a four-tiered system of national, regional, district and community health boards, all comprised of two-thirds health care users and one-third health care workers. It would be financed by a special health service tax on individuals and employers and by general

[59] Waldman, Saul. National Health Insurance Proposals. Provisions of Bills Introduced in the 94th Congress as of February 1976. Department of Health, Education and Welfare, Social Security Administration, HEW Publication No. (SSA) 76-11920.

[60] Ibid.

Federal revenues. H.R. 2402 also provides that, in health facilities established by the Service, health services would be provided by salaried health workers.[61]

C. MIXED PUBLIC/PRIVATE MODEL

Similar to the incrementalist approach described above, mixed public/ private proposals rely largely on employer-based or individual purchase of private health insurance coverage financed by employer and individual contributions. Ownership of the factors of production remains unchanged from the current system.

Many proposals illustrate this approach. For example, the Nixon-Ford Catastrophic Health Insurance Plan (93rd Congress, H.R. 12684) provided for a three-pronged strategy to achieve full coverage of the population: (1) mandated employer-provided insurance, (2) a federally-assisted plan for the low-income and high medical risk populations, and (3) an improved Medicare program for the aged. In the same Congress, Senator Paul Fannin introduced the National Health Standards Act (S. 3353). Endorsed by the U.S. Chamber of Commerce, this bill would have established a two-part program to require all employers to make available a comprehensive health care package to their employees, and to provide comparable protection for low-income persons as a replacement for the Medicaid program. Under the provision mandating employer provided coverage, the bill specified a minimum benefit package and provided for "benefit value equivalency." The legislation also provided for the establishment of insurance pools to provide coverage for the self-employed and small employers. A second pool, in each State, was to pay all or part of the cost of the premiums for the poor and near poor from general revenues.

The Carter Administration's National Health Plan (introduced by Senator Abraham Ribicoff in 1979 as S. 1812) had two major components to achieve coverage: a public plan (known as "Healthcare") providing coverage to the aged, disabled, the poor, and the near poor, and offering catastrophic coverage to those individuals and firms unable to obtain such insurance in the private sector; and a program requiring employers to provide to their full-time employees, their spouses, and dependents health benefits meeting uniform Federal standards.[62] Employers would have been able to satisfy the mandate to provide coverage by buying Healthcare coverage for employees and their families. The States would have continued to help finance care for the low- income population by contributing to the Healthcare Trust Fund.[63] This Fund would also have subsidized employers whose premium payments attributable to the mandated minimum benefit coverage exceeded 5 percent of the employer's payroll. The subsidy would have been set at the difference between those payments and 5 percent of payroll.

---

[61] For a discussion of the genesis of this proposal, see Rodberg, Leonard S. Anatomy of A National Health Program, Reconsidering the Dellums Bill After 10 Years. Health/PAC Bulletin, Winter 1987. pp. 12–16.

[62] Feder, Judith, John Holahan and Theodore Marmor, eds. National Health Insurance: Conflicting Goals and Policy Choices. Washington, The Urban Institute, 1980. Appendix.

[63] For a short critical analysis of the Carter proposal, see Enthoven, Alain C. Health Plan, The Only Practical Solution to the Cost of Medical Care. Reading, Mass., Addison-Wesley, 1980. p. 168–170.

S. 1812 would also have imposed requirements on insurers. Qualified non-employer plans would have been required to set premiums for groups of 10 to 50 individuals on a community-rated basis. In addition, a Health Reinsurance Fund would have been established in the Department of the Treasury. The Secretary would have been required to make reinsurance available to certified administrators of qualified plans and to HMOs, to cover 80 percent of expenses attributable to any individual that exceeded $25,000 annually (for a prescribed basic benefit package) and to cover other specified needs.

A more recent proposal is the Comprehensive Health Care Improvement Act of 1987 introduced by Representative Martin Sabo (H.R. 3766 in the 100th Congress). The bill would require all employers to offer coverage to their employees who work at least 17.5 hours per week, and to eligible employees' dependents. States are required to establish statewide pools of all health insurance companies that would in turn provide coverage to persons without employer-based coverage. These pools would be required to provide reinsurance for all insurers, self-insurers, HMOs, and other such entities. Businesses could also buy or offer insurance from the State pools. Through a new title to the Social Security Act, H.R. 3766 would also establish an optional Federal-State program to help low-income people buy health insurance. The bill would leave the design of the program to the State, but the Federal Government would contribute half of the funds needed to fund the program up to a specified maximum. The legislation would also create an optional State-Federal catastrophic health insurance program.

More incremental solutions to the problem of the uninsured are analyzed in the following chapters. In the next chapter, options to increase coverage through public programs such as Medicare and Medicaid are discussed.

CHAPTER 4.—PUBLIC PROGRAMS

The most direct way that government can increase the number of persons with health insurance is to provide coverage through the existing Federal and State insurance programs, chiefly Medicare and Medicaid. Proposals to expand these public insurance programs are of two basic types. First, persons not presently eligible to participate could be given coverage as an entitlement. Second, persons not entitled to coverage could be allowed to "buy in" to one or the other of the programs. The discussion in this chapter is confined to options for expanding eligibility for Medicare or Medicaid as an entitlement. (The buy-in options, under which the Federal or State government sells insurance to individuals or groups, are discussed in chapter 7.) The chapter concludes with a brief discussion of another possible use of direct public funding to expand coverage: grant programs for employers. Chart 4.1 shows the options to be considered.

Any proposal for expansion of entitlement under the public insurance programs faces one obvious barrier: the expansion must somehow be paid for from public funds.

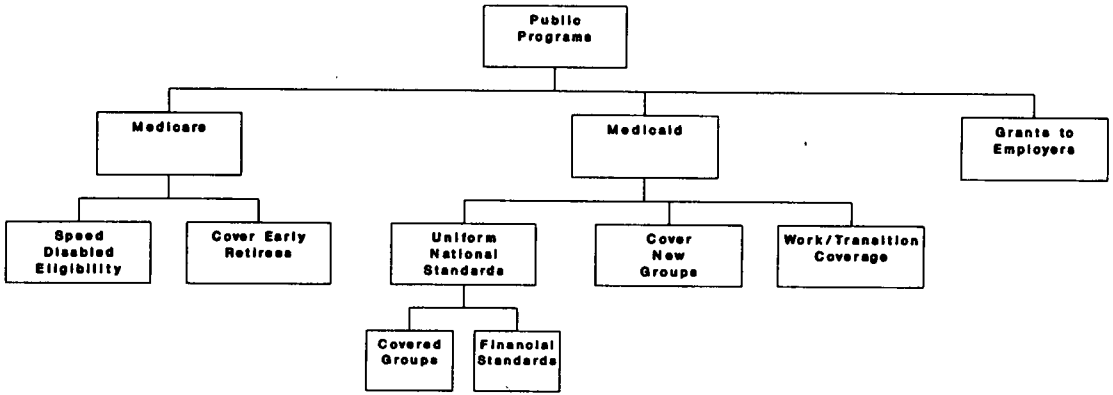
Medicare changes could be funded by the beneficiaries themselves, as is the case with the new catastrophic coverage provisions (P.L. 100-360), or by future beneficiaries, through a percentage increase in the Medicare payroll tax or the elimination of the current cap on earnings subject to the tax ($45,000 in 1988). The imposition of any further costs on beneficiaries would probably face heavy resistance, particularly if the revenues were used to extend Medicare to new populations instead of benefiting current enrollees. While it is possible that Congress will consider changes in the Medicare payroll tax, there are already other potential claimants for this revenue source. Some people would use any new revenues to fund another type of program expansion not addressed in this report: to increase the scope of covered services to include long-term care for persons currently eligible for Medicare.

In addition to State general revenues, States have adopted a variety of approaches to fund their share of the costs of Medicaid expansions, including dedicated revenue sources such as taxes on hospital charges, "sin" taxes on alcohol and tobacco, and lotteries. The ability of States to finance further expansions will be considered later in this chapter. The Federal matching funds, however, have come from Federal general revenues. Despite the pressures of the Federal deficit, Congress has approved funds for modest increases in the Medicaid program in recent years. However, the new populations added to the program have been relatively small and narrowly defined. Further expansion to reach larger numbers of the uninsured could involve major Federal spending increases.

90-441 0 - 88 - 3

Chart 4.1

Public Programs



Section II

Section III

Section IV

I. MEDICARE

A. EXISTING RULES

Medicare is made up of two programs, hospital insurance (Part A) and supplemental medical insurance (Part B). Part A covers inpatient hospital and skilled nursing facility care, hospice services, and home health care. Part B includes physician, hospital outpatient, and a variety of ancillary services. Beginning in 1990, Part B will also include the new catastrophic prescription drug benefit created by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

Coverage under Part A is available to persons in the following five basic groups:

- Any person who is 65 years old or over and who is eligible for Social Security or Railroad Retirement benefits.[64]
- Any person 65 years old or over who is a citizen or who has been a legal resident in the United States for 5 years, and who chooses to pay a monthly premium to participate in Part A.
- Retired Federal employees who are not eligible for Social Security but who have paid or been credited with sufficient quarters of the Medicare payroll tax.
- Any person under age 65 who has been receiving Social Security Disability Insurance (SSDI) payments for 24 months.
- Any person under age 65 with end-stage renal disease who is insured (meets the work requirements) for Social Security or Railroad Retirement, or who is actually receiving benefits under either program, or who is the spouse or dependent of someone who is insured or receiving benefits.

Some other persons are eligible for Part A under special transitional rules. These include persons who reached age 65 before 1974 and who had insufficient work history to qualify for Social Security, along with certain Federal, State and local government employees who began employment before their agencies participated in Medicare.

Coverage under Part B is voluntary. Any person covered under Part A, or any person over 65 whether or not covered under Part A, may choose to be covered under Part B by paying a monthly premium. There are some people who are covered under Part A who are not covered under Part B, and vice versa.

B. OPTIONS FOR EXPANDING MEDICARE COVERAGE

Although Congress could extend Medicare coverage to any part of the population, the following discussion of expansion options assumes that any Medicare expansion proposals would be restricted to groups that are somehow related to one of the groups presently entitled to coverage. Two options are considered: reducing or eliminating the Medicare waiting period for some or all SSDI beneficiaries, and providing Medicare coverage to early retirees. The section concludes with a brief discussion of uninsured persons over

[64] An eligible person may not actually be receiving Social Security or Railroad Retirement benefits; for example, some persons have sufficient earnings from continued employment to reduce their Social Security benefit to zero. These persons are still automatically entitled to Medicare at age 65.

age 65. However, because little is known about this population, no policy options are presented.

1. Reduce the Disability Waiting Period

Recipients of SSDI benefits must wait 24 months before they may receive Medicare (there are exceptions for persons with previous periods of disability). Because the SSDI benefits themselves begin 5 months after the onset of disability, the effective waiting period for Medicare coverage is 29 months.

Unpublished data from the Census Bureau's 1983–84 Survey of Income and Program Participation indicate that 585,000 of the 2.4 million SSDI recipients, or 24 percent, were not receiving Medicare. Of those without Medicare, 50 percent had some form of private coverage, either on their own or through a relative. Another 25 percent had Medicaid, while 3 percent had both private coverage and Medicaid. The remaining 22 percent, or about 129,000 recipients, either had no insurance coverage or were covered by CHAMPUS or CHAMP-VA. (The extent of coverage by these programs could not be determined.) If the Medicare waiting period were eliminated, Medicare would be secondary to any insurance furnished to recipients who were actively employed or were the dependents of active employees in firms with 100 workers or more (see chapter 6, section IV, for a discussion of the Medicare secondary coverage rules). However, Medicare could replace ongoing coverage furnished by employers to disability retirees. Medicare would also replace Medicaid as the primary payer for about 150,000 recipients.

The Health Care Financing Administration (HCFA) has estimated that elimination of the waiting period would result in increased costs to Medicare of $35 to $42 billion over a 5-year period.[65] These figures do not take into account the effect of the new Medicare catastrophic coverage, which is wholly financed by increased Part B premiums and a supplemental income-related premium paid by beneficiaries. This supplemental premium may be paid disproportionately by the aged, assuming that the disabled are less likely to have non-Social Security income sufficient to subject them to the tax.[66]

An alternative would be to coordinate Medicare coverage with the continuation coverage provided by title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272), which requires that someone leaving employment be permitted to continue purchasing insurance through the employer group for 18 months. One proposal that will be discussed further in chapter 6 would extend the COBRA continuation coverage for 29 months for persons ending work as a result of disability (see H.R. 4136 introduced by Rep. Nancy Pelosi in the 100th Congress). This extension would carry beneficiaries to the end of their waiting periods. The

[65] Roper, William L., and William Winkenwerder. Making Fair Decisions About Financing Care for Persons with AIDS. Public Health Reports, 103:3 (May-June 1988). p. 305–8.

[66] Particular concern was expressed during the congressional debate on the catastrophic legislation that the aged would be subsidizing the care of the growing population of SSDI beneficiaries with AIDS. This concern was dismissed at the time because so few persons with AIDS survive the Medicare waiting period. However, it could re-emerge as a major issue in debate over any proposal to reduce the waiting period.

converse option would be to reduce the waiting period to fit the current COBRA limit. This would mean a Medicare waiting period of 13 months (plus the 5-month SSDI waiting period). The latter approach would still have a large impact on Medicare expenditures.

2. Cover Early Retirees

An estimated 990,009 early retirees had no health insurance coverage in 1986. Of these, 589,174 were between the ages of 62, the Social Security early retirement age, and 65, the age at which retirees may first receive Medicare.[67]

Early retirees who do not have health insurance through their former employers could be permitted to opt for early Medicare coverage with reduced benefits. This option could be tied to the receipt of benefits under Social Security early retirement, which permits retirement at age 62 in exchange for a permanent reduction in benefits. (Comparable options exist in most other public and private retirement programs.)

Under early retirement options, benefits are generally reduced to the point that the expected lifetime payments to the retiree are the same as would have been made if the employee had retired at the normal age. For example, the average life expectancy of a 62-year-old in 1985 was 18.8 years, while the average life expectancy of a 65-year-old was 16.7 years.[68] The benefits for a 62-year-old would need to be reduced by 11.2 percent to produce a lifetime payout equal to that for the 65-year-old. (There are complications which will not be discussed here, such as the effects of inflation over the longer life expectancy and the loss of three years' worth of contributions to the fund. These factors would also affect an early Medicare option.)

A comparable Medicare option might involve a similar reduction in benefits, perhaps in the form of higher premiums and cost-sharing amounts. The reduction in benefits would not necessarily need to be proportionate to a beneficiary's expected additional years on the program. For most Medicare beneficiaries, the highest expenditures are made in the final 2 years of life. A study of 1978 Medicare data found that beneficiaries who died during that year cost 6.2 times as much as beneficiaries who survived the year. The costs in 1977, the next to last year of life for those who died in 1978, were 2.3 times the costs for survivors.[69] Since most persons age 62 would live past 65, their highest cost years would fall in the period during which they would have been entitled to Medicare in any case. The incremental cost of the additional years of coverage would be comparatively small.

This expectation might not hold, however, if early retirees were less healthy than those retiring at age 65, or if the subset choosing early Medicare benefits did so because they were less healthy. Some persons who retire early do so because they are no longer

---

[67] Congressional Research Service analysis of 1986 data from the March 1987 Current Population Survey. Note that there may be some overlap between the counts of retirees and the count of uninsured SSDI recipients.

[68] U.S. National Center for Health Statistics. Vital Statistics of the United States, 1985, vol. II, Mortality, Part A. DHHS Pub. No. (PHS) 88-1101. Washington, 1988.

[69] Lubitz, James, and Ronald Prihoda. The Use and Costs of Medicare Services in the Last 2 Years of Life. Health Care Financing Review, 5:3 (Spring 1984). p. 117-131.

able to perform their usual work. A recent Department of Health and Human Services (DHHS) study of newly retired workers aged 62-67 found that 16.7 percent of them reported that they were unable to work at the time of retirement, while another 16.6 percent reported some limitation in their ability to work.[70] While these activity limitations are not necessarily correlated with a need for medical treatment, some degree of adverse selection would be likely. This could be compensated for by a further reduction in benefits. However, the same study suggests that early retirees in poor health also have lower incomes than other early retirees. They might have difficulty meeting the increased cost-sharing and premium requirements needed to finance earlier coverage.

Again, assuming that all these factors could be taken into account, it might be possible to reduce benefits to the point at which they would be actuarially equivalent over a lifetime to those paid out to beneficiaries entering the system at age 65. This would mean that the Medicare trust funds would not ultimately be affected. In the short term, however, the accelerated pay-out would increase the Federal deficit.[71]

One final concern is the likelihood that employers, many of whom have unfunded retiree health commitments, would cut back retiree benefits in the face of a Medicare expansion. The Medicare catastrophic legislation addressed a similar concern by requiring "maintenance of effort" for a limited period. Employers whose current retiree benefits significantly duplicate the new Medicare Part A and Part B catastrophic benefits (other than the drug benefit) must either offer substitute benefits or provide refunds to retirees for 1 year after each new benefit takes effect (1989 for Part A and 1990 for Part B), or for the duration of any collective bargaining agreement.

3. The Uninsured Aged

An estimated 304,000 persons over age 65, or about one percent of the aged population, were without Medicare or any other form of health coverage in 1986.[72] Some of these persons may have been ineligible to exercise the option of purchasing Medicare coverage because they failed to meet the citizenship or 5-year residency requirement. Others may have declined to obtain health insurance for religious or other reasons. Finally, some people may simply have been unable to afford the Medicare premiums.

The poorest of the uninsured aged will become eligible for State assistance in purchasing Medicare coverage as a result of a change in Medicaid law included in the Medicare catastrophic legislation. This change, described in greater detail in section II.A.1. of this chapter, will require State Medicaid programs to pay Medicare premiums and cost sharing for all persons over age 65 who have family incomes below 100 percent of the Federal poverty level and

---

[70] Increasing the Social Security Retirement Age: Older Workers in Physically Demanding Occupations or Ill Health. Social Security Bulletin, 49:10 (Oct. 1986). p. 5-23. (Reprint of report to Congress by the Department of Health and Human Services, Social Security Administration, pursuant to section 201(d) of the Social Security Amendments of 1983, P.L. 98-21.)

[71] Note that Part A, hospital insurance, will be removed from the Federal budget in FY 1993.

[72] Congressional Research Service estimate based on the March 1987 Current Population Survey.

who meet resource standards established by the State. It is estimated that 77,000 of the uninsured aged, or 23 percent, were below poverty level in 1986.[73] Even if the new Medicaid rules had been in effect in that year, at least 227,000 persons over 65 would still have been uninsured.

So little is known about this group, however, that it is difficult to develop policy options for providing them with coverage. If they are short-term residents of the United States, it might be possible to consider modifying the 5-year residency requirement. If they are above poverty level, but too poor to purchase Medicare coverage (full coverage is expected to cost $2,254.80 in 1989), they might be assisted through an income-based premium scale or further extension of Medicaid assistance. If they are members of religious groups that refuse conventional health care or decline to participate in government programs, no policy change may be warranted. Further research on the characteristics of the uninsured aged will be needed before options can be evaluated.

II. MEDICAID

A. CURRENT RULES

Medicaid is a joint Federal-State program of medical assistance to limited groups of low-income persons. In order to qualify for Medicaid benefits, an individual must not only meet the program's financial standards, but must also fall into one of the categories of persons eligible for coverage, chiefly the aged, blind and disabled, and members of families with children. Coverage of some categories is mandatory, while others may be included in a State's Medicaid program at the State's option. In addition, States establish their own financial standards within general Federal guidelines. There is wide variation in the income and resource limits applied by States. As a result, States differ in the proportion of their low-income population receiving Medicaid benefits.

States are also free to determine, again within broad Federal guidelines, what services they will cover and how they will pay for those services. Although changes in Medicaid could conceivably focus on the scope of services covered or on modifying reimbursement rules, the focus of this section will be on options for increasing the numbers of persons covered.

1. Groups Covered

Eligibility for Medicaid benefits has traditionally been linked to actual or potential receipt of cash assistance under either of two programs: the Federal-State Aid to Families with Dependent Children (AFDC) program, and the Federal Supplemental Security Income (SSI) program for the aged, blind, and disabled. Recently States have been given the option to extend Medicaid to certain other low-income groups.

---

[73] Congressional Research Service estimate based on March 1987 Current Population Survey data. It should be noted that the Current Population Survey uses a representative sample of the United States population. The estimate of 77,000 is at the lower limits of reliable projection from this sample.

All States must cover the *categorically needy.*[74] These include all persons receiving AFDC and, in most States, persons receiving SSI. States have the option of limiting Medicaid coverage of SSI beneficiaries by using more restrictive standards for Medicaid, if those standards were in effect on January 1, 1972 (before implementation of SSI). The 14 States that continue to use more restrictive standards are known as "209(b)" States, after the section of the Social Security Act that grants this option.

States must also cover as categorically needy a number of groups that are not receiving AFDC or SSI. The following are among the more important of these groups:

- Certain persons whose family income and resources are below AFDC standards but who fail to qualify for AFDC for other reasons. These include all pregnant women, and children born after September 30, 1983, in families meeting AFDC financial standards, through age 6. Effective October 1, 1990, coverage will also be required for persons in two-parent families with an unemployed parent in States whose coverage of such families is less generous than permitted by law.
- Persons who have been receiving both Social Security and SSI benefits and who become ineligible for SSI because of increases in their Social Security benefits.
- Certain disabled people who lose SSI after returning to work but who remain disabled and who are able to continue working only because they receive health services covered by Medicaid.

In addition to the mandatory groups, there are several optional groups that States may elect to treat as categorically needy for Medicaid purposes. Perhaps the most important of these are so-called "Ribicoff children" in families with incomes below AFDC standards.[75] States may also cover persons in institutions who meet a special institutional financial standard set by the State; this standard may not exceed 300 percent of the SSI payment level. Finally, States may cover disabled children who are not in an institution but who would be eligible if they were in an institution.

Thirty-nine States and other jurisdictions also provide Medicaid to the *medically needy.* These are persons whose income or resources exceed the standards for the cash assistance programs but who meet a separate medically needy financial standard established by the State and also meet the non-financial standards for categorical eligibility (such as age, blindness or disability, or being a member of a family with dependent children). The separate medically needy income standard may not exceed 133⅓ percent of the maximum AFDC payment for a household of similar size. Persons with incomes and resources below the medically needy standard

---

[74] The terms "categorically needy" and "medically needy" are used in the following discussion because this is the traditional way of classifying Medicaid beneficiaries. The terms are not especially helpful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available in recent years, and some analysts believe they should be abandoned. However, the distinction between the categorically and medically needy is still an important one in Medicaid law. The scope of covered services that States must provide to the categorically needy is much broader than the minimum scope of services for the medically needy.

[75] Ribicoff children are children whom the State is not required to cover, because their families do not meet Medicaid's categorical restrictions, but who are under a maximum age set by the State, which may be 18, 19, 20, or 21.

are automatically eligible. Others may also become eligible through a process known as "spenddown." An applicant's incurred medical expenses are deducted from his or her income and resources for the purposes of determining eligibility. For example, if a State has a medically needy income standard of $350 a month and an applicant has an income of $400, the applicant must incur $50 in medical expenses before qualifying for Medicaid. This process is a frequent route to Medicaid eligibility for persons in nursing homes.[76]

Finally, beginning with the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Congress has permitted States to extend Medicaid coverage to certain *target populations,* using income eligibility standards that are not directly linked to those used in the cash assistance programs. The Act allowed States the option of covering pregnant women and young children and/or aged and disabled persons meeting State-established income standards as high as 100 percent of the Federal poverty level.[77] States choosing to cover the aged and disabled could provide all the services covered for the categorically needy, or could choose to cover only Medicare premiums and cost-sharing amounts (the deductibles and coinsurance which would otherwise be paid by the beneficiary).

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) converted the options to mandates for several of the target groups. States must phase in coverage of pregnant women, infants under 1 year old, and aged and disabled persons eligible for Medicare with family incomes below 100 percent of poverty. Lower mandatory income thresholds will be in effect during a transitional period for each group. For pregnant women and infants, States must reach full coverage by July 1, 1990. The transition period for the aged and disabled ends January 1, 1992, or January 1, 1993, in 209(b) States. Mandatory coverage for the aged and disabled is restricted to coverage of Medicare premiums and cost-sharing amounts and prescription drugs up to the new Medicare drug deductible; States may provide more comprehensive coverage.

States may still choose to extend coverage to any of these groups faster than the timetable requires. They may also choose to cover older children with family incomes below 100 percent of poverty. This option is being phased in on a timetable that ends October 1, 1991, at which time States will be able to cover children up to age eight.

Finally, the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) further expanded States' options by allowing coverage, beginning July 1, 1988, of pregnant women and children up to age one with incomes less than 185 percent of the Federal poverty level. The State may impose a premium for this coverage, equal to no more than 10 percent of the amount by which the family's income exceeds 150 percent of the poverty level.

---

[76] In the 209(b) States, those that do not automatically provide Medicaid to all SSI recipients, SSI recipients must also be permitted to spend down to the State's Medicaid income level.

[77] The aged and disabled could be covered only if the State also covered pregnant women and children.

2. Financial Eligibility Standards

In addition to the variation among States in the populations covered under Medicaid, States may use widely differing financial standards. There are now four different income standards applicable to different groups living in the community (a fifth applies to persons in institutions and a small number of chronically ill people receiving home care). Each of these standards varies by family size. Three are established by States, one by the Federal Government.

- *The AFDC payment standard, established by each State.* This standard, the maximum "countable" income allowed under AFDC, is the basic test of eligibility, not just for AFDC recipients, but also for other categories of Medicaid beneficiaries, such as Ribicoff children.[78] The AFDC payment standard is entirely at the discretion of the State, so long as the State is actually prepared to fund its share of payments to all eligible families. As of January 1, 1988, States' AFDC payment standards for a family of three ranged from $118 per month in Alabama to $779 per month in Alaska, followed by California at $633 per month.
- *The maximum SSI benefit level, established by each State.* The Federal monthly SSI benefit standard for 1988 is $354 for an individual or $532 for a couple. However, States may (and, in certain circumstances, must) supplement the Federal payment with an additional State payment. This supplement may raise the effective eligibility level for Medicaid for the aged and disabled. As of January 1988, 24 States had maximum SSI standards equal to the Federal benefit standards. In many of the rest, the State supplements increased the maximums only slightly. Only 11 States had individual maximums greater than $400 or maximums for couples greater than $600. The highest limits were in Connecticut: $747 for individuals and $1,134 for couples.[79]
- *The medically needy standard, established by the State.* The medically needy income standard for a family of a given size, in States covering the medically needy, may be from 100 percent to 133⅓ percent of the State's maximum AFDC payment for a family of comparable size.[80] As of July 1987, medically needy standards for a family of three ranged from a low of $217 in Tennessee to a high of $850 in California.
- *The Federal poverty income guidelines, defined by the Department of Health and Human Services.* The Federal poverty income guidelines will determine the upper income limit for the new mandatory coverage of pregnant women, infants, and aged and disabled Medicare beneficiaries, and for optional coverage of older children. A multiple of the guidelines, 185 per-

[78] Some families with incomes above the payment standard may be eligible because "disregards," allowable deductions, reduce their countable income to below the payment standard. The family's gross income, before the disregards are applied, may not exceed 185 percent of the State's AFDC "need standard." The need standard in most jurisdictions is higher than the AFDC payment standard.

[79] Data supplied by the Social Security Administration, except for Connecticut, from which the Congressional Research Service obtained the information directly.

[80] In nine jurisdictions, this maximum benefit level is lower than the "payment standard," the maximum countable income. In all other jurisdictions, the two are identical.

cent, is the maximum eligibility standard for States choosing to extend coverage to pregnant women and infants with incomes over 100 percent of the poverty guidelines. A State could, however, choose an income standard anywhere between 100 and 185 percent of the poverty level. Note that the poverty income guidelines used for eligibility purposes are different from (although derived from) the "poverty thresholds" used in the census and for other statistical purposes.[81]

3. Groups Remaining Uncovered

Medicaid expansion provisions in recent legislation have been of two kinds. Some provisions have added to the list of optional groups to whom States may elect to extend coverage. Others have mandated coverage of groups for whom coverage was previously optional.

Proposals for further expansion of Medicaid could provide for greater uniformity among the States by mandating coverage of groups presently optional or by establishing uniform financial standards. Alternatively, an expansion proposal could permit or mandate coverage of classes of persons who are now entirely excluded.

In 1993, when the most recent Medicaid changes (including those in the Family Support Act of 1988, P.L. 100-485) have been fully phased in, the following major populations will generally not be eligible for Medicaid in some or all States.

Those excluded in *some* States are:

- The medically needy.
- Persons receiving SSI benefits but not meeting more restrictive Medicaid standards in 209(b) States.
- Pregnant women and infants with family incomes higher than 100 percent of poverty.
- Children over age 7 in certain families not qualifying for AFDC for non-financial reasons.

Those excluded in *all* States are:

- Persons who are not aged, blind, disabled, or members of families with children. (First-time pregnant women and children living outside the home may be covered.)
- Most persons in families with incomes over 100 percent of poverty. (Exceptions include the medically needy and pregnant women and children up to one year old with incomes below 185 percent, in States that choose to cover these groups.)
- Adults and children over age 7 in families with countable incomes exceeding the State's AFDC level but below the poverty level. (Exceptions include pregnant women and persons in families whose heads have recently returned to the work force and are receiving work-transition coverage).
- Illegal aliens (except for emergency care, including deliveries), and aliens admitted under the amnesty provided by the Immigration Reform and Control Act of 1986 (P.L. 99-603) who are not children under 18, Cuban-Haitian entrants, or aged, blind,

[81] The poverty income guidelines are a simplified version of the thresholds. In addition, separate guidelines are established for Alaska and Hawaii. The poverty thresholds are the same in all 50 States and the District of Columbia.

or disabled. The newly admitted aliens excluded under these rules may receive emergency care or services and may apply for full coverage 5 years after the date they are granted "lawful temporary resident" status.[82]

B. OPTIONS FOR INCREASING UNIFORMITY

1. Mandate Coverage of Optional Groups

a. Ribicoff children

The optional group known as Ribicoff children consists of children in families that meet AFDC income and resource standards but fail to meet non-financial requirements for AFDC benefits. In the 1980s, Congress has gradually expanded mandatory coverage of children; the optional group of Ribicoff children has shrunk accordingly. Most recently, as a result of the Family Support Act of 1988 (P.L. 100–485), States will be required to cover children in needy two-parent families with an unemployed parent even if the State limits AFDC coverage for such families.

The major group of children for whom coverage remains optional are those aged 7 to 21 in two-parent families with one parent employed full-time (that is, more than 100 hours per month).[83] Coverage of children in foster care or other subsidized settings is also optional. States may choose to cover all Ribicoff children, or may limit coverage to specific groups, such as those in foster care. States may also set their own upper age limit, at 18, 19, 20 or 21. As of December 1986, 31 States and the District of Columbia were covering all groups of Ribicoff children, and the other 19 States were covering limited groups.[84]

The number of additional children who might be insured if coverage of all Ribicoff children were mandatory instead of optional cannot be reliably projected from available data. (Even the number of Ribicoff children currently covered cannot be determined from Federal Medicaid data.) In some States with very low AFDC income limits, the effect might be minimal, because many families not meeting the categorical standards for AFDC might also fail to meet the financial standards. For example, if one parent in a two-parent family worked full time, his or her income at the minimum wage would be $581 per month, of which $317 would initially be "countable income" for AFDC purposes (after 4 months of employment, countable income would be higher).[85] This income would exceed the income standard for a family of three in 7 of the 19 States with limited Ribicoff coverage; in 5 of these States, it would

---

[82] Extension of Medicaid coverage to illegal aliens is not included among the Medicaid expansion options discussed below, because it would be paradoxical to create an entitlement for persons not legally entitled to be in the country. It should be noted, however, that uncompensated treatment of illegal aliens may represent a growing burden for health care providers in areas with large illegal populations.

[83] Workers with fluctuating hours of work may exceed this limit in any given month if their average monthly hours are within the 100 hour limit.

[84] National Governors' Association. State Medicaid Program Information Center. A Catalogue of State Medicaid Program Changes. 1986 Edition. Washington. 1988. p. 79.

[85] Example based on law before passage of P.L. 100–485 and adapted from U.S. Congress. House. Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. Washington. March 1988. [WMCP: 100–29] p. 389. The example in this report assumes that a two-parent family with only one worker would not receive the child care deduction.

exceed the standard for a family of four. In Alabama a parent working just 100 hours a month at minimum wage, with a countable income of $153, would earn enough to disqualify a family of four for Medicaid coverage. It is possible, then, that an expansion of Ribicoff coverage would have little impact unless it were accompanied by changes in financial eligibility standards. The possibility of such changes will be discussed further in section 2 below.

b. Disabled SSI beneficiaries

The 209(b) States, which use more restrictive standards for Medicaid eligibility than for SSI benefits, will be required by the Medicare catastrophic legislation to pay at least the Medicare cost sharing for SSI beneficiaries receiving Medicare. This would include virtually all of the aged and some of the disabled: those who are receiving Social Security disability as well as SSI benefits and who have completed the 24-month waiting period for Medicare disabled coverage. About 20 percent of disabled SSI recipients fall into this group.

There will remain a group of disabled SSI recipients who will still have to meet the State's restrictive Medicaid standards. The exact size of this population cannot be determined, because HCFA data on Medicaid beneficiaries cannot be matched to Social Security Administration data on SSI recipients. However, a recent study estimated that 12.2 percent of persons receiving SSI benefits in late 1983 were not enrolled in Medicaid at that time or at any time in the subsequent 32 months.[86] Some of these persons might have qualified for Medicaid but failed to complete the necessary application or encountered other bureaucratic problems; others might have received Medicaid benefits but failed to report this in the survey on which the study was based. Still, the same study found that only 2.6 percent of AFDC recipients, who are eligible in all States, failed to report Medicaid enrollment. This difference would suggest that more disabled SSI beneficiaries do face barriers to obtaining Medicaid and that elimination of the 209(b) exception (and perhaps of the requirement in six States that a separate Medicaid application be filed) could benefit a large number of disabled persons.

If coverage of SSI recipients reached the same level as coverage of AFDC recipients, rising from 87.8 percent to 97.4 percent, an additional 228,000 disabled persons would have received Medicaid benefits in March 1987.[87] Assuming that 20 percent of these persons were receiving Medicare and would be covered under the new mandatory coverage for Medicare beneficiaries, the net maximum impact of this option would be coverage of an additional 182,000 persons. Despite the small numbers, coverage of this group could have a disproportionate impact on the burden of uncompensated

[86] Short, Pamela Farley, Joel Cantor and Alan Monheit. The Dynamics of Medicaid Enrollment. Unpublished paper presented at the annual meetings of the American Public Health Association in New Orleans, Oct. 1987 (updated Mar. 1988).

[87] There were 2.37 million blind and disabled persons under 65 receiving federally administered SSI payments in Mar. 1987. U.S. Congress. House. Committee on Ways and Means. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. Washington. Mar. 1988. [WMCP: 100–29] p. 528.

care in the affected States, as disabled beneficiaries tend to be the highest users of non-institutional Medicaid services.

c. Medically needy

Fourteen States have no medically needy program. Two others extend medically needy coverage only to pregnant women and children. (These programs will be partially superseded by the expansion of mandatory coverage of pregnant women and infants below poverty.)

Although a medically needy program may function as a source of ongoing health coverage for persons receiving long-term care (who essentially spend down to Medicaid eligibility every month), for persons receiving acute care services it serves chiefly as a catastrophic coverage program. They become eligible because their costs for medical care, often over a very short period, have reduced their incomes to the State-established level and have consumed nearly all of their savings. (State liquid asset limits for individuals ranged from $1,500 to $5,000 in 1987.) Unlike other proposed types of catastrophic coverage, then, medically needy programs do not limit out-of-pocket expenditures for medical care; they limit what can be left in the pocket.

Once medically needy status has been established, coverage may continue for a period of 3 to 6 months. Moreover, medically needy eligibility is often determined retroactively, covering expenses incurred prior to the date of application. The period of coverage after application is reduced accordingly. At the end of this period, unless the individual or family has ongoing medical expenses that continue to reduce income to the State's medically needy standard, coverage ceases.

In summary, extension of medically needy coverage as presently constituted would not produce a meaningful increase in the number of persons with health insurance. It would potentially reduce the burden of uncompensated care—charity care and unpaid bills—for hospitals and other providers in the affected States. It might also serve as an ongoing source of coverage for low-income chronically ill persons, who could spend down continuously.

d. Pregnant women and young children

As noted earlier, the Medicare Catastrophic Coverage Act (P.L. 100–360) requires all States to cover pregnant women and children under 1 year old with family incomes below 100 percent of the poverty level, effective July 1, 1990. Coverage of older children in such families remains optional. As of July 1988, 31 States were covering or planning to cover at least some children over 1 year old.[88] Coverage may be extended through age 7 for children born after September 30, 1983. (This means that children under age 6 are potentially eligible during FY 1989.) The State may choose to establish a lower age limit, and 22 have done so. Thus only 9 States are providing the maximum coverage permitted by law. (Because this option is relatively new, some States may still be debating implementation.)

[88] Information in this section on recent State actions was provided by the National Governors' Association.

All States could be required to provide Medicaid benefits to children under age 8 in families with incomes below the Federal poverty level. The potential impact of such a move is uncertain. Parents must actively apply for Medicaid benefits for their children and must reapply at intervals, undergoing an eligibility determination process comparable to that for welfare. Some analysts believe that parents will obtain coverage for their children only if those children are actually sick and in need of expensive services. Many parents might even be unaware that the coverage was available until, for example, they sought to have a child admitted to a hospital and learned of the Medicaid option from hospital admissions staff. In consequence, while the new coverage may help families through periods of acute need, it may not result in the continuous access to early childhood screening and prevention services that it was designed to provide. This problem might be partially overcome if States made aggressive efforts to inform families of the availability of the coverage and if the application process could be simplified.

Finally, it would be possible to require, rather than permit, States to cover pregnant women and infants with family incomes over 100 percent and less than 185 percent of the poverty level. This new option took effect in July 1988. As of that month, ten States had implemented it or were preparing for implementation in the near future. Of these, seven have adopted the maximum permitted 185 percent standard; two have set their limits at 150 percent of poverty, and one at 125 percent.

This option addresses a narrow population and provides very short term coverage; coverage for the mother is limited to services related to the pregnancy. Extension to all States would further the goal of the legislation, to address the problem of infant mortality, but would not have a measurable impact on the overall size of the uninsured population.

2. Uniform National Income and Resource Standards

States' financial standards for Medicaid eligibility may be even more important than States' decisions about coverage groups in determining the proportion of the low-income population that will be reached by Medicaid. The following discussion will focus on the AFDC standard, which affects the greatest number of current beneficiaries. As was indicated earlier, the other standards used in determining Medicaid eligibility also vary widely among the States.

As of January 1988, States' maximum AFDC benefits (the standard applicable to the greatest number of beneficiaries) for a family of three ranged from 14.6 percent of the Federal poverty level to 77.2 percent. The average State's maximum was $368.25, 45.6 percent of the 1988 poverty income guidelines.[89] Moreover, because States' payments have generally not kept pace with inflation, the ratio of the AFDC maximum to the poverty level has been dropping. In 1975, the average State's AFDC maximum payment for a family of three was 71.4 percent of the poverty guidelines.[90]

---

[89] For Michigan and New York, which vary payments by area, the limits used in computing this average are those for Wayne County (Detroit) and New York City.

[90] Curtis, Rick. The Role of State Governments in Assuring Access to Care. Inquiry 23: 277-285 (Fall 1986).

One option for expanding Medicaid coverage, then, is to establish a uniform national floor for Medicaid income and resource standards. What might this floor be? The one obvious possibility is some percentage of the poverty level. The use of the Federal poverty level, or any fraction of that level, as a standard for all States could be open to question. A uniform national definition of need would fail to reflect local and regional differences in the cost of living. Regional price adjusters might be possible. Even as a national average standard of need, however, the poverty level has been open to criticism on the grounds that it is arbitrary and fails to reflect current economic conditions.[91] Still, in the absence of any other uniform standard, Congress has adopted the poverty level as the basis for the recent expansions of Medicaid to cover more pregnant women and children, as well as the aged and disabled.

As important as the basis for a national standard is the distribution of the burden of meeting that standard. Table 4.1 shows the number of States that would need to raise their AFDC maximum payments, and the average increase required, to meet different percentages of the 1988 poverty income guideline. Depending on the minimum standard used, a uniformity requirement could affect just a few States or all of them. Would States with low payment levels be able to bring those levels up to a new national level?

This issue is fundamental, not only for a proposal to establish uniform financial standards, but also for the proposals discussed above to mandate coverage of populations for whom coverage is presently optional. The remainder of this section will therefore focus on the question of financing.

TABLE 4.1.—Increase in Monthly AFDC Maximum Benefit Levels Required to Meet Specified Percentages of the Federal Poverty Income Guideline, January 1988

Percent of poverty used as standard	Number of States below standard for a 3-person family	Average increase required
25	6	$40.16
50	34	113.35
75	49	253.39
100	51	446.07

Note.—Count of States is 51, including the District of Columbia but excluding the U.S. territories. For Michigan and New York, which vary payments by area, the payment limits used are those for Wayne County (Detroit) and New York City. For a family of 3, the 1988 income guideline is $807.50 per month (higher in Alaska and Hawaii).

Source: Congressional Research Service.

3. Financing Uniform Coverage

The differences in States' eligibility rules and income standards reflect, in part, policy decisions about the overall level of resources States are prepared to devote to cash assistance and medical care

[91] The poverty thresholds from which the income guideline are developed are based on estimates of a minimally adequate income dating from the early 1960s, updated by using the Consumer Price Index; it does not reflect any information or assumptions about families' needs in 1988. In addition there is a continuing debate over whether a family's poverty status should properly be determined before or after the family receives non-cash assistance, such as food stamps, housing subsidies, or Medicaid itself.

for the poor. However, a simple classification of States as more or less liberal or generous does not fully explain the variations.

Eligibility policy is only one of three factors that determine State Medicaid expenditure levels; the others are the scope of services covered and the level of reimbursement for those services. Some States may restrict the number of persons who may obtain Medicaid but provide very comprehensive coverage to those who qualify. Others may restrict both eligibility and services but pay health care providers at higher rates than other States. States in the South, for example, tend to have low eligibility income standards but are more likely than other States to pay the full cost of hospital services for Medicaid beneficiaries. Unless they were prepared to increase overall Medicaid spending levels, these States might be able to cover more individuals only at the price of potentially weakening their hospitals' financial condition.

Moreover, a disproportionate share of Medicaid expenditures goes to cover a small segment of the eligible population, those receiving long-term care. In 1986, 7 percent of the Medicaid population received services in nursing facilities or institutions for the mentally retarded or mentally ill, yet payments to these facilities accounted for 45 percent of total Medicaid spending.[92] States must balance the needs of these special populations against those of the low-income population in the community. This problem is expected to become more serious as the population ages.

Finally, State consideration of liberalized eligibility rules may have been forestalled by the tie between Medicaid and the cash assistance programs. The AFDC and SSI income ceilings determine the size and cost of a State's welfare programs, as well as its Medicaid program. Until recently, States could raise the basic income thresholds for their Medicaid programs only by raising the thresholds for cash assistance, thus bringing more families onto welfare and increasing the grant levels for all existing cases. This welfare tie has now been severed for pregnant women and young children, as well as for the aged and disabled, but still affects income standards for older children, mothers who are not currently pregnant, and fathers (in the States that cover two-parent families).

Different priorities, then, are competing for State Medicaid funds. At the same time, there are differences in States' basic ability to finance their Medicaid programs. Some States have limited tax capacity, while others make limited use of potential revenue sources. Medicaid spending may consume a high proportion of a low budget base, and still be inadequate to reach more than a fraction of the population in poverty. The proportion of a State's population in poverty also varies widely. Some States with limited revenues may also have the greatest need.

Some States could raise their eligibility standards to a new national minimum level by raising taxes or shifting budget priorities. Others, however, with limited resources and many people in need, might require greater Federal financial assistance. For this reason, some observers have argued that achieving greater uniformity in

[92] The count of persons receiving long-term care used in computing this percentage is a duplicated count. That is, persons treated in two different types of facilities during a year (e.g., both skilled and intermediate care) are counted twice.

State programs might require revisions in the Federal Medicaid funding formula, or even in the overall balance of Federal and State Medicaid responsibilities.

a. Federal Medicaid funding options

The current Federal Medicaid funding formula was designed to help equalize States' ability to provide Medicaid coverage. The Federal share in Medicaid service expenditures varies by State, according to a formula that makes the Federal percentage inversely proportional, within limits, to a State's per capita personal income. (Federal matching for State administrative costs is uniform for all States.) Thus, States whose residents' average income is lower than the national average receive a higher Federal matching rate than other States. The percentage may not be less than 50 or more than 83 percent; the percentage for the territories is fixed at 50 percent. Currently, 10 States and the District of Columbia receive the minimum 50 percent in Federal matching. The highest matching rate is Mississippi's, 79.65 percent.

Some people say that the use of personal income in establishing the Federal percentage is inappropriate. Average personal income may not correlate with the proportion of a State's population in poverty. Nor does income reflect the State's ability to raise funds, since States have numerous revenue sources other than personal income taxes. In a 1983 study, the General Accounting Office (GAO) found that under the current formula some States would need to make up to four times the tax effort of some other States to provide equivalent Medicaid coverage.[93]

GAO presented a set of options for modifying the formula to better reflect a State's needs and its ability to meet those needs. The Federal share could be tied to the proportion of a State's population in poverty and to its relative per capita fiscal capacity. As a measure of fiscal capacity, GAO used the "representative revenue system" (RRS) developed by the Advisory Commission on Intergovernmental Relations. The RRS estimates the resources available in a State—personal income, business income, and so on—and determines what the State's revenues from those resources would be if it imposed the same taxes, user fees, and other revenue measures as an average State.

Table 4.2 compares the current Medicaid formula with GAO's proposed basic tax capacity/poverty formula, along with a second GAO option designed to provide an incentive for efficiency in Medicaid programs. The second option (one of five variations included in the GAO study) rewards States whose spending per person in poverty is at or below the national average. Note that, under both options, GAO also reduces the minimum Federal match from 50 percent to 40 percent.

All the GAO options would redistribute funds from some States to others. Unless total Federal funding were increased, some States would have to increase their Medicaid expenditures simply to maintain their current programs, while others could hold spending level and expand their programs. In particular, New York's Feder-

[93] U.S. General Accounting Office. Changing Medicaid Formula Can Improve Distribution of Funds to States. [GAO/GGD-83-27] Washington, 1983.

al funding would increase significantly under each of GAO's formulas, because New York has a relatively low revenue capacity relative to its population in need. GAO points out that, since New York also accounts for nearly one-fifth of total Medicaid expenditures, the effect of a formula change could be a redistribution of funds from States with less generous programs to New York. For example, the first of the two options shown would have increased funding for 11 States and decreased it for 39 States. If New York were excluded, funding would have been increased for 20 States and reduced for 29.

TABLE 4.2.—Current Medicaid Funding Formula and 1983 General Accounting Office Options

Current formula:

$$Y = \frac{\text{State's per capita personal income}}{\text{National per capita personal income}}$$

Federal share = 100% — (45% x Y^2)
Federal share not less than 50% or more than 83%

GAO poverty and tax capacity option:

$$Y = \frac{\text{State's per capita per person in poverty}}{\text{National per capita per person in poverty}}$$

Federal share = 100% — (45% x Y)
Minimum Federal share reduced to 40%

GAO incentive option:

$$Y = \frac{\text{State's tax capacity per person in poverty}}{\text{National per capacity per person in poverty}}$$

$$Z = \frac{\text{State's Medicaid spending per person in poverty}}{\text{National Medicaid spending per person in poverty}}$$

Incentive factor (I) = 0.2
Federal share = 100% — (42% x Y x Z^I)
Minimum Federal share reduced to 40%

Source: U.S. Congress. General Accounting Office. Changing Medicaid Formula can Improve Distribution of Funds to States. [GAO/GGD-83-27] Washington, 1983.

b. Restructuring Medicaid

Some proposals would move beyond modifications in the funding formula, to a fundamental reshaping of the Federal-State Medicaid partnership. A 1982 Reagan Administration proposal, part of a "New Federalism" plan, would have made Medicaid a Federal responsibility; in return, States would have assumed sole responsibility for the AFDC and food stamp programs. After discussions with State and local officials, an alternative proposal emerged. The Federal Government would provide full funding for Medicaid acute care services, leaving the States responsible for long-term care under a block grant.

The Administration was unable to reach agreement with the States on certain details of this proposal, and it was never actually submitted to the Congress. However, the idea of splitting the acute

and long-term care components of Medicaid has periodically been revived. The rationale is that States, operating their long-term care programs under a fixed Federal grant or with no Federal funds at all, would have the flexibility and incentives to structure new community-based alternatives to institutionalization. At the same time, a Federal acute care program would overcome current differences in eligibility and coverage.

The long-term care component of this proposal is beyond the scope of this report, although the problem of long-term care financing is likely to have an important impact on the future of the Medicaid program. It may be useful, however, to examine in isolation the proposal for a uniform Federal Medicaid acute care program. For the purpose of the following discussion, it may be assumed that the loss of State contributions to acute care would be made up by an equivalent reduction in Federal matching for long-term care.[94] This would leave a Federal acute care budget equal to current combined Federal and State spending.

In order to operate uniformly and remain within that budget, the program would have to reduce coverage or benefits in some States at the same time that it improved coverage in other States. The Reagan Administration's proposal was to eliminate coverage of the medically needy and to limit reimbursement for inpatient care to a number of days equal to the weighted average of the day limits already imposed by individual States (some, but not all, States have such limits). Other combinations of benefit cuts might be devised to achieve budget neutrality. For example, a national Medicaid program might eliminate such optional services as dental and optical care.

However a national program was designed, the result would be a "leaner" set of benefits offered to a uniform population. Current beneficiaries in States with more comprehensive programs would lose some benefits. Depending on how national eligibility standards were developed, there might even be States where persons currently eligible for Medicaid would cease to qualify. States might still have the option of supplementing the standard program, covering more individuals or providing additional benefits without Federal matching funds.

A shift to a national program might have several consequences beyond increasing uniformity of eligibility and benefits. First, it would probably be necessary to develop standard reimbursement rules for hospitals, physicians, and other providers, replacing the widely varying payment systems now used by States. (It would be difficult to justify State-level variations in payment rules for an entirely Federal program.) There might even be pressure to make Medicaid payment rules conform to those used by Medicare, on the grounds that it would be inconsistent for two Federal programs to pay differently for comparable services.[95] As many States' pay-

[94] At present, Federal long-term care expenditures are almost exactly equal to State acute care expenses.

[95] States were required to follow Medicare principles in paying hospitals and nursing homes, but not physicians or other providers, until changes in the law in 1980 (for nursing homes) and 1981 (for hospitals) gave States the flexibility to develop their own systems.

ments are currently below Medicare levels, such a change would increase the cost of the program, and might need to be offset by further restrictions on eligibility or services.

A second consequence of a uniform Federal program might be the elimination of some of the alternative delivery systems developed by States in the 1980s, largely in response to the increased flexibility provided by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35). These have included managed care programs, such as health maintenance organization (HMO) contracts and primary care case management systems, as well as coordinated medical/social services programs designed to help persons at risk of institutionalization remain in the community (the latter programs might be especially vulnerable if financial responsibility for long-term and acute care were divided).

C. EXTENSION OF MEDICAID TO NEW POPULATIONS

The recent moves to extend Medicaid coverage to pregnant women and infants and to aged and disabled Medicare beneficiaries with incomes below the poverty level are sometimes spoken of as having weakened the "welfare link," the traditional tie between Medicaid and the cash assistance programs. Members of the new groups need not pass all the categorical tests previously required for Medicaid benefits, and the income tests are no longer those used for cash welfare. Still, all the newly covered persons will continue to fall into one of the traditionally protected populations: the aged, blind and disabled, and families with children. Single adults and childless couples who are under 65 and cannot meet disability criteria will continue to be excluded, regardless of their income.

Neither the welfare system, nor the Medicaid program that began as an extension of that system, was intended as a program of general assistance to "the poor." Instead, specific groups were singled out for help on the grounds that they could not help themselves. Underlying the current categorical system is some concept of responsibility for one's own condition. Those who cannot be expected to improve their situation through their own efforts—the aged, disabled, and children—may be assisted. Healthy adults are supposed to fend for themselves (except for some parents, who may enter the system on their children's coattails). Other rationales do exist for the distinctions made in the current system. For example, furnishing prenatal care and health care to children is often said to represent an investment in the future, while assistance to the disabled may help them return to productive lives. Overall, however, even the recent program extensions have not departed significantly from the historic welfare context.

The most sweeping proposals for the expansion of Medicaid would abandon the categorical tests for eligibility and grant Medicaid on the basis of financial need alone. The third report in this series will consider in detail the potential impact of extending Medicaid to everyone whose family income is below the Federal poverty level and who is presently without any form of insurance coverage. As the analysis in that report indicates, such an expansion would

reach over 8 million persons who are presently without any coverage.[96]

A Medicaid expansion on this scale could necessitate changes in the way State Medicaid programs buy services. States establish their own Medicaid reimbursement rates, frequently at levels below providers' usual charges or the amounts reimbursed by other payers. Low Medicaid payment levels have been shown to discourage physician participation in the program. The effect on hospital participation is less clear, although there is evidence that at least some hospitals seek to avoid non-emergency admissions of Medicaid patients. It is not clear that providers would absorb a significantly higher number of Medicaid patients at current payment rates. This problem applies to some extent to each of the expansion options raised in this section, but may be especially critical in the consideration of very large-scale Medicaid expansions, involving many millions of new beneficiaries. An extension of the program on this scale might simply mean a larger number of beneficiaries queuing up for the same limited supply of providers willing to accept them. States might therefore need to improve their current reimbursement levels before a Medicaid expansion could have a real impact on access to care. This would entail further increases in Federal and State expenditures. Moreover, because factors other than reimbursement levels influence providers' Medicaid participation decisions, payment changes alone might not guarantee access to care.[97]

D. MEDICAID AND THE WORKING POOR

Medicaid benefits are currently continued for brief periods for families that lose cash assistance because the principal earner has entered or reentered the labor force.[98] The Family Support Act of 1988 (P.L. 100-485) expands Medicaid "work-transition" coverage, effective April 1, 1990. The Act provides for 12 months continued eligibility after loss of AFDC because of earnings. Coverage during the first 6 months will be automatic. Coverage during the second 6 months will be at the option of the family; during this extended coverage period, the State may require payment of a premium if the family's income exceeds the poverty level. If a family is eligible for coverage through an employer group health plan, the State may pay any required employee premium contributions and cost-sharing amounts on the family's behalf. Medicaid would then become a secondary payer, covering only services not provided by the employer plan. The State may also choose to enroll the family in a State-operated insurance program for the uninsured.

---

[96] U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988.

[97] For an overview of issues in Medicaid provider participation, see U.S. Library of Congress. Congressional Research Service. Medicaid Source Book: Background Data and Analysis. (Scheduled to appear as House Committee and Energy and Commerce Committee Print, Fall 1988.) Appendix G.

[98] Under current law, States must continue coverage for 4 months if a family loses AFDC as a result of increased employment income or working hours. Further, Medicaid eligibility must be continued for 9 months after a family loses AFDC because of the loss of certain disregards and a consequent rise in countable income. For this group States may, at their option, extend coverage an additional 6 months beyond the mandatory 9-month extension. This option is superseded by P.L. 100-485.

Some analysts regard elements of this legislation as a potential model for a broader public/private insurance initiative for the working uninsured. Two components of this model are considered further elsewhere in this report. Chapter 6 discusses the possibility of public subsidies for the employee's share in the costs of an employer health plan, while chapter 7 provides an overview of proposals to allow low-income families to "buy in" to Medicaid or a comparable public program through payment of a premium.

III. Subsidized Employer Coverage

As an alternative to the use of public funds to expand individual coverage, public support could be targeted to small employers who do not offer coverage. Only 46 percent of the 2.8 million firms with fewer than 10 employees offer health insurance, compared to close to 100 percent of the 15,000 firms with 500 or more workers.[99] Most of the voluntary employer-based approaches that have been suggested in pending legislation and in congressional staff options papers are incentives aimed at expanding the availability of insurance products for small employers, rather than at increasing the number of people covered under insurance provided by small employers. (Options to expand availability are discussed in chapter 7.) Less commonly considered are direct funding alternatives to encourage small employers to extend coverage, either by covering more of their employees and their dependents or by newly offering insurance. The following is a discussion of one such policy alternative.

A Federal grant program could be established for small employers (with fewer than 10 employees) to assist them in providing qualified health insurance plans to their employees. The grant would be conditioned upon showing that the employer was providing a plan meeting a specific actuarial minimum value, including a specific employer premium contribution, and that the contribution exceeded a preestablished percentage of the employer's gross revenues or wages, e.g., 5 percent. The grants would be for the amount of the employer's contribution above the preestablished level. Thus, if an employer's contribution totalled 6 percent of gross revenues, the grant would be equal to the 1 percent excess contribution. The grants would be financed out of general revenues. (This option might be coupled with a cap on the employer tax exclusion to raise the needed funds; see chapter 5, section III.D.) The grant could be provided on a renewable basis for as long as the firm met the eligibility criteria, or it could be time limited. The rationale for limiting the grant to each employer to 1 or 2 years is that the grant would get the small employer through the door to purchase insurance. It would overcome the primary hurdle of motivating the employer to purchase coverage. Once insured, the employer should be more likely to remain insured (although the employer could be discouraged from renewing the policy if there were a large premium increase, especially if health care inflation drove up premiums higher than expected). Alternatively, the grant could be ongoing,

[99] U.S. Small Business Administration. Office of Advocacy. Health Care Coverage and Costs in Small and Large Businesses. Final Report. Washington. 1987. p. ES-2.

renewable each year for any amount of contribution in excess of the 5 percent revenue or payroll threshold, or it might be phased out over a number of years. It might be necessary to cap the amount of the potential grant to ensure that excessive benefit packages were not subsidized by taxpayer dollars. For the same reason, it might be necessary to require that participating employer plans include specified utilization review procedures.[100]

This option would have the advantage of providing a visible monetary inducement to small employers to purchase health insurance. For employers who find cost the most important barrier to providing insurance, such an incentive might be the spark that motivated them to purchase coverage. Once these employers bought insurance, it might be easier for them to remain insured. On the other hand, the employers most likely to take advantage of the grant program would be those who themselves needed coverage because of an existing health problem or because they had employees who were acutely interested in obtaining insurance (and in foregoing possible wage increases). The high probability of adverse selection might lead insurers to view such employers with extreme caution. They might reject such employers for coverage or classify them as substandard and price their premiums at above-average rates.

Because of this selection behavior, the grant could become a subsidy for high-risk, small employers rather than small employers more generally. Employers participating in the program would be those paying higher rates. While this might be socially desirable, it could drive up the costs of the grant program. Any minimum benefit standards and utilization review requirements would have to be designed with this in mind.

Such a Federal grant program would require personnel and other resources to administer it. Moreover, because firms would lose their subsidy if they increased their workforce to ten or more employees, the provision could have an adverse effect on employment. One way to avoid this problem would be to allow employers of any size to participate but to reduce the subsidy on a graduated basis as firm size increased, with no subsidy for employers over some size, such as 19 employees. Definitional issues, such as who is an eligible employer, could be modelled on title X of COBRA (P.L. 99-272), but using an employee threshold of nine instead of 20.[101]

It is difficult to estimate how many more people would receive insurance under this scheme. For firms of one to nine employees, 44 percent of the workers do not have health insurance from their employer; about 14 percent of these workers have declined current

[100] Thus, it might improve the effectiveness of the policy if certain requirements were placed on insurers who sold plans to employers participating in this program. For example, policies might have to meet certain standards such as guaranteed renewability, specified loss ratios, or even community rating. Of course, this might discourage insurers from offering policies.

[101] Such a proposal accepts the assumption that insurance should be provided through the workplace. It differs from the Massachusetts plan where funds are channeled through a State pool that is largely financed by a tax (the Medical Security contribution) on employers who do not provide insurance or who provide insurance that is valued below $1,680 in 1992. Individuals obtain insurance through the State pool. However, under the new Massachusetts law, there will be a hardship fund for small businesses for whom the Medical Security contribution exceeds 5 percent of gross revenues. The Hawaii Prepaid Health Plan also provides for a subsidy to employers for whom the premium contribution is a hardship. There is a State fund for subsidizing employers with fewer than 8 employees who are deemed "hardship cases." Early evaluations of Hawaii's program indicate that few employers have made use of this fund. See American Hospital Association, 1988. p. 111.

coverage, leaving about 30 percent—3.1 million people—who might elect coverage under the grant program.[102] However, only a fraction of eligible firms might apply for the grant program. For illustrative purposes, if it is assumed that 10 percent of the target 3.1 million population obtained coverage, 310,000 people would be newly insured. The cost of the program would depend upon how much their employers' contributions exceeded the 5 percent threshold. Administrative costs would also have to be added.

[102] The data are from the U.S. Small Business Administration, 1987.

CHAPTER 5.—TAX SYSTEM OPTIONS FOR INDIVIDUALS AND EMPLOYERS

I. INTRODUCTION

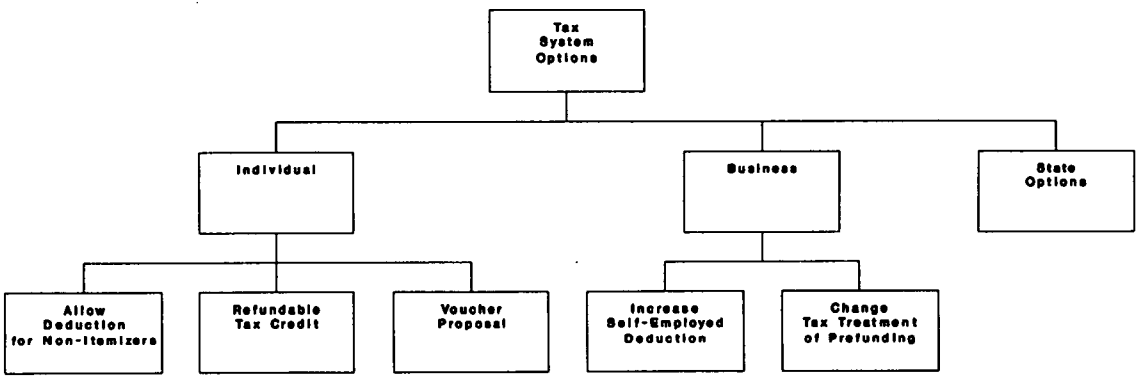
Under current law, the Federal Government provides incentives to employers to furnish health insurance by means of special income tax deductions and exclusions related to health. In addition, individuals may deduct medical expenses, including health insurance premiums, to the extent to which those expenses exceed 7.5 percent of adjusted gross income.[103] These indirect Federal payments are referred to as "tax expenditures." The term "tax expenditure" reflects an assumption that the objective of these tax provisions could in many instances be achieved through direct expenditure programs. Unlike direct spending programs, tax expenditure provisions are administered by the Internal Revenue Service. Federal tax expenditures for health care in 1989 are expected to total over $37 billion, more than the Federal share of the Medicaid program. In addition, health deductions and exclusions affect the revenues of those State and local governments that impose an income tax and that follow the Federal system or allow health deductions of their own.

There are a variety of ways in which current Federal or State tax law might be modified to help more individuals purchase insurance or to encourage more employers to provide group health plans. This chapter reviews the provisions of current Federal tax law and options for changing the law. The chapter concludes with a discussion of options that might be implemented at the State level. Chart 5.1 shows the options to be considered.

[103] U.S. Congress. House. Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 100th Congress, 2nd session, Washington, U.S. Gov't. Print. Off., 1988 edition. p. 594. Under current law, medical expenses that are eligible for the deduction include nonreimbursed amounts paid by the taxpayer for: (1) health insurance (including after-tax employee contributions to employer health plans and Medicare premiums); (2) diagnosis, treatment, or prevention of diseases or malfunction of the body; (3) transportation primarily for, and essential to, medical care; (4) lodging away from home primarily for, and essential to, medical care, up to $50 per night; and (5) the costs of prescription drugs and insulin.

Chart 5.1

Tax System Options



III. B III. C III. E IV. A IV. B V.

II. Current Federal Tax Law

A. The Federal Medical Expense Deduction

Individuals who itemize their Federal income tax returns have been able to deduct nonreimbursed medical expenses (including insurance premiums) above a specified floor since 1942. From 1954 through 1982, the floor for the medical expense deduction was three percent of the taxpayer's adjusted gross income (AGI). A separate floor of 1 percent of AGI applied to nonreimbursed expenditures for medicine and drugs. Under the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), the overall floor was increased to 5 percent of AGI, and was applied to the total of all eligible medical expenses, prescription drugs and insulin. The separate floor for medicine and drug expenses was eliminated. In addition, nonprescription drugs were made ineligible for the deduction. Under the Tax Reform Act of 1986 (P.L. 99-514), the floor for the medical expense deduction was increased to 7.5 percent of AGI, beginning in 1987.[104] The deductions can be taken for medical care of the taxpayer and of the taxpayer's spouse and dependents.[105] Thus, current law permits taxpayers to deduct the costs of health care that are, in effect, catastrophic as measured against family income.

Table 5.1 shows the projected distribution of the medical expense deduction by income class for 1989. Of the tax returns on which the medical expense deduction is expected to be claimed, 67 percent will represent taxpayers below the $40,000 income class, but returns below the $40,000 income class will obtain only 40 percent of the tax benefits provided by the deduction. Thus, 60 percent of the tax benefits of the medical expense deduction will go to higher income (above $40,000) taxpayers. In addition, the deduction will not help those taxpayers with high out-of-pocket medical expenses who do not itemize their returns.

Table 5.1.—Projected Distribution of Federal Medical Expense Deduction, 1989

Income class (thousands)	Returns with deduction (thousands)	Percent of total	Tax benefit (millions)	Percent of total
Below $10	71	1.4%	$ 7	0.3%
$10 to $20	767	15.0	170	6.7
$20 to $30	1,264	25.0	344	13.5
$30 to $40	1,323	26.0	421	16.6
$40 to $50	795	15.5	407	16.0
$50 to $75	651	12.7	432	17.0
$75 to $100	155	3.0	240	9.4
$100 to $200	82	1.6	338	13.3
$200 and Over	17	.3	172	6.8
Total	5,125	[1] 100	$2,531	[1] 100

[1] Details do not sum to 100 percent due to rounding.

Source: U.S. Congress. House. Committee on Ways and Means. 1988. p. 608.

[104] Several tax reform proposals would have completely eliminated the medical expense deduction.

[105] Ibid., p. 607-608.

Other aspects of the medical expense deduction have drawn criticism. The deduction (like other tax deductions) retains relatively low visibility and receives less routine oversight by the Congress than federally funded discretionary programs. Also, taxpayers historically have had high error rates in itemizing medical expenses for their tax returns. Moreover, some analysts have criticized the deduction for encouraging excessive use of medical services and fueling health care inflation.[106] This argument was more valid, however, when the deduction was set at 3 percent of AGI as compared to the present 7.5 percent.

Another limitation of the medical deduction as a subsidy for health care expenses is the time lapse between the payment of the expenses and the reimbursement obtained through any tax refund.

> Under current tax laws, a taxpayer with extraordinary expenses can obtain some savings by reducing the amount of income tax withheld. The withholding system, however, cannot immediately compensate for large medical expenses, because negative withholding is not allowed and tax savings from additional deductions are normally spread over the entire tax year. A taxpayer with large expenses early in the year may be able to recover most of that within a few months. If outlays come later, substantial reimbursement cannot come until the year's tax return is filed and a refund is received.[107]

B. THE EMPLOYER EXCLUSION

Section 106 of the U.S. Internal Revenue Code excludes from taxable income of workers all contributions made by employers to health and accident plans for them. (Employer-provided health insurance would otherwise be treated as an alternative to wages and salaries and thus treated as taxable income.) Section 3104 also excludes these contributions from the wage base for determining Social Security taxes, although the resulting revenue losses are not considered tax expenditures.[108] These tax incentives to provide coverage are known together as the "employer exclusion." For fiscal year 1989, the revenue loss from section 106 is projected to be $34.8 billion.[109] The exclusion of employer contributions is the largest tax expenditure for health care.

The "employer exclusion" for medical care operates as a special Federal subsidy to taxpayers with employer-provided health insurance. It is credited with encouraging the spread of employer-provided insurance so that almost 137 million Americans now receive coverage through the workplace.[110]

The tax code includes nondiscrimination provisions intended to ensure that plans receiving tax-favored treatment under the employer exclusion benefit lower-paid employees as well as those more highly compensated. These requirements, which once affected

---

[106] U.S. Congressional Budget Office. Tax Subsidies for Medical Care: Current Policies and Possible Alternatives. Washington, U.S. Gov't. Print. Off., Jan. 1980. p. 33-34.
[107] U.S. Congressional Budget Office. 1980. p. 33.
[108] Ibid., p. 5.
[109] U.S. Executive Office of the President. Office of Management and Budget. Budget of the United States Government, Fiscal Year 1989. Washington, U.S. Govt. Print. Off., 1988. p. 5-113.
[110] Ibid., p. 95.

only self-insured plans, were extended to all health benefit plans by the Tax Reform Act of 1986 (P.L. 99-514), effective for plan years beginning on or after January 1, 1989. Plans must meet a complex series of tests that measure differences in the plans available to high and low wage employees. If a plan fails to pass these tests, health benefits become taxable income for the highly compensated employees.

While the exclusion may have encouraged the growth in employer-provided health insurance, it has also been identified as a significant cause of inflation in health care costs. Since the exclusion encourages employers to provide insurance and employees to elect it, more insurance is available to pay for more health services for more people, often with few constraints on the scope and volume of services sought from providers. To the extent that employers subsidize premiums, employees have an incentive to select the most expensive set of benefits offered.[111] Because the insurance coverage encouraged by the exclusion has the effect of lowering out-of-pocket costs, employees are less sensitive to the differences in prices among providers. Moreover, lower out-of-pocket costs encourage employees to use more medical services.[112]

Proponents of the exclusion argue that, if it were not allowed, higher compensated workers would seek larger absolute increases in cash wages than lower income workers to replace the value of their lost benefits. In addition, they assert that the exclusion is necessary to ensure that employers provide insurance to workers. They also believe that it is more economical for the Federal Government to promote health insurance through tax incentives to employers than to provide benefits directly. Without such incentives, there could be more uninsured people. Moreover, the employer exclusion encourages healthy people to elect insurance coverage, thereby keeping the costs to the group lower. If employer-provided insurance were taxed like wages and salaries, employees who perceived themselves to be at low risk of using health services might drop their coverage or become underinsured by accepting lower-cost plans with high deductibles. Such arguments in favor of the exclusion might be less persuasive, however, if the alternative to the current tax subsidy were national health insurance or a mandate on employers to provide coverage.

The employer exclusion has important distributional effects. Although taxpayers at all income levels benefit from the exclusion, the distribution of savings to taxpayers is concentrated among upper-income taxpayers. Specifically, the exclusion produces two effects on the tax system that could be considered inequitable. First, the tax exclusion favors persons who receive part of their income in the form of health benefits over those whose earnings come entirely from taxable sources (for example, wages and salaries).

---

[111] Because medical care inflation in the 1980s continues to run high, even though general inflation rates have decreased, employers and employees are changing their attitudes about health insurance. Many employers are finding it financially stressful to maintain benefit plans and have begun to seek measures to contain costs or to shift costs to employees.

[112] U.S. Congressional Budget Office. 1980. p. 13-14. The effects of cost-sharing on utilization are discussed further in the third report in this series, U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988. This report also discusses recent efforts to make enrollees more price-sensitive, such as preferred provider organizations (PPOs).

Second, the exclusion is more valuable to higher income workers because taxes increase as income rises.[113]

C. THE EMPLOYER BUSINESS EXPENSE DEDUCTION

Under section 162 of the Internal Revenue Code, employers may deduct as an ordinary business expense 100 percent of the contributions made on behalf of their employees for health benefits. The law disallows this deduction in part or in full in two specific cases: (1) where the employer's group health plan discriminates against individuals with end stage renal disease or the need for renal dialysis, and (2) where the employer's group health plan fails to meet the health insurance continuation requirements that were established under title X of COBRA.

For the self-employed, the deduction for health insurance costs is limited to 25 percent of the amounts paid for health insurance for themselves, their spouses, and their dependents when calculating their adjusted gross income for the taxable year. The deduction is not allowed unless the self-employed person also provides health insurance for all employees in unincorporated trades or business of which he/she is at least a 5-percent owner. In addition, the nondiscrimination requirements must be satisfied as though the insurance were employer-provided. Moreover, the deduction is not allowed if the self-employed person is also eligible to participate in any subsidized health plan of another employer or the employer of his/her spouse. The amounts deductible do not reduce the income base for computation of the self-employed individual's Social Security tax.[114]

III. Options for Individuals

A. INTRODUCTION

This section provides a description of proposals that would create new Federal or State tax subsidies, or modify existing ones, to encourage individuals to purchase health insurance, or to assist them in paying the employee share of group health premiums. While the emphasis of this section is on Federal options, some of these options could be implemented at the State level by States with personal income taxes.[115]

To finance these proposals, money could be obtained by eliminating or reducing existing health care tax expenditures, such as the Federal exclusion for employer contributions to health insurance plans for their employees. Another possibility would be to fund these tax subsidies with new expenditures of Federal or State money.

This section begins with a discussion of individual tax deduction or credit options, reviews potential accompanying modifications of

---

[113] U.S. Congress. Congressional Budget Office. 1980. p. 6-7. As a result of the Tax Reform Act of 1986, the tax savings to higher income taxpayers is substantially less than when the maximum tax rate was 50 percent.

[114] The provision limiting the deduction to 25 percent for the self-employed is currently effective through Dec. 31, 1989, although legislation to make the deduction permanent is pending in the 100th Congress.

[115] As of 1987, all but 10 States had individual income taxes. The Council of State Governments. The Book of the States. 1988-89 Edition. Vol. 27. Lexington, KY. 1988.

the employer exclusion, and concludes with an examination of a comprehensive tax-based proposal developed by economist Alain Enthoven.

These proposals are generally grounded in the perspective that the number of people covered by health insurance should be expanded through the existing private market but that tax incentives are needed to provide lower-income consumers with the resources to purchase coverage. The focus is thus on ways to help people pay for private health insurance. The insurance may be purchased through an employer or directly from an insurer.

Tax subsidies represent an alternative to the direct public expenditure options described in chapter 4. The tax system provides a relatively simple way to transfer money to individuals and families. Tax subsidies could be administered using existing tax filing and refund procedures; they would not require the creation of new administrative agencies or procedures. In addition, while tax subsidies may be coordinated with employer-provided coverage, they would not impose financial burdens on employers.

Proponents of tax incentives claim they are preferable to mandates on employers and to the existing system of tax deductions and exclusions for employer-provided health insurance because they could be easily designed to provide subsidies to those most in need of financial assistance in buying health insurance. Also, they have the potential to expand coverage across the population regardless of employment status and would not leave a residual class of nonemployed, high-risk persons for whom access to health insurance is problematic.[116]

Opponents argue that tax subsidies, in and of themselves, (as opposed to being combined with other options), would not be an effective way to increase health insurance coverage because the poor and the near poor are unlikely to use the subsidies to buy insurance.[117] If they did buy coverage, it might be inadequate. In addition, tax subsidies are costly to public treasuries. Moreover, some people do not believe that public funds should be used for financing health insurance coverage.

B. ALLOW THE MEDICAL EXPENSE DEDUCTION FOR TAXPAYERS WHO DO NOT ITEMIZE

As was noted earlier, the medical expense deduction from individual income tax provides no assistance to taxpayers who do not itemize deductions on their returns. Except for homeowners, most low-income, and some middle-income taxpayers derive no benefit from the deduction, because their other potential deductions (such as State and local taxes or consumer interest) are insufficient to raise the total to an amount greater than the standard deduction. One possible solution would be to allow direct deduction of medical expenses by taxpayers who do not itemize. This option would paral-

[116] Enthoven, Alain C. Health Plan, The Only Practical Solution to the Cost of Medical Care. Reading, Mass., Addison-Wesley, 1980. p. 116–117.

[117] Tax subsidies can be included as elements in comprehensive health insurance plans that could be designed to overcome such limitations.

90-441 O - 88 - 4

lel the direct deduction of charitable donations that was permitted for tax years from 1982 through 1986.[118]

This approach is subject to some of the general objections to the medical deduction cited earlier. It might encourage excessive or unnecessary medical spending. This problem might be overcome in part by allowing the deduction only for the purchase of health insurance and only up to a limit equal to the national actuarial value of a standardized plan for a family of the size covered under the tax return. A second problem with the medical deduction is that its benefits tend to rise with income. However, the distributional effects in this case would not be as great as those for the existing deduction, since taxpayers who do not itemize are likely to be at the lower end of the income scale. A third argument against this option is that it would place health expenses above other deductible expenses as a national policy priority.

The potential impact of this option is uncertain. Most taxpayers who might benefit from it would be in the lowest tax bracket; in effect the deduction would subsidize no more than 15 percent of their premium costs. This might not be a sufficient incentive to prompt many persons to buy health insurance coverage. Nor would it assist those whose incomes are so low that they would have little or no tax liability even before the deduction.

C. CHANGE INDIVIDUAL EXPENSE DEDUCTION TO A REFUNDABLE TAX CREDIT

As has been suggested, the medical expense deduction is of little help to low-income workers. In order to be of greater assistance, an individual tax subsidy might instead take the form of a refundable health care tax credit, possibly modeled on the existing Earned Income Tax Credit (EITC).

The EITC, available to workers who are supporting dependent children, reduces the worker's tax liability by a fixed percentage of earnings up to specified limits. If the calculated credit exceeds the worker's original tax liability, the difference is paid to the worker. Workers may elect to receive this payment during the tax year as an add-on to their paychecks instead of waiting until the close of the year.

In 1986, the total amount of the EITC was about $2 billion. Only a quarter of this amount was credited against actual tax liability. The remaining $1.5 billion was "refunded" to workers (these payments are a direct Federal outlay, not a tax expenditure, and are so budgeted). The number of families assisted was 6.3 million, with an average credit of $321 each.[119]

A health care tax credit might, like the current medical deduction, apply only to expenses above a given percentage of AGI. Alternatively, it might apply to all expenses, or to a fixed percentage of those expenses. Those persons who qualified for the credit but had no tax liability would receive a refundable credit. This option would make subsidies available to nontaxpayers. It would also eliminate the tendency of the medical expense tax subsidy to rise

[118] The direct charitable deduction, established by P.L. 97-34, expired on Dec. 31, 1986, and was not extended by the 1986 Tax Reform Act.

[119] U.S. Congress. House. Committee on Ways and Means. 1988. p. 610.

with taxpayer income, especially if the credit involved a fixed percentage of all qualifying expenditures and the credit itself were not taxable.

If the refundable credit were not paid in the same year in which the high medical expenses were incurred, then the effectiveness of the subsidy would be somewhat diminished (especially as an incentive to purchase health insurance). It is possible to design this option so that taxpayers could adjust their withholding to reflect the anticipated tax refund, a design feature that would address the problem of time lag between expenses and the tax subsidy of those expenses. For workers with low incomes who face minimal withholding, the credit could actually be paid to the worker throughout the year, as with the EITC.

Potential variations of the tax credit option include:

- Change the current 7.5 percent threshold requirement to a fixed dollar amount (indexed to inflation) based on family size and composition. For example, a family of four would receive a 10 percent refundable deduction for nonreimbursed medical expenses exceeding $1,000. For a family of two, the threshold would be $2,000. Thus for every $100 of expenses above the threshold, the family would receive $10 in return in the form of a deduction or credit. The deduction could be increased or decreased depending on available revenues.
- Provide a refundable tax credit of 25 percent for medical expenses above 10 percent of adjusted gross income. Thus 25 cents of every dollar spent in excess of 10 percent of AGI would be reimbursed by the Federal Government in the form of a refundable tax credit. A family of four with an AGI of $10,000 and expenses of $1,000 would derive no benefit. If their expenses reached $1,100 in a year, the family would receive a $25 credit; if the expenses reached $2,000, the credit would total $250.

Because these options would require tracking medical expenses or premiums, they would impose new administrative burdens on taxpayers and/or employers, as well as on the Internal Revenue Service (IRS). In addition, the "family units" on which determinations would be made for the credit would have to be identical to IRS filing units.[120]

These options are likely to be expensive and could result in a substantial Federal revenue loss. Credits would create savings in other Federal programs but little savings would result if the tax credits were relatively small. For example, a small tax credit would give individuals little incentive to purchase private health insurance instead of being covered under Medicaid. As is true for most options to expand eligibility for insurance, these tax options could also increase the demand for health services and stimulate inflation.[121]

---

[120] Conrad, Douglas, and Theodore R. Marmor. Patient Cost Sharing, in Political Analysis and American Medical Care. New York, Cambridge University Press, 1983. p. 215.

[121] The effects on demand of expanded coverage are discussed in U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988.

D. FUNDING A TAX CREDIT BY MODIFYING THE EMPLOYER EXCLUSION

One way of making up for any revenue loss resulting from a tax credit option would be to modify the existing exclusion from individual income of amounts spent by employers for health benefits. Changes in the exclusion could increase revenues and at the same time further other policy objectives. Two options are discussed in this section: a fixed per capita ceiling on the employer exclusion, and elimination of the exclusion for higher income employees. Although these options are raised here in the context of funding a health care tax credit, revenues could also be used for Medicaid expansions or reductions in the Federal deficit.

1. Cap the Employer Exclusion

Under this option, employer contributions (including those in cafeteria plans and flexible spending accounts) exceeding some specified amount would be treated as taxable employee income. This option is generally referred to as a "tax cap," because insurance contributions that fall below the limit or cap would still retain their non-taxable status. A more complex variation of this option would be to vary the cap according to geographic area, size of firm, occupation, or other factors that contribute to differences in health care costs among employer plans.

The Congressional Budget Office (CBO) has estimated the revenue savings for an option in which the cap is imposed at $225 a month for family coverage and $90 a month for individual coverage (1989 dollars), with these amounts indexed to reflect future increases in general price levels. Designing the cap this way would raise income tax revenues by $31 billion and payroll tax revenues by about $17 billion in 1989–1993.[122]

As noted above, the revenue gain from placing a cap on the employer exclusion could be used to provide a health care tax credit. CBO has estimated the effects of an option under which all employer-paid health insurance premiums would be made taxable, but an individual would be given an income tax credit of 20 percent for health insurance premiums up to some limit, such as $225 a month for families and $90 for individuals. At this credit percentage and with these premium ceilings, CBO has estimated that the proposal would increase income tax revenues by about $29 billion and payroll tax revenues about $78 billion over the 1989–1993 period.[123] A more nearly budget neutral proposal would allow increased subsidy levels for lower-income workers or for all workers.

The principal rationale for capping the employer exclusion is that a cap set at an appropriate level would encourage employers to trim their health insurance plans to provide adequate insurance that cost no more than the amount below the cap. However, determining an actuarial benefit value for adequate insurance could be

[122] Including employer-paid health care coverage in the Social Security wage base, however, would lead to increased outlays on benefit payments that would offset most of the added payroll tax revenues from this option over the long run. This option would also raise individual income tax revenues for states whose tax base is linked to the Federal tax base, unless they took offsetting action. See: U.S. Congressional Budget Office. Reducing the Deficit. Spending and Revenue Options. A Report to the Senate and the House Committees on the Budget—Part II. Mar. 1988. p. 125–126.

[123] Ibid., p. 127.

difficult, especially in light of regional and other variations in insurance costs. If the limit is based on a flat dollar amount rather than on actuarial value, the cap would discriminate against employers that have higher costs per employee for the same coverage, such as smaller employers, employers in high cost areas, and employers with an older work force.[124]

The addition to employees' gross income would add to their liability for Social Security payroll taxes. Since employers also pay into Social Security for each employee, they too would experience increased payroll tax liability. The cap and the tax credit could present an administrative challenge for the IRS and employers since they would have to determine whether the health benefit contributions exceeded the specified statutory limits.

Insurance carriers presumably could compete in this new environment by offering reduced benefits and thus lower-priced plans. The availability of cheaper plans might encourage employers who failed to provide coverage before the tax change to purchase policies for their workers. In other words, the stimulus for lower-priced plans could increase the availability of lower-priced products to employers who, in turn, might be more willing to purchase them, thus increasing the number of workers with health insurance.

Given the voluntary nature of the tax cap approach to extending insurance coverage, it is unknown how many employers or employees would elect insurance. The approach assumes that the cap on the employer's insurance contribution would have a robust effect on insurance prices as well as on the cost of health care generally. While agreement exists in the research literature that the employer exclusion helped to expand insurance and to fuel health care inflation, there appears to be no evidence that a reduction in employer contributions for health insurance would have a dampening effect on health care expenditures and the price of insurance. It might be that other changes, such as Federal preemption of State mandated benefit laws, would be necessary before a tax cap could have a significant effect on the price of insurance. Without such a change, companies with insured plans (as opposed to self-insured plans) would still have to buy policies that included all the benefits mandated by a State.

2. Eliminate Employer Exclusion for High-income Employees

The employer exclusion could be eliminated, for example, for taxpayers (or employees) with adjusted gross income equal to or greater than $60,000. The exclusions could be phased out between $50,000 and $60,000 (or over a wider range of dollars) to avoid a threshold effect. In conjunction with this option, nondiscrimination rules as they apply to health benefits could be repealed.[125]

This option was identified by the staff of the Joint Tax Committee of the U.S. Congress as a revenue raiser and not as a health insurance reform measure. Nevertheless, it could reduce the distributional effects of the existing exclusion while encouraging expan-

[124] U.S. Congress. Staff of the Joint Committee on Taxation and the Committee on Ways and Means. Description of Possible Options to Increase Revenues. Prepared for the Committee on Ways and Means. Washington, U.S. Govt. Print. Off. June 25, 1987.

[125] U.S. Congress. Staff of the Joint Committee on Taxation and the Committee on Ways and Means, 1987. p. 111.

sion of coverage. In 1987, the Joint Tax Committee estimated that this option would save $1.1 billion in FY 1988, and $4.8 billion for FY 1988–1990.

The rationale for the existing exclusion of benefits from the income and wages of high-income employees is that, if the exclusion did not apply to such employees, employers would not provide health benefits. However, proponents of this option say that "for the vast majority of employers, the provision of employee benefits, especially health coverage, is necessary from an employee-relations perspective. Thus, denying the exclusion to high-income employees will generally not affect employers' willingness to maintain such plans." [126] Moreover, they argue that this approach would eliminate the subsidization of higher compensated workers' health insurance and would facilitate the elimination of the complex nondiscrimination rules.

Arguments against this approach include the following: Elimination of the exclusion for high-income employees would encourage employers to drop their health benefit plans, leaving lower- and middle-income employees without benefits. In addition, for small and medium employers, the employer's willingness to provide benefits to lower-income employees is largely influenced by the availability of an exclusion for higher-income employees. This is particularly true given the administrative costs of maintaining employee benefit plans. It is also argued that employers have the same need for health insurance as their lower-income employees and would be less likely to purchase it on their own.[127] Finally, phasing out a deduction would have the effect of raising the marginal tax rate for certain income brackets and restore the incentive to seek tax shelters, thereby potentially undermining one of the objectives of the Tax Reform Act of 1986 (P.L. 99–514).

E. THE "ENTHOVEN" TAX CREDIT/VOUCHER PROPOSAL

In 1980, Stanford economist Alain Enthoven proposed a detailed plan to expand health insurance coverage within a "competitive" model.[128] To finance the plan, the existing employer exclusions and deductions would be eliminated and counted as taxable income. They would be replaced by a refundable tax credit that would equal 60 percent of a family's "actuarial cost" of health insurance. The credit would not be dependent on the family's choice of health plan. Also, it would not be related to income, except for the poor, and the employee's tax withholding would be adjusted to approximate the taxpayer's final tax liability. In this way, employees would not have to wait until the end of the year to receive the tax credit. Further:

> Employers and health and welfare funds would continue contributing to employee health insurance under existing arrangements, but they would report such contributions as part of total pay on the employees' W–2 forms, and employees would include these amounts as a part of their taxable incomes. The tax credit would only be allowed if the

[126] Ibid., p. 111-112.
[127] Ibid., p. 112.
[128] Enthoven. 1980. p. 121.

> employer and employee had spent that much or more on premiums for a qualified health plan. . . . People would not be free to keep the money if they did not join a health plan. Thus this would be a form of compulsory premium contribution through the tax system. The taxpayer would support a claim for the tax credit by stapling to his or her tax return an 'H-2' form (like the W-2), a receipt from a qualified health plan stating that the health plan had received premium payments on behalf of the employee from a private source (the employer or the employee). . . .[129]

Enthoven provided the following example to illustrate how the tax credit could work. An employee gets family health insurance coverage through his employer. The employer contributes $1,600 to the health insurance plan. Because of the elimination of the employer exclusion, this $1,600 would be added to the family's income. Assuming that the couple was in the 40 percent tax bracket,[130] they would pay increased taxes of $640. However, because of the tax credit, the couple's tax liability would decline by $810 (60 percent of the estimated actuarial cost of the insurance, or $1,350). The family's net savings would be $170. As Enthoven explained, whether the family would gain or lose would depend on the employee's tax bracket, the actuarial cost of the plan, and the previous level of employer-paid coverage. "The importance of the change is that the $810 subsidy would be the same for people with higher and lower incomes (above the low-income line at which special subsidies begin) and that the subsidy would not increase if the employee chose a more costly health plan."[131]

For the poor, Enthoven recommended a voucher usable only as a premium contribution toward a qualified plan of the individual's choice.[132] The voucher would be administered through the cash assistance welfare system. The dollar value of the voucher would be related to family income and would decline gradually with increasing income on a sliding scale designed to preserve the incentive to purchase coverage.[133]

In addition to the tax credit/voucher scheme, Enthoven included other provisions in his plan aimed at ensuring that the tax incentives would be effective in expanding coverage. For example, premiums would have to be community rated within a defined market area. Information disclosure requirements would help consumers

---

[129] Ibid., p. 122.

[130] Readers should note that this plan was developed in 1980 and thus does not reflect the reduction in tax rates resulting from the 1986 Tax Reform Act (P.L. 99-514).

[131] Ibid., p. 122.

[132] It is not clear whether the voucher could be used to purchase employer-based coverage.

[133] In a 1984 article in Health Affairs, Enthoven recommended a refundable tax credit or direct subsidy to qualified health plans equal to, for example, 40 percent of premium payments up to a limit on subsidized premiums of $60 per month for an individual, $120 for a couple and $180 for a family in 1986, indexed to per capita GNP. In advancing this proposal, Enthoven argued that the tax credit for health insurance premiums would give everyone an incentive to buy a health plan up to the subsidized limit but would make them conscious of costs after that limit. Excluding Medicare and Medicaid beneficiaries, Enthoven estimated that his proposal would have cost the budget $47 billion in 1986 if the credits were fully used. On the other hand, by holding down the general costs of health care, the policy would have saved Medicaid and Medicare dollars, producing an estimated net savings of $7 billion in the first year. Enthoven further asserted that this proposal would encourage even people with low health care risks to buy insurance, thus lessening the problems of adverse selection that occur in the individual subscriber market. See: Enthoven, Alain. Health Tax Policy Mismatch. Health Affairs, Spring 1984. p. 5-13.

shop for cost effective plans. Health insurance plans would have to meet minimum standards, such as providing protection against catastrophic expenses.

The plan as a whole would require a vast restructuring of Federal tax law. Some of its features could draw substantial opposition from the insurance industry and other influential actors in the tax arena. It is possible that lawmakers might consider a tax credit and voucher scheme in isolation from the other features outlined in the Enthoven proposal. Such a scheme would have certain advantages. First, it would provide for a broad-based tax credit. Workers who do not have employer-sponsored coverage would have access to the same tax incentives as those with coverage. Household members could pool their earnings to obtain more benefits. Also, additional labor costs would not be imposed on employers to offer health insurance benefits, and consumers would have the freedom to choose among insurance plans. However, persons who could not obtain group coverage and those considered high risk would still face above-average premiums. To resolve this problem, the tax credit could be adjusted to reflect higher premiums, or insurance companies could be compensated by the Federal or State governments for the added risks of covering such persons. The tax credit approach could also be used with State pools for the uninsured by providing credits to pool enrollees with incomes under a specified level.[134] This would help to offset the economic burden created by the high cost of pool coverage.

Tax credits and vouchers also have disadvantages. First, because those most likely to use vouchers would be those in poor health, significant potential exists for adverse selection. Second, credits and vouchers could make it easier for some employers to continue not to provide coverage, and for others to decrease or stop coverage. Third, while vouchers would allow consumers to choose among health plans, they could expose consumers to the hazards of the market if they were not fully informed about the content of the plans. Unless health insurance plans were required to meet minimum standards, consumers might end up purchasing inadequate coverage. If minimum standards were established, then administration and enforcement would become more cumbersome. Even without such requirements, administering the voucher would require some agency to make income determinations. In short, a straight voucher without any minimum standards would be relatively easy to administer but would leave consumers and the government financing the vouchers vulnerable to wasteful and poor quality policies. If the government chose to limit the use of vouchers to plans that met requirements, then the government might be faced with substantial bureaucracy and administrative burdens. Finally, credits and vouchers would be costly, although most or all of the costs could be offset by the elimination of such tax expenditures as the employer exclusion.

---

[134] Monheit, Alan C., et al. The Employed Uninsured and the Role of Public Policy. Inquiry, 22. winter, 1985. p. 362.

IV. Options to Encourage Employer Coverage

Although Federal tax law already encourages employers to provide health benefits by permitting the costs to be deducted as a business expense and by allowing the exclusion of employer contributions from employees' taxable income, some changes in current law might increase the incentives for certain classes of employers to offer coverage. Two options are discussed in this section: increasing the business expense deduction for the self-employed and other unincorporated businesses, and modifying the tax treatment of self-insured plans.

A. INCREASE BUSINESS DEDUCTION FOR SELF-EMPLOYED AND UNINCORPORATED FIRMS

As noted above, the current deduction for health-related expenses for self-employed businesses is limited to 25 percent. The deduction could be increased to 100 percent and made permanent.[135]

Some observers say that the existing limited deduction for unincorporated businesses is partly responsible for the fact that sole proprietorships are less likely to offer coverage than similarly sized incorporated businesses. For example, 29 percent of sole proprietorships with 1 to 9 employees have coverage, whereas 70 percent of similarly sized incorporated businesses have health insurance.[136]

The Joint Tax Committee estimated that, if the business deduction for the self-employed had been increased to 100 percent effective January 1, 1988, the revenue loss would have been $500 million for FY 1988, $900 million for FY 1989, and $1.3 billion in FY 1990.[137] However, because some small businesses operate at marginal profitability, increasing the deduction to 100 percent for self-employed businesses might not be a sufficient incentive to encourage the provision of health insurance coverage. In 1983, for example, almost 3 million of the 11 million sole proprietorships had receipts of less than $2,500.[138] And if there are no profits at all, the business does not have to pay income taxes and thus cannot benefit from a deduction.

Some representatives of small business have suggested that a more effective incentive would be to provide a tax credit against payroll taxes (FICA and FUTA) for sole proprietorships. Because almost all self-employed businesses have to pay these taxes, the provision of the credit would not be contingent upon having taxable income.[139] In addition, a portion of the FICA tax (1.45 percent

---

[135] An intermediate step would be to provide for a Federal demonstration of the effectiveness of a 100 percent tax deduction. For example, under S. 2027 (introduced by Senator Quayle in the 100th Congress), the Secretary of Health and Human Services would be authorized to test the impact of such an approach by funding a subsidy to self-employed individuals in three counties with diverse economic conditions that would be equivalent to the benefit they would receive from the full tax deduction.

[136] American Hospital Association, 1988, p. 5. See, also, U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988. Chapter 3, for a discussion of this point.

[137] U.S. Congress. House Committee on Small Business. The Health Insurance Problem: Alternative Strategies to Expand Coverage Among Small Businesses. Washington. U.S. Gov't. Print. Off., Dec. 1987. p. 30.

[138] American Hospital Association, 1988. p. 23, table 7, p. 180.

[139] Testimony of John Motley III, National Federation of Independent Business, before the House Small Business Committee, June 16, 1987. In: The Health Insurance Problem. Hearings. Serial No. 100-7. p. 156-157.

on a maximum contribution base of $45,000 in 1988) goes to the Medicare hospital insurance trust fund, so there is precedent for such revenues being used for health-related purposes.[140] On the other hand, the revenue drain from FICA and FUTA could be substantial. This approach would thus be at odds with existing concerns about the status of these trust funds.

B. CHANGE FEDERAL TAX TREATMENT OF PREFUNDING

Under current Federal law, employers are permitted to claim as a business expense funds actually paid out for health benefits but not funds set aside to cover future benefits. The inability to recognize and prefund health expenses for tax purposes may have prevented some smaller firms from considering self-insurance as a way of providing coverage to their employees. Some people argue that more employers would offer health benefits if they did not have to purchase the benefits from insurers.

While the same barrier to prefunding exists for larger firms, they may be in a better position to cover unanticipated losses from their health plans out of current operating revenues. Smaller firms may have less financial flexibility and are therefore more likely to purchase stop-loss insurance to protect against catastrophic claims. They must obtain this reinsurance in the private market and may face some of the same underwriting and rating barriers that they would encounter if they were seeking to purchase basic health coverage.

If the Internal Revenue Code allowed self-insuring entities to set aside funds in a trust dedicated solely to paying health care costs *on a tax free basis,* these entities would be able to finance the benefits out of their reserves as obligations were incurred rather than out of their operating budgets. Given such a tax advantage, small firms might be encouraged to establish such trusts and provide health benefits, thereby potentially increasing the number of employees with health insurance.

Thus, *if the goal is to encourage more self-funding* on the part of employers, Federal tax law could be changed to allow tax-favored status of trusts set aside to fund health benefits.[141] (This idea is also advanced to encourage firms to finance retiree and long-term care health benefits.)

It is important to note, however, that without accompanying changes in Federal requirements on self-insured employer health plans, such plans would remain relatively unregulated. Opponents of this option argue that as smaller and smaller firms chose to self-insure, bankruptcies and the loss of benefits for plan enrollees would increase. Nevertheless, some small business advocates have suggested that prefunding would help encourage small employers to provide coverage.

The most common prescription for encouraging prefunding is to eliminate existing limits on 401(h) trusts and voluntary employee benefit associations (VEBAs) under the Internal Revenue Code.

---

[140] Ibid., p. 159.

[141] U.S. Congress. House. Committee on Small Business. Health Insurance Problem: Alternative Strategies to Expand Coverage Among Small Businesses. 100th Congress, 1st session. Washington. U.S. Gov't. Print. Off. Dec. 1987.

Partly because of concerns about abuses of VEBAs, Congress placed strict limits on their use in the Deficit Reduction Act of 1984. As a result, VEBAs have lost their value as a prefunding mechanism. The 1984 Act: (1) prohibits employers from taking a deduction for welfare benefits that may be provided in the future; (2) provides that benefits cannot discriminate in favor of highly paid employees; (3) requires separate accounts to be maintained for key employees; (4) prohibits assumptions about future medical price inflation and utilization to be recognized in actuarial calculations for determining employer costs for prefunding benefits; and (5) requires that taxes be paid on investment income earned on reserves.[142] Repeal of these limits would enable employers to set aside on a tax-free basis money to fund health benefits. These funds could also accumulate tax-free interest. Opponents of such a change point out that the DEFRA limits were imposed to ensure that employers were not using VEBAs for improper purposes and to reduce the loss in Federal revenues. Congress and the Treasury are unlikely to return to pre-DEFRA days without imposing strict vesting, portability and solvency requirements on self-insured plans, thereby eliminating some of the major reasons for an employer to self insure.

V. Options Using State Tax Incentives

A basic question for lawmakers interested in extending coverage through government action is whether responsibility for expanding access to insurance should be a State, Federal or joint responsibility. If it is determined that the States should assume a major role, then some of the employer-based options discussed above could be enacted and enforced at the State level. Hawaii provides a model of a State law requiring employers to provide coverage; it is conceivable, however, that a State might choose to experiment with less compulsory, tax-based approaches to expanding coverage tied to the workplace. Nevertheless, the range of State options is limited by ERISA, by variations in State tax and economic capacity, and by variations in political environments.[143]

A. SELF-EMPLOYED TAX DEDUCTION FOR HEALTH INSURANCE PREMIUM

Most States, like the Federal Government, allow a deduction from State income taxes of 25 percent of health insurance premiums paid by self-employed persons. One State option would be to increase the deduction of premiums paid by self-employed persons for health insurance for themselves. An additional option would be to condition the deduction upon the self-employed person offering comparable health insurance coverage to any employees.

This option would provide some additional coverage, especially if the deduction were made contingent upon offering coverage to employees. The proposal is more likely to be effective in States with high taxes and less effective in States with low taxes. Moreover, the low profitability of many self-employed businesses results in little income on which to pay taxes.

---

[142] The 1984 amendments also placed additional limits on VEBAs as they are used to prefund retiree health benefits. See Deficit Reduction Act of 1984 (P.L. 98-369).

[143] The Government Research Corporation. Options for Meeting Health Care Requirements of Uninsured Individuals: A Report of a Task Force. Washington, Feb. 1988. p. 16-19.

B. PROVIDE TAX SUBSIDIES TO EMPLOYERS

A State could provide tax subsidies to employers that offered coverage to their employees. This option could be tailored for small employers or provided to all employers. The subsidy could be based on the number of employees (and dependents) actually covered under the employer's plan. The benefits could be left to the employer to determine or could be set by the State in the form of a minimum benefit standard.

Given a large enough subsidy, employers could be encouraged to provide health insurance, achieving the objective of covering more people. However, the revenue outlays for many States might be prohibitive. Moreover, questions of equity would be raised if the provision were restricted to small employers, especially if employer eligibility were restricted by criteria such as number of full-time employees. The subsidy could be awarded on the basis of hardship (e.g., employers paying 5 percent or more of payroll for health insurance), thereby limiting the costs of the program but creating additional administrative tasks for the State or local government agency. Alternatively, the subsidy could be made available to all employers that provide coverage, either on a temporary or permanent basis. Financing could come out of general revenues or a designated tax on all employers.

Under the new Massachusetts Health Security Act, a tax credit against the personal and corporate income tax will be available in 1990 and 1991 for firms with 50 or fewer employees (including self-employed firms with at least one employee) that pay health insurance premiums in part or in full for their employees. The plan has to be made available to at least all full-time employees, and the tax credit is available only to employers that have not offered health insurance in the previous 3 years. The credit will equal 20 percent in the first year and 10 percent in the second year.

Under Oregon's Health Care Tax Credit Law of 1987, employers offering health insurance to their employees through a new State pool will be eligible for tax credits for each employee covered. The amount of the tax credit is scheduled to decline over a 5-year period.[144]

[144] American Hospital Association, 1988. p. 87.

CHAPTER 6.—EMPLOYMENT-BASED OPTIONS

I. INTRODUCTION

Employment-based plans are the major source of health insurance for Americans. In 1986, 137 million persons, or 65 percent of the total population, received health coverage through their own work or through that of another family member.[145] That employment-based coverage is so widespread is partly the result of Federal policy. As was discussed in the previous chapter, Federal tax law gives employers incentives to provide coverage. Other Federal policies have also played a historic role. Immediately after World War II, and again during the Korean conflict, when wage-price controls were in effect, employers offered or unions negotiated fringe benefits as an alternative to wage increases. These periods saw major growth in the number of employers offering coverage.

Still, employer coverage is by no means universal. Of the 37 million Americans who lacked any health insurance in 1986, 42 percent were employed full-time throughout the year or were dependents of a full-time worker. Another 46 percent worked part-time or for only part of the year, or were dependents of such a worker. Only 12 percent of uninsured persons under age 65 had no personal or familial connection to the labor force.[146]

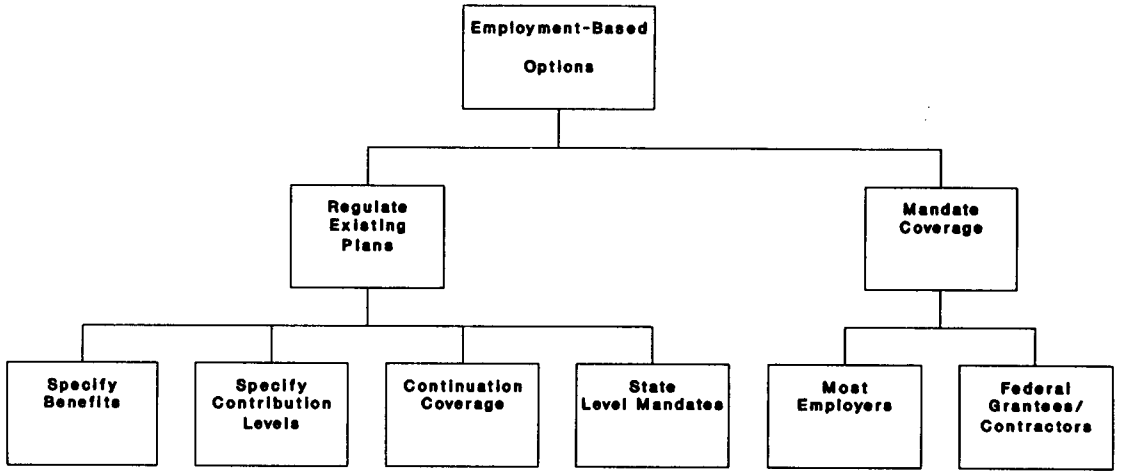
This chapter considers ways in which further Federal initiatives might be used to provide employment-based coverage to more persons or to improve the coverage already provided by employers. The analysis of employment-based options is divided into four major sections: (1) Federal requirements on existing employer-based health plans, (2) State-level mandates, (3) options in which employers nationwide are required to provide coverage, and (4) requirements for employers receiving Federal funds, such as State and local governments and government grantees or contractors. Chart 6.1 shows the options to be considered.

[145] Congressional Research Service estimate, based on data from the March 1987 Current Population Survey (CPS).

[146] Ibid.

Chart 6.1

Employment Based Options



II. B II. C II. D III. IV. V.

These options can be understood as being arrayed along a voluntary-compulsory continuum. One end of this continuum was described in chapter 5. At the voluntary end, incentive-based options, such as tax incentives, are the least intrusive on employers. The government provides inducements to encourage employers to provide coverage and employees to elect it. Moving along the continuum, incentives are replaced by penalties, most commonly applied when an employer with an existing health plan fails to meet certain requirements. Federal law already provides for a variety of penalties on existing employer-sponsored health plans that fail to meet requirements such as continuation coverage (title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA)) and the nondiscrimination provisions (section 89 of the Internal Revenue Code).[147] The employer's decision whether to provide coverage is still voluntary, but if coverage is provided, then various characteristics of that coverage are regulated by Federal law. While the employer can still choose not to comply with these Federal requirements, that choice may result in substantial penalties, such as the loss of a tax deduction. Penalties are also applied directly to higher compensated employees, who are likely to be at the management levels of the company. Placing requirements on existing employer plans tends to be more complex to administer than incentives, sometimes involving more than one Federal entity to apply the requirement to the broadest range of employers. For example, title X of COBRA is administered by three agencies: the Departments of Labor, Treasury and Health and Human Services.

At the other end of the continuum lies fully mandated employer-provided coverage. In this case, the role of the government is far more intrusive. It imposes a requirement that all employers (or a defined type of employer) provide health insurance to their employees and possibly to their employees' families. Such mandates normally would be coupled with explicit sets of rules for compliance. To enforce the mandate, the government would provide for a set of penalties.

While incentives are a positive form of reinforcement, penalties are a form of negative reinforcement. Under the penalty approach, if the employer elects not to provide health insurance, then it is subject to a penalty such as a monetary fine. Or, if the employer's plan fails to meet certain standards, tax-favored status for expenditures on health benefits may be revoked. If the cost of the penalty is manageable to the employer, then there is a degree of voluntarism involved. If the cost/pain of the penalty is so high as to, in effect, constitute an outright prohibition and a lack of choice, then it is no longer a penalty but a mandate. Here is where theory and practice could diverge. One employer's penalty may be another employer's mandate.

---

[147] For information on such existing Federal mandates on employer-sponsored health benefit plans, see chapter 3, U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. Prepared for the Subcommittee on Labor-Management Relations, and the Subcommittee on Labor Standards of the House Committee on Education and Labor and the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, and the Senate Special Committee on Aging. May 24, 1988. Education and Labor Serial No. 100-Z. Energy and Commerce Serial No. 100-X. Special Committee on Aging Serial No. 100-I.

In between the two major approaches discussed in this chapter, requirements for existing voluntary plans and mandatory coverage by all employers, there is an option that might be characterized as semi-voluntary: mandatory coverage by entities receiving Federal funds. Such a mandate would be voluntary in the sense that no entity is obliged to accept Federal funds or any restrictions that accompany those funds; it is mandatory in the sense that many public and private employers are substantially dependent on Federal funding. This intermediate option is considered at the end of the chapter.

II. Requirements on Existing Employer-Based Health Benefit Plans

A. INTRODUCTION

This section reviews options for extending coverage to those workers and their families who are linked to employers that already offer coverage. In such cases, the employer has made the choice to offer a plan and has overcome any problems with obtaining insurance. The options are organized under three major headings: (a) those that penalize employers with existing health plans that *fail to provide specific benefits* to plan participants, (b) those that penalize employers with existing plans that *fail to pay a specific percentage of the premium costs of the insurance,* and (c) those that penalize employers with existing plans that *fail to provide continued health insurance coverage to specific categories of employees and/or their families.* The next section of this chapter provides a brief discussion of comparable requirements imposed under State law.

In considering these options for legislation, several major questions have to be addressed: What is the nature of the requirement on the employer? Should the requirement apply to all employers who provide coverage, and, if not, where should the limits be drawn? For example, the Medicare working aged and COBRA title X (hereafter referred to as COBRA) requirements exempt employers with fewer than twenty employees, although the Medicare working disabled provisions enacted in the Omnibus Budget Reconciliation Act (OBRA) of 1986 (P.L. 99–509) apply to only those employers with 100 or more employees. To date, Congress has been wary of applying requirements to very small employers, largely because of concerns that these requirements would result in economic and administrative hardships. Congress has also excluded the Federal Government and religious organizations from certain requirements.

Additional questions relate to the population to be covered. Should the employer's responsibility be limited to active full-time employees, or expanded to include any or all of the following: part-time employees, temporary or seasonal employees, retired employees, spouses, widowed and/or divorced spouses, dependent family members, and employees who have terminated their employment, either voluntarily or involuntarily? COBRA and its subsequent amendments provide an example of a broad definition of beneficiaries.

Like COBRA, the option might be directed at ensuring that employers offer health benefits beyond the point at which the employee (and his/her dependents) has an immediate connection with the employer. In the past, Congress has considered proposals to require that employers pay for the continued group coverage of laid-off employees for a defined period of time. Such continuation of coverage requirements might extend to laid-off or otherwise terminated employees, retirees of the firm, and spouses and dependents of such active and retired employees.

Other questions relate to the financial liability of the employer and the employee. Who pays for what? Again, in COBRA, Congress authorized employers to require the employee or other qualified beneficiary to pay for the continued health coverage, plus a small additional cost to cover the employer's administrative costs. Other Federal legislation that affects the nature of the employer-provided plan's benefits tends not to prescribe who is to pay. The assumption is that the existing premium cost-sharing arrangement between employer and employee would not be affected, or that it is a decision to be negotiated between the employer and plan enrollees.

The major limitation of requirements that apply to employer-provided plans is that they affect only employers who choose to provide health benefits. For the uninsured who are attached to employers without coverage, these options could have no effect at all. Moreover, the addition of new requirements could, in some cases, discourage employers from offering health benefits and might lead some employers to terminate their plans. Also, many argue that it is unfair to place new requirements on employers that already provide coverage when there remain many employers that provide no coverage at all.

B. OPTIONS TO REQUIRE SPECIFIC BENEFITS

1. Require Prenatal and Early Child Care Coverage

Employers could be required to cover either prenatal or well-baby care or both under their group health plans. An employer that failed to provide such coverage might be subjected to the loss of the business deduction for health expenses, and/or the loss of the employer exclusion for highly compensated employees.[148] State and local governments could be subject to the loss of designated Federal funds, such as Public Health Service funds. If desired, a separate requirement could be included under title V of the U.S. Code relating to health plan coverage of Federal employees under the Federal Employees Health Benefit Plan (FEHBP). A health insurance plan would have to offer these benefits in order to participate in the Federal program.

In the 100th Congress, legislation was introduced to require employers to provide coverage of pediatric preventive health services. Under S. 968, introduced by Senator John Chafee, and H.R. 1449, introduced by Representative Ed Jenkins, employers would lose the deductibility of health insurance premiums if their health plan

[148] "Highly compensated employee" has a specific definition in the Internal Revenue Code. See Internal Revenue Code, section 105(h)(5). The loss of the exclusion for higher compensated employees is sometimes used to enforce requirements on non-profit firms.

failed to include children's preventive care and health supervision services for children up to age 18. The services are defined to include physical examinations, immunizations, laboratory procedures, vision and hearing tests, and developmental and behavioral assessments.

Most health plans do not cover well-baby care and many small firms do not provide prenatal care.[149] For a typical medium or large employer plan, the inclusion of coverage for well-baby care would add about $27 in annual premium costs for family coverage (individual coverage would not be affected).[150]

There is substantial evidence that prenatal and well-baby care benefits are cost effective. For example, the Institute of Medicine found that, for every $1 spent on prenatal care, $3.38 can be saved in the costs of care for low birthweight infants.[151] Well-baby care would also increase the percentage of children who receive immunizations, because these are generally not covered by group health plans.[152] Proponents of well-baby care argue that existing health benefit plans are inappropriately designed to benefit adults, who have different utilization patterns than children. Insured adults, on average, use significantly more hospital care than insured children under age 17.[153] Also, young parents tend to be less financially secure; they may be under tight budget constraints and may delay seeking health care for their children until there are serious problems, resulting in higher costs for the plan and its participants.

The policy option could be designed to include children up to a specific age, or all children. In addition, prevention requirements could be directed at the adult population. For example, employer plans could be required to include annual preventive examinations or annual or biannual cancer screening (e.g., breast and prostate) for employees over a certain age. Requirements applicable to adults as well might limit any incentive to discriminate in employment against mothers and children, a possible outcome of mandates applicable to children alone.

There might be substantial opposition from employers to requirements that their plans provide for such benefits. In addition to their philosophical objections to government "mandates," employers argue that such requirements would eliminate their flexibility

---

[149] A survey by Towers, Perrin, Foster and Crosby, Inc. found that 53 percent of companies do not provide well-baby care. See T. P. F. & C. News. Health Benefit Plans Fall Short of Proposed Legislative Requirements. Aug. 1987. Hay/Huggins estimated that 70 percent of companies would have to revise their plans to have prenatal coverage with no deductibles or coinsurance.

[150] U.S. Library of Congress. Congressional Research Service. Cost and Effects of Extending Health Insurance Coverage. 1988. Chapter 2.

[151] For a summary of the major studies of cost-effectiveness of prenatal care and childhood immunizations, see U.S. House. Select Committee on Children, Youth and Families. Opportunities for Success: Cost Effective Programs for Children. Updated. 100th Congress, 2nd session, 1988. Washington, U.S. Govt. Print. Off., 1988.

[152] Chafee, John. Child Health Incentives Reform Plan. Floor statement on introduction of S. 968. Congressional Record, Apr. 9, 1987, p. S4992-4. According to the Children's Defense Fund, the general levels of immunization for pre-school age children worsened or showed no improvement between 1980 and 1985. For example, the proportion of children younger than one receiving no doses of polio vaccine was 20.4 percent in 1985, a slight increase over 1980, but for nonwhites, it rose from 26.8 to 41.5 percent. Also, the proportion of infants inadequately immunized against diphtheria, tetanus and pertussis increased for all races. See Children's Defense Fund, Who is Watching Our Children's Health? The Immunization Status of American Children, December, 1987. While lack of insurance is one factor affecting the rate of vaccinations, so too is parents' fears that the vaccinations will produce adverse side effects.

[153] U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. 1988. p. 143-147.

in tailoring health benefit plans to the specific needs of their workers. In some firms with older workers, prenatal and well-baby benefits would not be used, although other required preventive services might be used. In addition, under plans in which premiums are calculated for individuals or families (and not separately for couples with no children), this requirement could increase the subsidization of families' health care by childless couples. Finally, the requirements might encourage employers to reduce their contribution to premiums for dependents.

2. Require Catastrophic Illness Coverage

Employers could be required to provide catastrophic coverage as a benefit under their health benefit plans. For example, H.R. 2300, the Catastrophic Illness Expense Protection Amendments of 1987, introduced in the 100th Congress by Representative Willis D. Gradison, Jr., would deny an employer a deduction for group health plan expenses unless an employer's plan included protection against catastrophic physician and hospital expenses. H.R. 2300 would limit employee liability for physician and hospital expenses to out-of-pocket costs for plan covered expenses of $2,000 for individuals and $3,500 for families. After the limit was reached, the plan would be required to pay 100 percent of subsequent physician and hospital expenses. The provision would apply to employers with 20 or more employees.[154]

Under a flat-dollar cap, out-of-pocket expenses of $2,000 for a family of four would equal 20 percent of a family's adjusted gross income of $10,000, but only 4 percent for a comparably sized family with $50,000 in income. To avoid this inequity, the out-of-pocket maximum could be varied with family income. A number of States have designed such income-related catastrophic plans, and a few now have them in operation. Under the income-related approach, the policy could be designed to apply to all existing and future employer group plans. Plans would be required to count toward the catastrophic limit any expenses that are considered covered medical expenses under other provisions of the plan. Catastrophic coverage would be triggered once out-of-pocket costs (coinsurance and deductibles for services covered by the plan) exceeded some percentage of adjusted gross income. The third report in this series analyzes the effects of a variation of this approach on access, utilization, costs and other factors influencing the health care system.[155] Possible details of an income-related catastrophic plan are also discussed in that report.

Most medium and large employers that provide health insurance already have some level of catastrophic coverage. In fact, most plans provide for a cap on out-of-pocket expenses for covered services that is less than $2,000 for individuals. For example, in 1987, 83 percent of the Hay/Huggins Benefits Report plans had explicit limits on the dollar amount of expenses enrollees paid for covered services, and all but about 5 percent of these plans limited individ-

---

[154] To ensure that non-profit organizations also provide catastrophic benefits, the penalty could be expanded to provide for the loss of the employer exclusion for highly compensated employees.

[155] U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988.

ual out-of-pocket expenses to $2,000 or less.[156] An SBA survey reports that in 1986, 75 percent of all health plans had annual out-of-pocket limits of $2,000 or less; only 5 percent had no limit. For those plans with limits, the overall average out-of-pocket limit was $1,687. For firms of 1 to 9 employees, the limit was slightly over $2,000.[157] Thus, a requirement that existing plans provide *flat dollar catastrophic coverage* would affect a relatively small percentage of firms, especially if the provision did not affect the smallest employers. For those firms that would need to add catastrophic coverage, the premium costs would be small. However, for newly covered employees and their families, the catastrophic protection could be very beneficial. The added coverage would provide many plan enrollees peace of mind that a major accident or illness would not result in bankruptcy. For millions of working Americans and their families who are "underinsured," catastrophic insurance would provide direct benefits in the form of increased coverage.[158]

Critics of this approach argue that such a requirement is misdirected, because the emphasis should be on increasing access to basic health care services. They argue that catastrophic benefits do not increase access to such services, especially if the benefits are designed as a flat dollar amount on out-of-pocket expenses. Instead, catastrophic benefits limit a person's financial liability in the rare event of a serious illness or accident. Moreover, employers may divert some or all of the dollars required to pay for catastrophic coverage from other benefits, possibly resulting in less "front-end" coverage or higher out-of-pocket costs for employees who do not reach the limit. While it is true that in the absence of such catastrophic coverage a person with unaffordable medical expenses might be required to spend down to poverty, the likelihood of a catastrophic event occurring is relatively low. Also, the health care provider might have to absorb the costs of an uninsured person's care. For this reason, proposals to provide catastrophic coverage are sometimes viewed as "bail outs" for providers.

Employer groups have opposed such proposals because they believe they set a precedent for Federal interference with plan design. They also argue that such proposals will result in less coverage because increased premium costs will cause some workers to drop coverage.[159] (However, the Congressional Research Service (CRS) estimates that the addition of a catastrophic limit to an existing health benefit plan would raise premiums by less than 1 percent.)[160]

An *income-related catastrophic benefit* could be difficult to design and administer. Either an employer or an external entity (such as

---

[156] For more detailed information on coverage of catastrophic expenses, see U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. 1988. p. 129–130.

[157] U.S. Small Business Administration. Office of Advocacy. Health Care Coverage and Costs in Small and Large Businesses. Final Report. Prepared by ICF, Inc., 1987. p. ES–4, IV–8.

[158] See U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage, 1988, for estimates of the effects of mandated catastrophic coverage proposals.

[159] U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Insurance Protection for Catastrophic Health Expenses for Individuals Under Age 65. Hearing 100–37, May 21, 1987. See especially the testimony of the ERISA Industry Committee, p. 88–92.

[160] U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988.

a State's Medicaid agency) would have to make income determinations as well as track insurance claims against the catastrophic limit. If the limit on out-of-pocket expenses were low, such as $500 (5 percent of an adjusted gross income of $10,000), then the policy would become, for most, basic coverage with an above-average deductible. As a result, the cost of the policy would approach the cost of an average employer group policy.

3. Prohibit Extended Waiting Periods

Employers with existing group health plans could be subject to a tax penalty if their plans required more than a 90-day period of employment (or other specified waiting period) before deeming an employee eligible for coverage.

The Small Business Administration (SBA) survey of employers in 1986 indicates that 11 percent of all firms had waiting periods of 4 to 6 months; 7 percent of all firms had waiting periods in excess of 6 months. Waiting periods for firms with 1 to 9 employees were similar: 15 percent had 4- to 6-month waiting periods, and 8 percent had waiting periods longer than 6 months. For firms of 500 and over, the percentages were 9 percent and 1 percent.[161] A 90-day limit would affect a minority of firms, but would have the potential for improving access to coverage for a substantial number of employees. Such a limit would mean that employees would have to work only 90 days (full-time) before becoming eligible for insurance coverage. The difficulty created by such an option is that it could create new burdens on firms using seasonal labor and other temporary employees. Although the requirement could be limited to "permanent employees," this too would create definitional problems and encourage some employers to evade the requirement by defining employees as temporary even if the employees are hired with the intention of becoming permanent.

C. OPTIONS TO REQUIRE EMPLOYER CONTRIBUTIONS FOR WORKERS

Employers could be required to pay for a set share of the premium costs for active workers. An analogous model is the contribution structure for the FEHBP, in which the Federal Government contributes 60 percent of the average of the premiums (using the high option where more than one option is offered) of six participating plans with large Federal enrollment. For any plan option, the Federal Government's contribution for employees and retirees cannot exceed 75 percent of the total premium cost. Given existing practices in medium and large private firms, the employer contribution requirement might be set at 80 percent for employee coverage and 60 percent for dependent coverage. This would be a minimum standard; at their option, employers could provide more generous contributions. To ensure that plans did not shift costs by increasing deductibles and coinsurance, it might also be necessary to provide that the employer's share be calculated as a percentage of total plan costs, including cost sharing, and not premium costs.

This option might result in increasing the percentage of employees and their dependents who obtained coverage under employer-

[161] U.S. Small Business Administration, 1987. Table III-12. p. 111-20.

based plans, because employers would be paying a larger portion of the premium. Based on 1987 Hay-Huggins Benefits Report (HHBR) data, if the minimum employer contribution for employee coverage were set at 80 percent, 42 percent of the employers would have to change their plans. Such a requirement would, however, have a differential effect on employers according to their firm size. For reasons described in chapter 2, small firms tend to require a lower premium contribution from enrollees than do large firms. Seventy-one percent of very small firms (1–9 employees) pay the entire premium for single employee coverage, compared to 60 percent of large firms (500 and above). Twenty-two percent of very small and 15 percent of large employers require employees to pay 40 percent or more for single coverage. For family coverage, 70 percent of very small firms pay the entire premium compared to 34 percent of large firms. Twenty-seven percent of very small and 51 percent of large firms require employee contributions of 40 percent or more for family coverage.[162]

D. OPTIONS TO REQUIRE EXISTING PLANS TO PROVIDE CONTINUED HEALTH INSURANCE

COBRA continuation coverage could be modified to increase the types of people eligible or to cover existing eligible persons for a longer period of time. A number of arguments against COBRA and potential expansions to COBRA would generally apply to such options. Opponents argue that it is not appropriate for the Federal Government to regulate employer-sponsored benefits. They say that expansion of COBRA would impose further government regulation and red tape on what have heretofore been private matters between employer and employee. Large numbers of employers already offer, and in many instances pay for, continuation of coverage. Moreover, additional requirements on employers might lead employers to pare back other fringe benefits that may be more appropriate or desired by their workforce. COBRA has already created some confusion for employers and employees. Expansion of the scope of COBRA coverage could compound these difficulties. And some argue that if COBRA's duration of coverage and/or eligibility were expanded, increasing numbers of employers, especially smaller ones, might drop their health benefits entirely. This would be even more likely if employers were required to contribute to the premiums.

Opponents of COBRA expansions also point to the probability of adverse selection. Employers assert that the people who elect COBRA continuation coverage are likely to be those persons who know that they will be using health services and are thus willing to pay for the more comprehensive continued employer-sponsored benefits rather than depend on their own resources or comprehensive but more costly individually purchased plans. For experience-rated plans, any deficit may affect premiums for all employees in the following year. In large firms, the size of the pool should help to minimize the effects of COBRA claims, but in small firms, the

[162] U.S. Small Business Administration. 1987. Tables iv–8, iv–9. Data are for plans that are not self-insured.

effects of adverse selection could be more significant. To the extent this is so, not only will insurers raise premium costs, but in some cases they might cancel the policy when the employer's contract is up for renewal. Employers argue that expansions of COBRA could exacerbate the adverse selection problem, especially if they were directed at high risk populations such as retirees or disabled persons.

However, the evidence to date on the effects of COBRA is inconclusive. According to one survey of large and small employers, about 12 percent of all employees and dependents eligible for COBRA coverage in 1987 actually took the coverage. Fewer than 50 percent of the employers surveyed responded to questions about the cost of the COBRA coverage. Their responses revealed no pattern, even as the size of the group of continued coverage enrollees increased (insurance theory says that the risk becomes more predictable as the size of the group grows). "Only 16 employers had COBRA costs between 90 percent and 110 percent of active [enrollee] costs; 13 employers had costs more than double and 15 had costs less than half of active employee costs."[163]

Proponents of COBRA expansions respond that it is not yet clear that COBRA coverage results in adverse selection. Even if it does, from a social welfare perspective it may make sense that active employees subsidize the health care costs of former employees and their families. These people are in a period of transition; many are financially weakened by the loss of a job or family breadwinner. In addition, such options would reduce the costs of uncompensated care that are passed along to employer-provided plans through increased provider charges.

Advocates of COBRA expansions also argue that there are advantages to the COBRA approach. First, COBRA expansions are not sweeping mandates on employers to provide insurance, only requirements on employers that offer group insurance. COBRA expansions might reduce the need for more comprehensive mandates. Moreover, since COBRA options would affect only employers with existing health plans, the administrative structures for their implementation are already in place. Also, because of the COBRA experience, the Federal Government has already established the capacity within three departments (Health and Human Services, Labor, and Treasury) to implement and enforce its provisions. Finally, with the exception of COBRA options that would require employers to contribute to the premium payments, they could be implemented with no direct effect on the Federal Treasury. Options requiring employer contributions would produce a revenue loss because of the increases in the employer exclusion and the business expense deduction for employer-paid premiums.

1. Extend Duration of COBRA Coverage

Under current law, COBRA requires a maximum period of continued coverage of either 18 or 36 months, depending on the qualifying event. Changes in family status trigger up to 36 months of coverage. Changes in employment status trigger 18 months, a

[163] Spencer, Charles D. and Associates. Spencer's Research Reports on Employee Benefits. Chicago [regularly updated]. Sections 329.04-5 through 329.04-12.

period that is too short for individuals who are disabled and awaiting coverage under Medicare because Medicare eligibility on the basis of disability requires a 29-month waiting period from the time the person first files for Social Security disability benefits.[164] COBRA could be amended to require employers to extend COBRA coverage for disabled terminated workers and their families from 18 to 29 months.

This approach is incorporated in H.R. 4136, the AIDS Health Care Financing Act of 1988, introduced in the 100th Congress by Representative Nancy Pelosi. Among other provisions, the bill amends the Internal Revenue Code, the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act to require continuation coverage of 29 months in the case of an individual who is determined, under title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event for continuation coverage. The bill also provides that the employer may charge a premium equal to 152 percent of the premium for similarly situated employees for coverage for months 19 through 29. In addition, the legislation provides for a special fund through the Health Resources and Services Administration of the Department of Health and Human Services to pay premiums and deductibles for those who cannot pay. Thirty million dollars would be authorized for this purpose for each of 3 years. The money would be distributed as grants among the States "in a manner that takes into account the relative number of individuals in the States who are eligible for assistance" under the COBRA extension for disabled persons.

The limitation on access to insurance created by the waiting period for Medicare has been much discussed with respect to AIDS victims, but it is also a problem for many persons who lose or quit their jobs because of other severe medical disabilities. Because of these persons' preexisting disabilities and health conditions, it can be expensive and sometimes impossible to buy insurance in the individual subscriber market.

As noted in chapter 4, unpublished data from the Census Bureau's 1983–84 Survey of Income and Program Participation indicate that 585,000 of the 2.4 million Social Security Disability Income recipients, or 24 percent, were not receiving Medicare. Of those without Medicare, 50 percent had Medicaid, while 3 percent had both private coverage and Medicaid. The remaining 22 percent, or about 129,000 beneficiaries, had no insurance coverage or were covered by CHAMPUS or CHAMP-VA (coverage by these programs could not be determined). This group was potentially in the waiting period for Medicare coverage. It is not known how many of these people fell between 18 and 29 months of the waiting period for Medicare, the potential population to benefit from H.R. 4136. It is also not known how many of these persons would have sufficient funds to elect continuation coverage for 18 months and to continue to pay the higher premiums for the 19th through the 29th month. This becomes particularly true if beneficiaries are asked to pay higher than the usual 102 percent COBRA premium costs for con-

[164] The waiting period is 5 months for the Social Security benefits themselves, then an additional 24 months for Medicare.

tinuation coverage, as would be the case if employers charged 152 percent of the group rate. In this respect, it might be necessary to provide some form of government payment of the premium for low-income enrollees, as would be done under H.R. 4136. A State, at its option, could pay the expenses of an individual eligible for Medicaid such as premiums, deductibles, coinsurance or similar costs for health benefits offered by or through the individual's employer, including continuation insurance. Thus, at the State's option, a person who was Medicaid-eligible could continue to be covered by an employer's plan, with Medicaid paying the premium and other coinsurance costs. However, given existing Medicaid eligibility criteria and the limited money allocated under H.R. 4136 for Federal grants to the States, the public "buy-in" of COBRA coverage might benefit only the very poorest persons.

Extending the duration of COBRA for disabled persons might fuel adverse selection. Given the high premiums and the preexisting disability of enrollees, it is probable that persons electing coverage would be heavy users of services. This could drive up premium costs for the employer's group as a whole. Through higher premiums, active workers might end up providing substantial subsidies for persons no longer directly tied to the employer. As noted above, smaller employers could also lose their access to insurance coverage if insurers moved to reduce their losses resulting from continued enrollees by raising their premium rates or cancelling contracts.

2. Extend Duration of COBRA Coverage for Retirees and Their Dependents

Employers could be required to provide additional periods of coverage for retirees and their spouses and/or dependents. One possibility would be to parallel the continuation requirement for retirees under the bankruptcy provision amendment in OBRA of 1986 (P.L. 99-509). Alternatively, COBRA coverage could be required until a person became eligible for Medicare.

OBRA of 1986 added an additional qualifying event to COBRA continuation: loss of health insurance coverage for retirees of companies that have filed on or after July 1, 1986 for bankruptcy under title XI of the U.S. Code. The continued coverage is required to be offered until the death of the retiree. For the surviving spouse or the dependent children of the covered retiree, the coverage is limited to 36 months.[165] In the same vein, the requirement could be modified so that it applies to retirees of all firms with group health plans. Enrollees could be charged at the same 102 percent premium rate (or a higher rate to ameliorate the effects of adverse selection on plan experience).

A more modest proposal would be to require continuation coverage until the enrollee became eligible for Medicare. This would ensure that at age 65, most persons would lose their right to continued coverage under the employer's group plan. Using figures based on the Current Population Survey, 990,009 early retirees had

[165] U.S. Library of Congress. Congressional Research Service. Private Health Insurance Continuation Coverage. Issue Brief No. IB87182, by Beth C. Fuchs (updated regularly). Washington, 1987. p. 9-10.

no health insurance coverage in 1986, or about 3 percent of the total uninsured population. Some portion of this population and their dependents could potentially benefit from the implementation of an option requiring employers to provide continuation coverage until age 65.[166]

Since early retirees are likely to be above-average users of health care because of their age, this option could lead to higher employer costs. From the employers' perspective, one possible solution would be to allow a separate, experience-rated premium for the continued coverage enrollees who are retirees. Of course, this might drive up premium costs to the point where few retirees would elect continued coverage.

3. Liberalize COBRA Termination Rules

Currently under COBRA, the continued coverage may be terminated upon the occurrence of certain events. One such event is that the person becomes covered under the group health plan of an employer other than the employer providing the continuation coverage. The new coverage may have a preexisting condition clause or other limitation that produces a gap in coverage. To ensure that people do not experience such coverage gaps, COBRA could be changed to require continuation coverage to extend 18 months (or 36 months) regardless of whether the person becomes covered under the new employer's plan.

The rationale for this option is that if a qualified beneficiary is willing to pay up to 102 percent of the premium for continued coverage even though now under the new employer's group health plan, this is a strong indication that the new employer's plan has left a significant gap in the beneficiary's coverage (or in the coverage of the employee's dependent).[167] This option could result in coordination of benefit problems, which presumably could be resolved through standardized coordination of benefit ordering rules. For example, the former employer's continued coverage could be designated as secondary payer.

This option was included in H.R. 4333 and S. 2238, the Technical Corrections Act of 1988, as introduced in the 100th Congress.[168] The employer community has generally opposed this approach and would prefer to limit the current rules so that a person loses eligibility for continued coverage once he or she becomes eligible for coverage under the new employer's group health plan.[169]

4. Provide for Paid Continued Coverage for "Parental Leave"

Employers with existing plans could be required to provide continued coverage for persons electing parental leave. Such a requirement would differ from current law in that the employer would be required to continue sharing in the premium contribution. Bills pending in the 100th Congress (such as H.R. 925, introduced by

---

[166] CRS analysis of March 1987 CPS.

[167] U.S. Congress. Joint Committee on Taxation Staff Description of Proposed Technical Corrections Act of 1988. JCS-10-88. Mar. 31, 1988.

[168] See also H.R. 4845 in the 100th Congress.

[169] Bills were introduced in the 100th Congress that would provide for this change in title X of COBRA. See: H.R. 1072, introduced by Rep. Paul Henry and S. 2401, introduced by Senator Tom Harkin.

Representative William Clay, and S. 249, introduced by Senator Christopher Dodd) that provide for parental leave include a requirement that employers provide continued coverage for a specified duration. Such proposals typically exclude small employers, although the definition of small employers in these proposals ranges from 15 to 50 employees.

For example, as amended by the House Education and Labor Committee, H.R. 925 permits employees to take up to 10 weeks of unpaid leave over a 2-year period upon the birth, adoption or serious illness of a child or parent, and up to 15 weeks every 2 years for their own illnesses. Upon returning to work an employee is guaranteed the same, or an equivalent, job. In the first 3 years after enactment, firms with 50 or more employees are subject to the requirement. Thereafter, firms with 35 or more employees would be covered by the requirement. H.R. 925 also requires that employers continue health benefits for workers while on unpaid leave on the same basis as if the employee were still working. Parental leave is defined to apply to men and women.

Although no firm estimate exists of the proportion of working women who have job-protected leave at the time of childbirth, it is known that the likelihood of having such a benefit decreases if the woman works for a small company. The General Accounting Office has estimated that for employers of 50 or more employees, the cost of providing continuation of health benefits for 10 or 15 weeks (depending on the qualifying event) would total $188 million annually, benefiting an estimated 1.675 million people. For firms between 35 and 49 people, GAO estimated the annual cost at about $212 million, potentially benefiting about 1.855 million people each year. GAO warned that the cost estimates may be too high because they do not take into account that some firms already have parental leave policies similar to provisions of H.R. 965. In addition, several States already have disability or parental leave statutes with similar provisions. Finally, while formal policies are not in place, many employers already make accommodations to workers who are ill or have children who are ill for extended periods.[170]

Health insurance continuation for parental leave is supported by those who believe that it is necessary to accommodate the contemporary family in which both parents work. In addition, they believe that Federal legislation is necessary to ensure that all workers have equal access to such benefits. They also contend that estimates of costs for parental leave policies should take into consideration societal benefits and such factors benefiting employers as improved workforce stability due to increased morale and loyalty.[171]

---

[170] U.S. General Accounting Office. Report to the Subcommittee on Labor-Management Relations. Committee on Education and Labor. House of Representatives. Parental Leave. Estimated Costs of H.R. 925, the Family and Medical Leave Act of 1987. GAO-HDR-88-34. See also GAO, Estimate of the Costs of the Parental and Medical Leave Act of 1987 (S. 249), May 18, 1988. GAO-HRD-88-103.

[171] U.S. Library of Congress. Congressional Research Service. Parental Leave: Legislation in the 100th Congress. Issue Brief No. 86132, by Leslie W. Gladstone (updated regularly). p. 7.

5. Require Time-Limited Employer Contributions for Continued Coverage for Certain Workers

Under COBRA, employers with 20 or more employees must offer continuation coverage to qualified employees and their families in the event of a change in work or family status, but the employer may charge the beneficiary 102 percent of the premium. In many circumstances, the potential beneficiary may elect not to continue because he or she cannot afford the cost of coverage. COBRA could be amended to require the employer to contribute to the premium for a laid-off worker for a specified period of time. Alternatively, employers could be required to contribute to the premium for specified populations, such as retirees, or child dependents.

In the 99th Congress, legislation (H.R. 4742, S. 2402, and S. 2403) was introduced to require employers to continue paying their portion of the premium for 4 months of health insurance for laid-off workers and their dependents. Under these bills, at the end of the 4 months, laid-off workers could continue the coverage for 18 months under title X of COBRA at 102 percent of the premium cost.

Because a large portion of the premium costs would be paid by the employer, this option could encourage individuals to elect continuation coverage. The 4 months of employer contributions should be sufficient to cover a majority of persons for the full period of their unemployment.[172] The Congressional Budget Office (CBO) estimated in 1986 that the maximum cost to employers of this provision would be $1.5 billion annually, and that it would help as many as 5.7 million workers and their dependents.[173]

Critics of this approach argue that it would have a harmful financial effect both on employers, especially those most likely to be laying off workers, and on the employees themselves. Companies that are closing a plant, for example, might have to reduce severance pay in order to pay for the continued coverage. Like all such requirements on employers, the very smallest employers could be hurt most. In addition, opponents say that it is unfair to impose such a requirement on those employers who are generous enough to provide health insurance while many employers provide little or no coverage at all. To hold down costs, companies might elect to reduce health benefits for current workers. Finally, opponents argue that it is wrong to assume that laid-off workers cannot afford health insurance premiums. Between unemployment compensation and severance pay, many short-term unemployed persons have sufficient funds to pay for continued coverage.

6. Require Employers to Contribute to Continued Coverage for Retirees

Employers could be required to contribute to the financing of continued coverage for persons who terminate employment to retire. In 1986 (prior to the implementation of COBRA), about three-fourths of the participants in health plans of medium and

---

[172] In 1987, the average duration of claims for weekly unemployment benefits was 14.1 weeks. See: U.S. House. Committee on Ways and Means. 1988. p. 336.

[173] Kennedy, Edward M. Access to Health Care Act. Floor statement upon introduction of S. 2402. Congressional Record. May 1, 1986. p. S5221.

large firms were eligible for coverage that extended into retirement. For about 15 percent of those participants, protection extended into retirement only if the retiree paid the full cost.[174] While COBRA may have increased the number of participants eligible for continued coverage, it is not likely to have led to more employers paying for that coverage. Under this option, employers would be required to contribute some specified share of the plan costs for the retiree until the retiree is eligible for Medicare.

Retiree health benefits are in a rather uncertain state. For a variety of reasons, including expected changes in accounting standards and the realization by employers that they have significant unfunded liabilities for retiree health benefits, many employers are looking for ways to reduce or eliminate their retiree health plans. Enactment of this COBRA option could further encourage employers to seek ways to reduce benefits for active workers as well as retirees. In order to extend coverage significantly to retirees, this option would probably need to be linked to changes in Federal tax law that would provide incentives to employers to prefund retiree health benefits.[175]

7. Cover Employers Currently Excluded from COBRA

Under existing law, there are a few categories of employers (and therefore their workers and dependents) who are exempt from COBRA. These include the Federal Government, the government of the District of Columbia, and church-related organizations such as schools. Federal Government and District of Columbia government employees are currently covered under the FEHBP. The FEHBP provides for coverage of annuitants and their dependents if the annuitant meets certain requirements. Plans under the FEHBP must currently provide terminated employees 31 days of continued coverage, during which the person is entitled to exercise the right of conversion. An employee choosing the conversion option must then pay for coverage at an individual rate, which will generally be higher than the rate (no more than 102 percent of the group rate) that would be charged if the same employee could elect COBRA continuation coverage. Employees in nonpay status can also continue coverage.

Federal and District of Columbia government employees could instead be included under COBRA (or an identical continuation requirement could be included under title V of the U.S. Code which authorizes the FEHBP).[176] This option would extend continuation rights to about 9 million enrollees and their dependents. (The remainder of the nine million FEHBP participants are annuitants, who would not be affected.) There might be constitutional problems in extending COBRA to church and church-related organizations.

---

[174] U.S. Department of Labor. Bureau of Labor Statistics. Employee Benefits in Medium and Large Firms. 1986. Bulletin 2281. U.S. Govt. Print. Off. Washington, June, 1987.

[175] U.S. Library of Congress. Congressional Research Service. Health Insurance for Retirees: An Uncertain Future. Issue Brief No. 88004, by Beth C. Fuchs (updated regularly). Washington, 1988.

[176] H.R. 5012, introduced by Representative Gary Ackerman and H.R. 4829, introduced by Representative Constance Morella (100th Congress) would provide COBRA title X rights to Federal employees and their dependents.

III. State-Level Mandates

At the State level, over 600 mandates govern health insurance. They include mandates for specific services (e.g., maternity coverage and newborn care), the services of specific providers (e.g., dentists and chiropractors), as well as requirements for conversion and continuation options. Two States have effectively mandated employer insurance: Hawaii requires most employers to provide coverage, and with the full implementation in 1992 of the Universal Health Security Act, most employers in Massachusetts will be required to either provide insurance or to pay a special tax. (Strictly speaking, the Massachusetts program is voluntary; the tax merely creates a very strong incentive to furnish coverage.)

While State mandates affect the nature and content of the health insurance plans of employers that purchase insurance, with the exception of Hawaii and Massachusetts they do not affect the plans of self-insured employers.[177] Thus, as a strategy for extending coverage, State mandated benefit laws start out with a significant handicap. They exert no control over a large and increasing percentage of employer group health plans. (Over 50 percent of employer plans self-insure.)

Consequently, where States have sought to define minimum benefit standards, the courts have determined that such laws do not extend to self- insured plans. While many of the proposals described above under Federal options could be adopted at the State level, ERISA preemption would limit their applicability to cases in which employers purchase coverage from insurance companies.

For example, many State continuation of coverage laws preceded the Federal COBRA requirements. Such State continuation requirements could be expanded to require employers with health insurance plans to pay for four or some other number of months of continued coverage for laid-off workers and their families, or to require such employers to provide continued coverage for retirees until they become eligible for Medicare.

However, such requirements at the State level might have somewhat different effects than they do at the Federal level. Because of the ERISA preemption limitation, State requirements on employers would produce a more uneven playing field between insured and self-insured employers. Additional "mandated benefits" (which is what these would become) might encourage some employers to move to self insurance, others to relocate in another State. These effects could be severe, especially in States with significant corporate taxes, high levels of unionization, and substantial business regulation. The potential movement of businesses from a highly regulated State to one with fewer requirements on employers is of great concern to State governments because of the fear of lost jobs and tax revenues.

---

[177] For a detailed discussion of the regulation of insurance by the States and the effect of ERISA preemption on self-insured plans, see U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. 1988. Chapter 3. See also chapter 7 of this report.

IV. Mandated Employer Coverage

A. Introduction

Lawmakers could decide to increase health insurance coverage by mandating that employers provide coverage to their employees, and possibly their employees' dependents. If this approach is pursued, many questions relating to the scope and the nature of the mandate will surface. This section provides a detailed analysis of such questions, including:

- Which employers must participate?
- Which workers must be covered by participating employers? Which dependents, if any, must be covered?
- Do employees (and their dependents) have to participate in the employer's health plan?
- What benefits should be included in the mandated plan?
- Who should pay for the plan coverage?
- What plan choices should be required (e.g., indemnity plans, HMOs, etc.)?
- How will employers and insurers prevent duplication of coverage?
- How should the mandate be enforced?

One other question, perhaps more fundamental than any of these, will be addressed in chapter 7: how would the employers obtain the required coverage?

B. Which Employers Must Participate?

"Employers" are defined in the Fair Labor Standards Act (FLSA), the Social Security Act, the Internal Revenue Code and other existing laws. Any of these laws could be amended to require employers, as defined in each law, to provide health insurance. Below are illustrations of different employer definitions and some of the implications of using them to define employers covered by a health insurance mandate.

1. The Fair Labor Standards Act (FLSA)

The mandate could be restricted to employers (and employees) covered by the FLSA's minimum wage requirement. Simply defined, this requirement applies to "all employees of certain enterprises having workers engaged in interstate commerce, producing goods for interstate commerce, or handling, selling or otherwise working on goods or materials that have been moved in or produced for such commerce by any person." [178] Additional specifications apply to certain types of enterprises, including retail, service and construction enterprises. Most businesses are defined to be covered if their gross volume of sale or business is not less than $250,000 a year. Exemptions include certain types of employees (executive, administrative and professional), employees of certain individually owned and operated small retail or service establishments, employees of certain seasonal amusement or recreational establishments, employees of certain small newspapers, and farm workers

[178] U.S. Congress. Department of Labor. Handy Reference Guide to the Fair Labor Standards Act. Employment Standards Administration, Wage and Hour Division. WH Publication 1282, revised Jan. 1981. See also U.S. Code, Title 29.

employed by anyone who used no more than 500 man days of farm labor in any calendar quarter of the preceding year.[179]

This strategy would exclude from the mandate various types of employers and employees that are not included under the minimum wage requirement. Some would argue that if for reasons of size, type of business, or type of employee it was decided that these employers should not be required to pay the minimum wage, it is logical to assume that, in general, these employers should be excluded from having to provide health benefits.

2. Social Security Payroll Tax

If a broad mandate were desired under which most of the Nation's employers would be included, it could be applied to employers subject to the Social Security payroll tax, including non-profit organizations and other employers, such as State and local governments, who have elected Social Security on a voluntary basis.[180] To include the self-employed, the mandate would have to specify that it covers those who pay the self-employment payroll tax. Under a Social Security definition, however, certain employees, including some State and local government employees, would be excluded. As of January 1, 1987, approximately 7 out of 10 State and local government employees were participating in the Social Security system.[181] Also left uncovered would be some ministers, casual labor and domestic workers.

3. Internal Revenue Code

The Internal Revenue Code is the vehicle for imposing a number of requirements on existing employer health benefit plans (e.g., COBRA title x, the section 89 nondiscrimination provisions, and the Medicare secondary payer provisions). The code provides great latitude if used to define which employers or which group health plans are to be brought under the mandate. For example, section 3121 provides a definition of "wages," "employee," and "employment," with respect to the Federal Insurance Contributions Act (FICA). Section 414(d) defines governmental plans while section 414(e) defines church plans. For example, if lawmakers want to include all private employers but exclude governmental employers, they can use the definition in section 414(d) of the Internal Revenue Code. Another section (162(d)) includes a definition of group health plans which are required to provide continued coverage under title X of COBRA (P.L. 99-272) to retain the business expense deduction. This section could be amended to require that the business deduction for expenses related to all employee benefits be contingent upon providing health insurance coverage. In short, the Internal Revenue Code provides definitions of employers and group health plans; it also provides a variety of enforcement sanctions

---

[179] Ibid.

[180] Section 209 of the Social Security Act defines wages subject to the Social Security payroll tax (the Federal Insurance Contributions Act payment) and provides for exceptions. Section 3101 of the Internal Revenue Code specifies the rate of the payroll (FICA) tax on employees as well as the Medicare Hospital Insurance tax. Section 3102 specifies how the payroll taxes are to be deducted from employee's wages.

[181] U.S. Library of Congress. Congressional Research Service. Medicare Coverage of Employees of State and Local Governments. Report No. 87-268 EPW, by David Koitz. Washington, Mar. 11, 1987. p. 5.

(i.e., loss of the business expense deduction, loss of the employer exclusion for higher-compensated employees, etc.).

4. Employers Defined in Terms of Numerical Standards

Various numerical definitions could be used to define which employers would have to provide health benefits. Definitions of employers with 5, 9, 15, 20 and 25 employees all have precedents in existing Federal law. For example, the Pregnancy Disability Act (P.L. 95-555) applies to employers with 15 employees or more. COBRA title X (P.L. 99-272) makes the cut at 20 or more as do the Medicare secondary payer provisions (although the requirements for the disabled apply only to firms with 100 or more employees). The mandate might be structured to provide for a transition period for the smallest employers, as is done in the version of S. 1265 reported by the Senate Labor and Human Resources Committee in the 100th Congress. Under this bill, employers with five or fewer employees would not be covered under the mandate for the first 3 years. For the next 2 years, such employers would be required to provide catastrophic coverage only.

The rationale for defining employers according to the number of employees is that a mandate would affect employers differently based on their firm size. Exclusions of small employers, however, would result in a significant reduction in the effectiveness of the proposal to cover the working uninsured, since a significant proportion of this population is concentrated in smaller firms.

By defining employers in terms of firm size, instead of other definitions such as those in the FLSA and Social Security Act, flexibility would be retained in establishing which Federal agency was to administer and enforce the mandate. Some would also argue that numerical definitions are simpler to understand and administer than definitions embedded in complex statutes.

5. Other Employer Definition Considerations

The type of an employer is also regarded by some to be important in determining whether it should be included under a mandate. Some analysts believe that the self-employed and family farms should be treated as distinct employer groups, excluded or partially excluded from the full requirements of mandated coverage. The rationale is that a mandate would impose undue economic hardship on these employers. Under S. 1265 as reported by the Senate Labor and Human Resources Committee (100th Congress), for example, family farms are treated as a distinct employer group under the mandate. The bill defines a family farm as one where most of the farm work is performed by the owner or members of the owner's family. Farms that rely on employee labor (as opposed to family members) are not considered family farms, regardless of their size or ownership. Family farms are given an explicit exemption from the mandate until the farm prices for the commodity group produced by the farm reach a specified level. The bill also provides for a mechanism to permit family farms within a commodity group to elect participation under the mandate.

Additional considerations in defining employers include: whether there should be an exclusion for foreign governments or international organizations, or any agency or instrumentality of them;

whether churches and church-related organizations should be excluded; and whether employers with collective bargaining agreements should be treated differently. Regarding the latter issue, proposals might be tailored to provide for effective dates that apply only after existing collective bargaining contracts expire. COBRA title X provides an illustration of such treatment.

C. WHICH WORKERS AND DEPENDENTS MUST BE COVERED BY THESE EMPLOYERS?

1. Workers

In defining employees to be covered under a mandate, consideration needs to be given to the nature of the employee. Should mandated coverage extend to employees who are full-time or should it also extend to part-time workers? Should it be restricted to permanent employees, or provided also to temporary and seasonal workers? Should employers be required to provide coverage to a part-time employee who may otherwise be able to get coverage through another source, such as through the spouse's employer? Each definition implies a choice about the appropriate scope of mandated employer-provided coverage. And each definitional choice is associated with significant consequences in terms of coverage and financial responsibilities for employers and employees.

If the goal is to achieve maximum coverage of workers under the mandate, the definition of worker should be as broad as possible. There are a number of possibilities, many of which have been used in previous proposals. An employee covered under the mandate may be defined as working:

- *At least 250 hours over 10 weeks.* This definition allows the employee's hours per week or month to vary but still assumes that a minimal level of service is required to warrant employer-provided coverage.
- *At least 17.5 hours per week.* This definition has the advantage that it is consistent with the section 89 definition in the Internal Revenue Code of full-time employees (relating to nondiscrimination requirements). It would cover more people than definitions set at higher hours-per-week thresholds. It has the disadvantage that it would create a cliff effect potentially encouraging employers to reduce hours of workers so that they would fall below the 17.5 hour cutoff. It would also require many employers with existing plans to change them (although they may change them anyway to conform to the section 89 requirements).
- *At least 20 hours per week.* This definition is used in Federal pension law (ERISA), and was once a pervasive standard for employers. Today, because of the section 89 requirements, 17.5 hours appears to be replacing this standard. Typical definitional language might be "the employee is expected to work at least 20 hours a week for at least 26 weeks during the next 12 months."
- *At least 10 hours per week* with a sliding scale for employer premium contributions. This combines a definition of covered worker with a requirement for employee contributions. It is designed to provide coverage to all but a small percentage of

part-time workers, but recognizes the difficulty of asking employers to pay for coverage for part-time workers. It provides for a sliding scale of employer contributions so that employers are required to contribute progressively more toward the cost of the health plan as the employee works increasingly more hours. It creates some administrative and enforcement complexities, since employees may often change the number of hours worked over a period of weeks or months. It may require an estimated contribution based on the previous month's experience, with corrections to be made annually or every 6 months or year. Perhaps more important is that employees with the fewest hours of service may be least likely to afford the premium contributions. Finally, it creates a cliff at 10 hours in the same way as does the 17.5 hour requirement, although it should affect fewer workers.[182]

A survey by Towers, Perrin, Forster and Crosby, Inc., indicates that 74 percent of all companies do not currently provide coverage to workers with as few hours as 17.5 per week.[183] A survey conducted for the Small Business Administration (SBA) found that in 1986, 68 percent of all employers and 76 percent of large employers did not cover part-time employees (although the survey did not define part-time).[184] In a National Rural Electric Cooperative Association survey, where part-time is defined as less than 35 hours, 77.4 percent of rural small businesses did not cover part-time employees, compared to 80.5 percent of all firms,[185] confirming the SBA assertion that small firms (with less than 100 employees) are more likely to cover part-time, temporary and seasonal workers.

Some groups have advocated extending any mandate to part-time as well as full-time workers because of the increased reliance on part-time labor. Twenty-three percent of all workers now hold part-time jobs compared to 16 percent a decade ago. In the service and retail sectors, part-time employment accounts for 33 to 50 percent of all jobs.[186] If the objective is to achieve maximum coverage of the working population through employer-based plans, then coverage of part-time employees is a key issue.

Another question is whether to restrict the mandate to the employer's permanent employees or extend it to the employer's total workforce. This question leads to difficult issues regarding coverage of "seasonal workers," migrant workers, and temporary help industry employees ("temps").

Restricting the mandate to permanent employees suggests the need for a workable definition of "permanent." Leaving the definition up to individual employers would not be workable, as employers providing coverage for the first time would have an incentive to define as many employees as possible as non-permanent. An alternative option is to require employers to cover all employees who

---

[182] The 10-hour approach is tested in the third report in this series. See U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Coverage. 1988.

[183] T.P.F.&C. News. Aug. 1987.

[184] U.S. Small Business Administration, 1987.

[185] National Rural Electric Cooperative Association. The NRECA Survey of Health Care Coverage in Smaller Firms: Evidence and Policy Implications. Washington. 1988.

[186] Bravo, Ellen. Part-time and Temporary Employers Are Not Given Any of the Benefits Pie. Business and Health, Apr., 1988. p. 60.

have worked for at least some period of time for the company. Under this approach, a definition of permanent would not be needed because all employees would be eligible for coverage after satisfying a specified waiting period. A 30-day waiting period would result in coverage of all but the most temporary of workers. Seasonal workers, such as summer employees, would thereby become eligible for coverage after their first month on the job, even though the coverage would terminate after only a month or two (unless COBRA title X requirements remained in effect, in which case the employer would have to offer the summer employee the option of remaining covered for 18 months, but at the employee's expense). Summer employees could be excluded by imposing a 3-month waiting period or longer.

Another approach—one that was used in much of the proposed employer mandate legislation of the 1970s—limits coverage to employees who work for at least 10 weeks or a total of 350 hours in the preceding 13-week period. Thus, for a new employee working 40 hours per week, coverage would start during the 9th week of employment (that is, after 350 hours of work).

This definitional issue is especially important for the temporary help services industry. The Bureau of Labor surveyed temporary help establishments with 50 or more workers during the week of September 14, 1987. The survey found that there are 630,000 temporary workers and 20,000 permanent employees in this industry. Only one-fourth of the workers employed by the industry are in businesses that provide at least part of the cost of hospitalization, surgical, medical and major medical plans.[187] If an objective of the mandate is to cover such employees, it may be necessary to address these employees explicitly. S. 1265, as reported in the 100th Congress, provides one illustration.[188] Permanent seasonal workers, such as those in the fish canneries of the Pacific Northwest, may also require specific treatment. Approximately 4.1 million uninsured reported working 20 or fewer weeks in 1986. Two million uninsured reported working 10 weeks or less in that same year. It is not known how many of these people were regular seasonal employees.[189]

Additional considerations include whether the mandate should be applied to nonpermanent alien residents, or whether it should be restricted to U.S. resident employees and members of their families. Should any exceptions to the mandate be made for U.S. firms with employees residing outside the U.S.?

A different approach to defining employees covered by a mandate is found in the new Massachusetts law. It requires employers to pay the medical security contribution (an excise tax) or provide coverage to employees who work 30 hours per week (20 hours if the employee is the head of a household or is an employee of 6 months

---

[187] BNA Pension Reporter, v. 15, May 30, 1988. p. 881-2.

[188] Temporary help services employees will qualify for coverage under S. 1265 if they are assigned to perform at least 750 hours of service on behalf of other entities in a period of 6 consecutive months. Following the initial period of qualification, such coverage must be provided in the month following any month in which such employee performs at least 100 hours of service for the same temporary help firm. See U.S. Senate. Committee on Labor and Human Resources. Report 100-360. p. 51.

[189] Congressional Research Service analysis of March 1987 Current Population Survey.

or more), or who meet certain other criteria. Employers are not required to insure or pay an excise tax for seasonal and agricultural workers, or many part-time workers. These employees may obtain coverage through a State health insurance pool.[190]

2. Dependents

Paralleling the definitional issues of which employers and which employees are to be covered by the mandate is the issue of which dependents and/or other family members employers should be required to cover. Should employers be required to cover the worker's spouse, and, if so, should that coverage be required if the spouse also works? Should an exception be made if the employee can demonstrate that the spouse already has coverage? (See section E, below) In addition, how are dependents to be defined? A common insurance approach is to define a dependent in terms of a minor child, specifying that minority terminates when the child turns 18 or some other age, such as 22 or 25. Married children may also be excluded from coverage under the parent's employer health plan. An exception to the definition of dependent is sometimes provided for full-time students, along the lines of the following: "unmarried children under age 21, or, if the dependent is a full-time student, under age 23."

Other considerations include whether employers should be responsible for covering the employee's dependent children not residing in the employee's household (a possibility if the employee is paying child support) and whether there should be allowances for transitional periods during which the covered dependent incurs an illness but at the same time reaches the age of majority. Such issues are addressed in other laws (see, for example, section 1614(a) of the Social Security Act).

E. EMPLOYEE PARTICIPATION RULES

Many workers whose employers offer health insurance decline coverage. Most of these are covered under another family member's plan. However, there are workers who have no other source of insurance and still decline employer coverage, because they do not wish to pay their required share of the premium and perhaps do not foresee a need for health care. Other workers obtain coverage for themselves but fail to secure coverage of their dependents because an extra payment is required.

The overall number of workers who decline coverage for themselves and fail to obtain alternative coverage cannot be measured. Data from the SBA survey of small businesses indicate that 14 percent of employees in these businesses declined coverage; they account for nearly a third of the 44 percent of small business employees who did not obtain coverage through their work.[191] However, because the survey is of employers, not employees, it cannot show what proportion of those who declined coverage did so because they were covered through another family member. An analysis of a 1980 survey by the Bureau of Labor Statistics found that 82.8 per-

[190] Section 46 of the Massachusetts Health Security Act of 1988 (chapter 23 of the Acts of 1988).

[191] U.S. Small Business Administration. 1987.

cent of employees in firms that offered health coverage obtained the coverage. The investigator points out that levels of participation may be affected by waiting periods, i.e., requirements that an employee work for the firm for a certain period before qualifying for health benefits. In businesses with high turnover rates and long waiting periods, many employees may never qualify for the health plan.[192]

More is known about dependent coverage. Data from the 1986 Current Population Survey (CPS) indicate that 3 percent of the spouses of insured workers were uninsured. Seven percent of children under age 18 whose parent or parents had employment-based coverage were not covered.[193] The failure of some covered workers to obtain coverage for dependents does not mean that the coverage was unavailable. All employer-based plans in the 1987 Hay/Huggins survey allow employees to obtain dependent coverage. Plans vary, however, in the extent to which the employer contributes to the additional cost of this coverage. Of the employers in the Hay/Huggins survey, 57 percent paid the entire premium cost for employees, while only 32 percent paid the entire cost of dependent coverage. Some workers who could obtain coverage for themselves at no cost might not have been able or willing to pay for dependent coverage.

Proposals to require employment-based health coverage generally place obligations on the employees as well as on the employers. Not only must the employer offer coverage; eligible employees must accept the offer for themselves and their dependents and must pay any premium contributions required by the plan. Is this a necessary feature of a mandatory program?

Mandating dependent coverage and requiring employees to obtain coverage for themselves present different sets of issues. Requiring that parents provide coverage for their children could be regarded as an extension of the traditional obligations of child support.[194] In this society, stronger arguments are usually required before government dictates what people must do for themselves, rather than for those who depend on them. For example, laws requiring that parents provide safety seats for children in automobiles have aroused less controversy than laws requiring that the driver fasten his or her own seat belt. The issues of employee and dependent coverage will therefore be considered separately.[195]

1. Requiring Employee Participation

There are three basic arguments for mandating that employees accept on their own behalf the coverage that is offered.

---

[192] Employee Benefit Research Institute. Employer Provided Health Benefits: Coverage, Provisions and Policy Issues. [by] Deborah J. Chollet. Washington. 1984. p. 33-7.

[193] These figures are based on household data and do not include uninsured children who could have been covered through an absent parent's health plan. CRS analysis of Current Population Survey, March 1987.

[194] The traditionally greater leeway of government to intervene on behalf of dependents, even at the expense of parents' rights, stems from the concept of the State as parens patriae, parent of the nation.

[195] There is one case in which the two issues overlap: that of a pregnant woman who has failed to obtain coverage for prenatal care and may therefore be endangering her baby as well as herself.

Society benefits if all its members have health insurance. Even persons who have refused health insurance and have no financial resources will seek and receive medical care in urgent situations. The costs of the care will then be borne by the society, through public subsidy, private charity, or indirect subsidy by third party payers. The individual who has failed to contribute to the insurance pool has nevertheless received benefits; he or she is a "free rider."

While this is a strong argument for requiring all persons eligible for insurance to accept the coverage, it is not necessarily an argument for requiring the level of health insurance coverage ordinarily available in employer-based plans. Society could be indemnified for the risk of free riders through a very limited insurance package, providing coverage for urgent care only.

Whether the limited coverage would in fact be much cheaper than a more comprehensive policy is not certain; those with more limited coverage might simply delay care until their conditions became more severe and costly to treat. Still, it is possible to conceive of two kinds of health insurance, one optional, covering routine, "elective" care, and the other mandatory, covering only catastrophic medical expense. The optional coverage would provide beneficiaries with access to the full range of medical care. Those who did not want to purchase this access could select the mandatory coverage and make the minimum necessary contribution to the potential costs of unforeseen needs for care. The possibility of such a system will be explored further later in this chapter. It is raised at this point to highlight the distinction between requiring the employee to accept insurance for his or her own good (the basis for the high-option elective plan) and requiring the employee to accept insurance for the good of society (the basis for the mandatory plan).

Voluntary participation may raise the cost of a plan. Insurers offering coverage to small employer groups often require that every member of the group be enrolled. This is to prevent younger and healthier employees from opting out of the plan, leaving the insurer covering only the higher cost employees. Similar requirements are not imposed for larger groups. This is not because self-selection does not occur in larger groups: presumably, employees in larger groups who perceive themselves to be at low risk would be just as likely to decline coverage as those in smaller groups.

Two factors make it possible for insurers to offer coverage to larger groups without a universal enrollment requirement. First, the insurer need not be concerned, as it must for smaller groups, that the employer might purchase group coverage simply because he anticipates high health care costs for himself or a dependent. In larger groups there will be enough healthier enrollees to offset the single high-risk case. Second, it is feasible to adjust the rates for larger groups to reflect the characteristics of the covered employees. Large employee groups are generally experience rated; if only the older and sicker employees tend to join the plan, the rates will rise accordingly. Small groups cannot be reliably experience rated, because costs for a small number of individuals may fluctuate considerably from year to year.

The first factor, the concern that a group seeking coverage may be doing so because of a single high-risk case, would cease to be sig-

nificant in a mandatory employer coverage program. If every employer of a given size must offer coverage, the insurer is protected against the possibility that the entire group is obtaining insurance only to cover one high-cost individual. The problem of rate-setting would also be diminished if small employers purchased coverage through some form of pooling arrangement. If a mandatory system did not require employee participation, insurers would eventually be able to predict the probable level of employee participation across all the groups in the pool. They could adjust their per capita premium rates to reflect the age, health status, and other characteristics of the employees likely to opt for coverage.

What would be the effect of optional employee enrollment on costs for employers and employees? Consider a group of three employees at a single firm who may be expected, on the basis of demographics or health care history, to incur annual medical expenses as follows:

Employee A	$1,000
Employee B	1,500
Employee C	500

If all three employees participated in an insurance plan, the annual total cost of insurance would be $3,000, or $1,000 per employee. If the employer contributed 80 percent of the cost, the employer's total cost would be $800 x 3, or $2,400. Each employee would contribute $200.

If Employee C is allowed to opt out of the plan (or join a distinct low-option plan), the annual cost of insurance for the remaining two employees would be $1,250 per employee. The employer's contribution, still at 80 percent, would be $1,000 x 2, or $2,000. Each employee participating would contribute $250.

The cost to the employer drops when the lower-cost employee drops out of the group. It is the cost to Employees A and B that rises, because Employee C's contribution is no longer available to help subsidize their care. What matters to the employer is the *aggregate* cost of furnishing coverage, not the *per capita* cost. The change in per capita cost affects the individual employees.[196]

All of this is true, however, only at the level of a single group. Employers' costs would be affected if they participated in a pooling arrangement. The effects of voluntary non-participation would then be reflected in rating for the pool as a whole. Employers would be winners or losers, depending on the proportion of their employees who elected coverage. A firm with a high participation rate would not only purchase coverage for more employees than another firm with a low participation rate. It would also pay higher rates for those employees, because the other firm's healthier employees were out of the pool. Again, the aggregate cost of fur-

[196] Note that the effect in the illustration, reduced employer costs and increased employee costs, would apply only in a system that tied the employer's financial responsibility to a fixed percentage of total premiums. An alternative arrangement might call for a fixed dollar contribution by the employee, with the employer responsible for the remainder of the premium. In the case cited, if the employees' contribution had been limited to the original $200 each, the employer's total share would have been $2,100, still lower than if the lower-cost enrollee had remained in the group.

nishing insurance to employees of the two firms jointly does not rise; it drops. What changes is the distribution of these costs between the two firms.

The policy issue raised by this line of argument for mandatory employee participation is, then, whether Firm E (whose employees do not want coverage) should assist in covering the costs for Firm D (whose employees do want coverage). This issue will be discussed further in the discussion of pooling arrangements in chapter 7.

If individuals are not obliged to accept an offer of insurance, they could face employer pressure to decline coverage. An employer might promise to grant wage increases or other, less expensive benefits if employees declined health insurance, or might threaten to withhold expected benefits if too many employees accepted coverage. This would be especially likely if the mandate were implemented in the absence of a pooling arrangement, so that each employer had to pay rates reflecting the level of risk presented by that employer's workers. If a high cost enrollee could raise costs for the group, pressure to decline coverage might be brought to bear on specific individuals. Although employers could be prohibited from attempting to influence employees' coverage decisions, the prohibition would be difficult to enforce. Requiring that employees accept coverage might protect them from coercion.

Not all employees would necessarily desire this protection. If an employer, in a voluntary system, threatened to cut wages or hours because too many employees opted for health coverage, some employees might prefer to do without insurance rather than lose direct income. If employees are not given this option, the employer may still cut wages or hours to meet the costs of health coverage. Those employees who prefer income to insurance would be deprived of this choice in order to protect the employees who prefer insurance to income.

The possibility that employers might seek to entice employees away from health coverage by offering alternative compensation raises a subsidiary issue, the treatment of new or existing "cafeteria plans." In these arrangements, employees may choose from among a variety of fringe benefits, which might include, for example, life insurance or assistance with child care as well as health insurance. Sometimes the health benefit option under a cafeteria plan supplements a basic health benefit plan. Thus a health plan that did not provide the minimum benefits specified in an employer mandate might be in compliance if one considered the supplemental benefits available to the employee through a cafeteria plan.

In such a case, would an employee be required to accept the supplemental health coverage instead of some alternative that the employee found personally more valuable? If it is concluded that employees in general must accept the health coverage provided under a mandate, there is no clear reason to exempt cafeteria plans. For most employees, the choice among benefits in a cafeteria plan is essentially the same as the choice an employer might offer between higher wages and health coverage if health coverage were voluntary (the choice is not precisely the same for employees in higher tax brackets).

2. Dependent Coverage

As was noted earlier, requiring an employee to purchase dependent coverage is different from requiring the employee to purchase personal coverage. The provision of insurance for one's dependents could be regarded as a natural extension of the traditional responsibilities to provide care and support. A case could be made for requiring dependent coverage even if employees were permitted to refuse coverage for themselves.

The major issues in dependent coverage involve coordination of health benefits: if a husband and wife both work, under which employer plan are they to be covered? Which plan covers their children?

a. Current system

(1) *Choice of plans.* Under the current system, employed couples' choices about how to obtain coverage would be expected to depend on two key factors:

- Employer contribution rules. Some employers pay for both employee and dependent coverage in full. Others pay for employee coverage in full but require employee contributions for dependents. Still others require contributions for both the employee and dependents.

Depending on the policies of their respective employers, a couple might decide to insure the entire family under one plan, or might choose separate coverage for the spouses, with the children enrolled in one plan or the other. In some cases the couple may obtain overlapping coverage. For example, if the wife's plan pays dependent coverage in full, while the husband's pays in full only for the employee, the husband might choose coverage under both plans in order to take advantage of some benefits offered only under his own employer's plan. If both employers paid in full, the couple might cover the entire family under both plans. (The rules governing insurers' payments in such dual coverage situations are described in section (2), below.)

- Rate structure. Some plans have just two rates, single and family, while others use multiple "tiers": single adults, two adults, adult and children, two adults and children.

In plans with just two rates, the family rate will reflect a mix of the different kinds of family structures represented in a multiple tier system. It will probably be higher than the two-adult or adult/children rate and lower than the two-adult/children rate. If both employers paid employee coverage in full and required a 25 percent contribution to the cost of dependent coverage, it would be reasonable for the spouses to obtain separate coverage for themselves and enroll the children in the plan with a separate adult/children rate.

In some cases, the rates or benefits offered by the two employers may be sufficiently different to override the effect of the contribution and rate structure rules. For example, one plan might have significantly higher deductibles than another. One might offer dental care while the other did not. Non-financial factors may also play a part. For example, one employer might require employees to use a PPO that excludes the family physician.

When both spouses work for the same employer, they are generally required to enroll separately; neither may be enrolled as a dependent. The children must be enrolled only once.

(2) *Coordination of benefits.* The effect of the current system is that cases occur in which individuals are covered both under their own employer's plan and under a spouse's plan. There are also cases in which children are covered under both parents' plans. Coordination of benefits (COB) rules have evolved to ensure that persons with dual coverage cannot obtain duplicate payment for the same medical expense.[197] The rules determine which plan is "primary," and which "secondary." The primary plan for any individual is responsible for all that individual's claims. The secondary plan pays only when the primary plan has failed to cover some or all of the individual's costs and those are coverable under the secondary plan. The National Association of Insurance Commissioners (NAIC) has produced recommended COB guidelines for adoption by States. Most, but not all, States have written these rules into their insurance codes. Insurers themselves may include COB rules in their policies, so long as the rules do not conflict with State law.[198]

While full uniformity in coordination of benefit rules has not yet been achieved, the following broad principles for establishing the primary plan are commonly used:

- A plan that has failed to specify coordination rules is primary if the other plan has specified rules.
- A plan that covers a person as an employee is primary; the plan that covers the same person as a dependent is secondary. A plan that covers an active employee is primary; a plan that covers the same employee as a retiree is secondary.
- When children are dually covered, the primary plan is the one obtained by the parent whose birthday falls earliest in the year, regardless of the years in which the two parents were born. If the father was born on June 3, 1942, and the mother on February 15, 1945, the mother's plan is primary. Some States have not adopted this "birthday rule." Under older rules, the father's plan is always primary.
- In the case of divorce or separation, the custodial parent's plan is primary, followed by the plan of the custodial parent's current spouse. The non-custodial parent's plan pays last.

One special problem under COB rules is the treatment of cost-sharing requirements. If the primary plan includes deductible and coinsurance requirements, are these to be paid by the enrollee or by the secondary plan? What if the secondary plan itself has deductible and coinsurance requirements? The traditional rule has been that the secondary plan paid any cost-sharing amounts left unpaid by the primary plan, even if the secondary plan had its own cost-sharing rules. Although the two plans together paid no more than 100 percent of costs, the deterrent effect of cost sharing was lost. More recent NAIC guidelines permit alternative rules that

---

[197] The following discussion is drawn from Charles D. Spencer and Associates. Spencer's Research Reports on Employee Benefits. Chicago [updated regularly]. Section 331.3.

[198] Because self-insured employers are exempt from State insurance rules, they may sometimes make themselves secondary payers in all cases, regardless of the usual COB rules. This practice has been prohibited by Federal courts in one circuit.

leave the enrollee responsible for some portion of charges up to an out-of-pocket limit.

Finally, it should be noted that COB rules apply only when an individual is actually enrolled under two or more plans. A plan may not currently claim that it is secondary because someone could have been enrolled in some other plan.

b. Dependent coverage options under a mandatory participation system.

(1) *Spouses.* A mandatory participation system could continue the current practice of permitting the couple to choose joint or separate coverage, or could require that each spouse obtain coverage through his or her employer.

The policy choice depends in part on assumptions about the extent to which existing employer health plans will be modified under a mandatory system. If employers are presently offering benefits more generous than those that would be required under a mandate, would they reduce those benefits to the minimum required once a mandate took effect? [199] The bargaining, employment market, or other factors that produced the current employer policies would not be changed by a mandate. If this is the case, there could remain some differences among plans that would lead a couple to choose joint coverage under an existing employer plan rather than separate coverage through their own employers.

This outcome would clearly be unacceptable to the firms with existing plans. One reason that some large employers who offer health benefits are supporting employer mandates is that they are presently covering, as dependents, working adults who were unable to obtain coverage through their own employment. They would argue that employees should be required to accept the new coverage offered at their own workplace.

The employers newly offering coverage could argue the reverse. The more generous plans offered by some other employers were presumably dictated by the labor market within which those employers operated. The employers offering only the minimum plan are able to do so because their labor market does not demand more. They have complied fully by offering the mandated plan. If some workers have secured, through collective bargaining or other means, benefits more generous than those required under the mandate, why should government dictate that they must give up what they have won and shift to the minimum plan?

This argument may cut both ways. The workers who negotiated generous benefits could also negotiate revised terms that would prevent any real decrease in those benefits resulting from a mandatory coverage shift. The terms might be as follows:

- Working spouses would be required to obtain coverage at their own workplace under the mandatory plan and would receive secondary coverage under the more generous existing employer plan of their spouse. The COB provisions might need to be modified to ensure that the two coverages together were at

[199] The statistical projections in the third report in this series assume that employers would not reduce benefits to the minimum under a mandate. See U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988.

least as generous as coverage under the existing plan would have been.

- A worker would pay less for this secondary coverage of the working spouse than would have been paid for primary coverage of a non-working spouse. The employee contribution might be set at such a level that the sum of the contributions made for the spouse under the two plans would not exceed the amount that would have been paid for a non-working spouse.[200]
- Separate rating for workers with working or non-working spouses would potentially result in increased costs for those with non-working spouses. This is because existing rates for coverage of a spouse already assume that some of the covered spouses have their own insurance and that the coverage through their spouse's plan will be secondary. Employees with working spouses are partially subsidizing those with non-working spouses. If the latter are to be indemnified, some modification of their contributions might also be negotiated.

The workers in the more generous plans would be held harmless, while the employers would save money by providing secondary instead of primary coverage.

Again, this is a plan that might emerge from negotiation. The question remains: should the Government dictate the circumstances from which these negotiations might emerge by requiring the shift in primary coverage? If the conclusion is that it should not, and that the matter should be left to bargaining, then it is necessary to consider the reverse question. Should the Government permit a plan of this kind to emerge from the bargaining process? That is, may an employer refuse to cover a spouse who could be covered through his or her own employment?

There appear to be three, rather than two, policy options:

- Require spouses to obtain primary coverage at their workplace, leaving secondary coverage to be negotiated.
- Permit employers to decline primary coverage of working spouses, again leaving the issue of secondary coverage to be negotiated.
- Require employers to offer the same coverage to working and non-working spouses, leaving the choice of plans wholly to the employee.

The last option would mean that some large employers would continue to furnish primary coverage to employed spouses. This outcome may not be inherently unacceptable. It could be argued that the purpose of mandated employer coverage is to give more people insurance, not necessarily to relieve large employers of their current burdens. However, a system of free choice of plan again raises the problem of employer coercion. Would some employers pressure their employees to obtain coverage through a spouse?

Even if this occurred, one might expect that the system would ultimately reach equilibrium. If all employers were pushing their employees towards other employers, the counter-pressures would

---

[200] If the mandatory plan included an employee contribution and an existing plan required no contribution for dependents, this arrangement could mean that an employer would actually refund the spouse's contribution to the primary plan.

eventually balance out, leaving everyone covered at his or her own workplace. It is possible, however, that not all employers are equally equipped to exert this pressure. Large employers' dealings with their employees may often be impersonal, systematized, and relatively public; they may also be constrained by contracts. Small employers might be more able to influence the decisions of their workers. The result could be that small employers could systematically, rather than randomly, avoid covering married employees.

The two remaining options, requiring that workers obtain primary coverage at their workplace or permitting employers to impose this requirement, would eventually produce identical results. Virtually all employers would refuse to offer primary coverage to working spouses; some would provide secondary coverage. The difference between the two options is in the way in which they would be enforced, the mechanics of verifying coverage. These will be discussed in section I of this chapter.

There is one possible drawback to any approach that leaves spouses, and potentially their children (see below), covered by separate health plans. Different members of a single family might be entitled to different sets of benefits, or they might face different procedures for obtaining services or claiming reimbursement. This situation could be confusing for many enrollees and could conceivably increase insurers' administrative costs for member communications and claims processing.

(2) *Children.* If it were decided that spouses in two-worker families would have to be covered by their own employers, there would remain the problem of allocating responsibility for their children. (If spouses could still choose between separate or joint coverage, they would presumably also be able to choose the coverage source for their children.) There are at least two possible approaches.

- The parents could choose to cover the children under one plan or the other.

Employers would be prohibited from refusing to offer dependent coverage to a parent on the grounds that the other parent was employed. This option could be expected to have an impact comparable to that of a free choice of plans for working spouses. That is, children might be disproportionately covered by employers with plans more generous than the mandated minimum.

- The children could be assigned to one plan or the other according to fixed rules.

The assignment might follow the current COB principles for establishing primary coverage of children, such as the birthday rule and the special rules for children of divorced or separated parents. Another possible approach would be to assign the children to the plan of the parent who was working the greatest number of hours. This approach might shift responsibility towards larger employers who use more full-time workers. The alternative, assignment through arbitrary decision rules, would exacerbate the existing disadvantage under a mandated benefit system of employers that use part-time workers whose hours of work exceed the coverage threshold. Their hourly labor costs would rise significantly more than those of employers with a full-time work force. However the assignment occurred, workers at some employers would be able to negotiate secondary coverage of children covered through a spouse's plan.

3. Workers with Multiple Employers

Finally, there is the question of persons who have two jobs, at both of which they work sufficient hours to qualify for employee coverage. If the threshold for mandatory coverage were as low as 10 hours per week, or even 17.5 hours, a considerable number of workers who "moonlight" might be eligible for coverage in more than one workplace.

The employee could be allowed to choose the plan from which to obtain coverage. This approach would, however, create problems comparable to those that arise if employees are permitted to choose between direct and spousal coverage. An alternative would be to specify that employees are covered by the employer for whom they work, on average, the greatest number of hours in a week. The effect of this solution might be to increase the incentives for employers to reduce part-time employees' working hours in order to avoid furnishing coverage. In addition, employers who relied heavily on part-time workers might hire workers who were employed full-time elsewhere in preference to persons seeking part-time employment only.

F. CONTENT OF THE MANDATE

Once it has been decided which employers and which employees would participate in a mandated benefit program, it is necessary to specify the product the parties are expected to purchase and their respective shares in the cost for that purchase. What is the coverage to be provided, and how is the financial responsibility for this coverage to be divided between the employer and the employee?

1. Specification of Minimum Benefits

a. Basic definition

The minimum benefits under a mandatory health insurance plan could be defined in terms of the scope of services covered or in terms of the dollar value of the benefit. That is, a mandate could read: "Every employee must receive unlimited inpatient hospital coverage and physician coverage with a $100 deductible." Or it could read: "Every employee must receive a health insurance plan costing $100 per member per month."

In the current market, neither form of mandate would have a uniform impact on all employers and employees. A definition in terms of services would result in higher costs for some groups than for others. A definition in terms of cost would mean that some groups received more extensive benefits than others. Some of the potential variation is due to practices of insurers: small groups pay more than larger ones, groups with older and sicker employees may pay more than others, and so on. The effect of these practices might be reduced through the adoption of pooling mechanisms, as will be discussed in chapter 7. An additional source of variation in group cost, less likely to be addressed in a pooling system, is the relative number of dependents attached to the group.

However, some of the variation in health plan costs is due to factors unrelated to characteristics of the insured group or practices of the health insurance industry. Health care simply costs more in

some places than it does in others. Variations in health care costs are due in part to differences in the cost of inputs such as labor and supplies, and would to some extent parallel existing variations in business costs. However, health care costs are also related to local or regional differences in the style of medical practice, such as greater or lesser reliance on surgery or high technology. The effect is that mandating a specific benefit package would result in higher costs on the West Coast than in New England or the Southeast; a mandated dollar expenditure would provide more extensive benefits in rural areas than in urban ones.[201]

A mandate in the form of *defined benefits* could, then, produce or heighten local or regional variations in the cost of doing business. It is not clear whether these variations would be sufficient to make the costs of health insurance a factor in business location decisions. In any case, many of the businesses that would be subject to a mandate are competing only on the local level.

Defined benefits would be more easily enforceable than defined expenditure levels, especially for self-insured firms. (What a self-insured firm actually spends during a year is subject to random fluctuations in the use of services and may or may not be equal to the value of its benefit plan if it had purchased coverage.) Unlike expenditure requirements, benefit requirements would give employers and insurers an incentive to seek out cost-effective providers or delivery systems.

Defined benefits also have disadvantages. They would impose unpredictable costs on the affected businesses in future years; employers would be unable to modify the benefits in the face of health care inflation. In addition, there could be continuing pressure to include in the mandate coverage of additional services or new types of providers.

A mandate in the form of *defined expenditure levels* would result in equal costs to all employers but variable extent of coverage for employees. There are precedents for mandates with variable impacts. For example, the minimum wage does not buy the same quantity of goods and services in all parts of the country. A minimum health benefit could similarly consist of the best plan an employer could purchase for a specific dollar outlay.

Defined expenditure requirements would have uniform and predictable economic impacts. They are readily combined, as in the Massachusetts plan, with a financing system that involves tax credits or penalties. One consequence, other than differential access to care, would be that employers might have little incentive to act as prudent purchasers. Moreover, a defined expenditure level would require annual updating. Annual increases might be indexed to projected inflation for a market basket of specified health care services. However, unpredictable changes in prices or medical practices could result in sudden erosion of benefits. In addition, the update process might be rapidly politicized.

---

[201] These variations could be eliminated by national pooling, at the price of considerable cross-subsidy among regions.

b. Alternative benefits and actuarial equivalency

A mandate with defined benefits could allow an employer to offer an alternative set of benefits, of equal value, in place of the specified minimum plan. Permitting this exception would serve at least two purposes. First, it would allow employers to tailor their plans to meet the needs or desires of their employees. An employer whose workforce included many women of childbearing age might offer enhanced benefits for prenatal and well baby care. Older workers might prefer a more extensive prescription drug benefit. Second, it would allow some employers who were already offering a plan to retain their current plan design, even if it differed in some details from the standard minimum plan.

If employers were to be permitted to offer alternative plans, two issues would need to be resolved. The first is the degree of allowable flexibility: should there be some core set of benefits that all plans must contain? The second is the measurement of value: how does one go about determining that two different health plans are "equal"?

(1) *Core benefits.* An employer mandate might serve a variety of objectives: to improve access to certain types of health services, to reduce individuals' risk of financial loss, to relieve providers of their uncompensated care burden, and so on. Different coverages of equal value might meet these goals more or less effectively. As will be shown below, for example, a plan that emphasized first dollar coverage for ambulatory care but offered very limited catastrophic protection could cost exactly the same amount as a plan that offered full catastrophic protection but required cost sharing for ambulatory care. The first plan could improve access to prenatal, pediatric, and preventive care, while the second would offer greater financial protection to families and providers. If one of these goals were seen as a greater priority, it might then be appropriate to limit the ability of employers or insurers to structure alternative plans that failed to meet that goal. Flexibility might be permitted only at the margins, while a minimum set of core benefits would be required of all plans.

The issues in defining a minimum core are comparable to those involved in defining the overall mandate. That is, core benefits could be described in terms of types and quantities of services to be covered: every plan must provide 60 days of inpatient hospital coverage or "some" prenatal care benefits. Or the core could be defined in financial terms: for example, no plan may expose a family to more than $2,000 in expenses for medical care.[202] Either form of definition presents, to a lesser degree, the same advantages and disadvantages discussed in the previous section.

(2) *Measurement of value.* Past proposals for mandated benefits have used various terms to describe the test of comparability for plans deviating from the prescribed minimum. Most recently, S. 1265 (100th Congress) has used the phrase "actuarial equivalency." As defined in the bill, two plans are actuarially equivalent if an accredited actuary is prepared to say that average benefit pay-

[202] Note, however, that the definition of "medical care" required for this option may itself require a definition of the types of services and expenses to which the limit would apply.

ments under the two plans will exceed the average enrollee's premium and cost-sharing payments by the same amount over the course of a year. The test of comparability, then, is the net benefit to the enrollee, not the cost of the plan to the employer. Although there are other possible ways of defining equivalency, the S. 1265 definition may serve as a starting point for a discussion of problems in measurement.

General measures of equivalency already exist. For example, a task force of the American Academy of Actuaries has recently developed a point scoring system for comparing the value of different health benefit plans. The system was submitted to the Treasury Department for possible use in enforcing the non-discrimination rules included in section 89 of the Tax Reform Act of 1986. Under section 89, highly compensated employees may be taxed if their health benefits are more generous than those provided to lower compensated employees.

In the Academy's system, benefits under different plans are assigned a standardized point value, with each point equivalent to 1989 dollars. Table 6.1 illustrates the point scoring for two hypothetical health benefit plans. Plan A is of a type sometimes recommended for low-income families. It provides very generous outpatient, physician, prescription drug, and dental benefits. Its inpatient hospital coverage is very limited, however, and it provides no catastrophic protection. Plan B more closely resembles large group health plans. Cost sharing is required for non-surgical physician services, but the enrollee's total out-of-pocket costs are limited. Despite all these differences, the Academy's system would find that the two plans were virtually identical in value.

This is true, however, only for a typical group of enrollees. The values are projected average national costs for comparable benefits, "independent of the geographic location and demographic characteristics of employees, the actual care utilization level by plan participants and the type of plan under which the benefits are provided (e.g., health maintenance organization versus indemnity medical plan)." [203]

As was suggested earlier, the cost to an employer of providing a defined benefit package will vary according to the health status and demographic characteristics of employees and their dependents, as well as by geographic area. If these cost variations were constant, they would have no impact on the measurement of value. If any health insurance policy, regardless of its specific benefits, would cost 20 percent more in Metropolis than elsewhere in the country, then two plans that were found to be actuarially equivalent on a national basis would also be actuarially equivalent in Metropolis.

[203] American Academy of Actuaries. Proposed Methodology on Valuation of Benefits under section 89, submitted to Treasury Department, Apr. 25, 1988. As reported, Bureau of National Affairs Pension Reporter, v. 15 (May 9, 1988), p. 782.

TABLE 6.1.—Benefit Valuation for Two Hypothetical Plans Using the American Academy of Actuaries' Methodology

	Item	Plan A		Plan B	
		Extent of coverage	Points	Extent of coverage	Points
A.	*Facility inpatient services:*				
	Hospital room & board	80%	176.00	100%	220.00
	Hospital ancillary service	80%	192.00	100%	240.00
	Mental and nervous	None	0.00	30 days	55.00
	Substance abuse	None	0.00	28 days	25.00
	Skilled/intermediate/custodial (No point value for active employees).		0.00		0.00
	Inpatient deductible	$300	(28.26)	None	0.00
	Mental health deductible	N/A	0.00	$100.00	(1.05)
	Subtotal, inpatient		339.74		538.95
B.	*Facility outpatient services:*				
	Surgery	100%	40.00	100%	40.00
	Emergency illness and accident	usual &	30.00	usual &	30.00
	Other services	customary	50.00	customary	50.00
	Subtotal, outpatient		120.00		120.00
C.	*Surgical Fees*	100% usual & customary	225.00	100% usual & customary	225.00
D.	*Physician and other professional (excluding surgery).*				
	Physician, inpatient	100%	100.00	80%	Major medical
	Physician, outpatient	100%	100.00	80%	Major medical
	Outpatient mental and nervous	25 visits, $150 ded., 75% paid	40.50	50 visits, no ded., 80% paid	Major medical
	Private duty nursing	Full	5.00	Full	5.00
	Subtotal, physician		245.50		5.00
E.	Diagnostic X-Ray and Lab	No limit	30.00	No limit	30.00
F.	Prescription drugs	$1.00 co-pay	51.94	$3.00 co-pay	45.83
G.	Other medical services	100%	25.00	100%	Major medical
H.	Dental care	$100 ded., ortho.	200.00	None	0.00
I.	Vision care	None	0.00	Fixed pmt. for exam & glasses	45.00
J.	Hearing care	None	0.00	None	0.00
	Total		1,237.18		1,009.78
K.	Major medical provisions (Excludes drugs, dental, vision).	None			
	Coinsurance for outpatient and physician services.			80%	
	Major medical deductible			$100	
	Out-of-pocket limit			$1,000	
	Major medical benefit value		0		226.80
	Final Total		1,237.18		1,236.58

However, the cost variations are not likely to be constant. For example, costs for hospital services might be 50 percent higher in Metropolis than the national average, while physician services were only 10 percent higher. Table 6.2 shows the effect of this difference on the two plans previously shown to be actuarially equivalent. Plan A was, on a national basis, worth 0.60 points more than Plan B. In Metropolis, however, Plan A is worth 84.03 points less than Plan B. Demographic variation among employer groups could have a similar impact. For example, one of the ways in which Plan A is superior to Plan B is its more generous prescription drug benefit. This benefit might not be especially valuable to a younger workforce that is less likely to require the "maintenance medications" prescribed for persons with heart disease or other chronic problems.

TABLE 6.2.—Effect of Regional Price Variation on Actuarial Equivalency

	Plan A	Plan B
National point value:		
Hospital inpatient	339.74	538.95
Outpatient facility	120.00	120.00
Physician	470.50	230.00
Other	306.94	120.83
Major medical adjustment	0.00	226.80
Total	1,237.18	1,236.58
Difference		—0.60
Point value in Metropolis:		
Hospital inpatient	523.74	808.95
Outpatient facility	180.00	180.00
Physician	517.55	253.00
Other	306.94	120.83
Major medical adjustment	0.00	249.48
Total	1,528.23	1,612.26
Difference		84.03

Note.—Hospital costs are 50 percent higher in Metropolis than the national average, physician costs are 10 percent higher, and costs for other services are equal to the national average. The difference in hospital inpatient costs is attributable to price levels and length of stay per admission, rather than to a higher number of admissions per enrollee. The negative point values for inpatient deductibles are therefore not affected by the regional cost difference.

The application of a uniform national test of equivalency that fails to take into account geographic and demographic variations would have several potentially adverse impacts. First, it might disqualify variant plans that were in fact just as valuable to enrollees as the mandated plan. Second, it could invite "gaming." Employers and insurers in particular regions might develop plans that met the national equivalency test but cost less than the mandated plan in their area. Plan A would be an attractive option for employers in Metropolis. At the same time, because hospital costs are high in Metropolis, employees would be even more exposed to catastrophic losses than employees with a similar plan elsewhere. Employers might even be able to tailor plans to emphasize coverage of services their workers are unlikely to require. To take an extreme example, an employer with an older workforce might offer well baby care, scoring points on a national equivalency scale but incurring no actual costs.

The hypothetical case in table 6.2 might itself be regarded as extreme, representing a degree of variation considerably greater than is common among current employer-provided plans. Under a mandatory system, however, employers newly offering coverage would have an incentive to exploit any cost-saving plan variations left open to them by the terms of the mandate.

These problems are not deficiencies in the Academy's system but are inherent in the use of a uniform national test of equivalency. Ideally, it might be preferable to establish group-specific tests of equivalency: is the plan that a given employer in Metropolis proposes to offer his employees equal, taking into account the characteristics of those specific employees, to the mandated plan? Applying this sort of test to every single employer's plan could, however, be very costly and administratively burdensome. There are a number of alternative options.

Accept some degree of variation. In Metropolis, Plan B is 5.5 percent more valuable than Plan A; the two plans may represent close to the maximum in plan variation that would be scored as equivalent under the Academy's system or a comparable method. This degree of variation among plans might be deemed acceptable. The section 89 nondiscrimination rules, for example, permit a 5 percent difference in the value of different plans offered by a single employer.

Limit the range of allowable variations. This could be accomplished through the definition of core benefits. This definition might even be tied to a scoring system. For example, a plan could be required to achieve a minimum point score of 500 for inpatient hospital services and 500 for physician and outpatient facility services. (The requirements might be developed through a more rigorous analysis of hypothetical cases comparable to the one used here.)

Establish regional or State level tests of equivalence, possibly with urban/rural factors. This approach would limit variation in value due to local differences in health care prices or styles of medical practice, but would not affect variation related to the demographics of a particular employer's workforce.

Develop a small number of approved alternative plans that can be shown to remain essentially equivalent regardless of geographic or demographic variation. An employer could be permitted to choose only from among these plans, or could be required to demonstrate that an alternative plan was equivalent to the basic plan for that employer's particular group. Placing the burden of proof on the employer could reduce the administrative burdens of group-specific equivalence testing, while still allowing employers with existing plans some opportunity to retain them. (Employers requesting an exception could be required to furnish demographic data, which could be combined with a general data base on geographic cost variations for different service types and run through a more sensitive point scoring model.)

Finally, it should be noted that equivalency is not constant through time, any more than it is constant for different groups at the same time. Inflation is not identical for different service types, and two plans that are of equal value in one year may not be in

the next. For this reason, any approach to measurement of plan value would require continual updating.

2. Content of Plans

The content of a plan—the services covered, the exclusions and limitations, the cost sharing and maximum benefit provisions—determines its cost. However, the content of a mandated plan involves policy as well as financial considerations. These are the subject of this section.

Much of this discussion assumes that a mandate would take the form of a defined benefit package. This does not mean that comparable issues would not arise if a mandate took the form of defined expenditure levels. At the outset, at least, an expenditure requirement implies a benefit requirement. The initial dollar level would presumably be established with some understanding of the average scope of services for which coverage can be purchased with expenditures at the specified level.

a. Basic plan design

Lack of health insurance or inadequate coverage affects individuals in two key ways. First, they may have difficulty in obtaining access to necessary services or may be deterred from seeking those services. Minor problems may go untreated until they become more serious and costly to treat, while both children and adults may fail to receive essential preventive services. Second, uninsured or underinsured persons may face catastrophic health care expenses. A single high cost episode could deplete a family's financial resources. A minimum health insurance plan could attempt to address both these problems or could focus on one or the other.

A plan designed to increase access to care might have very low deductible or coinsurance requirements, to ensure that low-income enrollees would not be deterred from seeking care. Providers of ambulatory and preventive services might be paid their full usual charges to encourage them to accept plan participants as patients. Payment for inpatient hospital services might be at some fraction of charges, or the plan might cover a limited number of inpatient days per admission or per year. This "front-end" plan would ease initial and routine entry into the health care system by providing first dollar coverage for ambulatory care, but would not protect against the cost of a catastrophic episode.

A catastrophic plan might be the inverse of a plan intended to increase access. It would offer little or no "front end" coverage for routine services, but would cover in full incurred medical care costs above a specified annual out-of-pocket limit. This limit might be a single flat amount per individual or family, or might be set as a percentage of family income. The coverage could be limited to costs for the condition or episode that triggered the catastrophic expenditure. Alternatively, the plan might cover all of the family's medical expenses once the threshold had been met.

These two types of plans not only address different problems, but may also meet the needs of different populations. Middle-income workers may be able to budget for routine medical expenses and may be in greater need of protection against the loss of their savings from a single catastrophic illness. Low-income workers and

their families may have difficulty obtaining routine care but may not be as concerned with the costs of a catastrophic episode, because they do not have accumulated assets. For this reason, some people have argued that a catastrophic plan benefits the providers of care more than the potential enrollees. Low-income patients without coverage are not in fact going to pay the costs of a catastrophic episode out of their own pockets. In this view, the costs paid by a catastrophic policy are those which hospitals would otherwise have treated as uncompensated care. On the other hand, it is possible that a reduction in the uncompensated care burden of some facilities would make them more able to provide routine services to low-income patients.

The plans currently offered by medium and large employers fall midway between the two extremes, but may meet the needs of middle-income workers better than those of a low-income population. The typical plan imposes deductible and coinsurance requirements and has an out-of-pocket limit of $1,000. Generally, premiums for employee coverage are paid in full, but the employee must contribute to the premiums for dependents. From the point of view of a low-income employee, it might be preferable to have no employee contribution to premiums and limited cost sharing. These employees might be willing to trade off some catastrophic protection and accept a higher out-of-pocket limit in return for the first dollar coverage. An alternative would be to provide a plan comparable to those currently offered by large employers but exempt low-income employees from some of the premium and cost sharing requirements. This possibility will be discussed further in section G, below.

The potential costs and impact of illustrative versions of each of these three types of plans are considered in the third report.[204]

b. Treatment of State mandates.

All States have laws requiring insurance companies to include or offer certain provisions in their health insurance policies. These State mandated benefit laws may require coverage of certain dependents, may specify services that must be provided or the types of practitioners who must be allowed to provide those services, or may provide (as the Federal COBRA title X rules do) for continued group coverage for persons leaving groups. Because of the ERISA preemption of State regulation of employee benefit plans, these State mandates apply only when an employer purchases coverage through an insurance company; they do not affect self-insured employers.[205]

The specification of benefits under a Federal employer mandate would presumably override any less extensive definition included in State insurance laws. Insurers providing coverage to employers would have to cover all the services included in the Federal definition, even if State law required fewer services. Should the reverse be true? That is, if State law requires insurance companies to pro-

---

[204] U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988. Chapter 3.

[205] For a further discussion of State mandated benefit laws, see chapter 7 of this report, as well as the previous report in this study, U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. 1988. p. 120–123.

vide benefits *more* comprehensive than a Federal mandate, should employers be required to furnish those additional benefits?

Although State mandates are often criticized on the grounds that they increase the cost of health insurance, under current law employers subject themselves to those mandates through their own choices. They could instead self insure or could choose to offer no health benefits at all. Under a Federal mandate, however, employers too small to self insure would have no option but to turn to insurance companies for coverage. They could then find themselves in the position of being mandated by Federal law to purchase a product defined by State law.

The benefits defined by a Federal mandate might be regarded as a uniform maximum, in which case the mandate could override any more extensive State requirements. Conversely, the Federal benefit specifications could be treated as a minimum, leaving States free to require more extensive benefits. In the latter case, it might be reasonable to modify ERISA, so that more stringent State requirements would apply to self-insuring employers as well as to the smaller employers newly obliged to purchase insurance.

c. High and low options

Some employer health plans allow employees to choose among two or more different types of coverage. The plan might, for example, include low and high options, with different scopes of benefits and different required employee contributions to premiums. Other employers may offer a single standard health plan but permit supplementation of the benefits as one of the options under a "cafeteria" plan.

As was suggested earlier, a dual option feature under an employer mandate might help to address concerns about requiring an employee with a low anticipated need for health care to contribute to, or forgo other benefits for, a comprehensive health plan. Employees who did not desire extensive health benefits might receive a minimum package, perhaps restricted to catastrophic coverage, with little or no employee contribution. Employees who wanted fuller coverage would have the right to select a high option plan. The incremental cost of the more extensive plan might be borne by the employee alone, or might be shared by the employer. The components and allowable employee contributions of both the high and low options would be defined by the mandate, again with possible exceptions for actuarially equivalent plans.

Some of the potential objections to a dual option system are the same as the arguments against permitting an employee to decline coverage altogether. Younger and healthier employees would tend to choose the low option plan; their contributions and those of their employers would then be unavailable to help subsidize the more costly plan. In addition, some employers might place pressure on their employees to accept the low option.

Even in the absence of overt pressure, older and sicker employees with low incomes might choose the less costly plan regardless of their perceived need for health services. Again, it might be possible to exempt low-income employees from some of the incremental cost of the high-option plan. However, many of the younger and healthier employees who would otherwise select a low option plan

might also qualify for the low-income exemption and choose the high option plan instead.

d. Alternate delivery systems

A second kind of choice offered to employees under many health benefit plans is between conventional insurance and one or more alternative systems, such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs). These alternate plans may be able to provide benefits at lower cost to the employee in return for the employee's acceptance of restrictions on the choice of medical care providers.

HMOs and PPOs present two issues within the context of an employer mandate. First, should employees be given a choice between an HMO or PPO and a conventional health insurance plan? Second, should employers be permitted to require all covered employees to select an HMO or PPO option?

(1) *Dual choice.* An employer that is subject to the Fair Labor Standards Act, that has 25 or more employees, and that provides health benefits is required by Federal law to offer an HMO alternative if there is an HMO in the area that wishes to be offered and that meets qualification standards set forth in the Federal HMO act (Title XIII of the Public Health Service Act). Under a mandate, this requirement could continue to apply to employers of 25 or more workers or could be extended to smaller groups.[206]

Employers and some independent studies have suggested that, where multiple options are offered, healthier employees may be more likely to join the alternative plans, leaving high-cost employees in the conventional plan (see chapter 2 for further discussion of this issue). If this is the case, then allowing employees to choose between conventional and alternative coverages might have the same effects that were discussed in the consideration of high/low option plans, above.

In any event, it is not clear that alternate coverage options could in fact be made available to all employers. HMOs have been at least as reluctant as other health insurers to cover small employers, in part because federally qualified organizations are prohibited from some of the practices that other insurers use in dealing with small groups, such as medical underwriting of individual employees or charging higher rates. HMOs might be more willing to cover small groups under a mandate. However, there are still large areas of the country not served by HMOs. If a pooling arrangement were adopted for small employers, inclusion of HMOs might be difficult, for this and other reasons (see chapter 7). A pooling arrangement could more readily accommodate PPO systems.

(2) *Mandatory enrollment.* In order to restrain health benefit costs, some large employers are beginning to consider requiring all participants in their health plans to join HMOs, PPOs, or comparable managed care programs. Under current law, the dual choice re-

[206] P.L. 100–517 repeals this requirement, effective in 1995. Some people say that this "dual choice" requirement, enacted in 1973 to help spur the development of HMOs, is now obsolete. They say that the HMO industry is now fully developed and that HMOs should be able to compete without the benefit of dual choice. The industry argues that there is still some employer resistance to the HMO concept and that HMOs have not reached the point of being fully competitive in all parts of the country (some States still have no HMOs at all).

quirement works in only one direction: an employer subject to the requirement may not offer a conventional plan without offering an HMO, but may offer an HMO without offering a conventional plan. (Not all HMOs are willing to enter into arrangements under which they are the sole offering.) Under a mandate, should employers be permitted to require HMO or PPO enrollment?

Obviously some enrollees would prefer the wider choice of providers available under a conventional service or indemnity plan. One possible response might be that they are still free to use other providers with their own funds and that a restricted choice is better than the lack of coverage under the current system. Medical providers who did not participate in alternative systems would oppose this view. In addition, there are still concerns about the potential for underutilization of services and limited access to care in some managed care programs. Some people argue that the ability of enrollees to opt out of these programs and return to more conventional coverage is an important guarantor of quality.

Finally, the use of PPO or HMO options in a mandated health benefit program could also have a paradoxical side effect. PPOs achieve savings by contracting with low cost providers or by obtaining discounts from providers' usual prices. HMOs may also save money in this way, although some of their savings stem from controls on the quantity of services used, rather than the price paid for each service. One of the factors that may allow a provider to enter into price competition for contracts with HMOs and PPOs is limited provision of services to the uninsured. Providers that treat patients who are unable to pay for their care often subsidize their costs for these patients by increasing charges to those who are able to pay. They are less likely than other providers to be able to offer discounts and might therefore be unable to obtain HMO or PPO contracts. If the newly insured population under a mandate were enrolled in HMOs and PPOs, the resulting patient revenues might, then, go to the health care providers that excluded uninsured patients. The providers that continued to treat the remaining uninsured population might not benefit at all.[207]

e. Waiting periods and pre-existing condition provisions

Many employer-based plans currently include provisions which delay or limit coverage of new employees, such as waiting periods for coverage or temporary exclusion of coverage for "pre-existing conditions," health problems an employee may have at the time employment begins.

Waiting periods have grown shorter in recent years, but many employer plans still require that new employees wait for periods of 2 to 3 months before joining the health insurance plan, and a few impose waiting periods of as long as 6 or 12 months. (Even plans without waiting periods customarily delay enrollment until the first day of the month following employment.) A waiting period may serve several different functions in the current system.[208]

---

[207] This effect is discussed further in U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988. Chapter 3.

[208] Some plans impose a waiting period only on employees who decline health coverage when first offered it and later request coverage. This prevents employees from obtaining insurance

Continued

First, it helps prevent workers from seeking employment at a particular firm simply in order to obtain health coverage for themselves or for their dependents, and thus reduces adverse selection. Employers and insurers may be particularly concerned that some new workers would join a health plan, immediately use expensive services, and then drop out.

Although an employer mandate would reduce the likelihood that workers would change jobs to obtain coverage, there is still the possibility that some people with a marginal attachment to the workforce would seek employment or seek to increase their working hours in order to obtain coverage for a brief period. These cases might be rare enough to have a limited impact on rates in a pooling arrangement. Still, employers might argue that it would be inappropriate to require them to subsidize the care of persons who are not committed to employment.

Second, a waiting period reduces the administrative burdens on employers with a high turnover rate, as well as on their insurers. They avoid processing enrollments and disenrollments for employees who may be in the group only for days or weeks. The administrative burdens of short-term enrollments would still exist under a mandate, although the costs might be reduced somewhat through economies of scale in a pooling arrangement.

Third, a waiting period may produce some continuing savings. If an employer has a steady 20 percent employee turnover rate in a year and offers a plan with a 3-month waiting period, then at any given time 5 percent of the employees might be without coverage. This factor might be particularly important if employers already offering health plans were required to change those plans when a mandate took effect. Elimination of waiting periods would result in an immediate cost increase over and above any increase resulting from required changes in benefits.

Because many firms not presently offering coverage are in the retail or service industries and may have high employee turnover, allowing waiting periods could diminish the coverage impact of a mandate. Prohibiting waiting periods might increase costs.

One possible solution would be to permit employers to offer some form of reduced interim coverage to new employees. The employee might receive catastrophic coverage only or might be required to make a larger contribution to premiums. Either approach would disproportionately impact low-income workers. They could be exempted and receive full coverage at the start. However, because low-income workers may change jobs more frequently than higher-paid ones, an exemption could negate the effect of an interim coverage provision.

An alternative might be to focus only on the sudden cost increases that could be faced by employers whose existing health plans include waiting periods. These employers might be permitted to shorten their waiting periods gradually or to phase in an interim coverage package. Employers not previously offering benefits might be prohibited from instituting waiting periods from the outset.

---

only when they need services. If an employer mandate did not require all employees to accept coverage, waiting periods for late enrollees might still be reasonable.

Exclusion of pre-existing conditions is rare in large employer plans, but is still common in small group and individual policies. Usually coverage of services for the pre-existing condition is denied for 12 months, although some policies may exclude some conditions for longer periods or even permanently. The possible reasons for such exclusions are comparable to those for waiting periods (except that enforcing the exclusion probably raises, rather than reduces, administrative cost). However, because pre-existing condition exclusions single out individuals and can result in substantive denial of coverage for much longer periods, they may be more difficult to reconcile with the fundamental rationale for an employer mandate.

As in the case of waiting periods, it might be possible to permit employers whose existing plans include exclusion provisions to phase these provisions out gradually. An alternative might be to permit the use of exclusions only for persons obtaining coverage for the first time. This would address any concern that some people might enter the workforce or increase their hours of work simply to obtain coverage for a known health problem. At the same time, persons who were previously insured and were changing employers would be protected against loss of coverage.

G. BALANCING EMPLOYER/EMPLOYEE COSTS

The services covered by a health benefit plan are financed in two ways: through premiums, whether paid by the employer, the employee, or both, and through cost sharing, the deductibles and coinsurance amounts paid by the employee.[209]

In the "typical" plan offered to nonbargaining employees by medium and large employers in the Hay/Huggins survey, the premium for the employee is paid by the employer in full. The employer also pays approximately 75 percent of the premium for dependent coverage. The employee is liable for the remainder of the premium for dependents, as well as for any cost sharing required by the plan. For basic hospital and physician services, this typically consists of an annual deductible of $100 plus 20 percent coinsurance for physician services, up to an out-of-pocket limit of $1,000. For families, the deductible is $200, and the out-of-pocket limit is $3,000.

Even this typical plan, then, fails to protect some workers from health expenses out of proportion to their income. Low-income workers may require some assistance in meeting premium and out-of-pocket costs. This assistance could take several different forms:

1. The Employer Could Be Required to Pay a Greater Share of the Costs for Low-income Employees

Employees with incomes below a fixed dollar limit could be exempted from some or all responsibility for premiums and cost sharing. The exemption might be a simple cut-off: employees below the line would pay nothing, while those above it would pay the standard employee share. Or the employees' responsibility might rise

[209] Almost no conventional health insurance plans are financed wholly through premiums, with no enrollee cost-sharing. HMOs, however, commonly require no deductible or coinsurance for basic services; enrollees may pay nominal "point of service" charges, such as a $2 to $5 fee for each physician office visit.

gradually with income. The lowest income employees would pay nothing, while the next tier would pay a modest deductible but no premium (or vice versa), and so on until the higher income employees paid the full standard employee share. (A possible extension of this approach to a full sliding scale mechanism will be discussed below.)

The financial thresholds could be tied solely to the employee's wages, in which case they might be based on some multiple of the minimum wage; or they could take into account the entire income of the employee's immediate family, perhaps using some multiple of the Federal poverty level for a family of the same size. Using the entire family income has the advantage of targeting this income-related assistance. An employer would not be obliged to furnish an extra subsidy to a low-income worker who was married to a high-income worker (this might be particularly important if two-income families could choose which plan covered the children). Use of family income has the disadvantage, however, of requiring a verification and information exchange system; this problem will be discussed in section I.

The major objection to an additional subsidy for low-income employees is that the employers required to pay these subsidies might be those least able to afford even the basic employer share of health plan costs: marginally profitable small firms with a minimum wage work force. The low-income subsidy simply aggravates the larger problem of some employers' inability to pay for health coverage. This issue is discussed in the context of the discussion of pooling arrangements in chapter 7. Possible ways of limiting the employer's obligations while retaining the subsidy are discussed in the remainder of this section.

2. Employees Could Cross-Subsidize One Another

An alternative would be to establish the extent of an employee's financial responsibility on a full sliding scale, with the lowest-income employees paying nothing. For example, the system could provide that an employee would be responsible for premiums and cost sharing equal to 5 percent of the employee's earnings above the minimum wage, up to some limit.[210] The limit could be some fixed maximum (such as the maximum employee cost in a typical employer plan) or could be the actual entire cost of the plan: that is, the highest-income employees might pay the full cost of their insurance without any employer contribution. In effect, the higher-paid employees would be subsidizing the costs for their lower-paid colleagues, with the employer picking up any remainder.

This could work, of course, only in a firm with a sufficient mix of high and low-paid employees. This is probably not the case in most of the small employers not presently offering insurance. Those employers who do have an adequate wage mix could presumably afford to pay the low-income subsidy directly. They might choose to fund it by cutting high-wage workers' salaries (which is the effect

[210] While sliding premiums could be administered relatively easily, sliding cost sharing might be cumbersome and confusing. If a sliding scale were adopted, it might be preferable to eliminate cost sharing and cover all plan costs through premiums. However, as was discussed in chapter 2, cost sharing has functions other than simply contributing to the overall funding of services; it also deters the use of services and reduces the overall cost of the plan.

of this approach) or by cutting costs in other areas. It is not clear why this business decision would need to be dictated at the individual firm level as part of an employer mandate.

On the other hand, even if the sliding scale approach is not a practical solution to the problem of subsidizing low-income employees, it does raise an important issue in a minimum benefit proposal.

An employer has two separate functions in the provision of a health plan. The first is to form the insurance group and arrange for coverage. The second is to assist in paying the costs of the plan. If all employees were highly compensated, performance of the first function might be sufficient: the employer would simply ensure that employees could purchase insurance on more favorable terms than would be available to them if they entered the market as individuals. The second function, an employer contribution to the cost of the plan, is a necessary component of a mandatory health benefit option only if some employees cannot afford the cost of coverage, even at group rates. The employer's minimum financial responsibility could thus be defined negatively: the employer covers the costs that individuals cannot afford to pay. A possible corollary might be that the employer does not cover the costs of employees who can afford to pay.

3. Low-Income Workers Could Be Assisted Through Tax Deductions or Credits

Employee contributions to premiums and cost sharing could be made fully or partly deductible from income tax or could be subsidized through a tax credit. Options for using the tax system to assist with employee health expenses were discussed in chapter 5. However, some special issues would arise if this option were adopted in the context of an employer mandate.

A health care tax credit to be used for premium contributions could, as is allowed for the EITC, be allocated to the worker throughout the year. If the credit were also intended to assist with cost sharing, the administration would be more complex. While in theory the credit for cost sharing expenses could be computed at the time workers filed their tax returns, many workers might be unable to pay cost sharing during the year and would require more immediate assistance. Tracking and crediting these expenditures could be a significant burden for small employers. An alternative would be to eliminate cost sharing for the low-income enrollees and finance the whole of their care through premiums. The employee share of premiums could be increased to reflect the elimination of cost sharing, and could then be offset through the tax credit system.

It would be necessary to decide whether the health care tax credit would, like the EITC, be targeted solely at families with children, or whether it would be available to all workers. This decision might depend on the employee contribution rules for the minimum benefit. If the mandatory plan resembled the typical plan offered by large employers, with the employee covered in full and required to contribute only to dependent coverage, assistance with contributions might be confined to families. If employees were required to

contribute to their own premiums, all low-income workers might need assistance.

4. Low-Income Workers Could Be Assisted Through Direct Federal or State Subsidies

A more direct option would be a government subsidy provided through an entitlement program. Low-income workers would apply for assistance and would be determined eligible through a formal certification process. The program would issue premium contributions directly to their employers and would process claims for cost sharing amounts. Administrative functions might be performed by State Medicaid agencies, which are already equipped to perform eligibility determinations and which routinely pay premiums and process cost sharing claims (Medicaid programs pay Medicare premiums and cost sharing amounts for beneficiaries dually entitled to Medicare and Medicaid). The program might be funded jointly by the Federal and State governments, as Medicaid is, or might be financed entirely with Federal funds.

A Federally funded subsidy program would have essentially the same fiscal impact as a Federal tax credit for health care costs serving an equivalent population; tax credits might be slightly cheaper because of delayed pay-outs. The chief difference would be in administration. A tax credit program could be administered chiefly by employers, as is the interim pay-out component of the EITC program.[211] While this would be less costly and cumbersome than a distinct entitlement application and claims payment process, it might also be less tightly controlled. The front-end savings might be needed to fund enhanced retrospective audit and verification capacity.

H. COORDINATION OF COVERAGE ISSUES

Some persons are covered both by an employer health plan and by Medicare or Medicaid. Under current law, Medicare is a secondary payment source for most persons who are still actively employed (retiree coverage is secondary to Medicare). Medicaid is always secondary to any other coverage. This section considers the impact of these rules under an employer mandate. It also discusses another coordination problem, the relationship between an employer mandate and the COBRA coverage continuation provisions. Coordination between overlapping employer plans was addressed in section E, above.

1. Medicare

Employers with 20 or more employees must offer active workers aged 65 and over the same coverage that they offer younger workers. If an employee's spouse is over 65 and Medicare-eligible, he or she must also be offered the same dependent coverage offered to any other employee's spouse. Similar rules apply, until January 1, 1992, to persons receiving Medicare disability coverage who are employees or the dependents of employees, but only in firms with 100

[211] The EITC payments are credited against the employer's quarterly payment of FICA and income tax withholding. Since only about 10,000 EITC beneficiaries have opted for interim payments, some small employers may not be familiar with the process.

or more workers. Finally, persons receiving Medicare as a result of end stage renal disease must be allowed to continue participating in their employer group coverage plan for the first 12 months after they begin receiving dialysis or could qualify for Medicare as a result of a kidney transplant.

Although employers with group health plans must offer coverage to these classes of Medicare beneficiaries, the beneficiaries do not have to accept the coverage. They may decline to participate, leaving Medicare as their only source of insurance. For those who do accept the employer's coverage, Medicare becomes a secondary payer. It covers only services not covered by the employer plan but payable under Medicare rules; it may also pay part of the cost of coverage that the employer plan does not pay in full.

It is possible that an employer mandate would make many more Medicare beneficiaries eligible for employer group coverage, particularly if coverage were extended to employees working as little as 10 or 17.5 hours per week. If employers were required to cover all these people, and if the current rules went unchanged, there could be a significant shift in expenditures from Medicare to the private sector, perhaps particularly to small employers. In 1986, an estimated 1.8 million actively employed persons over 65 received coverage through their work. A requirement that employers cover persons working 10 hours a week would raise this number to 5 million.[212] Moreover, although working beneficiaries are unlikely to be the costliest Medicare beneficiaries, their costs would certainly be higher than those for the younger or non-disabled workers who would receive employer coverage through a mandate. Their presence in the pool would result in an overall premium increase.

The Medicare secondary coverage rules were enacted in order to achieve Medicare savings by shifting some costs to employer groups. The rationale was that working beneficiaries were entitled to the same benefits as other workers at the same firms. This rationale would be equally applicable to newly covered workers under an employer mandate. At the same time, maintenance of the secondary coverage rules in their present form could increase the burdens on the employers newly adding coverage.

Medicare's rules were adopted in the context of the current insurance system, in which employers rarely furnish health coverage to part-time workers. If an employer mandate included coverage of persons working a smaller number of hours, the original congressional intent might be preserved by modifying the secondary coverage rules. Medicare might continue to be secondary to employer-based coverage of workers who are still fully employed, but primary for workers who have essentially retired but continue employment on a part-time basis.

2. Medicaid

Some workers and their families are receiving Aid to Families With Dependent Children (AFDC) benefits, and hence Medicaid, because their countable income (often after "disregards," subtractions

[212] Estimates by ICF-Lewin based on the March 1987 Current Population Survey. See U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage, 1988, chapter 3, for a discussion of the ICF-Lewin model.

from income used in determining eligibility) is within the eligibility standards. In addition, as chapter 4 indicates, AFDC beneficiaries losing cash assistance because of employment may continue to receive Medicaid benefits under "work-transition" provisions. Some groups of disabled workers also receive Medicaid. For all of these groups, Medicaid coverage is secondary to any coverage provided through employment.

A recent study by the National Center for Health Services Research indicates that, of persons under age 65 newly enrolled in Medicaid between late 1983 and mid-1986, at least 19 percent were in households whose head was still working after obtaining Medicaid benefits. Of those losing benefits during this period, at least 26 percent were in households whose head had been working for some period before the loss of Medicaid.[213]

The effect of current law is that there are two groups of working Medicaid beneficiaries: those whose earnings are insufficient to raise them above Medicaid income standards, and those whose incomes are above Medicaid standards but who continue receiving Medicaid for a limited period. The two groups might be treated differently in the context of an employer mandate.

Workers whose incomes remained below Medicaid standards might, as at present, continue to receive Medicaid benefits even though they were also receiving coverage through their employers. Under current law, Medicaid would pay any required enrollee cost sharing under the employer plan and would also cover any services included in a State's Medicaid plan that were not provided for in the minimum employer plan. For those receiving work-transition coverage, Medicaid would also pay the employee's share of premiums.

Whether, in the context of a mandate, Medicaid should continue to provide work-transition coverage for families with incomes above Medicaid standards is not clear. The extended coverage for Medicaid beneficiaries returning to the workforce is intended to address the concern that some families might remain on welfare because they had continuing medical needs and could not obtain health insurance through employment. The rationale for this coverage might disappear if an employer mandate would protect families returning to the workforce from losing health coverage. It might be inequitable to continue providing assistance with premiums and cost sharing for these families for an extended period, while other families at the same income level would receive only the basic employer plan. Continued work-transition coverage might be more justifiable if employers under a mandate were permitted to impose a waiting period or provide limited interim coverage for new employees. In these circumstances, Medicaid coverage could be continued until the new worker could qualify for full employee benefits.

3. COBRA Continuation Coverage

Under the continued coverage provisions of title X of COBRA (P.L. 99-272), someone who moves from a job that offers health in-

[213] Short, Pamela Farley, Joel C. Cantor, and Alan C. Monheit. The Dynamics of Medicaid Enrollment. Paper presented at the annual meetings of the American Public Health Association, New Orleans, Oct. 1987.

surance coverage to a job that does not offer coverage could continue to participate in his or her former employer's health plan for up to 18 months.[214] The charge to the worker for this continued coverage may be no more than 102 percent of the average per capita cost of the plan.

Under an employer mandate, the same worker would be entitled to insurance from his or her new employer. Depending on the design of the mandate, however, the worker might face a waiting period for coverage or might receive a reduced interim benefit package for the first several months after employment (see section F.2.e. for a discussion of these options). The two possibilities present slightly different coordination issues.

a. Waiting period

If employers could impose a waiting period under a mandate, the worker would face—as at present—the choice between going without coverage for some period or paying the full cost of group insurance through his or her former employer.

Some of the rationales for waiting periods, such as the concern that high-risk individuals will seek employment simply to obtain insurance coverage, would not apply to persons changing employers. One solution, then, would be to prohibit waiting periods for persons previously covered under their prior employer's plan, while allowing waiting periods for persons not previously covered. An alternative, somewhat more cumbersome, would be to permit the new employer to contribute to the employee's COBRA continuation coverage through the prior employer.

b. Interim coverage

If employers could offer reduced interim benefits to new employees, the worker would have to choose between accepting those limited benefits or paying for full COBRA continuation coverage that partly duplicated the interim plan.[215]

Again, one possible solution is to distinguish between newly employed persons and those changing employment. Employers might be required to provide full coverage for new employees previously covered elsewhere, while providing more limited coverage to employees newly entering the work force or increasing their hours. An alternative would be to modify the COBRA continuation rules to allow workers changing jobs to buy secondary coverage through their former employer's plan at reduced rates; this coverage could then supplement the limited coverage available through the new employer.

I. ENFORCING AN EMPLOYER MANDATE

Monitoring and enforcement of an employer mandate would involve three major concerns:

---

[214] Under current law, an employee may also continue under the former plan even if the new employer offers a plan. Once the employee becomes covered under the new employer's plan, the former employer may terminate continued coverage.

[215] Currently, such workers face the choice of electing coverage under the new employer's plan or remaining under the old employer's plan until the 18 months of continued coverage expires. This choice can be problematic when the new employer's plan includes a pre-existing condition exclusion.

- Is every employer providing or purchasing the required coverage?
- Is every employee who is required to obtain coverage doing so?
- Is the source of coverage, whether it is the employer itself or a private insurer, performing adequately? For example, is it fiscally sound? Is it honoring valid claims?

Under the ERISA division of responsibilities between the Federal and State governments, the first two areas would be Federal matters because they relate to employee benefit plans rather than to the sale of insurance. The third area would be the concern of the State if the employer were purchasing coverage from a licensed insurance company; regulation of self-insured employers would be a Federal responsibility. (A more detailed discussion of the Federal-State regulatory division appears in chapter 7.) The following discussion assumes that the current division of responsibilities would continue. The focus is on the administrative issues in enforcement, rather than on identification of the agencies involved. The choice of agencies to carry out the Federal responsibilities will be discussed in section J, below.

It should be noted that most of the enforcement activities described in this section could not possibly be performed routinely for every employer or employee in the Nation. As in other areas, such as immigration or tax law, monitoring would presumably occur on an exception basis, in response to complaints or through random audit. There is one area, however, in which this might not be feasible: determination that an employer was providing an actuarially equivalent plan. Employers would need to know in advance whether an alternative plan they were offering was acceptable, lest they be subjected to retroactive penalties after a spot review. Possible ways of reducing the potential administrative burdens of pre-certifying plans are discussed in the next section.

1. Enforcement of Employer Responsibilities

a. Certification of plans

The task of determining that an employer health plan meets the minimum requirements of a mandate would differ somewhat depending on whether the mandate took the form of a defined benefit package (with or without allowances for "actuarially equivalent" plans) or a defined minimum expenditure level.

(1) *Defined benefits.* Employers purchasing coverage could show that they met the minimum benefit requirements by displaying to the regulatory authority a group insurance policy issued by a State-licensed insurer and providing for the required coverage. Self-insured employers do not have policies, but are required under ERISA to file an annual description of the plan with the Department of Labor. In either case, verification of compliance would be complicated only if the mandate allowed for actuarially equivalent plans. The technical issues involved in determining actuarial equivalence were described in section F.1.b, above. From an administrative standpoint, the critical issue may be that equivalence testing, even using a simple point scoring system, could be labor-intensive and time-consuming—all the more so if real equivalence

changes from year to year because of different inflation rates for different service components of a health benefit plan.

Several steps could reduce the administrative burdens of verifying equivalence. First, the methodology for determining equivalence could be rigidly established and made available to applicants; the system would not involve subjective individual determinations by actuaries. Instead of reviewing provisions of health plans and attempting to score them, the responsible agency would review self-scoring application forms. Presumably it would receive few applications that did not meet the test of equivalence, since the failure to meet that test would be apparent in the application itself. One problem with this approach is that it might not accommodate existing health plans whose features could not be accounted for in a standardized system. This would defeat one of the purposes of actuarial equivalence. In addition, a fully standardized scoring system might be more open to "gaming" than a system that relied in part on direct evaluations by actuaries. Mechanical scoring techniques might never uncover variant plans that failed to provide acceptable coverage.

Another approach would be to impose certification fees for actuarially equivalent plans. This would offset the administrative costs and discourage frivolous applications. Higher fees might be imposed on insurers, who would be seeking certification of a plan to be offered to numerous groups, than on individual employers. A fee system, or any measure that made offering a non-conforming plan cumbersome for the employer, would relieve administrative burdens at the price of discouraging innovation. Again, this would be especially so if annual redeterminations were required to verify continuing equivalence. Over time, the number of options available to small and medium-sized employers might be reduced to a limited number of standardized plans.[216]

Finally, special provisions might be needed for the period immediately following implementation of an employer mandate, when the number of applications for equivalence determinations is likely to be highest. In addition to the time needed simply to process the initial workload, some time might elapse before the rules for equivalence testing were fully established, particularly if the system were subject to appeals or court challenges. Months or years might elapse before employers could be certain that their existing plans were or were not in compliance. It might be decided, then, not to penalize employers who offered a non-compliant plan during the start-up period. This approach, however, could allow some employers to retain plans that were significantly less comprehensive than the minimum required. A possible solution would be to apply retroactive penalties to employers whose plans were ultimately determined to fall below the minimum by a fixed amount, perhaps 10 or 15 percent. Employers whose plans fell within the margin would be required to modify their plans but would not be

[216] The number of options offered to small employers is limited in the current insurance market. The significant expansion in the small group market resulting from an employer mandate could be expected to produce a proliferation of new offerings. This might be true even if there were administrative hurdles involved in developing a new plan.

penalized for the period during which their plans were under review.

(2) *Defined expenditure levels.* If a mandate were to take the form of defined expenditure levels, rather than defined benefits, verification of compliance would appear to be simple: one would merely determine the employer's expenditures for health coverage during a given period and divide this amount by an average count of eligible workers. Inequities might arise, however, if the same approach were used for both insured and self-insured plans.

The costs of an insured plan are fixed at the start of the coverage period; the employer will pay the insurer a certain amount for a certain package of benefits.[217] The costs of a self-insured plan are not fixed. The employer may project those costs in advance and may be able to show that the benefits to be offered have an expected cost equal to the mandated expenditure level. However, the actual cost of those benefits may turn out to be higher or lower than the initial projections. If the actual costs are lower than the mandated amount, does the employer owe its workers the difference, in the form of a rebate or enhanced benefits the following year? If the costs are higher, can the employer collect the excess from employees or reduce benefits in the following year, or is the employer solely at risk for cost overruns?

One possible approach might be to verify compliance on a multiyear basis. Employers would not be penalized for uncontrollable year to year fluctuations in actual costs, but might be penalized if their expenditures were continually below the required minimum over a longer period.

b. Limitations on employee liability

A mandate might provide for limitations on the contributions to be made by employees to the cost of their health coverage. For example, employers might be prohibited from charging employees more than 25 percent of the premium for the employee's own coverage or 50 percent of the premium for dependent coverage. The mandate might also call for special treatment of low-income employees, in the form of reduced premium contributions or cost sharing. These options are discussed in section G, above.

Compliance with general limits on employee premium contributions could be readily verified for insured plans: the employer is or is not withholding from employees' pay a share of plan costs greater than the permissible amount. Self-insured plans, however, may present problems comparable to those discussed at the end of the previous section. If a self-insured employer requires employee contributions, the employer would ordinarily define in advance the expected cost of the plan and then set employee contribution levels equal to some percentage of the projected cost. What if the initial projections were wrong, and the employer's collections were more or less than the allowable percentage of plan cost? It might be possible to require that the employer make retroactive adjustments in employee premium contributions or adjust contributions in the fol-

[217] There are exceptions, in which larger employers share in the surplus or deficit if plan costs vary from the initial projections. These arrangements may be thought of as falling midway between insured and self-insured plans.

lowing plan year. Again, however, it would be administratively cumbersome to require that an employer's calculations work out precisely every single year. An alternative is to assess compliance on a multi-year basis.

Compliance with special limits on cost sharing or premiums for low-income employees might be more difficult to verify. As was suggested in section G, above, eligibility for reduced cost sharing might properly be based on total family income, rather than a particular worker's earnings. (Otherwise a high-income family could obtain subsidized coverage because one spouse had low earnings.) An individual employer is not in a position to assess family income. One option would be to have eligibility for subsidized coverage assessed by an outside agency, such as the State Medicaid or social services agency. Low income workers would complete an application, and their family income and resources would be verified through the State's standard eligibility determination systems. The agency would then notify the employer if a family was found to be entitled to reduced cost sharing.

2. Enforcement of Employee Participation

If employees are required to accept an offer of coverage for themselves and for dependents, there will need to be a mechanism for determining that all workers subject to the requirement have complied. As was indicated earlier, the compliance system required would differ somewhat depending on whether an employee was obliged to accept coverage at his or her workplace or could obtain coverage through an employed spouse. In either case, it would also be necessary to determine whether the employee had any nonworking dependents and whether they were covered by the employee or another family member.

a. Employee coverage

If employees must accept primary coverage at the workplace, compliance is readily determined: the employer either is or is not covering all eligible employees under the health plan. However, if John Doe is permitted to opt out of the plan on the grounds that he is covered under Jane Doe's plan, then it is necessary for the employer to obtain some evidence of exemption. This could take the form of certification by Jane's insurer or employer that John is indeed covered under Jane's plan.

Problems arise, not in the initial verification of coverage, but in ongoing monitoring. If Jane Doe leaves her job or cancels her dependent coverage, so that John is no longer covered, then her insurer or employer could notify John's employer, who could then require John to participate in his own employer plan. One difficulty is that neither Jane's employer or insurer nor John's current employer has any incentive to make sure that the information about John's coverage is kept current. In some cases, the notification may not be issued or received, while in others there may be a delay in establishing John's new coverage. The problems might be reduced if many employers participated in a pooling arrangement or if private insurers established a system for exchanging information about insureds. Still, it is possible that at any given time a consid-

erable number of persons who were supposed to have been covered through their employment would not be covered.

One partial solution would be to require periodic recertification. John's employer might be required to verify annually that John was still covered under Jane's plan. However, this would be burdensome for both of the employers and could still leave some persons uncovered for relatively long intervals. A possible alternative would be to wait for the lack of coverage to manifest itself, as would occur if John sought admission to a hospital or other expensive care. At that point, coverage through John's employer could be established retroactively to the date on which John ceased to be covered under Jane's policy. The retroactive coverage requirement would be necessary to equalize the impact of this approach on insured and self-insured plans. If coverage were restored only beginning on the date of the medical episode that brought the lack of coverage to light, the self-insured employer would pay the full treatment costs for that episode, while the employer purchasing insurance would pay only a single month's premiums.

b. Dependent coverage

Verifying that all employees have secured coverage for their dependents, either on their own or under a spouse's plan, presents a different set of problems. Under current law, there is no requirement that employers determine whether an employee is married or has children. Although the mechanisms for verifying dependent coverage would be comparable to those for verifying John Doe's coverage under Jane Doe's plan, there would also need to be some mechanism for determining whether an employee has dependents who are eligible for coverage.

This problem may be a serious one. As was noted earlier, even in the current system there are numerous workers who could have obtained coverage for their dependents and have not done so. Noncompliance under a mandatory system might be common if low-income workers were expected to contribute to the cost of dependent coverage. Employers themselves would have a financial incentive to accept an employee's denial that the employee had dependents in need of coverage.

How would an employer, or an agency monitoring the employer, verify that an employee who claimed to have no spouse or children was telling the truth? At a minimum, employers could investigate cases in which an employee claimed multiple exemptions from income tax withholding. Still, some employees might forgo the short term benefit of reduced withholding rather than pay dependent health care premiums. A stronger measure would be for IRS to notify employers when employees claimed multiple exemptions on their final returns. However, any such use of information from the income tax system for an unrelated purpose could be highly controversial. Again, an alternative is to wait until the lack of coverage manifests itself, when an uncovered dependent seeks medical care, and then establish coverage retroactively.

One way of reducing the incidence of failure to obtain dependent coverage would be to impose a fine or other sanction on the employee when the non-compliance was discovered. However, the penalties might fall disproportionately on low-income workers, assum-

ing that they would be the most likely to violate dependent coverage requirements. The sanctions could be income related; for example, the employee could be liable for a dependent coverage surcharge equal to a fixed percentage of wages. The heaviest fines might then fall on middle and higher income employees who were evading support responsibilities.

3. Monitoring the Performance of the Source of Coverage

If a mandate is to be meaningful, it is necessary to determine that the coverage set forth in a group insurance policy or a self-insured plan is actually provided. Insurers and self-insuring employers must honor valid claims for covered services and must at any time have sufficient resources to cover all outstanding claims. States are already monitoring insurers' practices and financial condition; the chief issue for insured plans is whether State standards and enforcement are sufficiently strong to provide uniform protection for all workers covered under a Federal mandate. At present, self-insured plans are essentially unregulated. The issue under a mandate would be whether to subject these plans to some form of regulation comparable to that presently imposed on insurance companies.

a. Insured plans

State insurance regulators protect enrollees in insured plans in a number of ways. Insurance companies may be required to maintain reserves; these may be on deposit with the regulatory agency itself, although this is rare in health insurance. Insurance regulators also periodically assess the financial condition of insurers and may have the authority to assume direct control of a company found to be financially unstable. In addition to monitoring the financial condition of insurers, regulators may also intervene in claims disputes, requiring insurers to carry out the terms of their policies. Finally, some State laws prohibit health care providers from holding patients liable for claims left unpaid by an insolvent insurer.

Regulation of insurers is not uniform across States and may not be uniform within a State. For example, a State may exempt Blue Cross/Blue Shield Plans from reserve requirements. Federal law preempts State reserve requirements for federally qualified HMOs, although qualified HMOs must demonstrate to the Secretary of HHS that they have adequate protections against insolvency.[218] Finally, PPOs or other new hybrid arrangements may not be regulated at all in some States, because they do not fit into the traditional categories provided for in State law.

The result of this variation is that not all purchasers of insurance enjoy the same protections. Some employees covered under a Federal mandate might still find themselves personally liable for claims left unpaid by their insurers. If it were decided that a mandate ought to be accompanied by more uniform protections for enrollees in insured plans, there are at least three possible approaches. The first is for the Federal Government to assume direct responsibility for regulation of health insurance. This would repre-

[218] A State could require an HMO to participate in a guaranty fund arrangement, and some States are now considering doing so.

sent a reversal of the 1945 decision, in the McCarran-Ferguson Act, to leave insurance regulation to the States. The other two approaches are modeled on current Federal policies and would represent a less significant change in course.

The first would be to establish a certification system comparable to that now in place for HMOs. Any HMO may apply to the Secretary of HHS for a determination that it is "federally qualified," that is, that it meets certain organizational, financial, and quality standards for HMOs set forth in the Public Health Service Act. Certain employers that provide health benefits must offer an HMO as an alternative to their conventional plans, if there is a Federally qualified HMO in the area and it asks to be included. An HMO may operate under a State license without being federally qualified, but may not take advantage of the mandatory employer offering.

A similar Federal certification system could be established for conventional health insurers. No insurer would be obligated to obtain Federal approval. An insurer could continue to operate solely under a State license. However, the lack of Federal certification would be a signal to employers and other purchasers that a given insurer could meet State standards but not stricter Federal standards. If certification served only this informational function, the enhanced competitive position of the certified insurers might be sufficient to improve the protections for enrollees. It would be possible to establish a more stringent requirement: that an employer would not be deemed to have complied with the mandatory benefit rules if the employer bought coverage from an uncertified insurer. However, this approach would make Federal certification so essential to an insurer's operations that it would amount to replacement of State regulation by a uniform Federal system.

A second option that could reduce the level of Federal intervention in insurance regulation would be to adopt a certification system comparable to that established for "Medigap" policies, private insurance policies intended to supplement the benefits available under Medicare. Any insurer may request certification by the Secretary of HHS that its Medigap policy meets minimum standards developed by the National Association of Insurance Commissioners (NAIC).[219] States may have their own Medigap certification systems. A State-approved policy is deemed to have Federal approval if the Secretary has determined that the State's requirements are at least as stringent as the NAIC standards.

Federal certification of insurers might similarly be delegated to States that can show that their systems of insurance regulation met some minimal national standards. Like the Medigap standards, standards for insurers seeking to cover employer groups might be based on the collective judgment of States, as reflected in NAIC model regulations. Direct Federal review of insurers might then occur only in States whose rules were less stringent than the NAIC standards. Again, Federal certification might be merely informational, or employers might be required to obtain coverage through certified insurers.

---

[219] This certification does not entitle the insurer to any privileges beyond the ability to state that its Medigap policy is an approved one.

b. Self-insured plans

Because ERISA prevents States from regulating self-insured employer health benefit plans, enrollees in these plans may not receive some of the protections that many States provide for persons covered by group insurance contracts. In particular, enrollees in self-insured plans may be left personally liable for payment of health care claims that their employer has failed to pay as a result of insolvency.

In an insured plan, if the employer becomes insolvent, the insurance company is still liable for claims for services received by enrollees up to the last date for which premiums have been paid. Many insurers will also continue coverage until the end of a hospital stay for persons in the hospital at the time coverage is terminated.[220]

If the employer offering a self-insured plan becomes insolvent, there may be a large number of outstanding claims for services received by the employees prior to the insolvency. A backlog of 60 to 90 days' worth of services rendered but not yet billed to the insurer would be routine under any insurance arrangement. More claims might be outstanding if an employer in financial difficulty slowed down claims payment. In this situation, the health care providers' claims are against the individual employee. The employee in turn has a claim against the company, one which the company may never make good. If the company is liquidating under chapter 7 of the Bankruptcy Code, the employee is an unsecured creditor. Health benefit claims enjoy some legal preference, but are payable only after the company's estate has satisfied all secured creditors, paid the expenses of liquidation (such as attorney's fees), and paid any back wages owed to former employees. If the company is continuing in operation under chapter 11, then health benefit claims, like all others, are in suspension pending court approval of a plan for satisfying creditors. The court may approve continuation of the employees' health benefit plan during this period, but claims under the plan prior to the filing may or may not be satisfied.

If provision of health insurance benefits were to become a mandatory, rather than an optional, activity of employers, it might be reasonable to strengthen the protections for employees whose companies choose to comply with the mandate through a self-insured plan. These protections might parallel those provided by insurance companies under State regulation or those required for employer pension plans under ERISA. In either case, employers could be required to: (a) establish reserves sufficient to cover any claims that might be outstanding at the time of an insolvency, or (b) contribute to a health plan guaranty fund.

Either approach would have certain disadvantages. Employers are generally not now permitted to fund their health plans in advance from before-tax earnings. If employers were required to establish health plan reserve funds, there would be pressure to allow contributions to the funds to be deducted from earnings. This could mean some loss of Federal revenues. In addition, there are difficul-

[220] Employees may not be protected if their employer has failed to pay premiums for some period prior to insolvency. The problem of uncollectible premiums will be considered in the discussion of pooling arrangements in chapter 7.

ties in establishing the size of the reserves necessary to provide absolute protection for enrollees. The alternative, establishment of a guaranty fund modeled on the Pension Benefit Guaranty Corporation (PBGC), also has potential drawbacks. Financially stable employers would be required to contribute to the unpaid bills left by other employers. The contributions required could grow rapidly if, as was the case with PBGC, a few major plan terminations seriously depleted the fund.[221]

J. SELECTING AN AGENCY TO ENFORCE THE MANDATE

Assuming that the employer mandate is enacted at the Federal level, enforcement and administration could be assigned to one or several Federal agencies. Administration could be accomplished entirely at the Federal level or delegated to the States. Of course, administrative complexity may be magnified if more than one agency is given jurisdiction; State participation could result in greater complexity as well as vast variations between States.

Precedent exists for placing enforcement responsibilities over employer mandates with the Departments of Health and Human Services, Labor, and Treasury. In the case of title X of COBRA (P.L. 99-272), all three agencies have jurisdiction. The Internal Revenue Service of the Department of the Treasury and the Pension and Welfare Benefits Administration of the Department of Labor are responsible for enforcing the title X requirement on private employers. The Public Health Service has responsibility for enforcing the mandate on State and local governments.

Another possibility is to create a new agency, either within an existing cabinet department or as a wholly independent entity. In Massachusetts for example, the Health Security Act requires the creation of the Department of Medical Security. This new agency will have the responsibility of monitoring employers as well as enforcing the legal requirement that they provide benefits or pay an excise tax. Many national health insurance proposals of years past would have created a new department of health or health insurance. This new entity could become the home for existing programs such as Medicare and Medicaid as well as for the administration of the employer mandate, or it could be limited to functions related to the mandate.

An alternative is to administer the mandate under one (or more) Federal agencies, but delegate day-to-day enforcement to the States. For example,[222] the Federal law could specify that States have the responsibility under Federal rules or guidelines for such activities as approval of employer and other related health plans, and for sanctioning of employers out of compliance with the law. The Federal agency would be responsible for reviewing the State laws, regulation and administration relating to these functions and to certify States which meet these requirements. Some agency decisions could be subject to hearing and review by Federal courts.

---

[221] U.S. Library of Congress. Congressional Research Service. Meeting the Pension Obligation: Underfunding and Overfunding Issues. Issue Brief no. IB87170, by Ray Schmitt. (Updated regularly)

[222] This illustration is based on H.R. 12684 and S. 2970 introduced by Representatives Mills and Schneebeli and Senator Packwood in the 93rd Congress.

K. POSSIBLE SANCTIONS FOR NONCOMPLIANCE

Prior legislation and existing law provide a wide array of sanctions and/or penalties to enforce employer mandates. Noncomplying employers (and related actors, such as insurance companies) could be subject to a variety of tax penalties, such as an excise tax calculated as a specified percentage of payroll or a per diem tax for each day the employer is out of compliance. These are most easily levied by the Internal Revenue Service, although other aspects of enforcement may be more appropriately handled within HHS, Labor, or a newly created agency. A variety of civil sanctions are possible as well. The employer could be assessed a penalty by the Secretary of the enforcing agency. For example, a penalty of $100 per day could be assessed on noncomplying employers. Employees and their families could be given the right to sue for injunctive relief and/or damages. The Federal government could be given the right to bring suit against an employer in Federal court to enforce the coverage and other provisions of the mandate.

Another possibility is to subject the noncomplying employer to a loss of Federal funds. This approach is especially useful for enforcing mandates on State and local government employers. It is also the basis for the final option to be presented in this chapter, a more limited mandate applicable only to Federal grantees.

V. MANDATES ON FEDERALLY FUNDED EMPLOYERS

Federal law has frequently imposed requirements on employers who receive Federal funds that do not apply to other employers. While civil rights laws may be the most familiar example, there are also requirements more specifically directed at the employer/employee relationship, such as the Davis-Bacon rules governing wages and labor relations under federally funded construction contracts. Conditions attached to Federal funds may be more restrictive than rules governing employers in general, because the entities subject to the special conditions are free to decline Federal funding. This freedom may sometimes be nominal: States depended on Federal funds for 19 percent of their total revenues in 1986,[223] while some private industries are substantially dependent on Federal contracts. Still, some may see mandates applicable only to Federal grantees and contractors as less intrusive and hence more politically feasible than mandates on all employers.[224] Others might object to such requirements on the grounds that they might serve as a precedent for broader Federal action. Mandates or near-mandates for federally funded employers might work as follows:

- a percentage of certain Federal funds, such as Medicaid payments or Public Health Service funds, could be withheld from State and local governments that failed to provide coverage to their full-time employees (and their dependents);

---

[223] Council of State Governments. The Book of the States: 1988-89 Edition (v. 27). Lexington, Ky. 1988. p. 232.

[224] In the 100th Congress, H.R. 5349 (Rep. Clay) would require Federal construction contractors and those furnishing materials and supplies to provide health benefits. Other Federal contractors or grantees are not addressed.

- government contracts (such as construction, procurement or consultant contracts) could be withheld from employers that failed to provide coverage; or
- conversely, in awarding contracts, preference could be given to employers that provide coverage.

Under each of these options, the incentives may not be sufficient to bring large numbers of the uninsured under employer-based plans. First, State and local governments tend to already provide health insurance plans, at least for their full-time employees. Fully paid coverage for dependents is less prevalent—an area where options such as those described above might produce expanded coverage—especially for State government employees and their dependents.[225]

These options are likely to impose administrative burdens on affected Federal agencies. At the least, each department responsible for withholding funds or letting contracts would have to establish some procedure for determining whether the employer in question provided health insurance to its employees. There may also be a concern that withholding Federal dollars from a State or local government that fails to provide coverage may harm those persons most in need of public support. For example, if the Federal Government withheld 2 percent of Medicaid matching funds from a State government that failed to provide coverage, the State might respond by tightening eligibility rules, thereby reducing access to Medicaid for some low-income persons. Consequently, while this option might increase coverage of State and local government employees, it could reduce coverage among low-income populations.

Finally, requirements imposed on non-governmental grantees or contractors would disproportionately impact the smallest entities. This policy might then conflict with other Federal rules that give some preference to small business in contracting or procurement.

[225] Information on the number of State and local government employees without insurance is not available. There is, however, plan-level information. Of 653 counties surveyed by the National Association of County Officials in 1987, 634 provided health insurance coverage, 12 provided no coverage and 7 did not respond to the health insurance question. Of the 12 counties without coverage, 11 were in counties of 25,000 people or less. A different survey of public and private employers found that cities were more likely to offer their employees comprehensive major medical or a basic plan with major medical than were State governments and private employers. Cities were least likely to require employee contributions for employee-only coverage (78 percent) compared with States (50 percent) and other employers (61 percent). Cities were, however, more likely to require employee contributions for dependent coverage (35 percent) than were States (13 percent) and other employers (31 percent). Nation's Cities Weekly. Survey says cities outpace other employers in medical benefits. May 23, 1988.

CHAPTER 7.—EXPANDING THE AVAILABILITY OF INSURANCE

I. INTRODUCTION

The current American private health insurance system evolved gradually over the course of this century, largely in response to the dictates of a free market.[226] The history of that evolution was recounted in the first report in this series.[227] One important trend in that history has been a gradual move away from cross-subsidization of health care.

In the 1930s the Blues, along with similar plans developed by providers or consumers of care, offered insurance at fixed rates to all purchasers. Under the community rating system, low-risk individuals and groups subsidized the costs for the higher-risk segments of the insured population. The rise of competition from commercial insurance companies in the 1940s led to a crucial innovation: experience rating for large groups. Low-cost groups demanded that the rates they paid for coverage be related to the costs incurred for their group alone. The commercial insurers met this demand. Ultimately the Blues were obliged to follow their lead and to offer some form of experience rating to large groups. Some groups found that they had sufficient resources to drop out of the market altogether and self insure.

The original community of insureds was fragmented into discrete populations. Some could buy coverage readily at low rates or could provide their own coverage. Others had to pay higher rates or could not find coverage at all because of insurance underwriting practices. This fragmented market is the one policymakers seeking to expand health insurance coverage confront today.

To say that the market has not provided insurance to all Americans is not to cast judgment on insurers or on the group purchasers who have shaped the products that insurers sell. The logic of the market has acted neutrally to create the present situation: private buyers and sellers of a commodity are not expected, acting on their own, to discard their own advantage and pursue social goals. If the society determines that everyone should be able to purchase coverage, it has two broad options:

- Modify the logic of the market by changing the rules or incentives under which it operates.
- Accept that the market will not furnish the desired social good and sell it directly.

---

[226] Some of the incentives in that market were created by government action. For example, as was discussed in chapter 5, tax policy has played an important role in promoting employer coverage.

[227] U. S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. Report No. 88-537 EPW. Washington, June 9, 1988.

The two approaches might be illustrated by an analogy with another good that the society wished to make available to all citizens: electricity. In many areas, government regulation of rates and other business practices of utility companies was used to ensure that most potential consumers could afford electric power. On the other hand, to bring electricity to one group that private enterprise was not reaching at all, the Government established the Tennessee Valley Authority (as well as other Federal power authorities) to produce and sell power directly.

In the area of health insurance, Federal and State governments have tried both approaches. Regulation of the insurance market has generally been left to the States, although some provisions of the Health Maintenance Organization (HMO) Act of 1973 may be interpreted as a form of Federal insurance regulation (see below). Programs in which government sells insurance directly have tended to focus on "uninsurable" individuals or groups, usually with some form of premium subsidy. The Federal Medicare program is the most conspicuous example, created in the face of the inability of many of the elderly to purchase coverage.[228] Some States have also developed programs that sell subsidized insurance to high-risk individuals.

The passage of the Employee Retirement Income Security Act (ERISA) in 1974, and subsequent court decisions, have complicated the regulatory environment by further segmenting the employer group insurance market into two parts: self-insured plans regulated solely under ERISA's limited rules for welfare benefit plans, and insured plans that are subject to State regulation of the insurance companies from which they are purchased. This division of authority has produced barriers to expanded availability. It has limited the flexibility of the States to provide for programs to expand access to affordable insurance by making it difficult for the States to regulate the behavior of self-insured firms. It has also created an "uneven playing field" in which employer plans have sought the shelter of self-insurance to avoid State premium taxes and mandated benefit laws.[229] Once beyond the reach of State regulators, self-insured employers have resisted attempts by the States to require their participation in pools and other programs to expand coverage. While ERISA preemption does not preclude State action affecting employer plans (e.g., States could impose excise taxes on the gross wages paid by employers that failed to participate in a pool), it has narrowed the range of State options.

ERISA has also left the self-insured plans essentially unregulated. State solvency requirements and consumer safeguards do not apply to self-insured plans. While employers who self insure may provide good health benefits to compete for labor, there are no regulatory standards to ensure that the health expenses of the employee are adequately covered. Nor are there regulatory safeguards

---

[228] The Medicaid program, enacted at the same time, does not sell insurance to its enrollees and so does not fit into this model. This will change as the result of the new option, under P.L. 100-203, for States to charge premiums for Medicaid coverage of pregnant women and infants with family incomes between 100 and 185 percent of the Federal poverty level. Further expansion of Medicaid as a seller of insurance will be considered later in this chapter.

[229] Companies have also turned to self-insurance to avoid paying the component of insurance companies' charges that constitutes the insurer's profit.

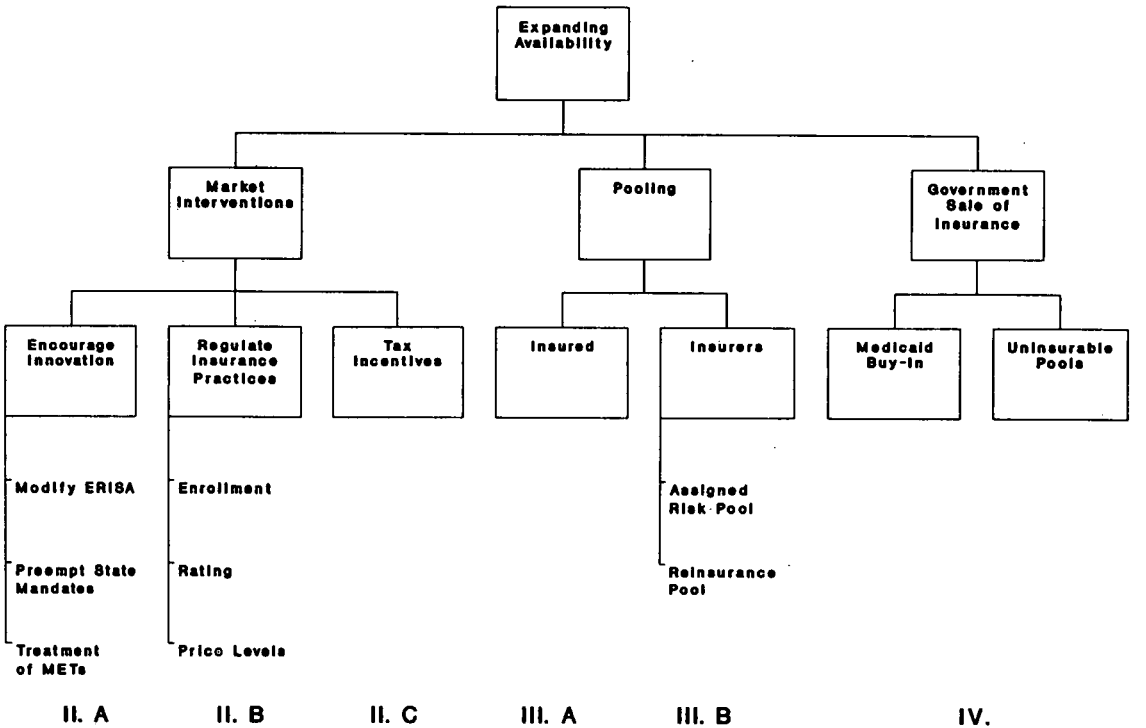
to ensure that the employer's plan will be able to pay claims if the employer terminates operations, or shuts down the health plan.[230]

This chapter considers the possibility of further Federal or State interventions in the insurance market. It begins with regulatory and incentive options; some of these address the issue of market fragmentation directly, while others address the division of responsibility between the Federal and State governments that has complicated and sometimes thwarted regulatory initiatives. The chapter concludes with options for direct government sale of insurance. In between, a middle choice is considered, the government-assisted development of pooling arrangements, which combine individuals or small groups into one large group in order to obtain some of the purchasing advantages large groups have in the current market, or which combine insurers to spread risk. Chart 7.1 shows the options to be considered.

[230] This issue was discussed, in the context of an employer mandate, in chapter 6, section III.I.3.

Chart 7.1

Expanding Availability



All of these options assume the existence of a market that is ready to purchase insurance if insurance were more available or affordable. The size of this market, and the price levels at which it would buy insurance voluntarily, cannot readily be estimated. Clearly, however, it does not include all 37 million uninsured Americans or all the employers not currently offering coverage. In order to significantly reduce the size of the uninsured population, the measures reviewed in this chapter might need to be considered in conjunction with the options discussed earlier in this report, which would encourage or mandate the purchase of insurance.

II. Government Interventions in the Insurance Market

To ease the presentation of the following analysis, this section identifies three aspects of market fragmentation that limit the availability of affordable coverage and could be targeted for change: (a) Federal and State laws that discourage innovation in designing programs to expand access to health insurance; (b) insurance practices, such as underwriting or rating practices, that contribute to market fragmentation and limit the availability of affordable coverage to individuals and small groups; and (c) the cost of health insurance, which acts to deter small employers and individuals from purchasing coverage.

Policymakers can choose to achieve changes through regulation or through tax incentives or penalties. Such measures could be adopted at either the Federal or State level, or both.

A. Remove Barriers to Innovation

The division of regulation of health benefits between the States (for insured plans) and the Federal Government (for self-insured plans) has played a role in limiting the availability of affordable health insurance for the small group and individual subscriber market. As suggested above, ERISA preemption has discouraged State innovation in designing pooling mechanisms and other policies to increase the availability of insurance. Also, State governments have imposed mandated benefit laws on insured plans, thereby limiting the flexibility of insurers to design low-cost plans that might appeal to small employers. Finally, conflict and confusion over State versus Federal regulation of multiple employer plans may have impeded their growth and effectiveness as a source of coverage for small employers. On the other hand, because multiple employer plans do not necessarily increase the availability of coverage for smaller employers, questions should be asked about whether public power should be used to encourage their development. These elements of divided regulation, as they affect strategies for expanding health insurance, are addressed below.

1. The ERISA Preemption

The 1985 Supreme Court decision in *Metropolitan Life Insurance Co.* v. *Massachusetts* reinforced the authority of the States to regulate the content of group insurance policies through which employ-

ee health benefit plans are provided.[231] Self-funded or self-insured plans, including those with stop-loss coverage, are under ERISA and cannot be made subject to State regulation by such measures as mandated benefit laws, or be forced to participate in State risk pools (such as the risk pools for the medically uninsurable). The courts have also ruled that self-insured plans that contract with insurers for administrative services only (ASOs) are not subject to State regulation, since ASOs only provide claims processing and do not assume any financial risk for the paying of claims.[232]

a. The Effects of ERISA

While ERISA has requirements relating to reporting, disclosure and fiduciary responsibility for the administration of welfare benefit plans, it does not regulate the substantive content of these plans. Therefore, when a company chooses to self-insure, it removes itself from governmental scrutiny of plan solvency, reserves, eligibility rules, and procedures for plan termination. With the exception of title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA), the non-discrimination rules under the Federal Internal Revenue Code, the pregnancy disability amendments to the Civil Rights Act, and the Medicare secondary payer requirements,[233] the design of the benefit content of these plans is also left to the employer (or, in the case of a multi-employer plan such as a Taft-Hartley plan, to the plan trustee in negotiation with member unions).

Because States have no regulatory reach over self-insured plans, it is difficult to design State mandated requirements on employers to provide coverage, to participate in pooling mechanisms, or to provide for specified benefits or coverage requirements.[234] The design and financing of State programs for high-risk individuals provide an illustration of the way in which the ERISA-State dichotomy regarding regulatory authority can affect both the politics and policy outcomes at the State level. States can select from a variety of measures to fund their programs, but divided regulation has left a mark on the choices States have made.

b. State health insurance pools and ERISA

As of 1988, 15 States have enacted laws establishing health insurance programs for persons who are unable to obtain coverage through other sources, or who can obtain coverage only at prohibitively expensive rates. Premium rates are capped by State law and generally range from 150 percent to 400 percent of the average individual standard risks in the State for comparable coverage. Given

---

[231] Metropolitan Life Insurance Company v. Massachusetts. 471 U.S. 224 at 242, 85 LE2d 728, 105 S. Ct. 2380, June 3, 1985.

[232] Spencer, Charles D. and Associates. Spencer's Research Reports on Employee Benefits. Chicago (Regularly updated). Sections 606.-19 through 606.-24.

[233] See U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. Washington, 1988. Chapter 3.

[234] Massachusetts' Health Security Act does not directly require that employers provide benefits. Instead, it imposes a payroll tax on employers and then permits employers who provide health coverage to credit their costs against the tax. This approach, intended to avoid the ERISA preemption, may still be challenged in the courts.

Note that States are permitted to regulate multiple employer welfare arrangements. The legal status of these organizations is treated under the section of this chapter entitled "Multiple Employer Plans."

the high-risk populations who enroll in the programs, however, premiums are usually insufficient to cover expenses. Consequently, the existing programs are expected to operate at a loss. To cover the losses, most State programs assess health insurance carriers in proportion to their share of the State insurance market. Because of ERISA's preemption, such an assessment necessarily applies only to coverage purchased through insurance companies; self-insuring employers are not required to participate. This exemption both limits the potential funding for the State program and increases the incentives for employers to self insure. As a result, some States have turned to other sources of financing, such as taxes on health care provider revenues or State general funds. (Section IV, below, provides a fuller discussion of financing mechanisms and other aspects of these programs.)

An alternative would be for a State to finance a program through assessments on all insuring entities—self-insured employers as well as commercial insurance companies and the Blues. However, such a law could be directly challenged under ERISA. For this reason, in past years the commercial insurance industry has sought Federal "enabling" legislation that would permit the States to require all insuring entities to participate in State risk pools. These entities would include employers that offer insurance as well as insurance companies. Entities that failed to provide coverage would be subject to a Federal excise tax. Such a proposal is explicitly designed to require self-insured companies to participate in the financing of State pools without amending ERISA.

This is just one example of ERISA's potential effect on State initiatives. Some analysts and lawmakers have suggested alternative strategies.

c. Alternative strategies

Congress could modify ERISA to preempt State laws only in areas where ERISA now explicitly regulates. This strategy is designed to remove participants in self-insured plans from ERISA preemption, bringing them under State regulations and benefit mandates, but would maintain the Federal Government's role in respect to notification, disclosure, and fiduciary responsibilities of health plan administrators. It would provide for more equitable treatment of workers in similar situations, and possibly expand the type of coverage available to workers in self-insured firms because workers currently under self-insured plans would acquire new safeguards. Depending on State law, benefits could be made more secure. Employers would also have fewer incentives to self insure, because the States could require self-insured plans to offer mandated benefits, pay premium taxes, and otherwise comply with State regulations. This approach might encourage States to experiment with minimum benefit standards and other coverage mechanisms, such as risk pools for uninsured persons. However, such a strategy would subject self-insured plans to two sources of regulation and might result in more confusion, higher costs and less flexibility, especially for multi-State plans. This approach might also encourage court challenges on the scope of ERISA.

Conversely, Congress could expand ERISA or otherwise impose Federal regulations on all insuring entities. Under this approach,

the States would be largely removed from the regulation of health insurance; uniform Federal standards would regulate the sale and content of both insured and self-insured plans. This option is discussed further below (see section 2.8).

2. Mandated Benefit Laws

Mandated benefit/mandated coverage laws fall into four categories that are roughly equivalent to "who, what, when and where." [235] There are laws regarding the kind of services covered under a health insurance contract (benefits); laws that define types of providers who must be permitted to participate; laws that extend the length of time coverage has to be provided (continuation/conversion); and those that define who must be covered, such as dependents. These laws grew in number and scope throughout the last 2 decades, and today there are over 600 different mandates across the Nation.

However, the addition of new mandated benefit laws is expected to slow. States are beginning to require that proposed mandated benefits be evaluated according to various social and economic criteria.[236] Another factor in slowing State mandates may be that the proponents of mandated benefits have shifted their focus to the Federal level, as evidenced by the enactment of COBRA title X in 1986. In this regard, it is significant that Federal mandates can do what is not possible at the State level—regulate self-insured as well as insured health plans.

a. The effects of State mandates

State mandates remain important in determining the content and pricing of health plans sold by commercial insurers and the Blues. State mandates remove benefit design decisions from the market place, and prevent insurers from offering lean benefit packages that would appeal to employers operating on the margin. Because the price of insurance is a key concern of employers in purchasing health insurance, and most especially of small employers, insurers and employers complain that mandated benefits reduce the availability of affordable coverage.

Measuring the cost of mandated benefits is difficult, and their effect on overall employer costs is widely debated. Much depends on whether the analyst looks only at the costs of adding the benefit to a given insurance package or at the effect on other aspects of employer expenses. For example, mandated coverage of treatment for drug and alcohol abuse may add to the price of an insurance plan, but it may also hold down overall costs by reducing traffic accidents and absenteeism, while also increasing productivity. However, opponents of mandated benefits say that such savings are not realized, that any law that requires more benefits, more people cov-

[235] U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. Report No. 88-537 EPW. Washington, June 9, 1988. Chapter 3.

[236] Washington, Oregon, Arizona, and Pennsylvania now require some form of evaluation of proposed mandated benefit laws. See Allison Alkire. A Research Based Approach to Curbing Mandates. Business and Health. Apr. 1987. p. 7-9.

ered, or longer periods of coverage must cost more money.[237] Moreover, for insurers that operate in multiple States, costs are magnified by the need to design policies that bridge the different State requirements.

One final factor complicating any analysis of the costs of mandated benefits is the difficulty of determining which of those benefits would have been included in health insurance plans even in the absence of State mandates. For example, outpatient psychiatric benefits are often cited as a costly State mandate. These benefits were provided by 95 percent of the large and medium-sized employers responding to the 1987 Hay/Huggins Benefit Report (HHBR), even though 40 percent of those firms were self-insured and therefore not subject to mandates.

In a State with a large number of benefits, such as California or Maryland, the added costs may be higher than in a State with few mandates, such as Delaware. A 1985 study of the costs of mandated benefits in Maryland, performed for Blue Cross/Blue Shield (which opposes mandated benefits) estimated that mandated benefits accounted for 17 percent of family premium costs for employer-provided group health plans.[238] Hay/Huggins' actuaries estimate that the average State mandated benefit provision adds about 2 to 5 percent to the costs of a typical medium or large employer's plan. For a State with extensive mandates, such as California, the added cost may be as much as 10 percent.[239]

b. Policy options

To reduce the adverse effects of mandated benefit laws on insured health plans, a variety of measures could be pursued at the State or Federal level. First, *the States could pare back their own laws.* This would give insurers greater flexibility to design lower cost packages which might suit the needs of uninsured small employers. To an extent, the States are already showing some inclination to at least limit future mandated benefit laws by imposing cost effectiveness evaluations on newly proposed mandates. Reducing benefits, however, could be politically difficult because of opposition from provider and consumer groups that fought hard to achieve mandated benefit laws.

A second alternative is for Congress to *place insured plans under ERISA without changing ERISA standards.* Under this option, the Federal Government would remove regulation of insured plans from the prerogative of the States and place them under Federal law. This would be a dramatic break with precedent as established by the McCarran-Ferguson Act. The advantages of this option include: (1) Insurers would achieve more flexibility to offer plans that

---

[237] The following illustrates the type of argument used against mandated benefits. Regarding the introduction of mandated benefits for chiropractic services in Hawaii in 1980, it was claimed: "While the chiropractors stated that they offered a 'less costly alternative' to medical doctors, their cost per case rose to more than three times the cost of a general practitioner between 1978 and 1984. During the same period, the number of chiropractors doing business in the state quadrupled." Carolyn Peterson. Mandated Health Benefits: Time to Evaluate. Washington, American Legislative Exchange Council, 1986. p. 3.

[238] Rasmussen, Brian. Mandated Coverage: An Employer Debate. Business and Health. Apr. 1, 1987. p. 12-14.

[239] The methodology for estimating these costs is demonstrated in U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Coverage. 1988. Chapter 2.

are tailored to an employer's preferences. Insurers say this would enable them to compete to offer the best buy in benefit packages. This might produce significant price reductions in insurance. For example, insurers have said that they would like to market catastrophic plans to employers if they did not have to comply with mandated benefit laws. These plans could be relatively inexpensive, especially if they were designed to cover only expenditures above a set amount and were not scaled according to income. In response, employers might be more willing to buy insurance for their workers, thereby increasing the percentage of the working population with health insurance. The savings and resulting growth in the number of insured persons would, of course, be realized only at the price of less comprehensive coverage. (2) The elimination of State requirements would reduce the administrative and benefit costs of multi-State employers who purchase coverage from insurers. (3) There would probably be an increase in the number of multi-employer arrangements such as METs, because there would be fewer restraints on their development, financing, marketing, and benefits. (See next section.) This too might expand the number of employers that purchased health insurance.

However, there are potential tradeoffs to removing States from the regulatory scene. Participants in insured plans might lose important benefits that they have under State regulation. They could also lose significant consumer safeguards provided under existing State laws.[240] For example, through mandated benefit laws, many States have provided for coverage of disabilities, "rare diseases" and non-physician providers—coverages that might not be retained by insurers or employers if no longer required by law. The elimination of mandated benefits could also lead to diminished freedom of choice for consumers. If an insurance company chose not to reimburse a type of provider, then the consumer could obtain such a provider's service only by paying for it out-of-pocket. In another sense, however, freedom of choice would be increased, because consumers could select from a larger variety of health plans.

In addition, some States, such as Hawaii, Massachusetts, Minnesota, and Wisconsin, have either achieved close to universal coverage or have established mechanisms to cover some subgroup of the uninsured such as the medically uninsurable. In the absence of a universal coverage requirement, Federal preemption would require such States to disband their programs unless the law allowed for grandfathering in these State programs.

There could be substantial opposition to the elimination of the State's role in regulating insurance. Interests that benefit from the current rush to self insure (self-funded employers and third-party administrators) might prefer the status quo because State regulation stimulates the growth of the self-insured market. Some insurance companies might prefer State regulation because they have developed longstanding relationships with State insurance commissioners. They may prefer the known to the unknown of Federal insurance regulation. Moreover, this approach could create the mo-

[240] This concern might be alleviated if the ERISA preemption applied only to plans meeting specified minimum Federal standards.

mentum for further erosion of State regulation of insurance companies and contracts in lines of business not related to health.

Some State legislators may also oppose Federal preemption of State laws because it would eliminate their ability to address the concerns of particular constituent interests, and to pass on to private insurers some coverage responsibilities which might otherwise have to be financed by the State's taxpayers in the form of expanded Medicaid, medical assistance, or other programs. They might also argue that State regulators can be more sensitive to regional variations in demographics, service mix, and insurance availability. Finally, some question whether the Federal Government has the will, the resources, and the ability to regulate insured plans, even under the limited requirements of ERISA.

Moving one step further, Congress could *place insured plans under ERISA or a new Federal statute.* Under this option, the Federal Government would assume the responsibility of regulator, enforcer and final authority over the nature of participation, solvency, and benefit design. A uniform system of regulation would be established, thereby eliminating divided regulation. Self-insured and insured plans would have to play by the same rules of the game. Insurers and employers would gain the administrative advantage of dealing with only one set of regulations.

This option would provide for the most dramatic change from current law. While this might be accomplished by amending ERISA, Congress has a number of other options. It can affect both insured and self-funded plans via the nondiscrimination route (section 89 of the Internal Revenue Code), the extension of civil rights route, or employer obligation legislation via the tax code.[241]

On the other hand, this strategy also has drawbacks and could provoke substantial opposition. It would shift the political debate over provider issues to the Federal arena, which means that Congress would be pressured to deal with questions like appropriateness of reimbursement for acupuncture (it already has to do this for FEHBP and CHAMPUS as well as Medicare). In the same vein, this option, like the one above, is likely to be opposed by non-physician provider groups.

In addition, moving regulation to the Federal Government would impose substantial burdens on a bureaucratic entity (perhaps a new U.S. Office of Health Insurance). This raises the question of whether any such Federal entity would be able to do an effective job of regulating such a decentralized activity and product as health insurance.

A final alternative would be for Congress to *amend ERISA to provide for narrow preemption of State insurance laws on a trial basis* as part of a larger experiment to test programs that might act to expand the availability of insurance. For example, the Secretary of Health and Human Services (or the Department of Labor) could be given the authority to provide for an ERISA preemption on a temporary basis to test pilot projects in which insurers would

---

[241] Feezor, Alan. No Future Guarantees for Self-Insured Plans. Business and Health. April 1987. p. 16–19.

be allowed to market low-cost, minimum health plans to small employers.[242]

3. Multiple Employer Plans

Many small employers or their employees can come together in one large pool, thereby creating the potential for reducing the costs of obtaining health insurance. Such arrangements can take a variety of forms. One such form is the multiple employer trust (MET), viewed by some as a solution to the problems of small employers in obtaining coverage. But the divided regulation between State and Federal authority for employer health plans extends to METs as well, thereby creating confusion and, in the view of some, impediments to the growth of these types of arrangements.

Moreover, as discussed in chapter 2, METs, and multiple employer arrangements more generally, do not guarantee that a given group member can obtain lower cost insurance than through the small group market. High risk applicants may be charged above-average rates or denied coverage. METs that accept high risk applicants run the danger of driving up premiums and losing better risk employers to other insurers. Thus, while divided regulation may inhibit the growth of METs, it is not evident that METs are an effective source of coverage for small employers.

While lots of multiple employer arrangements are commonly called "METs," there is, in fact, a complex set of distinctions drawn between multiple employer arrangements that are defined under ERISA and those that have no clear status under ERISA. As will be discussed, the term "MET" is not useful when trying to determine whether the arrangement falls under State or Federal regulation. Consequently, the more generic term "multiple employer plan" is used hereafter. The following section traces the development of the confusion over regulation of multiple employer plans. The section then looks at alternative options for clarifying the status of such plans under State and Federal law. The choice of options may depend on whether lawmakers are convinced that multiple employer plans offer an effective source of small group coverage.

a. The development of multiple employer plans

Pooling of employers for the purchase of insurance has been practiced since the end of World War II.[243] The number of multiple employer plans increased in the years following enactment of ERISA in 1974, probably because of the escalating costs of health insurance, especially as these costs applied to small groups, and the enactment of ERISA, which preempted the States from regulation of employer welfare benefit plans. Not surprisingly, most of the growth in multiple employer plans was of the self-insured type.

---

[242] Such a program is proposed in legislation (S. 2027) introduced in the 100th Congress by Senator Quayle.

[243] Information for this section is largely drawn from: Bovbjerg, Randall R. Insuring the Uninsured Through Private Action: Ideas and Initiatives. Inquiry 23:4 (Winter 1986), p. 403–418, and The American Hospital Association. Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage. Chicago. 1988. p. 70–73. See also U.S. Library of Congress. Congressional Research Service. Health Insurance and the Uninsured: Background Data and Analysis. Report No. 88–357 EPW. Washington, June 9, 1988. Chapter 3.

These plans offered small employers, who usually could not bear the risk of self-insurance on their own, some of the advantages associated with self insurance: avoidance of State taxes on insurance premiums, freedom from minimum reserve and mandated benefits requirements applicable to commercially insured plans.

Because ERISA did not establish minimum funding standards for welfare benefit plans or set up an insuring entity to guarantee payment of benefits as it did for pension plans, some multiple employer plans with unexpectedly high claims costs found themselves with insufficient assets to pay claims. Often State regulators did not know that the plan was in difficulty until complaints were filed that claims were going unpaid. The resulting insolvencies reportedly resulted in millions of dollars in unpaid claims.[244] In response, State insurance regulators began to challenge the claims of these plans that they were immune from State regulation because of ERISA's preemption of State laws governing employee benefit plans. Even when favorable court rulings upheld the legal authority of States to regulate multiple employer arrangements, there was the practical problem of discovering the existence of a self-insured arrangement before it became insolvent. This was one of the reasons that Congress decided to amend ERISA in 1982.

When Congress reviewed this issue in 1982, it had a number of options. The most important objective for lawmakers was to establish a mechanism for ensuring that multiple employer plans had to meet basic solvency requirements. Congress could place this responsibility entirely with the States, which already had the insurance regulation machinery and experience to do this. Such a move by Congress would create a precedent for eliminating the Federal Government's role in regulating employee welfare benefit plans. Alternatively, Congress could attempt to establish Federal solvency requirements, and Federal oversight and enforcement machinery. Finally, Congress could establish Federal requirements, but explicitly leave to the States the role of enforcement. In the end, Congress chose to establish a distinct category of multiple employer plans known as multiple employer welfare arrangements (MEWAs) and place them all under State solvency regulation and enforcement.

b. The 1982 MEWA Amendments

In 1982, Congress passed the Multiple Employer Welfare Arrangement Act (P.L. 97-243). It first distinguished MEWAs from those multiple employer organizations that were clearly under ERISA exclusively, and therefore entirely outside the reach of State regulation. These included plans or arrangements established under agreements which the Secretary of Labor finds to be collective bargaining arrangements, plans established by rural electric cooperatives, and single employer plans.[245]

---

[244] U.S. House Committee on Education and Labor, Subcommittee on Labor-Management Relations. Oversight Investigation of Certain Multiple Employer Health Insurance Trusts (METs), Evading State and Federal Regulation. Hearing, 97th Congress, 2nd Session, Mar. 5, 1982. U.S. Gov.t. Print. Off., Washington, 1983.

[245] Single employer plans were defined as follows: "two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within

Continued

The 1982 Act then defined two types of MEWAs. MEWAs of both types are subject to ERISA's reporting, disclosure, and fiduciary standards. The first type consists of fully insured arrangements. State regulation of this type of MEWA is limited to State insurance laws that require the maintenance of adequate reserve levels in order that promised benefits can be paid. The Secretary of Labor is given the authority to exempt from this requirement, individually or by class, MEWAs that are not fully insured, but only if such arrangements meet other requirements of ERISA necessary to be considered an employee welfare benefit plan.

The second type of MEWA consists of those multiple employer welfare benefit plans that are not fully insured (they might be self-insured but also have a stop-loss policy for catastrophic risks). This type of MEWA is subject to the full range of State laws regulating insurance, so long as such regulations do not conflict with the specific ERISA provisions dealing with welfare benefit plans.

Thus, as a result of the 1982 Act, a distinct set of arrangements is definable as MEWAs; other employer arrangements are either identifiable as clearly under Federal regulation, or are left undefined. In all, there are at least four types of arrangements, each with a different status under Federal and/or State law.

- Joint labor-management trusts, organized under section 302 of the Taft-Hartley Act to operate pension and welfare benefit plans, including health coverage. These are referred to as multiemployer plans, and are usually differentiated from multiple-employer trusts (METs). Employers contribute to the pool on the basis of amounts determined through collective negotiations with the employees: employees may or may not provide contributions. Estimates place the number of enrollees in these plans at between 8.5 and 9 million people, drawn from over 700,000 employers.[246] They are typically found in industries where there are a lot of small companies that cannot justify their own plan, or in industries where, because of seasonal or irregular employment patterns, few workers would qualify under an individual company's plan if one existed.[247] The construction industry is heavily represented in these plans. These plans clearly fall under ERISA, and are thus regulated by the U.S. Department of Labor. They are exempt from State regulation.
- Trade associations (such as the American Bar Association) representing employers in the same industry may also provide health insurance. These are considered under ERISA to be single-employer welfare benefit plans and are thus exempt from State regulation. They come under the regulation of the Department of Labor. Trade associations are distinct from multiemployer plans because they are not established through collective bargaining agreements.

---

the same control group." Control group was defined as "a group of trades or businesses under common control," which was further clarified through reference to other sections of ERISA. Gill, Kathleen D., Editor. ERISA. The Law and the Code. Bureau of National Affairs, Washington. 1985.

[246] See Employee Benefit Research Institute. Fundamentals of Employee Benefit Programs, 3rd edition., Washington, 1988. See, also, Bovbjerg, 1986.

[247] Employee Benefit Research Institute, 1988.

- Business associations or coalitions that cut across trade groups may form multiple employer plans. The U.S. Department of Labor has indicated that it does not consider these types of arrangements to fall under the definitions of employer welfare benefit plans (either ERISA-plans or MEWAs) and they are thus not under Federal regulation. They are viewed as insurance companies and therefore should be treated by the States as insurance companies, whether or not they are self-insured. The best known of these coalitions is Cleveland's Council of Smaller Enterprises (COSE) which offers a group health policy that in 1987 covered 4,500 of the 7,000 association members.
- Those established by independent administrators to market health insurance coverage to various firms. The regulatory status of these plans is less obvious, although the 1982 amendments were intended to provide clarification. However, if they are not treated by the States as insurance companies, then they should be regarded as MEWAs, and thus subject to State solvency requirements.

The practical effect of the 1982 amendments has been to reduce the burden of proof required by State insurance departments to regulate a multiple employer plan, especially in respect to solvency requirements. Still, confusion remains about the status of these plans. Some State insurance regulators complain that they cannot *license* such plans because, as employee welfare benefit plans, they come under ERISA. Without the authority to license these plans, they argue that they can not directly trace their existence. Typically, the State learns that the plan is operating within its borders only if a problem arises with its payment of claims.[248] Others argue that the 1982 ERISA amendment implies that the States themselves may promulgate registration requirements for MEWAs that would enable States to track their existence, saying that such requirements would be necessary to enforce claim reserve and rating standards.

The 1986 National Association of Insurance Commissioners (NAIC) model jurisdiction act adds to the confusion. Some believe the model legislation misinterpreted the MEWA amendments. The model legislation assumes that all plans are under the jurisdiction of the State's insurance department unless the plan can document that it is regulated by another government entity.[249] It further provides that if a person or entity is unable to show such documented proof, "it shall submit to an examination by the insurance commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not such person or entity complies with the applicable provisions of this code." [250] Because the Department of Labor does not provide such documen-

[248] At least one State, Illinois, has been able to track METs through licensing of third-party administrators or through filings made by insurance companies in which information is provided on contracts with METs. However, even in Illinois, METs which are self-funded and self-administered may fall completely through the cracks. National Governors Association. Facilitating Health Care Coverage of the Working Uninsured: Alternative State Strategies. 1987. p. 115-117.

[249] Feezor, Allen. p. 19. See, also, National Association of Insurance Commissioners. Model Regulation Service. Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Model Act. July, 1986.

[250] Ibid.

tation, the NAIC language has the effect of saying that the regulation of multiple employer plans is entirely under the States.

Besides the continued confusion over regulation, there remains the question as to whether the development of multiple employer plans should be encouraged. The legislative history of the 1982 MEWA amendments suggests that the statute was designed more to assure that such plans would operate under closer scrutiny than to encourage their growth. Lawmakers may have been skeptical about the effectiveness of multiple employer plans or about their claim to being something other than insurance companies. The question remains whether anything should be done to clarify the regulatory status of such plans, and/or to otherwise encourage their growth.

c. Policy options

The preferred option depends greatly on whether the objective is to remove restraints on the development of multiple employer plans, or to improve the ability of government to regulate their operations so that the insurance coverage of participants in such plans is more secure. If the goal is the former, then one option would be to remove the regulation of these plans from the States and place them entirely under Federal law. Assuming that no changes were made in ERISA to increase Federal regulation of such mechanisms, this would allow them to operate in a relatively unregulated environment. Like self-funded single employer plans, the only requirements multiple employer plans would have to meet would be those ERISA requirements relating to notification, plan disclosure and fiduciary responsibilities. This approach is supported by some third-party administrators, who would gain from removing self-insured multiple employer plans from State regulation.[251] If the goal is to provide for increased monitoring of their operations, then Congress could clarify or restate what appears to have been intended by the MEWA amendments: that together with regulating plan solvency, the States will have the sole authority to register any MEWA operating within its borders. Once enacted, such a law would ensure that State insurance departments could require multiple employer plans to register with the State just as insurance companies must do. Additional State requirements on MEWAs could be encouraged using the same approach.

B. MODIFY INSURANCE PRACTICES THROUGH REGULATION

Extending the availability of coverage could be accomplished through changing certain existing insurance practices that limit enrollment or contribute to costly (above-average) premiums. For example, insurers could be required to offer annual open enrollment periods during which any individual or group wishing to purchase coverage under a set of standard terms could do so. Insurance limitations resulting from medical underwriting, including denial of coverage or exclusions for pre-existing conditions, could be prohibited. Insurers could be required to use community rating,

---

[251] U.S. House Committee on Small Business. The Health Insurance Problem. Hearings, 100th Congress, 2nd Session, May 6, June 16 and 18, 1987, Serial no. 100-7. Testimony of Frederick Hunt and James K. Polk.

thereby offering uniform premium rates to all applicants. In addition, requirements could extend to the actual amount of premiums, to ensure that they were reasonably related to the value of the coverage being provided.

Regulatory options are presented in this section. The next section discusses how insurance practices may be modified by using tax incentives or penalties.

1. Modify Enrollment Practices

Insurers could be required to offer a standard insurance plan to all persons or groups wishing to purchase it. This requirement could take the form of a general prohibition of the individual or group underwriting practices described in chapter 2. An alternative would be to permit underwriting most of the time, but require each insurer to hold an annual open enrollment period, during which applicants could purchase coverage without being subject to underwriting rules. The latter approach would have the advantage of assuring that purchasers would not seek coverage only when they anticipated an imminent need for health services. However, there are reasons other than immediate need for care that might lead people to seek insurance in between open enrollment periods. For example, a person obtaining extended coverage as a result of the COBRA continuation rules might seek individual coverage when the continuation period expired. This might be impossible if the expiration date of COBRA coverage failed to coincide with any insurer's open enrollment period. Problems of this kind might be addressed by providing for year-round exceptions to underwriting rules for persons seeking insurance for specified non-health reasons.

Restrictions on underwriting practices, if they applied equally to all insurers, should in theory not affect the competitive position of any one of them. However, some insurers might withdraw from a State applying such restrictions or cease to offer certain coverages. Others might market actively only to low-risk groups.[252] The result could be reduced competition, along with a general increase in the rates for individual and small group policies.

In the current market, prospective purchasers of group coverage might be regarded as falling into three classes:

- Those able to negotiate favorable terms, such as group-specific rates or a share in the return on invested premiums, from insurers. These are generally large employers.
- Those able to obtain insurance on standard terms. These are employers who have passed insurers' underwriting tests but who are too small to negotiate favorable terms.
- Those able to obtain only substandard coverage, or unable to obtain coverage. These are small employers who have failed underwriting tests.

The effect of requiring open enrollment or otherwise restricting underwriting is to combine the last two groups, leaving only two

[252] This might be feasible only for little-known companies, who could target their marketing efforts and would be less likely to receive unsolicited insurance applications from high-risk individuals or groups. Blue Cross/Blue Shield plans, major commercial insurers, and some HMOs might receive more high risk applicants simply because they were widely known.

classes of purchasers: those receiving favorable terms and those receiving standard terms.[253] The second class will include both the high-risk groups presently excluded and the lower-risk groups that are now able to purchase coverage at standard rates but that lack the market power to demand more favorable terms. The lower-risk groups would pay higher premiums in order to make insurance more available for the higher-risk groups.

While the elimination of underwriting necessarily entails some degree of cross-subsidy, regulation of underwriting practices without corresponding regulation of rates might disproportionately affect small groups. They would bear the entire burden of subsidizing high-risk enrollees, while larger groups would obtain rates based solely on the experience of their own members. For this reason, changes in underwriting rules might not be feasible without parallel changes in rating practices.

2. Require Community Rating

Insurers could be required to use community rating: that is, to establish a single set of premium rates for all individuals or groups purchasing a specific package of health benefits. This rule might be comparable to the community rating rules presently governing Federally qualified HMOs.[254] Variations in rates would be permitted for individuals, small groups, and large groups, but only to the extent that individual and small group coverage involves higher administrative costs. "Community rating by class," variation in rates according to such factors as the age and sex breakdown in a particular group, might also be permitted. However, experience rating would be prohibited.

One objection to this form of regulation is the converse of the objection noted earlier to modification of underwriting practices. If insurers were required to use community rating, but were not prohibited from underwriting, they might seek to exclude high-cost groups, including some groups that would previously have been able to obtain coverage. Again, regulation of rating and underwriting practices may be inseparable.

A more fundamental objection to rate regulation is that large employers, who would no longer be able to obtain more favorable rates from insurers, would have an even stronger incentive than at present to withdraw from the insurance market and self insure their plans.

Five years ago, there appeared to be some difference between the firm size that made experience rating possible (perhaps 25 or more workers) and the firm size at which it became feasible to self insure (perhaps 500 workers). If this were still the case, then elimination of experience rating would leave medium-size firms in the insurance market, paying community rates and helping to make coverage affordable for smaller firms. However, the threshold at which firms begin to consider self insurance is now much lower.

---

[253] As was suggested in chapter 2, something of the kind has already occurred in Blue Cross/Blue Shield Plans that offer open enrollment to small groups.

[254] P.L. 100-517, enacted in 1988, will permit HMOs to use systems very close to full experience rating.

There are even reports that very small firms are now self insuring, with generous stop-loss protection.[255]

The effect of a community rating requirement could be vitiated if all but the smallest firms opted out of the insurance market. In addition, any move that increased incentives for steadily smaller organizations to self insure would heighten the concerns about the financial stability of self-funded plans discussed in chapter 6. More stringent regulation of potentially underfunded self-insured arrangements might address this problem and at the same time reduce the incentives to self-insure.

3. Regulate Rates

Another way to increase the availability of coverage is to regulate rates directly. State insurance regulators have traditionally reviewed Blue Cross/ Blue Shield rates, at least those offered to individual purchasers and small groups, but not those of commercial insurers.[256] If it were determined that insurance rates were out of proportion to the value of the coverage being furnished, regulation might help to make coverage more affordable.

Rate regulation of private enterprises usually involves establishing the reasonable cost of an activity and then allowing some amount of "return on equity," or profit. In determining allowable return on equity, the regulators may use some fixed percentage of costs or may use some external index of what the investors in the business might have made if they had put their capital to some other use. Determining the reasonable cost of the activity may be more critical. Regulators do not merely accept all expenditures that are demonstrably related to the activity in question, but often have the right to approve or veto the underlying business decisions that lead to those expenditures. For example, a power commission may refuse to allow an electric company to include in its rates the interest costs incurred for a new generating plant the commission regards as unnecessary.

By analogy, regulation of health insurance rates might necessarily involve scrutiny both of the profit margins of insurers and of the underlying basis for insurers' rates: the services health insurers buy, and what the insurers pay for those services. Some States that regulate Blue Cross plan rates do in fact review the plans' payments to providers. They may, for example, require prior approval for changes in physician fee schedules.[257] Similar regulation could

---

[255] Firms with just a few employees are now nominally self insuring. This may be feasible only with stop-loss insurance so extensive that it closely resembles primary coverage. U.S. Congress. House. Committee on Small Business. The Health Insurance Problem. Hearings, 100th Congress, 1st Session. May 6, June 16 and 18, 1987. Serial No. 100–7. Testimony of Frederick Hunt. 1987. p. 165–172. Courts considering ERISA preemption questions may eventually have to determine at what point stop-loss coverage constitutes direct insurance.

[256] Commercial rates may sometimes be subject to general tests of reasonableness, such as a review of the ratio of benefits paid to premium income (the "loss ratio"). However, the general presumption is that market competition will restrain commercial rates. The Blues, on the other hand, are often given special treatment under State enabling laws; they may be exempted from premium taxes or from the strict reserve requirements governing other insurers. The government-conferred competitive advantage may be seen as placing the Blues in a position comparable to that of a public utility and thus subjecting them to similar regulation.

[257] State policies on this subject may have stemmed in part from the fact that some Blue Cross plans were historically provider-controlled.

be applied to all insurers and to all types of services. Indeed, it may be argued that, unless the rules apply to all purchasers, providers will make up for any rate constraints imposed on some insurers by raising their charges to other payers. Once the regulation applies to all insurers, however, it ceases to be insurance regulation, but becomes direct regulation of the providers themselves.

Some States have experimented with this approach, developing "all-payer" systems that regulate the rates charged by hospitals.[258] The extent to which these systems have actually reduced the rate of health care price increases has been the subject of an ongoing debate. Some people say that rate regulation can only control the price of services, and that providers will make up for the price constraints by increasing the volume of services they deliver. In this view, competition rather than regulation is the solution: HMOs and other alternative systems that give providers an incentive to reduce the volume of services they furnish will gradually gain market share and thus reduce overall costs. Others fear that giving providers incentives to reduce the volume of services may compromise the quality of care.

A full discussion of the debate over the growth in health care costs and ways of controlling this growth is beyond the scope of this report. The numerical modeling in the third report,[259] as well as the discussion elsewhere in this document, assume a health care system functioning essentially as it does today. However, if the national health insurance debates of the 1970s are a guide, increasing congressional interest in expanding the availability of insurance is likely to be accompanied by renewed attention to the problem of health care cost containment.

C. USE TAX INCENTIVES/PENALTIES TO MODIFY INSURANCE PRACTICES

To reduce barriers to coverage, or to lower the price of coverage, the States could provide direct tax incentives to insurers. The rationale for this approach is that insurers are the actors most responsible for establishing plan designs for the individual and group market.

A tax strategy raises interesting issues. It is included as an option on the assumption that some would prefer a voluntary to a regulatory approach. Moreover, the political environment of a State might not be conducive to increased regulation. A program of direct public financing of insurance for the State's uninsured population might be similarly problematic for political reasons or because the State does not have the financial resources to support a public program. But a tax approach also has consequences for the State in the form of revenue losses. State revenues will flow to insurers or employers or both, depending on the design of the policy. Some might question whether it makes sense for a State to finance what are, in effect, the reduced profits, or even losses, of a private entity, be it an insurer or an employer, in order to facilitate the

---

[258] Four of these experiments, in Maryland, Massachusetts, New Jersey, and New York, were genuinely "all-payer," in the sense that they included the Medicare and Medicaid programs, as well as private insurers. Only the Maryland and New Jersey programs still include all payers.

[259] U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. 1988.

availability and affordability of insurance. Is it appropriate for public funds to be used to correct practices in the insurance market that create the uninsurance problem in the first place?

1. Premium Tax Offsets

One possibility would be to design incentives using existing State premium taxes. In 1988, all States impose a tax ranging from .5 to 4 percent on the premium revenues of companies selling health insurance.[260] Some States already provide offsets or credits for various insurance company behaviors, such as having its home office in the State or paying into a medically uninsurable risk pool. The State might provide for a tax reduction (or rebate) of a specified percentage of the premium tax if the company's policies met specified requirements relating to plan design. To strengthen the incentive, the State might provide for a higher premium tax for insurers that fail to meet the specified requirements (thus, changing the incentive to a penalty on plans that fail to comply with the requirements). For example, the State might forgive a percentage of the insurer's premium tax if the insurer provided open enrollment once per year for all individual policies, group policies, or both. It might reduce the premium tax further if the plan provided for continuous enrollment. Along similar lines, the reduction in premium taxes could be determined based on the percentage of the company's premium revenues that were collected from community rated plans.

The premium tax approach has several limitations. Insurers use waiting periods, medical underwriting measures, and limited enrollment opportunities to limit adverse selection against their plans. They experience rate in order to compete with other insurers for group business, especially the large group business. It is unlikely that insurers would find the tax incentives sufficient to overcome the financial losses that could result from such changes in their plans. (Even in the States with the highest premium tax rates, a rebate of the entire tax would mean a difference in revenues of just 4 percent.)

In addition, the use of premium tax offsets or reductions would not have any effect on self-insured plans because they are not subject to these taxes. Finally, as noted above, it is not clear that such tax measures would result in many newly covered persons. At best, they would reduce temporary coverage gaps for some persons. If community rating increased, more dramatic effects might result, but only to the extent that employers do not have the escape of self-insurance, thus suggesting the need to couple this option with an ERISA change.

2. Corporate Tax Reductions

The same kind of tax incentives and penalties could be structured using State corporate income taxes. States could provide for a corporate tax reduction or credits for those insurers that meet

[260] Illinois does not tax domestic companies. Foreign companies pay 2 percent. Oregon also does not charge domestic companies. In some States, such as Kentucky, the tax is on capital and reserves rather than on premiums. In Louisiana, the rates for foreign and domestic companies are $140 for the first $7,000 in premiums plus $225 for each $10,000 or fraction thereof. From National Association of Insurance Commissioners, unpublished table, 1988.

the specified plan requirements described above. Again, a penalty approach could be used where the noncomplying insurer would have to pay a higher corporate tax rate or perhaps an excise tax. The advantage of this strategy over premium taxes is that the tax credit, refund, or penalty could be applied to employers that provide health insurance, as well or in lieu of insurers, thus affecting self-insured as well as insured plans.

It is possible, however, that such a tax treatment of employers might be challenged in the courts under the ERISA preemption clause. Employers might sue on the grounds that the State was seeking to regulate the content of welfare benefit plans.

III. Pooling Approaches

Some of the disadvantages that individuals or small employers face in the current insurance market could conceivably be overcome if many individuals or firms were combined into one large group. This is the principle behind METs, which group many firms into a single insurance-purchasing (or sometimes insuring) entity. It also forms the basis for proposals to expand the availability of coverage through pooling arrangements.

The first part of this section is devoted to this type of arrangement, *pooling of insureds.* The word "pool" is sometimes used to describe arrangements in which several insurance companies combine to share the costs of high-risk applicants. (Most State pools are of this type.) *Pooling of insurers* is discussed in the second part of this section.

The section concludes with an overview of some other ways in which public agencies might mediate between insurers and purchasers of insurance, including the provision of technical assistance to purchasers, and the operation of insurance information clearinghouses.

A. POOLING OF INSUREDS

As a practical matter, it may not be feasible to mandate that employers purchase a product that, at least in the current market, may be unaffordable for many firms and entirely unavailable to very small firms or those presenting the highest risks. For this reason, proposals to mandate that employers provide health coverage are generally accompanied by proposals for some form of pool of insureds.

In this section, the word *pool* will be used to mean a group of individuals or employers brought together for the purpose of purchasing insurance. The word *intermediary* will be used to refer to an agency or entity that serves to link the members of the pool with potential sources of health coverage. The assumption in the following discussion is that the intermediary would be a public entity, established at either the State or Federal level.

Most of this section will focus on the potential role of pooling arrangements within the context of proposals to mandate that employers provide health benefits. However, many of the issues to be discussed would also arise under pooling arrangements designed to facilitate the voluntary purchase of coverage by firms or individuals.

A pooling arrangement could serve several possible functions within the context of an employer mandate.

- Numerous small firms combined into one pool could obtain some of the purchasing advantages of a large group, such as greater predictability and a balanced mix of high-risk and low-risk members. This group could be more attractive to insurers than individual small firms are, and might receive rates comparable to those offered to large and medium-sized employers.
- "Uninsurable" firms, those involving hazardous occupations or in businesses with a high failure rate, would be able to participate.
- Certain administrative costs that can result in higher rates for small groups might be reduced through economies of scale. Some other administrative activities, such as underwriting and possibly marketing, could be eliminated altogether.
- Small employers, who may have little knowledge of health insurance and may be unable to evaluate competing coverage options, could be presented with a clear array of choices.

Pooling arrangements face one key obstacle: adverse selection. If participation in a pool were entirely voluntary, the familiar cycle of market fragmentation and systematic elimination of cross-subsidy could be expected to recur. Employers large enough to self insure would do so, while employers with a younger or healthier workforce would shop in the private insurance market for favorable rates. The groups left in the pool would be those unable to exercise these options. Gradually the pool would be made up of smaller firms with higher-risk employees. There would be a centrifugal effect: with every rate increase, the lower-risk groups would spin off into the private market, resulting in a further rate increase to cover the higher-risk groups remaining in the pool. At some point, insurers themselves might cease to participate, as the level of risk presented by the remaining groups became greater than insurers would be prepared to assume at any price.

In order for the pool to make insurance affordable for all participating groups, some form of subsidy is likely to be required. This subsidy could be in the form of direct government financing, possibly using revenues from some form of tax on employers not participating in the pool. The alternative to direct subsidy is to break the cycle of market fragmentation: compel participation in the pool by some employers who could otherwise self insure or could obtain favorable treatment in the private market.[261]

1. Subsidy Options for Voluntary Pooling Arrangements

A directly subsidized pooling arrangement assumes that participants are not able to pay the full actual cost of their own insur-

[261] The two different approaches are reflected in two employer mandate proposals introduced in the 100th Congress. H.R. 4951, the Employee Health Benefits Improvement Act of 1988 (Rep. Stark), would have the Federal Government establish pools only in States that failed to do so on their own. In States establishing pools, all employers, whether or not in the pool, would be required to contribute to the pool's losses. In States with federally established pools, losses would be subsidized by a dedicated Federal excise tax on employers. S. 1265/H.R. 2508, the Minimum Health Benefits for All Workers Act of 1987 (Sen. Kennedy/Rep. Waxman), provides for federally certified regional insurers. Certain employers would be required to purchase insurance through these insurers at standard rates. The employers subject to this requirement would constitute, in effect, an involuntary pool.

ance. The subsidy would make up the difference between actual insurance costs and the fraction that pool participants were able to contribute. How should the balance between subsidy and payment by the pool participants be established, and where should the subsidy come from?

The approach used in some existing State pooling arrangements is to establish a maximum premium level at some percentage of the average cost outside the pool for comparable coverage. A State pool might begin to provide subsidies when premiums for participants exceeded 125 or 150 percent of the average statewide premium for employer groups. Subsidies are financed through general revenues, through a tax on health insurance premiums, or on health care providers.

As noted earlier, insurers object to premium taxes, because ERISA prevents States from taxing the costs of health plans of self-insured employers. The premium tax drives up the cost of insurance and increases incentives for employers to self insure. ERISA could be modified to permit taxation of the costs of self-insured plans. Even then, however, a tax based on premiums or costs would mean that employers with above average health care costs would also be making a disproportionate contribution to the pool subsidy. An alternative is to subsidize the pool through a payroll tax. (This is the option adopted in the Massachusetts plan; see below.)

Table 7.1 illustrates some potential consequences, over a two-year period, of a system under which the threshold for pool insurance subsidies is set at a fixed percentage of average group health plan premiums, in this case 125 percent. The basic workings of the system are seen in Year One, while Year Two shows what occurs if an employer shifts from the pool to the private insurance market.

- In Year One, Employers A and B are purchasing group insurance outside the pool, in the private market, for a combined average monthly premium of $89.29 per worker. Employers C and D are in the pool, whose monthly premiums are set at 125 percent of the private market rate, or $111.61. Actual total health care costs for the enrollees in the pool are $295,000 per month. Employers C and D have paid premiums of only $279,018; the remaining $15,982 in costs is covered under the subsidy mechanism, funded through a payroll tax on all four employers.
- In Year Two, Employer C finds an insurer who will provide coverage at a rate equal to the actual health care costs for Employer C's workers, $110 a month (the example disregards inflation). Employer C leaves the pool. In shifting to the private insurance sector, Employer C raises the average premium cost in that sector from $89.29 to $91.88. This in turn raises the pool premium, still at 125 percent of the average private rate, from $111.61 to $114.84. Even though Employer D's premium payments have risen, the amount of subsidy required has also risen because of Employer C's departure from the pool. The payroll tax for all employers rises proportionately.

TABLE 7.1.—Effect of an Indexed Subsidy Threshold in a Voluntary Pool (Subsidy fixed at 125% of private group insurance rates)

	Enrollees	Premium rate	Total Premiums
Year one:			
Employers in private market:			
Employer A	10,000	$85	$850,000
Employer B	4,000	100	400,000
Weighted average premium: $89.29			
125% of average: $111.61			

	Enrollees	Per capita medical costs	Total actual cost	Premiums paid at $111.61
Employers in pool:				
Employer C	2,000	$110	$220,000	$223,214
Employer D	500	150	75,000	55,804
Total			$295,000	$279.018
Pool subsidy required: $15,982				

	Enrollees	Premium rate	Total Premiums
Year two:			
Employers in private market:			
Employer A	10,000	$85	$850,000
Employer B	4,000	100	400,000
Employer C	2,000	110	220,000
Weighted average premium: $91.88			
125% of average: $114.84			

	Enrollees	Per capita medical costs	Total actual cost	Premiums paid at $114.84
Employer in pool:				
Employer D	500	$150	$75,000	$57,422
Pool subsidy required: $17,578				

The total cost of insuring all four employers is not affected by the pooling arrangement. However, the system moves progressively from internal cross-subsidy to external subsidy as firms capable of leaving for the private market do so. At the same time, the rates paid by pool participants mount steadily. The subsidy and pool premium rates may stabilize only when the pool consists entirely of groups treated by the private insurance market as uninsurable and hence unable to move back into the market. Equilibrium would be reached earlier if the pool premium rate were fixed, instead of tied to private market averages; that is, if the rate were not affected by the migration of Employer C.

This type of arrangement has, and achieves, limited objectives. It ensures that all employers can buy insurance (in practice, some State risk pools exclude very high-risk applicants or charge very

high rates) and holds the premium rates to a maximum level determined to be affordable for most or all employers. Still, no matter how the pool premium is set, at least some employers are going to have difficulty meeting the cost. Even if the premiums were equal to the Statewide average, instead of some higher figure, the cost of health insurance could financially jeopardize marginally profitable firms.

Of course, any business cost may be too much for a marginal firm. Employers are not exempted from the employer share of the Social Security (FICA) payroll tax because they cannot afford to pay it. The difference between a mandatory employer contribution to health insurance and a mandatory employer share of the FICA tax is that the FICA burden falls more or less uniformly on all firms. It is a fixed percent of a firm's labor costs (except to the extent that the highest paid employees are partially exempt). The cost of health insurance falls more randomly. Not only is it unrelated to payroll, but it may vary according to circumstances wholly outside the employer's control, such as the number of workers with dependents. (The latter problem will be discussed further in section 6.)

The remainder of this section will review several ways of combining taxes with pool subsidies to equalize the burdens on employers. Whether the burdens should in fact be equalized is a fundamental issue in a mandated benefit proposal. The question is partly a philosophical one, dependent on individual perspectives of what is equitable. In addition to the equity issue, however, there are also practical concerns. For example, a system that rewards employers with a younger, healthier workforce might lead to discriminatory hiring practices. On the other hand, a system that protects employers whose workers require more services could also reduce incentives to contain health care costs.

Tax-plus-subsidy options could seek to equalize employers' health care costs as a percent of total payroll or could seek to equalize the premiums themselves. The two approaches are illustrated in Tables 7.2 and 7.3.

a. Tax equals percent of payroll less actual health care expenditures.

A tax on employers could be set equal to the average ratio of employer health care costs (whether insured or self-insured) to payroll. The employer would be permitted to deduct actual premiums paid from the computed tax; if premiums exceeded the tax, the employer would receive a tax credit. The net effect is to make the sum of the tax or credit plus actual health care expenditures an equal percentage of payroll for all employers (Table 7.2, option 1).

This approach potentially penalizes employers who offer higher wages. It thus would strengthen incentives for the wage reductions that some observers regard as a possible response to mandated benefits. A payroll-based tax might also be seen as penalizing employers for whom labor costs are a larger proportion of total operating cost. An alternative would be to base the tax on gross revenues, rather than on payroll. This might merely reverse the imbalance, adversely affecting industries that are not labor-intensive. It would

also limit the ability of employers to make up for health care costs through price increases rather than wage restraints.

TABLE 7.2.—Tax Subsidy for Voluntary Pooling Arrangement

Option A: Tax on Total Payroll Set Equal to Weighted Average Ratio of Health Care Costs to Payroll

	Employees	Average salary	Monthly payroll	Health cost per worker	Total health cost
Employer A	1,000	25,000	2,083,333	100	100,000
Employer B	200	20,000	333,333	110	22,000
Employer C	20	15,000	25,000	120	2,400
Total			2,441,667		124,400

Weighted average health care cost as percent of payroll: 5.09%

	Tax at 5.09% of payroll	Deduct full health care cost	Net tax	Sum of health cost and tax	Percent of payroll
Deduction option 1:					
Allow deduction of full health care cost—					
Employer A	106,042	100,000	6,042	106,042	5.09
Employer B	16,967	22,000	(5,033)	16,967	5.09
Employer C	1,273	2,400	(1,128)	1,273	5.09

	Tax at 5.09% of payroll	Allowable deduction	Net tax	Sum of health cost and tax	Percent of payroll
Deduction option 2:					
Allow deduction of health care cost plus or minus 50% of difference between health care cost and tax—					
Employer A	106,042	103,021	3,021	103,021	4.95
Employer B	16,967	19,483	(2,517)	19,483	5.85
Employer C	1,273	1,836	(564)	1,836	7.35

The redistributive effects of a payroll-based system could be limited in a number of ways. An individual's wages subject to a tax could be capped, as is the case with FICA; this might prevent professional or high technology firms from making payments grossly disproportionate to their employees' health care needs. Another approach would be to require tax payment or allow a tax credit for only a portion of the amount by which an employer's health care costs differed from the average. This method is illustrated in Table 7.2, option 2.

b. Tax equals average health care cost per worker less actual cost

A tax on employers could be based on the number of workers, rather than total payroll. The tax per worker would be equal to the average per capita health insurance cost (whether insured or self-insured). Again, the employer would be permitted to deduct actual

costs from the tax, and could receive a tax credit. The effect of this approach is to equalize the costs themselves, rather than to equalize the sum of costs plus tax as a percent of payroll (Table 7.3, option 1). This would limit the incentives for employers to self insure or leave an insurance pool, because they would still have to pay the statewide average cost. At the same time, it would protect employers whose workers were higher-risk or had a higher number of dependents. However, a per capita tax would not indemnify employers who did not previously offer benefits and for whom health care costs would represent a significant increase in operating expenses.

TABLE 7.3.—Tax Subsidy for Voluntary Pooling Arrangement

Option B: Payroll Tax Per Worker Set Equal to Average Per Worker Health Care Costs

	Employees	Average salary	Monthly payroll	Health cost per worker	Total health cost
Employer A	1,000	25,000	2,083,333	100	100,000
Employer B	200	20,000	333,333	110	22,000
Employer C	20	15,000	25,000	120	2,400
Total	1,220		2,441,667		124,400

Average health care cost per worker: $101.97

	Tax at $101.97 per worker	Deduct full health care cost	Net tax	Sum of health cost and tax	Percent of payroll
Deduction option 1:					
Allow deduction of full health care cost—					
Employer A	101,970	100,000	1,970	101,970	4.89
Employer B	20,394	22,000	(1,606)	20,394	6.12
Employer C	2,039	2,400	(361)	2,039	8.16

	Tax at $101.97 per worker	Allowable deduction	Net tax	Sum of health cost and tax	Percent of payroll
Deduction option 2:					
Allow deduction of health care cost plus or minus 50% of difference between health care cost and tax—					
Employer A	101,970	100,985	985	100,985	4.85
Employer B	20,394	21,197	(803)	21,197	6.36
Employer C	2,039	2,220	(180)	2,220	8.88

Employers whose health expenditures are below average and who would therefore be subject to the tax might instead choose to expand their health benefits. This might be the desired effect in the case of employers offering what is perceived as inadequate coverage. However, some employers who are offering comprehensive benefits would still have below average premiums because they had a younger workforce or one with fewer dependents. Any additions

they would be prompted to make to their health plans might be mere "bells and whistles," or they might simply abandon current cost control efforts. Cost-increasing responses would be less likely if the average premium were recomputed annually; additions to the plan in one year would raise statewide average cost and help to increase tax liability in the next. Less restraint could be expected if the average premium were instead updated by applying a cost index to a base year amount. Again, the incentives to expand health care expenditures could be limited by taxing or crediting only a part of the difference between an employer's premiums and the average; this option is illustrated in Table 7.3. option 2.

It should be noted that the per capita tax approach is similar to the Massachusetts plan, with two important differences. First, the Massachusetts tax is a percentage of each worker's wages up to $14,000. The maximum tax for each worker is equal to the amount of average expected premiums (initially $1,680), but the tax would be less than that amount for part-time or very low-paid workers. Second, the Massachusetts plan does not provide for ongoing tax credits (employers newly offering insurance may receive credits for the first two years). Deduction of the maximum amount can only reduce the tax to zero. The Massachusetts tax and deduction mechanism gives employers an incentive to provide health benefits up to the level of the tax, but does not directly subsidize any employer group. Some of the proceeds from the tax may go into a hardship fund for small employers with health care costs greater than 5 percent of revenues. However, there is no guarantee that this fund will be maintained at a level sufficient to compensate all eligible employers.

One other feature of the Massachusetts plan raises an important issue for a per capita tax option. Should the tax apply to the entire workforce, or only to those workers who are eligible for coverage under the terms of the employer mandate? In the Massachusetts plan, the tax applies to all workers, even part-time workers whose working hours would not make them eligible for health benefits. Employers would therefore have an incentive to replace two part-time workers with one full-time worker. Basing the tax on workers eligible for coverage would have the reverse impact, encouraging employers to split full-time jobs.

2. Mandatory Pool Participation Options

The second way of keeping a pool's premium rates affordable is to require the participation of some low-risk groups who could have found less costly coverage outside the pool. The major problem to be resolved in this approach is defining the groups that would be required to participate. This question might be put in the opposite way: which employers are exempt? Equity might seem to dictate that, if any employers are going to be required to join the pool against their economic interests, all employers should be subject to the same requirement. This solution would disrupt the existing insurance or self-insurance arrangements of a majority of the Nation's large and medium-sized firms. The following are three less sweeping approaches to mandatory pooling; the list of options is undoubtedly not exhaustive.

a. Size

One option is to require participation by groups below a given size. All employers of fewer than 50 or 100 workers, or some other number, would be required to join the pool. Larger firms would remain free to purchase coverage in the private insurance market or to self insure.

This policy would represent a reversal of the usual approach to business regulation. More commonly, if requirements do not apply equally to all firms, stricter requirements are placed on larger firms rather than smaller ones. Constructing the pool entirely of small employers would limit its potential cross-subsidy advantages and would penalize the small employers who had already made an effort to provide health coverage for their workers. The costs of small insurable firms could increase; they could in effect bear the entire burden of making coverage available to small firms that are presently uninsurable.

If size determined whether pool participation was mandatory, it would also be necessary to decide whether growing firms would remain subject to the requirement once they exceeded the cut-off point.

b. Exemption for existing plans

A second possibility would be to require participation by any employer that did not have a health plan in place on the date the mandate took effect (or on some earlier date, to prevent a last minute rush into the private insurance market). This would represent a sort of transitional rule, protecting current arrangements while bringing large employers without plans into the pool.[262]

Like any transitional rule, this option treats similarly situated entities differently. Two firms of the same size, in the same industry, would face different costs for providing the mandated coverage because one could self-insure or obtain favorable terms from an insurer and the other could not. This could increase the potential negative impact of an employer mandate on the competitive position of firms not presently offering benefits.

If firms with existing health plans were exempted from pool participation, it would be necessary to decide whether the exemption was permanent or temporary (i.e., whether it is really a transitional rule, as opposed to a "grandfather" clause). A permanent exemption might confer a permanent advantage on the firms with existing plans.

c. Exclusion of self-insured plans

A third option would be to allow firms of any size to self insure, but require any firm that purchased coverage to join the pool. This approach would affect insurance companies as well as employers. The impact on insurers might be limited if any insurer were free to

[262] S. 1265 allows employers with more than 25 workers to retain their current arrangements. However, an employer that modifies its arrangements at any future time, by changing insurance companies or converting from a self-insured to an insured plan, would be required to join the pool. In effect, an exempt firm could voluntarily join the pool by deliberately subjecting itself to this requirement. Some potential problems with voluntary entry into a pool are discussed further below.

participate in the pooling arrangement. (The issue of open versus limited participation by insurers is discussed in section 4.)

Some of the consequences of permitting self-insurance as the only alternative to a community rated system have already been mentioned in the discussion of regulatory approaches. The key question is whether enough medium-size firms would remain in the pool to make it work as a subsidy mechanism. Again, stronger fiscal requirements for self-funded plans might encourage more middle-size firms to remain in the purchased insurance sector and hence in the pool. If not, this approach would have the same disadvantages as a requirement based on the size of the firm. Firms too small to self-insure but currently able to obtain insurance at affordable rates would bear the entire burden of subsidizing the costs for previously "uninsurable" firms.

If a pooling arrangement were to involve mandatory participation, it would also be necessary to decide whether firms not obliged to participate would be permitted to do so. Could an exempt firm join the pool voluntarily? Could it decide to join after having taken advantage of the exemption?

Just as there is a likelihood that costs of a pool will escalate if low-risk groups can choose not to join, so there is a possibility that costs will rise if groups not required to join are permitted to do so. For example, if the rule were that all employers with fewer than 100 workers had to join the pool, the only reason an employer with 200 workers would rationally choose to join would be that the pool offered more favorable rates than the employer could find elsewhere. The larger employer joining voluntarily could thus raise the costs for the pool and enjoy a subsidy at the expense of smaller businesses.

Similar effects would occur under the other two options. A firm initially exempt would join the pool if its premium rates or self-insurance costs rose at any future time to the point at which they exceeded the pool's. A firm with an aging work force might eventually find that its health care costs were higher than those of the pooled firms, chiefly smaller employers with younger work forces.[263]

One possible way of limiting the adverse impact of late pool entrants would be to permit firms to join or leave the pool only during periodic re-enrollment periods. A firm might be allowed to change its decision only at two or three-year intervals.

3. Functions of the Intermediary

The intermediary's involvement in the actual insurance transaction could be minimal or extensive. It could serve merely as a mediator between employers and participating insurance companies. It could assume some of the administrative tasks associated with health plans that are usually the responsibility of the employer or the insurer. Finally, it could actually assume some or all of the financial risk of providing insurance.

---

[263] This could be the case at the outset. Although this discussion has assumed that large employers with existing health plans would seek to avoid a pooling arrangement, it is possible that joining a pool with smaller employers could reduce many large employers' costs. The older work forces in large firms would be subsidized by the younger workers in small firms.

The following discussion begins with the narrowest option, in which the intermediary performs minimal coordinating functions, before considering options for more extensive market intervention.

a. Basic functions

At a minimum, the intermediary would (a) determine which insurers would offer coverage to pool participants and approve the terms of those offerings, (b) identify employers eligible or required to participate in the pool, and (c) notify those employers of the options available to them. These functions would not necessarily need to be performed by a single agency. For example, an independent commission could certify participating insurers and plans, while identification of and notice to participating employers could be the job of the agency with general enforcement responsibility for the employer mandate. (See section 5, below, for a discussion of issues in the selection of participating insurers.)

Under this minimal approach, certified insurers and participating employers would deal with one another directly. The employer would select an insurer; the insurer would write a group contract and collect premiums. The only significant difference between the pool operations and those of the current insurance market would be the insurers' advance commitment to accept any eligible group at a standard rate.

Although this system would be the most easily organized and involve the least government intrusion into business operations, it has a number of drawbacks. The direct contact between employers and insurers means that marketing operations would continue. These not only raise the administrative cost of a plan but open the possibility that insurers would compete for low-risk pool participants. They might market aggressively to certain types of businesses and not others. In addition, insurers might try to discourage high-risk groups from selecting their plans and divert them to other pool insurers. For example, if insurers offered different actuarially equivalent plans, an insurer might persuade a group applicant that a competitor's plan was better suited to the needs of the group.

A second possible problem is in the area of premium collection. One reason that insurers hesitate to deal with certain types of businesses (such as restaurants) is not because they present special health risks but because they have a high failure rate. Collection costs and bad debt are important factors in the higher administrative costs for small groups. If insurers faced the same problems in dealing with individual firms in the pool, premiums would rise, and some insurers might hesitate to participate in the pool at all.[264]

Finally, small employers have little experience with insurance and lack the specialized employee benefits staff of larger employers. They might not be able to furnish their employees with accurate information about plan provisions or to play a role in benefit determination and the resolution of claims disputes.

---

[264] This problem could potentially be alleviated by giving health insurers a priority claim on the estate of bankrupt firms. However, it might be argued that insurers have no special right to precedence over other sellers of business services.

b. Enhanced administrative functions

The intermediary could function more actively in connecting employers and insurers. Employers could receive all information about coverage options solely from the intermediary and could notify the intermediary of their choice of plan. This would reduce the possibility of marketing abuses and could eliminate marketing costs. The extent to which this would actually reduce premiums is not certain. If multiple insurers participated in a pooling arrangement, each seeking its share of the pool's members, current costs of direct marketing to employers might be partially replaced by advertising cost.

The intermediary could process all enrollment transactions and would serve as a central registry of participating groups and of individuals within those groups. The intermediary could then assume responsibility for the enrollment verification and data exchange required to enforce an employer mandate (see chapter 6), reducing costs for employers and insurers and insuring continuity of group and individual enrollment.

Employers might make premium payments directly to the intermediary, which would in turn pay the insurers. The intermediary might even enter into the direct insurance contract with employers; the selected insurer would then function as a subcontractor. This would alleviate insurers' concerns about premium collection, but would merely shift the problem to the intermediary. One possible way of funding bad debt will be discussed later in this section.

Finally, the intermediary could serve as a central source of benefit information and could mediate claims disputes. This mediating function would be reinforced if the intermediary were the direct insurance contractor.

If the intermediary performed all of these functions, its role would be comparable to that of the Office of Personnel Management (OPM) in administering the Federal Employees Health Benefits Program. OPM stands between insurers and Federal employees in the same way that the intermediary would stand between insurers and employers. It certifies insurers, approves their rates and benefits, and determines individuals' eligibility to participate. It also oversees communication between insurers and enrollees and serves as the final arbiter in claims disputes.

c. Insurance functions

The preceding discussion has assumed that either the participating employers or the intermediary itself would purchase coverage from private insurance companies. One consequence, of course, would be that the insurers would realize profits from the new market (otherwise they would not participate). For employers unable to find coverage outside the pool (or required to join it under one of the mandatory participation options), mandated health coverage would amount to a mandate that certain private enterprises turn over funds to a select group of other private enterprises. Employers might demand some limits to the participating insurers' profits or might even ask why private insurers were involved at all.

If the intermediary performed the variety of administrative functions described, what role would be left to insurers? They would still be responsible for claims processing and for implementation of any managed care features of their plans, such as pre-admission review or case management. These functions, however, need not be performed by insurers. While it happens that the Medicare program contracts with insurers for claims processing, some Medicaid programs use other kinds of firms as fiscal agents for claims processing and managed care functions. A non-insuring fiscal agent might still realize some profit on the administrative component of costs, but not on the total premium. The intermediary might even perform claims processing on its own, as some State Medicaid programs do, further reducing cost.

The other major function of insurers is the assumption of risk. Insurers justify their profits by assuming the potential for loss; this is why the built-in profit margin in some premium calculations is referred to as the "risk factor." With very large groups, however, risk is limited. Costs for large groups are predictable, and the insurer risks a loss only if some unanticipated factor (such as higher than expected health care cost inflation or utilization) invalidates the initial cost projections. For experience rated firms, even this loss is made up by retroactive rate adjustments, unless the firm changes insurers before the adjustments can take effect. The intermediary could develop its own reserves, not only to cover unanticipated claims losses, but also to help defray losses from uncollectible premiums.[265]

There are some arguments for using independent insurers. A governmental or quasi-governmental intermediary may have little incentive to operate efficiently or to develop innovative cost containment programs. Insurers may also serve as a buffer between the intermediary and providers, possibly avoiding some of the politicization of coverage and reimbursement decisions characteristic of public health insurance programs. Although insurers might make a profit from their pool operations, competition for a share of the pool market would be expected to restrain prices and possibly lead to improved insurance products (see section 5), although there might still be pressure from employers to subject the insurers to price and profit regulation.

4. National, Regional, or State Pools

Pools could be established by individual States, or could be established by the Federal Government at the regional or national level. The choice of a State, regional, or national pool could affect the degree of cross-subsidy in the pool and the pool's effect on the insurance market, and would also have administrative implications.

a. Subsidy effects

Health care costs vary by region, partly because of differences in the cost of labor and supplies, partly because of differences in medi-

[265] One possible source of the intermediary's reserves would be the interest earned on premiums between the time they were paid by employers and the time the intermediary paid claims for services. These earnings, ordinarily returned to the employer in the form of a rate credit, might instead be retained by the intermediary.

cal practice. For the population currently insured through employers, premium rates in the Mid-Atlantic census region are an estimated 21 percent higher than those in the East South Central region.[266] A national pool with standard national premium rates would mean that employers in areas of the country with lower health costs would be subsidizing the coverage of workers in higher cost areas.

Even regional pool rates would not entirely overcome this problem, as costs may vary for different States in the same region. A recent study by the National Rural Electric Cooperative Association of health insurance premium variation within regions found that premiums paid by its members in the individual States in the East North Central region were above or below the regional mean premium cost by an average of 27 percent. While variation in some other regions was smaller, the study suggests that regional rates would involve considerable cross-subsidy.[267] Moving to State-level rates could reduce, but would not eliminate, this cross-subsidy. Health care costs vary between urban and rural areas within States, and may even vary between two adjacent counties in a single metropolitan area.

The decision about the scale of a pool, then, may be partly a decision about the degree of cross-subsidy desired. Regional or national rates, resulting in a high degree of cross-subsidy, would reduce incentives for employers and health care providers to control costs and to scrutinize variations in medical practice that may be unrelated to health care outcomes. On the other hand, State or local rates could affect the relative competitiveness of some areas and could penalize employers for circumstances they are unable to control.

Of course, it is not inevitable that rates would be uniform for all pool participants. Insurers in a national pool could establish regional rates; those in a regional pool could have State-level rates. Differential rates within a pool raise some administrative and price evaluation problems; these will be discussed further in section 6.

b. Competitive effects

The geographic scale of a pool could determine what insurers would be able to participate. Only the largest commercial insurers might be prepared to offer coverage to national or regional pools; the Blues might also participate by forming networks or consortiums. Small, local insurers might be unable to compete.

One type of insurer that might not be able to compete at the regional or national level would be HMOs. Because HMOs generally have close links to their participating providers, most operate only in a single metropolitan area or at most a single State. There are some regional or national HMO chains. These consist, however, of a limited number of individual entities that cover small areas. No HMO organization at present could cover as much as an entire census region.[268] An HMO could expand to cover a larger terri-

[266] See U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance, 1988.

[267] National Rural Electric Cooperative Association. The NRECA Plans and the Minimum Health Benefit: A Comparison of Provisions and Costs. Washington. 1988.

[268] Kaiser-Permanente comes close in the Pacific region.

tory, or a number of local HMOs could form a regional network. However, such expansions might come at the price of less systematic coordination with providers, possibly depriving the HMO of much of its cost-saving potential. PPOs could more readily be organized to blanket an entire region, since their ties to providers involve only price negotiation, rather than ongoing coordination of services.

The potential anti-competitive effects of regional or national pooling might be reduced somewhat if insurers were permitted to participate in limited areas rather than cover the entire pool. However, this approach might produce vigorous competition in some areas while leaving others with few or no insurance options.

c. Administration

Finally, there are administrative arguments for choosing State pools or federally administered regional or national ones. Some of these are familiar from other debates over State versus Federal regulation. Proponents of State pools would contend that States can better tailor programs to local needs or can serve as laboratories for innovative approaches. This argument would be strengthened if the pool intermediary's responsibilities went beyond the minimum functions outlined earlier.

Those favoring regional or national pools would say that Federal administration might ensure greater uniformity and equity, as well as provide economies of scale. Multi-State employers in particular might prefer to deal with a single pool, rather than several. (This might not be a factor if pool participation were voluntary; most multi-State employers would then be likely to self insure.) In addition, national administration could ease coordination between the intermediary's enrollment functions and the compliance verification functions required to enforce an employer mandate.

5. Selection of Participating Insurers

Participation in a pool could be open to any insurer meeting specified standards, or a limited number of participants could be selected through bidding or some other competitive process. In either case, insurers would be competing for their share of the pool market (assuming that the pool would be attractive to insurers at all). The second approach would merely shift some of the choice among competing options from the individual buyers to the intermediary. While this might ease administration, it would also have the effect of shutting many insurers out of a substantial portion of the health insurance market. Particularly if pooling involved mandatory participation by specified groups of employers, a system that involved government selection of a small number of competitors would probably not be politically workable.[269]

Still, an open participation system would present some potential problems. These are best understood in terms of the two key factors on the basis of which insurers would potentially compete, price and product. (Other factors, such as service and reputation, might also have some effect on competition.)

---

[269] It is conceivable that smaller insurers could form consortiums and compete for pool participation as a single entity. This would, however, raise antitrust concerns.

a. Price

At least at the outset, competing insurers might offer different rates for the basic mandated plan. These might reflect variations in administrative cost, differing initial estimates of claims cost, or simply different profit margins. Over time, it might be expected that prices for equivalent benefits would even out. In the short term, however, insurers with sufficient resources might engage in preemptive underpricing in the hopes of capturing a larger market share. (As was noted in chapter 2, underpricing for the first year of a contract is already common in the small group insurance market.)

Early underpricing could have a number of effects. First, there is a possibility that a few insurers with "deep pockets" could corner the market early on and count on employer inertia to retain their share once they returned prices to true levels. Meanwhile, employers would be led to underestimate their actual health coverage costs and might fail to make necessary adjustments in their product prices or operating expenses. A sudden rate surge some time after the initial implementation of an employer mandate might cause greater disruption than realistic rates at the outset. Second, small insurers attempting to maintain their competitive position might underprice at the risk of their own financial stability. Resulting failures could lead to interrupted coverage and uncompensated services, and might also strain State insurance guaranty funds.

These problems might be overcome through a system of rate approval for participating insurers, to assure that rates were reasonably related to anticipated costs. Some of the issues in rate evaluation are discussed in section 6, below.

b. Product

If actuarially equivalent plans were permitted, insurers might structure approved policies that were more or less attractive to particular segments of the market. As was suggested in the discussion of actuarial equivalence in chapter 6, two plans that were deemed to be actuarially equivalent for the pool as a whole might not be equivalent for any particular employer group. Plans could be structured in such a way as to attract low-risk groups.

The selection effects of benefit variation might also be controlled, or at least compensated for, through rate regulation. However, this would require individual plan cost reporting and a regulatory determination of acceptable profit levels.

A second concern with multiple product options is the difficulty small employers might have in evaluating the choices available to them. In an open participation pool, employers might face a multiplicity of plans with minute benefit variations. This could strengthen the role of marketing and lead to some of the possible abusive practices described in section 3. Again, these problems might be avoided if the pool intermediary mediated between employers and participating insurers.

6. Rate-Setting Issues

Because the main point of a pooling arrangement would be to spread risk across many groups, participating insurers would have to be required to establish community rates. There are, however, a number of variants of community rates that might be considered.

a. Community rating by class

As discussed in chapter 2, community rating by class involves setting the rates for a particular group on the basis of its demographic composition (e.g., age or sex). An employer with an older workforce might pay more than one with younger employees, and so on. Community rating by class differs from experience rating because it does not take into account a particular group's actual use of health services. Instead, it considers factors which tend to be correlated with the use of services. Two firms with an identical age-sex breakdown might thus receive the same rates, even though one firm's employees were actually more costly than the other's.

Allowing insurers to set community rates by class would, in a voluntary pooling system, reduce the incentives for low-risk groups to leave the pool. At the same time, however, class rates would create financial incentives for employment discrimination against older workers and others falling into higher rate classes.

b. Single rate

In a pooling arrangement, the basic source of variation in employers' expenses for full time workers' health care would be dependent coverage. In some industries, it is conceivable that the relative competitiveness of different firms would be directly related to the number of dependents their workers brought into the health plan. Like class rates, rates based on family size (single, adult/child, family, and so on) could potentially lead to discrimination in favor of single workers.[270] One possible solution would be to establish a uniform premium rate for each insured worker, regardless of the number of dependents. This approach would mean that firms with predominantly young, single employees would overpay, perhaps significantly. The relative degree of cross-subsidy could depend on the rules governing pool participation. If participation were voluntary and many large employers currently offering health coverage remained out of the pool, the ratio of dependents to workers for pool participants might be relatively low.[271]

c. Area prices

As was noted above, insurers might be permitted to establish different rates for different parts of the area covered by a pool, to reflect local variations in health care utilization or prices. Area price variation might also occur if, in order to allow participation by small insurers or HMOs, insurers were permitted to serve only a portion of the pool area.

---

[270] The Massachusetts plan would explicitly prohibit firms from asking prospective employees about their dependents' health insurance status.

[271] Currently, the working uninsured tend to have fewer dependents than the working insured. See U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Coverage, 1988.

As table 7.4 illustrates, area rating policies are potentially subject to manipulation in a competitive market. In the first price comparison, with no assumptions about the relative share of the market insurers might achieve in different areas, Insurer 1 appears to be slightly more expensive than either of the others. If only two insurers could be selected, the appropriate choice would appear to be Insurers 2 and 3. The second set of price comparisons shows each insurer in direct competition with one of the others and assumes that market share in each area is inversely proportional to price. Now Insurers 1 and 3 appear to be the better choice. The unpredictable effects of relative market penetration levels mean that area prices could result in selection of the wrong competitors in a limited participation pool, or could complicate price regulation in an open participation pool.

TABLE 7.4.—Price Comparison for Insurers Offering Sub-Regional Rates

	Area One: Population	Rate	Area Two: Population	Rate	Weighted average rate
Price comparison without assumptions about market share:					
Insurer 1	200,000	$115	150,000	$90	$104.29
Insurer 2	200,000	110	150,000	95	103.57
Insurer 3	200,000	95	150,000	115	103.57
Price comparison with share inversely proportionate to rate:					
Insurer 1	95,652	$115	79,167	$90	$103.68
Insurer 2	104,348	110	70,833	95	103.93
Insurer 1	82,609	$115	95,833	$90	$101.57
Insurer 3	117,391	95	54,167	115	101.31
Insurer 2	86,364	$110	90,789	$95	$102.31
Insurer 3	113,636	95	59,211	115	101.85

7. Administration of the Pool

If Federal administration is elected, Congress may wish to designate for that purpose one or more agencies or departments of the Federal Government. These agencies may be instructed to carry out all responsibilities on their own, or to contract with a private or quasi-public entity to exercise all or some of those responsibilities.

Which agency should be responsible for administering the regional/State pools? Most previous proposals in Congress to establish pools have placed the administering responsibilities with the Secretary of the Department of Health and Human Services (HHS) (or Health, Education and Welfare), especially those that have created the pool through amendments to the Social Security Act. HHS has the advantage of experience with running health insurance programs, as well as the vast data bases needed to coordinate the various sources of third party payers. (This could be helpful in ensuring that the pools pay as primary insurers in cases where enrollees also have Medicare or Medicaid.) Other options include the Department of Labor, OPM, or the creation of a new agency. The Labor Department might have an interest in the pool since the creation

of the pool would be linked to an employer mandate. OPM has the experience of the Federal Employees Health Benefits Programs (FEHBP), but its mission may not be appropriate to running a program encompassing the general population. The experience of OPM in running FEHBP might be instructive to another agency charged with establishing government facilitated or operated pools.

Federal administration does not necessarily mean centralized operations. Administration could be decentralized through regional or district offices. Some tasks, such as claims processing, could be contracted out to private entities, as is done for the Medicare program with insurance carriers. Alternatively, the Federal Government could support (through contract funds) the creation of new entities to perform specific tasks at the regional, State, or local levels. Illustrations include the Peer Review Organizations or the Health Systems Agencies.[272]

If pools are organized at the State level (rather than at the regional or national level), another possibility would be to place the overall responsibility for the pools with a Federal agency but delegate to the States supervision of the pools under Federal guidelines and rules. This would facilitate flexibility and State experimentation. On the other hand, this would also lead to substantial variation among the States in the way in which the pools operate.

B. POOLING OF INSURERS

To this point, the focus has been on options to expand the availability of affordable insurance by aggregating individuals and small groups into insurance pools that would achieve the premium rating and administrative advantages of a large group. A different approach would be to aggregate insurers into pools. Insurers could form one of a variety of pooling arrangements that would allow them to share on an equitable basis either the burden of covering high-risk individuals or groups or the financial losses associated with covering them. The rationale of such arrangements is that insurers as separate units may not be willing to sell insurance to high-risk individuals and small groups (at an attractive rate) because they do not have the resources to absorb the losses that are likely to result. Given a means to shelter themselves from such losses, insurers might be encouraged to expand their small business and individual subscriber markets and to accept higher-risk applicants for coverage.

1. Assigned Risk Pools

One possibility is to create an assigned risk pool whereby insurance companies would share in the financing of otherwise uninsurable individuals or groups.[273] The specific arrangement for an assigned risk system could take a variety of forms.

---

[272] For an analysis of administrative issues related to health insurance proposals, see Feder, Judith, John Holahan and Theodore Marmor, eds., National Health Insurance: Conflicting Goals and Policy Choices. Urban Institute, Washington, 1980, p. 22. Drawing from the experience of Medicaid, Social Security, and other Federal programs, the authors discuss the advantages and disadvantages of national, State and private insurer administration of health insurance programs.

[273] Similar arrangements are used in automobile insurance. Automobile insurance plans, originally called assigned risk plans, serve two functions: (1) they provide auto liability insur-

Continued

a. Voluntary pool assignment

Within each State (or possibly region), a "high-risk insurance plan (HRIP)" would be established to which insurers could refer high-risk applicants.[274] The HRIP would be subsidized through assessments paid by participating insurers, or by all participating entities, including self-insured employers.[275] It could be designed to provide coverage for individuals, small groups or both.

Under this arrangement, insurers would continue existing underwriting and rating practices. Applicants who were turned down for coverage or could only be insured at a high premium (for example, 125 percent of the standard premium) would be referred by the insurer to HRIP. Enrollees in HRIP would receive a standardized benefit package and be charged a set premium. Because enrollment in HRIP would be voluntary, the premium level would be a critical component of the arrangement. Low enrollment would result if the premium were too high. If set too low, the major financing burden would fall on the pool of insurers or the general population of insureds, depending on the financing scheme. Preexisting conditions might be excluded from coverage for a specified period, such as 6 months. One insurer could be designated to write the policies for the enrollees in the HRIP, or the HRIP itself could serve this function (some would oppose the latter because HRIP coverage might be perceived as stigmatizing for enrollees).

Giving insurers the freedom to select which applicants were referred to the HRIP would limit the need to monitor selection practices. And because the HRIP would not compete for the business of existing insurers (applicants would have to show evidence of being turned down by an insurer and HRIP premiums would be higher than those of insurers), it would not have a major effect on the existing market. Finally, this arrangement might allow for economies of scale in covering groups that are normally very expensive to insure.

A variation of voluntary pool assignment would work as follows. Insurers would rate and underwrite as they do now, and would refer high-risk applicants whom they do not want to accept to the high-risk insurance plan. The plan would, in turn, assign each applicant to an insurer who would write the standardized plan policy, at the standardized premium rate, under its company's name. The insurer would then provide the administrative and claims services for that policyholder. Insurers would be assigned high-risk applicants by the plan based on their proportion of the total health insurance premiums in the State (or region) for the individual and/or small group market.

---

ance (and other types of auto insurance) to those individuals who cannot obtain it through the normal sources, and (2) they provide a procedure for the equitable distribution of high-risk drivers among all the auto liability insurers in a State. The automobile insurance plans and alternate loss-sharing arrangements (such as reinsurance pools) have "consistently experienced heavy dollar losses, currently in excess of $1 billion a year. These financial losses are passed on to other drivers in higher auto insurance rates. . . ." See Vaughan, 1986, p. 504-5.

[274] The HRIP model is not very different from the health insurance organizations which exist in some States to write policies for high-risk individuals. See Trippler, Aaron K. Comprehensive Health Insurance for High-Risk Individuals. A State-by-State Analysis. Minneapolis: Communicating for Agriculture. Second edition, Sept. 1987.

[275] Financing is discussed in greater detail below.

This type of assignment arrangement is used by some State automobile liability insurance plans. It may be more feasible in liability than in health insurance because the expected losses to the insurer are relatively predictable. As discussed in chapter 2, the nature of health care is such that costs and utilization at the individual level are less predictable than those for other types of insurance. It might be more difficult to achieve an equitable allocation of high-risk health insurance applicants among insurers. By the luck of the draw, some insurers might end up covering enrollees with very high utilization, while other insurers cover enrollees with relatively low utilization experience. One solution would be to periodically compensate those insurers that experienced disproportionate losses, using assessments on other insuring entities.

b. Compulsory pool assignment

Another way to arrange an assigned risk pool is to authorize the State/regional HRIP to establish criteria specifying eligibility for referral to the plan. Under the most restrictive arrangement, insurers would be required to accept for coverage all applicants except those who met the plan criteria. While this arrangement would limit the pool to the most uninsurable individuals and groups, it would keep pool enrollment low. Problems might arise in finding workable criteria and in establishing an effective monitoring and enforcement system to prevent manipulation by the insurers.

2. Reinsurance Pools

To create an effective mechanism for providing coverage of high-risk individuals and/or groups, coverage has to be made available at affordable rates to applicants regardless of their risk factors. Some have suggested that one way to ensure such rates is to provide insurers with a source of reasonably priced reinsurance. Insurers who experienced major losses as a result of covering high risks could then make claims against the reinsurer to cover the losses. The purpose of reinsurance would therefore be to compensate insurers that write policies for high-risk individuals and groups for incurred losses that exceed some threshold. While a pool provides a way to aggregate into one large group the risk of many small groups, the intent of reinsurance is to spread the risks for catastrophic claims.[276]

a. Nature and function of reinsurance

In the conventional insurance market, reinsurance is a contract under which one insurer agrees to indemnify another with respect to actual loss sustained under the latter's policy or policies of insurance. A reinsurer cannot reinsure what was not first insured. A

[276] In automobile liability insurance, some States have a reinsurance pool which operates much as the arrangement described above, whereby the losses from high risk enrollees are passed on to the high-risk insurance plan. In such States, the reinsurance pool covers the total losses incurred by the primary insurer from high-risk drivers who have been placed by the primary insurer into the reinsurance pool. In the following arrangements, the reinsurance pool is used to cover excess rather than total losses.

reinsurer may reinsure less than the amount originally insured, but not more.[277]

The general purpose of reinsurance is to enable an insurer to assume larger amounts of liability under individual policies or a number of policies than its own resources permit. It provides for a further spreading of risk beyond the original pool of insureds. By passing on the portion of the risk that is too large for it to handle, an insurer can avoid catastrophic losses.

The success of the private reinsurance market is dependent upon the ability of reinsurers to achieve profit from underwriting risks of primary carriers. Typically, reinsurers will pass on their risks by purchasing coverage from another reinsurer. This process has the effect of spreading the risks among an ever-expanding number of participants, thereby reducing the possibility that any one reinsurer will suffer substantially from the claim of a primary carrier.

Left alone, the private reinsurance market is unlikely to encourage primary health insurance carriers to insure groups that traditionally have been regarded by insurers as high risks. The price of a reinsurance policy is likely to be prohibitively expensive if the losses are almost certain to be high. (If this were not true, reinsurers would already have developed a major market in high-risk health insurance.) It is conceivable, however, that a reinsurance mechanism could be designed as a non-profit pool, whose purpose would be to underwrite the excess losses of insurers (or a pool of insurers) that cover high-risk groups and/or individuals.

b. Reinsurance corporation

Insurers could create a reinsurance corporation that would provide coverage to primary insurers for excess losses resulting from high-risk enrollees. The corporation might be operated as a private, not-for-profit organization, administered by a board comprised of representatives of insurance companies and others (e.g. regulators, consumers, etc.). To be eligible for reinsurance through the corporation, the primary insurer would have to agree to provide open enrollment without medical underwriting to all applicants at standard rates. This would ensure expansion of coverage to previously uninsured individuals and groups. It would also prevent the corporation from competing with existing reinsurers for the conventional reinsurance market. The reinsurance corporation would be financed through premiums paid by primary insurers and through assessments on insuring entities (insurers plus self-insured businesses). The implications of such a financing scheme are further discussed in the next section.

3. Financing Insurer Pools

The insurer pools described above (both the assigned risk and reinsurance arrangements) are designed to spread the financial burden of insuring a segment of the currently uninsured, primarily those individuals and groups that cannot otherwise buy insurance or who can only buy it at prohibitive rates because they represent high risks to insurers or employers. Such arrangements could be

---

[277] Kramer, Henry T. The Nature of Reinsurance, in Robert W. Strain ed. Reinsurance. The College of Insurance, New York, 1980. p. 1-31.

financed solely through premiums on the newly insured, but this would result in premiums so high as to prevent much expansion of coverage. Alternatively, financing could be shared by the newly insured and the insurance industry. Under such a financing scheme, losses in excess of premiums could be assessed to all insurers. However, it is likely that the insurers would then pass on the assessments to their purchasers as increased premiums. This, in turn, might encourage more employers to self insure, thereby leaving a smaller pool of purchasers to pay for the costs of the pool. To avoid this situation, the assessment of excess losses could be spread across all insuring entities, including self-insured plans. A final possibility would be to provide for public subsidies.

In addition to determining who is to contribute to the financing is the question of how the excess losses should be allocated. For example, should each entity be assessed an equal proportion of the losses? This could have an adverse effect on smaller insurers and employers. Alternatively, the assessment could be based on the insuring entities' premiums (total premiums, or premiums for its individual and small group business). The burden would thereby fall on the entities with the larger market.[278]

Additional factors might have to be considered in determining how to allocate the pool's losses. It might be necessary, for example, to factor into the loss allocation methodology whether enrollment in the pool was controlled by individual insurers (as envisioned in the voluntary pool assignment plan described above) or by the pool itself through the use of assignment criteria. Should insurer A, which refers a large number of applicants to the pool, be required to pay more into the pool than insurer B, which writes a large number of policies for high-risk applicants and only refers a small percentage of its high-risk applicants to the pool?

Perhaps a more fundamental financing issue is whether it is reasonable to ask purchasers of health insurance to subsidize the costs of health insurance for high-risk individuals and small groups. Given that any assessment on insuring entities is likely to be shifted to their policyholders, some would question whether it is fair to ask the population of insureds to subsidize the costs of those who become newly insured as a result of these insurer pools. One response might be that it is fair to make the insured population pay for pool enrollees so long as the burden is spread on an equitable basis. What would be unfair would be a situation where some insureds were able to escape assessments, or to pay less than an equitable share. In addition, it could be argued that this type of pool subsidy would ultimately reduce insurance premiums for the generally insured population because employers and insurers would not have to pay as much in excess provider charges to cover un-

---

[278] In conjunction with a proposal to develop an insurer pool to provide insurance to small employers, the health insurance industry has recommended that such pools be financed on an equitable basis, with each contributing "competitor" paying for the pool's excess losses in proportion to that competitor's premiums. It suggests that the assessment be levied first against competitors based on their premiums for groups with fewer than 25 enrollees. Any remaining losses would be assessed across all larger health plans. See Health Insurance Association of America. Materials on the Uninsured, Description of the HIAA Proposal for Employer Coverage. Washington, 1988, unpublished document.

compensated care. This is because there would be fewer charity care patients.

However, others might argue that the more equitable means of financing these insurer pools is to provide for direct public subsidies, with revenues derived from the tax system. Enrollees in the pool would pay a set premium, but excess pool losses would be financed entirely by public funds. In this way, financing coverage for the uninsured would be shared by those who obtain coverage as well as by society at large.

However, given the high cost of health care, lawmakers may be wary of committing what could be substantial revenues to financing insurance for high-risk individuals and groups. The experience of existing State health insurance pools indicates that their competing objectives of increasing access to coverage while controlling pool costs may not coexist very well. Because high premiums and cost sharing make pool coverage relatively expensive, the pools have drawn only a small fraction of those eligible for enrollment.[279] If the pools were to offer less expensive coverage, higher subsidies would then be required.

A final option is to provide for joint public-private financing. For example, some have suggested that the Federal Government establish a Federal Reinsurance Corporation, its purpose to subsidize abnormal or catastrophic losses of State or regional pools, or possibly even insurers that provide coverage to all applicants at standard rates. To keep pool coverage premiums as low as possible, financing could be a joint public-private venture. The Federal Government could contribute a portion of the funds needed to build up reserves. Additional funds could be collected through premiums charged to the primary insurers, be they carriers or pools. In effect, the pool or carrier would still be the primary insurer but would purchase, on a subsidized basis, reinsurance coverage from the Corporation.[280]

C. NON-POOLED INTERMEDIARY APPROACHES

It may be possible for government to provide for expanded availability of insurance through approaches that do not use a public intermediary. The following are some possible options.

1. Government-Financed Pilot Projects

The approaches described above are intended to be comprehensive in scope. Smaller-scale projects might be preferred, especially

---

[279] U.S. General Accounting Office. Briefing Report to the Committee on Labor and Human Resources, U.S. Senate. Health Insurance. Risk Pools for the Medically Uninsurable. Apr. 1988. GAO/HRD-88-66BR.

[280] See the Carter Administration's National Health Plan Act (introduced as S. 1812 in 1979 by Senator Ribicoff) for an example of a Federal reinsurance pool used in tandem with an employer mandate. There are many potentially complex design issues in establishing a Federal reinsurance entity, such as: how much money would be needed to start up the reinsurance fund? How much would be required in reserves to maintain solvency? Should the initial capital be appropriated from public funds or derived from an assessment on insuring entities, or both? Should money be sought from outside investors? How much should primary carriers be charged in premiums to reinsure through the Federal entity? Should the premiums be subsidized or should the corporation be designed to be self-financing after initial start-up is completed? What should the rules be for participating in the reinsurance pool? Under what conditions should a participant be allowed to exit from the pool? Finally, who should oversee the reinsurance entity?

if they could be designed to test various broker models. Such an idea is incorporated in S. 2027, introduced by Senator Quayle in the 100th Congress. Under this bill, the Secretary of HHS would be authorized to approve one or more pilot projects for the development and marketing of low-cost small business health insurance plans. Approved plans would be exempt from the requirements of State mandated benefit laws. This would make it possible to test the marketing of catastrophic plans and other variations that did not conform to State requirements.

2. Technical Assistance to Employers

If it is assumed that many small employers would be willing to purchase insurance if information about alternatives were more readily available, then it may be worthwhile to establish programs to counsel employers on product availability, pricing and other matters important to buying insurance, such as tax and regulatory issues. One possibility would be to expand the capability of local offices of the Small Business Administration (SBA) (there are about 67 SBA offices) to provide technical assistance to small employers that request it. The same function could be served by local offices of other Federal agencies, such as HHS or the Department of Labor. Alternatively, an 800-number could be established by one of the Federal agencies. Counselors could provide information to callers about purchasing health insurance.

This function may also be performed by the private sector, through business coalitions, local chambers of commerce or similar organizations. The Federal Government could facilitate private action through a grant program, administered by the SBA, HHS or Department of Labor. Another possibility would be to provide grants to the States to set up technical assistance programs either through State agencies or through contracts with private entities.

3. Insurance Information Clearinghouse

Another option would be for government to provide directly or through assisted projects a source of information for small employers and individuals. The Robert Wood Johnson Foundation has been experimenting with this type of project. For example, it awarded a grant to the United Way of San Francisco to test the hypothesis that "there are reasonably priced plans currently available but small employers are unaware of them," [281] because they do not have time to find out what coverage may be available. A survey found that there were "numerous health insurance plans for small employers being marketed in the Bay Area." Some policies were expensive, but others charged monthly premiums of $60 to $80. These policies were usually sold for workers under age 30.[282]

Funding is being provided by the Foundation to explore the feasibility of creating a health insurance information and referral service to assist small employers in obtaining group coverage for their workers. The plan is to create an insurance information service

[281] Alpha Center, Health Care for the Uninsured Program Quarterly Report, Mar. 1987. No. 2, p. 1.
[282] Alpha Center, Mar. 1987. p. 6.

that would answer small employer inquiries regarding: the type of coverage packages available, cost, range of benefits, and enrollment procedures. Information would also be available to individuals seeking coverage.[283]

IV. Government Insurance Programs

The final way in which Federal or State government can help make insurance more available is to begin selling it directly. A number of States have established health insurance programs for the "uninsurable," often subsidized through premium taxes on insurers (financing mechanisms will be discussed further below).[284] Other States are developing programs for uninsured (as opposed to uninsurable) individuals or small businesses.

Recent years have also seen numerous proposals to allow individuals or groups to "buy in" to government health programs, particularly Medicaid. Some buy-in proposals target the special populations already served by these programs, such as families with children. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) established the first such buy-in program, under which States may provide Medicaid to pregnant women and infants with incomes below 185 percent of the Federal poverty level and must charge a small premium to those between 150 and 185 percent of poverty. Other proposals, such as the Chafee-Lagomarsino "MedAmerica" bill (S. 1139/H.R. 3580) introduced in the 100th Congress, would also permit "uninsurable" individuals and small businesses to purchase Medicaid coverage, with premiums approaching the actual cost of insurance. There have also been suggestions that limited groups of the uninsurable, perhaps persons with a specified disease or condition, might be permitted to buy into Medicare.

Public insurance proposals may thus be said to constitute a continuum, running from expanded entitlement programs with token beneficiary contributions to the actual sale of insurance, possibly with some government subsidy. The following discussion focuses on programs closer to the insurance end of the scale, and does not distinguish among Medicaid or Medicare buy-ins and independent State programs. Essentially the same issues arise regardless of the name given to the program. The chief difference between a Medicaid or Medicare buy-in program and existing State insurance programs for the uninsured or uninsurable would be the potential use of Federal funds as a source of subsidy, instead of State funds alone.

The next section discusses the relation between public and private insurance programs to explain why public insurance programs cannot be fully funded by their clients and thus require subsidies. This discussion is followed by a brief review of potential funding sources. The chapter concludes with a consideration of eligibility rules and premium development.

---

[283] Alpha Center, Mar. 1987.

[284] These programs are often spoken of as "risk pools." The term is not used here, both to avoid confusion with the pooled purchasing arrangements described in the previous section of this chapter and because the term is still sometimes used to describe an entirely different kind of pool, under which insurers agree to accept high-risk applicants, assigning them to the participating insurers on a rotating basis.

A. PUBLIC PROGRAMS AND THE PRIVATE MARKET

Existing public insurance programs have been designed to serve populations that were unable to find affordable coverage in the private insurance market. Medicaid serves people too poor to buy coverage, while Medicare serves high-cost populations that could previously buy coverage only at prohibitive rates. Most State programs have been targeted at the "uninsurable," usually requiring evidence that applicants have sought and failed to receive coverage in the private market before allowing them to enroll.

There are no natural, absolute boundaries between the populations now served by public programs and those served by the private market. Except for some people classed as uninsurable because of specific medical conditions, most of the clients of public programs could in theory buy coverage on their own, but not at rates they can afford. Even participants in programs for the uninsurable may qualify, not by showing that they could not get insurance at all, but by showing that the rates they were offered exceeded some fixed ceiling, such as 150 percent of an average insurance rate.

When a program for the uninsurable accepts an applicant who could not find coverage at 150 percent, the insurer who was prepared to sell coverage at 160 percent has lost a sale. Similarly, when Medicare was enacted, it replaced much of the private coverage already purchased by higher-income senior citizens. Public insurance programs have the potential of displacing the private market, rather than merely filling gaps in it, because they are potentially able to offer coverage for less than its private market value.

Public programs may finance coverage at less than its market value in several ways:

- *By forgoing profit.* A public program can offer lower rates than commercial insurers or even private non-profit insurers, such as many Blue Cross/Blue Shield Plans and HMOs, which tend to retain surpluses for future development even though the surpluses are not distributed to shareholders.
- *By obtaining exemptions from State regulation. A public program might not be subject to premium taxes or State mandated benefit laws. (This assumes, however, that the legislation creating the public program would be free from the provider pressure that shaped mandated benefit laws to begin with.)*
- *By sharing administrative systems with other programs and sharing in the benefits of economies of scale.* This would be the case, for example, if a State high-risk pool used the State's Medicaid claims processing system.
- *By obtaining discounts from providers comparable to those presently obtained by many Medicaid programs.* (As chapter 4 indicated, however, it is not certain that these discounts would continue to be available if public program enrollments were significantly increased.)

The impact on rates of these factors might be approximately 12 percent, assuming no savings from provider discounts and no ex-

emption from the State's benefit mandates.[285] From the perspective of the insurance industry, a large part of these savings would be attributable to unfair advantages enjoyed by the public program—its exemption from taxes and regulations governing the private sector—and to its ability to operate without profit. The industry might argue that, given comparable advantages, a public program could underprice the private sector in furnishing any service or commodity.

Because these arguments are serious ones in the American system, public insurance programs have generally not entered segments of the market that were already fully served by the private sector. Public programs could, but do not, offer coverage at reduced rates to persons or groups who can afford to pay market rates. Instead, they set eligibility criteria that minimize the incursion into the private market: maximum income levels for low-income clients or minimum premium levels for high-risk clients.[286]

Public programs can be fully self-supporting only if they define their clientele narrowly, serving people outside the reach of the private market, but not very far outside. For example, a program that can save 12 percent of private market rates can offer insurance at $150 to people who would have to pay from $151 to $168 in the private market. If it begins to accept applicants who would have to pay $170 or $180 in the private market, its savings will be insufficient to sustain the $150 rate. It will then have two choices: raise its rate, driving its lower-risk clients into the private market and beginning the selection spiral described earlier in this chapter, or rely on public subsidies. If the same program were aimed at low-income families, it could afford to accept families able to pay 88 percent of the usual private market cost of their own insurance, a very limited segment of the target clientele. If it accepted poorer families it would again be obliged to find some form of subsidy. Potential sources for this subsidy are discussed in the next section.

B. SUBSIDIZING PUBLIC INSURANCE PROGRAMS

As was noted in section III of this chapter, most State programs for the uninsurable assess member health insurance carriers in proportion to their share of the State insurance market.[287] But in most of the States using this approach, the assessments are offset by a dollar-for-dollar tax credit to the insurer. This credit is applied

---

[285] The estimates are based on the administrative cost factors for private insurance used in the CRS Health Insurance Premium Model described in U.S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Coverage, 1988. Savings are relative to private insurance costs for the smallest employers and are assumed to be as follows: 3 percent reduction in claims administration cost, 7 percent reduction in risk and profit charges, 2.7 percent reduction in premium taxes, 4 percent reduction in commissions (assuming that part of this expense would be replaced by expenses for individual application and enrollment processing). No reduction is assumed in general administration. Total administrative cost is reduced from 34.6 percent of claims to 17.9 percent of claims. This equates to a 12.4 percent reduction in premium rates.

[286] The obvious exception is Medicare, which does not use financial eligibility standards. However, its failure to do so was a central issue in the debate at the time of its enactment. In 1972, when coverage of the disabled was added, a 24-month waiting period for coverage was included, in part to limit the substitution of Medicare for private insurance.

[287] The rationale for this approach is that the uninsurable population exists to some extent because of insurance company underwriting practices. Insurers, on the other hand, would argue that the most seriously ill segments of the population are a general social responsibility and that their care is properly financed through more broadly based revenue sources.

against the State tax on the carrier's health insurance premiums or against the carrier's corporate income tax.[288] In this way, program losses that are initially financed by the health insurance industry are ultimately financed out of general revenues.

If losses grow to the point where either premiums are so high as to be totally unaffordable or assessments so great that the insurers cannot readily pass along or absorb their assessment costs, then this financing scheme breaks down. Partly because of the anticipated effect of AIDS and partly because of the loss experience of State programs to date, insurance companies have proposed that the financing system be redesigned. One alternative is to finance the programs directly through general revenues, an option chosen in Illinois. Financing could come from nondedicated State funds. Alternatively, the State can dedicate a percentage of a specified tax, such as a corporate income tax, for the program. However, this approach is not always politically feasible. Employers who provide health insurance argue that it is inequitable that they be taxed to solve a problem that is created by the underwriting practices of insurers, and by employers that do not offer insurance.

A different approach is to fund the program from taxes on providers. In Maine, for example, losses are to be financed by a tax on hospitals' gross patient revenues. This policy may not be acceptable in many States because of opposition from hospitals, whose representatives argue that it would have a costly impact on hospital revenues, and from insurers and employers, who argue that the hospitals would shift the tax onto them in the form of increased charges.

Another financing approach is for the State to levy an excise tax on employers' payrolls, and use the resulting revenues to finance the insurance program. But employers are unlikely to support this move for the same reasons described above. In addition, they may challenge the action in the courts on the basis that it violates the ERISA preemption clause.

As was noted in section II, State insurance programs might also be financed through assessments on all insuring entities—self-insured employers as well as commercial insurance companies and the Blues. Again, this approach is subject to challenge under ERISA and would require Federal enabling legislation.

Finally, a Medicaid or Medicare buy-in program might also rely on Federal financing. This approach, too, would require Federal legislation.

C. ELIGIBILITY AND PREMIUMS

A public insurance program could focus on any of three groups: low-income individuals and families, high-risk or "uninsurable" individuals regardless of income, or small businesses. Most State initiatives aimed at businesses have taken the form of State-sponsored METs, which are expected to be self-supporting. The following discussion will therefore concentrate on partially subsidized programs for individuals.

---

[288] Intergovernmental Health Policy Project. Focus on . . . the risk pool strategy. Comprehensive health insurance associations. Washington. Feb. 1988. p. 9.

The basic issues to be resolved in designing a public program are defining the target population and determining the amount that beneficiaries are able to contribute to the cost of their own coverage. As has been suggested, the two decisions are complementary; both rest on some fundamental assumption about how much people can afford to pay for their own care. What percentage of family income can reasonably be devoted to health insurance?

From the beneficiaries' point of view, not very much. A 1986 survey conducted as part of the planning for a Washington State public insurance initiative found that an average family with an income below 100 percent of the poverty level was prepared to spend $10 to $11 per month for health insurance. The average family with an income below 200 percent of the poverty level was prepared to spend $28 per month.[289] For a family of three in 1986 with an income of 200 percent of the poverty level, this would have amounted to 2 percent of gross family income and would have covered only 13 percent of the total cost of an insurance plan comparable to those offered by large employers.[290] (Over three-quarters of nonaged persons without health insurance in 1986 were in families with incomes below 200 percent of the poverty level.)

A buy-in program with premiums at levels that low-income families would regard as affordable would, then, require subsidies equal to 87 percent or more of the total costs. The cost might approach 100 percent if, as in some proposals, the family's premium contribution were set at a fixed percentage of income (or of income in excess of the poverty level). In its budgetary impact, the program would not be very different from a simple extension of Medicaid entitlement to a larger segment of the low-income population.

The premium could be set at a higher percentage of income, but only at the risk of adverse selection. Families willing to pay a higher percentage would be those anticipating a greater need for health care. The costs of coverage could be expected to rise accordingly, and the amount of subsidy required might be unchanged or even increase.

Some proposals would address this problem in part by encouraging businesses to participate on behalf of their employees. A firm that could not afford to buy full health coverage for its workers might nevertheless be willing to make some contribution to the cost of their care. Total coverage cost would then be divided among the family, the employer, and the government. (Maine and Michigan are developing plans of this type on a demonstration basis.)

The eligibility and financing issues are somewhat different for the other possible target population, high-risk or "uninsurable" individuals. Proposals for this population tend to involve a fixed premium rate, often set at some percentage of the "standard" individual rate in the State, such as 125 or 150 percent. All participants in the program pay the same rate, regardless of their personal financial resources or the level of risk they present to the program. As was suggested earlier, a program whose premium was set at 150

---

[289] Remarks by Robert Crittenden, as reported in National Governors' Association. Facilitating Health Care Coverage for the Working Uninsured: Alternative State Strategies. Washington. 1987. p. 28.

[290] For the premium calculation, see U. S. Library of Congress. Congressional Research Service. Costs and Effects of Extending Coverage, 1988.

percent of the statewide standard rate might attract persons who would otherwise have to pay 151 percent and persons whose private market premiums (if they could obtain coverage at all) might be 200 or 300 percent of the standard rate. This would mean, not only that large subsidies might be necessary to sustain the rate, but also that the lower-risk participants would be covering a much larger proportion of their own costs than the higher-risk participants.

Some programs have sought to limit these effects by using the same underwriting techniques that created the "uninsurable" population in the first place. These programs may use much higher upper limits of insurability than private insurers do, but they still exclude the very highest-risk applicants or limit coverage for preexisting conditions.

One possible alternative would be to abandon the single rate principle and establish rates on a two-dimensional scale of ability to pay and level of risk. Table 7.5 illustrates such a system, with premiums capped at the lesser of 5 percent of gross monthly income or the "true" premium, a rate representing the level of risk presented by the individual applicant.

TABLE 7.5.—Illustration of an Income-Risk Related Premium System for a Public Insurance Program for the "Uninsurable"

	"True" monthly premium:				
	$100.00	$150.00	$250.00	$300.00	$350.00
	Monthly premium assessed:				
Income:					
$10,000–$19,999	$83.33	$83.33	$83.33	$83.33	$83.33
$20,000–$29,999	100.00	125.00	125.00	125.00	125.00
$30,000–$39,999	100.00	150.00	166.66	166.66	166.66
$40,000–$49,999	100.00	150.00	208.33	208.33	208.33
$50,000–$59,999	100.00	150.00	250.00	250.00	250.00
$60,000–$69,999	100.00	150.00	250.00	291.66	291.66
$70,000–$79,999	100.00	150.00	250.00	300.00	333.33
$80,000–$89,999	100.00	150.00	250.00	300.00	350.00

Note.—Individual contribution set at the lesser of 5 percent of gross income or true premium cost.

BIBLIOGRAPHY

Alkire, Allison. A Research Based Approach to Curbing Mandates. Business & Health. Apr. 1987. pp. 7-9.

Alpha Center. Health Care for the Uninsured Program Quarterly Report, No. 2. Mar. 1987.

———. Health Care for the Uninsured Update. July 1988.

American Hospital Association. Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage. Chicago. 1988.

Anderson, Gerard, Judith Lave, Catherine Russe and Patricia Neuman. No Free Lunch. Baltimore. Johns Hopkins University Press. [Forthcoming.]

Arrow, Kenneth J. Uncertainty and the Welfare Economics of Medical Care. American Economic Review, 53:5 (Dec. 1963). p. 941-973.

Bovbjerg, Randall R. Insuring the Uninsured Through Private Action: Ideas and Initiatives. Inquiry, 23:4 (Winter 1986). p. 403-418

Bravo, Ellen. Part-time and Temporary Employers Are Not Given Any of the Benefits Pie. Business & Health. Apr. 1988. p. 60.

Bureau of National Affairs. BNA Pension Reporter, v. 15, May 30, 1988.

Chafee, Sen. John. Child Health Incentives Reform Plan. Floor statement on introduction of S. 968. Congressional Record, Apr. 9, 1987, p. S4992-4.

Childrens' Defense Fund. Who is Watching Our Children's Health? The Immunization Status of American Children. Washington. Dec. 1987.

Commerce Clearing House. State Tax Guide. Chicago. (Updated regularly.)

Conrad, Douglas, and Theodore R. Marmor. Patient Cost Sharing. In: Political Analysis and American Medical Care. New York. Cambridge University Press. 1983.

Council of State Governments. The Book of the States: 1988-89 Edition (v. 27). Lexington, Ky. 1988.

Curtis, Rick. The Role of State Governments in Assuring Access to Care. Inquiry 23:3 (Fall 1986), p. 277-285

Dickerson, O.D. Health Insurance. Third edition. Homewood, Ill. Richard D. Irwin, Inc. 1968.

Employee Benefit Research Institute. Employer Provided Health Benefits: Coverage, Provisions and Policy Issues. [by] Deborah J. Chollet. Washington. 1984.

———. Fundamentals of Employee Benefit Programs. Third edition. Washington. 1988.

Enthoven, Alain C. Health Plan, The Only Practical Solution to the Cost of Medical Care. Reading, Mass. Addison-Wesley. 1980.

———. Health Tax Policy Mismatch. Health Affairs. Spring 1984. p. 5-13.

Feder, Judith, John Holahan and Theodore Marmor, eds. National Health Insurance: Conflicting Goals and Policy Choices. Washington. Urban Institute, 1980.

Feezor, Alan. No Future Guarantees for Self-Insured Plans. Business & Health. April 1987. p. 16-19.

Gill, Kathleen D., Editor. ERISA: The Law and the Code. Washington. Bureau of National Affairs. 1985.

Government Research Corporation. Options for Meeting Health Care Requirements of Uninsured Individuals: A Report of a Task Force. Washington. 1988.

Handley, Thomas L. Developing Premium Rates for a Preferred Provider Organization (PPO). Transactions, Society of Actuaries, vol. xxxvii, 1985. p. 187-200.

Health Insurance Association of America. 1986-1987 Source Book of Health Insurance Data. Washington. 1987.

———. A Course in Group Life and Health Insurance. Washington. 1985.

———. A Course in Individual Health Insurance. Washington. 1983.

———. Materials on the Uninsured, Description of the HIAA Proposal for Employer Coverage. (Unpublished document) Washington. 1988.

Hellinger, Fred J. Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence. Health Care Financing Review. 9:2 (Winter 1987), p. 55-63.

Himmelstein, David, and Steffie Woolhandler. Cost Without Benefit. Administrative Waste in U.S. Health Care. New England Journal of Medicine, vol. 314, no. 7, Feb. 13, 1986.

Intergovernmental Health Policy Project. Focus on . . . the risk pool strategy. Comprehensive health insurance associations. Washington. Feb. 1988.
Kennedy, Sen. Edward M. Access to Health Care Act. Floor statement upon introduction of S. 2402. Congressional Record. May 1, 1986. p. S5221.
Kramer, Henry T. The Nature of Reinsurance, in Robert W. Strain ed. Reinsurance. New York. College of Insurance. 1980.
Lohr, Kathleen N., et al. Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis- and Service-Specific Analyses in a Randomized Controlled Trial. Medical Care, 24:9 (Supplement, Sep. 1986)
Lubitz, James, and Ronald Prihoda. The Use and Costs of Medicare Services in the Last 2 Years of Life. Health Care Financing Review, 5:3 (Spring 1984). pp. 117–131.
Monheit, Alan C., et al. The Employed Uninsured and the Role of Public Policy. Inquiry, 22:4 (Winter 1985).
Morone, James, and Andrew Dunham. Slouching Toward National Health Insurance: The New Health Care Politics. Yale Journal of Regulation, 2:2. 1985.
National Association of Insurance Commissioners. Model Regulation Service. Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Model Act. July, 1986.
National Governors' Association. Facilitating Health Care Coverage of the Working Uninsured: Alternative State Strategies. Washington. 1987.
———. State Medicaid Program Information Center. A Catalogue of State Medicaid Program Changes. 1986 Edition. Washington. 1988.
National Rural Electric Cooperative Association. The NRECA Plans and the Minimum Health Benefit: A Comparison of Provisions and Costs. Washington. 1988.
———. The NRECA Survey of Health Care Coverage in Smaller Firms: Evidence and Policy Implications. Washington. 1988.
Peterson, Carolyn. Mandated Health Benefits: Time to Evaluate. Washington, American Legislative Exchange Council, 1986.
Rasmussen, Brian. Mandated Coverage: An Employer Debate. Business & Health. Apr. 1987. pp. 12–14.
Rodberg, Leonard S. Anatomy of A National Health Program, Reconsidering the Dellums Bill After 10 Years. Health/PAC Bulletin, Winter 1987. pp. 12–16.
Roper, William L., and William Winkenwerder. Making Fair Decisions About Financing Care for Persons with AIDS. Public Health Reports, 103:3 (May–June 1988). pp. 305–8.
Schieber, George J. Financing and Delivering Health Care. Social Policy Studies No. 4, OECD, 1987.
Short, Pamela Farley, Joel Cantor and Alan Monheit. The Dynamics of Medicaid Enrollment. Unpublished paper presented at the annual meetings of the American Public Health Association in New Orleans, Oct. 1987 (updated Mar. 1988).
Society of Actuaries. Medical Coverage for Groups of Two to Fourteen. Panel at the San Francisco Meeting. Apr. 1–2, 1985. Record, vol. 11. no. 1. p. 33–51.
Spencer, Charles D. and Associates. Spencer's Research Reports on Employee Benefits. Chicago. (Regularly updated)
Survey Says Cities Outpace Other Employers in Medical Benefits. Nation's Cities Weekly. May 23, 1988.
Towers, Perrin, Foster and Crosby, Inc. Health Benefit Plans Fall Short of Proposed Legislative Requirements. T.P.F. & C. News. August 1987.
Trippler, Aaron K. Comprehensive Health Insurance for High-Risk Individuals. A State-by-State Analysis. Second edition. Communicating for Agriculture. Minneapolis. 1987.
U.S. Congress. Congressional Budget Office. Reducing the Deficit. Spending and Revenue Options. A Report to the Senate and the House Committees on the Budget—Part II. Washington. Mar. 1988.
———. Tax Subsidies for Medical Care: Current Policies and Possible Alternatives. Washington. Jan. 1980.
U.S. Congress. Congressional Research Service. Costs and Effects of Extending Health Insurance Coverage. Washington. 1988.
———. Health Insurance and the Uninsured: Background Data and Analysis. Prepared for the Subcommittee on Labor-Management Relations, and the Subcommittee on Labor Standards of the House Committee on Education and Labor and the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, and the Senate Special Committee on Aging. May 24, 1988. Education and Labor Serial No. 100–Z. Energy and Commerce Serial No. 100–X. Special Committee on Aging Serial No. 100–I.

———. Health Insurance for Retirees: An Uncertain Future. Issue Brief No. 88004, by Beth C. Fuchs (updated regularly). Washington. 1988.
———. Medicaid Source Book: Background Data and Analysis. Prepared for Committee on Energy and Commerce, U.S. House of Representatives. Washington. 1988.
———. Medicare Coverage of Employees of State and Local Governments. Report No. 87-268 EPW, by David Koitz. Washington. Mar. 11, 1987.
———. Meeting the Pension Obligation: Underfunding and Overfunding Issues. Issue Brief no. IB87170, by Ray Schmitt. (Updated regularly)
———. Parental Leave: Legislation in the 100th Congress. Issue Brief No. 86132, by Leslie W. Gladstone (updated regularly).
———. Private Health Insurance Continuation Coverage. Issue Brief No. IB87182, by Beth C. Fuchs (updated regularly). Washington, 1987. p. 9-10.
U.S. Congress. General Accounting Office. Changing Medicaid Formula Can Improve Distribution of Funds to States. Washington. 1983. [GAO/GGD-83-27]
———. Estimate of the Costs of the Parental and Medical Leave Act of 1987 (S. 249). Washington. May 18, 1988. [GAO-HRD-88-103]
———. Health Insurance: Comparing Blue Cross/Blue Shield Plans with Commercial Insurers. Washington. July 11, 1986. [GAO-HRD-86-110]
———. Health Insurance: Risk Pools for the Medically Uninsurable. Briefing Report to the Committee on Labor and Human Resources, U.S. Senate. Washington. Apr. 1988. [GAO/HRD-88-66BR]
———. Report to the Subcommittee on Labor-Management Relations. Committee on Education and Labor. House of Representatives. Parental Leave. Estimated Costs of H.R. 925, the Family and Medical Leave Act of 1987. Washington. 1987. [GAO-HRD-88-34]
U.S. Congress. House. Committee on Education and Labor, Subcommittee on Labor-Management Relations. Oversight Investigation of Certain Multiple Employer Health Insurance Trusts (METs), Evading State and Federal Regulation. Hearing, 97th Congress, 2nd Session, Mar. 5, 1982. Washington. 1983.
———. Committee on Small Business. The Health Insurance Problem: Alternative Strategies to Expand Coverage among Small Businesses. Committee print. 100th Congress, 1st Session. Washington. December 1987.
———. Committee on Small Business. The Health Insurance Problem. Hearings, 100th Congress, 1st Session, May 6, June 16 and 18, 1987, Serial no. 100-7. Washington. Dec. 1987.
———. Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. Washington. March 1988. [WMCP: 100-29]
———. Committee on Ways and Means. Subcommittee on Health. Insurance Protection for Catastrophic Health Expenses for Individuals Under Age 65. Hearings, 100th Congress, 1st Session. Serial no. 100-37, May 21, 1987.
———. Select Committee on Children, Youth and Families. Opportunities for Success: Cost Effective Programs for Children. Updated. 100th Congress, 2nd session. Washington. 1988.
U.S. Congress. Joint Committee on Taxation. Staff Description of Proposed Technical Corrections Act of 1988. JCS-10-88. Washington. Mar. 31, 1988.
U.S. Congress. Office of Technology Assessment. AIDS and Health Insurance: An OTA Survey. Washington. Feb. 1988.
U.S. Congress. Senate. Committee on Labor and Human Resources. Minimum Health Benefits for All Workers Act of 1988. Report Together with Additional and Minority Views to Accompany S. 1265. Report 100-360. Washington. May 25, 1988.
———. Committee on Small Business. Hearing to examine the cost and availability of health care benefits for small businesses and proposals for federally mandated health benefits. Hearings, 100th Congress, 1st session. Washington. April 23, 1987.
U.S. Congress. Staff of the Joint Committee on Taxation and the Committee on Ways and Means. Description of Possible Options to Increase Revenues. Prepared for the Committee on Ways and Means. Washington. June 25, 1987.
U.S. Department of Health and Human Services. Assistant Secretary for Planning and Evaluation. Office of Health Policy. Insuring Catastrophic Illness for the General Population. [Washington] 1987.
———. National Center for Health Statistics. Vital Statistics of the United States, 1985, vol. II, Mortality, Part A. DHHS Pub. No. (PHS) 88-1101. Washington, 1988.

———. Social Security Administration. Increasing the Social Security Retirement Age: Older Workers in Physically Demanding Occupations or Ill Health. Social Security Bulletin, 49:10 (Oct. 1986). p. 5–23. (Reprint of report to Congress pursuant to section 201(d) of the Social Security Amendments of 1983, P.L. 98–21.)

U.S. Department of Labor. Bureau of Labor Statistics. Employee Benefits in Medium and Large Firms. 1986. Bulletin 2281. Washington, June, 1987.

———. Employment Standards Administration, Wage and Hour Division. Handy Reference Guide to the Fair Labor Standards Act. WH Publication 1282, revised Jan. 1981.

U.S. Office of Management and Budget. Budget of the United States Government, Fiscal Year 1989. Washington. 1988.

U.S. Small Business Administration. Office of Advocacy. Health Care Coverage and Costs in Small and Large Businesses. Final Report. (Prepared by ICF, Inc.) Washington. 1987.

Vaughan, Emmet J. Fundamentals of Risk and Insurance. 4th Edition. New York. John Wiley and Sons, 1986.

Waldman, Saul. National Health Insurance Proposals. Provisions of Bills Introduced in the 94th Congress as of February 1976. Department of Health, Education and Welfare, Social Security Administration, HEW Publication No. (SSA) 76–11920.

○