COOPER ANALYSIS

TOPIC: TAX CAP

1. Current Law

The tax code provides preferential treatment for employer contributions for health insurance benefits. First, the gross income of an employee does not include employer-provided coverage under an accident or health plan. Employees can also exclude employer contributions to cafeteria plans for health insurance from gross income. Employer contributions for health insurance are also excluded from social security earnings. Second, business expenses are deducted from employers' gross income. Wages, salaries, and fringe benefits (including health insurance) are allowable business expenses.

In combination, these provisions mean that employees can receive tax-free income from their employers in the form of health insurance benefits. In contrast, most other forms of compensation (both cash and fringe benefits) are subject to income and employment taxes.

Self-employed individuals can deduct from income 25 percent of the amounts paid for health insurance for the taxpayer and the taxpayer's spouse and dependents. The deduction is limited to earnings from self-employment, and no deduction is allowed if the taxpayer has other employer-provided accident or health coverage.

Taxpayers whose medical care expenses exceed 7.5 percent of their adjusted gross incomes (AGI) can deduct the excess from taxable income (this is known as a below the line deduction).

2. Description of Congressman Cooper's Proposal

Under Congressman Cooper's plan, an employer would be subject to a 34 percent excise tax on any "excess health plan expenses" paid or incurred by the employer. Health plan expenses are considered "excess" if they exceed the lowest-cost accountable plan in the individual's health plan purchasing cooperative (HPPC). In addition, health insurance must be attributable to coverage under an accountable plan. The excise tax would also apply to employer contributions for cafeteria plans. The excise tax is non-deductible. Employees would continue to exclude all employer-provided health insurance benefits from taxable income.

The net effect of the Cooper tax cap is to subject a portion of employees' compensation -- the employer contributions for health insurance -- to a 34 percent excise tax. (The tax is collected from their employers.)

Taxpayers would be able to deduct premiums for coverage under an accountable health plan "above the line" -- without regard to the

7.5 percent-of-AGI floor on medical expense deductions. Deductible expenses could not exceed the cost of the lowest-price accountable plan in the HPPC. Moreover, the amount of the allowable deduction would be reduced by payments, if any, made by employers or a government entity for coverage of the individual under any health plan.

The deduction for health insurance expenditures by self-employed persons would be increased from 25 percent to 100 percent. However, qualifying expenditures would be limited to amounts paid for the lowest-cost accountable plan in the individual's region.

These provisions are generally effective for expenses incurred after December 31, 1994. A transition rule is provided for collectively bargained plans.

3. **Differences from the Health Security Act**

- The Health Security Act limits the employee exclusion for health insurance contributions but does not restrict employer deductions. Cooper's plan levies an excise tax on employers but does not directly apply a tax on workers.

- The Health Security Act allows employees to exclude and employees to deduct the full amount of employer contributions for the comprehensive benefit plan from gross income. Under Cooper's plan, employers would only be able to deduct expenditures for the lowest-cost plan providing the standard benefits.

- The Health Security Act gives employees and their employers ten years to adjust compensation packages to reflect the tax cap. The Cooper tax cap takes effect immediately.

- The Health Security Act prohibits employers from making contributions on behalf of their employees for health insurance benefits through cafeteria plans. Cooper's bill allows employers to make such contributions, but levies the 34 percent excise tax on most cafeteria plan contributions, i.e., those in excess of the lowest cost accountable plan.

4. **Effects of the Proposal**

- Undermines Current Employer-Based System -- The Cooper plan essentially says to employers who have been providing good health insurance to their employees that we want them to stop. If they offer anything better than the cheapest plan around, they have to pay a 34 percent tax to the Federal government. The Health Security Act builds on the current employment-based system and is based on the premise that employers have a responsibility to help their employees with health insurance. The Cooper bill is based on the premise that the employers' role in providing health care for their employees should be reduced.

- Excise Tax Will Affect All Employers Equally -- Cooper's tax cap proposal is often described as a denial of the employer's deduction for the excess benefits. However, the Cooper bill's excise tax is generally more draconian than a loss of deduction -- the 34 percent tax would apply regardless of whether the employer had any taxable income for the year and would also apply to non-profit organizations.

- Workers Bear the Cost of Excise Tax -- Employers will pass on the costs of the excise tax to their employees. Many employers will be forced to scale back health insurance benefits for their workers. To the extent that employers substitute cash wages for health insurance benefits, workers will pay income and employment taxes on the additional wages. Other workers may be able to retain their current health insurance benefits, but their wages or other benefits will be reduced to pay for the 34 percent employer tax.

- Key Details Are Missing -- Cooper's plan is short on details. Cooper has not identified which benefits must be offered by accountable health plans. Under Cooper's plan, the National Board selects the standard benefit package after the enactment of the bill. This is a critical omission. Because the effects of a tax cap depend on the scope of benefits included in the standard package, Congress is being asked to OK a tax increase without knowing its effects on taxpayers.

  -- If the National Board includes only a limited number of benefits in the standard benefit package, millions of taxpayers could be hit by a substantial tax increase.

- Cost Containment and Bureaucracy -- The Administration's plan has been criticized for being overly bureaucratic. Cooper's bill may look less bureaucratic because the National Board is not required to determine and enforce premium caps for each Health Alliance. But Cooper relies on a complicated tax cap in order to contain costs.

- Cooper Bill Increases Burden for Both Employers and IRS -- Under the Cooper plan, the tax cap applicable to each worker's health insurance costs would vary depending on the worker's residence, age, and family status. If each state had only two health alliances and the cost of the standard benefit plan was allowed to vary for five distinct age groups, the IRS would be required to enforce as many as 1,000 distinct tax caps. Businesses would find it difficult to comply with such a confusing array of tax caps. With existing resources, the IRS would find it difficult to monitor compliance.

- Cost Containment or Rationing -- Applying the tax cap to the lowest-cost plan in a region will penalize many consumers. Consumers will suffer if the lowest-cost plan is inexpensive

simply because it skimps on some service many consumers value (such as short waits in the reception area or doctors who spend a little extra time with their patients).

- Federal Government Gets Preferential Treatment -- The President said in his State of the Union Address that the American people deserve the same health care protection that Congress and other Federal government workers currently have. That is why the Health Security Act would put everyone into the same health care system. The Cooper bill, on the other hand, says that employers that want to provide more benefits to their employees must pay the Federal government a 34 percent excise tax for the privilege. Interestingly enough, this rule would not apply to the Federal government. The Feds would pay the 34 percent excise tax to itself.

- Self-Employed Individuals Fare Better Under the Administration's Plan -- The Administration and the Cooper bills look like they provide the same tax breaks for self-employed persons. Both the Administration's plan and Cooper's bill increase the health insurance deduction for self-employed workers from 25 percent to 100 percent. But under the Cooper plan, self-employed workers will only be able to deduct expenditures toward the lowest-cost plan. Under the Administration's plan, self-employed persons can deduct the full costs of the comprehensive benefit package.

- Deductibility Is No Substitute for Universal Coverage -- Under the Cooper bill, some taxpayers may receive a tax break because they will be allowed to deduct some expenditures on health insurance. Some observers may think that the Administration's plan is harsh because these taxpayers would not receive the same benefit under the Administration's plan. But Cooper provides this tax deduction only as a way of encouraging uninsured persons to purchase health insurance. If the uninsured do not respond to this incentive, those of us with insurance will continue to pay higher premiums to cover the costs of caring for the uninsured. The Administration's plan provides for universal health insurance coverage which will reduce this type of cost-shifting. Cooper's plan does not. That is the critical difference between the Administration and Congressman Cooper.

5. **Background**

Pegging the tax cap to the lowest-cost plan in a region can be a very aggressive approach to cost containment. Unless the National Board chooses a very generous set of benefits to be included in the standard benefit package, millions of taxpayers are likely to be affected by this provision.

In certain respects, the effects of a 34 percent excise tax on

employers should be similar to a comparable limitation on employees' exclusion of employer-provided health insurance. In each case, the actual tax is borne by the worker -- either directly in the case of the limitation on the exclusion or indirectly through changes in compensation in the case of an excise tax. Limiting employer deductions, however, may not be as effective in controlling costs as a change in the employee exclusion because workers may not perceive the link between their choice of health insurance and reductions in wages.

Ultimately, the Cooper tax cap, combined with the proposed above-the-line deduction, can weaken the foundations of the current employer-based system for providing health insurance benefits. Under the current system, most employers pay for a significant portion of workers' health insurance benefits. In large part, the extensive employer-based health insurance system in the current system reflects the fact that workers can only obtain preferential tax treatment for health insurance expenditures through their employer. Cooper's approach penalizes workers whose employers provide health insurance benefits in excess of the standard benefit plan. Moreover, it provides employers with a rationale to opt out of providing health insurance benefits for their workers, by allowing individuals to deduct such costs from their own taxable income.

TOPIC: COVERAGE

1. **Current Law**

- 38.5 million Americans, 17.4% of the population, were uninsured in 1992.
- 84% of the uninsured live in families headed by workers; 25% of the uninsured are children.
- Covered services and cost-sharing requirements for those who are insured vary considerably.

2. **Description of Cooper Bill's Provisions**

- No mandate for either employers or individuals.
- Firms with fewer than 100 employees who choose to offer insurance must do so through the Health Plan Purchasing Cooperative (HPPC), if they are to retain tax preference for health insurance.
- Individuals who work in firms that offer through the HPPC, those who work in firms that do not offer at all, and those who do not work may all purchase coverage through the HPPC.
- States may choose to set higher firm size cutoffs for the HPPC, but not if more than 50% of the population would end up in the HPPC.
- Exact benefits covered and cost-sharing requirements are not specified in the Cooper bill. The Health Care Standards Commission (HCSC), an executive branch agency, would recommend a uniform set of benefits and cost-sharing to Congress. This benefit package would be required of all accountable health plans (AHPs, both inside and outside the HPPC). The recommendations of the HCSC are adopted unless Congress disapproves them.
- Premiums must be age-adjusted community rated inside the HPPC, and either pure community rated or age-adjusted community rated outside.
- Medicaid acute care is abolished and replaced by subsidies. Individuals with incomes lower than 100% of poverty will be eligible for wraparound services (dental, vision, drugs) beyond the standard benefit package.
- Medicare benefits are expanded to include some preventive

benefits and Part B premiums are increased slightly to finance this.

3. **Differences from the Health Security Act**

- Neither employers nor individuals have obligations to purchase health insurance.

- The firm size cutoff for the key purchasing cooperative unit (alliance in HSA) is much smaller (100 vs. 5000).

- Benefits and cost-sharing options are precisely specified in the HSA. The National Health Board may adjust them over time.

- Under the HSA, Medicaid cash recipient adults and poor children get wraparound services.

- Under the HSA, Medicare beneficiaries get prescription drug coverage and a Part B premium increase equal to 25% of its cost.

- Under the HSA, the new home and community based long term care benefit is available to all severely disabled individuals regardless of age or income.

4. **Policy Effects**

- The absence of any mandate means that universal coverage is much less likely to be obtained. This has two implications: adverse selection will continue to be a problem; and uncompensated care will not be substantially reduced.

- Adverse selection will make the standard benefit package cost more, ceteris paribus, as those most likely to buy are those most likely to be sick.

- While age rating will lower this higher premium for the young, it will raise it for older Americans. The empirical evidence on responsiveness to price changes in private health insurance suggests that the average price must fall tremendously to substantially reduce the number of uninsured voluntarily.

- Continued large numbers of uninsured means virtually unchanged amounts of uncompensated care. This will preserve the cost-shift to private payers that exists today. Coupled with the end of Medicaid disproportionate share payments (under the abolished acute care Medicaid program), this could also be very hard on some local hospitals treating large numbers of the poor.

5. <u>Background</u>

- This bill is basically partial insurance reform for the existing small group market. It probably would make the existing market work somewhat better, but it is very

- The most definitive studies of health insurance purchasing behavior would suggest that average premium reductions on the order of 30% would be necessary to engender universal coverage voluntarily. This seems highly unlikely under any scenario.

TOPIC: MEDICAID

1. Current Law

The Medicaid program currently pays for:

- Services that are included in the comprehensive benefits package proposed in the Health Security Act for those receiving cash assistance (AFDC or SSI) and for a large number of low income people not receiving cash assistance (the 'medically need', pregnant women up to 185% of poverty, and children below 100% of poverty);

- 'Disproportionate share hospitals (DSH)' that serve, in theory, large numbers of low income persons. Many of these payments are used for other purposes by states;

- Institutionally based long term care for the elderly and the disabled, and for home and community based long term care; and

- A variety of supplemental services (e.g., non-emergency transportation, extended physical, occupational and speech therapy, extended inpatient and outpatient mental health services) that are normally not included either in a comprehensive package of acute care services nor in long term care; and

- Services delivered to the elderly and disabled who are covered by both Medicare and Medicaid ('dual eligibles').

In FY 94, projected total Medicaid provider payments are $146 billion, of which $83.5 billion is federal and the remaining $62.5 billion is state money. The FY 93 distribution of expenditures:

Type of Service	Percent of Total Expenditures
Comprehensive Benefits Package Cash Recipients Non-Cash recipients	 25% 15%
DSH Payments	12%
Long Term Care Institutional Home and Community Based	 28% 7%
Supplemental ('wraparound')	4%
Dual Eligibles	8%
Total	100%

2. Cooper Proposal

Cooper proposes eliminating the Medicaid program, effective 1/1/95.

- Cash and non-cash recipients would be included in the community rated HPPC pool, and provided partial subsidies for premiums and cost sharing through the low income subsidy program;

- DSH payments would be eliminated (replaced by a $50 million per year transition fund for 'safety net' hospitals, as compared with current DSH spending of over $15 billion);

- A new federally funded program for wrap-around services for all persons below 100% of poverty (including Medicare eligibles) would be established. The Health Care Standards Commission would be empowered to establish the exact scope of services (the bill specifies prescription drugs, eyeglasses and hearing aids, and other services commonly provided under Medicaid currently but not included in the basic benefits package or in long term care), and methods of administering this program;

- A new federally funded program for Medicare eligibles below 120% of poverty for payment of part B premiums, and a new

federally funded entitlement program for Medicare eligibles below 100% of poverty for payment of Medicare deductibles and coinsurance;

- States would be financially responsible for providing all long term care services (both institutional and home and community based).

3. Differences from the Health Security Act

- In the HSA, federal and state governments make payments for the AFDC and SSI recipients at FY 93 levels, trended forward (in effect, experience-rated premiums). These persons are not included in the community rated pool.

  In Cooper, the high costs of the SSI population are transferred to relative small alliances, while in the HSA this liability is retained by the government and not transferred to employers and employees.

- In the HSA, DSH payments are replaced by an $800 million 'Vulnerable Population Adjustment' fund, much larger than the $50 million fund in Cooper. In the HSA, DSH funds are eliminated only as universal coverage is achieved. In Cooper, DSH funds are eliminated without achieving universal coverage.

- In the HSA, a federally funded program for supplemental (wraparound) services is established for children, and expenditures for this program are capped; Cooper establishes this program for all persons below 100% of poverty (including Medicare eligibles), and does not cap expenditures.

- In the HSA, financial responsibility for Medicare premiums and cost sharing for low income elderly remains, as in current law, as a shared federal/state responsibility. In Cooper, this responsibility is entirely federal.

- In the HSA federal/state sharing of institutional long term care is maintained, and a new home and community based program (outside of Medicaid) is established. In Cooper, all financial responsibility for long term care is transferred to the states.

4. Policy Effects

- **Including the Medicaid population in HPPCs at a community rate will increase the premiums for small employers and their employees by as much as 45%.** If the funds available for subsidy do not meet the total need for subsidies (as seems likely), then a further increase in the community rate

will result.

- Cooper could avoid this increase in the community rate only by leaving Medicaid recipients out of the alliance. However, if he does this, less money will be available to fund the low income subsidy program, and other taxes would need to be raised in order to claim That affordable access to insurance (even at the levels specified in the Cooper bill) was being offered.

A substantial part of the financing mechanism in the Cooper bill comes from transferring the currently 'experience rated' payments for the SSI and medically needy disabled populations into a 'community rated' payment in HPPCs. This transfer, however, substantially increases costs for the employers and employees in HPPCs.

- Health care for the poor is likely to remain segregated and second class. Many providers and health plans will have even stronger incentives than they do today to avoid serving those who are currently receiving Medicaid.

- Eliminating DSH without achieving universal coverage will create hardships for both providers and patients, especially if increased competitive pressure decreases the ability of providers to 'cost shift' to the insured.

- New federally funded programs for supplemental services will be expensive drains on federal funds, and it is difficult to see how the Health Care Standards Commission can provide for effective management of these programs.

TOPIC: LONG-TERM CARE

Long-Term Care Tax Provisions

The Cooper bill contains no tax provisions for long-term care. It simply provides the sense of the Congress that tax preferences and direct federal subsidies for long-term care should be provided to the extent that additional financing is "made available" on a pay-as-you-go basis. It is not clear what or who would make available additional financing and when.

Topic: FEDERAL SUBSIDIES

1. Current Law

The closest analogue to federal subsidies in the current health care system is payments through the Medicaid program. In FY 1993, the federal government paid an estimated $72.8 billion for Medicaid benefits. $20.2 billion went to Medicaid benefits for those receiving cash assistance (AFDC, SSI), and $12.1 billion for Medicaid benefits to those who were otherwise categorically eligible for Medicaid. An additional $9.3 billion in federal monies went for disproportionate share payments to hospitals The remaining $31.2 billion went for long term care and benefits to those dually eligible for Medicare and Medicaid.

2. Federal Subsidies Under Cooper

There are two components of premium assistance on behalf of the low income populations. The first is an adjustment to the premium price associated with low income persons/families. This is a maximum premium that an insurance plan can charge with respect to a low income person/family. The second is a payment by the federal government to the plan enrolling the low income person/family.

The federal payment plus payments made by the enrolling individual/family and/or employer do not add up to the premium price faced by the non-low income enrollees. The difference is left as a responsibility to the plan. This amount would presumably be recouped through cost shifting to the small employers making payments into the alliance on behalf of their workers and to the non-low income individuals/families enrolling in the alliances. Separate premium adjustments are made for those under 100% of poverty and for those between 100 and 200% of poverty. Those over 200% of poverty are responsible for the full premium, which presumably, includes the cost shift.

In addition, a fixed amount of federal out-of-pocket subsidy dollars will be provided. These dollars will be paid out to plans on an average basis (i.e., on behalf of each low income unit, a plan will received a fixed amount of federal out-of-pocket dollars, adjusted for the family type).

Federal assistance is also provided for low-income Medicare beneficiaries: Those below 120% of poverty receive full subsidization for Part A and Part B premiums and those under 100% of poverty are not required to pay their co-insurance and deductibles.

The total dollar amount available for federal subsidies is equal to federal Medicaid dollars that would have been payable to states for the year, plus the net change in revenues resulting from provisions in the bill, particularly the tax cap provisions. This total applies to the financing of all of the following provisions in the bill: long-term care phase-down assistance to states; Medicare low-income assistance; cost-sharing assistance; low-income assistance; and grants and other expenditures. Estimation errors on the total federal dollars available are corrected in full in the next year.

3. Differences from the HSA

- Under the HSA, total subsidy dollars available to employers and low income households are fixed in the legislation. Under the Cooper plan, the subsidy dollars available for premium payments to low income persons are contingent upon how other provisions in the bill play out in reality. If, for example, the net effect of the tax provisions is to lower tax revenue to the federal government, then there will be less federal funds available to cover low income subsidies.

- Subsidies in the Cooper plan are based upon the lowest cost plan. The HSA subsidies are based upon the average cost plan in an alliance.

- Under the HSA, the premium faced by a family/individual is not a function of income, as it is under the Cooper plan. Under the HSA, however, the total payments required, by or on behalf of, an individual/family does vary by the number of workers in the family.

4. Policy Effects

- The Cooper bill explicitly forces a cost-shift of potentially substantial proportions from the low income enrollees in the alliances (those under 200% of poverty) to the non low income individuals and their small employers who purchase insurance through the alliances. The greater the enrollment of the low income population, the greater the burden upon the non low income populations/small employers enrolled in the alliances.

- The premiums in the Cooper alliances are seemingly indeterminate. This is because the following are all functions of one another:
  - actual alliance enrollment of individuals and families by income group;
  - the premiums charged (by income group);
  - the extent to which federal subsidies are "funded" (the national subsidy percentage).

- Due to the cost-shifting inherent in the Cooper alliances, small employers (< 100 workers) who currently provide coverage for their workers might find it preferable to drop coverage of their employees or to forgo the tax preference that comes with the alliance plans and purchase insurance for their workers outside the alliances. Individual purchasers could be priced out of the insurance market completely.

- The smaller the alliances become as a result of the incentives for purchasers to opt out of them, the greater the cost shifting burden becomes for those who remain. Depending upon the severity of the migration of private payers out of the alliances, it may become difficult to convince insurers to provide coverage through the alliances at all.

- Premium payment requirements by those under 100% of poverty who do not have access to the lowest cost plan and to all those between 100 and 200% of poverty may mean that a substantial number of Medicaid recipients and other low income persons will opt out of obtaining coverage. The number of uninsured could <u>rise</u> as a result.

Background

A detailed exposition of the premium adjustments and the federal subsidy payments on behalf of individuals/families is available in a separate document. A quantification of the cost-shifting discussed above is presented below.

For each individual/family under 100% of poverty, the following is the difference between the premium of the plan chosen by the family (P_{choice}) and the sum of payments made by the federal government, the household, and the employer (if any) is:

$$(P_{choice}*90\%)-P_{low}*\left[\left(\frac{\text{Federal Medicaid \$+Tax Cap Rev.+Other Net Savin[g]}}{\text{Fed. Cost if Subsidies Fully Funded}}\right.\right.$$

P_{low} is equal to the premium of the lowest cost plan in the alliance.

For each individual/family between 100% and 110% of poverty, the cost shift is:

$$90\%*\left(P_{choice}-P_{low}*\left(\frac{\text{Federal Medicaid \$+Tax Cap Rev.+Other Net Savings}}{\text{Federal Cost if Subsidies were fully financed}}\right)\right.$$

For each individual/family between 110% of poverty and 200% of poverty, the cost shift is:

$$\left(100\% - \left(\frac{family\ income}{relative\ to\ poverty} - 100\%\right)\right) *$$

$$\left(P_{choice} - P_{low} * \left(\frac{Federal\ Medicaid\ \$ + Tax\ Cap\ Rev. + Other\ Net\ Savings}{Federal\ Cost\ if\ Subsidies\ were\ fully\ financed}\right)\right)$$

TOPIC: ALLIANCES/INSURANCE REFORM

1. Current Law

Alliances There is not currently any statutory basis for health alliances or purchasing cooperatives. ERISA (the Employee Retirement Income Security Act) permits employers to self-insure outside of state regulation of insurance, which in effect prevents states from establishing mandatory purchasing alliances. A number of voluntary, state-sponsored purchasing cooperatives have formed (e.g. California and Florida). There are a variety of private group purchasing arrangements, some of which operate in a manner similar to health alliances.

Insurance Reform Insurance practices are primarily regulated by the states and state laws related to availability of coverage and insurance rating practices vary significantly. In general, insurers are permitted to restrict access to health insurance offered to people with poor health status. Insurers also are permitted to adjust premiums based on health status and claims experience of covered people. In the past few years, many States have adopted laws that assure availability of coverage offered to small employers (under 25 or 50 employees) and to restrict premium variation related to health status or claims experience.

Group health insurance arrangements are also subject to fiduciary and other standards in ERISA. ERISA preemption of state laws prevents states from regulating self-funded employer plans.

2. Description of Bill's Provisions on Health Alliances and Insurance Reform

The Cooper bill establishes Health Plan Purchasing Cooperatives (HPPCs), which have the following characteristics:

- In general, states would be expected to establish HPPCs as non-profit organizations with elected boards. Each region would have only one HPPC. A HPPC area could not subdivide a metropolitan statistical area, but could cross state boundaries by agreement of the adjoining states

- All employers with 100 or fewer employees would be required to offer coverage to employees through the HPPC (but would not be required to contribute towards the coverage). Former Medicaid recipients, the unemployed, and the self-employed who choose to purchase coverage would be required to do so through the HPPC.

A state could raise the 100 employee threshold, but only to the point where no more than 50% of the employees in the state were required to participate in the HPPC.

- Employers with more than 100 employees would **not** have the option of joining the HPPC. They would be required to offer coverage to employees (but not required to pay for it).

- HPPCs contract with "accountable health plans" to offer a choice of plans to HPPC participants (but there is no requirement that a choice of plans, in fact, be available). HPPCs collect premiums from employers and families and, in turn, pay health plans.

  HPPCs may **not** set or enforce payment rates for providers or premium rates for health plans. Nor may a HPPC, in general, exclude a health plan certified by the National Health Board from participating in the HPPC.

- HPPCs are required to use risk adjustment to compensate plans that have riskier than average populations.

Requirements for Accountable Health Plans under the Cooper bill

- All health plans are certified by the National Health Board.

- Within a HPPC, health plans would not be permitted to vary premiums charged to families by health status. Health plans could, however, vary premiums by age (the premium for an older individual could be up to twice the premium for a younger person).

  The bill limits preexisting condition exclusion periods applied by AHPs to no more than six months. The exclusion period must be reduced or waived for enrollees who are continuously insured.

- A health plan would be required to guarantee access to coverage for anyone participating in a HPPC.

- Providers that participate in health plan networks cannot balance-bill patients. However, for providers outside of networks -- in a PPO, point of service plan, or fee for service plan -- there are no limits on balance billing.

- For insured health plans (as distinct from self-insured plans offered by large employers), states would continue to regulate financial solvency. However, in certifying insured health plans, the National Health Board is required to ensure that the state in which the health plan is operating has adequate solvency protection.

For self-insured employer health plans, the Board may require that the plan post a bond (or other assurance) to protect enrollees from insolvency.

The Cooper bill includes no major insurance reform provisions for employers with more than 100 employees:

- Health plans would be permitted to charge experience-rated premiums to employers with more than 100 employees, and could therefore raise premiums without limit when an employee gets sick.
- Large employers would not be permitted to participate in HPPCs for employers with 100 or fewer employees.
- Large employers would be required to offer their employees the opportunity to enroll in a health plan, but not necessarily to contribute towards the coverage.
- Large employers would be permitted to operate self-insured plans, but no federal guaranty fund would be established.
- Large employers may offer "closed" AHPs, where enrollment is limited to the firms's employees and their families. The insurance reforms relating to availability and rating generally apply to those covered within the closed AHP, but not across employers. Existing Taft-Hartley plans can also form closed AHPs.

3. **Differences from the Health Security Act**

Primary differences from the Health Security Act are:

- The employer size threshold for required participation in a HPPC/alliance is lower under Cooper (100) than under the HSA (5,000).
- Alliances under the HSA are required to negotiate a provider fee schedule for use by fee-for-service plans, and are permitted to exclude a health plan whose premium is more than 120% of the alliance's premium target. HPPCs under the Cooper plan do not have either of these authorities.
- Alliances under the HSA are required to offer at least one fee-for-service plan. HPPCs under the Cooper plan are not.
- The HSA prohibits balance-billing by health care providers. The Cooper bill only prohibits balance-billing by network providers, but not by out of network providers in PPOs or fee-for-service plans.
- Alliances under the HSA are subject to conflict of interest,

fiduciary, and cash management standards. The HSA also requires independent and federal audits of alliances. The Cooper bill contains no provisions relating to fiduciary or cash management standards for HPPCs.

- Health plans under the HSA must charge the same premium to all persons in an alliance, while accountable health plans under the Cooper bill may vary premiums by the age of the participant. For employers with more than 100 employees, there are no restrictions on how premiums may vary.

- States have substantially more flexibility in determining the governance structure of alliances under the HSA than under the Cooper plan. Alliance areas may cross state boundaries under the Cooper plan, but not under the HSA.

- The HSA requires self-funded health plans to establish reserves to cover their current liabilities. The Cooper bill does not have an explicit standard.

- The HSA establishes standards for state guaranty funds for health plan insolvencies. The HSA also establishes a national guaranty fund to protect health care providers if self-funded health plans fail (e.g., large employers become bankrupt). The Cooper bill has no corresponding provisions.

- The HSA eliminates preexisting condition exclusions; the Cooper bill limits them but does not prohibit them (in part because coverage is voluntary).

- Large employers under the HSA are required to offer employees a choice of at least three plans. Employers with more than 100 employees under the Cooper plan are required to make available only one plan.

4. Policy Effects

- Because the Cooper bill creates purchasing cooperatives only for employers with 100 or fewer employees, the benefits of insurance reforms would be limited to employees of small businesses, the self-employed, and the unemployed. If an employer has 101 employees and one of them gets sick, there is no limit on how much an insurance company can raise the company's premium.

- Alliances and purchasing cooperatives permit families, rather than employers, to choose their health plan. Under the Cooper bill, no one working for an employer with more than 100 employees is guaranteed choice. An employer could offer only an HMO to its employees, with no opportunity to see a doctor outside of the HMO.

- Less choice also means less continuity of coverage. Under the Cooper bill, changing jobs would likely mean having to change health plans (and possibly doctors) as well. This is particularly true since the Cooper bill provides no guarantee that a fee-for-service plan is available to people working for small or large employers.

- Without protection from balance-billing in non-network health plans, competitive pressures on AHPs and providers may result in a shifting of costs to enrollees. Balance billing also distorts competition since consumers will not know the true out-of-pocket costs associated with each health plan.

- Purchasing cooperatives that require only employers with 100 or fewer employees to participate mean that the cost of serving Medicaid recipients and the unemployed are loaded exclusively on small businesses and their workers.

- Permitting employers with as few as 101 employees to self-insure threatens the health security of their employees (since these firms are not large enough to adequately assume risk). Without a federal guaranty fund for self-insured plans, consumers and providers could at substantial risk.

5. <u>Background</u>

Approximately 215 million people would obtain coverage through regional alliances under the HSA, while about 115 million would be eligible to receive coverage through HPPCs under the Cooper bill. Under the HSA, about one-third of the participants in regional alliances would be under 200% of poverty, while about half of the eligible people in HPPCs would be under 200% of poverty under the Cooper bill.

The ability of the federal government to monitor firms outside of alliances/HPPCs deteriorates significantly as the number of such firms grows. Under the HSA, no more than a couple of thousand of firms would be eligible to form corporate alliances. Under the Cooper bill, 50,000 to 100,000 firms would operate outside of HPPCs.

TOPIC: COST CONTAINMENT

1. Current Law

The market for health plans does not function well:

- Approximately 40% of employees with employer sponsored insurance have no choice of plans;
- Most (80%) of those with a choice do not fully benefit financially from choosing a lower cost plan;
- When choice does exist, consumers do not have information on satisfaction or quality;
- When choice does exist, benefit packages often vary across plans, segmenting the market and making people nervous about changing plans for fear of not being covered by a benefit they need;
- Providers that serve large numbers of uninsured and Medicaid recipients are forced to charge higher prices to their paying patients in order to recover their costs; hence these providers cannot prosper even if they are able to deliver high quality care economically.
- Health plans can prosper by selecting good risks -- they can drop small groups from coverage when one or more members becomes sick; they can refuse to insure the sick, and/or apply pre-existing condition exclusions and waiting periods; they can discourage the sick from enrolling by charging high premiums; they can subtly encourage their sickest members to disenroll; they can refuse to contract with Medicaid and avoid many of the poor.

As a result of these market failures, health plans and providers are not systematically rewarded for efficiency or quality.

In addition to market failure, no regulatory mechanism exists to achieve cost containment in the private sector.

2. Cooper Proposal

The Cooper proposal reorganizes the health insurance market for individual purchasers and for families working for employers with 100 or fewer employees.

- States would create a health plan purchasing cooperative (HPPC) in each geographic area. Employers with 100 or fewer

employees who choose to purchase insurance must buy it through the cooperative if they want to retain the ability to deduct health plan payments as a business expense.

- HPPCs would offer a choice of health plans (called 'Accountable Health Plans' or AHPs in Cooper).
- The health plans would offer a standard benefit package (although the contents are not specified), and cooperatives are required to monitor disenrollment and provide information to consumers on health outcomes and quality.
- A risk adjustment system is required for coverage offered through HPPCs.

Employers with more than 100 employees would be required, as a condition of being able to deduct health plan payments as a business expense, to offer AHPs.

The tax deduction available to all employers for providing health benefits to their employees would be limited to the cost of the low cost plan in each HPPC area.

3. Differences from the Health Security Act

- The Cooper bill requires family choice of health plan only for individual purchasers and those working for employers with 100 or fewer employees. The HSA requires that all families be provided choice of health plan.
- The Cooper bill has a tax cap pegged to the price of the low cost plan in each HPPC area. The HSA does not have a tax cap; after the year 2004, only employer contributions for the comprehensive benefit package will be excludable from wages.
- The Cooper bill prohibits balance billing only for providers in networks. The HSA prohibits balance billing by all providers.
- The Cooper bill does not have a provision for premium caps.

4. Policy Effects

Although Cooper's proposal is touted as 'pro-competitive', it is unlikely to create a market structure that systematically rewards providers for quality and efficiency.

- Employers with more than 100 employees limit the number and type of plans offered to their employees. Reduced family choice will attenuate the rewards to health plans that are able to offer a quality product at a good price.

- Because the community pool is relatively small (only employers with 100 or fewer employees) and includes Medicaid recipients and the unemployed, AHPs contracting with HPPCs will be required to charge much higher community rates than health plans not contracting with HPPCs. AHPs that can avoid contracting with HPPCs can prosper even if they are not efficient.

- Although the bill has language that requires AHPs contracting with HPPCs to share, nationwide, underpayments that result from premium and cost-sharing subsidies provided to low income persons and underpayments that result if total subsidies for low income persons are insufficient, it is very likely that those plans that serve large numbers of poor persons will be at a competitive disadvantage.

  Since lower income people are most likely to choose low cost plans because that is all they can afford, requiring health plans to absorb the underpayments penalizes low-cost plans the most. This penalizes efficiency.

- Without protection from balance-billing in non-network health plans, competitive pressures on AHPs and providers may result in a shifting of costs to enrolless. Balance billing also distorts competition since consumers will not know the true out-of-pocket costs associated with each health plan.

- The insurance market structure proposed by the Copper bill is likely to be completely unstable. Because there are insufficient subsidies for low income people, continual increases in premiums charged to small employers and employees are likely. Some small employers and individuals are likely to stop purchasing coverage, making the pool of insured even smaller. This is not fertile conditions for making a market work.

The Copper bill does not assure universal coverage. Without universal coverage, uncompensated care will continue to be a problems and will continue to distort competition.

Without a cap on private sector premiums, employers, families and taxpayers bear the risks of cost increases.

TOPIC: INFORMATION SYSTEMS

For the most part the bills do not differ substantially with regard to Information systems, Administrative Simplification and Privacy. All three bills envision a national information network with minimum electronic data standards, privacy protection and standardized forms.

Some differences that are notable include:

Confidentiality protection seem to only apply to electronic information.

This would be problematic for patient medical records that will be predominantly paper for the next 5 - 10 years.

There is the possibility for states to maintain their own confidentiality laws if they are consistent with the Federal law.

This could create problems if information for individuals readily crosses state lines and individuals believe they have a set of protection according to their state requirements that is not carried out elsewhere.

Industry is given the task to achieve uniformity for forms, identifiers and coverage information among plans for purposes of coordination of benefits within national goals and time frames. If the deadlines are not met, the Commission issues standards and requirements.

Less definitive than the Administration bill for when standards will be developed.

Both the Cooper and Chaffee bills seem more definitive with respect to information systems standards for address coordination of benefits.

TOPIC: OTHER GOVERNMENT PROGRAMS

FEHB

Overview

- General Objective -- to reform the health care market to provide universal access to high quality, cost-effective care through competitive health plans.
- Cost Containment Objective -- to bring the rate of increase in health care costs by the year 2000 down to the rate of increase in costs in the economy as a whole.

1. Specific Measures

- Employer tax deduction limited to premium for the lowest price plan in an area
- Promote competition based on cost-effective care through standardized benefits, prohibition of experience rating, and premium adjustments based on the risk characteristics of individuals in the plan
- Access to coverage regardless of employment status
- Promotion of competition through reporting and public dissemination of information on the performance of plans
- Financial assistance for premiums and cost-sharing requirements for low-income individuals

2. Health Plan Purchasing Cooperatives

- Each State shall establish a not-for-profit Health Plan Purchasing Cooperative in each HPPC area.
- Each State is, at a minimum, a HPPC area.
- Each State may subdivide the State into more than one HPPC area so long as certain criteria are met.
- Contiguous states may establish a HPPC including portions of each so long as each metropolitan statistical area remains intact.
- Each HPPC will be governed by a Cooperative Board which is responsible for insuring its performance. The members of the Board will initially be appointed and subsequently

elected.

- The HPPC's are responsible for:

entering into agreements with Accountable Health Plans;
entering into agreements with small employers;
offering enrollment and enrolling individuals in AHP's;
charging, receiving, and forwarding premiums;
coordinating with other HPPC's;
establishing the complaint process and an ombudsman;
conducting and analyzing satisfaction surveys;
and monitoring disenrollment.

3. **Accountable Health Plans**

- The Health Care Standards Commission will register each Accountable Health Plan (AHP).

- The AHP must meet the following qualification in order to be eligible to be registered:

provide uniform set of benefits, cost-sharing adjustments for low income individuals, and meet quality standards;
provide required data to the Health Care Standards Commission and the HPPC's;
prohibit discrimination in enrollment or benefits;
have standard premiums;
be financially solvent;
meet requirements for grievance procedures, physician incentive plans, advance directives, and agent commissions;
open plans must meet additional requirements re-- offering of plans, acceptance of enrollees, and participation under Medicare and the Federal Employees Health Benefits (FEHB) Program;
coordinate benefits with low income assistance;
provide for Medicare adjustment payments;
pay certain premiums to the National Medical Education fund
pay registration fees.

- AHP's will be either Closed plans or Open plans. A Closed plan is one which is limited by structure or law to one or more large employers. An Open plan is one which in not so limited.

3. **Employer Groups**

- Employers will be considered either small employers or large employers.

- The employer obligations differ according to whether the employer is "small" or "large".

- A small employer is defined on one that normally employs fewer than 101 employees.

- A small employer is obligated to have an agreement with a HPPC to offer its employees coverage through an AHP.

- A large employer is obligated to:

  offer enrollment to each employee (and the eligible dependents);
  deduct the premiums from the employee's wages;
  have initial, annual, and special open enrollment periods.

4. **FEHB: Overview**

Open Accountable Health Plans (AHP's) must meet additional requirements relating to participation under the Federal Employees Health Benefits (FEHB) Program. An Open plan is one that is not limited by structure or law to one or more employers.

Each AHP, in order to be a registered open health plan, must enter into an agreement with the Office of Personnel Management (OPM) to offer the health plan to Federal employees, and annuitants, and family members, under the FEHB Program under chapter 89 of title 5, United States Code, under the same terms and conditions (except premiums) offered by the AHP for enrollment of eligible individuals through HPPC.

Effective January 1, 1995, the FEHB Program cannot enroll employees under any health benefits plans that are not AHP's.

The Federal Government's premium contribution will be the same for any premium class for all AHP's in a HPPC area, will not be more than the base individual premium, and will be equal in the aggregate to what would have been paid by the Government had this Managed Competition Act not been passed.

Certain agencies whose receipts and disbursements are off-budget shall be required to prepay the Government contributions which are or will be required to provide health benefits coverage for annuitants in conformance with the provisions of standard 106 of the Financial Accounting Standards Board.

Effects of the Managed Competition Act on the FEHB Program

- OPM would have to execute an agreement with every AHP in order for it to meet the qualifying criteria to be registered by the Health Care Standards Commission.

- Every health plan currently offered under the FEHB Program would have to become registered as an AHP in order to

continue in the Program. This would be more challenging for the Employee Organization Plans than the Service Benefit Plan or the Comprehensive Medical Plans.

- The Federal Government would have to calculate the average government contribution at the time of the effective date of the Managed Competition Plan in order to determine the aggregate amount of Government contributions that would have been made but for the requirement of this Managed Competition Plan. The Government contribution would then continue at a rate equal to this calculation.

- Certain agencies, whose receipts and disbursements are off budget, e.g., the Postal Service, would be required to prefund the Government contributions for health benefits for annuitants. The prefunding liability calculations would need to conform to the provisions of standard 106 of the Financial Accounting Standards Board. The liability would be calculated as if this requirement had taken effect 20 years prior to the effective date of this requirement. The agencies would then be responsible for the payment of the "old" liability as well as current liability. "Old" liability would be payable in equal installments over a 20 year period beginning on the effective date of the Managed Competition Plan.

  Currently the Federal Government spreads the cost of all annuitants over all participants (employees and annuitants) on a "pay-as-you-go" basis. If one group of the "pool" starts to prefund future liabilities, there would have to be two separate premium structures.

- Currently the FEHB Program does not allow any exclusions for pre-existing conditions. The Managed Competition Plan would allow an AHP to exclude coverage for a pre-existing condition for a period not to exceed six months. This exclusion would be modified by credit for previous coverage and by a transitional amnesty period.

CHAFEE ANALYSIS

TOPIC: TAX CAP

1. Current Law

The tax code provides preferential treatment for employer contributions for health insurance benefits. First, the gross income of an employee does not include employer-provided coverage under an accident or health plan. Employees can also exclude employer contributions to cafeteria plans for health insurance from gross income. Employer contributions for health insurance are also excluded from social security earnings. Second, business expenses are deducted from employers' gross income. Wages, salaries, and fringe benefits (including health insurance) are allowable business expenses.

In combination, these provisions mean that employees can receive tax-free income from their employers in the form of health insurance benefits. In contrast, most other forms of compensation (both cash and fringe benefits) are subject to income and employment taxes.

Self-employed individuals can deduct from income 25 percent of the amounts paid for health insurance for the taxpayer and the taxpayer's spouse and dependents. The deduction is limited to earnings from self-employment, and no deduction is allowed if the taxpayer has other employer-provided accident or health coverage.

Taxpayers whose medical care expenses exceed 7.5 percent of their adjusted gross incomes (AGI) can deduct the excess from taxable income (this is known as a below the line deduction).

2. Description of Chafee's Proposal

Under Senator Chafee's plan, an employer would not be able to deduct health plan expenses for an employee which exceed certain limits. The applicable dollar limit is equal to the average premium cost of the lowest price half of qualified health plans offered in the health care coverage area (HCCA) in which the employee is enrolled. In addition, health insurance must be attributable to coverage under a qualified plan. The limitation on deductions would also apply to employer contributions for health insurance which were made through cafeteria plans.
In addition, employees would not be able to exclude excess health insurance benefits paid by employers from gross income.
Taxpayers would be able to deduct premiums paid for coverage under a qualified plan "above the line" to the extent the premiums do not exceed the applicable dollar limit -- without regard to the 7.5 percent-of-AGI floor on medical expenses deduction. The amount of the allowable deduction would be reduced by payments, if any, made by employers or a government entity for coverage of the individual under any health plan. However, taxpayers could no longer claim expenditures on

supplemental health insurance policies which provide benefits beyond the qualified plan as an itemized deduction.

The effect of the Chafee tax cap is to subject a portion of employees' compensation -- the employer contributions for health insurance -- to very high effective tax rates. An individual in the 15 percent tax bracket could be subject to a 65 percent tax on income received in the form of health insurance benefits (roughly 30 percent from the combination of individual income and payroll taxes plus 35 percent paid, on their behalf, by their corporate employer).

The deduction for health insurance expenditures by self-employed persons would be increased from 25 percent to 100 percent. However, qualifying expenditures would be limited to the applicable dollar limit.

These provisions are generally effective for expenses incurred during the year following the year in which states implement health reform plans.

3. **Differences from the Health Security Act**

- The Health Security Act limits the employee exclusion for health insurance contributions but does not restrict employer deductions. Chafee's plan subjects both employers and employees to higher taxes.

- The Health Security Act allows employees to exclude the full amount of employer contributions for the comprehensive benefit plan from gross income. Under Chafee's plan, employers would only be able to deduct the average cost of the lowest priced half of plans providing the standard benefits.

- The Health Security Act gives employees and their employers ten years to adjust compensation packages in view of the tax cap. The Chafee tax cap takes effect immediately.

- The Health Security Act prohibits employers from making contributions on behalf of their employers for health insurance benefits through cafeteria plans. Chafee's bill allows employers to make such contributions, but denies them a deduction for contributions in excess of the applicable limit.

4. **Effects of the Proposal**

- Double Hit on Taxpayers -- Chafee restricts both the employer's ability to deduct health insurance expenses and the employee's ability to exclude employer contributions from taxable income. Effectively, the same income will be

taxed twice. Many taxpayers could be paying nearly 70 percent more for health insurance benefits which supplement the standard benefit package. Such punitive tax rates would likely disrupt the health insurance market.

- Some Employers Will Be Exempt from Chafee -- Employers who do not have tax liabilities are exempt from the Chafee tax cap because they have no deductions to lose. Non-profit organizations and government employers will have an advantage over private employers in competing for workers. (Even under the Chafee plan, their workers would no longer be able to exclude employer-provided health insurance benefits from taxable income.)

- Workers Bear the Full Cost of Chafee's Tax Cap -- Employers will pass on the costs of the Chafee tax cap to their employees. Many employers will be forced to scale back health insurance benefits for their workers. To the extent they substitute cash wages for health insurance benefits, workers will pay tax on the additional wages. Other workers may be able to retain their current health insurance benefits, but their wages or other benefits will be reduced to pay for the loss of the corporate deduction.

- Key Details Are Missing -- Chafee's plan is short on details. Chafee has not identified which benefits must be offered by accountable health plans. Under Chafee's plan, the Benefits Commission selects the standard benefit package after the enactment of the bill. This is a critical omission. Because the effects of a tax cap depend on the scope of benefits included in the standard package, Congress is being asked to OK a tax increase without knowing its effects on taxpayers.

  -- If the Benefits Commission includes only a limited number of benefits in the standard benefit package, millions of taxpayers could be hit by a substantial tax increase.

- Cost Containment and Bureaucracy -- The Administration's plan has been criticized for being overly bureaucratic. Chafee's bill may look less bureaucratic because a National Board is not required to determine and enforce premium caps for each Health Alliance. But Chafee relies on a complicated tax cap in order to contain costs.

- Chafee Bill Increases Burden for Both Employers and IRS -- Under the Chafee plan, the tax cap applicable to each worker's health insurance costs would vary depending on the worker's residence, age, and family status. If each state had only two health alliances and the cost of the standard

benefit plan was allowed to vary for five distinct age groups, the IRS would be required to enforce as many as 1,000 distinct tax caps. Businesses and individuals would find it difficult to comply with such a confusing array of tax caps. With existing resources, the IRS would find it difficult to monitor compliance.

- Cost Containment or Rationing -- Applying the tax cap to the lowest-price plans in a region will penalize many consumers. Consumers will suffer if the lowest-cost plans are inexpensive simply because they skimp on some service many consumers value (such as short waits in the reception area or doctors who spend a little extra time with their patients).

- Federal Government Gets Preferential Treatment -- The President said in his State of the Union Address that the American people deserve the same health care protection that Congress and other Federal government workers currently have. That is why the Health Security Act would put everyone into the same health care system. The Chafee bill, on the other hand, says that employers that want to provide more benefits to their employees must pay the Federal government as much as 35 percent more for the privilege. Interestingly enough, this rule would not apply to the Federal government. Because the Federal government does not pay income tax, it would be exempt from the Chafee tax cap.

- Self-Employed Individuals Fare Better Under the Administration's Plan -- The Administration and the Chafee bills look like they provide the same tax breaks for self-employed persons. Both the Administration's plan and Chafee's bill increase the health insurance deduction for self-employed workers from 25 percent to 100 percent. But under the Chafee plan, self-employed workers will only be able to deduct expenditures toward the lowest price plans. Under the Administration's plan, self-employed persons can deduct the full costs of the comprehensive benefit package.

- Deductibility Proposal Creates Winners and Losers -- Under the Chafee bill, some taxpayers may receive a tax break because they will be able to deduct expenses on qualified health insurance plans up to the applicable limit. Under current law, these taxpayers may not have sufficient medical expenses to meet the required 7.5 percent-of-AGI floor. However, other taxpayers will no longer be able to deduct expenses on supplemental health insurance policies.

5. **Background**

The Chafee bill contains an extremely aggressive tax cap. Under Chafee, both the employers' deduction and employees' exclusion of "excess" health insurance benefits would be subject to tax. This is equivalent to taxing the same income twice and would likely severely disrupt the market for health insurance.

TOPIC: MEDICAL SAVINGS ACCOUNTS

1. **Current Law**

Tax-preferred Medical Savings Accounts (MSAs) do not exist under current law. Current law does allow for limited tax-preferred saving in Individual Retirement Accounts (IRAs) subject to income based limitations.

2. **Description of Proposal**

Under the proposal, tax-preferred MSAs could be established. Individuals would be allowed to accumulate the difference between the cost of a low-cost standard benefit plan and a catastrophic plan in an account (called an MSA). The low-cost standard benefit plan would be the average of the lowest priced half of standard benefit plans.

Employer contributions to an employee's MSA would be deducted as business expenses, but not included as income for the employee for income tax and employment tax purposes. Individuals could also make deductible contributions to the MSA to the extent that employer and individual contributions for health insurance and to the MSA do not exceed the cost of a low-cost standard benefit plan. Accruing income on the MSA would not be taxed.

Funds in the account could be used for medical expenses, including co-payments and deductibles, long-term care, catastrophic insurance and long-term care insurance. For individuals 65 years of age or older, funds could also be used for a medicare supplemental policy or for payment of premiums under part A or part B of Medicare. To qualify as a long-term care expense, an individual must be unable to perform at least 3 activities of daily living including bathing, dressing, eating, toileting, transferring and walking without substantial assistance.

Cash withdrawals would be permitted. Cash withdrawals not used for medical expenses would be included in income for income tax purposes but not for employment tax purposes. In addition, there would be a penalty equal to 10 percent of nonmedical withdrawals. Furthermore, if nonmedical withdrawals cause the account balance to fall below the deductible amount under the catastrophic health plan covering the individual, the penalty would increase to 50 percent of the nonmedical withdrawal. Individuals that incur expenses which are countable towards co-payments or deductibles under their catastrophic health plan or Medicare plan but that do not use available funds from their MSA would pay a penalty. The penalty would be equal to the amount of the expense not reimbursed by the MSA.

MSAs could be established during the tax year following the end of the year in which states were required to implement health reform under the bill.

3. Differences from the Health Security Act

The Chafee proposal would allow the creation of MSAs, whereas the Health Security Act would not.

4. Policy Effects

- Eliminates community rating. The Chafee plan allows individuals to choose between a standard benefit package and a catastrophic benefit package. The MSA feature enables individuals to make that choice. In combination, these provisions encourage healthy individuals to select out of the standard benefit package. This feature goes against the principle of community rating.

- Enables tax-advantaged saving. The proposal allows for tax-free build-up of funds in the MSA which could later be withdrawn for nonmedical purposes. Although there is a penalty for nonmedical withdrawals, the penalty may be less than the tax advantage, depending on the length of deposit and earnings on the accounts. The purpose of health reform is to provide universal coverage and not to provide a mechanism for tax-advantaged saving.

- Combines tax-advantaged saving with generous tax treatment for long-term-care. The proposal allows for extremely generous tax treatment for long-term care in combination with a cash withdrawal option. Under frequent circumstances, these accounts could provide individuals with a tax-preferred way of saving for the uncertainties of the future.

- Less healthy individuals would not be given the same advantages. Because less healthy individuals would either buy the more expensive standard benefit plan or use funds in the account to pay for deductibles and co-payments, they would not enjoy the same generous tax treatment for long-term-care in combination with a cash withdrawal option.

- Erodes the Social Security wage base. Employment taxes would not be paid on contributions to MSAs nor on nonmedical withdrawals from MSAs. As a result, healthy individuals could use MSAs as a way of avoiding Social Security and other employment taxes. (As a consequence, some of these individuals will receive lower Social Security benefits in the future.)

5. Background

The proponents of MSAs argue that the savings from purchasing a catastrophic plan rather than a standard benefit plan could be used to pay for co-payments and deductibles. In making this claim, they compare the price of a catastrophic and a standard plan in the market today. However, the price of these plans reflect different risk populations. Less healthy individuals are more likely to select more generous standard plans. For a given population, the difference in price between a standard plan and a catastrophic plan would not be enough to cover the difference in co-payments and deductibles.

Compared to first-dollar coverage, deductibles and co-payments may discourage individuals from demanding excessive medical services. In some cases, higher co-payments and deductibles may discourage individuals from obtaining preventive care and early care which may reduce total health expenditures. The amount of co-payments and the deductibles in the standard plan should be chosen to take these factors into consideration. Then the chosen level of co-payments and deductibles should be applied to everyone to uphold the principle of community rating.

The proposal has several features that somewhat limit the ability of individuals to use MSAs as a tax-preferred form of savings. First, contributions to MSAs are limited. In addition, a tax penalty applies to withdrawals not used for medical purposes. The penalty is increased if a nonmedical withdrawal causes the account to fall below the deductible amount. Even so, individuals who make nonmedical withdrawals may still have insufficient funds to pay for co-payments or to pay for a second year's worth of deductibles. The penalty on not withdrawing funds to pay for co-payments or deductibles also limits the ability of individuals to use MSAs as a tax-preferred form of saving.

Because both the standard benefit plan and the catastrophic benefit plan are unspecified, the amount of the tax-advantaged saving cannot be determined. However, a larger difference in deductibles between the plans causes both a larger incentive for individuals to demand fewer medical services and a greater ability for healthy individuals to gain from tax-advantaged saving. For example, if a catastrophic plan costs $1000 less than a low-cost standard benefit family plan, a family with an average of $200 per year in health expenses could save $16,000 plus interest over a 20 year period. Less healthy individuals would not be able to receive the same tax benefits for saving.

TOPIC: COVERAGE

1. Current Law

- 38.5 million Americans, 17.4% of the population, were uninsured in 1992.
- 84% of the uninsured live in families headed by workers; 25% of the uninsured are children.
- Covered services and cost-sharing requirements for those who are insured vary considerably.

2. Description of Chafee bill's provisions

- By 2005, individuals must have health insurance coverage. There is no mandated employer contribution.
- Firms with fewer than 100 employees who choose to offer insurance must do so through the Health Care Coverage Areas (HCCAs).
- Health plans that offer to groups through the HCCAs must offer either a catastrophic plan or a standard benefit package.
- Health plans that offer to groups outside the HCCAs must offer both a catastrophic and a standard benefit package. Thus, all Americans will eventually have access to both a standard benefit package and a catastrophic plan.
- Individuals who work in firms that offer through the HCCA, those who work in firms that do not offer at all, and those who do not work may all purchase coverage through the HCCA.
- States have the option to fold in Medicaid slowly, at capitated rates.
- Exact benefits covered and cost-sharing requirements are not specified in the Chafee bill, though categories of benefits are listed. The National Benefits Commission will submit a detailed benefits package to Congress.

3. Differences from the Health Security Act

- Employers have no obligations to contribute to their employees' health insurance.
- The firm size cutoff for the key purchasing cooperative unit (alliance in HSA) is much smaller (100 vs. 5000).

- Benefits and cost-sharing options are precisely specified in the HSA. The National Health Board may adjust them over time.

- Under the HSA, Medicare beneficiaries get prescription drug coverage and a Part B premium increase equal to 25% of its cost. The Chafee bill has no Medicare expansions.

- Under the HSA, the new home and community based long term care benefit is available to all severely disabled individuals regardless of age or income. The Chafee bill has no long term care expansion.

4. <u>Policy Effects</u>

- The slow phase-in of universal coverage means that the market analysis is somewhat similar to that of the Cooper bill until 2005.

- The absence of any mandate until 2005 means that universal coverage will not be obtained until then. This has two implications: adverse selection will continue to be a problem; and uncompensated care will not be substantially reduced until 2005.

- Adverse selection will make the standard benefit package cost more, <u>ceteris paribus</u>, as those most likely to buy are those most likely to be sick.

- Adverse selection may be made worse by widespread use of the catastrophic option. Even after 2005, those who expect to be sickest will opt for the standard benefit package with relatively comprehensive out-of-pocket coverage, and those who expect to be need minimal health care will buy the catastrophic plan.

- The empirical evidence on responsiveness to price changes in private health insurance suggests that the average price must fall tremendously to substantially reduce the number of uninsured voluntarily. This is extremely unlikely to occur for the standard benefit plan, since its premium price will be driven up. Perhaps the catastrophic option will become inexpensive enough eventually, but experience with catastrophic plans in the marketplace today do not bode well for serious voluntary reduction in the number of uninsured.

- Continued large numbers of uninsured means virtually unchanged amounts of uncompensated care. This will preserve the cost-shift to private payers that exists today, at least until 2005.

- Reliance on the individual mandate instead of the employer

mandate will sever the employers' interest in controlling health care costs.

- In the long run with an individual mandate and widespread catastrophic coverage, there will be a greater tendency toward a two-tier system of health care, with the comprehensively insured getting preventive and early care and the catastrophically insured getting essentially the care the uninsured get today -- too much too late. Providers will get paid for delivering this care, but it is not cost-effective.

5. **Background**

- The most definitive studies of health insurance purchasing behavior suggest that average premium reductions on the order of 30% would be necessary to engender universal coverage voluntarily. This seems highly unlikely under any scenario. Thus, Chafee will not achieve anything like universal coverage until 2005.

The remainder of this section provides some notes on individual vs. employer mandates.

- Global judgments are not possible without considering the tax and subsidy rules that accompany each specific type of mandate.

- In principle, and in conjunction with appropriate tax and subsidy policies, it is possible to make either type of mandate as progressive as one likes, though the total cost of doing so may differ.

- The fundamental tradeoff is between more carefully targeted subsidies to low income households with an individual mandate vs. the implicit redistribution within and across firms through an employer mandate.

- Since employer payments for health insurance ultimately come mostly out of wages, at least in total, and since total labor supply is not very responsive to compensation, the aggregate employment effect of either type of mandate is likely to be small. Secondary workers, part time workers, and minimum wage workers are likely to see the greatest employment effects from an employer mandate.

- Pro employer mandate:

  -- Builds upon the current shared responsibility system of financing, and it preserves employers and employees' joint interest in cost containment and quality care.

-- May provide some hidden redistribution to low wage workers in high wage firms. Certainly provides redistribution from two-earner families to one-earner families and nonworkers.

- Pro individual mandate:

-- Easier to target subsidies to low income families.

-- Makes all redistribution explicit (this could be a drawback, depending upon policy goals).

- Major questions

-- Enforcement of the individual mandate may be harder than a combined employer-individual mandate. Chafee has a 20% penalty for signing up at the point of service. This may be insufficient, unless employer collection of employee payments is established as the norm for
the individual mandate.

-- Reliance on the tax system to reconcile individual-only obligations may be cumbersome for those millions who change tax filing and employment status each year, maybe numerous times.

-- Firms may not "give back" their current health insurance payments in wages immediately, or at all. In these cases, workers will lose with an individual mandate.

TOPIC: MEDICAID

1. Current Law

The Medicaid program currently pays for:

- Services that are included in the comprehensive benefits package proposed in the Health Security Act for those receiving cash assistance (AFDC or SSI) and for a large number of low income people not receiving cash assistance (the 'medically need', pregnant women up to 185% of poverty, and children below 100% of poverty);
- 'Disproportionate share hospitals (DSH)' that serve, in theory, large numbers of low income persons. Many of these payments are used for other purposes by states;
- Institutionally based long term care for the elderly and the disabled, and for home and community based long term care; and
- A variety of supplemental services (e.g., non-emergency transportation, extended physical, occupational and speech therapy, extended inpatient and outpatient mental health services) that are normally not included either in a comprehensive package of acute care services nor in long term care; and
- Services delivered to the elderly and disabled who are covered by both Medicare and Medicaid ('dual eligibles').

In FY 94, projected total Medicaid provider payments are $146 billion, of which $83.5 billion is federal and the remaining $62.5 billion is state money. The FY 93 distribution of expenditures:

Type of Service	Percent of Total Expenditures
Comprehensive Benefits Package Cash Recipients Non-Cash recipients	 25% 15%
DSH Payments	12%
Long Term Care Institutional Home and Community Based	 28% 7%
Supplemental ('wraparound')	4%
Dual Eligibles	8%
Total	100%

2. Chafee Proposal

- At state option, the partial integration of Medicaid recipients into the 'qualified health plans' that serve non-Medicaid recipients. If a state chooses this option, it can, in theory, require a portion of the AFDC and SSI population enroll in 'qualified health plans.' The state pays the health plans no more than the 'applicable dollar limit' for the area -- that is, the average premium for the lowest half of standard packages (this is the amount that can be excluded from taxable income). If a state chooses this option, up to 15% of the AFDC and SSI caseload could be enrolled in 'qualified health plans' during the first three years that a state exercises this option, and an additional 10% per year can be added after that. At the discretion of the Secretary of HHS, these limits on the percentage of the caseload that can be enrolled in 'qualified health plans' can be waived.

- State flexibility in optional eligibility groups is limited. States are required to maintain eligibility for any "class or category" of individuals eligible in FY 1994.

- A cap on the per-capita rate of growth of federal Medicaid payments for acute care services is set at 9.4% per year for 1995 and 1996, 6% per year for the years 1977 through 2000, and 5% per year following the year 2000.

- State flexibility to implement managed care programs for Medicaid recipients is increased. States would no longer need to apply for waivers to restrict freedom of choice.
- Federal payments for DSH would be phased out; payments would be reduced to 80% in FY 1996, 60% in FY 1997, and down to 0 in FY 2000.

3. Differences from the Health Security Act

- Under the HSA, Medicaid recipients would have the same choices of health plans available to others. Under the Chafee bill, partial integration might occur, but the provisions of the bill make it unlikely. The "applicable dollar limit" that is the upper limit for Medicaid payments to plans will be much less than the costs of care for the disabled and medically needy. It is unlikely that many health plans would be willing to accept Medicaid recipients at these payment rates, and there seems to be no provision for sharing the "underpayment" across plans. It seems likely that Medicaid recipients would remain in separate systems of care.
- To the extent that this prediction is wrong and Medicaid recipients are integrated into the mainstream, the community rate paid by employers and employees will be increased, since Medicaid payments would be at the community rate rather than at experience rates as in the HSA.
- In the HSA, DSH payments are eliminated as universal coverage is achieved. In the Chafee bill, DSH is phased out before universal coverage.
- In the HSA, limits on the rate of growth of per capita Medicaid payments are proposed in tandem with limits n the rate of growth of private sector premiums and in tandem with the integration of Medicaid recipients into the mainstream delivery system. In the Chafee bill, limits on federal payments are proposed without any limits on the private sector.
- The Chafee bill proposes to require states to maintain current Medicaid eligibility rules and administrative apparatus for non-cash recipients, while the HSA eliminates non-cash eligibility as a separate category.

4. Policy Effects

- Health Care access and quality for Medicaid recipients will likely deteriorate: Pressure from capping Federal financial participation without matching restraint on private sector cost increases combined with increased state flexibility to

restrict beneficiary freedom of choice raises serious concern.

- Increased shifting to the private sector is expected.
- Eliminating DSH before achieving universal coverage will create hardships for both providers and patients, especially if increased competitive pressure decreases the ability of providers to 'cost shift' to the insured.
- If states exercise the option to enroll some Medicaid recipients into health plans, these plans would be at a competitive disadvantage because the payments made for Medicaid recipients are inadequate.

TOPIC: LONG-TERM CARE

Long-Term Care Tax Provisions

1. Current Law

Deduction for long-term care expenses In determining taxable income for Federal income tax purposes, a taxpayers allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during any taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year. For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

The cost of personal services, including custodial care is a medical expense if there is a direct connection between the service and a recognized, specific medical condition and the services are performed directly for the individual. Old age is not a sufficiently specific medical condition for this purpose. Regulations provide that the entire amount of an expense may be treated as a medical expense if the expense is incurred primarily to provide medical care.

Treatment of long-term care insurance Generally, the treatment under current law of benefits provided under a long-term care insurance policy is unclear. To the extent that long-term care is not treated as medical care, employer-provided long-term care coverage would not be excluded accident or health coverage under Internal Revenue Code section 106, and the value of the coverage would be taxable to the employee. Generally, benefits paid under a long-term care plan or policy would not be treated as amounts received through accident and health insurance on an excluded basis under Internal Revenue Code section 104 or 105, unless the amounts received for long-term care represent reimbursement for medical care.

Accelerated death benefits under life insurance contracts
Payments made under a life insurance contract other than by reason of an insured's death are generally taxable under current

law. However, the tax treatment of payments made with respect to terminally ill insured in anticipation of death is not entirely clear.

The Federal income tax treatment of an insurance contract to the policyholder, beneficiaries, and the issuing company depends upon whether the contract qualifies as a life insurance contract under section 7702 of the Code.

Proposed regulations that would permit tax-free acceleration of death benefits in certain circumstances were issued under the guidance of the prior administration. In addition, accelerated death benefits riders could be added to life insurance contracts without disqualifying the contract as life insurance.

2. Description of the Chafee Bill

Tax treatment of long-term care services The bill would clarify the tax treatment of qualified long-term care services for the functionally impaired. Expenses for services incurred by a taxpayer that requires assistance with at least three out of five activities of daily living (ADLs) would be allowed as an itemized medical expense deduction, to the extent that such expenses and other eligible medical expenses of the taxpayer exceed 7.5 percent of adjusted gross income. For services provided for home care, assistance with only two ADLs would be required. The deductibility of expenses for services that do not satisfy the bill's requirements would continue to be governed by present law.

Tax treatment of qualified long-term care insurance policies The bill would provide that (1) a qualified long-term care insurance policy is to be treated as an accident or health insurance contract, (2) any plan of an employer that provides coverage under a qualified long-term care insurance policy is to be treated as an accident or health plan with respect to such coverage, (3) amounts received under such a contract or plan with respect to qualified long-term care services are to be treated as amounts received for personal injuries or sickness, (4) amounts paid for a qualified long-term care insurance policy are treated as amounts paid for insurance for purposes of the medical expense deduction, and (5) the insurer's reserves for a qualified long-term care insurance policy are to be computed using a one-year preliminary term method.

Thus, amounts received under a qualified long-term care insurance policy would be excluded from the gross income of the recipient. Amounts paid to purchase qualified long-term care insurance would be deductible by individuals and employers. The value of employer-provided coverage would not be included in an employee's income.

Benefits under a qualified long-term care policy could be paid on a "reimbursement" basis for long-term care expenses actually incurred or on a "per diem" basis without regard to the expenses incurred during the period to which the payments relate. For reimbursement policies, an unlimited amount of benefits could be received by the consumer on a tax-free basis. However, under a per diem policy, only benefits up to $100 per day could be received tax-free.

The criteria for when benefits can be paid to a consumer is needed assistance with 3 ADLs (or 2 ADLs for home care).

The bill does not alter the current law treatment, which is somewhat unclear, of long-term care in cafeteria plans. However, the bill permits "medical savings accounts" to be used for the purchase of long-term care services and long-term care insurance.

<u>Accelerated death benefits under life insurance contracts</u>
The bill would provide an exclusion from gross income for certain distributions received by an individual under a life insurance contract if the insured under the contract is terminally ill. For this purpose, an individual would be considered terminally ill if a licensed physician certifies that the individual has an illness or physical condition that reasonably can be expected to result in death within twelve months of the certification.

3. **<u>Differences from Health Security Act</u>**

- <u>Different Consequences For Benefits in Excess of Daily Cap</u> -- The Health Security Act permits generous tax treatment for a policy in which benefits, by the policy's terms, cannot exceed $150 per day. If additional benefits are desired, the policyholder can purchase a supplemental long-term contract. This stratification of policies between a standard and a supplemental policy mirrors the distinction between the comprehensive benefit package and supplemental health insurance in the Health Security Act.

  The Chafee bill permits favorable tax treatment for benefits up to $100 per day. Amounts in excess of $100 per day do not receive favorable tax treatment, unless spent on long-term care services. But the entire policy is not disqualified.

  The approach in the Health Security Act is a "cleaner" way for the IRS and insurers to administer the provision and is far more clear for potential purchasers. Everyone will know that qualified policies receive favorable tax treatment and supplemental policies do not. There will be no need to quantify and report benefits in excess of a certain amount and to monitor the services purchased with the benefits.

- <u>Different Treatment for Per Diem and Reimbursement Policies</u> -- The Chafee bill provides extremely generous tax treatment for the "reimbursement type" of private long-term care insurance - more favorable than any other insurance product. It also creates a competitive marketing disadvantage between certain types of long-term care insurance.

  The Health Security Act would treat equally "per diem" (fixed amount of daily benefit regardless of how benefit is spent) and "reimbursement" (benefit only provided to reimburse long-term care expenses) long-term care policies. The Chafee bill would allow tax-free long-term care benefits of up to $100 per day for both types of policy. Benefits in excess of $100 per day would only be tax free if they are used to reimburse actual long-term care expenses. So under the Chafee bill, a reimbursement policy could provide unlimited tax-free long-term care benefits.

- <u>Medical Savings Accounts Replace Cafeteria Plan Generosity</u> -- Long-term care cannot be provided on a before-tax basis through a cafeteria plan under the Health Security Act. The Chafee bill would not alter the current law treatment in which it is unclear whether long-term care benefits can be provided through a cafeteria plan (it depends on whether long-term care is viewed as deferred compensation with a savings or investment feature). More importantly, the Chafee bill essentially allows cafeteria plan results in a limited way by permitting medical savings accounts to be used for long-term care services and long-term care insurance.

  Without a specific prohibition on the use of cafeteria plans and specific permission to use medical savings accounts, the Chafee bill would produce an open-ended entitlement for private long-term care insurance since there is no explicit cap on tax-free benefits that can be funded on a tax-preferred basis.

- <u>Different Eligibility Triggers</u> -- While the Chafee bill is less fiscally responsible in terms of unlimited tax-free benefits for reimbursement long-term care policies, its criteria for when benefits can be paid to the consumer is more stringent than the Health Security Act. Moreover, the Chafee criteria do not reflect today's market.

  In today's private long-term care insurance market, the standard eligibility trigger to reimburse for long-term care benefits is generally 2 ADLs or severe cognitive impairment. The Health Security Act requires assistance with 2 ADLs or severe cognitive impairment. The Chafee bill requires 3 ADLs (2 ADLs for home care) and fails to mention severe cognitive impairment.

The eligibility for the federal home and community-based services program in the Health Security Act is 3 ADLs and it is designed to target those with very severe disabilities.

- Stricter Deductibility Rules for Services -- The Chafee bill would clarify the tax deductibility as an itemized medical expense for qualified long-term care services incurred by an individual that requires assistance with at least 3 ADLs (2 ADLs for home care). The Health Security Act provides similar clarification of the deductibility but requires assistance only with 2 ADLs, with no distinction between institutional and home care.

- Effective Dates -- The long-term care provisions in the Health Security Act apply to contracts issued after 12/31/95. The Chafee provisions take effect for contracts entered into after 12/31/94. Under the Chafee bill, the cost to the federal government begins sooner, with less time available for insurers and federal agencies to prepare for fiscally sound administration of the policy.

- Less Responsible Accelerated Death Benefits' Provision -- Both the Health Security Act and Chafee allow death benefits to be received prior to death in the case of an insured who is terminally ill. But, the Health Security Act prevents insurers and their policyholders from abusing the tax deferral allowed for investment earnings within a life insurance contract. Specifically, the Act requires that a contract's cash value must be reduced in proportion to the accelerated payout of a death benefit. The Chafee bill does not contain similar provisions.

4. Policy Effects

Weaknesses in the Chafee bill are that it:

- Provides an open-ended entitlement in that it fails to limit the benefits that can be received tax free from a "reimbursement" long-term care contract

- Requires severe (3 activities of daily living ("ADLs")) impairment before long-term care benefits can be received tax free (today's long-term care insurance market has a looser - 2 ADL - standard and thus the Chafee bill has limited practical value)

- Does not allow long-term care benefits to be received free from tax due to severe cognitive impairment (today's long-term care insurance contracts typically provide benefits upon the suffering of severe cognitive impairment)

- Creates a tax system that favors reimbursement over per diem

long-term care contracts, causing an inappropriate distortion in the marketplace

- Provides tax treatment that is too favorable (more favorable than that provided in pension, health, life insurance, or any other tax-favored benefit) because of medical savings accounts' usage, and potential for cafeteria plan usage, for long-term care insurance

- Lacks adequate safeguards against abuse of the accelerated death benefit provision

5. Background

Chafee Is Much Like The Secretary's Long-Term Care Bill -- The Chafee bill is similar to the long-term care bill that was introduced by then Senator Bentsen and others in 1992. However, it has not been updated to reflect changes that have occurred in the long-term care market since that bill was drafted.

The Chafee bill:

- Clarifies the tax treatment of qualified long-term care services for the chronically ill.

- Allows a tax deduction to individuals and employers for the purchase of a long-term care insurance contract.

- Permits benefits to be received tax free, subject to certain limitations, from a long-term care contract.

- Allows life insurance benefits to be received tax free prior to death if the insured is terminally ill.

- Allows long-term care insurance and long-term care services to be provided through a medical savings account.

TOPIC: FEDERAL SUBSIDIES

1. Current Law

The closest analogue to federal subsidies in the current health care system is payments through the Medicaid program. In FY 1993, the federal government paid an estimated $72.8 billion for Medicaid benefits. $20.2 billion went to Medicaid benefits for those receiving cash assistance (AFDC, SSI), and $12.1 billion for Medicaid benefits to those who were otherwise categorically eligible for Medicaid. An additional $9.3 billion in federal monies went for disproportionate share payments to hospitals The remaining $31.2 billion went for long term care and benefits to those dually eligible for Medicare and Medicaid.

2. Federal Subsidies Under Chafee

Vouchers which may be applied against the cost of the premium for a qualified health plan are given to qualified families. The voucher amount is equal to the lesser of:

a. the plan premium, and
b. the voucher percentage times the dollar limit for each family type.

The voucher percentage is equal to:

$$\textit{Voucher}\ \%=100\%-\left(\frac{100\%}{140\%}*(\textit{family income}-100\%\ \textit{poverty})\right)$$

And the applicable dollar limit for each family type (adjusted with respect to the age of the principal enrollee) is equal to the average premium cost of the lowest priced one half of standard benefit packages of qualified plans.

Cost sharing for the low income non-Medicare population (< 200% of poverty) is also subsidized. The AHP is required to lower the cost sharing to a nominal amount. The federal government then pays:

$$\left(\frac{\textit{total cost sharing \$}}{\textit{number of units}}\right)*\left(\frac{\textit{avg value of cost sharing assistance withi}}{\textit{avg value of cost sharing assistance in a}}\right)$$

There is a wrap program for the very low income (those below 100% of poverty) which covers prescription drugs, eyeglasses, hearing aids, and other services commonly provided under Medicaid. The wrap program explicitly excludes services in the standard package and long term care.

A phase-in percentage schedule delineates the income levels (as a percentage of poverty) which are permitted subsidy assistance in

each calendar year. In the first year, only those at or below 90% of poverty are eligible. Full phase-in in the year 2005 includes those at or below 240% of poverty.

The total dollars available for subsidies are calculated as follows:

a. Total expenditures under Medicaid and Medicare are estimated for the year.

b. If the sum in (a.) is less than the baseline amount delineated in the legislation, and if the year is prior to full phase-in, then:

   In the following year, the applicable phase-in percentage can be increased so that aggregate expenditures do not exceed the baseline amount. The increased percentage cannot exceed the phase-in expenditure amount for the next year.

c. If the sum in (a.) is greater than the baseline amount, then:

   In the following year, the phase-in percentage is decreased by such amount that is estimated to result in an aggregate decrease in expenditures equal to the amount by which (a.) exceeded the baseline amount.

3. **Differences from Health Security Act**

- As a combination of employer and individual mandates, the HSA includes subsidies to employers as well as to individuals/families. The Chafee plan, being an individual mandate only, provides all subsidies to individuals/families.

- The income eligibility for federal subsidy dollars is fixed under the HSA. Under the Chafee plan, eligibility for federal subsidy dollars is phased in through the year 2005 by income level, and can fluctuate from the phase-in path based upon experience with Medicare and Medicaid savings achieved relative to the baseline delineated in the Act.

- Subsidies in the HSA are based upon the weighted average cost plan in the regional alliance. Subsidies in the Chafee plan are based upon the average of the lowest priced half of standard benefit plans.

4. **Policy Effects**

- Given the slow phase-in of the subsidies, universal coverage cannot be required until 2005.

- The mechanism that allows for fluctuations away from the phase-in schedule implies that universal coverage might be achieved much later than 2005, or that even after full phase-in has been accomplished, eligibility for subsidies could be reduced again.

TOPIC: ALLIANCES AND INSURANCE REFORM

1. Current Law

Alliances There is not currently any statutory basis for health alliances or purchasing cooperatives. ERISA -- in permitting employers to self-insure outside of state regulation of insurance -- in effect prevents states from establishing mandatory purchasing alliances. A number of voluntary, state-sponsored purchasing cooperatives for small employers have formed (e.g. California and Florida). There are a variety of private group purchasing arrangements, some of which operate in a manner similar to health alliances.

Insurance Reform Insurance practices are primarily regulated by the states and state laws related to availability of coverage and insurance rating practices vary significantly. In general, insurers are permitted to restrict access to health insurance offered to people with poor health status. Insurers also are permitted to adjust premiums based on health status and claims experience of covered people. In the past few years, many States have adopted laws that assure availability of coverage offered to small employers (under 25 or 50 employees) and to restrict premium variation related to health status or claims experience.

Group health insurance arrangements are also subject to fiduciary and other standards in ERISA. ERISA preemption of state laws prevents states from regulating self-funded employer plans.

2. Description of Bill's Provisions on Health Alliances

The Chafee bill does not require the formation of any type of health alliances or group purchasing cooperative.

A variety of insurance reform rules apply to employees in firms with 100 or fewer employees and to those unattached to an employer:

- Employees in small firms (100 employees or fewer) could enroll with any health plan in their area. Employers are not required to contribute towards coverage.

  (If a small employer makes a contribution towards a health plan, however, it is unclear if the bill permits an employee to use that contribution towards the purchase of coverage in another health plan.)

- Within a region, health plans would not be permitted to vary premiums charged to families working for small employers by health status. Health plans could, however, vary premiums by age (the premium for an older individual could be up to

twice the premium for a younger person).

The bill limits preexisting condition exclusion periods applied by AHPs to no more than six months. The exclusion period must be reduced or waived for enrollees who are continuously insured.

- Health plans would be subject to solvency standards established by the National Association of Insurance Commissioners.

- Health plans would be required to participate in risk adjustment systems administered by states.

The Chafee bill permits the formation of voluntary and competing health purchasing groups for small employers:

- Purchasing groups would be state chartered and operate under an elected board.

- A purchasing group would be required to accept any employee of a small business (or a self-employed or unemployed person) who wished to enroll.

- A purchasing group would be required to offer any health plan that wished to be offered through the group, and could not set or enforce payment rates for providers.

- The premium charged by health plan to a purchasing group or to an individual or employer not affiliated with a purchasing group could vary only by a factor reflecting differences in administrative costs (as well as age).

  So while the Chafee bill permits purchasing cooperatives to compete, the competition can occur only over service and administrative costs (as long as the access and rating rules are enforced).

The Chafee bill also permits small employers to band together and form Multiple Employer Welfare Arrangements (MEWAs) -- organizing a health plan around, for example, a trade association. MEWAs would operate under the rules applicable to large employers, meaning that they would be exempt from the insurance reforms that apply to small employers.

The Chafee bill includes no major insurance reform provisions for employers with more than 100 employees:

- Health plans would be permitted to charge experience-rated premiums to employers with more than 100 employees.

- The Chafee bill requires employers to make available to its

employees a plan with the standard benefits package and a plan with the catastrophic benefits package (regardless of whether or not the employer contributes towards the coverage).

- If an employer contributes towards the cost of coverage, employees must enroll in a plan offered by the employer. If an employer does not make a contribution, a majority of employees may vote to require the employer to offer a particular health plan.

- A large employer plan may be self-insured, though the Chafee bill does not provide for a federal guaranty fund for self-insured plans.

- The Secretary of Labor establishes financial solvency standards for large employer health plans.

3. <u>Differences from the Health Security Act</u>

Primary differences from the Health Security Act are:

- The HSA requires all employers with fewer than 5,000 employees to participate in a regional health alliance.

  The Chafee bill has no such requirement. To the extent purchasing groups exist under the Chafee bill, they would be voluntary and competing.

- Health plans under the HSA must charge the same premium to all persons in an alliance, while health plans under the Chafee bill may vary premiums by the age of the participant. For employers with more than 100 employees, there are no restrictions on how premiums may vary under the Chafee bill.

- The Chafee bill does not require the creation of health alliances or purchasing groups. However, the insurance reforms applying to employees of businesses with 100 or fewer employees serve to create a risk pool similar to a health alliance. Under the Chafee bill, this risk pool would be limited to small employers, while under the HSA it would extend to employers with up to 5,000 employees.

- Under the HSA, enrollment would occur exclusively through health alliances. Under the Chafee bill, enrollment directly through insurance companies is likely to continue, meaning greater opportunities for cherry-picking by insurance companies.

- Large employers under the HSA are required to offer employees a choice of at least three plans. Employers with

more than 100 employees under the Chafee plan are required to make available only one plan.

- Alliances under the HSA are required to negotiate a provider fee schedule for use by fee-for-service plans, and are permitted to exclude a health plan whose premium is more than 120% of the alliance's premium target. Purchasing groups under the Chafee plan do not have either of these authorities.

- The HSA prohibits balance-billing by health care providers. The Chafee bill does not.

- Alliances under HSA are subject to conflict of interest, fiduciary and cash management standards. HSA also requires independent and federal audits of alliances. The Chafee bill contains no provisions relating to fiduciary or cash management standards for purchasing groups.

- Without protection from balance-billing, competitive pressures on AHPs and providers may result in a shifting of costs to enrollees. Balance billing also distorts competition since consumers will not know the true out-of-pocket costs associated with each health plan.

4. **Policy Effects**

- The benefits of insurance reforms under the Chafee bill would be limited to employees of small businesses (100 or fewer employee), the self-employed, and the unemployed. If an employer has 101 employees and one of them gets sick, there is no limit on how much an insurance company can raise the company's premium.

- Alliances and the choice mechanism proposed in the Chafee bill permit families, rather than employers, to choose their health plan. Under the Chafee bill, however, no one working for an employer with more than 100 employees is guaranteed choice. An employer could offer only an HMO to its employees, with no opportunity to see a doctor outside of the HMO.

- Less choice also means less continuity of coverage. Under the Chafee bill, changing jobs would likely mean having to change health plans (and possibly doctors) as well. This is particularly true since the Chafee bill provides no guarantee that a fee-for-service plan is available to people working for small or large employers.
- Permitting Multiple Employer Welfare Arrangements (MEWAs) to exist would create a significant loophole in the Chafee bill's insurance reforms for small employers. MEWAs are difficult to regulate, and would allow associations to skim

off healthy families leaving sicker families and higher premiums in insured plans available to small employers.

- Permitting employers with as few as 101 employees to self-insure threatens the health security of their employees (since these firms are not large enough to adequately assume risk). Without a federal guaranty fund for self-insured plans, consumers and providers could at substantial risk.

5. **Background**

- The Chafee bill seeks to permit families (at least those working for small employers) the ability to choose health plans, but without an alliance or purchasing group structure.

Offering a family choice mechanism without alliances means:

- Administrative costs will likely be higher, since there is no centralized mechanism for collecting premiums and paying health plans and no benefit from economies of scale.

- Greater regulation of the insurance market is required. Conducting enrollment and premium payment through alliances means that insurance reforms are enforced automatically, without the need for a separate policing mechanism.

- Insurance companies will be able to avoid sick enrollees using subtle means that can never be effectively regulated. The ability of insurance companies to engage in risk selection activities rests largely on their ability to enroll people through direct contact. An agent of an insurance company could, for example, simply delay sending an application to a prospective enrollee from an undeserved area.

  Enrollment through alliances -- with requirements that any marketing materials be distributed through a health plan's service area -- makes avoiding sick enrollees much more difficult.

- Approximately 215 million people would obtain coverage through regional alliances under the HSA, while about 115 million would receive the benefits of choice and modified community rating (based on age) under the Chafee bill. Under the HSA, about one-third of the participants in regional alliances would be under 200% of poverty, while about half of the participants in the "community rated" pool would be under 200% of poverty under the Chafee bill.

- The ability of the federal government to monitor self-insured firms deteriorates significantly as the number of

such firms grows. Under the HSA, no more than a couple of thousand of firms would be eligible to form corporate alliances, and therefore self-insure. Under the Chafee bill, 50,000 to 100,000 firms with more than 100 employees would be able to self-insure.

TOPIC: COST CONTAINMENT

1. **Current Law**

The market for health plans does not function well:

- Approximately 40% of employees with employer sponsored insurance have no choice of plans;
- Most (80%) of those with a choice do not fully benefit financially from choosing a lower cost plan;
- When choice does exist, consumers do not have information on satisfaction or quality;
- When choice does exist, benefit packages often vary across plans, segmenting the market and making people nervous about changing plans for fear of not being covered by a benefit they need;
- Providers that serve large numbers of uninsured and Medicaid recipients are forced to charge higher prices to their paying patients in order to recover their costs; hence these providers cannot prosper even if they are able to deliver high quality care economically.
- Health plans can prosper by selecting good risks -- they can drop small groups from coverage when one or more members becomes sick; they can refuse to insure the sick, and/or apply pre-existing condition exclusions and waiting periods; they can discourage the sick from enrolling by charging high premiums; they can subtly encourage their sickest members to disenroll; they can refuse to contract with Medicaid and avoid many of the poor.
- As a result of these market failures, health plans and providers that lower their price and improve their quality do not necessarily gain additional subscribers.
- In addition to market failure, no regulatory mechanism exists to achieve cost containment in the private sector.

2. **Chafee Proposal**

The Chafee bill reorganizes the health insurance market by:

- Requiring health plans to accept all employers and individual purchasers.
- Requiring risk adjustment for health plans in the small employer and individual market.

- Requiring modified community rating (with adjustments for age and differences in administrative expenses) for individual purchasers and those working for employers with 100 or fewer employees.

- Requiring individuals to have health insurance by the year 2005.

- Capping the tax exclusion for health benefits (to the weighted average of the costs of those health plans with premiums below the weighted average of all health plans in HCCA.

- Providing for the creation of voluntary small employer purchasing groups.

- Providing for the creation of a standard package and a catastrophic package.

3. **Difference from the Health Security Act**

- The requirements in the Chafee bill regarding family choice of health plan are not clear. While it is clear that families in the small employer and individual market can go to any health plan in their HCCA, it is not clear that employees of small employers can take any employer contributions to other health plans. It appears that the employer can limit their contribution to one health plan.

  Employees of large employers only must be offered a standard and a catastrophic plan. If the employer makes a contribution, the employees must purchase health care from the health plan(s) chosen by the employer. If the employer does not make a contribution, the employees must purchase from the health plan(s) offered by the employer unless 50% of employees vote for the employer to offer another health plan. The HSA requires that all families be provided choice of health plan.

- The Chafee bill has a tax cap pegged to the average price of the plans below the average price in each HCCP area. The HSA does not have a tax cap; after the year 2004, only employer contributions for the comprehensive benefit package will be excludable from wages.

- The Chafee bill does not prohibit balance billing. The HSA prohibits balance billing by all providers.

- The Chafee bill does not have a single point of enrollment for families purchasing through purchasing groups. The HSA has all families purchasing through alliances.

- The Chafee proposal authorizes multiple employer welfare arrangements, or MEWAs. There are no requirements set forth in the bill relating to eligibility of who can be part of a MEWA (today they are generally are small employers). The HSA does not permit MEWAs for employers of less than 5000.

- The Chafee bill provides for a standard and a catastrophic benefit package. The HSA provides for a comprehensive benefit package.

- The Chafee bill does not have a provision for premium caps.

4. Policy Effects

- Large employers are not required to offer choice of health plan under the Chafee bill. Reduced family choice will reduce the competitive pressures on health plans and attenuate the rewards to health plans that are able to offer a quality product at a good price.

  It is unclear if there is real choice of health plan in the small employer market, because it is unclear whether families can take their employer contribution to any health plan they wish.

- Because health plans can directly market to and enroll individuals, there are still significant opportunities for risk selection by health plans. Without a common point of enrollment, families may face obstacles to enrolling in one or more health plans. Risk selection and the lack of a common point of enrollment will reduce the amount of competition based solely on price and service.

- The Chafee proposal permits MEWAs to be certified by the Department of Labor. MEWAs can attract small employers to their pool by competing against the coverage offered by health plans to small employers and individual purchasers. MEWAs could remove healthier small employers from the individual pool, reducing its size and ability to spread risk.

  It appears MEWAs would be able to select which employers participate (either by affiliation with a trade organization, by location, etc.), leading to tremendous risk selection against the community-rated small employer and individual market.

- Without protection from balance-billing, competitive pressures on health plans and providers may result in a shifting of costs to enrollees. Balance billing also distorts competition since consumers will not know the true out-of-pocket costs associated with each health plan.

- The Chafee bill does not achieve universal coverage until the year 2005. Until universal coverage is achieved, uncompensated care will continue to be a problems and will continue to distort competition.
- Without a cap on private sector premiums, employers, families and taxpayers bear the risks of cost increases.
- If states exercise the option to enroll some Medicaid recipients into health plans, these plans would be at a competitive disadvantage because the payments made for Medicaid recipients are inadequate.

TOPIC: INFORMATION SYSTEMS

For the most part the bills do not differ substantially with regard to Information systems, Administrative Simplification and Privacy. All three bills envision a national information network with minimum electronic data standards, privacy protection and standardized forms.

Some differences that are notable include:

The panel making decisions for information systems is only comprised of Federal agency representatives. It is advised by the National Health Information Commission comprised of representatives for the various outside stake holders. OMB promulgates the proposed and final rules submitted by the panel.

> The composition of the panel could create unnecessary bias toward current Federal systems. The OMB role is not consistent with our general oversight function and would create resource and legal responsibilities that could be troublesome.

Clearinghouse requirement insofar as a participant in the health care system is not automated.

> The automation requirement is placed on all participants in the health care system including providers. This additional automation cost could be perceived as unduly burdensome.

Stipulations on additional data requirement - two participants "voluntarily" agreeing or waivers for additional requirements.

> Depending upon what constitutes voluntary, particularly between plans and providers the waiver process could get very cumbersome. It is unclear why we should care about maintaining records according to standards as long as they can be reconfigured to meet the standard. This stringency is appropriate to interchange standards to allow interoperability.

Establishment of a uniform working file and underlying code sets. Code sets will be implemented in the least disruptive way with a minimum of 90 days notice.

> A 90 day minimum will be considered unrealistic for any substantial change.

Establishment of data standards for a computerized patient record (CPR) within 3 years of enactment.

> 3 years for CPR standards will also be considered

unrealistic.

Both the Cooper and Chaffee bills seem more definitive with respect to information systems standards for address coordination of benefits.

TOPIC: OTHER GOVERNMENT PROGRAMS

FEHB

Under Section 1202(d), FEHB plans would be required to meets the standard set forth in this bill, without regard to the requirements of chapter 89 of title 5. The standards affect the following areas:

- Guaranteed eligibility as described in sec. 1111. (Must be available to "eligible employees." Under this bill, an eligible employee is someone who normally works at least 30 hours a week. Temporary employee don't seem to be excluded as they are under FEHB. However, since OPM has regulatory discretion in this area, we could bring FEHB into compliance if this bill were to pass.))

- Nondiscrimination under Sec. 1112. (This section allows more limitations on preexisting conditions that does FEHB.)

- Benefits as described in section 1301 (sec. 1113).

- Enrollment as described in section 1115. (Provides for initial enrollment period, annual open season, enrollment based on changes in family status, employment status, or residence. Effective dates would be based on standards not yet specified. Under FEHB, we regulate effective dates that avoid gaps in coverage to the extent possible. It appears that this bill would allow greater gaps in coverage than FEHB currently allows and that effective dates under this bill would override FEHB's effective dates.)

- Collection and provisions of standardized information under section 1118. (This is information that a qualified health plan must provide the State. States have no jurisdiction over OPM's contract with plans. This requirement would be particularly meaningless with regard to Government-wide plans. This is related the requirement under section 1405 that States make information available to purchasing groups and employers regarding that State's qualified health plans. It is also related to a "health care data interchange system" created under section 3301.)

- Quality assurance under section 1119 that complies with standards developed under section 3001. Since these standards would not be developed until after the passage of the bill, we can't assess their impact on FEHB at this point.)

- Financial solvency under section 1114. (Plans would be required to meet certain unspecified financial requirements. It also would make an enrollee not liable for bills the

insurer was supposed to pay but didn't. Under FEHB, we already look at the financial circumstances of the plans with which we contact. Since the requirements aren't specified, we can't assess their impact on FEHB. Removing liability from the enrollee is unlikely to have the outcome that the drafters of this anticipate. Providers, insurers, and enrollees may have widely divergent views on whether or not a plan should pay a specific bill. Enrollees will be caught in the middle, just as they are now.)

- Payment of premiums under sec. 1116(g). (This would allow the plan to require advance payment of the premium. It also allows the employee to pay directly in the event the employer fails to send the payment to the plan. Neither advance payment of premiums nor direct payment of premiums to the plan by the enroll is compatible with the FEHB Program. The system is set up so that payments are withheld from the pay that accrues during the period of coverage. Since the Government doesn't actually pay the employee for 10 days after the end of that pay period, the employee withholdings and Government contribution don't happen until the payroll paid date. Further, all premiums collected come to OPM's account and OPM pays the plans the portion of the amount collected that is required by law. The individual employees to whom the premiums apply are not specified. If an employing office fails to make withholdings for an employee, the plan cannot know that it has happened, much less identify the employee for whom payment was not made.

- Mediation of malpractice claims under section 1120 based on standards developed under section 4011. (This may be applicable to group practice plans; however, fee-for-service plans would not normally be involved with a malpractice suit against a provider. In case for IPA's, it would depend on whether suit was brought against the provider or the plan.)

- Different benefit packages under section 1203. (This would require a large employer to offer a plan the includes the standard benefits package only, and a plan that also includes the catastrophic package. This provision would largely gut the FEHB Program, since the benefit structure proposed in this bill would replace the structure that now exists under FEHB.)

Benefits structure under this bill:

- Standard package would include--

  Medical and surgical services (and supplies incident to such service)
  Medical equipment

Prescription drugs and biologicals
Preventive services
Rehabilitation and home health services related to and acute care episodes
Service for severe mental illness.
Substance abuse services
Hospice services
Emergency transportation for non-elective medically necessary services in frontier and similar areas.
Cost-sharing features (deductibles, copayments, and out-of-pocket limits)

- Catastrophic package would include--

A general deductible amount and an out-of-pocket limit on cost sharing established for a standard package (and may include other deductibles, copayments and coinsurance).

Benefits structure under FEHB:

Under the FEHB law, the type of benefits to be offered under the Service Benefits Plan and Indemnity Benefit plan are specified. Other plans must offer benefits similar to those specified for the 2 Government wide plans. The Benefits specified for the Service Benefit Plan are:

Hospital benefits
Surgical benefits
In-hospital benefits
Ambulatory patients benefits
Supplemental benefits
Obstetrical benefits.

Within this broad framework, plans currently offer a wide variety of benefits package. Most packages include catastrophic coverage. To comply with this bill we would either have to require that at least one fee-for-service plan drop coverage for catastrophic coverage or drop catastrophic coverage from low options. Since the plans compete with each other, it would not be desirable to forcing some plan into a non-competitive position. On the other hand, since most people who have Medicare coverage have low option FEHB coverage, which gives them the catastrophic coverage they need at a reasonable cost. Forcing them into high option to get catastrophic coverage would raise their cost significantly without giving them anything they don't have now.

Taxation of employer contributions

"Excess" employee contributions would be taxable. Whether contributions are excess or not depends on the cost of other plans in a geographic area, determined with respect to the age of

an individual. FEHB rates do not vary by age nor do fee-for-service plan rates vary by geographic area. This bill contemplates that all plans would be geographically based, which would not be true for FEHB fee-for-service plans. In isn't clear how this "excess" employee contribution could be fairly applied to Federal workers. Also, the bill required that determination be made on a monthly basis; however, most Federal employees are paid on a biweekly basis.

Retirees:

I can't tell for sure what happens generally to people who retire before age 65 when Medicare begins. I think they become "eligible individuals" who can enrolled in a qualified plan and pay premiums directly to the plan. If this is the case, I don't think there is any impact on FEHB retirees who are not yet age 65. It's less clear whether a surviving spouse who is working could be considered an "eligible individual" and so continue enrollment in FEHB as a survivor annuitant. (Also, we still have post-age 65 retirees and survivor annuitants who do not have one or both parts of Medicare.)

It appears that SSA could make monthly payments to a qualified health plan on behalf of a medicare beneficiary as part of the payment of the premium. This wouldn't make any sense for Federal retirees because we withhold the annuitant's share and make the Government contribution to the plan as a part of the aggregate of the withholdings and contributions for all enrollees in the plan. Premiums couldn't be offset by amounts paid by SSA to the plans.

Low income workers

This bill would provide a complicated voucher system for low paid workers. These vouchers would be given to the plan in which they were enrolled to offset the premiums. It is not clear how this would work in the case of Federal employees; the concept of giving the vouchers to the plans wouldn't work for the same reason as explained above for Medicare beneficiaries.

Conclusion:

While this bill appears to let FEHB stand, it actually overrides major portions of the FEHB law. The remaining portions of the FEHB law would remain as binding as ever. It is not clear that the resulting hybrid would be viable as a staff health benefits program.